STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495118	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mount Health & Rehab Center	300 Hatcher Street Rocky Mount, VA 24151

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on resident and staff interview, record review and facility document review, the facility staff failed to promote resident self-determination through support of resident choice related to bathing for 1 of 28 current residents in the survey sample, resident # 41. The findings included: For resident # 41 (R41) the facility staff failed to provide three showers weekly per resident preference. R41's diagnoses included but were not limited to pneumonia, respiratory failure unspecified with hypoxia, hypertension, diabetes mellitus, chronic obstructive pulmonary disease and muscle weakness. The minimum data set (MDS) assessment for R41 with an assessment reference date of 12/31/24 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15 indicating the resident was cognitively intact. On 3/24/25 at 7:00 PM during the initial tour this surveyor interviewed R41. The resident had a disheveled appearance and when asked about being assisted with baths and showers R41 stated, I'm supposed to get one three times a week but that hardly ever happens. It depends on the aide, I usually get one on Wednesdays but never know about the other days. Surveyor asked if lack of showers was related to low staffing and they stated, I think it's related to who is working. Some of them just don't want to do it. On 3/25/25 at 11:15 AM this surveyor asked the Administrator for bathing records for February and March for R41. The Administrator provided copies of daily assignment sheets for the days R41 was showered, but nothing from the clinical record. This surveyor asked if the documents provided were part of the clinical record, they stated they were not. This surveyor asked again for the bathing record in R41's clinical record and the Administrator stated, What's in the record isn't reflective of the care provided. Surveyor asked if the record should match the assignment sheets and they stated, Of course it should, but the showers are documented here. This resident wouldn't let us not give her a shower. She would definitely complain. According to the documents provided, R41 had a shower on 3/24/25. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/25/25 at 01:54 PM this surveyor interviewed R41 again. Surveyor asked if they got a shower the night before on 3/24/25. They stated, I did, I'm sure it was because you were in here and we had talked about it. I'm used to taking a shower every day and I know that isn't possible here, but I have asked if they could at least do it three times a week and they said they could. Surveyor asked how often they are showered, I would say I do usually get one at least twice a week, but not always. On 3/25/25 at 2:15 PM this surveyor asked the Director of Nursing (DON) for the bathing records for February and March out of R41's clinical record and they were promptly provided. The assignment sheets for February were compared with the clinical record for February. According to the documentation, R41 was showered at least two times weekly and three times weekly for three of the 4 weeks. For March the documentation was compared. R4 was documented as having had one shower for week one, three showers for week two, and one shower for week three documented. For the current week, week four, resident was documented a shower on 3/24/25. The care plan for R41 was reviewed. There was a problem statement that read in part, ADLs (activities of daily living) Functional Status/Rehabilitation Potential Resident has made personal preferences known, and an approach for that problem statement that read, Allow choice of bath if desired. The Physician's orders were reviewed. An order with a start date of 12/24/24 read, Shower Days Monday/Wednesday/Saturday Evenings. The policy entitled, Resident Bath/Showering/Scheduling Policy with a revision date of 9/9/22. The document read in part, Residents will be bathed or showered according to their preferences in order to maintain healthly hygiene and skin condition . (A) Each resident will be asked about his/her bathing preferences upon admission (type of bathc, preferred days and times). On 3/26/25 at 4:00 PM the survey team met with the Administrator, DON, and Regional Director of Clinical services (RDCS), this concern was discussed at that time. No further information was provided to the survey team prior to the exit conference. 3/27/25 at 10:23 AM this surveyor met with the DON and informed them I was still looking for evidence that 3 showers/week were provided in March for R41. Explained that the resident told me that depending on who works she usually gets the Wednesday showers, but the other days she never knows if she will get one or not, and frequently not. Reviewed the dates that evidence had already been provided which indicated only one shower was given the first week of March and the third week of March. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/27/25 04:00 PM the survey team met with the Administrator, DON, RDCS and Administrator in Training. The DON brought shower sheets for R41 and stated here are more for the time period you said you were focused on. Included sheets for 3/3 which had already been provided,3/5, 3/7, 3/14, 3/17 and 3/19. This surveyor asked why these shower sheets were not provided with the others on 3/25/25, they stated, The unit manager gave them to me today, I went back and asked her if she had anything else to show the showers were done and she gave me those. This surveyor informed those present that the resident repeatedly stated that three showers a week are not being given they would like them to know that.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and clinical record review, the facility staff failed to ensure a Durable Do Not Resuscitate (DDNR) form was signed by the ordering medical provider for one (1) of 28 sampled current residents (Resident #73). The findings include: Resident #73's DDNR order form was not signed by the ordering medical provider. Resident #73's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/7/25, was signed as completed on 1/9/25. Resident #73 was assessed as able to make self understood and as able to understand others. Resident #73's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact or borderline cognition. Resident #73's clinical record included a DDNR order form dated as completed on 1/16/25. This form included the following information: Physician's Order . I, the undersigned, state that I have a [NAME] fide physician/patient relationship with the patient named above. I have certified in the patient's medical record that he/she or a person authorized to consent on the patient's behalf has directed that life-prolonging procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. This form was not signed by a medical provider. On 3/25/25, The Administrator provided the surveyor with a copy of Resident #73's DDNR form, dated 1/16/25, which now included a medical provider signature. The Administrator reported the medical provider had emailed the signed DDNR order on 3/25/25. On 3/27/25 at 3:57 p.m., the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to ensure Resident #73's medical provider had signed the DDNR form was discussed.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interview, clinical record review and facility document review, the facility staff failed to notify the provider and the resident's responsible party of a change in condition for 1 of 28 current residents in the survey sample, resident # 66. The findings included: For resident #66 (R66), the facility staff failed to notify the provider or the responsible party (RP) of a significant weight loss. R66's diagnoses included but were not limited to, Alzheimer's disease with late onset, other seizures, dysphagia unspecified, other secondary Parkinsonism, other frontotemporal neurocognitive disorder and muscle weakness. R66's face sheet listed a sibling as the emergency contact as well as the responsible party. The minimum data set with an assessment reference date of 12/19/24 indicated that resident has severely impaired decision making and impaired short- and long-term memory. The comprehensive care plan included a focus for nutritional status that read, Resident has increased nutrition/hydration risk r/t (related to) mechanically altered textures. There was an approach dated 3/19/25 that read, Supplements as ordered. On 03/25/25 03:00 PM during a review of the weight record this surveyor noted a significant weight loss. R66 weighed 157.6 lbs. on 2/5/25 and on 03/11/2025, the resident weighed 144.4 pounds. This is a 8.38 % Loss in a month. The progress notes were reviewed. A note dated 3/18/25 read, New orders per RD consult: Administer Mighty Shake (a nutritional supplement drink) 2 times per day. RP aware. On 3/27/25 09:47 AM this surveyor interviewed the wound nurse who put in the above order. When asked where or how the order originated, they stated, The RD sends his recommendations by email, and we get them approved and put in the orders. When asked if they know why the RD recommended the Mighty Shakes, they stated they did not. When asked if they were aware that R66 had a weight loss, they stated they were not aware. The nurse stated they did get the order approved by the provider but would not have informed them the recommendation was due to weight loss as they did not know. They stated they did notify the RP of the new order but not the weight loss. This surveyor reviewed the policy entitled, Resident Change in Condition Policy. The document read in part, 5. They Physician/Provider and Resident/Family/Responsible Party will be notified when there has been .f. Significant weight loss of 5% in 30 days, 10% in 180 days. On 3/26/25 at 4:00 PM the survey team met with the Administrator, Director of Nursing, Regional Director of Clinical Services and the Administrator in Training. This concern was reviewed with them at that time and during a pre-exit meeting on 3/27/25 at 4:00 PM. No further information was provided to the team prior to the exit conference.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure an accurate MDS assessment for 1 of 28 sampled residents (Resident #12). The findings include: For Resident #12, the facility staff failed to code the resident as having an indwelling catheter on the minimum data set (MDS) assessment dated [DATE]. Resident #12's diagnosis list indicated diagnoses, which included, but not limited to, Congestive Heart Failure, Vascular Dementia, Hypertension, Chronic Kidney Disease-Stage 3, Chronic Respiratory Failure with Hypoxia, Neuromuscular Dysfunction of Bladder, Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Anxiety Disorder, and Depression. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/6/25 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognitive abilities. Surveyor observed Resident #12 on 3/25/25 at 9:50 AM in bed with a catheter present and urine drainage tubing/bag hanging off the left side of resident's bed. A review of the medical provider orders revealed an order for Foley Catheter. A review of the February 2025 MAR (medication administration record) revealed resident received daily foley care from 2/6/25 through 2/28/25. A review of the resident's census revealed resident was hospitalized from [DATE], through February 6, 2025. A progress note dated 2/6/25 read in part, .Resident has Foley (catheter) in place . A review of the MDS dated [DATE] Section H (Bladder and Bowel) H0100. Appliances was not coded to reflect and indwelling catheter. A review of the comprehensive person-centered care plan read in part, .Indwelling Catheter .foley catheter care every shift . On 3/26/25 at 1:54 PM, surveyor interviewed licensed practical nurse #9 (LPN#9) and she reviewed the 2/13/25 MDS with surveyor. LPN#9 could not find any evidence the resident did not have a catheter. Surveyor also interviewed licensed practical nurse #1 (LPN#1) and she stated she thought Resident #12's catheter had been discontinued for a voiding trial. LPN#1 looked for evidence of a voiding trial with surveyor and stated she needed more time to look for evidence the catheter had been discontinued or for evidence the resident was on a voiding trial. LPN #9 retuned to surveyor and informed surveyor no evidence of a voiding trial could be located, and she agreed the MDS had been coded incorrectly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This concern was discussed on 3/26/25 at 4:00 PM at the end of day meeting with the administrator, director of nursing, administrator in training, and regional director of clinical services. A review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1 with a revision date of 10/2024, read in part, [page H-1] .It is important to know what appliances are in use .[page H-2] .Steps for Assessment .1. Examine the resident to note the presence of any urinary .appliances .2. Review the medical record, including bladder .records, for documentation of current .use of urinary .appliances .Coding Instructions .Check next to each appliance that was used at any time in the past 7 (seven) days . No further information regarding this concern was presented to the survey team prior to the exit conference on 3/27/25.

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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 2. The facility staff failed to ensure Resident #73's Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability form was completed according to document guidance. Resident #73's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/7/25, was signed as completed on 1/9/25. Resident #73 was assessed as able to make self understood and as able to understand others. Resident #73's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact or borderline cognition. Resident #73's preadmission screening document, dated 12/31/24, included two (2) sections which required sub-questions in the section to be answered prior to completing the main question of the sections. - Section 2 DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)? was answered No without the individual completing this form answering questions 2a, 2b, and 2c. - Section 4 DOES THE INDIVIDUAL HAVE A RELATED CONDITION? was answered No without the individual completing this form answering questions 4a, 4b, 4c, and 4d. On 3/27/25 at 12:15 p.m., the surveyor interviewed the facility's Social Worker via telephone. The Social Worker reported when the answer to the aforementioned unanswered questions is 'no' that she does not mark 'no.' The Social Worker stated she would have marked 'yes' if that had been the appropriate response. The Social Worker reported she was comfortable with the answers that was documented for the main question of Section 2 and the main question of Section 4. On 3/27/25 at 3:57 p.m., the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to complete all questions of Resident #73's preadmission screening document was discussed. 3. The facility staff failed to ensure Resident #94's Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability form was completed according to document guidance. Resident #94's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/14/25, was signed as completed on 3/18/25. Resident #94 was assessed as rarely/never able to make self understood and as rarely/never able to understand others. Resident #94 was documented as having problems with long-term memory and as having problems with short-term memory. Resident #94's preadmission screening document, dated 1/4/24, included two (2) sections which required sub-questions in the section to be answered prior to completing the main question of the sections. - Section 2 DOES THE INDIVIDUAL HAVE A CURRENT SERIOUS MENTAL ILLNESS (MI)? was answered No without the individual completing this form answering questions 2a, 2b, and 2c. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Section 4 DOES THE INDIVIDUAL HAVE A RELATED CONDITION? was answered No without the individual completing this form answering questions 4a, 4b, 4c, and 4d. On 3/27/25 at 12:15 p.m., the surveyor interviewed the facility's Social Worker via telephone. The Social Worker reported when the answer to the aforementioned unanswered questions is 'no' that she does not mark 'no.' The Social Worker stated she would have marked 'yes' if that had been the appropriate response. The Social Worker reported she was comfortable with the answer that was documented for the main question of Section 2 and the main question of Section 4. On 3/27/25 at 3:57 p.m., the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to complete all questions of Resident #94's preadmission screening document was discussed. Based on staff interview. record review and facility document review, the facility staff failed to ensure a Level I PASRR (Preadmission screening and resident review) was completed for 3 of 28 current residents in the survey sample, residents # 66, #73, and $94. The findings included: 1. For resident #66 (R66) the facility staff failed to accurately complete the Level I PASRR before including it in the medical record. R66's diagnoses included, Alzheimer's disease, late onset, seizure disorder, frontotemperal neurocognitive disorder, major depressive disorder, anxiety disorder and unspecified mood disorder. A document entitled, Screening For Mental Illness, Retardation/Intellectual Disability, Or Related Condition was located in the clinical record. Question 5 was for whether or not R66 required a secondary, or level II assessment was blank. On 3/25/25 at 4:00 PM the survey team met with the Director of Nursing, Administrator and Administrator in training. This concern was discussed at that time. On 3/26/25 at 9:20 AM this surveyor was provided with the policy entitled, Social Services Policy with a revision date of 2/24/25 that read in part, B. Social Services will assist in implementing interventions for the resident's needs by developing and maintaining care plans which are individualized, realistic, with measurable goals, including, but not limited to; 1. Code Status, 2. Discharge planning, 3. Smoking ability, 4. Current and/or history of mood/behavior, cognitive and/or psychosocial issues, 5. Leave of absence, 6. Trauma, PTSD, 7. Cultural Preferences, 8. PASRR level II information and, 9. Substance abuse issues. There was no Level II in the record. This concern was reviewed with the Administrator, Director of Nursing, and Regional Director of Clinical Services again on 3/27/25 at 4:00 PM. The Director of Nursing stated that the the Level I Screening had been corrected and R66 did not require a Level II. No further information was provided to the survey team prior to the exit conference.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on staff interviews, clinical record review, and facility document review, the facility staff failed to provide care and/or services to address resident needs for two (2) of 28 current sampled residents (Resident #26 and Resident #94). The findings include: 1. The facility staff failed to promptly notify Resident #94's medical provider of abnormal laboratory results. Laboratory results reported on 1/17/25 at 11:13 p.m. was not documented as being reported to the medical provider until 1/19/25 at 2:02 p.m. (The medical provider initialed the laboratory results on 1/22/25.) Resident #94's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/14/25, was signed as completed on 3/18/25. Resident #94 was assessed as rarely/never able to make self understood and as rarely/never able to understand others. Resident #94 was documented as having problems with long-term memory and as having problems with short-term memory. Facility nursing staff documented a change in condition in Resident #94's nursing progress note dated 1/17/25 at 10:11 p.m. This note indicated Resident #94: - experienced emesis last night and this morning, - did not eat well all day, - not displaying normal behavior, - not following person or objects moving with eyes. This note indicated the on-call medical provider ordered the following laboratory tests: (a) complete blood count (CBC), (b) basic metabolic panel (BMP), and (c) urinalysis. Resident #94's clinical record included laboratory orders, dated 1/17/25, for (a) complete blood count (CBC), (b) basic metabolic panel (BMP), and (c) urinalysis. These laboratory tests were schedule for 10:00 p.m. The following urinalysis results were reported by the laboratory on 1/17/25 at 11:13 p.m.: - Positive for white blood cell esterase, - [NAME] blood cells were documented as being high with a greater than 100 (reference range 0 - 5), and - Bacteria was documented as many. This laboratory report also included the following statement: This specimen meets the criteria for culture. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The following blood test results were reported by the laboratory on 1/17/25 at 10:51 p.m.: - an elevated urea nitrogen of 30, - an elevated creatinine of 2.54, and - an elevated white blood count of 17.2. No evidence was found by, or provided to, the surveyor to indicate a medical provider was notified of the aforementioned laboratory results prior to 1/19/25 at 2:02 p.m. This note indicated the resident was ordered antibiotics. On 1/20/25 at 10:35 a.m., a nursing progress note indicated antibiotics were changed due to urine culture results; the medical provider gave additional orders for repeat laboratory tests and intravenous fluids. A medical provider progress note dated 1/20/25 at 11:16 a.m., indicated the medical provider decided to send Resident #94 to the local emergency department. Resident #94's HOSPITALIST DISCHARGE SUMMARY, for a hospital stay dated 1/20/25 - 1/25/25, included Sepsis due to urinary tract infection as one of the resident's active problems. On 3/27/25 at 3:57 p.m., the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to ensure a prompt response to Resident #94's abnormal laboratory results was discussed. 2. For Resident #26, the facility staff failed to follow the provider orders for the administration of the antiviral medication Tamiflu. Resident #26 had tested positive for Flu A on 03/18/25. Resident #26's face sheet included the diagnoses included mild cognitive impairment, dysphagia, hydrocephalus, and severe intellectual disabilities. Section C (cognitive patterns) of Resident #26's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/01/25 was coded 1/1/3 to indicate this resident had problems with long-and short-term memory and was severely impaired in cognitive skills for daily decision making. Resident #26's comprehensive care plan included the problem Infection Flu A. Approaches included medications/antibiotics as ordered. Resident #26's clinical record included a progress note dated 03/18/25 indicating Resident #26 had tested positive for Flu A. The provider had ordered Tamiflu (oseltamivir) 75 mg 1 capsule twice a day to begin on 03/19/25. A review of Resident #26's medication administration records (MARs) revealed that Resident #26 was administered Tamiflu beginning on 03/19/25 at 4:00 p.m. and the last dose was given on 03/23/25 at 4:00 p. m. Indicating Resident #26 did not receive the full 10 doses of Tamiflu. On 03/25/25 at 9:20 a.m., during an interview with the physician/medical director this staff stated Tamiflu needs to go the entire course and the resident should have received 10 doses. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rocky Mount Health & Rehab Center	300 Hatcher Street Rocky Mount, VA 24151

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 03/25/25 at 12:47 p.m., the surveyor and Licensed Practical Nurse (LPN) #2 checked the medication cart for any Tamiflu. This medication cart contained a box of Tamiflu with Resident #26's name and read quantity 10. This box contained 2 capsules of Tamiflu. LPN #2 stated she had administered this resident's Tamiflu and was unable to explain why there were 2 capsules left. The facility staff provided the surveyor with a copy of their policy titled, General Dose Preparation and Medication Administration. This policy read in part, .Verify each time a medication is administered .Confirm that the MAR reflects the most recent medication order . On 03/25/25 at 1:16 p.m., the Director of Nursing (DON) was made aware of the issue with Tamiflu not being given for a full 10 doses and that 2 capsules of this medication remained on the medication cart for this resident. On 03/25/25 at 5:00 p.m., during an end of the day meeting with the Regional Director of Clinical Services, Administrator, and DON the issue with the Tamiflu not being administered for 10 doses was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on resident interviews, staff interviews, and clinical record review, the facility staff failed to provide adequate supervision and/or monitoring in response to an accident/incident for one (1) of 28 sampled current residents (Resident #5). The findings include: The facility staff failed to ensure an assessment was completed and/or documented for Resident #5 after an event involving a handrail coming out of the bathroom wall. Review of Resident #5's clinical documentation failed to include information related to an event reported by Resident #5; this event was described as the handrail came out of the wall when the resident reported she was attempting to stand from the toilet. Resident #5's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/20/25, was signed as completed on 2/23/25. Resident #5 was assessed as able to make self understood and as usually able to understand others. Resident #5's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact or borderline cognition. On the afternoon of 3/26/25, Resident #5 reported she had fallen from the toilet when the handrail had detached from the wall when she was attempting to stand from the toilet. Resident #5 reported the fall resulted in her having a decreased ability to use her right leg and left arm. Resident #5 was unable to provide the date of the alleged fall. Resident #5 reported the facility's maintenance staff would be able to provide the date. Interviews with the Director of Maintenance, on 3/26/25 and 3/27/25, indicated the event happened on either 6/17/24 or 6/18/24. The Director of Maintenance could not confirm a fall. The Director of Maintenance reported the resident had already exited the bathroom prior to him entering the bathroom. Review of Resident #5's activities of daily living (ADL) documentation, for June 2024 and July 2024, showed the resident had not experienced a decline in ADL abilities. Resident #5's MDS assessment, with an ARD of 6/24/24, did not identify: (a) a decline in the resident's ADL activities and/or (b) a fall since the previous MDS assessment. On 3/26/25 at 4:02 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Administrator in Training (AIT), and Regional Director of Clinical Services. During this meeting, Resident #5's report of falling due to the handrail in her bathroom coming loose was discussed. The Administrator reported the resident did not fall when the handrail came loose. On 3/27/25 at 8:52 a.m., Licensed Practical Nurse (LPN) #8 reported she was not present when the handrail came out of the wall. LPN #8 stated the event occurred prior to her coming in for her work shift. LPN #8 reported that her understanding was the resident did not fall but sat back down on the toilet when the handrail dislodged from the wall. On 3/27/25 at 10:13 a.m., the Administrator confirmed the event involving Resident #5, when the handrail came free from the wall in the resident's bathroom, had not been documented in the resident's clinical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following information was found as part of a facility document titled Incident/Accident Policy (with a revision date of 10/1/24): - An incident/accident is any occurrence which is not consistent with the routine care of a particular resident. An incident/accident can occur anywhere and be discovered by anyone (resident, visitor, employee or volunteer). All incident/accidents involving residents will be analyzed and reported. - The incident/accident will be recorded in the electronic health record. The report will be completed as soon as possible after the occurrence but no later than by the end of the shift on which it occurred. - Documentation/assessment post-incident will be completed, including neurological assessment when indicted [sic]. Further assessments will be conducted as ordered by the provider or as indicated by nursing judgement. On 3/27/25 at 3:57 p.m., the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to have evidence of assessing Resident #5 after the aforementioned incident/accident was discussed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to provide respiratory care consistent with the medical provider orders for 1 of 28 sampled residents (Resident #175). The findings include: For Resident #175, the facility staff failed to administer supplemental oxygen at the rate ordered by the medical provider. Resident #175's diagnosis list indicated diagnoses that included, but were not limited to, Senile degeneration of brain, Insomnia, Hypertension, Pain, Restlessness and agitation, and Anxiety disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of, 3/21/25 coded the resident in Section C (Cognitive Patterns), as being severely impaired in decision-making with short and long-term memory problems. On 3/24/25 at 7:21 PM, surveyor observed Resident #175 in bed receiving oxygen via nasal cannula at the delivery rate of 2.0 l/m (two liters per minute) per the oxygen concentrator setting. On 3/25/25 at 9:15 AM, surveyor again observed Resident #175 in bed receiving oxygen via nasal cannula at the delivery rate of 2.0 l/m per the oxygen concentrator setting. Resident #175's current medical provider orders included an order for Oxygen at 3.0 (three) l/m via nasal cannula continuously with special instructions to check concentrator to ensure functioning and appropriate setting every shift. A review of the March 2025 MAR (medication administration record) revealed the oxygen concentrator had been checked to ensure appropriate setting on day shift and night shift on 3/24/25 and on day shift on 3/25/25. On 3/25/25 at 12:05 PM, surveyor again observed Resident #175 in bed receiving oxygen via nasal cannula at the delivery rate of 2.0 l/m per the oxygen concentrator setting. Surveyor spoke with registered nurse #2 (RN#2) and inquired how much oxygen Resident #175 was on and she stated three liters. RN#2 accompanied surveyor to the resident's room and agreed the oxygen concentrator was set on two liters. Surveyor asked RN#2 the process for verifying oxygen is on the proper setting and she stated she tries to check it when she is in the room. RN#2 agreed the oxygen should be on three liters and she set the flow meter to the correct flow rate of 3.0 m/l on the oxygen concentrator. This concern was discussed on 3/25/25 at 5:00 PM at the end of day meeting with the administrator, director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled, Oxygen Administration (all routes) Policy with a revision date of 7/30/24 that read in part, .licensed clinicians with demonstrated competence will administer oxygen .as ordered by the provider .For oxygen concentrator .set flow meter to correct flow rate . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to exit on 3/27/25.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure the drug regimen of each resident was reviewed at least monthly by a licensed pharmacist and failed to provide evidence of medical provider review of a drug regimen review with recommendations for 1 of 28 sampled residents (Resident #42). The findings included: For Resident #42, the facility staff failed to ensure the resident's drug regimen was reviewed during January 2025 and facility staff were unable to provide evidence of medical provider review of the July 2024 drug regimen review. Resident #42's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Obstructive and Reflux Uropathy, Anxiety Disorder and Major Depressive Disorder. The recent minimum data set (MDS) with an assessment reference date (ARD) of 2/02/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #42's comprehensive person-centered care plan included a focus area stating the resident was at risk for adverse effects related to psychoactive medication use with an intervention for pharmacy review per routine. Resident #42's clinical record included a 7/29/24 pharmacy progress note indicating a drug regimen review was completed with recommendations. Surveyor was unable to locate the recommendation in the resident's clinical record. Surveyor reviewed Resident #42's clinical record and was unable to locate evidence of a January 2025 drug regimen review. On 3/26/25 at 4:03 PM, surveyor met with the Administrator, Director of Nursing (DON), and the Regional Director of Clinical Services (RDCS) and requested the July 2024 and January 2025 drug regimen reviews for Resident #42. On 3/27/25 at 10:15 AM, the DON provided a copy of a drug regimen review for Resident #42 dated 7/29/24 and stated the report was not in the resident's chart but the Atorvastatin was addressed. The 7/29/24 drug regimen review had not been signed by the medical provider. This drug regimen review read in part . (Issued on 7/29/2024) ***CLINICAL PRIORITY RECOMMENDATION: PROMPT RESPONSE REQUESTED. *** [Resident #42] receives daptomycin and statin therapy with Atorvastin Calcium concomitantly, which may be associated with myopathy and rhabdomyolysis. Recommendation: Please consider temporarily discontinuing Atorvastatin Calcium during daptomycin therapy A review of Resident #42's clinical record revealed the daptomycin ended on 8/03/24 as scheduled and the Atorvastin was discontinued on 8/13/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at 10:15 AM, the DON also provided a Consultation Summary Report for January 2025 which included all residents who had a drug regimen review completed. Reviews were completed between 1/24/25 and 1/27/25. Resident #42 was not listed on this report indicating no drug regimen review was completed. Surveyor requested and received the facility policy titled Medication Regimen Review with a revision date of 6/01/24 which read in part .8. The consultant pharmacist will provide the resident's MRRs [medication regimen reviews] to facility identified personnel who will ensure that the attending physician, medical director, director of nursing and other necessary facility staff receive the recommendations . No further information regarding this concern was presented to the survey team prior to the exit conference on 3/27/25.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record review and facility document review, the facility staff failed to ensure residents are free of significant medication errors for 2 of 28 sampled residents (Resident #69 and Resident #77). The findings included: 1. For Resident #69, the facility staff failed to administer the medication Novolin as ordered by the provider. Resident #69's diagnosis list indicated diagnoses, which included, but not limited to Weakness, Atherosclerotic Heart Disease of Native Coronary Artery, Type 2 Diabetes Mellitus, Acute Respiratory Disease, Polyneuropathy, Chronic Kidney Disease-Stage 4, and Hypertension. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 12/28/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Resident #69's current provider orders included the following insulin order: Novolin R FlexPen (insulin regular human) 100 unit/mL (milliliters) (3 mL) amount 6 units subcutaneous (applied under the skin); Hold for BG (blood glucose) <150 (less than one-hundred-fifty) Before Meals 8:00 AM, 12:00 PM, and 4:00 PM. A review of Resident #69's January 2025 and February 2025 MARs (medication administration records) indicated Novolin was administered on the following dates with BS (blood sugars) outside of the ordered parameter of holding if BS <150: 1/29/25-BS 123 2/9/25-BS 142 2/20/25-BS 137 2/26/25-BS-132 Resident #69's current comprehensive person-centered care plan included a focus area stating the resident had a diagnosis of Type 2 Diabetes with an intervention to administer medications as ordered. This concern was discussed on 3/26/25 at 4:00 PM at the end of day meeting with the administrator, director of nursing, administrator in training, and regional director of clinical services. Surveyor requested and received a facility policy titled, Medication Administration through Certain Routes of Administration that read in part, .ensures that medications are administered according to .physician orders . Subcutaneous injections .Procedure .2. Verify Medication Order on EMAR/MAR (electronic medication administration record/medication administration record); Check against physician order . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit conference on 3/27/25. 2. For Resident #77, the facility staff failed to administer the medications Lantus, Humalog, and Insulin Glargine as ordered by the provider. Resident #77's diagnosis list indicated diagnoses, which included, but not limited to Hypothyroidism, Hyperlipidemia, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Major Depressive Disorder with Severe Psychotic Features, Vascular Dementia, Parkinson's disease without Dyskinesia, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Chronic Respiratory Failure with Hypoxia, and Chronic Kidney Disease-Stage 3. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/10/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Resident #77's current provider orders included the following insulin orders: Humalog 100 unit/mL-amt (amount) 16 units: subcutaneous Special instructions: Hold if less <175, Three Times a Day. Insulin glargine: 100 Unit/mL (3mL): amt: 54 units; subcutaneous Special instructions: hold if BS <150, Twice a Day. Resident #77 also had a previous order from the provider for Lantus Solostar 100 unit/mL (3mL); amt; 36 units; subcutaneous Special instructions: hold if BS <150 with an end date of 1/27/25. A review of Resident #77's January 2025 MAR indicated Lantus was administered on the following dates with BS (blood sugars) outside of the ordered parameter of holding if BS <150: 1/18/25 BS 102 1/23/25 BS 130 A review of the January, February, and March 2025 MARs indicated Humalog was administered on the following dates with BS outside of the ordered parameter of holding if BS <175: January 2025 1/4/25 BS-171 1/15/25 BS-169 1/17/25 BS-168 1/22/25 BS-140 1/25/25 BS-173 February 2025 2/1/25 BS-147 (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	March 2025 3/9/25 BS 141 3/19/25 BS 173 3/22/25 BS 156 A review of the February and March 2025 MARs indicated Insulin Glargine was administered on the following dates with BS outside of the ordered parameter of holding if BS <150: 2/1/25 BS 147 3/9/25 BS 141 Resident #77's current comprehensive person-centered care plan included a focus area stating the resident is at risk for hypo/hyperglycemia related to diabetes with an intervention to administer medications as ordered. This concern was discussed on 3/26/25 at 4:00 PM at the end of day meeting with the administrator, director of nursing, administrator in training, and regional director of clinical services. Surveyor requested and received a facility policy titled, Medication Administration through Certain Routes of Administration that read in part, .ensures that medications are administered according to .physician orders . Subcutaneous injections .Procedure .2. Verify Medication Order on EMAR/MAR (electronic medication administration record/medication administration record); Check against physician order . No further information regarding this concern was presented to the survey team prior to the exit conference on 3/27/25.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 3. The facility staff failed to ensure Resident #94's clinical record included the correct information related to documents sent with the resident to the local emergency department. Resident #94's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/14/25, was signed as completed on 3/18/25. Resident #94 was assessed as rarely/never able to make self understood and as rarely/never able to understand others. Resident #94 was documented as having problems with long-term memory and as having problems with short-term memory. Resident #94's clinical record included the following information as part of a nursing progress note dated 1/31/25 at 2:01 p.m.: . All paperwork sent including face sheet, copy of DNR/Advanced Directive, order summary, transfer sheet, care plan . This note documented activities and information related to Resident #94 being transferred to the emergency department. Resident #94 was ordered to be a full code. Resident #94 did not have a DNR (do not resuscitate) order. On 3/27/25 at 3:57 p.m., the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to maintain a complete and/or accurate clinical record for Resident #94 was discussed. 4. Resident #68's clinical documentation included an incorrect weight documented on 2/11/25. Observations and interviews indicated the 2/11/25 weight was incorrect. Resident #68's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/5/25, was signed as completed on 2/9/25. Resident #68 was assessed as able to make self understood and as usually able to understand others. Resident #68's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. On 2/11/25, Resident #68's weight was documented at 168.1 pounds. This was approximately 97 pounds less than the resident's weight documented for the prior month. No documentation was found to indicate this documented change in weight had been addressed by the facility's staff. On 3/25/25 at 5:02 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Regional Director of Clinical Services (RDCS). During this meeting, Resident #68's weight being incorrectly documented was discussed. The DON reported Resident #68's weight should have been corrected and/or the resident reweighed. On 3/27/25 at 3:57 p.m., the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to maintain a complete and/or accurate clinical record for Resident #68 was discussed. 2. For Resident #4, the facility staff failed to document the residents bath/showers in the clinical record. Resident #4's face sheet included the diagnoses spastic hemiplegia, cerebrovascular disease, convulsions, and anxiety disorder. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section C (cognitive patterns) of Resident #4's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/16/25 included a brief interview for mental status (BIMS) score of 15. Per the MDS manual a score of 15=cognitively intact. Section GG (functional abilities) was coded with a 1 for shower/bathe self to indicate this resident was dependent on staff in this area. Resident #4's comprehensive care plan included the problem area activities of daily living (ADL) functional status. Approaches included allow choice of bath if desired and bathing/hygiene with assist of one. On 03/25/25 at 8:35 a.m., Resident #4 stated they had not had a shower in a week. A review of Resident #4's point of care history for ADL care revealed that the facility staff had documented that this resident received a shower on 03/05/25 and complete bed baths on 03/05/25, 03/10/25, and on 03/11/25. On 03/25/25, the facility staff provided the surveyor with copies of documents identified as shower sheets. A review of these sheets indicated Resident #4 had a shower on 03/15/25, 03/19/25 and on 03/22/25. After providing the survey team with these documents the Administrator stated what was in the clinical record was not reflective of the care provided. On 03/25/25 at 5:00 p.m., during an end of the day meeting with the Administrator, Regional Director of Clinical Services and Director of Nursing the issue with the documentation regarding this resident's bathing not being part of the clinical record was reviewed. On 03/26/25 at 9:40 a.m., this Resident stated they had received a bath last night and had their sheets changed. No further information regarding this issue was provided to the survey team prior to the exit conference. Based on observation, staff interview and clinical record review the facility staff failed to ensure a complete an accurate clinical record for 4 of 28 residents, Resident #38, Resident #4, Resident #68 and Resident #94. The findings included: 1. For Resident #38 the facility staff failed to discontinue physician's orders related to intravenous access. Resident #38's face sheet listed diagnoses which included but not limited to chronic kidney disease, dehydration, and vomiting. Resident #38's most recent minimum data set with an assessment reference date of 02/05/25 assigned the resident a brief interview for mental status score of 10 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #38's comprehensive care plan was reviewed and contained a plan for Infection: UTI (urinary tract infection), Hx (history) IV (intravenous) access right FA (forearm). Resident #38's clinical record was reviewed and contained a physician's order summary for March 2025 which read in part, 1 L (liter) NS (normal saline) IV @ 100 ml/hr. Special Instructions: x 1L. Start Date: 03/20/2025. End Date: 03/21/2025 (DC [discontinue] Date), Peripheral IV: Change IV administration set every 4 days for continuous infusions. Start Date: 03/20/2025. End Date: 03/25/2025 (DC Date), and Peripheral IV: Change IV site/dressing as needed. Start Date: 03/20/2025. End Date: 03/25/2025 (DC Date). Resident #38's electronic medication administration record (eMAR) for the month of March 2025 was reviewed and contained entries as above. The entry for change IV administration set was initialed as completed on 03/24/25. Resident #38's nurse's progress notes were reviewed and contained notes which read in part, 03/23/2025 16:44 residents IV dislodged from right arm, cath piece intact, dry dressing placed ., 03/25/2025 12:38 Clarification note: NP (nurse practitioner) was notified that IV was dislodged on 03/23/25. NP gave order okay to not reinsert at that time ., and 03/25/2025 13:01 Clarification note related to peripheral IV documentation on 03/25/2025, resident does not have an IV inserted at this time. NP is aware of the IV site being removed and documentation occurring by this nurse on 3/24/2025. This nurse meant to put a progress not in for clarification during the shift. MD/RP aware. Surveyor spoke with licensed practical nurse (LPN) #12 on 03/25/25 at 12:30 pm regarding Resident #38's IV access. LPN #12 stated that resident no longer had IV access. Surveyor spoke with the director of nursing (DON) on 03/26/25 at regarding documentation of Resident #38's IV access. DON stated that the orders should have been discontinued when the IV access was removed. The concern of not discontinuing IV orders was discussed with the administrator, administrator-in-training, DON, and regional director of clinical services on 03/26/25 at 4:00 pm. 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 - Some	Provide and implement an infection prevention and control program. 3. The facility staff failed to ensure that Resident #94's indwelling urinary catheter and/or drainage collection bag was positioned in a manner to decrease the risk for the development of infections. Resident #94's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/14/25, was signed as completed on 3/18/25. Resident #94 was assessed as rarely/never able to make self understood and as rarely/never able to understand others. Resident #94 was documented as having problems with long-term memory and as having problems with short-term memory. On 3/25/25 at 11:55 a.m., the surveyor noted the drainage tube (from the urine collection bag connected to the indwelling urinary catheter) was in contact with the floor beside the resident's bed. On 3/25/25 at 3:20 p.m., the surveyor noted the drainage tube (from the urine collection bag connected to the indwelling urinary catheter) continued to be in contact with the floor beside the resident's bed. On 3/25/25 at 4:55 p.m., the surveyor noted the drainage tube (from the urine collection bag connected to the indwelling urinary catheter) was in contact with the floor beside the resident's bed. The surveyor asked LPN (licensed practical nurse) #2 to check the placement of the urine collection bag. LPN #2 stated the urine collection bag had come out of its protective bag; LPN #2 stated she would change the drainage/collection bag. On 3/27/25 at 3:57 p.m., the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to prevent Resident #94's urine collection bag's drainage tube from coming into contact with the floor was discussed. Based on observation, staff interviews, clinical record reviews, and facility document reviews, the facility staff failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 28 current sampled residents (Resident #90, #15, #94, and #26). The findings were: 1. For Resident #90, facility staff failed to appropriately clean and disinfect a blood glucometer. Resident #90's face sheet listed diagnoses which included but were not limited to, Type 2 diabetes mellitus without complications. Resident #90's clinical record contained a provider order for Isolation/Transmission-Based Precautions: Droplet Precautions/Isolation with a start date of 03/23/25 and an end date of 03/30/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/25 at approximately 8:40 a.m. during a medication pass, the surveyor observed licensed practical nurse (LPN #3) take a clear plastic bag with the Resident #90's name written on it, out of the medication cart drawer. The bag contained a glucometer, and the nurse took the bag with its contents into the resident's room. LPN #3 laid the bag in a chair beside the resident's bed and removed the glucometer and laid the glucometer on the arm of the chair. The nurse obtained Resident #90's blood glucose. After administering the resident's medications, the nurse put the glucometer in the bag, put the bag in her scrubs' pocket while doffing personal protective equipment while verbally reporting she should not place the bag in her pocket but had nowhere to put it. LPN #3 took the bag outside of the room and placed it on top of the medication cart before putting the bag in the medication cart's drawer with other similar bags. LPN #3 then removed the bag and placed it back on top of the medication cart, removed the glucometer and wiped it with an alcohol swab before putting the glucometer back in the bag when it had dried. LPN #3 wiped the bag with and alcohol swab and placed the bag back in the medication cart's drawer. The surveyor asked LPN#3 if alcohol was the appropriate cleansing agent and the nurse replied, yes. There was no container of wipes noted on the medication cart and when asked whether the facility used wipes, the nurse did not comment and opened the medication cart's bottom drawer. There was no container of wipes or any wipes at all noted in the bottom drawer. The facility's glucometer policy and manufacturer's directions for use was provided on 03/25/25 at approximately 11:45 a.m. The clinical infection prevention document provided was named, Glucometer/Point of Care Blood Testing and Disinfection Procedure with an effective date of 10/15/2015 and last revision date of 12/27/2023. The policy read in part, . Whether shared or assigned to a singular resident, blood testing meters will be disinfected between each use (before use-the clinician should assume the meter is dirty and disinfect before use) according to manufacturer instructions and infection prevention guidelines Procedure: 2. Wipe meter using friction with recommended type of germicidal disinfectant wipe. 3. Maintain visible wetness of meter for required kill time according to the germicidal disinfectant instructions. Use multiple wipes if necessary. Do not reuse wipes. 6. Following specific testing processes outlined in manufacturer guidance: . Place glucometer on clean surface or place a barrier on surface that glucometer is placed/rests on Perform hand hygiene again and don clean gloves . The Assure Prism blood glucose monitoring system User Instruction Manual read on page 41, Only wipes with EPA registration numbers listed in the previous tables have been validated for use in cleaning and disinfecting the meter. Any disinfectant product containing these EPA registration numbers may be used on this device. These EPA registration numbers can be found on the EPA website. On page 44, a caution box read in part, Please note only Clorox Healthcare Bleach Germicidal Wipes, Dispatch Hospital Cleaner Disinfectant Towels with Bleach, CaviWipes1, and PDI Super Sani-Cloth Germicidal Disposable Wipe [sic] have been tested with the Assure Prism multi meter at the time of printing this manual. Contact the manufacturer or distributor for the recent updates. On 03/25/25 at 5:00 p.m. during an end of day meeting, the administrator, director of nursing (DON), and regional director of clinical services (RDCS) was informed of the glucometer/infection control observation of LPN #3. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/25 at 1:40 p.m. the DON who was also the infection preventionist (IP) was interviewed and asked to describe her expectations for glucometer care and disinfection. I would not expect glucometers to be cleaned with alcohol. They (alcohol swabs) don't encompass every germ. The DON/IP reported she'd expect staff to follow manufacturer's directions for use. The DON/IP stated she would expect the medication cart to be wiped down after lying things on top of the cart, especially with an isolation room. The DON reported she had spoken with LPN #3 and the nurse told the DON she did use alcohol to wipe the glucometer. The DON informed the surveyor the facility does have wipes; the purple, orange, and white top containers which were all approved for use with the glucometers. No further information was provided prior to the exit conference. 4. For Resident #26, the facility staff failed to identify a resident was on droplet precautions prior to entering an isolation room and failed to follow their policy regarding donning personal protective equipment prior to entering a room of a resident on droplet precautions. Resident #26 had tested positive for Flu A. Resident #26's face sheet included the diagnoses mild cognitive impairment, dysphagia, hydrocephalus, and severe intellectual disabilities. Section C (cognitive patterns) of Resident #26's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/01/25 was coded 1/1/3 to indicate this resident had problems with long-and short-term memory and was severely impaired in cognitive skills for daily decision making. Resident #26's comprehensive care plan included the problem area infection Flu A. Approaches included Droplet/Contact precautions as ordered start date 03/19/25. Resident #26's clinical record included a progress note dated 03/18/25 indicating Resident #26 had tested positive for Flu A and a laboratory report indicating the positive Flu A results were reported to Registered Nurse (RN) #1 on 03/18/25 at 4:43 p.m. The provider ordered the following: Tamiflu (oseltamivir) 75 mg 1 capsule twice a day to begin on 03/19/25 at 4:00 p.m. this medication ended on 03/23/25 at 4:00 p.m. Isolation/Transmission based precautions combined droplet/contact precautions/isolation related to Flu A positive. The start date was documented as 03/19/25 end date was documented as open ended. These precautions were discontinued on 03/25/25. The facility staff provided the survey team with a copy of their policy titled, Infection Prevention and Control Program Policy last revision date 02/19/24 that read in part, It is our policy to maintain an organized, effective facility-wide program designed to systematically prevent, identify, control and reduce the risk of acquiring and transmitting infections . The facility staff also provided the survey team with a copy of a document titled, Guidance in Managing Respiratory Illnesses & Outbreaks. This document read in part, Outbreak Management .Notify all departments and re-educate all on hand hygiene, standard, and contact precautions. Use TBP [transmission based precautions] signage on residents room doors . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/24/25 at approximately 7:20 p.m., during initial tour of the facility the surveyor observed personal protective equipment (PPE) on the resident's door and signage outside this residents room that read: Stop, droplet-contact precautions. Perform hand hygiene before entering and when exiting. Respirator/mask before entering room. Discard and replace when exiting. Gown before entering room. Discard when exiting. Gloves before entering room. Discard when exiting. Eye protection before entering room. Discard or disinfect when exiting. After observing the PPE and signage the surveyor observed RN #1 inside the room without the required PPE. Upon exiting the room RN #1 was asked if anyone in the room was on precautions. RN #1 stated she had just taken the medication cart/hall, and she was not told that in report from the off going nurse. The surveyor approached RN #1 a few minutes later after this observation/interview and asked who they were administering medications to in this room. RN #1 stated they were administering medications to Resident #26's roommate. This Resident was not on precautions. This did require RN #1 to walk by Resident #26's bed to get to the other side of the room. On 03/24/25 at 7:25 p.m., Licensed Practical nurse (LPN) #2 stated Resident #26's Tamiflu had ended. A review of Resident #26's MAR's revealed that LPN #2 had signed for Resident #26's isolation on the MAR for 03/24/25 for day shift. RN #1 had not previously signed this MAR for the residents precautions/isolation. The facility staff provided the surveyor with a form titled; in-service attendance sign-in sheet dated 03/24/25 and signed by RN #1. Inservice topic was documented as when a resident finishes Tamiflu it does not indicate the isolation period is over. Flu patients are to be on isolation for 7 days. On 03/26/25 at 4:05 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), Administrator in Training, and Regional Director of Clinical Services the DON/Infection Preventionist was asked their expectations about a staff entering a room of a resident that was FLU positive. The DON stated the nurse should have put on PPE for the resident on precautions. When asked the expectations of the off going nurse regarding reporting a positive flu case to the oncoming nurse. The DON stated she would have expected the off going nurse to let the oncoming nurse know about the precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/27/25 at 9:50 a.m., during a phone interview with RN #1 this nurse was asked how she had clarified that Resident #26 was on droplet precautions. RN #1 stated the nurse she had received report from LPN #2 was still in the building and she spoke with them. LPN #2 had mistakenly thought the resident had finished their Tamiflu sooner than they had and thought the droplet precautions had ended. On 03/27/25 at 3:55 p.m., during a meeting with the Administrator, DON, Administrator in Training, and Regional Director of Clinical Services. The DON confirmed the facility had 8 active flu cases when the survey team entered the building on 03/24/25 and as of 03/27/25 had 14 active cases of the flu. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #15 the facility staff failed to follow infection control procedures for the cleaning of a glucometer. Resident #15's face sheet listed diagnoses which included but not limited to type 2 diabetes mellitus. Resident #15's most recent minimum data set with assessment reference date of 02/20/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #15's clinical record was reviewed and contained a physician's order summary which read in part Insulin lispro insulin pen; 100 units/ml; amt: 8 units; Subcutaneous. Task to record: Before: BS (blood sugar) . and Isolation/Transmission-based precautions: Combined Droplet/Contact Precautions/Isolation related to: FLU A POSITIVE. Start Date: 03/24/2025. Surveyor observed licensed practical nurse (LPN) # 12 on 03/25/25 at 1:30 pm checking Resident #15's blood sugar. LPN #12 retrieved resident's glucometer from the medication cart, donned PPE (personal protective equipment) prior to entering resident's room, checked resident's blood sugar, removed PPE, performed hand hygiene, and exited resident's room. Upon exiting room, LPN #12 placed the glucometer on top of the medication cart, retrieved a cleaning wipe from the cart, cleaned the glucometer with wipe, placed glucometer back onto the medication cart to dry then returned glucometer to storage bag and placed back into the cart. Surveyor did not observe LPN #12 clean the top of the medication cart after placing glucometer on it. Surveyor spoke with the facility infection preventionist (IP) on 03/26/25 at 12:50 pm regarding glucometer/medication cart cleaning. IP stated that it would be their expectation that LPN #12 clean the top of the medication cart after placing glucometer on it. The concern on not cleaning top of medication cart after placing contaminated glucometer on it was discussed with the administrator, administrator-in-training, director of nursing, and regional director of clinical services on 03/26/25 at 4:00 pm. No further information was provided prior to exit.