STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ridge Rehabilitation and Nursing	94 South Avenue Harrisonburg, VA 22801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 41449 Based on observation, resident interview, staff interview, facility documentation review, and clinical record review the facility staff failed to ensure it was determined clinically appropriate to self-administer medications by the interdisciplinary team for one resident (Resident #79- R79) in a survey sample of 31 Residents. The findings included: For R79, who had Bengay cream, antifungal powder and tums at the bedside, the facility staff had not assessed the resident to determine if it was appropriate for the resident to self-administer medications, failed to obtain physician orders for the medications, and failed to remove the medications. On 8/26/24 at 6:19 p.m., R79 was visited in her room during the initial tour and on the over bed table a tube of Bengay ointment and a container of antifungal powder was observed. While talking to R79, the bedside tabletop drawer was open, and it was easily observed that a bottle of tums was inside. R79 was asked about the Bengay and reported she often has pain and reported the has arthritis. When asked about the Bengay cream, R79 reported she applied it to her right leg and knee several times a day. On 8/26/24 at 7:09 p.m., an interview was conducted with licensed practical nurse (LPN #4). LPN #4 was asked about medication storage. LPN #4 reported that all medications are stored in the medication cart or in the medication room. When asked if that included over the counter medications, she said, yes. When asked if residents were able to keep anything in their room, LPN #4 said, no, unless they have an order that says they can self-administer, but I don't think we have anyone. On 8/27/24 at 8:31 a.m., R79 was visited again in her room. R79's bedside table drawer was observed to be open again and the Bengay, antifungal powder and tums were easily seen. (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 8:36 a.m., the surveyor met with the unit manager. The unit manager said that all medications are stored in the medication cart for safety reasons. When asked if any residents self-administer medications, the unit manager confirmed no. The unit manager was asked to accompany the surveyor to R79's room. The unit manager confirmed and removed the Bengay, antifungal powder and tums. The unit manager also confirmed that the antifungal cream was a facility supplied item and not brought in by family. When gathering the items R79 told the unit manager she could throw away the tums. The unit manager was asked what she expects staff to do when they see the medications in resident rooms. The unit manager said, staff should be looking when they go in the room, and I expect them to pull them and bring them to me. On 8/27/24, a clinical record review was conducted of R79's chart. This review revealed that on 7/8/24, an order was written for house stock antifungal BID (twice daily) to breast and abdominal folds. There was no physician order for the Bengay or tums. According to R79's care plan, there was no indication that the interdisciplinary team had assessed nor determined R79's ability to self-administer medications. Review of the assessment tab of R79's chart, revealed no assessment for the ability to self-administer medications. On 8/27/24 at approximately 3:20 p.m., the surveyor was provided with a document titled, Medication Self-Administration Safety Screen that had been requested at 8:57 a.m., that morning, for R79. Also provided was an Education In-Service Attendance Record where the unit manager had educated staff that read in part, . when in a resident room, if you see any medications (pills, creams, etc.) on bedside tables, in drawers, etc. remove the items and give to charge nurse or unit manager. Do not leave in room unless previously ordered by physician. Review of the facility policy titled Resident Self-Administration of Medication with a review date of 12/1/22 read in part, 1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team. 2. Resident's preference will be documented on the appropriate form and placed in the medical record . On 8/27/24, during an end of day meeting held at approximately 1:30 p.m., the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide dignity when moving personal property for one of thirty-one residents in the survey sample (Resident #200). The findings include: Resident #200's personal property/items were moved to another room while the resident was out of the facility at an appointment. There was no advance notice of the room/property move and the resident was not given an opportunity to assist or accompany staff during transfer of personal items to a different room. Resident #200 (R200) was admitted to the facility with diagnoses that included congestive heart failure, hip fracture, neurogenic bladder, diabetes, anxiety and depression. The minimum data set (MDS) dated [DATE] assessed R200 as being cognitively intact. R200's closed clinical record documented a room change on 5/21/24. There was no documentation of a verbal or written notice provided to the resident prior to the 5/21/24 room change. A nursing note dated 5/21/24 at 11:01 a.m. documented a voice message was left for the resident's spouse about a room move. R200's clinical record documented the resident was out of the facility on 5/21/24 for a urology appointment. A nursing note dated 5/21/24 at 4:58 p.m., documented, .returned from urology appointment . A psychology progress note dated 5/27/24 documented that R200 felt the facility should do a better job of communicating with him, in addition to gain his permission before action is taken. Patient does not appreciate his 'pretzels' being misplaced . On 8/27/24 at 3:22 p.m., R200 was interviewed about the personal property/room move on 5/21/24. R200 stated he received no verbal or written notification prior to the room change. R200 stated the room change was done because of his complaints about a roommate. R200 stated he was out of the facility at a doctor's appointment and when he returned, his personal items/property had been moved to another room without his supervision or input. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 10:02 a.m., the facility's social worker (other staff #4) was interviewed about R200's property moved without resident notice or input. The social worker stated she thought the room change on 5/21/24 was made because R200 had conflicts and complaints about the roommate. The social worker stated she recalled that on 5/21/24, the resident returned from an outside appointment. The social worker stated the unit manager at that time reported R200 was upset about his items being moved and was especially upset that his pretzels had been discarded. The social worker stated she went to the store and bought R200 a new container of pretzels. The social worker stated she replaced the pretzels twice because the first replacement was not R200's preference. The social worker stated R200 was upset about his property being moved and especially the discarded pretzels. The social worker stated R200 mentioned the discarded pretzels to his psychologist. The social worker stated a voice message was left for the resident's spouse on the day of the move (5/21/24) but that there was no written or verbal notification to R200 prior to the move. The social worker stated she did not know why staff chose to move the resident that day or why the resident's property was moved when he was out of the facility. R200's unit manager on the date of the room change on 5/21/24 was not available for interview as she no longer worked at the facility. On 8/28/24 at 11:26 a.m., the licensed practical nurse unit manager (LPN #3) that cared for R200 was interviewed about the moving of personal property without the resident's consent or supervision. LPN #3 stated she did not recall why R200's personal items were moved while he was an appointment. On 8/28/24 at 11:36 a.m., certified nurses' aide (CNA) #3 that cared for R200 during his stay was interviewed. CNA #3 stated R200 was upset about the room change on 5/21/24. CNA #3 stated R200 complained frequently about the roommate and still complained after the room change. CNA #3 stated R200 was upset that he got moved while he was out of the facility at an appointment. On 8/28/24 at 11:49 a.m., the director of nursing (DON) was interviewed about R200's property handled/moved without the resident's permission or oversight. The DON stated she remembered the resident was moved but did not recall the events of that day (5/21/24). The DON stated R200 was moved due to complaints and issues with the roommate. The DON stated she did not recall the time of day the items were moved. The DON stated, I don't think it [room change] was done with malice. On 8/28/24 at 2:46 p.m., the administrator was interviewed about R200's room change and personal property transfer without notice. The administrator stated it was not the expectation for staff to move personal items without the resident's permission or oversight. The administrator stated residents were supposed to be notified ahead of time and be allowed time to plan for room and/or roommate changes. This finding was reviewed with the administrator, DON and regional director of clinical services during a meeting on 8/28/24 at 2:00 p.m. with no further information presented prior to the end of the survey.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on staff interview and clinical record review, the facility failed to ensure preferences were met for showers/bathing for 3 of 31 residents. Resident #'s 71, 57, and 53 did not receive showers on multiple scheduled shower days. The Findings Include: 1. Resident #71 (R71) received one shower between 7/29/24 through 8/27/24. R71's most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 8/5/24 and assessed R71 with a cognitive score of 15 indicating cognitively intact. On an annual MDS dated [DATE] preferences were assessed and indicated that it was very important to choose between tub bath, shower and bed bath. On 8/26/24 at 7:40 PM during an interview with R71, R71 verbalized showers were not being provided twice a week as scheduled and rarely gets a shower anymore and contributed it to staff just not doing their job. R71 said that the staff are providing bed baths, but likes to get in the tub in the evening because it helps her (R71) to relax and sleep. R71's showers schedule was reviewed and indicated R71 was to get showers on Wednesday and Saturday. Review of the ADL (Activities of daily Living) shower report from 7/29/24 through 8/27/24 documented R71 received one shower/tub bath out of 6 opportunities. On 8/27/24 at 4:53 PM license practical nurse (LPN #1, unit manager) was interviewed regarding R71 not getting showers. LPN #1 said that the aides are supposed to be documenting showers on the ADL report and telling the nurse if a resident refused or did not get a shower. LPN #1 then reviewed hand documented shower reports forms for R71 also indicating one shower given to R71 between 7/31/24 and 8/24/24. LPN #1 verbalized we are short staffed on occasion but not to the extent of residents not getting showers. On 8/28/24 at 2:48 PM the above finding was presented to the administrator, director of nursing (DON), and nurse consultant. The DON verbalized awareness to the concern and has been trying to change some things such as using a dedicated shower aide, but the aides are saying, they sometimes can't get to everyone. No other information was presented prior to exit on 8/28/24. 41449 2. For resident #57 (R57), the facility staff failed to accommodate the resident's preference to receive showers twice weekly. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at approximately 7 p.m., R57 was visited in his room. R57 reported to the surveyor that he was not getting showers. When asked how often he was supposed to get showers, he said twice weekly. On 8/27/24, a clinical record review was conducted of R57's chart. This review revealed that from July 27-August 27, 2024, R57 received five showers, which occurred on 8/1/24, 8/5/24, 8/12/24, 8/16/24, and 8/22/24. According to R57's most recent annual minimum data set (MDS) assessment, with an assessment reference date of 7/4/24, R57 was assessed as having been able to make himself understood. Section F of the MDS, which was preferences for customary routine and activities was not assessed, as indicated by a dash. In section GG, it indicated that R57 required substantial/maximal assistance of facility staff for showers and bathing. On 8/27/24, a review of the facility's grievance log was reviewed. This revealed that on 7/11/24, R57 filed a grievance about not receiving regularly scheduled showers. There were also five other residents that had filed complaints in July about the lack of showers. On 8/27/24, during a group interview conducted with nine residents, they expressed ongoing concerns about the lack of showers. Review of the resident council minutes revealed four meetings in 2024, two in February, once of which was a make-up meeting for January, August and one which had no date. During those meetings residents expressed concerns about the lack of showers. On 8/27/24, a review of the facility's shower assignment sheet was reviewed and revealed that each room within the facility was assigned two shower days per week on first and second shifts. According to the shower schedule, R57's assigned shower days were Monday and Thursdays on the 7am-3 pm shift. During the survey, the survey team observed an adequate quantity of nursing staff available on each of the units and were unable to determine why resident's requests and preferences with regards to showers were not being upheld. On 8/27/24-8/28/24, various staff interviews were conducted with numerous nursing staff, which included but were not limited to licensed practical nurses (LPN #4 and LPN #5), the unit manager (LPN #3), and certified nursing assistants (CNA #6 and CNA #7), all who reported showers were given twice weekly based on the shower assignment. The facility's ADL (activities of daily living) policy was reviewed. It made no mention as to the frequency of showers. It read in part, . 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene . On 8/27/24 at approximately 1:30 p.m., during a meeting held by the survey team with the facility administrator and director of nursing (DON) the above concerns regarding the lack of resident's preference for showers was discussed. The director of nursing said this had been an area of ongoing concern that they had been working to address but were still having issues with and had not fully resolved. The DON indicated that a lack of staff was not the issue, they just weren't being done. No additional information was provided. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	21875 3. Resident #53 did not receive a shower per her preferred frequency of twice per week. Resident #53 (R53) was admitted to the facility with diagnoses that included coronary artery disease, hypertension, diabetes and depression. The minimum data set (MDS) dated [DATE] assessed R53 as cognitively intact and as requiring partial/moderate assistance for showers/bathing. On 8/26/24 at 6:46 p.m., R53 was interviewed about quality of life/care in the facility. When asked about assistance with baths/showers, R53 stated she was not getting two showers per week as she preferred. R53 stated she had been ten days without a shower. R53 stated she preferred a shower to a bed bath, and she knew it was a state requirement for residents to get two showers per week. R53 stated her scheduled shower days were Tuesdays and Fridays. R53 stated she did not know why she was unable to get a shower twice per week. R53's shower records from 7/29/24 through 8/25/24 documented the resident's last shower was on 8/16/24. R53's shower records documented four showers in the last 30 days on 7/30/24, 8/2/24, 8/13/24 and 8/16/24. R53's clinical record documented no evidence the resident was offered and refused showers. R53's plan of care (revised 6/6/24) documented the resident required assistance with activities of daily living due to limited mobility, weakness and history of falls. Interventions to maintain hygiene and activities of daily living included helping with bathing/showering as needed. On 8/28/24 at 8:23 a.m., certified nurses' aide (CNA) #2 caring for R53 was interviewed about showers. CNA #2 stated residents wanting showers were scheduled twice per week and assignments were recorded in a shower book at the nursing desk. CNA #2 stated R53's showers were scheduled for evenings. CNA #2 stated she was not sure why R53 was not getting twice per week showers. On 8/28/24 at 8:49 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about R53's shower frequency. LPN #1 stated R53 was scheduled to get a shower twice per week during the evening. LPN #1 stated she did not know why R53 was not getting showers twice per week. LPN #1 stated showers given were documented in the activities of daily living records. On 8/28/24 at 2:48 p.m., the director of nursing (DON) was interviewed about R53 not getting showers twice per week as preferred. The DON stated residents were supposed to get showers at least twice per week if desired. The DON stated, I've looked at shower records. They [residents] are not getting them. The DON stated there were enough staff members but that showers were just not getting done. The DON stated she had audited showers in the last two weeks and recognized there was an issue with shower frequency. This finding was reviewed with the administrator, DON and regional director of clinical services during a meeting on 8/28/24 at 2:00 p.m. with no further information presented prior to the end of the survey.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide written notice prior to room changes for five of thirty-one residents in the survey sample (Residents #12, #13, #53, #57 and #200). The findings include: 1. No written notice was provided to Resident #53 prior to room changes on 5/10/24 and 7/1/24. Resident #53 (R53) was admitted to the facility with diagnoses that included coronary artery disease, hypertension, diabetes and depression. The minimum data set (MDS) dated [DATE] assessed R53 as cognitively intact. On 8/26/24 at 6:46 p.m., R53 was interviewed about quality of life/care in the facility. R53 stated she had moved rooms twice and had no notice prior to the changes. R53 stated, They just come in and tell you, you are moving. R53 stated she felt her room changes were due to issues with roommates. R53 again stated that she received no verbal or written notice prior to the room/roommate changes. R53's clinical record documented no notification about the room changes on 5/10/24 and 7/1/24. Nursing notes made no mention that the resident changed rooms and/or roommates. On 8/28/24 at 9:53 a.m., the facility's social worker (other staff #4) was interviewed about notification to R53 about room changes. The social worker stated the room changes were due to roommate conflicts. The social worker stated no written notices were provided to R53 prior to the room changes. On 8/28/24 at 2:46 p.m., the administrator was interviewed about room changes without prior notice. The administrator stated residents were supposed to be notified ahead of time regarding room changes and be allowed time to plan for room moves. The facility's policy titled Change of Room or Roommate (revised 12/1/22) documented, .The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required . This finding was reviewed with the administrator, DON, and regional director of clinical services, during a meeting on 8/28/24 at 2:00 p.m., with no further information presented prior to the end of the survey. 2. No written notice was provided to Resident #200 prior to room changes on 1/8/24, 2/6/24, and 5/21/24. Resident #200 (R200) was admitted to the facility with diagnoses that included congestive heart failure, hip fracture, neurogenic bladder, diabetes, anxiety and depression. The minimum data set (MDS) dated [DATE] assessed R200 as cognitively intact. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R200's closed clinical record documented room changes on 1/8/24, 2/6/24 and 5/21/24. The clinical record documented no written notice to R200 prior to these room changes. There was no written notification provided to the resident indicating the reason for the room changes. On 8/27/24 at 3:22 p.m., R200 was interviewed about notification of room changes. R200 stated he moved rooms three times during his stay at the facility and received no verbal or written notification prior to the room moves. On 8/28/24 at 10:02 a.m., the facility's social worker (other staff #4) was interviewed about written notification to R200 prior to room changes. The social worker stated no written notices were provided to R200 prior to the room changes. The social worker stated she verbally told R200 on 2/5/24 about the room change on 2/6/24. The social worker stated she saw no other notifications to the resident about the room changes. On 8/28/24 at 2:46 p.m., the administrator was interviewed about room changes without notice. The administrator stated residents were supposed to be notified ahead of time regarding room changes and be allowed time to plan for room moves. The facility's policy titled Change of Room or Roommate (revised 12/1/22) documented, .The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required . This finding was reviewed with the administrator, DON and regional director of clinical services during a meeting on 8/28/24 at 2:00 p.m. with no further information presented prior to the end of the survey. 41449 3. For resident #57 (R57), the facility failed to provide written notification prior to a room change. On 8/27/24 at 8:08 a.m., an interview was conducted with R57. When asked about a recent room change, R57 said he had a room change to be on isolation. On 8/27/24, a clinical record review was conducted. According to the census tab of R57's chart, he had a room change on 8/13/24. Then on 8/26/24, was moved back to the original room. According to the progress notes an entry was made by the social worker on 8/13/24 at 2:50 p.m., that read, Both myself and DON (Director of Nursing) spoke with [resident's wife's name redacted] about pt [patient] room move and isolation protocol and treatments. There was no indication that the room change had been discussed with the resident prior to the move on 8/13/24 or 8/26/24. There was no evidence that the room change was provided in writing to the resident. 4. For resident #12 (R12), the facility failed to provide written notification prior to a room change. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at approximately 7 p.m., an interview was conducted with R12. R12 reported that she had been separated from her prior roommate, who she identified as resident #22 (R22), and expressed a desire to room with her again. When asked if she was notified in writing of the change, R12 said, No, nothing was provided in writing. R12 went on to say she was told they were moving her because they were going to do renovations but reports no renovations had taken place. On 8/27/24, a clinical record review was conducted of R12's chart. This review revealed that 6/29/22, R12 was moved into room [ROOM NUMBER], where she remained until she was moved to another unit on 3/8/23. According to the progress notes, an entry was made by the facility administrator on 3/7/23, that read, This writer and director of nursing notified resident this evening of need for a room change so that room renovations can begin. Resident in agreement and is going to begin organizing things for the room move to take place tomorrow, 3/8/23. There was no evidence within the clinical record that a written notice was provided. 5. For resident #13 (R13), the facility failed to provide written notification prior to a room change and failed to address her preference to room with her prior roommate. On 8/27/24 at approximately 11:30 a.m., R13 stopped the surveyor and wanted to express concerns. R13 shared concern that she and her roommate had been split up, in the facility's efforts to make a male room, but says that didn't occur and that she missed her former roommate. R13 reported that they liked being roommates and she, R13 was able to encourage the roommate to attend out of the room activities, which the roommate's family was appreciative of. When asked if R13 received anything in writing about the room change, R13 reported she had not. On 8/27/24 and 8/28/24, a clinical record review was conducted. According to the census tab of R13's chart, she was moved to room [ROOM NUMBER] on 9/15/23. On 2/5/24, she received a new roommate who was being admitted to the facility. They remained roommates until 8/12/24, when both were moved to different rooms, and R13 was moved to a separate unit. Review of the progress notes, assessment tab, and misc. tab of R13's clinical record revealed no information with regards to the room change nor that R13 was given written information about the change. On 8/28/24 at approximately 1:30 p.m., the facility administrator and director of nursing were made aware of the above findings with regards to the lack of written notification for room changes. The concern expressed by R13 and her desire to room with her prior roommate was also discussed. The facility administrator reported that R13's prior roommate had expressed concerns about being roommates and didn't desire to room with R13. The administrator stated that she had statements about this. The survey team asked the administrator to provide any information she had. Following the above meeting, the surveyor went and visited the prior roommate of R13 in her room. When asked about the prior roommate, this resident said that she missed R13. When asked if she would like to be roommates with her again, she said, Yes. No concerns or complaints regarding R13 was shared. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at approximately 2:30 p.m., the facility administrator provided the survey team with a statement written 8/7/24, by the wound treatment nurse. The statement read in part, This nurse has observed on several occasions during treatment and care, [R13's prior roommate's name redacted] performing task for [R13's name redacted] . This nurse feels that [R13's name redacted] takes advantage of and could potentially cause harm, even unintentionally, towards [roommate's name redacted] . I have attempted to speak with both residents regarding these actions . This nurse feels that is in [sic] the best interest of both residents that they do continue to be roommates. I am concerned that [R13's prior roommate's name redacted] could hurt herself, fall, or have a serious injury. There was no evidence of this within R13's clinical record or that the care plan team had discussed such concerns with the residents and/or resident's family members. There was nothing in the statement that the former roommate had expressed concerns or indicated not wanting to room with R13. On 8/27/24, in the afternoon, an interview was conducted with the facility's social worker (SW). The SW was asked about room changes and reported that they discussed room changes as a team to attempt to determine compatibility. The SW went on to say that she is usually the one that will notify the resident of the room change. When asked if she provides anything in writing regarding the reason for the room change, the SW said no, that that she has never given anything in writing. Review of the facility policy titled Change of Room or Roommate with a review date of 12/1/2022 read in part, . It is the policy of this facility to conduct room changes or roommate assignments when considered to be necessary by the facility and/or when requested by the resident or resident representative .4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. 5. The notice of a change in room or roommate will be provided in writing, in a language and manner the residents and representative understands and will include the reason(s) why the move or change is required No further information was provided.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interviews, and facility documentation review, the facility staff failed to maintain adequate funds on-site so that two residents (resident #226 - R226 and resident #53 - R53) had access to their personal funds/trust accounts, which had the potential to affect 41 residents with a trust account. The findings included: 1. For R226, the facility failed to maintain sufficient funds and denied the resident's request to make withdrawals from his account. On 8/27/24 at approximately 8:15 a.m., R226 asked the surveyor to come into his room. R226 reported that he had failed to mention on the prior evening a concern with regards to him having access to his bank account. R226 went on to say that on multiple occasions he had attempted to get money out of his trust account for shopping but had been denied the ability to make withdrawals. R226 went on to say that he could get money previously but now he is told he must make a list of what he wants first or talk to the activities person or is told they don't have the money. On 8/27/24 at 4:22 p.m., an interview was conducted with the business office manager (BOM) (other employee #5). The BOM was asked to explain the process when a resident wants to withdraw funds from their trust account. The BOM explained that she would check to see if they have an account, if they have funds and then will fill out a receipt and give them cash. She said the residents are permitted to withdraw $40 per day. The BOM went on to say, Resident shopping is a different program, the activity director will go around and ask if they want to purchase anything. Those are collectively entered under resident shopping and a check is requested from corporate. Once they approve and send me the check, we cash the check and [activities director's name redacted] gets the cash and list and goes shopping. When asked what the turnaround time is for her to get the check, the BOM said, It varies, depending on what is going on in the building. We just started this process a few weeks ago and I am reinstituting it. We only keep $245 here and we last got that on August 2. We went through that within a week. We have some residents who will withdraw their $40 per day and that doesn't leave much for the others. When asked again for clarification that if a resident requests money for shopping, are they denied that request because there is a process where a check is requested from corporate, the business office manager said, Yes. During the above interview, the BOM was asked about resident's access to funds and where they go to make withdrawals. The BOM said she handles that now, but the position was vacant for eight months. When asked about if a resident's family comes on the weekend and the resident wants to withdraw funds, what is done, the BOM said, They have to get it ahead of time or the family can provide receipts to get reimbursed. The BOM went on to say that she is only at the facility Monday through Friday. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The BOM was asked about R226. The BOM said, He does have an account, but I don't have any petty cash on hand right now. We only have $5. I am waiting for it to get replenished. There has been some confusion for him. He said someone was going shopping for him. He kept saying [activities director name redacted] was going shopping, which means resident shopping which is once a month. I explained the procedure is that she would get a list from him, and I thought he was talking about resident shopping. I told him we only have $5, and we just changed banks last week. We got it set up where the administrator can cash checks. The BOM provided the surveyor with a transaction history for R226. Review of this revealed R226 had last had a withdrawal on 7/24/24. On 8/27/24 at 4:45 p.m., an interview was conducted with the activity assistant. The activity assistant was asked about resident shopping and said, I go around and write down a list of what they want, and they give me $40 because that is as much as they can get. A lot of times they will tell me, they didn't get money this week. They don't have any money right now, they switched banks, so no one can get money right now. When asked specifically about R226, the activity assistant said, He is always the short end of the stick somehow. The last 2 shopping trips they ran out of money before he could get any. So I just went on my day off. I've had to buy things for him myself because I felt bad, but I never got reimbursed and I can't afford that. So I can't keep doing that. The activity assistant went on to explain that they were just notified that the process for resident shopping was changing, and they would no longer get money from residents. She explained that they will get a list of what residents want, must go online to get prices for everything, and then they will get a check for everything. The activity assistant explained that this was a new process they were just told about. The BOM stated that a sign was posted in the lobby of when residents could access/withdraw money from the trust account. The lobby was searched, and no posting was noted. At 5:12 p.m., the administrator had the maintenance director put up a sign outside of the BOM's office that indicated banking hours were Monday-Saturday, 7am-7pm. When asked about this, the administrator stated that she had found the sign in the activity's office. When asked how residents will access funds during those hours, the administrator said that the receptionist will keep the money since that is their hours. When asked about this, the BOM confirmed that currently she had the money box, that the receptionist did not have it, and that money is only available Monday-Friday, when they have money to give to residents. On 8/28/24 at 1:30 p.m., during a meeting with the facility administrator and director of nursing, the facility was made aware of the above findings. The facility provided a policy regarding resident trust accounts, but it did not address resident's access to the funds, it only stated the procedures of the business office with regards to trust accounts. No additional information was provided. 21875 2. R53 did not have timely access to money from her personal fund account. Resident #53 (R53) was admitted to the facility with diagnoses that included coronary artery disease, hypertension, diabetes and depression. The minimum data set (MDS) dated [DATE] assessed R53 as cognitively intact. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 7:04 p.m., R53 was interviewed about quality of life/care in the facility. R53 stated during this interview that money from her personal fund account at the facility was not always available when requested. R53 stated, You never get it [money] when you ask. R53 stated sometimes it took several days to get money from her account. R53 stated she had asked for money and was told there was not enough cash or nobody was there to issue the money. R53 stated that if she had an outing planned, she asked for the money a week ahead to get it in time. R53's personal fund account documented the resident had available funds with amounts of $50.00 or less provided on 3/21/24 and 6/5/24. On 8/27/24 at 4:55 p.m., the business office manager (other staff #5) was interviewed about R53 having to wait days to access her funds. The business office manager stated she just started work at the facility on 8/1/24 and did not know what the issues were for accessing resident funds prior to that date. The business manager stated as of today (8/27/24) there was $5.00 in the available cash for residents. The business office manager stated the facility recently switched banks and there had been a down time for cashing checks. The business office manager stated, I just don't think we are keeping enough money in the petty cash account. This finding was reviewed with the administrator, director of nursing, and regional director of clinical services, during a meeting on 8/28/24 at 2:00 p.m., with no further information presented prior to the end of the survey.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 21875 Based on employee record review, facility document review, and staff interview, the facility staff failed to follow abuse prevention policies regarding pre-employment screening and background checks for 18 of twenty-five records reviewed. The findings include: Twenty-five employee records were reviewed for compliance with the facility's policy for background checks and pre-employment screenings. Of the twenty-five records reviewed, 18 records had no reference checks, 2 licenses were not verified prior to employment; and 6 records documented no sworn statement regarding any criminal history. The list of employee records identified with missing information was provided to the facility's human resource manager (other staff #5) on 8/28/24. On 8/28/24 at 5:04 p.m., the human resource manager (other staff #5) was interviewed about the missing reference checks, license verifications, and criminal history statements. The human resource manager stated, I've reviewed and am not finding any of the missing information. The human resource manager stated the employee records were unorganized with information being difficult to locate. The human resource manager stated the facility required a statement about criminal history, criminal background check, license verification and reference checks for all new employees. The facility's policy titled Background Investigation (revised 10/28/20) documented, Job reference checks, drug screenings, licensure verifications and criminal conviction record checks are conducted on all personnel making application for employment with this company .The facility will not employ individuals who .Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law .Have a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of resident, or misappropriation of resident property . Have a disciplinary action in effect against his or her professional license in a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of resident, or misappropriation of property . This finding was reviewed with the administrator, director of nursing, and regional director of clinical services, during a meeting on 8/28/24 at 7:00 p.m., with no further information provided prior to the end of the survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 28106 Based on staff interview and clinical record review, the facility failed to develop a care plan for one of thirty one residents. Resident #60 (R60) did not have a complete care plan developed for dialysis. The Findings Include: Diagnoses for R60 included: End stage renal disease receiving dialysis, congestive heart failure, pulmonary embolism, and hypertension. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 6/13/24. R60 was assessed with a cognitive score of 12 indicating cognitively intact. Review of R60's blood pressures (BP) from 7/25/24 through 8/24/24 indicated an average systolic pressure of 140's and diastolic pressure of 70's and also indicated recently (on 8/22/24 and 8/23/24) an increase in BP to 183/83 and 179/83. Review of physicians orders did not indicated blood pressure parameters for dialysis. The care plan was then reviewed and also did not indicate blood pressure parameters in the dialysis care plan or throughout the care plan in any other focus area. On 8/28/24 at 3:43 PM license practical nurse (LPN #2) was interviewed. LPN #2 verbalized noticing an increase in R60's BP lately and verbalized this could be a sign of kidneys failing. When asked if this had been reported, LPN #2 responded only working a few days when needed and wasn't sure if it had been reported, but would make sure it gets reported to the physician. On 8/28/24 at 3:56 PM the above finding was presented to the director of nursing (DON). The DON reviewed record and also could not find evidence of parameters for blood pressures on the care plan. No other information was presented prior to exit conference of 8/28/24.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for four of thirty-one residents in the survey sample (Residents #32, #39, #57 and #80). The findings include: 1. Resident #80's care plan was not revised to reflect the resident's ability to communicate verbally and without use of a communication board. Resident #80 (R80) was admitted to the facility with diagnoses that included cerebrovascular accident (stroke), hemiplegia, anxiety, depression, hypertension and respiratory failure. The minimum data set (MDS) dated [DATE] assessed R80 as cognitively intact. On 8/27/24 at 1:55 p.m., R80 was interviewed about quality of life/care in the facility. R80 verbally answered the interview questions and responded to conversation without use or need of a communication board. R80's plan of care (revised 5/28/24) documented the resident had aphasia due to cerebral infarction and was nonverbal and uses a dry erase board for communication. Interventions for impaired communication included, .requires dry erase board to communicate. Ensure availability and function of adaptive communication equipment . On 8/28/24 at 8:35 a.m., the licensed practical nurse unit manager (LPN #1) caring for R80 was interviewed about the communication care plan. LPN #1 stated R80 was unable to talk/communication when she was initially admitted . LPN #1 stated R80 was now able to speak and converse without use of the dry erase board. LPN #1 stated R80 had not used the communication board for approximately four months. LPN #1 stated the care plan had not been revised to delete the communication board and indicate the resident was now verbal. This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 8/28/24 at 2:00 p.m. with no further information presented prior to the end of the survey. 41449 2. For R57, who fell on [DATE], the facility staff failed to review and revise the care plan to indicate the fall and if any needed revisions were needed to prevent a future fall. On 8/26/24 at approximately 7:30 p.m., R57 was visited in his room. R57 reported he had recently fallen. When asked what the facility had done following the fall to prevent future falls, the resident said he didn't know. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24, a clinical record review was conducted. This review revealed a nursing note entry dated 8/13/24, that read, Resident was informed that he needs to move to room [ROOM NUMBER]. CNA reports resident became anxious and agitated and called his wife. Afterwards this nurse was called to resident's room, resident was observed on the floor on his left hip/buttock. Resident reports pain in left hip but also has chronic pain in left hip. MD (medical doctor) [name redacted] notified, new order for hip x-ray. Resident assisted back into his w/c (wheelchair) and moved to room [ROOM NUMBER]. Resident also medicated per order for pain. Staff will continue to monitor. According to R57's care plan, it noted the resident was at risk for falls d/t [due to] impaired mobility and impaired cognition . The most recent intervention for this fall focus area was dated 3/27/24. There was no indication that the care plan had been reviewed or revised following the fall on 8/13/24. According to a fall risk assessment completed on 7/4/24, R57 was identified as having been at high risk for falling. 3. For resident #39 (R39), who had a fall that required a hospital visit, the facility staff failed to review and revise the care plan. On 8/27/24 at 8:14 a.m., R39 was visited in his room. When asked if he had any recent falls, R39 said, he had experienced a couple of falls and I got banged up and all. When asked, what do they do to try to keep you from falling? The resident said, they tell you not to get up too fast. On 8/27/24, a clinical record review was conducted of R39's chart. According to a post- fall review which was locked [indicating complete] on 8/23/24, indicated the resident had an unwitnessed fall on 8/14/24 at 9:30 a. m., and sustained an abrasion to the left side of his forehead. According to section C of this document, which was intervention recommendations it stated, educated pt [patient] on calling for assistance before ambulating and the box 2a. was checked to indicate Indicate all intervention recommendations: 2 a. Care plan revision. According to the nursing notes, an entry dated 8/14/24 at 9:34 a.m., indicated the resident had a fall, the doctor was notified that the resident was requesting to go to the emergency room . On 8/14/24 at 9:59 a.m., another entry was made that indicated the resident was sent to the emergency department for evaluation. According to R39's assessments, a Morse Fall Scale was performed on 7/10/24, which indicated the resident was High Risk for Falling. A care plan indicating R39 was at risk for falls was initiated on 5/9/22. The most recent intervention revision was performed on 1/21/23. The goal that the resident . will not sustain serious injury r/t [related to] falls through the review was revised on 7/19/24. On 8/28/24 at3:46 p.m., the Director of nursing (DON) was made aware of the above findings. The DON reviewed the care plan for R39 and confirmed the findings and indicated the care plan should have been reviewed and revised following the incident. 4. For R32, who weight indicated a 22.6-pound weight loss in one month, the facility staff failed to review and revise the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24, at approximately 6:30 p.m., R32 was visited in his room. R32 reported that he goes to dialysis three times weekly. On 8/27/24, a clinical record review was conducted of R32's chart. According to weights tab of R32's chart, on 7/10/24, the resident's weight had been recorded as 180.4 lbs. The resident's weight on 8/14/24, was recorded as 157.8 lbs. The dialysis communication book was observed, and it was blank, therefore no information was available from dialysis with regards to the weight change. A Quarterly Nutrition Review was within the progress notes and dated 8/13/24. The note read in part, .7/10 [July 10, 2024] 180.4# post dialysis dry weight. BMI 28.3, no weight exception triggered. August weight pending . He is at nutritional risk for sx [side effects] to his previous amputation and dialysis dependence. His PO [by mouth] intake appears adequate a.e.b [as evidenced by] his stable weight and wound healing. Rec: [recommendation] Record an August weight. On 8/19/24, a Weight change note was entered into the progress notes. It read, -10.0% change [12.5%, 22. 6] Will re-request a post dialysis dry weight for August. His current weight is showing a 22.6#change in a month. This is a severe weight loss if verified . This review revealed that R32 had an order to obtain the dry weight from dialysis every four weeks. However, on 8/13/24, an order was written that read, Weigh one time only for 1 Day - Call dialysis to get a dry weight for August. On 8/14/24, a weight of 157.8 lbs. was recorded. Then on 8/19/24, another order read, Call dialysis to get a post dialysis weight for August one time only for 1 Day. The weight recorded on 8/20/24, noted 157.8 lbs. Review of R32's care plan revealed he had been identified as having potential nutritional problem r/t [related to] therapeutic diet. All the associated interventions were dated 2/13/24. The care plan goal was revised on 8/26/24, and read, [R32's name redacted] will maintain adequate nutritional status as evidenced by maintaining weight with no s/sx [signs or symptoms] of malnutrition, and nutritional needs provided through review date. There was no indication that the care plan was revised to reflect the significant weight loss, nor any interventions were implemented in response to the weight loss. On 8/27/24, attempts were made to interview the care plan coordinator, but the survey team was notified that she was not available nor working during the survey period. On 8/28/24 at 1:30 p.m., the above findings were reviewed with the facility administrator and director of nursing. On 8/28/24 at 3:40 p.m., interviews were conducted with LPN #1 [licensed practical nurse]. LPN #1 reported, If a resident had a fall, it would get put on the care plan the next business day. We talk about them the next morning. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at 3:43 p.m., an interview was conducted with the director of nursing (DON). When asked about care plan revisions, the DON stated, They should be updated with each change or event. When asked why this is important, the DON said, So that we know what the plan of care is and went on to say, interventions are put in place to reduce the risk of falls or fall related injuries. The facility policy titled, Comprehensive Care Plans was reviewed. The policy did not address revisions when a resident experiences a fall, significant weight change, or other acute change outside of the scheduled assessments. Review of the facility policy titled, Fall Prevention Program was conducted. The policy read in part, A fall is an event in which an individually unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force. The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere . 9. When any resident experiences a fall, the facility will: . e. Review the resident's care plan and update as indicated . No additional information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41449 Based on observation, resident and staff interviews, clinical record reviews, and facility documentation reviews, the facility staff failed to provide activities of daily living (ADL) care to residents who required staff's assistance, for five residents (resident #12- R12, resident #22- R22, resident #57-R57, resident #40-R40, and resident #49-R49), in a survey sample of 31 residents. The findings included: 1. For R12, who was dependent upon facility staff for toileting assistance, the facility staff failed to respond timely to the resident's call light, which resulted in R12 urinating on the floor on one occasion. On 8/26/24 at 6:30 p.m., R12 was observed with her call bell on. R12 was sitting at her doorway waiting for staff to respond. When the certified nursing assistant (CNA) responded, at 6:48 p.m., the CNA noticed a wet spot on the room floor with a towel over it. R12 reported that she had not been able to hold it and had urinated on the floor. The CNA assisted R12 with being cleaned up and put in the bed. On 8/26/24 at 7 pm., the surveyor interviewed R12 in her room. R12 reported that frequently she must wait hours for staff to respond to her call bell. On 8/27/24 at 10:40 a.m., upon the surveyor's arrival on the unit, R12's call bell was observed to be engaged, the light outside of the room was illuminated and an auditory alarm sounding. Numerous staff were observed on the hallway, a nurse performing medication administration, a housekeeper cleaning, and four nursing assistants, who were in and out of rooms on the unit. It was 11:28 a.m., before a staff member responded to R12's room to see what she needed. This was 48 minutes after the surveyor observed the call bell, which was already on when the surveyor made the observation at 10:40 a.m. Following R12 receiving care at 11:28 a.m., the surveyor interviewed R12 in her room. R12 reported she had been waiting for staff to clean her up/provide incontinence care. On 8/27/24, a clinical record review was conducted of R12's chart. R12's most recent minimum data set (an assessment tool) with an assessment reference date of 6/29/24, was reviewed. According to section G of this assessment, R12 required extensive assistance of facility staff for bed mobility, transfers, and toileting. R12 was also coded on this assessment as having had a brief interview for mental status score of 15 out of 15, which indicated she was cognitively intact. According to R12's care plan, she was noted to have a self-care performance deficit Interventions included, but were not limited to, Toilet use: nursing staff to provide assistance as needed, [R12's name redacted] uses a bed pan at times . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 2:09 p.m., R12's call bell was again observed engaged. At 2:15 p.m., a nurse entered the room and came out and told certified nursing assistant (CNA) #8 that the resident needed to be cleaned up. CNA #8 was interviewed about call bell responses, and she stated, they should be answered as soon as we can. When asked about R12 having to wait 48 minutes earlier in the day, CNA #8 said, Yeah, that's too long, I don't know what happened, that's a long time, too long. I went and answered another call bell, but I know for them 5 min seems like 5 hours. At 2:20 pm CNA #8 entered R12's room to provide care. 2. For R22, a female resident who had significant facial hair approximately 1 inch long, the facility staff failed to provide assistance to remove the facial hair. On 8/27/24 at 11:25 a.m., during an observation of the nurse administering tube feeding and medication, R22 was observed with a significant amount of facial hair on her chin approximately an inch long. When asked about the facial hair, R22 said, I know, I do [have the facial hairs]. They look terrible and make me look ugly. Can I get them off? LPN #5, the nurse said, Yes, we will get it today. R22 said, That sounds wonderful. That will make me happy, and it will make me feel good. On 8/27/24, a clinical record review was conducted of R22's chart. According to R22's care plan, it noted the resident had a self-care performance deficit and the interventions included, Personal Hygiene/oral care: [R22's name redacted] requires extensive to total assist for grooming and oral care. On 8/28/24 at8:06 a.m., R22 was observed again in bed and the chin/facial hairs were still present. On 8/28/24 at 8:10 a.m., an interview was conducted with LPN #5. When asked when residents are to be shaved, LPN #5 said, I would assume in the shower or whenever they [the staff] have a minute. When asked why R22 had not been shaved when she had requested it yesterday, LPN #5 said, We didn't have time and then she was in therapy by the time we got to her. She scooted off to therapy and we just didn't get back down that way. On 8/28/24 at 8:13 a.m., an interview was conducted with the unit manager. When asked when residents are shaved, the unit manager said, Usually on their shower days, unless they request it in between. None that we have now do it every day. When asked about women with facial hair, the unit manager said, It should be on their shower days. The unit manager was notified that R22 had requested yesterday to be shaved, the unit manager said, It should have been done. Also, she probably changed her mind, She agrees that it needs to be done but often when you go to do the activity, often she doesn't participate. I would have to do some checking to see what transpired. On 8/28/24 at 10:42 a.m., R22 was again observed in bed, with the facial hair still present. On 8/28/24 at 1:30 p.m., during a meeting with the facility administrator and director of nursing, they were made aware of the above findings. On 8/28/24 at approximately 2:30 p.m., the director of nursing reported to the surveyor that R22 was in the activity being held and they would get the resident shaved after the activity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. For R57, who had been left unsupervised/unattended sitting on the toilet, had engaged the call bell, and was yelling out for assistance, the facility staff failed to respond timely to assist the resident off the commode. On 8/27/24 at 10:40 a.m., the surveyor arrived on the unit. R57's call bell was engaged at 10:52 a.m., noting that a light was blinking outside of the room and an auditory alarm was sounding in the hallway. R57 could be heard yelling out for help. LPN #5 was observed in the hallway outside of R57's room at the medication cart. Three CNAs were observed on the unit, entering and exiting the utility room, various resident rooms, and up and down the hallway. A housekeeper was also observed on the hallway cleaning. At 11:05 a.m., LPN #5 entered the room and was heard to tell the resident, You don't have to keep yelling, give us a minute. Following the above observation, LPN #5 was approached by the surveyor and asked why R57 was yelling. LPN #5 reported that R57 was sitting on the toilet and waiting for the staff to get him off. At 11:28 a.m., two CNAs were observed to enter R57's room to assist with getting the resident off the commode. On 8/27/24 at 2:09 p.m., an interview was conducted with LPN #5. When asked if residents can be left unassisted and unsupervised on the toilet, LPN#5 said, They can leave him in the bathroom, they were just busy and didn't have to change to get there yet. LPN #5 was asked if she can assist residents with toileting, LPN #5 said, I am able to help out but if I'm on the cart and have narcotics, I can't leave them. When asked if residents should have to wait 36 minutes to be assisted off the toilet, LPN#5 said, I'm agency, so I've only been here a few times, but of course not. Five to ten minutes is reasonable. LPN #5 went on to confirm that they had adequate staffing for the shift and that staff were just busy. According to R57's care plan, the interventions read, Toilet use: Nursing staff to provide assistance as needed. [R57's name redacted] has incontinence and staff assist with changing him . Encourage [R57's name redacted] to use bell to call for assistance . Review of the facility policy titled, Call Lights: Accessibility and Timely Response was conducted. This policy read in part, . 8. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified . On 8/28/24 at 1:30 p.m., the facility administrator and director of nursing were made aware of the above findings. No additional information was provided. 21875 4. Facility staff failed to cut/trim Resident #40's toenails as required in the plan of care. Resident #40 (R40) was admitted to the facility with diagnoses that included lower leg fracture, atrial fibrillation, heart failure, urinary tract infection and depression. The minimum data set (MDS) dated [DATE] assessed R40 as cognitively intact and as requiring substantial/maximum assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at 7:12 p.m., R40 was observed in bed with feet/toenails visible. R40's toenails were thick, yellow, and jagged with several extending approximately 1/8 inch beyond the end of the toes. The left great toenail had layers of brown nail material between the nail surface and the toe. R40 was interviewed at this time about the length and condition of the nails. R40 stated her toenails were too long and needed cutting. R40 stated an aide tried to cut them during a shower but was unable to do it. On 8/27/24 at 4:30 p.m., the certified nurses' aide (CNA #1) caring for R40 was interviewed about the resident's long toenails. CNA #1 stated the resident's nails needed trimming. CNA #1 stated nails were usually trimmed during showers and that she thought R40's showers were scheduled for the day shift. On 8/27/24 at 4:35 p.m., the registered nurse (RN #2) caring for R40 was interviewed about the resident's toenails. RN #2 stated he assessed the resident upon admission and the nails were not in good shape when she arrived at the facility. Accompanied by RN #2 and with the resident's permission, R40's toenails were observed. The nails were thick, jagged, uneven and extended beyond the ends of the toes. RN #2 stated he thought someone had attempted to cut them and he was not sure what options were available to address the nails. R40 stated again at this time that the toenails needed trimming. On 8/28/24 at 8:21 a.m., CNA #2, who was caring for R40, was interviewed about the long toenails. CNA #2 stated she had seen the nails and that they needed trimming. CNA #2 stated that aides were expected to trim nails during showers, if the resident was not diabetic. On 8/28/24 at 8:37 a.m., the director of nursing (DON) was interviewed about R40's toenails. The DON stated R40 was not diabetic and that the aides were expected to cut nails during shower time. The DON stated if the aides had difficulty cutting the nails, nurses was expected to assist with cutting/trimming nails. The DON stated if aides/nurses were unable to trim the nails, podiatry was an option. R40's plan of care (revised 7/12/24) documented the resident required assistance with activities of daily living (ADLs) due to fracture, weakness and difficulty moving. Interventions to maintain ADLs included, . Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse . This finding was reviewed with the administrator, DON, and regional director of clinical services, during a meeting on 8/28/24 at 2:00 p.m., with no further information presented prior to the end of the survey. 49456 5. The facility staff failed to ensure Resident #49's call bell within reach. Resident #49 (R49) was not able to call for assistance. On 8/26/24 a tour of the facility was conducted. During the tour, it was observed that R49's room door was closed, and she was yelling out continuously for someone come help me. When this surveyor entered the room, R49's call bell was on the floor under the bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at 6:45 p.m., an interview was conducted with R49's nurse. The licensed practical nurse, LPN #4 stated, The call bell should not be under the bed but within her reach. LPN #4 (LPN4) indicated that she was going to get an aide to come in and assist R49 with a bath. On 08/26/24 7:30 p.m., an interview was conducted with R49. When asked why she had been yelling, R49 said that she was yelling out for help because I needed someone. R49 then stated, I stink. I need a bath. I smell. On 8/27/24 at 9:00 a.m., an observation was made of R49's call bell, which was again out of her reach. The call bell was laying over the bedside table, where R49 was not able to reach, and was unable to use the call bell to call for assistance. On 8/27/24 at 9:10 a.m. an interview was conducted with LPN #6 (LPN6). LPN6 stated, The call bell should be within her reach to be able to call for assistance if she needs it. On 8/28/24 a clinical record review was conducted. R49's care plan was reviewed and read in part, . [name redacted] has an ADL self-care performance deficit r/t Limited Mobility. The care plan had that R49's ADL (activity of daily living) needs would be provided by staff. On 8/28/24 a clinical record review was conducted. R49's MDS (minimum data set -an assessment tool) with the ARD (assessment reference date) of 5/23/24 documented that R49 was dependent on staff for toileting, bathing, and dressing, while maximal assistance was needed with personal hygiene and oral care On 8/28/24 a facility document was provided and reviewed. The facility policy titled, Call lights: Accessibility and Timely Response, read in part, .all staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed. On 8/28/24, during an end of day meeting, the above concerns were discussed with the DON, the administrator, and the nurse consultant. No additional information was provided.

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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** 21875 Based on staff interview and clinical record review, the facility staff failed to follow physician orders for three of thirty-one residents in the survey sample (Residents #32, #57 and #77). The findings include: 1. For over two months, Resident #77 was not administered the nutritional supplement Pro-stat twice per day as ordered by the physician for treatment of protein-calorie malnutrition. Resident #77 (R77) was admitted to the facility with diagnoses that included congestive heart failure, protein-calorie malnutrition, seizures, dementia, chronic obstructive pulmonary disease, and obstructive uropathy. The minimum data set (MDS) dated [DATE] assessed R77 as cognitively intact. R77's clinical record documented a physician's order dated 2/8/24 for the nutritional supplement Pro-stat 30 milliliters twice per day for management of protein-calorie malnutrition. R77's medication administration record (MAR) documented Pro-stat was not administered as ordered on 3/28/24 through 4/4/24 and from 4/8/24 through 5/30/24. MAR notes on these dates documented the Pro-stat was out of stock, on order, and unavailable for administration. Physician orders were entered on 4/11/24, 4/18/24, 4/25/24, 4/27/24, 5/9/24 and 5/23/24 to hold the Pro-stat as the facility was awaiting delivery. On 8/27/24 at 4:23 p.m., the registered nurse (RN #2) caring for R77 was interviewed about the availability of Pro-stat during April and May (2024). RN #2 stated Pro-stat was now in stock but had been unavailable for a time during April and May. RN #2 stated, We went for a time without it [Pro-stat]. I think they were changing vendors. On 8/28/24 at 8:44 a.m., the licensed practical nurse unit manager (LPN #1) caring for R77 was interviewed about the Pro-stat not administered as ordered. LPN #1 stated she thought there were problems getting the supplement from a different vendor but was not sure why it was not available. On 8/28/24 at 10:56 a.m., the dietary manager (other staff #2) was interviewed about R77 not getting ordered Pro-stat. The dietary manager stated central supply usually ordered supplements that included Pro-stat. The dietary manager stated when a new central supply clerk was in training, she assisted with ordering nutritional items. The dietary manager stated she attempted to order the Pro-stat from her food service supplier, and it was denied by corporate. The dietary manager stated corporate wanted the Pro-stat ordered from the central supply vendor. The dietary manager stated she did not have access to the central supply ordering system so was unable to get the order placed timely. The dietary manager presented a purchase order request dated 5/16/24 for Pro-stat, approved by the administrator on 5/17/24, denial by corporate on 5/17/24 and with instructions to order through the central supply vendor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at 11:03 a.m., the administrator was interviewed about the unavailable Pro-stat. The administrator stated there had been a transition in central supply and the supplement was not ordered timely. On 8/28/24 at 11:52 a.m., the director of nursing (DON) was interviewed about R77 not getting Pro-stat as ordered. The DON stated there had been issues with ordering Pro-stat with declined purchase orders due to use of an alternate vendor. The current supply clerk was out of the facility and unavailable for interview during the survey. This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 8/28/24 at 2:00 p.m. with no further information presented during the survey. 41449 2. For Resident #57 (R57), the facility staff failed to remove sutures and schedule a follow-up dermatology appointment as ordered by the doctor. On 8/26/24 at approximately 6:50 p.m., R57 was interviewed in his room. R57 had a hospital gown on that left his back exposed as well as his arms and legs. It was noted that R57 had red lesions areas all over his visible body parts and some had dried blood. When asked about this areas, R57 reported that it was scabies. On 8/27/24, a clinical record review was conducted. According to the physician orders, there was an order dated 8/26/24 that read, derm [dermatology] follow up post scabies treatment ASAP [as soon as possible]. According to the progress notes from the on-site medical provider, the most current note was dated 8/26/24. It read in part, Patient who presents today with concerns about stitches and an area of redness on their abdomen. HPI [history and physical information] Relating to this Visit: Patient has recently had a biopsy and was told they had stitches that needed to be removed. However, upon examination, no sutures were found on the patient's shoulder or back Recommended an immediate follow-up with a dermatologist to re-evaluate the need for continued use of clobetasol. The various sections of the clinical record were reviewed with no information from the dermatologist found. On 8/27/24 in the mid-morning, the unit manager was interviewed. The unit manager confirmed that R57 had been dealing with the rash for an extended time and that the scrapings they did were all negative. Dermatology was consulted and did a biopsy, which had confirmed that the rash was scabies. When advised that the surveyor was not able to find any information from the dermatologist, the unit manager reviewed R57's chart and confirmed the information was not present. The unit manager stated she would check up front to make sure it just had not been scanned into the record yet. When asked about any additional dermatology appointments, the unit manager said that she would have to check with the person that schedules appointments but was not aware of any appointments being scheduled. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 in the afternoon, the unit manager provided the surveyor with notes from the dermatologist. The unit manager confirmed that they did not have them at the facility, and that she had called the dermatologist office, who had faxed the information over. When asked if this information would have been expected to be a part of R57's clinical record, the unit manager stated, Yes. Review of the records received from the dermatologist were reviewed. The dermatology note dated 8/7/24, read in part, . biopsy by punch method: location left posterior shoulder . A 8 mm punch biopsy was performed on the left posterior shoulder. Hemostasis was achieved with drysol. Epidermal closure was achieved with 4-0 Ethilon . Patient was provided a home suture removal kit and will remove their sutures at home . Plan: Punch biopsy done today will follow up for results. Patient is having sutures removed at his nursing home facility . The notes indicated the sutures were to be removed in two weeks, which would have been 8/21/24. On 08/28/24 at 8:22 a.m., the surveyor attempted to meet with the transport/appointment clerk but, after being unable to locate them, went to the director of nursing (DON). The DON confirmed that the appointment clerk was not working that day. When asked if R57 had an appointment with dermatology scheduled and how we would find that out, the DON said, Let me double check [while reviewing the electronic health record]. I see where they put the order in for derm follow-up, I saw an order for asap derm follow-up. Let me look through the paperwork up here. The surveyor also stated that no dermatology notes could be located within the chart but had noted that the on-site provider was unable to locate any sutures to remove. On 8/28/24 at 8:40 a.m., the DON and surveyor went to R57's room and asked if they could look for his sutures, to which the resident agreed and reported that the biopsy was taken from his shoulder blade. The area was observed, and one suture was identified. The DON told the resident that she would have the physician assistant look at it today and remove it. On 8/28/24 at approximately 9 a.m., the DON reported that she had called R57's wife, who had said that she was supposed to take resident to dermatology to have sutures removed but wasn't able to get the resident last week. The DON said that she told the wife of the order to follow-up with dermatology, to which the wife had said for the facility to make the appointment, so they will call to have this done. On 8/28/24 at 11:27 a.m., the DON provided the survey team with a physician order that indicated a dermatology appointment had been scheduled for R57 on 9/3/24 at 9:20 a.m. 3. For Resident #32 (R32), the facility staff failed to perform wound care and apply a multi-podus boot, as ordered by the physician. On 8/26/24 at 7:16 p.m., R32 was visited in his room. During the interview, R32 reported, I developed a foot ulcer and went on to say that the facility staff are supposed to change the bandage every other day, but often times they miss treatments. R32 reported it was last changed, day before yesterday. R32 also reported he was scheduled for amputation of a toe on his left foot on 8/29/24. R32 agreed for the surveyor to observe his foot. When the bed linen was lifted it was noted that R32 had a sock on his foot, so the surveyor explained she would need a staff member to assist. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24, a clinical record review was conducted. This review revealed the following physician orders: cleanse left 2nd toe with NS [normal saline] or DWC [dermal wound cleanser], pat dry, apply hydrofera or derma blue and cover with fluff gauze and cleanse left heel with NS or DWC, pat dry, apply hydrofera or derma blue to wound bed, cover with dry dressing. The directions with those two orders read, Every day shift every other day. Documentation within the chart revealed the wounds were vascular in nature and not pressure wounds. R32 also had an order that read, PWB [partial weight bearing] to LLE [left lower extremity], may transfer if wearing multi-podus boot to left leg. According to the treatment administration record (TAR), of the 13 occurrences that the treatment was to be provided from 8/1-8/27, only 5 had been signed off as having been conducted. On 8/27/24, the unit manager was made aware that the surveyor wanted to observe R32's foot wound(s). On 8/28/24 at 9:05 a.m., the surveyor interviewed R32 who reported, I was waiting for the wound nurse to come yesterday because it was due, but I didn't see anyone. When questioned further, R32 stated that the wound treatments are frequently not done. On 8/28/24 at approximately 9:15 a.m., the unit manager was notified again that the surveyor wanted to see the resident's wound before he left for dialysis. On 8/28/24 at 9:35 a.m., the unit manager was accompanied by the surveyor to R32's room to observe the wound. It was noted that the wound had drained through the bandage and onto the bed linen. There was no multi podus boot in place. The dressing on the foot was dated 8/24/24, which was confirmed by the unit manager. The unit manager said, This has been an ongoing problem of staff not changing his bandage as ordered. When told by the surveyor that the resident reported this happens frequently where his dressings are not done as ordered, the unit manager said, It does, and as a wound nurse, you can't be here 24 hours a day, and you expect them to do what they are supposed to do. On 8/28/24 at 9:58 a.m., a follow-up interview was conducted with the unit manager. The unit manager was told that the surveyor saw an order for a multi-podus boot but did not see the boot on the resident. The unit manager explained that they don't really use it much because it presses on the area on his toes. The unit manager looked through papers on her desk and provided an order from the wound care specialist that was dated 8/20/24 and read, Please order and provide multi podus boot, patient to wear multi podus boot to protect the left heel especially while in bed, can be removed for ambulating. May wear surgical shoe for ambulating. The unit manager confirmed that the order for multi-podus boot was not correct in the clinical record and this order had not been updated, but she would take care of correcting it. On 8/28/24 at 1:30 p.m., the administrator and director of nursing were made aware of the above findings. No additional information was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to implement interventions in response to a resident's fall to prevent future falls and prevent accidents for one resident (resident #57-R57) in a survey sample of 31 residents. The findings included: For R57, who fell on [DATE], the facility staff failed to respond to the fall and implement interventions to prevent future accidents. On 8/26/24 at approximately 7:30 p.m., R57 was visited in his room. R57 reported he had recently fallen. When asked what the facility had done following the fall to prevent future falls, the resident said he didn't know. On 8/27/24, a clinical record review was conducted. This review revealed a nursing note entry dated 8/13/24, that read, Resident was informed that he needs to move to room [ROOM NUMBER]. CNA reports resident became anxious and agitated and called his wife. Afterwards this nurse was called to resident's room, resident was observed on the floor on his left hip/buttock. Resident reports pain in left hip but also has chronic pain in left hip. MD (medical doctor) [name redacted] notified, new order for hip x-ray. Resident assisted back into his w/c (wheelchair) and moved to room [ROOM NUMBER]. Resident also medicated per order for pain. Staff will continue to monitor. There was no evidence of any assessment of the resident following the fall, nor any interventions to prevent reoccurrence. According to R57's care plan, it noted the resident was at risk for falls d/t [due to] impaired mobility and impaired cognition . The most recent intervention for this fall focus area was dated 3/27/24. There was no indication that the care plan had been reviewed or revised following the fall on 8/13/24. According to a fall risk assessment completed on 7/4/24, R57 was identified as having been at high risk for falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at 8:15 a.m., an interview was conducted with the unit manager. When asked what is done with it is reported that a resident has fallen, she explained, we do an initial assessment which says what you did those first actions, if you administered first aid or sent out. When asked if this is documented, the unit manager said, Yes, there is a post fall review that goes along with the risk. It is automatically generated as it happens. The unit manager accessed R57's chart and said, I don't see one in risk or the post fall assessment. When asked what was done to prevent future incidents/accidents, the unit manager said she was not aware because nothing was documented. When asked why that step is important, she said, It keeps follow-up and keeps them safe. The surveyor asked, what are the risks of not having it done? The unit manager said, it could be anything, they could have an undiagnosed fracture, hematoma, slow bleed, could be anything. The lack of assessment and follow-up to monitor for injury. She went on to say, it's got to be education for staff because they know better. I can see the notes where they did his room change, did she get overwhelmed, those are important things you can't be missing, especially with our long-term patients, who else is going to be their advocate? Review of the facility policy titled; Fall Prevention Program was conducted. The policy read in part, A fall is an event in which an individually unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force. The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere . 9. When any resident experiences a fall, the facility will: a. assess the resident, b. complete a post-fall review and post-fall follow up note in PCC [the electronic health record software system], c. complete an incident report in PCC, d. Notify physician and family. e. Review the resident's care plan and update as indicated, f. Document all assessments and actions, g. Obtain witness statements in the case of injury. h. If there are signs of serious injury or there are concerns about the circumstances of the fall, notify the director of nursing and/or the administrator. i. begin neurologic assessment using neurological record assessment tool in PCC . On 8/27/24 at approximately 1:30 p.m., during a meeting with the facility administrator and director of nursing (DON), the above concerns were shared. The DON reported that she recalled R57 having a fall where he placed himself in the floor because he was upset about a room change. The DON was asked how she knew this, since the only documentation was a nursing progress note, which did not indicate that the fall was witnessed. She said she thought she had some statements from staff. She would look for them and provide to the surveyor. No further information was provided prior to completion of the survey.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on observation, staff interview and clinical record review, the facility failed to ensure a device was implemented for a catheter for one of thirty one residents and failed to ensure a catheter bag was located to prevent infection for one of thirty one residents. 1. Resident 41 (R41) did not have catheter tube anchored to prevent dislodging. 2. Resident 77 (R77) catheter bag was touching the floor and had potential for infection. The Findings Include: 1. Diagnoses for R41 included; Benign prostatic hyperlasia, and obstructive uropathy requiring catheter. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 7/16/24. R41 was assessed with a cognitive score of 15 indicating cognitively intact. Review of R41's physician orders (on 8/27/24) revealed an order to check placement of catheter strap every shift. Original order date was 5/7/24. On 8/28/24 at 10:00 AM R41 was interviewed and was asked if there was a strap anchoring the catheter tube down to prevent dislodging the catheter. R41 verbalized he doesn't have an anchor for the tube and also verbalized not having pain or any other skin concerns to the groin area. R41 was asked and gave permission to observe the catheter tubing and placement with a nurse. On 8/28/24 10:06 AM registered nurse (RN #1) observed (along with this surveyor) R41's catheter and tubing. The tubing was not anchored. R41's penis was also observed and did not indicate concern for abrasions or skin tears to the area. RN #1 verbalized that the tubing should be anchored. On 8/28/24 at 2:48 PM the above finding was presented to the administrator, director of nursing (DON), and nurse consultant. No other information was presented prior to exit conference on 8/28/24. 21875 2. Resident #77's catheter bag was observed positioned in an unsanitary manner in the floor. Resident #77 (R77) was admitted to the facility with diagnoses that included congestive heart failure, protein-calorie malnutrition, seizures, dementia, chronic obstructive pulmonary disease, and obstructive uropathy. The minimum data set (MDS) dated [DATE] assessed R77 as cognitively intact. On 8/27/24 at 9:27 a.m., R77 was observed in bed. The resident's urinary catheter bag was positioned in the floor under the edge of the bed. The collection bag was attached to the bed rail with a hook and clips were positioned along the tubing. The hook/clips were not positioned to keep the bottom half of the catheter bag off the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 8:17 a.m., R77's urinary catheter bag was observed with the bottom half of the bag resting on the floor under the edge of the bed. On 8/28/24 at 8:25 a.m., the certified nurses' aide (CNA #2) caring for R77 was interviewed about the catheter bag in the floor. Accompanied by CNA #2, R77's catheter bag was observed with the bottom half of the bag resting on the floor under the edge of the bed. CNA #2 stated the catheter bag was not supposed to be in the floor. CNA #2 stated the hook and clips were supposed to be positioned to keep the bag off the floor. On 8/28/24 at 8:46 a.m., the licensed practical nurse unit manager (LPN #1) was interviewed about R77's catheter bag in the floor. LPN #1 stated catheter bags were supposed to be suspended below bladder level and above the floor to prevent infection. R77's plan of care (revised 6/6/24) documented the resident had a urinary catheter due to obstructive uropathy. Interventions to prevent catheter related complications included checking the catheter and/or tubing each shift to maintain proper positioning. The facility's policy titled Catheter Care (revised 10/1/23) documented, It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care . This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 8/28/24 at 2:00 p.m. with no further information presented prior to the end of the survey.

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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. 41449 Based on observation, resident interview, staff interview, and clinical record review, the facility failed to provide oxygen therapy consistent with infection control measure and professional standards of practice for one resident (Resident #79- R79) in a survey sample of 31 residents. Findings included: For Resident #79, the facility staff failed to change the oxygen tubing and nebulizer tubing and mask weekly. During initial tour on 8/26/24 at approximately 6:30 p.m., R79 was visited in her room. It was observed that R79 had a nebulizer on her bedside table. The nebulizer mask was sitting in the top drawer of the bedside table and was open to air. The nebulizer mask and tubing were dated 7/16/24, as the date it was changed. The oxygen tubing was not labeled with a date and the nasal cannula was on the floor. On 8/26/24 at 7:09 p.m., an interview was conducted with licensed practical nurse (LPN) #4. LPN #4 was asked about oxygen and nebulizer tubing and storage of them when not in use. LPN #4 said, we are to wrap it and put it in a bag and store it in the drawer, so it doesn't get dirty. It is also a fall hazard. When asked about changing of them, LPN #4 said they are to be changed weekly. On 8/27/24 at 8:31 a.m., R79 was observed with her oxygen tubing and nebulizer tubing stored in a bag. The nebulizer mask that was removed was observed in the trash can at R79's bedside. On 8/27/24 at 8:33 a.m., an interview was conducted with the unit manager. The unit manager said that oxygen tubing was to be changed weekly and said, this unit is set for Sundays. When asked where it will be documented, the unit manager said, it should be documented on the TAR (treatment administration record) on the night shift. The unit manager then accompanied the surveyor to R79's room and confirmed that the nebulizer had been changed that day 8/27/24. The discarded nebulizer mask in the trash was confirmed to be dated 7/16/24. On 8/27/24, a clinical record review was conducted of R79's chart. The physician orders read, Change O2/Nebulizer tubing, humidification bottle (label and date tubing) and bag cover every week every night shift every Thu [Thursday]. The TAR was signed off, to indicate it had been changed 8/1/24, 8/15/24, and 8/22/24, despite it being dated 7/16/24. There were no physician orders related to the changing of oxygen tubing. On 8/27/24 at approximately 1:30 p.m., the above findings were shared during a meeting with the facility administrator and director of nursing. The facility policy titled; Nebulizer Therapy was reviewed. The policy read in part, . 2. Care of the Equipment . g. Once completely dry, store the nebulizer cup and mouthpiece in a zip lock bag. h. Change nebulizer tubing once weekly . No additional information was provided.

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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. 41449 Based on observation, interview, record review, and facility menu review, the facility failed to coordinate services and provide meals and/or snacks for one of three sampled residents (Resident #32- R32) reviewed for dialysis and received dialysis treatments at an outside dialysis center. The findings include: 1. For R32 who received dialysis at an offsite location, the facility staff failed to provide meals or snacks for the resident when he would miss the lunch meal. Review of R32's Med Diag [medical diagnosis] tab in the resident's electronic medical record (EMR) revealed R32 was admitted to the facility with diagnoses which included end stage renal disease (ESRD), type 2 diabetes, and dependent on renal dialysis. Review of R32's Physician Orders, located under the Orders tab in the resident's EMR, revealed current orders for R7 to receive outpatient hemodialysis on Monday, Wednesday, and Friday and orders for a liberal renal diet, regular texture, thin consistency diet. Review of R32's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/12/24, located in the resident's EMR, specified the resident received dialysis. The resident had a Brief Interview for Mental Status (BIMS) score of 15 of 15, which indicated the resident was cognitively intact. Review of R32's current care plan, located in the EMR under the care plan tab, revealed a Focus area initiated on 2/13/24, that specified, has potential nutritional problem r/t [related to] therapeutic diet: dx [diagnosis] ESRD, HTN [hypertension], DM [diabetes mellitus]. Care plan approaches/interventions included, provide, serve diet as ordered, monitor intake and record q [every] meal, provide and serve supplements as ordered . During an interview on 8/26/24 at 7:18 p.m., R32 stated he was transported from the facility to dialysis treatments every Monday, Wednesday, and Friday. R32 explained that on the days he received dialysis treatments, he leaves the facility around 10 a.m. and returned around 3 p.m. The resident stated his only concern is that no food items are sent with him, nor is anything provided when he returns, he has to wait until the evening meal. On the dialysis days he goes all day without anything to eat or drink, despite being an insulin dependent diabetic. On 8/28/24 at 8:56 a.m., an interview was conducted with CNA #4 (certified nursing assistant). CNA #4 confirmed she normally works this unit where R32 is. CNA #4 said, he is here for breakfast but then leaves for dialysis and doesn't come back until close to dinner time. When asked if any food is sent with the resident, she said, No lunch or anything is sent with him, if he asks for snacks we will give them to him here, but nothing gets sent from the kitchen to send with him. The only bag that goes with him is full of blankets because it is cold in there. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 9:00 a.m., an interview was conducted with the dietary manager (DM). She was asked about dialysis residents and if food is sent with them for dialysis. The DM said, they [dietary staff] usually aren't here when they go to dialysis, we don't send it [food] because we try not to send people meals if they aren't here because it goes missing. We don't know exactly what time they leave or get back; we don't send any kind of snacks or packed lunches for them; we've never done that. On 8/28/24 at 9:59 a.m., an interview was conducted with the unit manager. The unit manager was asked about R32's dialysis. The unit manager reported, it is closer to 4-4:30 when he gets back. When asked if a lunch meal is sent with the resident since he is away during that meal, she said, they don't pack a lunch, he should be having lunch there. I wouldn't have thought to look at it that way. He is diabetic and he has a lot of issues going on, he has nutritional issues, he doesn't like a lot of the food here. We've got to eat that with a big spoon, and I hate that because he is one of my favorites. On 8/28/24 at 10:19 a.m., a phone call was placed to the dialysis center. They confirmed that while residents are unable to eat during the actual dialysis session, they can eat before and after and while they wait for transport. 2. For R32, who went to dialysis at an offsite location three days per week, the facility staff failed to maintain communication with the dialysis center to maintain continuity of care and communicate resident changes. On 8/28/24 at approximately 8:15 am. R32 was visited in his room. When asked about communication between the facility and the dialysis center, the resident reported there was a folder that gets sent with him at times, but no one fills out anything. On 8/28/24 at approximately 8:20 a.m., the surveyor looked at the nursing station and didn't see anything identified as a dialysis communication book for R32. On 8/28/24 at 8:57 a.m., LPN #5 was asked how they communicate with dialysis and know what has occurred at dialysis. The nurse said there should be a book but was unable to find one. On 8/28/24 at 9:15 a.m., the unit manager was asked about communication between the facility and dialysis. She stated there is a book that they send back and forth. When asked if she could locate the book for the surveyor, she was not able to. On 8/28/24 at approximately 9:20 a.m., the unit manager provided the surveyor with a dialysis communication book for R32, which she found at the nursing station on the other unit within the facility. According to R32's clinical record and census tab, R32 had been transferred to the current unit on 8/14/24. When the surveyor looked at the book, it was full of blank pages, with no information filled in. R32's clinical record had no information with regards to communication between the facility and dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 9:24 a.m., an interview was conducted with the unit manager. When asked if she had looked at the dialysis communication book, she said, I didn't look at it but I'm sure it is not up to date because it was on the other unit. When asked what the purpose of the dialysis communication book is, she said, to monitor how they do while they are there, record their heavy weight and dry weight. They don't write stuff down for us. The surveyor explained that during a clinical record review and resident interview, he had reported missing multiple doses of antibiotic. According to the medication administration record, it was noted that it was not given because the resident was at dialysis. The surveyor explained that she was looking to see what medications had been administered at dialysis in hopes that the resident had received the antibiotics while there. The unit manager said, usually if they want something [medication] sent, they will ask for it. The unit manager accessed R32's EHR and looked at the dialysis communication book and confirmed there was no information with regards to R32's care and treatment while at the dialysis center. She sent on to say, I feel like it is beating our heads against the wall because it is lack of follow-up. I expect them to do what they are supposed to do, it is getting them to understand if they don't do what they are supposed to this could happen and making sure there is follow-up. The facility dialysis policy was requested. The facility policy titled, Care Planning Special Needs- Dialysis was provided and reviewed. It read in part, . 2. The care plan will reflect the coordination between the facility and the dialysis provider and will identify nursing home and dialysis responsibilities. 3. Interventions will include, but not limited to: a. Documentation and monitoring complications, b. pre- and post-weights, c. accessing, observing, and documenting care of access sites, as applicable, d. nutrition and hydration, including the provision of meals and snacks on treatment days, lab tests, f. vital signs, g. provision of medications on dialysis treatment days, such as which medications are: i. administered during dialysis, ii. held prior to dialysis, iii. given prior to dialysis, iv. administered by dialysis staff, h. transportation arrangements 4. Nursing staff will provide a report to the dialysis provider regarding the resident's condition and treatment previsions each dialysis treatment day, and as needed. 5. If no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report . Review of the dialysis contract executed 3/27/23, between the facility and the dialysis center was conducted. The contract read in part, . Shared communication between both parties: the care of the resident receiving dialysis services must reflect ongoing communication, coordination and collaboration between the nursing home and the dialysis staff. The communication progress should include how the communication will occur, who is responsible for communicating, and where the communication and response will be documented in the medical record . On 8/28/24 at 1:30 p.m., during a meeting with the survey team and the facility administrator and director of nursing, the above findings were discussed. No additional information was provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure two residents (Resident #32-R32 and Resident #249) were free from significant medication errors/omissions, in a survey sample of 31 residents. The findings included: 1. For Resident #32 (R32), the facility staff failed to ensure the resident received antibiotic medication, as ordered by the physician. On 8/26/24 at 7:16 p.m., R32 was interviewed in his room. During the interview, R32 reported that he had osteomyelitis, a serious bone infection, and had been treated for c-diff (clostridioides difficile - an infection of the colon) but had missed a lot of his antibiotic doses .because they don't have the vanc [vancomycin] frequently. On 8/27/24, a clinical record review was conducted. This review revealed a physician order dated 7/20/24 that read, Vancomycin HCl Suspension 50MG/ML Give 2.5 ml by mouth in the morning every 2 day(s) for c diff for 8 Weeks. According to the medication administration record (MAR), R32 was not provided the vancomycin on 8/9/24 and 8/21/24. On 8/9/24, there was a nursing note that indicated the vancomycin was not available, re-ordered. On 6/21/24, there was a physician order written that read, Vancomycin HCl Suspension 50 MG/ML Give 2.5 ml by mouth four times a day for c diff for 14 Days. According to the MAR, R32 missed 12 of the scheduled doses of vancomycin. There was a progress note dated 6/28/24, that indicated that this physician ordered antibiotic was on order and another that read, none available - reordered. There was no indication that the doctor had been called and made aware of the missed doses or given the opportunity to give alternate orders. 2. For Resident #249 (R249), who was an insulin dependent diabetic, the facility staff failed to administer multiple doses of insulin and the physician was not notified of the omitted doses of medication. On 8/26/24 at 6:35 p.m., R249 was interviewed in his room. The resident expressed concern that, they run out of antibiotic often. They say they have to get it through pharmacy. The resident explained that he has an artificial hip joint and is on the antibiotic for that. On 8/27/24, a clinical record review was conducted. This review revealed R249 was receiving antibiotics as ordered with no indication of missed doses. During the record review it was noted that the resident had a physician order for Basaglar Kwik Pen 100 UNIT/ML Solution pen-injector Give 10 unit by mouth in the morning for DM [diabetes mellitus]. According to the MAR, R249 was not given the Basaglar insulin on 8/7/24, 8/12/24-8/15/24. According to the nursing progress notes there was no indication why the dose on 8/7/24 was not administered. There was a nursing note entry on 8/12/24, regarding the Basaglar insulin that read, not available. There was no indication as to why the insulin was not given on 8/13/24-8/15/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was another physician order for Humalog Kwik Pen Solution Peninjector100 UNIT/ML (Insulin Lispro (Human)) Inject 8 unit subcutaneously three times a day for DMII, ordered 8/21/24. According to the MAR, R249 missed two does on 8/21/24 and 8/22/24. There was a nursing medication administration note dated 8/22/24 at 9:48 a.m., that read, awaiting arrival. There was no indication that the physician had been called and notified that the medication was not available for administration, nor that a call to the pharmacy had been placed. On 8/27/24 at 2:22 p.m., an interview was conducted with licensed practical nurse # 6 (LPN #6). LPN #6 was asked to explain what the process is if during medication administration she doesn't have a medication available. LPN #6 said, if a medication is not available, I will check the cart, check the cubex [emergency supply of medications], call the doctor to notify them and see if there is a substitution that needs to be done or if it can be held. I call the pharmacy and see when the medicine will get here in a reasonable time and put in a note about it. Following the above interview with LPN #6, the nurse took the surveyor into the medication room and observations were made of the emergency insulin supply. Within the box it was noted that the box was supposed to contain both Humalog/Lispro insulin pen and Basaglar. However, upon opening the box only aspart and levimier was present. LPN #6 said the pharmacy is supposed to restock/change out the box, but she didn't know how often that occurred. LPN #6 also provided the surveyor with a listing of the medications contained in the cubex and it was noted that vancomycin was available only in a 1 gram and 500 mg injectable dose. On 8/28/24 at 3:31 p.m., an interview was conducted with the unit manager. She was made aware of the above findings regarding insulin not being available. The unit manager said, there are times when we don't have insulin. The unit manager again accompanied the surveyor into the medication room and accessed the emergency supply of insulin which revealed only levimier and a 70/30 mix. The pharmacy doesn't change it out very often, we don't have any slips to let them know when they are being pulled, so unless you pull from the cubex or IV box, there is no record of what you are pulling, there are no insulin slips. When asked if she would expect them to check the other unit to see if the medication was available in their box and if not, to let doctor know, the unit manager said, absolutely. On 8/28/24 at 3:35 p.m., an interview was conducted with registered nurse #1 (RN #1), who was working on the other unit. RN #1 was asked to explain what is done if insulin is not available. RN #1 said, we go to refrigerator and look and if not there go to stat box we call the doctor and get a hold order and check blood sugars often. We call pharmacy and beg them to send it to us. RN #1 was asked if they had a local pharmacy they could call as a back up to deliver and she said, no, everything comes out of Maryland. The surveyor was then accompanied into the medication room on that unit and the emergency box of insulin was observed, it was noted that the following insulins were present: Aspart insulin pen, Levemir flex pen, Lispro, Humulin N Kwik pen, Lispro Kwik pen and a multi-dose vial of Humulin R. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review was conducted of the facility policy titled, Unavailable Medications. The policy read in part, 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn [as needed], and emergency medications. 2. A STAT [emergent] supply of commonly used medications is maintained in-house for timely initiation of medications. 3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications. 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that a medication is unavailable: a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold . 5. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication. On 8/28/24, during a mid-day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 21875 Based on observation, staff interview and facility document review, the facility staff failed to label a medication per pharmacy standards on one of two units (B wing). The findings include: A Novolog prefilled insulin pen stored on a B wing medication cart had no pharmacy label indicating the drug name, resident's name, prescribed dose, strength or administration instructions. On 8/27/24 at 4:42 p.m., accompanied by licensed practical nurse (LPN #7), a B wing medication cart was inspected. Stored in the cart drawer was a Novolog prefilled insulin pen. There was no pharmacy label on the insulin pen. Resident #93's name was handwritten on the insulin pen along with the date opened. LPN #7 was interviewed about the Novolog insulin pen without a pharmacy label. LPN #7 stated she did not why the insulin pen had a handwritten name, and she did not know what happened to the bag or label typically provided by pharmacy. On 8/28/24 at 9:47 a.m., the director of nursing (DON) was interviewed about the Novolog insulin pen without a pharmacy label. The DON stated the insulin pen had been retrieved from a back-up supply kit. The DON stated LPN #6 wrote Resident #93's name on the insulin pen. On 8/28/24 at 11:17 a.m., the consultant pharmacist (other staff #9) was interviewed about the insulin pen observed without pharmacy labeling. The pharmacist stated that nurses were not authorized to label prescription medications. The pharmacist stated the insulin pen should not have been stored on the cart with a handwritten name applied. The pharmacist stated that a form was supposed to be completed and sent to pharmacy when medicines were removed from a back-up or emergency supply. On 8/28/24 at 12:04 p.m., the consultant pharmacist stated he talked with his supervisor and verified that if the facility used a medication from a back-up medication supply, they were supposed to notify pharmacy with use of a form. The pharmacist stated that only pharmacists were authorized to label medications. The facility's undated policy titled EDK (emergency drug kit) provided by the pharmacy documented completion of a usage slip was required if drugs were removed from a drug kit and the white copy of the usage slip was to be placed in the drug kit before re-locking. This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 8/28/24 at 2:00 p.m. with no further information provided prior to the end of the survey.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide a handled cup for one of thirty-one residents in the survey sample (Resident #28). The findings include: Resident #28 did not have a two-handled sippy cup provided as recommended by therapy and per her plan of care. Resident #28 (R28) was admitted to the facility with diagnoses that included atrial fibrillation, hypertension, arthritis, anxiety, depression, hypothyroidism and urinary tract infection. The minimum data set (MDS) dated [DATE] assessed R28 as cognitively intact. On 8/27/24 at 8:21 a.m., R28 was observed eating breakfast in her room. R28 stated at this time that she was supposed to have a sippy cup for her beverages because she had hand tremors. R28 stated she had the sippy cup a few times after it was first recommended but the cup had not been provided in several weeks. Tremors were observed on both of R28's hands and there was no sippy cup on the resident's breakfast tray. The meal ticket for R28's breakfast listed no requirement for a handled cup. R28's clinical record documented a speech therapy recommendation dated 7/31/24 for a handled cup at all meals to assist with oral intake. R28's plan of care (revised 8/10/14) documented the resident had deficits with self-care performance of activities of daily living due to muscle weakness, muscle spasms and arthritis. Interventions to maintain activities of daily living included, .Handled cup at meals to assist in oral intake. On 8/28/24 at 8:47 a.m., the licensed practical nurse unit manager (LPN #1) caring for R28 was interviewed about the handled cup. LPN #1 stated she was not aware the resident required a two-handled cup. On 8/28/24 at 9:20 a.m., the rehab director (other staff #3) was interviewed about R28's recommendation for a handled cup. The rehab director reviewed the therapy records and stated a two-handled sippy cup was recommended by speech therapy on 7/31/24 to assist with fluid intake. The rehab director stated the need for the handled cup was added to R28's plan of care on 7/31/24. On 8/28/24 at 9:43 a.m., the certified nurses' aide (CNA #5) caring for R28 was interviewed about a therapeutic cup. CNA #5 stated that the kitchen usually provided sippy cups on the meal trays. CNA #5 stated therapeutic cups/devices were listed on the meal tickets. CNA #5 stated she did not recall a sippy cup listed on R28's meal ticket. CNA #5 stated sippy cups were available, but she was not aware R28 needed a therapeutic cup. On 8/28/24 at 10:44 a.m., the dietary manager (other staff #2) was interviewed about R28's handled cup. The dietary manager stated no notification was sent to the kitchen communicating that the resident required the therapeutic cup, so no sippy cup had been placed on the meal trays. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 8/28/24 at 2:00 p.m. with no further information presented prior to the end of the survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 28106 Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare, and serve food accordance with professional standards for food safety in the main kitchen and on one of two units (B Wing). The findings included: 1. Multiple open food products were not labled with an open date and expired meat product, sugar and flour was accessible for distribution. On [DATE] at 6:10 PM an initial kitchen tour was conducted with the dietary staff member (other staff, OS #1). The dry storage room yielded an opened syrup container, loaf of bread containing 4 slices, and open case of croissants with 9 croissants in the package did not have an opened date or use by date. The walk in refrigerator had an opened bag of mozzarella shredded cheese with no open date and an opened bag of cubed ham with a use by date of [DATE] was accessible for distribution. The main kitchen had bulk barrels of stored sugar and flour with a used by date of [DATE] and was accessible for distribution. OS #1 verbalized all opened food product are supposed to have an open date on them and the cubed ham, sugar and flour should have been thrown away on the last day of the used by date. On [DATE] at 7:00 PM the dietary manager (OS #2) had returned to the facility and all concerns was relayed to OS #2. OS #2 verbalized that the concerns would be taken care of. On [DATE] at 2:48 PM the administrator and director of nursing (DON) was notified of the above finding. A facility policy titled Date Marking for Food Safety was obtained and read in part, 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. No other information was provided prior to exit conference on [DATE]. 41449 2. The facility staff failed to distribute food in a manner to prevent contamination and within food safety standards on unit 2. On [DATE] at 8:53 a.m., the distribution of breakfast trays was observed on unit 2. The certified nursing assistants were preparing beverages, placing them on the tray and taking that tray to a specific resident it had been prepared for. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the above observation, CNA #2 was observed to take resident #12-R12 her breakfast tray. CNA #2 then exited the resident's room with the meal tray in hand and it appeared that items were removed. When asked to observe the tray, CNA #2 held the tray for the surveyor to make an observation, the resident had removed a few food items, and some remained on the plate. CNA #2 stated that the resident removes what she wants and then they take away the rest. CNA #2 then proceeded to place the tray that had been taken to R12 onto the cart with other meal trays that had yet to be distributed, therefore mixing clean and soiled trays. The surveyor discussed this with CNA #2 who said she should have put R12's tray on a separate rack that was empty and would be used to pick up trays once residents finished eating. CNA #2 further confirmed that she understood this could be an infection control concern. On [DATE] at 1:30 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for four residents (resident #79-R79, resident #57-R57, resident #32-R32 and resident #93-R93), in a survey sample of 31 residents. The findings included: 1. For Resident #79, the facility staff failed to maintain an accurate clinical record with regards to the changing of oxygen tubing and nebulizer tubing and mask. During initial tour on [DATE] at approximately 6:30 p.m., R79 was visited in her room. It was observed that R79 had a nebulizer on her bedside table. The nebulizer mask was sitting in the top drawer of the bedside table and was open to air. The nebulizer mask and tubing were dated [DATE], as the date it was changed. On [DATE] at 7:09 p.m., an interview was conducted with licensed practical nurse (LPN) #4. LPN #4 was asked about oxygen and nebulizer tubing and the frequency they were changed, LPN #4 said they are to be changed weekly. On [DATE] at 8:31 a.m., R79 was observed with her oxygen tubing and nebulizer tubing stored in a bag. The nebulizer mask that was removed was observed in the trash can at R79's bedside. On [DATE] at 8:33 a.m., an interview was conducted with the unit manager. The unit manager said that oxygen tubing was to be changed weekly and said, this unit is set for Sundays. When asked where it would be documented, the unit manager said, it should be documented on the TAR (treatment administration record) on the night shift. The unit manager then accompanied the surveyor to R79's room and confirmed that the nebulizer had been changed that day [DATE]. The discarded nebulizer mask in the trash was confirmed to be dated [DATE]. On [DATE], a clinical record review was conducted of R79's chart. The physician orders read, Change O2/Nebulizer tubing, humidification bottle (label and date tubing) and bag cover every week every night shift every Thu [Thursday]. The TAR was signed off, to indicate it had been changed [DATE], [DATE], and [DATE], despite it being dated [DATE]. On [DATE] at approximately 1:30 p.m., the above findings were shared during a meeting with the facility administrator and director of nursing. The facility policy titled; Nebulizer Therapy was reviewed. The policy read in part, . 2. Care of the Equipment . h. Change nebulizer tubing once weekly . No additional information was provided. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For R57, who was being treated by a dermatologist, the facility failed to maintain a complete and accurate clinical record to include treatment notes from the dermatologist. On [DATE] at approximately 6:50 p.m., R57 was visited in his room. R57 had a hospital gown on that left his back exposed as well as his arms and legs. It was noted that R57 had red lesions areas all over his visible body parts and some had dried blood. R57 was asked about it and reported it was scabies. On [DATE], a clinical record review was conducted. This review revealed multiple entries within the nursing notes that were written by the on-site medical provider that referenced the diagnosis of scabies and being seen by a dermatologist. The most recent entry that noted the scabies diagnosis was dated [DATE]. It read in part, Chief Complaint/Reason for this Visit: Patient who presents today for a medication review and follow-up on scabies treatment. HPI [history and physical information] Relating to this Visit: Patient was diagnosed with scabies by a dermatologist after a second skin scraping, with the first one being negative. Patient has been using permethrin cream, with one dose given last week and the second dose recently administered. They report improvement in itching and a reduction in small areas of excoriation on their arms. However, they still have some affected areas on their bilateral legs and belly. Patient is also taking hydroxyzine three times a day and clobetasol for their skin condition The various sections of the clinical record were reviewed with no information from the dermatologist found. On [DATE] in the mid-morning, the unit manager was interviewed. The unit manager confirmed that R57 had been dealing with the rash for an extended time and the scrapings they did were all negative. Dermatology was consulted and did a biopsy, which confirmed it was scabies. When advised that the surveyor was not able to find any information from the dermatologist, the unit manager reviewed R57's chart and confirmed the information was not present. She stated she would check up front to make sure it just had not been scanned into the record yet. On [DATE] in the afternoon, the unit manager provided the surveyor with notes from the dermatologist. The unit manager confirmed they did not have them at the facility, and she had called the dermatologist, and they faxed the information over. When asked if this information would have been expected to be a part of R57's clinical record she stated yes. 3. For R32, the facility staff failed to maintain a complete clinical record to include information from dialysis regarding dialysis treatment sessions. On [DATE] at approximately 8:15 am. R32 was visited in his room. When asked about communication between the facility and the dialysis center, the resident reported there was a folder that gets sent with him at times, but no one fills out anything. On [DATE] at 8:57 a.m., LPN #5 was asked how they communicate with dialysis and know what has occurred at dialysis. The nurse said there should be a book but was unable to find one. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:15 a.m., the unit manager was asked about communication between the facility and dialysis. She stated there is a book that they send back and forth. When asked if she could locate the book for the surveyor, she was not able to. The unit manager reviewed R32's electronic health record and confirmed that no information was within the chart with regards to dialysis visits. On [DATE] at approximately 9:20 a.m., the unit manager provided the surveyor with a dialysis communication book for R32, which she found at the nursing station on the other unit within the facility. According to R32's clinical record and census tab, R32 had been transferred to the current unit on [DATE]. When the surveyor looked at the book, it was full of blank pages, with no information filled in. R32's clinical record had no information with regards to communication between the facility and dialysis, nor any treatment details, medications given while at dialysis, pre and post dialysis weights on a routine basis or any complications encountered during dialysis sessions. On [DATE] at 9:24 a.m., an interview was conducted with the unit manager. When asked if she had looked at the dialysis communication book, she said, I didn't look at it but I'm sure it is not up to date because it was on the other unit. When asked what the purpose of the dialysis communication book is, she said, to monitor how they do while they are there, record their heavy weight and dry weight. They don't write stuff down for us. Review of the dialysis contract executed [DATE], between the facility and the dialysis center was conducted. The contract read in part, . Shared communication between both parties: the care of the resident receiving dialysis services must reflect ongoing communication, coordination and collaboration between the nursing home and the dialysis staff. The communication progress should include how the communication will occur, who is responsible for communicating, and where the communication and response will be documented in the medical record . On [DATE] at 1:30 p.m., during a meeting with the survey team and the facility administrator and director of nursing, the above findings were discussed. No additional information was provided. 4. For resident #32- R32, the facility staff failed to maintain an accurate clinical record with regards to wound treatments being performed as ordered by the physician. On [DATE] at 7:16 p.m., R32 was visited in his room. During the interview, R32 reported, I developed a foot ulcer and went on to say that the facility staff are supposed to change the bandage every other day, but often times they miss treatments. R32 reported it was last changed, day before yesterday. R32 also reported he was scheduled for amputation of a toe on his left foot on [DATE]. On [DATE], a clinical record review was conducted. This review revealed the following physician orders: cleanse left 2nd toe with NS [normal saline] or DWC [dermal wound cleanser], pat dry, apply hydrofera or derma blue and cover with fluff gauze and cleanse left heel with NS or DWC, pat dry, apply hydrofera or derma blue to wound bed, cover with dry dressing. The directions with those two orders read, Every day shift every other day. Documentation within the chart revealed the wounds were vascular in nature and not pressure wounds. (continued on next page)

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	495146	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ridge Rehabilitation and Nursing	94 South Avenue Harrisonburg, VA 22801

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the treatment administration record (TAR), R32 had received wound treatments to the left toe and heel on [DATE], as indicated by the treatment being signed off. On [DATE] at 9:05 a.m., the surveyor visited R32 who reported, I was waiting for the wound nurse to come yesterday because it was due, but I didn't see anyone. On [DATE] at 9:35 a.m., the unit manager was accompanied by the surveyor to R32's wound to observe the wound. It was noted that the wound had drained through the bandage and onto the bed linen. The dressing on the foot was dated [DATE], which was confirmed by the unit manager. The unit manager said, this had been an ongoing problem of staff not changing his bandage as ordered. The unit manager was told by the surveyor that the resident reported this happens frequently where his dressings are not done as ordered, she said, It does, and as a wound nurse you can't be here 24 hours a day and you expect them to do what they are supposed to do. No additional information was provided. 49456 5. The facility failed to accurately document R93's code status. The nurse practitioner noted R93 as a full code and CPR was to be performed and according to the care plan and physician orders R93 was a do not resuscitate (DNR). On [DATE] a clinical record review was conducted. A DNR was in the clinical record and signed on [DATE] by R93. R93's care plan, that was revised on [DATE] had R93 as a DNR. R93 had a physician's order the code status to be a DNR and was dated [DATE]. The nurse practitioner had a progress note dated [DATE] and it read in part, .Code status, Full Code - attempt CPR {Cardiopulmonary resuscitation}. The nurse practitioner had a progress note dated [DATE] and it read in part, .Code status, Full Code - attempt CPR {Cardiopulmonary resuscitation}. On [DATE] at 2:00 p.m. an interview was conducted with the director of nursing (DON). The DON stated, she does not know why she [nurse practitioner] put that in her notes and she will speak with her. On [DATE] at the end of day meeting the above concerns were discussed with the DON, the administrator and the nurse consultant. No new information was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interviews, clinical record review, and facility documentation review, the facility staff failed to maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections, and failed to respond to a COVID outbreak in accordance with the guidance from the Centers for Disease Prevention and Control (CDC), which involved two residents (Resident #22 and Resident #57) but had the potential to affect numerous residents on 2 of 2 nursing units. The findings included: 1. The facility staff failed to provide care and adhere to infection control practices to include the use of personal protective equipment (PPE) to minimize the spread of multi-drug resistant organisms (MDROs), by implementing enhanced barrier precautions for Resident #22 (R22). On 8/26/24 at approximately 7 p.m., observations were conducted, and it was noted that R22's room had a sign on the door that indicated enhanced barrier precautions. There was a plastic storage hanger also on the door, but it was empty and contained no PPE supplies. A bottle of tube feeding was observed on R22's over bed table (which indicated R22 had a feeding tube), and wound care supplies were noted on the sink area and at the roommate's bedside table. On 8/27/24 at 9:03 a.m., observations were conducted of the breakfast meal being distributed. It was noted that two staff members, certified nursing assistants #6 and #7 (CNA #6 and CNA #7), entered R22's room with breakfast trays. At approximately 9:10 a.m., the two staff persons were observed each sitting at the bedside of the two residents, one of which was R22, feeding the residents. Neither CNA #6 or CNA #7 had any PPE on, no isolation gown or gloves. At this time, the sign was again noted on the door that indicated enhanced barrier precautions and that the storage hanger on the door contained no supplies. On 8/27/24 at approximately 9:20 a.m., an interview was conducted with CNA #6. When asked about the enhanced barrier precautions sign on the room door, CNA #6 said, I don't know because they never told us. So I don't know if it [wearing PPE] is just the nurse when they do her tube feeding or what. On 8/27/24 at approximately 9:30 a.m., an interview was conducted with CNA #9. CNA #9 was asked what the signs on the door that read enhanced barrier precautions meant. CNA #9 said, If stuff is on the door, supposed to put gown and gloves on when enter, but if no supplies on door, I'm not sure what to do. (SIC) On 8/27/24 at 11:25 a.m., the surveyor observed licensed practical nurse #5 (LPN #5) administer medication and bolus tube feeding to R22. It was noted that LPN #5 was wearing gloves during the administration of the medication and the tube feeding, which were both given through the peg tube, but no other PPE had been worn. At this time, it was again noted that the sign on the exterior of the room door indicated enhanced barrier precautions, which indicated facility staff were to wear an isolation gown and gloves when providing any direct resident care. Upon completion of the above observations, LPN #5 was asked about the sign on the door. LPN #5 stated that it was not for R22, it was related to the roommate who had wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24, a clinical record review was conducted of R22's chart. This review revealed documentation that R22 had a peg tube and received supplemental nutrition, as well as medications, via the peg tube. There were no physician orders with regards to enhanced barrier precautions. According to the care plan for R22, the activities of daily living focus area had an intervention implemented 4/14/24, that read, Enhanced barrier precautions for direct care. On 8/28/24 at 04:32 p.m., an interview was conducted with the facility's infection preventionist (IP). During the interview, the IP was asked about various levels of isolation. The IP said, Contact Isolation, you have to wash hands, wear a gown, gloves, separate his stuff from everyone else, and on the way-out don and doff [PPE] properly and wash hands again. When asked how that differs from enhanced barrier precautions, the IP said, Enhanced barrier protects the patient from the germs you have, contact protects you from them. They are similar. When asked who is on enhanced barrier precautions, the IP said, Anyone that has a hole they were not born with. The facility policy titled Enhanced Barrier Precautions was reviewed. The policy read in part, . c. Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves . 2 b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status .3. Implementation of Enhanced Barrier Precautions- a. Make gowns and gloves available immediately outside of the resident's room . 2. The facility staff failed to follow transmission-based precautions and wear appropriate personal protective equipment (PPE), while providing direct care to Resident #57. On 8/26/24 at approximately 6:50 p.m., Resident #57 (R57) was interviewed in his room. It was noted that a sign on the door indicated Enhanced Barrier Precautions. R57 had a hospital gown on that left his back exposed, as well as his arms and legs. It was noted that R57 had red lesion-like areas all over his visible body parts, with some that had visible dried blood. When asked about these areas, R57 stated that it was scabies. On 8/27/24, a clinical record review was conducted. This review revealed evidence that R57 did have scabies. According to the active physician order dated 8/13/24, it read, Contact Isolation for Scabies. Resident to be on isolation with all meals, activities, therapy, and all services are provided in room. Staff to utilize contact isolation precautions. According to R57's care plan, which was created on 8/13/24, it read in part, [R57's name redacted] has scabies and is on contact isolation. R57's care plan interventions included: CONTACT ISOLATION: Wear gowns and gloves when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry, instruct family/visitors/caregivers to wear disposable gown and gloves during physical contact with resident. Discard in appropriate receptacle and wash hands before leaving room and Instruct visitors to wear disposable gloves and gown when in residents' room and to wash hands before leaving room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 10:52 a.m., it was observed that R57's call bell was engaged, a light was on and blinking outside of the room, and an auditory alarm was sounding in the hallways. R57 could be heard yelling out for help. At 11:05 a.m., LPN #5 entered the room and was heard to tell the resident You don't have to keep yelling, give us a minute. After exiting the room, LPN #5 was asked why R57 had been yelling. LPN #5 reported that R57 was sitting on the toilet and waiting for the staff to get him off. At 11:28 a.m., two CNA's were observed to enter R57's room to assist with getting the resident off the commode. None of the staff that entered the room had put on any PPE prior to entering the room or during the provision of care. It was again observed that no PPE supplies were present outside R57's room. At 12:07 pm, an interview was conducted with the unit manager, LPN #3, for the unit R57 resided on, Unit 2. When questioned about R57's isolation precautions, LPN#3 stated that R57 had initially tested negative for scabies. LPN#3 stated that it wasn't until the punch biopsy, performed by Dermatology, showed positive results for scabies that his diagnosis was known. LPN#3 then stated that since he was last treated on 8/21/24, that R57 was basically clear from isolation two days later. Later that day, R57 was again observed self propelling his wheelchair in the hallway. No physician order was found that discharged the Contact Isolation precautions. On 8/28/24, in the morning, R57 was again observed out of his room in the hallway around the nursing station. While still in the hallway, it was observed that the unit manager stopped the resident, cleansed an open lesion area on R57's left arm that was bleeding, and applied a band aide, without wearing any PPE. On 8/28/24 at 04:32 p.m., an interview was conducted with the facility's infection preventionist (IP). During the interview the IP was asked about various levels of isolation. The IP said, Contact isolation, you have to wash hands, wear a gown, gloves, separate his stuff from everyone else, and on the way-out don and doff properly [PPE], and wash hands again. Review of the facility policy titled; Transmission-Based Precautions was conducted. The policy read in part, . 3. Contact Precautions- a. Intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or the resident's environment . c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination 3. The facility staff failed to respond to and implement quarantine and testing measures in accordance with CDC (The Centers for Disease Control and Prevention) recommendations to manage COVID-19 during an outbreak. On 8/27/24 at approximately 8 a.m., a sign was observed on the front door that indicated the facility was in an COVID outbreak that began 8/8/24. On 8/28/24 at 4:32 p.m., the surveyor met with the facility's infection preventionist (IP). During the interview, the IP was asked about the COVID outbreak. The IP was unsure how many people had tested positive for COVID and if they had been admitted with COVID or tested positive while a resident. The IP went on to say that the receptionist (Other Employee #8 - OE#8) had tested positive. When asked if she had a line listing that showed the COVID cases, the IP said, No I don't. I just hung myself. I am supposed to do that. I'm still new at this and there is a lot to learn. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP was asked to explain what they did when OE#8 tested positive. The IP said, We sent her home for five days and housekeeping came and cleaned up front. That must be when we hung the sign, but one person doesn't make an outbreak. She came back and tested on day five and she was negative, so she returned to work. When asked for evidence of OE #8's COVID testing, the IP said that she didn't have it or the details of when OE #8 was tested . When asked if they did contact tracing for broad based testing, the IP said, You are going to think I'm stupid, but what is contact tracing? The surveyor explained contact tracing and then asked again, if anyone else was tested . The IP said, We tested all of the dialysis patients. There was a potential outbreak at dialysis, and they were all negative. When asked to see evidence of the resident testing, the IP said, They were tested on the 9th. I will have to find out where that is. When asked about occurrences of COVID testing, the IP said, We only test if they are symptomatic and we didn't have any. No evidence of any resident testing was provided. When asked if the local health department had been contacted, the IP looked through her emails and provided the surveyor with a copy of email correspondence dated 8/22/24 and 8/26/24. According to this documentation, the IP emailed the local health district's respiratory illness mitigation specialist (RIMS) on 8/22/24, and reported, The employee has returned with no symptoms, we currently have 2 resident who are positive with hospital acquired. One is coming off isolation the 23rd and the other the 26th. The RIMS responded on 8/26/24 and said, The only two cases that I know about tested positive on 8/8/24, which means that isolation would have ended for them around the 18th. Their names are [names redacted]. If there are two more cases with later onsets, please let me know. No other email documentation was provided. Following this document review, one of the two residents noted by the RIMS was identified as Resident #119 (R119). A clinical record review was conducted and revealed that R119 had a readmission to the facility on [DATE], following a fall at the facility and being sent to the emergency room . Review of R119's nursing notes revealed a readmission note dated 8/4/24, that read, admitted from hospital for loss of consciousness, UTI [urinary tract infection] colitis, lactic acidosis, LOC [loss of consciousness] . There was no mention of COVID-19 being diagnosed . On 8/7/24, R119's chart documented a progress note that read, Resident c/o [complained of] sore throat and sudden onset of cough. Oral temperature 102.5F. Resident received PRN Tylenol at 1651 for c/o generalized pain. Contacted the provider on call number and left message requesting return call to this LPN. R119's chart documented another note was entered on 8/7/24 that read, Called and spoke with Dr. [name redacted]. Verbal order received to do a COVID test and monitor and contact MD if any changes and or no improvement of fever. On 8/7/24 at 7:27 p.m., R119's chart documented a nursing note entry which read, COVID test positive. MD notified. Isolation precautions in place. Resident educated on isolation requirements and is in her room. No evidence was found that the facility had conducted any contact tracing to determine if R119 had exposed others to the infection. No evidence was found that broadband testing in response to the COVID outbreak had been conducted. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the CDC guidance for helthcare settings, titled Infection Control Guidance: SARS-CoV-2, dated 6/24/24, recommendations read in part, .Responding to a newly identified SARS-CoV-2-infected HCP or resident . A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 (Accessed online at https://www.cdc.gov/covid/hcp/infection-control/index.html.) No additional information was provided. 4. The facility staff failed to maintain an infection surveillance/monitoring program. On 8/28/24 at 04:32 p.m., an interview was conducted with the facility's infection preventionist (IP). When asked about infection surveillance, the IP stated that the only line list she had was regarding R57 having scabies. The IP said that she didn't know anything about a line listing until she talked to the health department, and they wanted her to fax them a line listing. When asked about the other two residents who had also been symptomatic with scabies and subsequently treated, the IP said that she was not tracking that because they had not tested positive for scabies. The IP said, The health department only wanted the one confirmed. We will go back and add the others. The IP was also asked about the recent COVID outbreak as a sign was on the front door that indicated as of 8/8/24, the facility was in a COVID outbreak. The IP said that she didn't have any type of listing to indicate who had tested positive, what their symptoms were, or when they had been cleared. A review was performed of the facility policy titled, Infection Prevention Control Program, with a review date of 12/1/22. The policy read in part, . 3. Surveillance: a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual agreement based upon a facility assessment and accepted national standards. b. The infection preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee. c. The RNs and LPNs participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections . 5. The facility staff failed to correctly respond to the identified presence of Legionella bacteria within the facility's water system. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at approximately 4:45 p.m., the survey team met with the facility's maintenance director who oversees the facility's Legionella and water management program. The maintenance director provided the survey team with a book that contained the water management risk assessment and the water flow diagram, which indicated the risk areas identified. Included within the book was a laboratory report dated 12/5/23, which indicated various areas within the facility were tested for the presence of Legionella pnemophila bacteria. The report indicated that .test results less than MPN [most probable number] of 35 do not need treatment. The results showed the presence of Legionella pneumophila in the .shower B wing with a result of 14.6 . ice machine kitchen 58.3 and shower A wing >2272. Also attached was a letter from the company that reported the test results, dated 12/5/23, which was addressed to the maintenance director. The letter read in part, Severe problem areas are 11&12 Ice Machine kitchen & particularly A-Wing Shower. Recommend remove shower heads & aerators throughout building. Soak units in 10% bleach solution for 1 hour then rinse thoroughly . While shower heads & faucets are removed take a bottle brush and dip in 10% chlorine solution containing 10% soap solution such as Simple Green. The soap acts as a spreader sticker so chlorine can do work. Then brush inside pipes to remove any biofilm around opening. Let stand 15 minutes then brush again before rinsing . Ice machine in kitchen needs cleaning. Please request some swabs & jars so that contaminated area can be tested again after decontamination procedure . The maintenance director reported that he cleaned the ice machine in the kitchen, and they replaced the shower head. There was a notation on the bottom of the above letter dated 12/5/23, that indicated cleaned ice machine 12/20/23, replaced shower head 12/22/23. When asked if any cleaning of the aerators and faucets, as well as if any follow-up testing had been done, the maintenance director indicated he was not aware of those recommendations. When the recommendations were pointed out in the letter, the maintenance director said that he hadn't been aware but would do it, now that he knew. Review of the facility policy titled; Legionella Surveillance was performed. The policy read in part, . 1. Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems. 2. In the absence of Legionella infections for a period of at least one year, the facility shall implement primary prevention strategies . 5. Primary prevention strategies: a. Diagnostic testing: b. Investigation for facility source of Legionella, which may include culturing of facility water for Legionella. C. Physical controls . iii. Non-potable water systems shall be routinely cleaned and disinfected ., and D. Temperature controls . On 8/28/24, during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide education and offer the flu and pneumonia immunizations to 3 of 5 residents (Resident #80 - R80, Resident #42 -R42, and Resident #70 - R70) sampled for immunizations. The findings included: On 8/27/24, five residents were reviewed for compliance with immunization protocols, as part of the infection control task. During this review, the clinical record of each resident was reviewed. For R80 and R42, the clinical record documented no evidence that either resident had been educated about the vaccines or offered the flu and pneumonia vaccines since admission. There was no documentation for R80 or R42 regarding consent or refusal of the immunization. R70's clinical record had no evidence of being offered the flu vaccine, despite being admitted during the flu season. R70's clinical record revealed that she had received Prevnar 13, but there was no indication that the pneumococcal 23 vaccine was offered. The clincal record reviews revealed that each of the residents had been residing in the facility for at least eight months and that all were residing in the facility during the flu season. On 8/28/24 at 4:32 p.m., an interview was conducted with the facility's infection preventionist (IP). During the interview, the IP reviewed each record and confirmed the lack of documentation regarding the flu and pneumonia immunizations, including education and consents for R80, R42, and R70. The IP said, I don't see anything where it was offered. When asked about the facility's process with regards to immunizations, the IP stated, The floor nurses offer immunizations upon admission, then we can contact the responsible party to see if that is something they want. When asked why immunizations are important, the IP said, To make sure we don't have outbreaks. The facility policy titled, Influenza Vaccination with a review date of 12/1/22, was reviewed. This policy read in part, . 2. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine . 8. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal . The facility's policy titled Pneumococcal Vaccine (Series) (revised 12/1/22) documented under procedures, 1. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. 2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized . 3. Prior to offering the pneumococcal immunization, each resident or resident's representative will receive education regarding the benefits and potential side effects of the immunization . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ridge Rehabilitation and Nursing	94 South Avenue Harrisonburg, VA 22801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at approximately 5:30 p.m., the facility administrator, director of nursing, and corporate nurse consultant was made aware of the above findings. The Director of Nursing stepped out to see if she could find any additional information but returned and reported that she had nothing further to provide. No additional information was provided.

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide education and offer the COVID-19 immunization to 4 of 5 residents (Resident #80 - R80, Resident #42 - R42, Resident #60 - R60 and Resident #70 - R70). The facility also failed to provide education to the employee regarding the spike vaccine booster for the 2023-2024 season for 1 of 1 staff sampled (Other Employee #8). The findings included: On 8/27/24, clinical record reviews were conducted of the five residents sampled for immunizations. The findings revealed no evidence of the residents being educated nor offered the COVID-19 2023-2024 spik vaccine. R80 had no immunization information noted, only a PPD tuberculin skin test. R42, had no immunization information noted. R60 and R70 had no information regarding COVID immunization listed. There was no information that the 2023-2024 Spike vaccine was offered, education provided, or that it was declined/refused. On 8/28/24 at 4:32 p.m., an interview was conducted with the facility's infection preventionist (IP). During the interview the IP reviewed and confirmed the above findings with regards to the lack of documentation within the clinical record with regards to COVID immunizations for R80, R42, R60 and R70. The IP said, I don't see anything where it was offered. When asked about the facility's process with regards to immunizations, the IP stated, The floor nurses offer immunizations upon admission, then we can contact the responsible party to see if that is something they want. When asked why immunizations are important, the IP said, To make sure we don't have outbreaks. On 8/28/24 at approximately 5 p.m., the human resources manager (HRM) was asked to pull the COVID immunization information for Other Employee #8 (OE#8). The HRM and administrator were unable to find any information within the employee's file regarding COVID immunization. The administrator had the employee text a photo copy of her COVID immunization card, which indicated that OE#8 had the primary series and one booster dose in October 2022. The facility had no evidence of OE#8 being educated on the COVID immunization or being offered subsequent boosters. (continued on next page)

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	495146	A. Building B. Wing	08/28/2024

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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 - Some	The facility policy titled; Coronavirus Prevention and Response with a review date of 7/29/24 was reviewed. This policy read in part, . 9. Vaccination Planning: a. Residents will be assessed for COVID 19 immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented in the medical record, including efforts to determine date of immunization or type of vaccine received. b. Each resident will be offered a COVID 19 immunization unless it is medically contraindicated, or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. c. Prior to offering the COVID 19 immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization. i. The individual receiving the immunization, or the resident representative, will be provided with a copy of the CDC's current vaccine information statement relative to that vaccine. ii. If necessary, the vaccine information statement will be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding. d. The resident/representative retains the right to refuse the immunization. A consent form shall be signed prior to the administration of the vaccine and filed in the individual's medical record (see consent form). e. The type of COVID 19 vaccine offered will depend upon and, in accordance with current CDC guidelines and recommendations. f. The resident's medical record shall include documentation that indicates at a minimum, the following: a. The resident or resident's representative was provided education regarding the benefits and potential side effects of the COVID 19 immunization. b. The resident received the COVID 19 immunization or did not receive it due to medical contraindication or refusal. g. For employees, documentation related to COVID 19 immunizations will be maintained in the employee file. Employees will be assessed for COVID 19 status upon hire. All facility staff will be encouraged to get vaccinated against Covid 19 . The FDA (Food and Drug Administration) gives information about the 2023-2024 spike vaccine on their website, accessed at: https://www.fda.gov/vaccines-blood-biologics/coronavirus-covid-19-cber-regulated-biologics/novavax-covid-19-vaccine-adjuvanted. The guidance read, On October 3, 2023, the Food and Drug Administration amended the emergency use authorization (EUA) of Novavax COVID-19 Vaccine, Adjuvanted to include the 2023-2024 formula. The Novavax COVID-19 Vaccine, Adjuvanted, a monovalent vaccine, has been updated to include the spike protein from the SARS-CoV-2 Omicron variant lineage XBB.1.5 (2023-2024 formula). The Novavax COVID-19 Vaccine, Adjuvanted (Original monovalent) is no longer authorized for use in the United States. Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is authorized for use in individuals [AGE] years of age and older as follows: Individuals previously vaccinated with any COVID-19 vaccine: one dose of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is administered at least 2 months after receipt of the last previous dose of an original monovalent (Original) or bivalent (Original and Omicron BA.4/BA.5) COVID-19 vaccine. Individuals not previously vaccinated with any COVID-19 vaccine: two doses of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) are administered three weeks apart . On 8/28/24 at approximately 5:30 p.m., the facility administrator, director of nursing, and corporate nurse consultant were made aware of the above findings. The Director of Nursing stepped out to see if she could find any additional information, but returned and reported she had nothing further to provide. No additional information was provided.