STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of University Park	2420 Pemberton Rd Richmond, VA 23233

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 27660 Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure the privacy of resident information on one of six medication carts. The findings include: An observation was made on 4/22/2024 at 11:32 a.m. of RN (registered nurse) #1 administering medications on the 200 hallway. RN #1 entered a resident room, while leaving her report sheet on top of the cart. The report sheet contained resident's room numbers, names, vital signs, and notes regarding the residents. This information was left where residents or family members could see. While RN #1 was in a room, five residents went past her medication cart and one family member walked by. An interview was conducted with RN #1 on 4/22/2024 at 11:50 p.m. When asked why the document was on the cart, with resident information visible, RN #1 stated she should have turned it over. When asked why, RN #1 stated because of resident privacy. The facility policy, Guest/Resident Rights documented in part, The staff will safeguard the privacy of guests/residents protected health information from improper use and disclosure and will inform the guest/resident both orally and in writing of his or her rights as a resident, as well as the rules and regulations governing the guests/ residents conduct and responsibilities during his or her stay at the facility. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator, were made aware of the above concern on 4/23/2024 at 4:50 p.m. No further information was provided prior to exit.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to evidence the required documents were sent to the hospital upon transfer for two of 39 residents in the survey sample, Resident #2 and Resident #137. The findings include: 1. For Resident #2, the facility staff failed to evidence the required documents were sent to the hospital with the resident on 1/7/2024. The nurse's note dated, 1/7/2024 at 1:09 a.m. documented, Guest called 911 requesting transport. States to paramedics c/o (complaint of) chest pain. Guest did not notify staff at any point of chest discomfort or SOB (shortness of breath). Guest medicated due to c/o coughing episode only. Guest currently being transported to (Name of hospital). Further review of the clinical record failed to evidence what documents were sent with the resident to the hospital. An interview was conducted with LPN (licensed practical nurse) #7 on 4/24/2024 at 10:35 a.m. When asked what documents are sent with the resident if they are transferred to the hospital, LPN #7 stated she sends the face sheet, medication list, diagnoses list, bed hold policy and the care plan. When asked if the resident calls 911 do you still send the paperwork, LPN #7 stated yes. LPN #7 was asked where you document the paperwork that is sent to the hospital, LPN #7 stated it should be documented in a nurse's note. On 04/24/2024 at 12:37 p.m., ASM (administrative staff member) #3, the regional clinical coordinator, stated she had no documentation of what papers went to the hospital. She stated it was a resident-initiated transfer, the resident called 911. When asked if the papers sent should still be sent and documented, ASM #3 stated, yes. The facility policy, Transfer and Discharge documented in part, A transfer form is completed, a list of medications and a copy of the care plan goals is sent to the receiving hospital. Nursing documents the transfer in the medical record. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, were made aware of the above concern on 4/24/2024 at 2:03 p.m. No further information was obtained prior to exit. 2. For Resident #137, the facility staff failed to evidence the required documents were sent to the hospital with the resident on 2/4/2024. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 2/4/2024 at 6:52 p.m. documented in part, At 10:15 a.m. Resident was brought by her physical therapist this morning concerning her rapid breathing. Physical therapist has stated her respirations was 40. Nurse practitioner has assessed resident signs and her symptoms . Resident is not verbally responding to the nurse. Resident was only just looked at the nurse .Nurse Practitioner has stated to send resident out to the ER (emergency room) to be evaluated. Writer (nurse) has called 911 and emergency response team has arrived and sent the resident to (name of hospital) at 10:30 A.M. Called RP (responsible party) left voicemail to give the facility a return call. Further review of the clinical record failed to evidence what documents were sent with the resident to the hospital. On 4/24/2024 at 1:19 p.m., ASM #3 presented a copy of the SNF/NF Transfer to hospital form. When asked if it documents the paperwork that was sent with th resident, ASM #3 stated, no. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, were made aware of the above concern on 4/24/2024 at 2:03 p.m. No further information was obtained prior to exit.

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide a bed hold notice upon transfer for two of 39 residents in the survey sample, Resident #2 and Resident #137. The findings include: 1. For Resident #2, the facility staff failed to provide a bed hold notice upon transfer to the hospital on 1/7/2024. The nurse's note dated, 1/7/2024 at 1:09 a.m. documented, Guest called 911 requesting transport. States to paramedics c/o (complaint of) chest pain. Guest did not notify staff at any point of chest discomfort pr SOB (shortness of breath). Guest medicated due to c/o coughing episode only. Guest currently being transported to (Name of hospital). Further review of the clinical record failed to evidence what documents were sent with the resident to the hospital. An interview was conducted with LPN (licensed practical nurse) #7 on 4/24/2024 at 10:35 a.m. When asked what documents are sent with the resident if they are transferred to the hospital, LPN #7 stated she sends the face sheet, medication list, diagnoses list, bed hold policy and the care plan. When asked if the resident calls 911 do you still send the paperwork, LPN #7 stated yet. LPN #7 was asked where you document the paperwork that is sent to the hospital, LPN #7 stated it should be documented in a nurse's note. On 4/24/2024 at 12:37 p.m., ASM (administrative staff member) #3, the regional clinical coordinator, she stated she had no documentation of what papers went to the hospital or evidence of the bed hold. She stated it was a resident-initiated transfer, the resident called 911. When asked if the required papers should still be sent and documented, yes. Should the bed hold be sent also, ASM #3 stated, yes and documented in the clinical record. The facility policy, Bed Hold, documented in part, 2. Within 24 hours of a hospital transfer the Admission Director or designee will contact the Resident and/or Responsible Party regarding the possible length of transfer and offer a bed hold. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, were made aware of the above concern on 4/24/2024 at 2:03 p.m. No further information was obtained prior to exit. 2. For Resident #137, the facility staff failed to provide a bed hold notice upon transfer to the hospital on 2/4/2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 2/4/2024 at 6:52 p.m. documented in part, At 10:15 a.m. Resident was brought by her physical therapist this morning concerning her rapid breathing. Physical therapist has stated her respirations was 40. Nurse practitioner has assessed resident signs and her symptoms . Resident is not verbally responding to the nurse. Resident was only just looked at the nurse .Nurse Practitioner has stated to send resident out to the ER (emergency room) to be evaluated. Writer (nurse) has called 911 and emergency response team has arrived and sent the resident to (name of hospital) at 10:30 A.M. Called RP (responsible party) left voicemail to give the facility a return call. Further review of the clinical record failed to evidence what documents were sent with the resident to the hospital. On 4/24/2024 at 1:19 p.m., ASM #3 presented a copy of the SNF/NF Transfer to hospital form. When asked if it documents the paperwork that was sent with the resident, ASM #3 stated, no. ASM #3 stated, there is no evidence of a bed hold either. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, were made aware of the above concern on 4/24/2024 at 2:03 p.m. No further information was obtained prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure accurate MDS assessments for one of 39 residents in the survey sample; Resident #63. The findings include: For Resident #63, the facility staff failed to accurately code the MDS (Minimum Data Set) assessments regarding the administration of insulin. The 3/20/24 quarterly, 9/28/23 quarterly, and 6/28/23 annual MDS assessments were coded as the resident being on insulin, having received one insulin injection during the seven day look back period. The resident was on Trulicity (1), which was not an insulin. The resident was not on any prescribed insulin. A review of the above MDS assessments revealed the following: In Section N - Medications, was documented, Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. In the box was typed 1 for one day. The next part, Insulin documented, Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days. In the box was typed 1 for one injection of insulin. A review of the clinical record revealed an order dated 11/8/22 for Trulicity, 0.75 mg (milligrams) / 0.5 ml (milliliters) injection every Tuesday. Further review of the clinical record revealed there were no active insulin orders at the time of any of the above MDS assessments. On 4/24/24 at 10:50 AM, an interview was conducted with RN #2 (Registered Nurse) the MDS nurse. She stated that there were new MDS staff who misunderstood about coding insulin injections. She stated that it was coded incorrectly, and that they probably confused it with insulin because it is an injection used for diabetes. The facility policy, Accuracy of MDS was reviewed. This policy documented, Purpose: The Accuracy of the MDS must be verified to ensure that the residents strengths, weaknesses, status and areas of actual decline or risk of decline are addressed to provide quality care and to develop and individualized plan of care for the resident. Accuracy is also necessary as the MDS is directly responsible and linked to the Medicare Prospective Payment System, state Medicaid reimbursement programs, Quality Indicator Reports, Public Reporting, Research and development of Policies. Procedure: 1. Each individual that completes a section of the MDS must verify accuracy of the MDS as specified by the MDS 3.0 User's manual by: Review of the resident's record, Observation of the resident, Communication with the resident, direct care staff, physician, family and licensed professionals, Any other route by which information needs to be obtained (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 2:15 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing and ASM #3 the Regional Clinical Coordinator were made aware of the findings. No further information was provided by the end of the survey. References: (1) Trulicity - Dulaglutide injection is in a class of medications called incretin mimetics. It works by helping the pancreas to release the right amount of insulin when blood sugar levels are high. Information obtained from https://medlineplus.gov/druginfo/meds/a614047.html

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure a PASARR was completed accurately for one of 39 residents in the survey sample; Resident #20. The findings include: For Resident #20, the facility staff failed to ensure the PASARR (Pre Admission Screening and Resident Review) was completed accurately to determine if the resident did or did not have a mental condition requiring additional services. A review of the clinical record for Resident #20 revealed a PASARR form, dated 7/20/22. This form documented the following: 2. DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)? Yes No (Check Yes only if each item below are all Yes. If No, do not refer for evaluation of active treatment needs for MI (mental illness) Diagnosis.) a. Is this major mental disorder diagnosable under DSM (Diagnostic and Statistical Manual of Mental Disorders) (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or other mental disorder that may lead to a chronic disability)? Yes No b. Has the disorder resulted in functional limitations in major life activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace; and adaptation to change? Yes No c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? Yes No In the above form, for Question #2, does the individual have a current serious mental illness, was marked Yes. However, each of the following three questions, Items a, b, and c, were all marked No. This was not in accordance with the instructions documented above to Check Yes (for Question #2) only if each item below (a, b, and c) are all Yes. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 8:52 AM, an interview was conducted with OSM #1 (Other Staff Member) the Director of Social Services. She stated the PASARR was not completed correctly. She stated that the facility would not know if the resident needed any kind of additional services, based on the way it was completed. She stated that is she saw one come in like that, the facility would have to make an adjustment and do another one because that one was not correct. She stated that the resident either she has a mental illness or she doesn't and the way the PASARR was completed did not reflect which status was accurate for the resident. The facility policy, Pre-Admission Screening and Guest/Resident Review - PASARR Virginia was reviewed. This policy documented, screen all individuals admitted for nursing care to ensure that needs are met to assist the individual in reaching their highest potential. All persons seeking admission to a nursing facility, who are seriously mentally ill and/or have an intellectual/developmental disability, are required to be evaluated to determine if a nursing facility is the appropriate place to receive services Complete: a new Level 1/DMAS 95 (PASARR screening) for the following changes in condition: 1. An incorrect Level 1/DMAS 95 received upon admission . On 4/24/24 at 2:15 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing and ASM #3 the Regional Clinical Coordinator were made aware of the findings. No further information was provided by the end of the survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observations, resident/staff interviews, facility document review and clinical record review, it was determined the facility staff failed to develop/implement the care plan for five of 39 residents in the survey sample, Residents #17, #18, #35, #135 and #189. The findings include: 1.The facility staff failed to develop the comprehensive care plan for anticoagulation therapy for Resident #17. Resident #17 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: CHF (congestive heart failure) and DM (diabetes mellitus). A review of the comprehensive care plan dated 4/18/24, which revealed, FOCUS: Resident is at nutritional and/or dehydration risk related to: edema, CHF and DM. Requires therapeutic diet and mechanically altered diet with fluid restriction. INTERVENTIONS: Provide diet as ordered. Fluid Restriction: 1800cc. There is no evidence of anticoagulation therapy on the care plan. A review of the physician's order dated 3/28/24 revealed, Eliquis Oral Tablet 5 MG (milligram) Give 5 mg by mouth every 12 hours. An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked the purpose of the care plan, LPN #3 stated, it is to develop the plans for the resident to receive care. When asked if anticoagulation therapy should be on the care plan, LPN #3 stated, yes, it should. When asked what should be included, LPN #3 stated, monitoring for bruising/bleeding and notifying the physician if this occurs. On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. A review of the facility's Care Planning policy revealed, In addition to care plans based on admission orders, goals for admission and desired outcomes, IDT (interdisciplinary team) assessments, physician orders, dietary needs, therapy services, social services, PASSAR (preadmission screening and resident review) recommendations, and discharge plans the baseline care plans are triggered in PCC (point click care) from the Nursing Comprehensive assessment. No further information was provided prior to exit. 2.The facility staff failed to develop the comprehensive care plan for anticoagulation therapy for Resident #18. Resident #18 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: CHF (congestive heart failure), acute respiratory failure and chronic kidney disease stage III. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the comprehensive care plan dated 3/6/24, which revealed, FOCUS: Resident is at nutritional and/or dehydration risk related to: CHF and respiratory failure. Requires therapeutic diet with fluid restriction. INTERVENTIONS: Encourage to follow fluid restriction order: 2000cc. There is no evidence of anticoagulation therapy on the care plan. A review of the physician's order dated 2/29/24 revealed, Apixaban Oral Tablet 2.5 MG (milligram) Give 2.5 mg by mouth two times a day. An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked the purpose of the care plan, LPN #3 stated, it is to develop the plans for the resident to receive care. When asked if anticoagulation therapy should be on the care plan, LPN #3 stated, yes, it should. When asked what should be included, LPN #3 stated, monitoring for bruising/bleeding and notifying the physician if this occurs. On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. No further information was provided prior to exit. 3. The facility failed to develop the comprehensive care plan for dialysis care and to implement the care plan for oxygen therapy for Resident #35. Resident #35 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: ESRD (end stage renal disease), COPD (chronic obstructive pulmonary disease) and diabetes. A review of the comprehensive care plan dated 3/20/24 and revised 4/22/24, which revealed, FOCUS: Resident is at risk for complications related to dialysis due to: End Stage Renal Disease. Resident has a potential for difficulty breathing and risk for respiratory complications related to: Asthma, COPD, SOB (shortness of breath) with exertion and when lying flat. INTERVENTIONS: Observe signs/symptoms of the following: Bleeding, Bruising, Hemorrhage, presence of aneurysm, Bacteremia & septic shock. Document and report abnormal findings to the physician. Oxygen 2LPM continuously. Administer medication & treatments per physician orders. Monitor for ineffectiveness, side effects and adverse reactions, report abnormal findings to the physician. There is no evidence of monitoring for bruit/thrill of fistula. A review of the physician's orders dated 4/11/24, revealed, Oxygen continuous @ 2Liters nasal cannula (lnc). A review of the physician's orders dated 4/23/24, revealed, Hemodialysis Tuesday, Thursday, Saturday. Observe dialysis catheter for bleeding, infection, and catheter caps intact. every shift. Observe dialysis site for thrombosis, bleeding, stenosis, infection, Steal Syndrome, and aneurysm every shift for HD (hemodialysis). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked the purpose of the care plan, LPN #3 stated, it is to develop the plans for the resident to receive care. When asked if dialysis care should be on the care plan, LPN #3 stated, yes, it should. When asked what should be included, LPN #3 stated, monitoring the bruit/thrill and for bleeding and notifying the physician if this occurs. When asked if oxygen is set at a rate different from what is in physician orders and on the care plan, has the care plan been implemented, LPN #3 stated, no, it was not implemented. On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. No further information was provided prior to exit. 4. The facility staff failed to develop the comprehensive care plan for anticoagulation therapy for Resident #35. Resident #135 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: breast cancer with metastasis to the bone and DM (diabetes mellitus). A review of the comprehensive care plan dated 3/8/24, which revealed, FOCUS: Resident is at risk for is at risk for pain and has acute/chronic pain related to low back pain. INTERVENTIONS: Offer Non-Pharmacological Interventions: 1) Massage, 2) Meditation/Relaxation, 3) Positioning, 4) Ice/cold pack, 5) Diversional Activity, 6) Guided Imagery, 7) Rest, 8) Social Interaction. Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal finding to the physician. There is no evidence of anticoagulation therapy on the care plan. A review of the physician orders dated 3/8/24 revealed, Apixaban Oral Tablet 5 MG (milligram) Give 1 tablet by mouth two times a day for anticoagulant. An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked the purpose of the care plan, LPN #3 stated, it is to develop the plans for the resident to receive care. When asked if anticoagulation therapy should be on the care plan, LPN #3 stated, yes, it should. When asked what should be included, LPN #3 stated, monitoring for bruising/bleeding and notifying the physician if this occurs. On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. No further information was provided prior to exit. 27660 5. For Resident #189, the facility staff failed to implement the comprehensive care plan to administer treatments for pressure injuries (1). The comprehensive care plan dated, 2/2/2022, documented in part, Focus: (Resident #189) is at risk for impaired skin integrity/pressure injury and currently has PU (pressure ulcer - injury) on admission. The Interventions documented in part, Tx (treatment) as ordered. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sacral Wound The physician order dated, 10/15/2022, documented, Cleanse sacral wound with ns (normal saline) and apply hydrofera blue (3) and secure with island border dsg (dressing) QD (every day; every evening for wound care. The November 2022 TAR (treatment administration record) documented the above order. On 11/12/2022, there was a blank where the treatment was to be documented as completed. The physician order dated 1/8/2023 documented, Cleanse sacral wound with Dakin's solution (4), apply hydrofera blue and secure with island border dsg QD every evening shift for wound care. The January2023 TAR documented the above order. On 1/22/2023 and 1/24/2023, there was a blank where the treatment was to be documented as completed. Review of the nurse's notes failed to evidence documentation as to why the dressings were not completed. Left Heel The physician order dated 10/15/2022, documented, Cleanse wound left heel with NS, apply medihoney (5) with calcium alginate (6) and secure island border dsg every evening shift for wound care. The November 2023, TAR documented the above order. On 11/12/2023, there was a blank where the treatment was to be documented as completed. The December 2023 TAR documented the above order. On 12/8/2023 and 12/19/2023, there was a blank where the treatment was to be documented as completed. The January 2023 TAR documented the above order. On 1/4/2023 and 1/5/2023, there was a blank where the treatment was to be documented as completed. The physician order dated 1/7/2023, documented, Cleanse wound left heel with Dakin's, apply Dakin's moistened gauze with gentamicin ointment (antibiotic), wrap with kerlix and secure with retention tape, every evening shift for wound care. The January 2023 TAR documented the above order. On 1/22/2023 and 1252023, there was a blank where the treatment was to be documented as completed. Review of the nurse's notes failed to evidence documentation as to why the dressings were not completed. Right heel The physician order dated, 1/12/2023, documented, Iodine to right heel QD preventative every evening shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The January 2023 TAR documented the above order. On 1/22/2023 and 1/24/2023, there was a blank where the treatment was to be documented as completed. Review of the nurse's notes failed to evidence documentation as to why the dressings were not completed. An interview was conducted with LPN (licensed practical nurse) #1 on 4/24/2024 at 10:17 a.m. When asked the purpose of the care plan LPN #1 stated it's to assist the resident in their needs. LPN #1 was asked if the care plan should be followed, LPN #1 stated, yes. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator, were made aware of the above concern on 4/24/2024 at 2:03 p.m. No further information was obtained prior to exit. References: (1) Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf (2) Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf (3) Hydrofera Blue -- A foam dressing bound with gentian violet and methylene blue (GV/MB) antibacterial agents (Hydrofera Blue; [NAME] Wound Care, Libertyville, IL) has been shown to be effective against a wide spectrum of microorganisms found in wounds, including methicillin-resistant staphylococcus aureus (MRSA), vancomycin-resistant enterococcus VRE and Candida. This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4717508/ (4) Dakin's solution: Dilute Dakin solution (0.05% to 0.025%) can be used to irrigate, cleanse, or as a component in wet-to-dry dressings to treat or prevent skin and soft tissue infections.[5] This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/books/NBK507916/ (5) Medi - honey (medical honey) Applying honey preparations directly to wounds or using dressings containing honey seems to improve healing. Honey seems to reduce odors and pus, help clean the wound, reduce infection, reduce pain, and decrease time to healing. This information was obtained from the following website: https://medlineplus.gov/druginfo/natural/738.html. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(6) Calcium alginate is a highly absorbent, biodegradable alginate dressing derived from seaweed. Alginate dressings maintain a physiologically moist microenvironment that promotes healing and the formation of granulation tissue cover with dry dressing. This information was obtained from the following website: https://www.o-wm.com/content/wonder-calcium-alginate.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide ADL care of a dependent resident to one of 39 residents in the survey sample; Resident #136. The findings include: For Resident #136, the facility staff failed to evidence that ADL care was provided. Resident #136 was admitted to the facility on [DATE] and discharged on [DATE]. A review of the ADL (Activities of Daily Living) record for December 2023 and January 2024 revealed that the resident was to have showers on Mondays and Thursdays. In December 2023 there were seven opportunities for a shower. There were four showers documented. One occasion contained documentation that the resident was unavailable. On two occasions, no shower was documented. In January 2024 there were seven opportunities for a shower. There were four showers documented. On three occasions, no shower was documented. The facility's ADL logs did not include a line item for documenting any bathing outside of shower days. Therefore it could not be determined how much bathing, if any, the resident received outside of showers. On 4/24/24 at 11:43 AM, an interview was conducted with CNA #2 (Certified Nursing Assistant). She stated that regarding showers, it should be documented on the ADL log. She stated that if it was not documented, then she would assume the resident didn't get the shower and the nurse should be notified of it. A policy regarding ADL care - showers/bathing was requested. None was provided. On 4/24/24 at 2:15 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing and ASM #3 the Regional Clinical Coordinator were made aware of the findings. No further information was provided by the end of the survey.

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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** 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure four of 39 residents in the survey sample, received care and services in accordance with professional standards of practice and the comprehensive care plan, Residents #2, #17, #18, and #135. The findings include: 1. For Resident #2, the facility staff failed to follow physician orders for obtaining weights and notifying the provider of a change in weight. The physician order dated, 3/31/2024, documented, Weights in the morning every Mon, Wed, Fri for HF (heart failure). NOTIFY PROVIDED IF WEIGHT GAIN OF 3 LBS (POUNDS) IN 24 HOURS OR 5 LBS IN A WEEK. The MAR (medication administration record) for April 2024, documented the above order. There were no weights documented on 4/5/2024 and 4/12/2024. Further review of the Weight tab in the medical, record failed to evidence weights for those two days. The MAR documented the following weights: 4/15/2024 - 238.2 4/22/2024 - 244.2 An increase of 6.2 pounds in a week. Review of the nurse's notes failed to evidence documentation of notification to the nurse practitioner or physician of the gain of over five pounds in one week. An interview was conducted with LPN (licensed practical nurse) #7 on 4/24/2024 at 10:35 a.m. The above order was reviewed with LPN #7. When asked what the nurse should do with this order, LPN #7 stated they should carry it through. LPN #7 was asked where to document the notification of the physician or nurse practitioner, LPN #7 stated they document it in the communication book and in the nurse's notes. When asked what the blanks on the MAR where there were not any weights documented, LPN #7 stated, It's the golden rule, if not documented not done. The facility policy, Physician Orders, documented in part, Treatment rendered to a resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician or other licensed health professional ordering within their scope of practice and clinical privileges. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator, were made aware of the above concern on 4/24/2024 at 2:03 p.m. No further information was obtained prior to exit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42183 2. The facility failed to evidence monitoring of anticoagulation side effects for Resident #17. Resident #17 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: CHF (congestive heart failure) and DM (diabetes mellitus). A review of the comprehensive care plan dated 4/18/24, which revealed, FOCUS: Resident is at nutritional and/or dehydration risk related to: edema, CHF and DM. Requires therapeutic diet and mechanically altered diet with fluid restriction. INTERVENTIONS: Provide diet as ordered. Fluid Restriction: 1800cc. A review of the physician's order dated 3/28/24 revealed, Eliquis Oral Tablet 5 MG (milligram) Give 5 mg by mouth every 12 hours. A review of the March and April MAR/TAR (medication administration record/treatment administration record) revealed no evidence of anticoagulation monitoring. An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked the process for monitoring anticoagulants, LPN #3 stated, we would assess the resident for signs of bruising and bleeding. When asked where the anticoagulation monitoring would be documented, LPN #3 stated, it would be documented on the MAR/TAR. Asked if the documentation was missing what that indicated, LPN #3 stated, it means that it was not done. On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. A review of the facility's Anticoagulation Therapy policy revealed, Throughout anticoagulant therapy monitor the resident for signs and symptoms of bleeding. If signs and symptoms of bleeding are noted, hold anticoagulant medication and notify physician immediately. No further information was provided prior to exit. 3. The facility failed to evidence monitoring of anticoagulation side effects for Resident #18. Resident #18 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: CHF (congestive heart failure), acute respiratory failure and chronic kidney disease stage III. A review of the comprehensive care plan dated 3/6/24, which revealed, FOCUS: Resident is at nutritional and/or dehydration risk related to: CHF and respiratory failure. Requires therapeutic diet with fluid restriction. INTERVENTIONS: Encourage to follow fluid restriction order: 2000cc. A review of the physician's order dated 2/29/24 revealed, Apixaban Oral Tablet 2.5 MG (milligram) Give 2.5 mg by mouth two times a day. A review of the March and April MAR/TAR (medication administration record/treatment administration record) revealed no evidence of anticoagulation monitoring. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked the process for monitoring anticoagulants, LPN #3 stated, we would assess the resident for signs of bruising and bleeding. When asked where the anticoagulation monitoring would be documented, LPN #3 stated, it would be documented on the MAR/TAR. Asked if the documentation was missing what that indicated, LPN #3 stated, it means that it was not done. On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. No further information was provided prior to exit. 4. The facility failed to evidence monitoring of anticoagulation side effects for Resident #135. Resident #135 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: breast cancer with metastasis to the bone and DM (diabetes mellitus). A review of the comprehensive care plan dated 3/8/24, which revealed, FOCUS: Resident is at risk for is at risk for pain and has acute/chronic pain related to low back pain. INTERVENTIONS: Offer Non-Pharmacological Interventions: 1) Massage, 2) Meditation/Relaxation, 3) Positioning, 4) Ice/cold pack, 5) Diversional Activity, 6) Guided Imagery, 7) Rest, 8) Social Interaction. Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal finding to the physician. A review of the physician orders dated 3/8/24 revealed, Apixaban Oral Tablet 5 MG (milligram) Give 1 tablet by mouth two times a day for anticoagulant. A review of the March and April MAR/TAR (medication administration record/treatment administration record) revealed no evidence of anticoagulation monitoring. An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked the process for monitoring anticoagulants, LPN #3 stated, we would assess the resident for signs of bruising and bleeding. When asked where the anticoagulation monitoring would be documented, LPN #3 stated, it would be documented on the MAR/TAR. Asked if the documentation was missing what that indicated, LPN #3 stated, it means that it was not done. On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. No further information was provided prior to exit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide care and services for the treatment of pressure injuries for one of 39 residents in the survey sample, Resident #189. The findings include: For Resident #189, the facility staff failed to evidence, the treatments for pressure injuries (1), were completed per the physician orders. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/4/2022, the resident scored a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section M - Skin Conditions, the resident was coded as having two stage three pressure injuries (2). Sacral Wound The physician order dated, 10/15/2022, documented, Cleanse sacral wound with ns (normal saline) and apply hydrofera blue (3) and secure with island border dsg (dressing) QD (every day; every evening for wound care. The November 2022 TAR (treatment administration record) documented the above order. On 11/12/2022, there was a blank where the treatment was to be documented as completed. The physician order dated 1/8/2023 documented, Cleanse sacral wound with Dakin's solution (4), apply hydrofera blue and secure with island border dsg QD every evening shift for wound care. The January2023 TAR documented the above order. On 1/22/2023 and 1/24/2023, there was a blank where the treatment was to be documented as completed. Review of the nurse's notes failed to evidence documentation as to why the dressings were not completed. Left Heel The physician order dated 10/15/2022, documented, Cleanse wound left heel with NS, apply medihoney (5) with calcium alginate (6) and secure island border dsg every evening shift for wound care. The November 2023, TAR documented the above order. On 11/12/2023, there was a blank where the treatment was to be documented as completed. The December 2023 TAR documented the above order. On 12/8/2023 and 12/19/2023, there was a blank where the treatment was to be documented as completed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The January 2023 TAR documented the above order. On 1/4/2023 and 1/5/2023, there was a blank where the treatment was to be documented as completed. The physician order dated 1/7/2023, documented, Cleanse wound left heel with Dakin's, apply Dakin's moistened gauze with gentamicin ointment (antibiotic), wrap with kerlix and secure with retention tape, every evening shift for wound care. The January 2023 TAR documented the above order. On 1/22/2023 and 1252023, there was a blank where the treatment was to be documented as completed. Review of the nurse's notes failed to evidence documentation as to why the dressings were not completed. Right heel The physician order dated, 1/12/2023, documented, Iodine to right heel QD preventative every evening shift. The January 2023 TAR documented the above order. On 1/22/2023 and 1/24/2023, there was a blank where the treatment was to be documented as completed. Review of the nurse's notes failed to evidence documentation as to why the dressings were not completed. The comprehensive care plan dated, 2/2/2022, documented in part, Focus: (Resident #189) is at risk for impaired skin integrity/pressure injury and currently has PU (pressure ulcer - injury) on admission. The Interventions documented in part, Tx (treatment) as ordered. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 4/23/2024 at 5:01 p.m. When asked what blanks on the TAR indicated, ASM #2 stated, In general, it would indicate the employee did not document the medication or treatment. ASM #2 was asked how you can tell if the nurse did the treatment, ASM #2 stated, It does not disclose if it was done or not. An interview was conducted with LPN (licensed practical nurse) #1 on 4242024 at 10:17 a.m. When asked what a blank on the TAR indicated, LPN #1 stated, if it's not documented it wasn't done. The facility policy, Skin Management documented in part, Guest/residents with wounds and/or pressure injuries and those at risk for skin compromise, are identified, evaluated and provided appropriate treatment to promote prevention and healing. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, were made aware of the above concern on 4/24/2024 at 2:03 p.m. No further information was obtained prior to exit. References: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf (2) Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. This information was obtained from the following website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf (3) Hydrofera Blue -- A foam dressing bound with gentian violet and methylene blue (GV/MB) antibacterial agents (Hydrofera Blue; [NAME] Wound Care, Libertyville, IL) has been shown to be effective against a wide spectrum of microorganisms found in wounds, including methicillin-resistant staphylococcus aureus (MRSA), vancomycin-resistant enterococcus VRE and Candida. This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4717508/ (4) Dakin's solution: Dilute Dakin solution (0.05% to 0.025%) can be used to irrigate, cleanse, or as a component in wet-to-dry dressings to treat or prevent skin and soft tissue infections.[5] This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/books/NBK507916/ (5) Medi - honey (medical honey) Applying honey preparations directly to wounds or using dressings containing honey seems to improve healing. Honey seems to reduce odors and pus, help clean the wound, reduce infection, reduce pain, and decrease time to healing. This information was obtained from the following website: https://medlineplus.gov/druginfo/natural/738.html. (6) Calcium alginate is a highly absorbent, biodegradable alginate dressing derived from seaweed. Alginate dressings maintain a physiologically moist microenvironment that promotes healing and the formation of granulation tissue cover with dry dressing. This information was obtained from the following website: https://www.o-wm.com/content/wonder-calcium-alginate.

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The Laurels of University Park	2420 Pemberton Rd Richmond, VA 23233

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to provide monitoring for fluid restriction and intake for three of 39 residents, Resident #17, Resident #18 and Resident #35. The findings include: 1.The facility failed to provide monitoring for fluid restriction and intake for Resident #17. Resident #17 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: CHF (congestive heart failure) and DM (diabetes mellitus). A review of the comprehensive care plan dated 4/18/24, which revealed, FOCUS: Resident is at nutritional and/or dehydration risk related to: edema, CHF and DM. Requires therapeutic diet and mechanically altered diet with fluid restriction. INTERVENTIONS: Provide diet as ordered. Fluid Restriction: 1800cc. A review of the physician's orders dated 3/28/24, revealed, Fluid Restriction diet Chopped Meat texture, Regular consistency, 1800ml per day 720 ml nursing/ 1080 ml kitchen for CHF. A review of the March 2024 MAR (Medication Administration Record) did not evidence any fluid restriction. A review of the April 2024 MAR revealed that day shift was allocated 300 ml, evening 300 ml and night shift 120 ml. On 4/13/24 and 4/14/24 day shift documented 330 ml; and on evening shifts 4/6/24, 4/7/24, 4/9/24, 4/11/24, 4/12/24 and 4/13/24 documented 330 ml exceeding the fluid restriction amount. An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked how fluid restrictions are determined, LPN #3 stated, the physician writes the order then dietary and nursing divide the amount. When asked where evidence of fluid restriction is documented, LPN #3 stated, it would be on the MAR (Medication Administration Record). On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. A review of the facility's Fluid Restriction policy revealed, Upon notification of a fluid restriction via physician order, the Dietary Manager meets with the Charge Nurse to determine the amount of total fluid that will be provided by each department. The Dietary Manager visits with the guest/resident and adjusts their beverage preferences to adhere to the fluid restriction. The guest/resident and family are educated on the fluid restriction and documented in the medical record. No further information was provided prior to exit. 2.The facility failed to provide monitoring for fluid restriction and intake for Resident #18. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #18 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: CHF (congestive heart failure), acute respiratory failure and chronic kidney disease stage III. A review of the comprehensive care plan dated 3/6/24, which revealed, FOCUS: Resident is at nutritional and/or dehydration risk related to: CHF and respiratory failure. Requires therapeutic diet with fluid restriction. INTERVENTIONS: Encourage to follow fluid restriction order: 2000cc. A review of the physician's orders dated 2/29/24, revealed, No Added Salt diet Regular texture, Thin consistency, small portions per guest request-2000CC FR (fluid restriction). A review of the March and April 2024 MAR revealed missing documentation on following shifts and dates: day shift: 3/24/24, 4/5/24; evening shift: 3/22/24, 3/23/24, 3/25/24, 4/1/24 and night shift: 3/21/24, 3/23/24 and 4/5/24. An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked how fluid restrictions are determined, LPN #3 stated, the physician writes the order then dietary and nursing divide the amount. When asked where evidence of fluid restriction is documented, LPN #3 stated, it would be on the MAR (Medication Administration Record). On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. A review of the facility's Fluid Restriction policy revealed, Upon notification of a fluid restriction via physician order, the Dietary Manager meets with the Charge Nurse to determine the amount of total fluid that will be provided by each department. The Dietary Manager visits with the guest/resident and adjusts their beverage preferences to adhere to the fluid restriction. The guest/resident and family are educated on the fluid restriction and documented in the medical record. No further information was provided prior to exit. 3.The facility failed to provide monitoring for fluid restriction and intake for Resident #35. Resident #35 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: ESRD (end stage renal disease), COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure) and DM (diabetes mellitus). A review of the comprehensive care plan dated 4/18/24, which revealed, FOCUS: Resident is at nutritional and/or dehydration risk related to: CHF, ESRD, COPD and DM. Requires therapeutic diet with fluid restriction. INTERVENTIONS: Provide diet as ordered. Fluid Restriction: 1500cc. A review of the physician's orders dated 4/16/24, revealed, No Added Salt diet Regular texture, Regular consistency, 1500cc Fluid restriction: 800cc dietary/700cc nursing. A review of the April 2024 MAR did not evidence any fluid restriction. An interview was conducted on 4/24/24 at 9:40 AM with Resident #35. When asked if they knew their fluid restriction Resident #35 stated, no, I do not. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked how fluid restrictions are determined, LPN #3 stated, the physician writes the order then dietary and nursing divide the amount. When asked where evidence of fluid restriction is documented, LPN #3 stated, it would be on the MAR (Medication Administration Record). On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. A review of the facility's Fluid Restriction policy revealed, Upon notification of a fluid restriction via physician order, the Dietary Manager meets with the Charge Nurse to determine the amount of total fluid that will be provided by each department. The Dietary Manager visits with the guest/resident and adjusts their beverage preferences to adhere to the fluid restriction. The guest/resident and family are educated on the fluid restriction and documented in the medical record. No further information was provided prior to exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29843 Based on observation, resident interview, staff interview, and clinical record review, it was determined that facility staff failed to provide respiratory care and services for four of 39 residents in the survey sample, Resident #s (R) R32, R38, R 35 and R2. The findings include: 1a. For R32, the facility staff failed to store a Bi-PAP mask (1) in a sanitary manner. R32 was admitted to the facility with diagnoses that included but were not limited to obstructive sleep apnea (2) and COPD (chronic obstructive pulmonary disease) (3). On the most recent comprehensive MDS (minimum data set), a 5-Day admission assessment with an ARD (assessment reference date) of 01/04/2024, R32 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R32 was cognitively intact for making daily decisions. On 04/22/2024 at approximately 1:00 p.m., an observation of R32's Bi-PAP mask revealed it was laying on top of the bed side table uncovered. On 04/22/2024 at approximately 2:05 p.m., an observation of R32's Bi-PAP mask revealed it was laying on top of the bed side table uncovered. On 04/23/2024 at approximately 8:20 a.m., an observation of R32's Bi-PAP mask revealed it was laying on top of the bed side table uncovered. The physician's order for R32 dated 04/16/2024 documented in part, Check BI-PAP placement and function on night shift, every night shift for sleep apnea. Order Date: 4/16/2024. On 04/22/2024 at approximately 2:15 p.m., an interview was conducted with R32. When asked about the Bi-PAP mask R32 stated she uses the Bi-PAP at night for sleep apnea. She further stated that the nurse takes it off her in the morning and puts it on her at night. On 04/24/2024 at approximately 10:22 a.m., an interview was conducted with LPN #1 regarding R32's Bi-PAP mask. When informed of the observations of R32's Bi-PAP mask being uncovered LPN #1 stated that it should be placed in a plastic bag when it is not being used. On 04/23/2024 at approximately 4:45 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit. References: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) Stands for Bi-level Positive Airway Pressure. A BiPAP machine is a non-invasive form of therapy for patients suffering from sleep apnea. It deliver pressurized air through a mask to the patient's airways. The air pressure keeps the throat muscles from collapsing and reducing obstructions by acting as a splint. A BiPAP machines allow patients to breathe easily and regularly throughout the night. This information was obtained from the website: https://www.alaskasleep.com/blog/what-is-bipap-therapy-machine-bilevel-positive-airway-pressure. (2) Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html. (3) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 1b. For R32, facility staff failed to administer oxygen according to the physician's orders. The physician's order for R32 dated 04/16/2024 documented in part, O2 (oxygen) at 6 LPM (liters per minute) via (by) NC (nasal cannula) when on portable tank, as needed for COPD. Order Date: 04/24/2024. 8:47 a.m. On 04/24/2024 at 10:25 a.m., an observation of R32's oxygen flow meter on portable oxygen cylinder position of the back of R32's wheelchair revealed she was receiving oxygen at four liter per minute. On 04/24/2024 at approximately 10:22 a.m., an interview was conducted with LPN #1 ([NAME]) regarding R32's oxygen flow rate on the portable oxygen cylinder. At 10:25 a.m., an observation conducted with LPN #1 of R32 revealed she was sitting in her wheelchair receiving oxygen by nasal cannula. Further observation with LPN #1 of the portable oxygen cylinder positioned on the back of R32's wheelchair revealed an oxygen flow rate of four liters per minute. After a review of R32's physician's orders for oxygen as stated above LPN #1 stated the flow rate should have been at six liters per minute. The facility's policy Physician's Orders documented in part, Treatment rendered to a resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician or other licensed health professional ordering within their scope of practice and clinical privileges. On 04/23/2024 at approximately 4:45 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit. 2. For R38, facility staff failed to administer Oxygen according to the physician's order. R38 was admitted to the facility with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease) (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/06/2024, R38 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R38 was cognitively intact for making daily decisions. Section O Special Treatments, Procedures and Programs coded R38 as receiving oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/23/2024 at 9:47 a.m., an observation of R38 revealed he was laying in bed. Further observation revealed an oxygen concentrator next to his bed running and the oxygen tubing and nasal cannula laying on the floor in front of the oxygen concentrator and R38 not receiving oxygen. At 10:11 a.m., an observation revealed R38 laying in bed and LPN (licensed practical nurse) #1 enter R38's room and spoke with him then left the room. Further observation revealed the oxygen concentrator next to his bed running and the oxygen tubing and nasal cannula laying on the floor in front of the oxygen concentrator and R38 was not receiving oxygen. At 10:14 a.m., LPN #1 re-entered R38's room and provided him a beverage and left the room. Further observation revealed the oxygen tubing and nasal cannula in the same position as stated above and R38 was not receiving oxygen. At 10:28 a.m., an observation revealed LPN #1 entered R38's room, administered his medications then left the room. Further observation revealed R38 was not receiving oxygen. On 04/23/2024 at approximately 10:45 a.m., an interview was conducted with LPN #1. After reviewing the physician's order for R38's oxygen she was asked to explain what was indicated by Oxygen continuous. LPN #1 stated R38 was to receive oxygen all, the time. When informed of the observation stated above LPN #1 stated that R38 refused the oxygen. When asked at what point in time did R38 refuse the oxygen she stated that she asked R38 when she administered his medication. When asked if R38 received his oxygen from 9:47 a.m. to 10:28 a.m., approximately 41 minutes, LPN #1 stated no. When asked if R38 should have been offered his oxygen earlier LPN #1 stated yes. The physician's order for R38 dated 02/06/2024 documented in part, Oxygen Continuous at 2L (two liters) via (by) NC (nasal cannula) while in bed every shift for COPD. Order Date: 2/06/2024. On 04/23/2024 at approximately 4:45 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit. References: (1) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 42183 3. The facility staff failed to provide respiratory therapy per physician orders for Resident #35. Observations of Resident #35's oxygen setting on 4/22/24 at 12:45 PM and 4/24/24 at 9:30 AM revealed the oxygen setting was at 3 lnc (liters nasal cannula). Resident #35 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: ESRD (end stage renal disease), COPD (chronic obstructive pulmonary disease) and diabetes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the comprehensive care plan dated 4/22/24, which revealed, FOCUS: Resident has a potential for difficulty breathing and risk for respiratory complications related to: Asthma, COPD, SOB (shortness of breath) with exertion and when lying flat. INTERVENTIONS: Oxygen 2LPM continuously. Administer medication & treatments per physician orders. Monitor for ineffectiveness, side effects and adverse reactions, report abnormal findings to the physician. A review of the physician's orders dated 4/11/24, revealed, Oxygen continuous @ 2Liters nasal cannula (lnc). An interview was conducted on 4/22/24 at 12:45 PM with Resident #35. When asked if they knew what their oxygen setting was, Resident #35 stated, it is on 2 liters. An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked the oxygen setting, LPN #3 stated, it is on 3 lnc, it should be on 2 lnc. When asked where she read the oxygen level, LPN #3 stated, the line should be in the middle of the ball. On 4/24/24 at 2:05 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. A review of the facility's Use of Oxygen policy revealed, To promote guest/resident safety in administering oxygen. No further information was provided prior to exit. 27660 4. For Resident #2, the facility staff failed to store a BiPap (1) mask in a sanitary manner. On the most recent MDS (Minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/12/2024, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using a Non-invasive Mechanical Ventilator. Observation was made of Resident #2's BiPap machine 4/23/2024 at 10:46 a.m. The BiPap mask was hanging over the BiPap machine, not contained or covered. An interview was conducted with Resident #2, she stated the staff hand her, her mask and she puts it on and off but they put it on the machine. Resident #2 further stated she believed the mask should be stored in a bag during the day when it's not in use to keep it clean. The physician order dated, 2/15/2024 documented, BiPap on q(every) hs (hours of sleep) a set by pulmonologist with 3 liters of oxygen. Dx (Diagnosis): Sleep apnea every day and evening shift for sleep apnea. An interview was conducted with LPN (licensed practical nurse) #7 on 4/24/24 at 10:35 a.m. When asked how a BiPap mask is to be stored when not in use, LPN #7 stated the mask is usually put in a zip lock baggies to store them in. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the above concern on 4/24/2024 at 2:03 p.m. No further information was obtained prior to exit. (1) Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. Bilevel positive airway pressure (BiPAP or BIPAP) has a higher pressure when you breathe in and lower pressure when you breathe out. This information was obtained from the following website: https://medlineplus.gov/ency/article/001916.htm.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29843 Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program for three of 39 residents in the survey sample, Resident #s R97, R38 and R135. The findings include: 1. For R97, the facility staff failed to attempt non-pharmacological interventions prior to the administration of a prn (as needed) pain medications of Oxycodone (1) 5mg (five milligrams). On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 04/04/2024, R97 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R97 was cognitively intact for making daily decisions. Section J Pain Management coded R97 as having occasional pain at a pain level of five out of ten, with ten being the worse pain. The physician order for R97 documented in part, Oxycodone Tablet 5MG. Give 1 (one) tablet by mouth every 8 (eight) hours as needed for pain. Order Date: 11/29/2023. The eMAR (electronic medication administration record) for R97 dated April 2024 documented the physician's orders as stated above. The eMAR revealed that R97 received Oxycodone 5mg on 04/02/2024 at 5:26 a.m. with a pain level of four, 04/07/2024 at 5:00 a.m. with pain level of five, on 04/14/2024 at 8:17 a.m. with a pain level of three, 04/15/2024 at 6:16 a.m. with a pain level of seven, 04/20/2024 at 1:06 a.m. with a pain level of five, 04/21/2024 at 6:44 a.m. with a pain level of four, and on 04/22/2024 at 1:18 a.m. with a pain level of four and at 10:15 p.m. with a pain level of eight. Further review of the April 2024 eMAR failed to document evidence of non-pharmacological interventions for the dates and times listed above. The facility's progress notes for R97 for the dates and times listed above on the eMARs dated 04/01/2024 through 04/23/2024 failed to evidence documentation of non-pharmacological interventions. On 04/23/24 at approximately 10:58 a.m., an interview was conducted with R97 regarding the prn pain medication. When asked if the nursing staff attempt non-pharmacological interventions before administering his prn pain medication R97 stated the nurses try most of the time. On 04/23/2024 at approximately 2:30 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When to describe the procedure for administering prn pain medications LPN #1 stated she would assess the resident, ask the where the location of the resident's pain is, try non-pharmacological interventions, and if the interventions were not effective, administer the medication that was prescribed. LPN #1 further stated that non-pharmacological interventions should always be attempted before administering the prn pain medication. When asked where it would be documented that the non-pharmacological interventions were attempted, she stated in the nursing notes or on the eMAR. LPN #1 was asked to review the eMAR and progress notes for R97 for documented evidence of non-pharmacological interventions being attempted on the above dates. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/24/2024 at approximately 10:10 a.m., an interview was conducted with LPN #1 regarding the documentation of non-pharmacological interventions for R97. After reviewing the nursing progress notes and the April 2024 eMAR for the dates and times listed above, LPN #1 stated that it appeared that the interventions were not attempted. The facility's policy Pain Management documented in part, Individualized interventions related to that resident's individual control of pain management should include both pharmacological, non-pharmacological and include Complementary and Alternative Medicine (CAM) pain management interventions. On 04/23/2024 at approximately 4:45 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit. References: (1) Oxycodone is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html. 2. For R38, the facility staff failed to attempt non-pharmacological interventions prior to the administration of a prn (as needed) pain medications of Oxycodone (1) 5mg (milligrams) and Acetaminophen (2) 650mg. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/06/2024, R38 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R38 was cognitively intact for making daily decisions. Section J Pain Management coded R97 as having occasional pain at a pain level of four out of ten, with ten being the worse pain. The physician order for R38 documented in part, Oxycodone Tablet 5MG. Give 1 (one) tablet by mouth every 8 (eight) hours as needed for pain. Order Date: 2/06/2024 and Acetaminophen Tablet 650MG. Give 2 (two) tablet by mouth every 4 (four) hours as needed for General Discomfort/Pain. Order Date: 2/06/2024. The eMAR (electronic medication administration record) for R38 dated April 2024 documented the physician's orders as stated above. The eMAR revealed that R38 received Oxycodone 5mg Oxycodone on 04/07/2024 at 10:36 a.m. with a pain level of seven, on 04/09/2024 at 11:00 a.m. with a pain level of three, on 04/10/2024 at 10:22 a.m. with a pain level of two, on 04/14/2024 at 9:05 p.m. with a pain level of three, on 04/20/2024 at 1:03 p.m. with a pain level of five and at 11:15 a.m. with a pain level of eight, on 04/21/2024 at 12:22 p.m. with a pain level of five, on 04/23/2024 at 10:24 a.m. with a pain level of three and on 04/24/2024 at 3:15 a.m. with a pain level of seven. The April eMAR further documented R38 received Acetaminophen on 04/04/2024 at 5:52 p.m. with a pain level of two, on 04/05/2024 at 7:06 p.m. with a pain level of three, on 04/09/2024 at 6:30 p.m. with a pain level of four, on 04/12/2024 at 4:20 p.m. with a pain level of five, on 04/19/2024 at 4:43 a.m. with a pain level of four, and on 04/20/2024 at 3:41 p.m. with a pain level of five. Further review of the April 2024 eMAR failed to document evidence of non-pharmacological interventions for the dates and times listed above. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's progress notes for R38 for the dates and times listed above on the eMARs dated 04/01/2024 through 04/23/2024 failed to evidence documentation of non-pharmacological interventions. On 04/23/2024 at approximately 2:30 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked to describe how they determine which prn (as needed) pain medication to administer a when the physician has ordered two pain medications, LPN #1 stated go by the pain level on the physician's order and use the residents pain level. When asked to describe the procedure she would follow if the physician's orders do not specify the pain level for each prn pain medication LPN #1 stated she would use her nursing judgement. When asked to describe the procedure for administering prn pain medications LPN #1 stated she would assess the resident, ask the where the location of the resident's pain is, try non-pharmacological interventions, and if the interventions were not effective, administer the medication that was prescribed. LPN #1 further stated that non-pharmacological interventions should always be attempted before administering the prn pain medication. When asked where it would be documented that the non-pharmacological interventions were attempted, she stated in the nursing notes or on the eMAR. LPN #1 was asked to review the eMAR and progress notes for R38 for documented evidence of non-pharmacological interventions being attempted on the above dates. On 04/24/2024 at approximately 10:10 a.m., an interview was conducted with LPN #1 regarding the documentation of non-pharmacological interventions for R38. After reviewing the nursing progress notes and the April 2024 eMAR for the dates and times listed above, LPN #1 stated there was no documentation of non-pharmacological interventions being implemented and the order for the prn pain medications should have been clarified with a pain scale. LPN #1 further stated If the non-pharmacological interventions are not documented then they were not done. On 04/23/2024 at approximately 4:45 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit. References: (1) Oxycodone is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html. (2) Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html. 42183 3.The facility failed to provide a complete pain management program for Resident #135. Resident #135 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: breast cancer with metastasis to the bone and DM (diabetes mellitus). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the comprehensive care plan dated 3/8/24, which revealed, FOCUS: Resident is at risk for is at risk for pain and has acute/chronic pain related to low back pain. INTERVENTIONS: Offer Non-Pharmacological Interventions: 1) Massage, 2) Meditation/Relaxation, 3) Positioning, 4) Ice/cold pack, 5) Diversional Activity, 6) Guided Imagery, 7) Rest, 8) Social Interaction. Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal finding to the physician. A review of the physician orders dated 3/8/24 revealed, Pain-Non-Pharmacological Interventions: Document Non-Pharmacological interventions used: 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4)Ice/cold pack. 5) Diversional Activity. 6) Guided Imagery. 7) Rest. 8) Social Interaction. as needed Document Non-Pharmacological interventions using the corresponding number. A review of the March and April MAR (medication administration record) revealed the section to document Pain-Non-Pharmacological Interventions: Document Non-Pharmacological interventions used: 1) Massage. 2) Meditation/Relaxation. 3) Positioning. 4)Ice/cold pack. 5) Diversional Activity. 6) Guided Imagery. 7) Rest. 8) Social Interaction. as needed Document Non-Pharmacological interventions using the corresponding number was blank for both months. An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked the process to pain management, LPN #3 stated, we would assess the resident's pain level and implement non-pharmacological pain interventions. If they did not work, we would administer the pain medication ordered. When asked where the non-pharmacological pain interventions would be documented, LPN #3 stated, it would be documented on the MAR. Asked if the documentation was missing what that indicated, LPN #3 stated, it means that it was not done. On 4/23/24 at 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse was made aware of the findings. A review of the facility's Pain Management policy revealed, Each resident identified with pain will have a Pain Management Care Plan. The care plan will have: a consistent pain scale to measure the pain and frequency of re-evaluation, a desired level of pain reduction or acceptable level of pain, resident centered functional outcomes, pain monitoring and who will monitor for pain, nursing comfort measures to alleviate pain, potential adverse effects of treatment and individualized interventions related to that resident's individual control of pain management should include both pharmacological, non-pharmacological and include Complementary and Alternative Medicine (CAM) pain management interventions. No further information was provided prior to exit.

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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** 42183 Based on resident and staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 39 residents in the survey sample, Resident #35. The findings include: The facility failed to provide evidence of monitoring for bruit and thrill for Resident #35. Resident #35 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: ESRD (end stage renal disease) and diabetes. A review of the comprehensive care plan dated 3/20/24, which revealed, FOCUS: Resident is at risk for complications related to dialysis due to: End Stage Renal Disease. INTERVENTIONS: Observe signs/symptoms of the following: Bleeding, Bruising, Hemorrhage, presence of aneurysm, Bacteremia & septic shock. Document and report abnormal findings to the physician. A review of the physician's orders dated 4/23/24, revealed, Hemodialysis Tuesday, Thursday, Saturday. Observe dialysis catheter for bleeding, infection, and catheter caps intact. every shift. Observe dialysis site for thrombosis, bleeding, stenosis, infection, Steal Syndrome, and aneurysm every shift for HD (hemodialysis). A review of Resident #35's medical record evidenced that she went to dialysis on 3/21, 3/23, 3/26, 3/28, hospitalized ,d+[DATE]-[DATE], 4/16, 4/18, 4/20 and 4/23/24. A review of Resident #35's March and April 2024 MAR (medication administration record) and TAR (treatment administration record) revealed no evidence of assessment of bruit and thrill of left arm fistula. An interview was conducted on 4/22/24 at 12:45 PM with Resident #35. When asked if they monitor the bruit and thrill of her fistula, Resident #35 stated, no, I do not believe so. On 4/23/24 at 1:00 PM, ASM (administrative staff member) #2, the director of nursing, stated, we do not have the bruit and thrill evidence for this resident. An interview was conducted on 4/24/24 at 9:45 AM with LPN (licensed practical nurse) #3. When asked where the bruit and thrill are documented, LPN #3 stated, it would be documented on the TAR. Asked if the documentation was missing what that indicated, LPN #3 stated, it means that it was not done. On 4/23/24 at 4:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional quality nurse were made aware of the findings. A review of the facility's Hemodialysis policy revealed, Evaluate the resident daily for dialysis access site and possible complications, including, but not limited to: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Evaluation of the access site for: i. Thrombosis or bleeding, ii. Stenosis - small blue/purple veins. Constriction or narrowing within an orifice, iii. Infection - redness, drainage, abscess, warmth of the extremity. b. Thrill- palpation of the fistula site, it can be described as a purring vibration. c. Bruit- a continuous, machine-like sound that can be heard during auscultation with a stethoscope. It can also be described as a whooshing or a high pitched whistling. d. If the resident has a catheter for hemodialysis access, evaluate the catheter and site for: i. Bleeding, ii. Signs of infection, iii. To ensure that the catheter caps are intact. e. Notify physician of absence of bruit or thrill, signs of infection or other irregularity. No further information was provided prior to exit.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 29125 Based on staff interview, employee record review, and facility document review, it was determined that the facility staff failed to evidence annual performance reviews were conducted for six of six employee records reviewed. The findings include: On 4/23/24 and on 4/24/24, a request was made for annual evaluations for six CNA's (Certified Nursing Assistant), CNA#3, CNA #4, CNA #5, CNA #6, CNA #7, and CNA #8, for the most recently completed anniversary years. The anniversary years were as follows: CNA #3 was 6/30/22 to 6/30/23 CNA #4 was 3/10/23 to 3/10/24 CNA #5 was 10/2/22 to 10/2/23 CNA #6 was 11/15/22 to 11/15/23 CNA #7 was 10/23/22 to 10/23/23 CNA #8 was 9/2/22 to 9/2/23 On 4/24/24 at 11:00 AM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing (DON). She stated that she was not able to locate any of them. She stated that the time frames were prior to her transition to the role of DON. She stated she had been the DON since September, 2023. The facility policy, Staff Development was reviewed. This policy documented, Policy: Staff development includes the planning, coordination, provision, and management of orientation, and inservice activities for facility employees Procedure 9. A competency evaluation will be completed annually for all certified nurse aides / state tested nursing assistants. Training will be added to the calendar based on the weakness identified On 4/24/24 at 2:15 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing and ASM #3 the Regional Clinical Coordinator were made aware of the findings. No further information was provided by the end of the survey.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 29125 Based on staff interview and facility document review, it was determined that the facility staff failed to ensure that 25 out of 30 staff postings reviewed contained the required daily census information. The findings include: On 4/22/24, The daily staff posting for March 23, 2024 through April 21, 2024 was reviewed. This review revealed that the Census information was not included on 25 of the 30 days reviewed. On 4/22/24 at 3:30 PM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing (DON). She stated that the scheduler usually posts the daily staffing but that individual would not be in the facility on 4/22/24 and 4/23/24. She stated that in their absence, she, as the DON, posts it. She stated that the census information should be documented on the posting. She stated that she would be educating the scheduler on documenting the census information. A policy was requested regarding the daily staff posting. None was provided. On 4/24/24 at 2:15 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing and ASM #3 the Regional Clinical Coordinator were made aware of the findings. No further information was provided by the end of the survey.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29843 Based on observation, staff interview, and facility document review it was determined facility staff failed to store, prepare, and serve food in a sanitary manner in one of one facility kitchens. The findings include: On [DATE] at approximately 11:25 a.m., an inspection of the facility's kitchen was conducted with OSM (other staff member) #4, dietary manager. 1. On [DATE] at approximately 11:35 a.m., an observation of the top shelf inside the walk-in refrigerator revealed five bags of chopped cabbage available for use. Further observation revealed each of the one-gallon zip-loc storage bags had a use-by-date of [DATE]. OSM #4 immediately removed the bags of cabbage from the refrigerator. 2. On [DATE] at approximately 11:38 a.m., an observation of the three-compartment sink in the facility's kitchen revealed two cooking pots, a whisk, a ladle, pair of tongs and a large colander, submerged in the sink compartment labeled Sanitize. OSM #4 was asked to test the level of sanitizer. She removed a test strip from its container, placed it in the sanitized solution and compared the results with the sanitizer color scale. When asked what the sanitizer level was, OSM #4 stated it was 50ppm (parts per million). When asked if that was the correct level of sanitizer for the item soaking in the sink OSM #4 stated no and that it should have been 200ppm. 3. On [DATE] at approximately 11:45 a.m., an observation of the tray line inside the facility's kitchen releveled OSM #5, dietary aide, standing, wearing a beard uncovered at the tray line. Further observation revealed OSM #5 moving resident's trays that were plated with food and beverages, down the tray line to another dietary aide who placed the tray on the food carts. 4. On [DATE] at approximately 1:40 p.m., an observation of the facility's three nourishment rooms was conducted with OSM #4. Observation of the inside of the freezer in the nourishment located on the 200-hallway revealed a box containing a one serving frozen dinner. Observation of the box failed to evidence a resident's name and/or a room number; Observation of the inside of the refrigerator in the nourishment located on the 500-hallway revealed two 16-ounce bottles of soda approximately half full and a 12-ounce bottle of a tropical drink approximately three-quarters full. Observation of the inside of the freezer revealed a box containing a one serving frozen breakfast sausage bowl. Further observation of the above food items failed to evidence a resident's name and/or a room number; Observation of the inside of the refrigerator in the nourishment located on the 300-hallway revealed a one-pound package of lunch meat, 5-ounce container of yogurt, and a package of five strips of uncooked bacon. Observation of the inside of the freezer revealed a five-ounce bowl of ice cream, three slices of lunch meat in a zip-loc bag, a pint size zip-loc bag containing half-a-dozen shrimp, frozen burrito, eight-ounce package of chocolate truffles, a zip-loc bag containing a Salsbury steak, and a one serving frozen dinner. Further observation of the above food items failed to evidence a resident's name and/or a room number. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at approximately 1:55 p.m., an interview was conducted with OSM #4. When asked to describe the procedure for food brought in from outside of the facility OSM #4 stated that nursing should label the food item with the resident's name and room number. When asked who was responsible for checking the refrigerators and freezers in the nourishment rooms OSM #4 stated that the dietary aides should be checking the food when they stock the refrigerators with snacks and supplements for the residents. When asked how often the staff stock the refrigerators and freezers, she stated that it is done two times a day and the refrigerators and freezers should be checked each time. On [DATE] at approximately 2:00 p.m., an interview was conducted with OSM #5. When asked to describe the task he was performing at the tray line earlier that day OSM #5 stated he was checking the food on the resident's trays with the resident's meal ticket to make sure the resident was receiving the correct food. When informed of the above observation OSM #5 stated he should have had his beard covered but did not know where the beard guards were kept. When asked if found out where they were kept, he stated and showed the surveyor the beard guards were on top of the hair nets next to the kitchen door. When asked why it was important to have a beard covered, he stated to prevent hair from falling into the food. On [DATE] an interview was conducted with OSM #4. When asked to describe the procedure for keeping expired food items from being available for use she stated the cooks should be checking the items in the walk-in refrigerator daily. When asked to describe the procedure for the ensuring the correct amount of sanitizer is put in the sink OSM #4 stated the sanitizer level should be checked before placing items in the sanitizer. The facility's policy Three Compartment Sink documented in part, 5. Monitor and record sanitizing solution concentration with appropriate test strip: QAC (Quaternary Ammonium Compound) ,d+[DATE] ppm concentration, 60 second contact time (per Manufacturer's Instructions). The facility's policy Dress Code documented in part, 7. Culinary staff must wear hair restraints(e.g.) hair net, hat, and beard restraint) to prevent their hair from contacting exposed food . The facility's policy Food from Outside Sources documented in part, 5. All food brought in is to be checked by the Nurse, Dietary Manager, or Dietician. It must be placed in a sealed container and labeled for the content, the guest's/resident's name, and date the food was received, and an expiration date of 3 (three) days after the food was brought in . On [DATE] at approximately 4:45 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing and ASM #3, regional clinical coordinator, were made aware of the above findings. No further information was provided prior to exit.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. 29843 Based on observation, staff interview and facility document review, the facility staff failed to maintain one of one trash compactors in a sanitary manner. Facility staff failed to keep the door to the facility's trash compactor closed. The findings include: On 04/22/2024 at approximately 11:40 a.m., an observation of the facility's trash compactor revealed the door was open revealing the debris inside the compactor. On 2:06 p.m., an interview was conducted with OSM (other staff member) #4, dietary manager. When asked who was responsible for ensuring the door to the trash compactor was closed OSM #4 stated that it was the responsibility of all the facility staff, but the dietary department would be held accountable. When asked why it was important to keep the trash compactor door closed, she stated it was to keep the rodents out and keep them away from the building. No further information was provided prior to exit.

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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. 27660 Based on observation, staff interview, and facility document review, it was determined the facility staff failed to maintain infection control practices during the medication administration observation for one of three nurses observed. The findings include: Observation was made on 4/22/2024 at 11:32 a.m. of RN (registered nurse) #1 administering medications on the 200 hallway. RN #1 was observed popping two medications out of the medication bubble pack and dropping the pills into her hand. She then put the pills into the medication cup and administered the medications to the resident. An interview was conducted with RN #1 on 4/22/2024 at 11:55 a.m. The above observation was shared with RN #1. She stated she guessed she had done that. When asked should the nurse touch a resident's medications with her hands, RN #1 stated, no. When asked why, RN #1 stated because of sanitary reasons, germs. The facility policy, Medication administration, documented in part, 1 . If medications come into contact with the bare hands of the nurse/med(medication) tech (technician), or with the med cart, the medication should be disposed of per policy and new medications obtained. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator, were made aware of the above concern on 4/23/2024 at 4:50 p.m. No further information was provided prior to exit.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement a complete immunization program for one of five residents reviewed for immunizations, Resident #5. The findings include: For Resident #5 (R5) the facility staff failed to provide education for and offer the most recent influenza vaccination. R5 was admitted to the facility on [DATE]. A review of R5's clinical record revealed no evidence that she was educated about or offered the most recent influenza vaccine. On 4/24/24 at 12:34 p.m., ASM (administrative staff member) #2, the director of nursing was interviewed. She stated the assistant director of nursing, who no longer works at the facility, was responsible for making sure all residents were offered the influenza vaccine when it became available in the fall of 2023. She stated residents should have been given a form with the risks and benefits of receiving the vaccine, and provided an opportunity to accept or decline its administration. She stated she could not explain why the staff member responsible for the vaccinations did not follow through with their responsibilities. On 4/24/24 at 2:30 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the regional clinical director, were informed of these concerns. A review of the facility policy, Immunizations: Influenza Vaccination of Guest/Residents, revealed, in part: Beginning in October .Follow standing protocol to administer vaccine. If guest/resident is eligible, obtain an order for the vaccine and provide education. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of University Park	2420 Pemberton Rd Richmond, VA 23233

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement a complete immunization program for one of five residents reviewed for immunizations, Resident #5. The findings include: For Resident #5 (R5) the facility staff failed to provide education for and offer the most recent COVID vaccination. R5 was admitted to the facility on [DATE]. A review of R5's clinical record revealed no evidence that she was educated about or offered the most recent COVID vaccine. On 4/24/24 at 12:34 p.m., ASM (administrative staff member) #2, the director of nursing was interviewed. She stated the assistant director of nursing, who no longer works at the facility, was responsible for making sure all residents were offered the most recent COVID vaccine when it became available. She stated residents should have been given a form with the risks and benefits of receiving the vaccine, and provided an opportunity to accept or decline its administration. She stated she could not explain why the staff member responsible for the vaccinations did not follow through with their responsibilities. On 4/24/24 at 2:30 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the regional clinical director, were informed of these concerns. A review of the facility policy, COVID-19 Vaccination, revealed, in part: The vaccine administrator will identify residents that would qualify to receive the additional dose of booster dose of COVID-19 vaccine based on CDC (Centers for Disease Control) recommendations .Educate resident or responsible party on additional dose of COVID-19 vaccine. The facility will obtain a signed consent form for the administration of the additional dose of COVID-19 vaccine from the resident .A declination will be signed if consent is not given. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of University Park	2420 Pemberton Rd Richmond, VA 23233

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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 0947 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 29125 Based on staff interview, employee record review, and facility document review, it was determined that the facility staff failed to evidence all required training requirements for five of six employee records reviewed. The findings include: The facility staff failed to ensure that five of six CNA (Certified Nursing Assistant) records reviewed met the training requirements of a minimum of 12 hours annually and/or were provided the required training of abuse and/or dementia care. On 4/23/24 and on 4/24/24, a review was conducted for the required training requirements for six CNA's (Certified Nursing Assistant), CNA#3, CNA #4, CNA #5, CNA #6, CNA #7, and CNA #8, for the most recently completed anniversary years. The anniversary years were as follows: CNA #3 was 6/30/22 to 6/30/23 CNA #4 was 3/10/23 to 3/10/24 CNA #5 was 10/2/22 to 10/2/23 CNA #6 was 11/15/22 to 11/15/23 CNA #7 was 10/23/22 to 10/23/23 CNA #8 was 9/2/22 to 9/2/23 The following was noted to be missing: CNA #3 was missing dementia care training. CNA #4 did not have the required minimum of 12 hours annually. CNA #5 did not have the required minimum of 12 hours annually. CNA #6 was missing dementia care training and did not have the required minimum of 12 hours annually. CNA #7 was missing abuse training and did not have the required minimum of 12 hours annually. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0947 Level of Harm - Potential for minimal harm Residents Affected - Many	On 4/24/24 at 11:00 AM, an interview was conducted with ASM #2 (Administrative Staff Member) the Director of Nursing (DON). She stated that she was not able to locate anymore training than what was provided. She stated that the time frames were prior to her transition to the role of DON. She stated she had been the DON since September, 2023. The facility policy, Staff Development was reviewed. This policy documented, Policy: Staff development includes the planning, coordination, provision, and management of orientation, and inservice activities for facility employees Procedure 5. The annual training schedule should include programs relating to but not limited to: .Abuse Prohibition Dementia Care 8. Nurse aides are provided no less than 12 hours of in-service education per year from the employee's date of hire On 4/24/24 at 2:15 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing and ASM #3 the Regional Clinical Coordinator were made aware of the findings. No further information was provided by the end of the survey.