STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495192	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrenceville Health & Rehabilitation	1722 Lawrenceville Plank Road Lawrenceville, VA 23868

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility document review, the facility staff failed to treat a resident with dignity for one of 29 residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to provide feeding assistance in a dignified manner at breakfast on 3/18/25. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/13/24, R1 was coded as being severely impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). She was coded as requiring supervision or touching assistance for eating. On 3/18/25 at 8:44 a.m., R1 was observed sitting up in chair in the day room. She was being fed breakfast by OSM (other staff member) #5, the business office manager. OSM #5 was observed standing beside and over R1 as she fed the resident. On 3/19/24 at 7:43 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated when she feeds or partially assists a resident with eating, she sits down beside the resident. She stated: I like to have eye contact. Standing on top of someone is not good. It is [NAME] important to face them and have eye contact with them. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility policy, Assistance with Meals, revealed, in part: Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. No additional information was provided prior to exit.

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

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of required physician documentation after a resident is transferred to the hospital for one of 29 residents in the survey sample, R24. The findings include: The facility staff failed to evidence required physician documentation after a resident is transferred to the hospital for R24. R24 was transferred to the hospital on [DATE]. R24 was admitted to the facility on [DATE] with diagnosis that included but were not limited to TIA (transient ischemic attack), dysphagia and cognitive communication deficit. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/28/25, coded the resident as scoring a 08 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing and supervision for eating. A review of the comprehensive care plan dated 12/9/24 revealed, FOCUS: Resident has had an actual fall related to Confusion, Gait/balance problems, mild visual impairment, and HTN (hypertension). INTERVENTIONS: Bed lowest position. Re-educate resident on the importance of using call light for assistance and not transferring himself with no assistance. Call light is within reach and encourage the resident to use it for assistance as needed. He needs prompt response to all requests for assistance. A review of the nursing progress note dated 11/29/24 at 4:39 PM revealed, This nurse was contacted by another nurse r/t resident being in the bed. Resident was assessed, but denied any pain at the time, and no signs of external rotation at this time. Resident was assisted back to bed via staff and transfer lift device. Upon getting resident in the bed, he had c/o of R hip pain, while attempting to do VS. Area assessed further and noticed that R hip bone has a bulge, and it could be seen. MD was contacted to have resident sent out to hospital but left message with receptionist. RP was contacted and informed that resident would be sent to the hospital. EMS contacted for resident transfer. Resident left facility approximately 4:00 PM to hospital. Physician notes were dated 11/16/24 and 12/18/24 with no post hospital physician/NP transfer note evidenced. An interview was conducted on 3/19/25 at 7:25 AM with LPN (licensed practical nurse) #2. When asked when physicians write their notes after a resident is transferred to the hospital, LPN #2 stated, their notes are in PCC (point click care), but I do not know when they write them. There is one book on the [NAME] unit that we document what residents; the physician needs to see. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 3/19/25 at 12:22 PM with ASM (administrative staff member) #4, the physician. When asked about timing of his resident visits and notes, ASM #4 stated, every Wednesday and extra Friday or Saturday, about six times per month. I did not have remote access for about six months to document. The nursing staff give me a shopping list of the people who are due to be seen. I started doing this in December. I run a whole list of my own, so I do not miss anyone. I use PCC to document my progress notes. The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/18/25 at 4:45 PM. A review of the facility's Physician/Practitioner Progress Notes policy revealed, Physician progress notes must be maintained for each resident. Physician/practitioner progress notes reflect the resident's progress and response to his or her care plan, medications, etc. Physician/practitioner documentation will be accurate, made timely, and signed/dated by the physician/practitioner. No further information was provided prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to complete an accurate MDS (minimum data set) for one of 29 residents in the survey sample, Resident #51. The findings include: For Resident #51 (R51), the facility staff failed to complete an accurate 12/31/24 MDS. On R51's most recent MDS, an annual assessment with an ARD (assessment reference date) of 12/31/24, the resident was coded as having no cognitive impairment. He was coded as being physically restrained when in a chair or out of bed. Observations of R51 occurred at the following dates and times: 3/17/25 at 1:00 p.m. and 4:40 p.m.; and 3/18/25 at 8:51 a.m. At none of these observations was R51 physically restrained. On 3/17/25 at 1:00 p.m., R51 stated he had never been physically restrained, and had always had free and independent movement in the bed and in a chair. On 3/19/25 at 8:24 a.m., LPN (licensed practical nurse) #6, the MDS coordinator, was interviewed. She stated she had originally coded R51 as being physically restrained because he used a seatbelt when he was out of bed in a wheelchair. She stated she had recently learned that the seatbelt was not considered a restraint because the resident could release the seatbelt independently, and the seatbelt did not restrict his movement in any way. She stated the process to correct the 12/31/24 MDS was underway, but the modified MDS has not yet been submitted. She did not know why the MDS was not yet submitted. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility policy, MDS Correction, revealed, in part: If an error is discovered in a record that has already been accepted by the [Centers for Medicare and Medicaid Services], implement procedures for either Modification or Inactivation of the information in the system within 14 days of the discovery of the error. No additional information was submitted prior to exit.

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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. Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to develop a comprehensive care plan for three of 29 residents in the survey sample, Residents #17, #19, and #1. The findings include: 1. For Resident #17 (R17), the facility staff failed to develop a care plan for the resident's dietary needs. On 3/17/25 at 12:48 p.m., R17 was observed sitting up in bed eating lunch. The resident's lunch tray contained one regular roll and peach cobbler (peach slices and cobbler crust). A review of R17's meal ticket revealed, in part: Dysphagia mechanical soft, nectar thick liquid .moistened white cake with chopped peaches .no straws. At 1:00 p.m., OSM (other staff member) #4, a speech therapist, also observed R17's meal tray. She confirmed that the regular roll and peach cobbler did not conform with a mechanical soft diet. On 3/17/24 at 5:53 p.m., R17 was observed sitting up in bed eating dinner. The dinner tray contained cubed chicken (approximately 1.5 centimeters cubed). A review of R17's meal ticket revealed, in part: Dysphagia mechanical soft .ground chicken nuggets with barbecue sauce. A review of R17's prescribers' orders revealed the following order, dated 9/27/24: Mechanical Soft texture, Nectar liquids consistency, for oropharyngeal dysphasia; high aspiration risk. NO STRAWS. A review of R17's care plan revealed no information regarding the resident's altered diet. On 3/19/25 at 7:52 a.m., LPN (licensed practical nurse) #2 was interviewed. She stated care plans are developed so the residents may have a more productive lifestyle, to do as much as possible independently, and to determine those things with which residents need help. On 3/19/25 at 8:24 a.m., LPN #6, the MDS (minimum data set) coordinator was interviewed. She stated she reviews care plans daily for accuracy, and particularly focuses on new orders or items contained in the 24 hour report. She stated she does not put specific diets on the care plan because these can change. She stated if a resident has a modified diet, she indicates it in the care plan as, Diet as ordered. She stated floor nurses have the ability to update care plans, but generally they do not. She stated comprehensive care plan reviews include all orders and interventions a resident requires. On 3/19/25 at 9:08 a.m., LPN #6 stated that she had not been able to locate information related to resident diets on any of the care plans, and this is something she would need to correct. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Care Planning - Comprehensive Person-Centered, revealed, in part: A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident .the resident will receive the services and/or items included in the plan of care .Each resident's comprehensive care plan will describe .services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. No additional information was provided prior to exit. 2. For Resident #19 (R19), the facility staff failed to develop a care plan for the resident's dietary needs. On 3/17/25 at 1:09 p.m., R19 was observed sitting up in bed eating lunch. The resident's lunch tray contained one regular roll and peach cobbler (peach slices and cobbler crust). A review of R19's meal ticket revealed, in part: Dysphagia mechanical soft .pureed bread .moistened white cake with chopped peaches. On 3/17/24 at 5:49 p.m., R19 was observed sitting up in bed eating dinner. The dinner tray contained cubed chicken (approximately 1.5 centimeters cubed) and canned pineapple slices. A review of R19's meal ticket revealed, in part: Dysphagia mechanical soft .ground chicken nuggets with barbecue sauce .choice of soft, canned, chopped fruit. A review of R19's prescribers' orders revealed the following order, dated 5/14/24: Mechanical Soft texture, Regular/Thin consistency [for liquids]. A review of R19's care plan revealed no information regarding the resident's altered diet. On 3/19/25 at 7:52 a.m., LPN (licensed practical nurse) #2 was interviewed. She stated care plans are developed so the residents may have a more productive lifestyle, to do as much as possible independently, and to determine those things with which residents need help. On 3/19/25 at 8:24 a.m., LPN #6, the MDS (minimum data set) coordinator was interviewed. She stated she reviews care plans daily for accuracy, and particularly focuses on new orders or items contained in the 24 hour report. She stated she does not put specific diets on the care plan because these can change. She stated if a resident has a modified diet, she indicates it in the care plan as, Diet as ordered. She stated floor nurses have the ability to update care plans, but generally they do not. She stated comprehensive care plan reviews include all orders and interventions a resident requires. On 3/19/25 at 9:08 a.m., LPN #6 stated that she had not been able to locate information related to resident diets on any of the care plans, and this is something she would need to correct. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. For Resident #1 (R1), the facility staff failed to develop a care plan for the resident's dietary needs. On 3/17/24 at 6:00 p.m., R1 was observed sitting in the day room being fed dinner by a OSM (other staff member) #5, the business office manager. The dinner tray contained cubed chicken (approximately 1.5 centimeters cubed). A review of R1's meal ticket revealed, in part: Dysphagia advanced .ground chicken nuggets with barbecue sauce. A review of R1's prescribers' orders revealed the following order, dated 4/30/24: Dysphagia - Advanced texture. A review of R1's care plan revealed no information regarding the resident's altered diet. On 3/19/25 at 7:52 a.m., LPN (licensed practical nurse) #2 was interviewed. She stated care plans are developed so the residents may have a more productive lifestyle, to do as much as possible independently, and to determine those things with which residents need help. On 3/19/25 at 8:24 a.m., LPN #6, the MDS (minimum data set) coordinator was interviewed. She stated she reviews care plans daily for accuracy, and particularly focuses on new orders or items contained in the 24 hour report. She stated she does not put specific diets on the care plan because these can change. She stated if a resident has a modified diet, she indicates it in the care plan as, Diet as ordered. She stated floor nurses have the ability to update care plans, but generally they do not. She stated comprehensive care plan reviews include all orders and interventions a resident requires. On 3/19/25 at 9:08 a.m., LPN #6 stated that she had not been able to locate information related to resident diets on any of the care plans, and this is something she would need to correct. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit.

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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** 3. For Resident #13 (R13) the facility staff failed to review and revise the care plan with a specialized diet order. On 3/17/25 at 12:55 p.m., R13 was observed sitting up in bed eating lunch. The resident's lunch tray contained regular consistency potato salad and peach cobbler (peach slices and cobbler crust). A review of R13's meal ticket revealed, in part: Dysphagia advanced .peaches and cream cake. On 3/17/24 at 5:55 p.m., R13 was observed sitting up in bed eating dinner. The dinner tray contained cubed chicken (approximately 1.5 centimeters cubed). A review of R13's meal ticket revealed, in part: Dysphagia advanced .ground chicken nuggets with barbecue sauce. A review of R13's prescribers' orders revealed the following order, dated 2/11/25: Dysphagia - Advanced texture. A review of R13's care plan revealed no information regarding the resident's altered diet. On 3/19/25 at 7:52 a.m., LPN (licensed practical nurse) #2 was interviewed. She stated floor nurses have the ability to update a resident's care plan, but generally the floor nurses tell members of management when care plans need to be updated. The management team usually review and revise the care plans based on nurse input. On 3/19/25 at 8:24 a.m., LPN #6, the MDS (minimum data set) coordinator was interviewed. She stated she reviews care plans daily for accuracy, and particularly focuses on new orders or items contained in the 24 hour report. She stated she does not put specific diets on the care plan because these can change. She stated if a resident has a modified diet, she indicates it in the care plan as, Diet as ordered. She stated floor nurses have the ability to update care plans, but generally they do not. She stated comprehensive care plan reviews include all orders and interventions a resident requires. On 3/19/25 at 9:08 a.m., LPN #6 stated that she had not been able to locate information related to resident diets on any of the care plans, and this is something she would need to correct. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. 4. For Resident #20 (R20), the facility staff failed to review and revise the care plan with a specialized diet order. On 3/17/24 at 5:50 p.m., R20 was observed sitting up in bed eating dinner. The dinner tray contained cubed chicken (approximately 1.5 centimeters cubed). A review of R20's meal ticket revealed, in part: Dysphagia advanced .ground chicken nuggets with barbecue sauce. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R20's prescribers' orders revealed the following order, dated 10/10/24: Dysphagia - Advanced texture. A review of R20's care plan revealed no information regarding the resident's altered diet. On 3/19/25 at 7:52 a.m., LPN (licensed practical nurse) #2 was interviewed. She stated floor nurses have the ability to update a resident's care plan, but generally the floor nurses tell members of management when care plans need to be updated. The management team usually review and revise the care plans based on nurse input. On 3/19/25 at 8:24 a.m., LPN #6, the MDS (minimum data set) coordinator was interviewed. She stated she reviews care plans daily for accuracy, and particularly focuses on new orders or items contained in the 24 hour report. She stated she does not put specific diets on the care plan because these can change. She stated if a resident has a modified diet, she indicates it in the care plan as, Diet as ordered. She stated floor nurses have the ability to update care plans, but generally they do not. She stated comprehensive care plan reviews include all orders and interventions a resident requires. On 3/19/25 at 9:08 a.m., LPN #6 stated that she had not been able to locate information related to resident diets on any of the care plans, and this is something she would need to correct. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. Based on observation, clinical record review, staff interview, and facility document review, it was determined the facility staff failed to revise the comprehensive care plan for four of 29 residents in the survey sample, Resident #37, #39, #13, and #20. The findings include: 1. For Resident #37 (R37), the facility staff failed to revise the comprehensive care plan to include the use of a divided plate at meals. Observation of R37 on 3/17/25 at 1:24 p.m. revealed the resident sitting in bed eating lunch. The lunch was observed to be served with each portion in separate bowls on a tray. On 3/18/25 at 1:14 p.m., an observation of R37's lunch revealed it served on a regular plate. The physician orders for R37 documented in part, Divided/sectional plate at all meals. Order Date: 10/24/2024. The comprehensive care plan for R37 documented in part, Nutritional Status: the resident is at risk for weight loss, malnutrition or poor hydration status related to chronic disease, cognitive impairment, GERD (gastrointestinal reflux disease). Date Initiated: 01/29/2025. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan failed to evidence documentation of the use of assistive devices during meals. On 3/18/25 at 3:42 p.m., an interview was conducted with LPN (licensed practical nurse) #5 who stated that the staff supervised R37 when eating and queued them to eat. She stated that R37 used their hands and fingers to eat a lot. She stated that she did not recall the resident using a divided plate during meals but may had seen one used in the past. She stated that the purpose of the care plan was to show the care that they were to give the patient, and it was a tool to follow. On 3/18/25 at 4:13 p.m., an interview was conducted with OSM (other staff member) #4, speech language pathologist. OSM #4 stated that they had not worked with R37 since May of 2024, but they placed the order for the divided plate on 10/24/2024. She stated that it was probably from a recommendation that was made from a routine screening, and she would check her files. On 3/18/25 at approximately 4:35 p.m., OSM #4 provided a handwritten therapy evaluation for R37 dated 10/24/24 which documented recommendations of . Recommend divided/sectional plate at all meals to (decrease) spillage from plate, thereby increasing po (by mouth) intake. On 3/19/25 at 8:24 a.m., an interview was conducted with LPN #6, the MDS (minimum data set) coordinator. She stated that she reviewed care plans daily for accuracy, and particularly focused on new orders or items contained in the 24-hour report. She stated floor nurses had the ability to update care plans, but generally they did not. She stated that the comprehensive care plan reviews included all orders and interventions a resident required. LPN #6 stated that the divided plate was an intervention that should have been included on R37's care plan and she had updated the care plan on 3/18/24. The facility policy Care Planning-Comprehensive Person Centered documented in part, . Each resident's comprehensive care plan will describe the following: a. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . 13. The comprehensive care plan will: a. Incorporate identified problem areas; b. incorporate risk factors associated with identified problems . e. Reflect treatment goals, timetables and objectives in measurable outcomes . On 3/19/25 at 12:38 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. 2. The facility failed to revise the comprehensive care plan for oxygen administration for R39. R39 was admitted to the facility on [DATE] with diagnosis that included but were not limited to acute respiratory failure, COPD (chronic obstructive pulmonary disease) and MI (myocardial infarction). The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 2/13/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the comprehensive care plan dated 2/10/25 revealed, FOCUS: RESPIRATORY: the resident is at risk for respiratory complications secondary to COPD, supplementary oxygen requirement. INTERVENTIONS: Administer oxygen as ordered. Administer medications as ordered. Care Plan revised 2/11/25. A review of the physician's order dated 2/12/25 revealed, Oxygen 4 liters via NC (specify continuous) DUE TO RESP FAILURE. every shift related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA. Oxygen Therapy @ 2 LM continuous every shift related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA. A review of the February and March 2025 MAR (medication administration record), oxygen 2lnc and oxygen 4lnc are both documented as administered. An interview was conducted on 3/18/25 at 8:45 AM with LPN (licensed practical nurse) #1. When asked to review the oxygen rate of R39, LPN #1 stated, it is on 2 liters nasal cannula. When asked to review the orders, LPN #1 stated, there are two conflicting orders for oxygen administration, one for 2 lnc and one for 4 lnc. When asked where oxygen administration would be evidenced, LPN #1 stated on the MAR. When asked to review R39's MAR, LPN #1 stated, oxygen 2lnc and oxygen 4lnc are both documented as administered. When asked what the professional standard of practice would be in this situation, LPN #1 stated, we should have called to clarify the physician's order and not documented that both rates were administered. When asked if the care plan should have been reviewed and revised with oxygen setting, LPN #1 stated, yes, it should have been reviewed. The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/18/25 at 4:45 PM. A review of the facility's Care Planning-Comprehensive Centered policy, revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to meet professional standards for one of 29 residents, R39. The findings include: The facility staff failed to meet professional standards by clarifying the oxygen order for R39. R39 was admitted to the facility on [DATE] with diagnosis that included but were not limited to acute respiratory failure, COPD (chronic obstructive pulmonary disease) and MI (myocardial infarction). The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 2/13/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 2/10/25 revealed, FOCUS: RESPIRATORY: the resident is at risk for respiratory complications secondary to COPD, supplementary oxygen requirement. INTERVENTIONS: Administer oxygen as ordered. Administer medications as ordered. A review of the physician's order dated 2/12/25 revealed, Oxygen 4 liters via NC (specify continuous) DUE TO RESP FAILURE. every shift related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA. Oxygen Therapy @ 2 LM continuous every shift related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA. A review of the February and March 2025 MAR (medication administration record), oxygen 2lnc and oxygen 4lnc are both documented as administered. An interview was conducted on 3/18/25 at 8:45 AM with LPN (licensed practical nurse) #1. When asked to review the oxygen rate of R39, LPN #1 stated, it is on 2 liters nasal cannula. When asked to review the orders, LPN #1 stated, there are two conflicting orders for oxygen administration, one for 2 lnc and one for 4 lnc. When asked where oxygen administration would be evidenced, LPN #1 stated on the MAR. When asked to review R39's MAR, LPN #1 stated, oxygen 2lnc and oxygen 4lnc are both documented as administered. When asked what the professional standard of practice would be in this situation, LPN #1 stated, we should have called to clarify the physician's order and not documented that both rates were administered. The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/18/25 at 4:45 PM. A review of the facility's Daily Work Assignments policy, revealed, All nursing service personnel shall follow daily work assignments and perform assigned duties in accordance with professional standards of practice and facility policy. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff /resident interviews facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care services for one of 29 residents, R39. The findings include: The facility staff failed to provide respiratory therapy per physician orders for R39. R39 was admitted to the facility on [DATE] with diagnosis that included but were not limited to acute respiratory failure, COPD (chronic obstructive pulmonary disease) and MI (myocardial infarction). The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 2/13/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 2/10/25 revealed, FOCUS: RESPIRATORY: the resident is at risk for respiratory complications secondary to COPD, supplementary oxygen requirement. INTERVENTIONS: Administer oxygen as ordered. Administer medications as ordered. A review of the physician's order dated 2/12/25 revealed, Oxygen 4 liters via NC (specify continuous) DUE TO RESP FAILURE. every shift related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA. Oxygen Therapy @ 2 LM continuous every shift related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA. A review of the February and March 2025 MAR (medication administration record), oxygen 2lnc and oxygen 4lnc are both documented as administered. An interview was conducted on 3/18/25 at 8:45 AM with LPN (licensed practical nurse) #1. When asked to review the oxygen rate of R39, LPN #1 stated, it is on 2 liters nasal cannula. When asked to review the orders, LPN #1 stated, there are two conflicting orders for oxygen administration, one for 2 lnc and one for 4 lnc. When asked where oxygen administration would be evidenced, LPN #1 stated on the MAR. When asked to review R39's MAR, LPN #1 stated, oxygen 2lnc and oxygen 4lnc are both documented as administered. When asked what the professional standard of practice would be in this situation, LPN #1 stated, we should have called to clarify the physician's order and not documented that both rates were administered. The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/18/25 at 4:45 PM. A review of the facility's Oxygen Administration policy, revealed, The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Turn on the oxygen at the number of liters / minutes as ordered by the physician/practitioner. Report other information in accordance with facility policy and professional standards of practice. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide a complete pain management program including implementation of non-pharmacological interventions prior to the administration of as needed pain medications for one of 29 residents in the survey sample, Resident #58. The findings include: For Resident #58 (R58), the facility staff failed to evidence implementation of non-pharmacological interventions prior to administration of as needed pain medications on multiple dates in January, February and March of 2025. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/21/2025, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section J documented R58 having almost constant pain and receiving as needed pain medications. Section J further documented not receiving non-medication interventions for pain. On 3/17/25 at 1:06 p.m., an interview was conducted with R58 who stated that they had pain from a gout flare up and from a recent fall at home with a broken hip. R58 stated that the nurses gave them medications when they asked for it. When asked about non-pharmacological interventions prior to medication administration, R58 stated that they were not sure. The physician order's for R58 documented in part, - Acetaminophen Oral Tablet 325 MG (Acetaminophen) Give 3 tablet by mouth every 8 hours as needed for pain related to Pain in Unspecified Joint. Order Date: 01/17/2025. - Oxycodone HCl Oral Capsule 5 MG (Oxycodone HCl) Give 5 mg by mouth every 4 hours as needed for moderate pain related to Pain in Unspecified Joint. Order Date: 01/17/2025. The eMAR (electronic medication administration record) dated 1/1/25-1/31/25 documented the Oxycodone administered to R58 a total of 8 times for pain levels ranging from 3-9. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of the Oxycodone. The eMAR dated 2/1/25-2/28/25 documented the Oxycodone administered to R58 a total of 4 times for pain levels ranging from 4-5. The eMAR documented the Acetaminophen administered to R58 once for a pain level of 5. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of the Oxycodone or Acetaminophen. The eMAR dated 3/1/25-3/31/25 documented the Acetaminophen administered to R58 once for a pain level of 7. The eMAR failed to evidence documentation of non-pharmacological interventions prior to the administration of the Acetaminophen. The progress notes for R58 failed to evidence documentation of non-pharmacological interventions attempted prior to the administration of the as needed pain medication documented on the eMARs. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 3:42 p.m., an interview was conducted with LPN (licensed practical nurse) #5 who stated that prior to administering as needed pain medications she assessed the resident, asked them the pain level and how long the pain had been going on. LPN #5 stated that she attempted to reposition the resident and offer non-pharmacological interventions first and if that did not work, she administered the pain medication. She stated that the non-pharmacological interventions should be attempted prior to medication administration unless refused and they were documented on the eMAR or in the progress notes. The facility policy Pain Management documented in part, . 9. Various strategies and modalities may be utilized to assist the resident in achieving optimal comfort. Such strategies and modalities may include, but are not limited to: a. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: i. Environmental - adjusting the room temperature, smoothing the linens, providing a pressure-reducing mattress, repositioning, etc.; ii. Physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; iii. Exercise - range of motion exercises to prevent muscle stiffness and contractures; iv. Cognitive or Behavioral - relaxation, music, diversions, activities, etc . On 3/18/25 at 4:42 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident / staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of the frequency of physician visits at least every 60 days for five of 29 residents in the survey sample, R48, R9, R59, R28 and R56. The findings include: 1. R48 was admitted to the facility on [DATE] with diagnosis that included but were not limited to acute respiratory failure, COPD (chronic obstructive pulmonary disease) and CHF (congestive heart failure). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/19/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring supervision for mobility/transfers/bathing/dressing and eating. A review of the comprehensive care plan dated 1/7/25 revealed, FOCUS: the resident is a long-term care resident and requires assistance with their ADL's related to chronic health conditions, muscle weakness. INTERVENTIONS: Encourage the resident to participate to the fullest extent possible with each interaction. Supervision or touching assistance with bed mobility and transfers. A review of the Physician / NP (nurse practitioner) notes, revealed, physician notes: 9/25/24, 11/16/24, 2/5/25. A period of 81 days between physician visits on 11/16/24 to 2/5/25. An interview was conducted on 3/17/25 at approximately 2:00 PM with R48. When asked if she had any concerns, R48 asked, can I get another doctor. I do not see this doctor and he does not seem to be doing much for me. An interview was conducted on 3/19/25 at 7:25 AM with LPN (licensed practical nurse) #2. When asked when physicians write their notes, LPN #2 stated, their notes are in PCC (point click care), but I do not know when they write them. There is one book on the [NAME] unit that we document what residents; the physician needs to see. An interview was conducted on 3/19/25 at 12:22 PM with ASM (administrative staff member) #4, the physician. When asked about timing of his resident visits and notes, ASM #4 stated, every Wednesday and extra Friday or Saturday, about six times per month. I did not have remote access for about six months to document. The nursing staff give me a shopping list of the people who are due to be seen. I started doing this in December. I run a whole list of my own, so I do not miss anyone. I use PCC to document my progress notes. On 3/19/25 at 2:00 PM, ASM (administrative staff member) #3, the regional director of clinical services, stated, we do not have any additional evidence to provide. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/19/25 at 12:45 PM. A review of the facility's Physician Visits policy revealed, The Attending Physician and Non-physician practitioner will make visits in accordance with applicable state and federal regulations. The Attending Physician / designee must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. A review of the facility's Physician/Practitioner Progress Notes policy revealed, Physician progress notes must be maintained for each resident. Physician/practitioner progress notes reflect the resident's progress and response to his or her care plan, medications, etc. Physician/practitioner documentation will be accurate, made timely, and signed/dated by the physician/practitioner. No further information was provided prior to exit. 2. R9 was admitted to the facility on [DATE] with diagnosis that included but were not limited to MS (multiple sclerosis), DM (diabetes mellitus) and respiratory failure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/16/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing and supervision for eating. A review of the comprehensive care plan dated 11/15/24 revealed, FOCUS: CARDIAC: the resident is at risk for cardiac complications secondary to hypertension. INTERVENTIONS: observe for signs and symptoms of fluid overload including pulmonary or lower extremity edema and shortness of breath and notify MD as indicated. A review of the Physician / NP (nurse practitioner) notes, revealed, physician notes: 12/11/24, no January 2025, February 2025 or March 2025 physician notes. As of 3/19/25, 98 days since 12/11/24 note. An interview was conducted on 3/19/25 at 7:25 AM with LPN (licensed practical nurse) #2. When asked when physicians write their notes, LPN #2 stated, their notes are in PCC (point click care), but I do not know when they write them. There is one book on the [NAME] unit that we document what residents; the physician needs to see. An interview was conducted on 3/19/25 at 12:22 PM with ASM (administrative staff member) #4, the physician. When asked about timing of his resident visits and notes, ASM #4 stated, every Wednesday and extra Friday or Saturday, about six times per month. I did not have remote access for about six months to document. The nursing staff give me a shopping list of the people who are due to be seen. I started doing this in December. I run a whole list of my own, so I do not miss anyone. I use PCC to document my progress notes. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 2:00 PM, ASM (administrative staff member) #3, the regional director of clinical services, stated, we do not have any additional evidence to provide. The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/19/25 at 12:45 PM. A review of the facility's Physician Visits policy revealed, The Attending Physician and Non-physician practitioner will make visits in accordance with applicable state and federal regulations. The Attending Physician / designee must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. A review of the facility's Physician/Practitioner Progress Notes policy revealed, Physician progress notes must be maintained for each resident. Physician/practitioner progress notes reflect the resident's progress and response to his or her care plan, medications, etc. Physician/practitioner documentation will be accurate, made timely, and signed/dated by the physician/practitioner. No further information was provided prior to exit. 3. R59 was admitted to the facility on [DATE] with diagnosis that included but were not limited to encephalopathy, dysphagia and respiratory failure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 3/6/25, coded the resident as scoring a 02 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing and supervision for eating. A review of the comprehensive care plan dated 12/17/24 revealed, FOCUS: ANTICOVULSANTS: the resident is at risk for adverse reactions related to requiring anticonvulsants for treatment of Mood Disorder Stabilization. INTERVENTIONS: Observe for signs and symptoms of convulsive activity and notify MD as indicated. observe for increased sedation, drowsiness, dizziness, and report to MD as indicated. A review of the Physician / NP (nurse practitioner) notes, revealed, physician notes: 11/23/24, 11/27/24 and 2/15/25. No December 2024 or January 2025 physician notes. 80 days between 11/27/24 and 2/15/25 physician notes. An interview was conducted on 3/19/25 at 7:25 AM with LPN (licensed practical nurse) #2. When asked when physicians write their notes, LPN #2 stated, their notes are in PCC (point click care), but I do not know when they write them. There is one book on the [NAME] unit that we document what residents; the physician needs to see. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/19/25 at 12:22 PM with ASM (administrative staff member) #4, the physician. When asked about timing of his resident visits and notes, ASM #4 stated, every Wednesday and extra Friday or Saturday, about six times per month. I did not have remote access for about six months to document. The nursing staff give me a shopping list of the people who are due to be seen. I started doing this in December. I run a whole list of my own, so I do not miss anyone. I use PCC to document my progress notes. On 3/19/25 at 2:00 PM, ASM (administrative staff member) #3, the regional director of clinical services, stated, we do not have any additional evidence to provide. The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/19/25 at 12:45 PM. A review of the facility's Physician Visits policy revealed, The Attending Physician and Non-physician practitioner will make visits in accordance with applicable state and federal regulations. The Attending Physician / designee must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. A review of the facility's Physician/Practitioner Progress Notes policy revealed, Physician progress notes must be maintained for each resident. Physician/practitioner progress notes reflect the resident's progress and response to his or her care plan, medications, etc. Physician/practitioner documentation will be accurate, made timely, and signed/dated by the physician/practitioner. No further information was provided prior to exit. 4. R28 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular infarction), hemiplegia/hemiparesis and COPD (chronic obstructive pulmonary disease). The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 3/11/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximum assist for mobility/transfers/bathing/dressing and supervision for eating. A review of the comprehensive care plan dated 1/29/25 revealed, FOCUS: CONVULSIVE DISORDER: The resident has a risk for complications secondary to epilepsy. INTERVENTIONS: Observe for convulsive activity and notify MD as indicated. Administer meds as ordered. A review of the Physician / NP (nurse practitioner) notes, revealed, physician notes: 11/27/24, no additional physician notes from 11/27/24 to 3/19/25 a period of 112 days. An interview was conducted on 3/19/25 at 7:25 AM with LPN (licensed practical nurse) #2. When asked when physicians write their notes, LPN #2 stated, their notes are in PCC (point click care), but I do not know when they write them. There is one book on the [NAME] unit that we document what residents; the physician needs to see. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/19/25 at 12:22 PM with ASM (administrative staff member) #4, the physician. When asked about timing of his resident visits and notes, ASM #4 stated, every Wednesday and extra Friday or Saturday, about six times per month. I did not have remote access for about six months to document. The nursing staff give me a shopping list of the people who are due to be seen. I started doing this in December. I run a whole list of my own, so I do not miss anyone. I use PCC to document my progress notes. On 3/19/25 at 2:00 PM, ASM (administrative staff member) #3, the regional director of clinical services, stated, we do not have any additional evidence to provide. The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/19/25 at 12:45 PM. A review of the facility's Physician Visits policy revealed, The Attending Physician and Non-physician practitioner will make visits in accordance with applicable state and federal regulations. The Attending Physician / designee must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. A review of the facility's Physician/Practitioner Progress Notes policy revealed, Physician progress notes must be maintained for each resident. Physician/practitioner progress notes reflect the resident's progress and response to his or her care plan, medications, etc. Physician/practitioner documentation will be accurate, made timely, and signed/dated by the physician/practitioner. No further information was provided prior to exit. 5. R56 was admitted to the facility on [DATE] with diagnosis that included but were not limited to metabolic encephalopathy, CHF (congestive heart failure) and Alzheimer's. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/25/25, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers/bathing/dressing and supervision for eating. A review of the comprehensive care plan dated 12/15/24 revealed, FOCUS: CARDIAC: the resident is at risk for cardiac complications secondary to congestive heart failure. INTERVENTIONS: observe for signs and symptoms of fluid overload including pulmonary or lower extremity edema and shortness of breath and notify MD as indicated. Administer medications as ordered. A review of the Physician / NP (nurse practitioner) notes, revealed, physician notes: 8/21/24, 11/20/24 and 2/21/25. No additional notes from 8/21/24 to 11/20/24 a period of 91 days and no additional notes from 11/20/24 to 2/21`/25 a period of 93 days. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 3/19/25 at 7:25 AM with LPN (licensed practical nurse) #2. When asked when physicians write their notes, LPN #2 stated, their notes are in PCC (point click care), but I do not know when they write them. There is one book on the [NAME] unit that we document what residents; the physician needs to see. An interview was conducted on 3/19/25 at 12:22 PM with ASM (administrative staff member) #4, the physician. When asked about timing of his resident visits and notes, ASM #4 stated, every Wednesday and extra Friday or Saturday, about six times per month. I did not have remote access for about six months to document. The nursing staff give me a shopping list of the people who are due to be seen. I started doing this in December. I run a whole list of my own, so I do not miss anyone. I use PCC to document my progress notes. On 3/19/25 at 2:00 PM, ASM (administrative staff member) #3, the regional director of clinical services, stated, we do not have any additional evidence to provide. The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/19/25 at 12:45 PM. A review of the facility's Physician Visits policy revealed, The Attending Physician and Non-physician practitioner will make visits in accordance with applicable state and federal regulations. The Attending Physician / designee must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. A review of the facility's Physician/Practitioner Progress Notes policy revealed, Physician progress notes must be maintained for each resident. Physician/practitioner progress notes reflect the resident's progress and response to his or her care plan, medications, etc. Physician/practitioner documentation will be accurate, made timely, and signed/dated by the physician/practitioner. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on staff interview, and facility document review, the facility staff failed to ensure the DON (director of nursing) did not serve as a charge nurse for one of 30 days reviewed. The findings include: The facility staff failed to ensure the DON did not serve as a charge nurse on 3/1/25. A review of facility staffing data revealed the resident census was 72 residents on 3/1/25. A daily nursing assignment form dated 3/1/25 revealed ASM (administrative staff member) #2 (the director of nursing) was documented as the nurse working on the west wing. On 3/18/25 at 4:47 p.m., an interview was conducted with ASM #2. ASM #2 stated she worked as a charge nurse on the floor and medication cart on 3/1/25. On 3/19/25 at approximately 12:15 p.m., ASM #1 (the executive director) and ASM #2 were made aware of the above concern. A specific policy regarding this concern was not provided. No further information was presented prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 2. For Resident #15 (R15), the facility pharmacist failed to perform a medication regimen review in June and December of 2024. The attending physician failed to respond to the pharmacist's recommendations in June, September, and October 2024. A review of R15's clinical record revealed a 4/19/22 order for Protonix (to treat esophageal reflux) 40 mg (milligrams) daily, an 8/4/22 order for Lorazepam (to treat anxiety) 1 mg twice daily, and a 4/25/24 order for Trileptal (to prevent seizures) 150 mg twice daily. Further review of R15's clinical record revealed no evidence of a monthly medication regimen review by the pharmacist in June and December 2024. This review also revealed the following recommendations by the pharmacist: In May and October 2024, the pharmacist recommended a dose reduction of the Protonix to 20 mg twice daily. In September 2024, the pharmacist recommended a dose reduction of the Lorazepam to 0.5 mg in the morning and 1 mg in the evening. The pharmacist also recommended a dose reduction of Trileptal to 75 mg in the morning and 150 mg in the evening. R15's clinical record revealed no evidence that the facility physician considered and responded to these recommendations in a timely manner. On 3/18/25 at 12:47 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were interviewed. ASM #2 stated for each resident, the pharmacist reviews residents whom he/she deems necessary. The pharmacist lets ASM #2 know of any urgent concerns prior to leaving the building, then emails the remainder of the reports and recommendations to her. ASM #2 stated she distributes the documents to the appropriate attending physicians, and the physicians respond to the recommendations. She stated she has not regularly been scanning the physician recommendations into the residents' electronic medical record. She did not identify a process for follow up to make sure the medication regimen reviews are completed as required, or for physician response to the pharmacist's recommendations. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. 3. For Resident #17 (R17), the facility pharmacist failed to perform a medication regimen review in April and November of 2024. A review of R17's clinical record revealed no evidence of a monthly medication regimen review by the pharmacist in April and November 2024. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 12:47 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were interviewed. ASM #2 stated for each resident, the pharmacist reviews residents whom he/she deems necessary. The pharmacist lets ASM #2 know of any urgent concerns prior to leaving the building, then emails the remainder of the reports and recommendations to her. She did not identify a process for follow up to make sure the medication regimen reviews are completed as required. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. Based on clinical record review, staff interview and facility document review it was determined that the facility staff failed to complete and/or act upon monthly pharmacy medication regimen reviews for three of 29 residents in the survey sample, Residents #27, #15 and #17. The findings include: 1. For Resident #27 (R27), the facility staff failed to act upon pharmacy recommendations. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/21/24, the resident was documented as taking an antianxiety and an anticonvulsant medication. The physician orders for R27 documented in part, - Depakote Oral Tablet Delayed Release 125 MG (milligram) (Divalproex Sodium) Give 2 tablet by mouth one time a day for anxiety. Order Date: 03/09/2024. - Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth one time a day for anxiety. Order Date: 10/11/2022. The comprehensive care plan for R27 documented in part, - Anticonvulsants: the resident is at risk for adverse reactions related to requiring anticonvulsants for treatment of Mood Disorder Stabilization. Date Initiated: 12/27/2024. - Psychoactive Medications: the resident is at risk for complications related to psychoactive (antidepressant, anxiolytic or hypnotic) medications use secondary to diagnoses of: anxiety disorder. Date Initiated: 12/27/2024. The clinical record for R27 failed to evidence documentation of monthly pharmacy medication regimen reviews completed for the past 12 months. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 12:48 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing who stated that the pharmacist did a review of residents medications monthly and gave her a report upon their exit of any immediate concerns. She stated that he sent her an email with all the reviews and recommendations which she printed out and reviewed. She stated that she completed any nursing recommendations and sent any recommendations for the physician to their offices or contacted them for review. She stated that after the physician reviewed the recommendations, she put in any orders for any medication changes as needed. ASM #2 stated that some of the recommendations were not in the medical record. At that time, a request was made to ASM #1, the executive director, ASM #2 and ASM #3, the regional director of clinical services for evidence of monthly medication regimen reviews for R27 with evidence of physician response for any recommendations made. Review of the facility provided pharmacist medication regimen reviews for the past 12 months for R27 revealed the following recommendations: - A recommendation dated 9/29/24 which documented in part, .The resident has been taking Depakote DR 125mg, 2 tablets (250mg) once daily since (3/10/2024) without a GDR (gradual dose reduction). Could we attempt a dose reduction at this time to perhaps Depakote DR 125mg once daily to verify this resident is on the lowest possible dose? If not, please indicate the response below . The recommendation was observed to be blank with an attached psychiatric progress note for R27 dated 8/7/24 which documented a review of current medications with no changes recommended at that time. The progress note was observed to be dated 8/7/24 which was prior to the pharmacy recommendation for the GDR on 9/29/24. - A recommendation dated 12/16/24 which documented in part, .The resident has been taking Lorazepam 0. 5mg once daily since (10/12/2022) without a GDR. Could we attempt a dose reduction at this time to perhaps Lorazepam 0.25mg once daily to verify this resident is on the lowest possible dose? If not, please indicate the response below . The recommendation was observed to be blank with an attached psychiatric progress note for R27 dated 12/10/24 which documented a review of current medications with no changes recommended at that time. The progress note was observed to be dated 12/10/24 which was prior to the pharmacy recommendation for the GDR on 12/16/24. The facility policy Medication Regimen Review documented in part, .The Consultant Pharmacist with perform a medication regimen review (MRR) for every resident in the facility. Routine reviews will be done monthly . The pharmacist will report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon . The attending physician or medical director will document in the resident's medical record that the identified irregularity has been reviewed and what, if any, has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record . On 3/19/25 at 12:38 p.m., ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to implement interventions to prevent unnecessary medication administration for two of 29 residents in the survey sample, Residents #15 and #39. The findings include: 1. For Resident #15 (R15), the facility staff failed to respond to a pharmacist's recommendation to reduce the dose of Protonix (to treat esophageal reflux) and Trileptal (to prevent seizures). A review of R15's clinical record revealed a 4/19/22 order for Protonix (to treat esophageal reflux) 40 mg (milligrams) daily, an 8/4/22 order for Lorazepam (to treat anxiety) 1 mg twice daily, and a 4/25/24 order for Trileptal (to prevent seizures) 150 mg twice daily. In May and October 2024, the pharmacist recommended a dose reduction of the Protonix to 20 mg twice daily. In September 2024, the pharmacist recommended a dose reduction of Trileptal to 75 mg in the morning and 150 mg in the evening. R15's clinical record revealed no evidence that the facility physician considered and responded to these recommendations in a timely manner. On 3/18/25 at 12:47 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were interviewed. ASM #2 stated for each resident, the pharmacist reviews residents whom he/she deems necessary. The pharmacist lets ASM #2 know of any urgent concerns prior to leaving the building, then emails the remainder of the reports and recommendations to her. ASM #2 stated she distributes the documents to the appropriate attending physicians, and the physicians respond to the recommendations. She stated she has not regularly been scanning the physician recommendations into the residents' electronic medical record. She did not identify a process for follow up to make sure the physician responds to the pharmacist's recommendations. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Medication Regimen Review, revealed, in part: Medication regime reviews will be conducted with the intent to ensure that each resident's entire drug/medication regimen will be managed and monitored to achieve the following goals .Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed conditions .The consulting pharmacist will provide a copy of recommendations to the attending physician, medical director, and director of nursing within 5 working days of completion of the review .The director of nursing or designee will review the recommendations and the attending physicians will be contacted for review and response .If the attending physician does not respond within 30 days, the medical director will be asked to review the recommendations and/or contact the attending physician .The attending physician or medical director will document in the resident's medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it .If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. No additional information was provided prior to exit. 2. The facility staff failed to ensure R39 was free of unnecessary medications by monitoring anticoagulant as ordered. R39 was admitted to the facility on [DATE] with diagnosis that included but were not limited to acute respiratory failure, COPD (chronic obstructive pulmonary disease) and MI (myocardial infarction). The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 2/13/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and set-up for eating. A review of the comprehensive care plan dated 2/11/25 revealed, FOCUS: ANTICOAGULANTS: the resident is at risk for bleeding and bruising related to use of an anticoagulant for diagnosis of history of heart disease. INTERVENTIONS: Observe for s/s of abnormal bleeding or bruising and or black tarry stools and report to MD as indicated. A review of the physician's order dated 2/10/25 revealed, Eliquis Oral Tablet 5 MG (Apixaban) Give 5 mg by mouth two times a day for heart health and physician order dated 3/17/25 ANTICOAGULANT MEDICATION - MONITOR FOR DISCOLORED URINE, BLACK TARRY STOOLS, SUDDEN SEVERE HEADACHE, N&V, DIARRHEA, MUSCLE JOINT PAIN, LETHARGY, BRUISING, SUDDEN CHANGES IN MENTAL STATUS AND/ OR V/S, SOB, NOSE BLEEDS. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings every shift -Start Date03/17/2025 2300. R39's MAR (medication administration record) does not evidence any monitoring of anticoagulation monitoring till night shift on 3/17/25 after we entered on day shift 3/17/25. On 3/18/25 at 8:30 AM, an interview was conducted with LPN (licensed practical nurse) #1. When asked what monitoring is provided for anticoagulation, LPN #1 stated, we monitor for bruising, bleeding and blood in the urine or stool. When asked where this would be evidenced, LPN #1 stated, we document this on the MAR. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/18/25 at 4:45 PM. A review of the facility's Medication and Treatment Orders policy, revealed, Orders for anti-coagulants will be prescribed only with appropriate clinical and laboratory monitoring. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on staff interview, clinical record review, and facility document review, the facility staff failed to implement interventions to prevent unnecessary psychoactive medication administration for two of 29 residents in the survey sample, Residents #15 and #39. The findings include: 1. For Resident #15 (R15), the facility staff failed to respond to a pharmacist's recommendation to reduce the dose of Lorazepam (to treat anxiety). A review of R15's clinical record revealed an 8/4/22 order for Lorazepam (to treat anxiety) 1 mg twice daily. In September 2024, the pharmacist recommended a dose reduction of the Lorazepam to 0.5 mg in the morning and 1 mg in the evening R15's clinical record revealed no evidence that the facility physician considered and responded to this recommendations in a timely manner. On 3/18/25 at 12:47 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were interviewed. ASM #2 stated for each resident, the pharmacist reviews residents whom he/she deems necessary. The pharmacist lets ASM #2 know of any urgent concerns prior to leaving the building, then emails the remainder of the reports and recommendations to her. ASM #2 stated she distributes the documents to the appropriate attending physicians, and the physicians respond to the recommendations. She stated she has not regularly been scanning the physician recommendations into the residents' electronic medical record. She did not identify a process for follow up to make sure the physician responds to the pharmacist's recommendations. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Medication Regimen Review, revealed, in part: Medication regime reviews will be conducted with the intent to ensure that each resident's entire drug/medication regimen will be managed and monitored to achieve the following goals .Each resident receives only those medications, in doses and for the duration clinically indicated to treat the resident's assessed conditions .The consulting pharmacist will provide a copy of recommendations to the attending physician, medical director, and director of nursing within 5 working days of completion of the review .The director of nursing or designee will review the recommendations and the attending physicians will be contacted for review and response .If the attending physician does not respond within 30 days, the medical director will be asked to review the recommendations and/or contact the attending physician .The attending physician or medical director will document in the resident's medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it .If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. No additional information was provided prior to exit. 2. For Resident #27 (R27), the facility staff failed to respond to pharmacy recommendations to prevent potential unnecessary psychotropic medications. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/21/24, the resident was documented as taking an antianxiety and an anticonvulsant medication. The physician orders for R27 documented in part, - Depakote Oral Tablet Delayed Release 125 MG (milligram) (Divalproex Sodium) Give 2 tablet by mouth one time a day for anxiety. Order Date: 03/09/2024. - Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth one time a day for anxiety. Order Date: 10/11/2022. The comprehensive care plan for R27 documented in part, - Anticonvulsants: the resident is at risk for adverse reactions related to requiring anticonvulsants for treatment of Mood Disorder Stabilization. Date Initiated: 12/27/2024. - Psychoactive Medications: the resident is at risk for complications related to psychoactive (antidepressant, anxiolytic or hypnotic) medications use secondary to diagnoses of: anxiety disorder. Date Initiated: 12/27/2024. The clinical record for R27 failed to evidence documentation of monthly pharmacy medication regimen reviews completed for the past 12 months. (continued on next page)

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Lawrenceville Health & Rehabilitation	1722 Lawrenceville Plank Road Lawrenceville, VA 23868

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 12:48 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing who stated that the pharmacist did a review of residents monthly and gave her a report upon their exit of any immediate concerns. She stated that he sent her an email with all the reviews and recommendations which she printed out and reviewed. She stated that she completed any nursing recommendations and sent any recommendations for the physician to their offices or contacted them for review. She stated that after the physician reviewed the recommendations, she put in any orders for any medication changes as needed. ASM #2 stated that some of the recommendations were not in the medical record. At that time, a request was made to ASM #1, the executive director, ASM #2 and ASM #3, the regional director of clinical services for evidence of monthly medication regimen reviews for R27 with evidence of physician response for any recommendations made. Review of the facility provided pharmacist medication regimen reviews for R27 documented the following recommendations: - A recommendation dated 9/29/24 which documented in part, .The resident has been taking Depakote DR 125mg, 2 tablets (250mg) once daily since (3/10/2024) without a GDR (gradual dose reduction). Could we attempt a dose reduction at this time to perhaps Depakote DR 125mg once daily to verify this resident is on the lowest possible dose? If not, please indicate the response below . The recommendation was observed to be blank with an attached psychiatric progress note for R27 dated 8/7/24 which documented a review of current medications with no changes recommended at that time. The progress note was observed to be dated 8/7/24 which was prior to the pharmacy recommendation for the GDR on 9/29/24. - A recommendation dated 12/16/24 which documented in part, .The resident has been taking Lorazepam 0. 5mg once daily since (10/12/2022) without a GDR. Could we attempt a dose reduction at this time to perhaps Lorazepam 0.25mg once daily to verify this resident is on the lowest possible dose? If not, please indicate the response below . The recommendation was observed to be blank with an attached psychiatric progress note for R27 dated 12/10/24 which documented a review of current medications with no changes recommended at that time. The progress note was observed to be dated 12/10/24 which was prior to the pharmacy recommendation for the GDR on 12/16/24. On 3/19/25 at 12:38 p.m., ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, resident interview, facility staff interview, facility document review, and clinical record review, the facility staff failed to serve food in a form to meet resident needs for five of 29 residents in the survey sample, Residents #17, #19, #13, #1, and #20. The findings include: 1. For Resident #17 (R17), the facility staff failed to serve a mechanical soft diet on 3/17/25 at both the lunch and dinner meals. On 3/17/25 at 12:48 p.m., R17 was observed sitting up in bed eating lunch. The resident's lunch tray contained one regular roll and peach cobbler (peach slices and cobbler crust). The resident's tray also contained an empty Mountain Dew can with a straw. R17 stated his sister had brought the Mountain Dew earlier in the day and he had consumed the whole can using a straw. He stated the Mountain Dew was not thickened. A review of R17's meal ticket revealed, in part: Dysphagia mechanical soft, nectar thick liquid . moistened white cake with chopped peaches .no straws. At 1:00 p.m., OSM (other staff member) #4, a speech therapist, also observed R17's meal tray. She confirmed that the regular roll and peach cobbler did not conform with a mechanical soft diet. She also confirmed that the resident should not have a can of unthickened Mountain Dew on his overbed table and should not have consumed the Mountain Dew using a straw. On 3/17/24 at 5:53 p.m., R17 was observed sitting up in bed eating dinner. The dinner tray contained cubed chicken (approximately 1.5 centimeters cubed). A review of R17's meal ticket revealed, in part: Dysphagia mechanical soft .ground chicken nuggets with barbecue sauce. A review of R17's prescribers' orders revealed the following order, dated 9/27/24: Mechanical Soft texture, Nectar liquids consistency, for oropharyngeal dysphasia; high aspiration risk. NO STRAWS. A review of R17's care plan revealed no information regarding the resident's altered diet. On 3/18/25 at 3:46 p.m., OSM #4 was interviewed. She stated a resident who has orders for a mechanical soft diet should always receive pureed bread, ground meat (consistency of ground hamburger), soft vegetables, and soft fruit that is chopped. She stated residents who eat food that is not the correct consistency run the risk of choking, aspirating food, and potentially developing complications like pneumonia. On 3/19/25 at 7:43 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated CNAs play a role in assuring that the food on a resident's tray matches what is on the meal ticket. She stated before she lifts the lid on a resident's plate, she looks at the meal ticket. She stated she does this to make sure the food served to the resident is at the correct consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 8:49 a.m., OSM #1, the dietary manager, was interviewed. She stated the nursing staff sends her information regarding the consistency of resident diets. She enters that information into her software system and generates a meal ticket for each resident for every meal. She stated the meal ticket should contain the most up-to-date information regarding residents' food needs. She stated anyone on a mechanical soft diet should receive ground meat, soft (cooked) vegetables, chopped cold side dishes, mashed potatoes, chopped desserts, pureed bread, and chopped fruit. She stated mechanical soft meat should be the consistency of ground beef. She stated R17's 3/17 lunch potato salad should have been chopped. She stated she did not check the cobbler before it left the kitchen, and the cobbler should have been cut into smaller pieces. She stated R17 should not have been given a regular roll at any time. She stated R17's dinner meat should have been ground, not cubed. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. A review of the facility policy, Texture and Consistency-Modified Diets, revealed, in part: Texture and consistency-modified diets will be individualized with modifications made by the speech-language pathologist and physician in conjunction with the registered dietician-nutritionist and director of food and nutrition services. A written order is needed .The food and nutrition services department will be responsible for preparing and serving the diet texture and fluid consistency as ordered .Diets should be adjusted to meet individual needs. No additional information was provided prior to exit. 2. For Resident #19 (R19), the facility staff failed to serve a mechanical soft diet on 3/17/25 at both the lunch and dinner meals. On 3/17/25 at 1:09 p.m., R19 was observed sitting up in bed eating lunch. The resident's lunch tray contained one regular roll and peach cobbler (peach slices and cobbler crust). A review of R19's meal ticket revealed, in part: Dysphagia mechanical soft .pureed bread .moistened white cake with chopped peaches. On 3/17/24 at 5:49 p.m., R19 was observed sitting up in bed eating dinner. The dinner tray contained cubed chicken (approximately 1.5 centimeters cubed) and canned pineapple slices. A review of R19's meal ticket revealed, in part: Dysphagia mechanical soft .ground chicken nuggets with barbecue sauce .choice of soft, canned, chopped fruit. A review of R19's prescribers' orders revealed the following order, dated 5/14/24: Mechanical Soft texture, Regular/Thin consistency [for liquids]. A review of R19's care plan revealed no information regarding the resident's altered diet. On 3/18/25 at 3:46 p.m., OSM (other staff member) #4, a speech therapist, was interviewed. She stated a resident who has orders for a mechanical soft diet should always receive pureed bread, ground meat (consistency of ground hamburger), soft vegetables, and soft fruit that is chopped. She stated residents who eat food that is not the correct consistency run the risk of choking, aspirating food, and potentially developing complications like pneumonia. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 7:43 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated CNAs play a role in assuring that the food on a resident's tray matches what is on the meal ticket. She stated before she lifts the lid on a resident's plate, she looks at the meal ticket. She stated she does this to make sure the food served to the resident is at the correct consistency. On 3/19/25 at 8:49 a.m., OSM #1, the dietary manager, was interviewed. She stated the nursing staff sends her information regarding the consistency of resident diets. She enters that information into her software system and generates a meal ticket for each resident for every meal. She stated the meal ticket should contain the most up-to-date information regarding residents' food needs. She stated anyone on a mechanical soft diet should receive ground meat, soft (cooked) vegetables, chopped cold side dishes, mashed potatoes, chopped desserts, pureed bread, and chopped fruit. She stated mechanical soft meat should be the consistency of ground beef. She stated R19's 3/17 lunch potato salad should have been chopped. She stated she did not check the cobbler before it left the kitchen, and the cobbler should have been cut into smaller pieces. She stated R19's dinner meat should have been ground, not cubed, and the resident should have been given crushed or chopped pineapple, not a whole pineapple slice. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. 3. For Resident #13 (R13), the facility staff failed to serve an advanced dysphagia diet on 3/17/25 at both the lunch and dinner meals. On 3/17/25 at 12:55 p.m., R13 was observed sitting up in bed eating lunch. The resident's lunch tray contained regular consistency potato salad and peach cobbler (peach slices and cobbler crust). A review of R13's meal ticket revealed, in part: Dysphagia advanced .peaches and cream cake. On 3/17/24 at 5:55 p.m., R13 was observed sitting up in bed eating dinner. The dinner tray contained cubed chicken (approximately 1.5 centimeters cubed). A review of R13's meal ticket revealed, in part: Dysphagia advanced .ground chicken nuggets with barbecue sauce. A review of R13's prescribers' orders revealed the following order, dated 2/11/25: Dysphagia - Advanced texture. A review of R13's care plan revealed no information regarding the resident's altered diet. On 3/18/25 at 3:46 p.m., OSM (other staff member) #4, a speech therapist, was interviewed. She stated a resident who has orders for a dysphagia advanced diet should always receive ground meat, soft vegetables, and soft fruit. She stated residents who eat food that is not the correct consistency run the risk of choking, aspirating food, and potentially developing complications like pneumonia. On 3/19/25 at 7:43 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated CNAs play a role in assuring that the food on a resident's tray matches what is on the meal ticket. She stated before she lifts the lid on a resident's plate, she looks at the meal ticket. She stated she does this to make sure the food served to the resident is at the correct consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/19/25 at 8:49 a.m., OSM #1, the dietary manager, was interviewed. She stated the nursing staff sends her information regarding the consistency of resident diets. She enters that information into her software system and generates a meal ticket for each resident for every meal. She stated the meal ticket should contain the most up-to-date information regarding residents' food needs. She stated anyone on an advanced dysphagia diet should receive chopped meat. She stated R1's dinner meat should have been ground, not cubed. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. 4. For Resident #1 (R1), the facility staff failed to serve an advanced dysphagia diet on 3/17/25 at dinner. On 3/17/24 at 6:00 p.m., R1 was observed sitting in the day room being fed dinner by a OSM (other staff member) #5, the business office manager. The dinner tray contained cubed chicken (approximately 1.5 centimeters cubed). A review of R1's meal ticket revealed, in part: Dysphagia advanced .ground chicken nuggets with barbecue sauce. A review of R1's prescribers' orders revealed the following order, dated 4/30/24: Dysphagia - Advanced texture. A review of R1's care plan revealed no information regarding the resident's altered diet. On 3/18/25 at 3:46 p.m., OSM (other staff member) #4, a speech therapist, was interviewed. She stated a resident who has orders for a dysphagia advanced diet should always receive ground meat, soft vegetables, and soft fruit. She stated residents who eat food that is not the correct consistency run the risk of choking, aspirating food, and potentially developing complications like pneumonia. On 3/19/25 at 7:43 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated CNAs play a role in assuring that the food on a resident's tray matches what is on the meal ticket. She stated before she lifts the lid on a resident's plate, she looks at the meal ticket. She stated she does this to make sure the food served to the resident is at the correct consistency. On 3/19/25 at 8:49 a.m., OSM #1, the dietary manager, was interviewed. She stated the nursing staff sends her information regarding the consistency of resident diets. She enters that information into her software system and generates a meal ticket for each resident for every meal. She stated the meal ticket should contain the most up-to-date information regarding residents' food needs. She stated anyone on an advanced dysphagia diet should receive chopped meat. She stated R13's dinner meat should have been ground, not cubed. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. For Resident #20 (R20), the facility staff failed to serve an advanced dysphagia diet on 3/17/25 at dinner. On 3/17/24 at 5:50 p.m., R20 was observed sitting up in bed eating dinner. The dinner tray contained cubed chicken (approximately 1.5 centimeters cubed). A review of R20's meal ticket revealed, in part: Dysphagia advanced .ground chicken nuggets with barbecue sauce. A review of R20's prescribers' orders revealed the following order, dated 10/10/24: Dysphagia - Advanced texture. A review of R20's care plan revealed no information regarding the resident's altered diet. On 3/18/25 at 3:46 p.m., OSM (other staff member) #4, a speech therapist, was interviewed. She stated a resident who has orders for a dysphagia advanced diet should always receive ground meat, soft vegetables, and soft fruit. She stated residents who eat food that is not the correct consistency run the risk of choking, aspirating food, and potentially developing complications like pneumonia. On 3/19/25 at 7:43 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated CNAs play a role in assuring that the food on a resident's tray matches what is on the meal ticket. She stated before she lifts the lid on a resident's plate, she looks at the meal ticket. She stated she does this to make sure the food served to the resident is at the correct consistency. On 3/19/25 at 8:49 a.m., OSM #1, the dietary manager, was interviewed. She stated the nursing staff sends her information regarding the consistency of resident diets. She enters that information into her software system and generates a meal ticket for each resident for every meal. She stated the meal ticket should contain the most up-to-date information regarding residents' food needs. She stated anyone on an advanced dysphagia diet should receive chopped meat. She stated R20's dinner meat should have been ground, not cubed. On 3/19/25 at 12:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services, were informed of these concerns. No additional information was provided prior to exit.

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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. Based on observation, clinical record review, staff interview, and facility document review, it was determined the facility staff failed to provide assistive devices during meals for one of 29 residents in the survey sample, Resident #37. The findings include: For Resident #37 (R37), the facility staff failed to provide a divided plate as ordered during meals. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/10/24, the resident scored three out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were severely impaired for making daily decisions. Section K documented no weight loss or swallowing difficulty. Observation of R37 on 3/17/25 at 1:24 p.m. revealed the resident sitting in bed eating lunch. The lunch was observed to be served with each portion in separate bowls on a tray. On 3/18/25 at 1:14 p.m., an observation of R37's lunch revealed it served on a regular plate. The physician orders for R37 documented in part, Divided/sectional plate at all meals. Order Date: 10/24/2024. The comprehensive care plan for R37 documented in part, Nutritional Status: the resident is at risk for weight loss, malnutrition or poor hydration status related to chronic disease, cognitive impairment, GERD (gastrointestinal reflux disease). Date Initiated: 01/29/2025. The care plan failed to evidence documentation of the use of assistive devices during meals. On 3/18/25 at 3:42 p.m., an interview was conducted with LPN (licensed practical nurse) #5 who stated that they supervised R37 when eating and queued them to eat. She stated that R37 used their hands and fingers to eat a lot. She stated that she did not recall the resident using a divided plate during meals but may had seen one used in the past. On 3/18/25 at 4:13 p.m., an interview was conducted with OSM (other staff member) #4, speech language pathologist. OSM #4 stated that they had not worked with R37 since May of 2024, but they placed the order for the divided plate on 10/24/2024. She stated that it was probably from a recommendation that was made from a routine screening, and she would check her files. On 3/18/25 at approximately 4:35 p.m., OSM #4 provided a handwritten therapy evaluation for R37 dated 10/24/24 which documented recommendations of . Recommend divided/sectional plate at all meals to (decrease) spillage from plate, thereby increasing po (by mouth) intake. The facility policy Assistance with meals documented in part, .Residents will receive assistance with meals in a manner that meets the individual needs of each resident . 2. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. 3. Assistance will be provided to ensure that residents can use and benefit from special eating equipment and utensils . (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 4:42 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to maintain the kitchen in a sanitary manner. The findings include: On 3/17/25 at 10:20 AM, an observation was conducted in the main kitchen. In the refrigerator, there was found one large five-pound bag of shredded sharp cheese that was opened and not dated. OSM (other staff member) #1, the dietary manager was observed with the back of her hair without a hair net covering. An interview was conducted on 3/17/24 at 10:40 AM with OSM (other staff member) #1, the dietary manager. When asked to review the five-pound bag of shredded sharp cheese, OSM #1 stated, that should be dated, we just opened it for breakfast. When asked about the back of her hair not having a covering, OSM #1 stated, there was one on my hair, I do not know where it went. The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/18/25 at 4:45 PM. The facility's Food Safety and Sanitation policy revealed the following, Food Storage: When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food. Employees: Are required to have their hair styled so that it does not touch the collar. Hair restraints are required and should cover all hair on the head. No further information was provided prior to exit.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to dispose of refuse properly. The facility staff failed to maintain clean dumpster area during the facility task- kitchen observation 3/17/25 at 10:30 AM. The findings include: On 3/17/25 at 10:30 AM, an observation was conducted in the dumpster area outside of the main kitchen, with OSM (other staff member) #1, the dietary manager. Dumpster #1 had an open seam on the front bottom of the dumpster. Tin foil with food debris and a white paper/trash bag were hanging out of the seam. In front of the dumpster was a half sandwich and citrus peel. Dumpster #2 had a bifold lid. The right side of the bifold lid was open all the way back. An interview was conducted on 3/17/24 at 10:40 AM with OSM #1, the dietary manager. When asked about the findings, OSM #1 stated, they just picked the trash up this morning, and we have not had a chance to come out and clean this area. We communicated with the county about a new trash dumpster last week. When asked who was responsible for the dumpster area, OSM #1 stated, maintenance and dietary. On 3/18/25 at 7:30 AM, ASM (administrative staff member) #1, the executive director stated, we have been calling the county about a new dumpster, and they finally brought a new one this morning. The ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services was made aware of the finding on 3/18/25 at 4:45 PM. The facility's Waste Disposal policy revealed the following, Prior to disposal, all waste shall be kept in leak-proof, non-absorbent containers that are kept covered when not in use. Trash will be deposited into a sealed container outside the premises. No further information was provided prior to exit.