STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Center	20 Westwood Medical Park Bluefield, VA 24605

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 47299 Based on resident and staff interviews, clinical record review, and facility document review, the facility staff failed to ensure that residents and/or resident representatives had the opportunity to develop an advanced directive for 3 of 22 residents in the survey sample, residents # 32, # 44 and # 39. The findings included: 1. For resident # 32, the facility staff failed to ensure the resident had the opportunity to develop an advanced directive. Resident # 32's diagnoses included but were not limited to metabolic encephalopathy, sepsis, chronic respiratory failure, chronic obstructive pulmonary disorder, type II diabetes, congestive heart failure, and chronic kidney disease stage 3. The minimum data set (MDS) with an assessment reference date (ARD) of 7/2/24, assigned the resident a brief interview for mental status (BIMS) score of 14 indicating they were cognitively intact. During a review of the clinical record, a physician's order with a revision date of 6/26/24 that read, Full Code was noted. Under the Assessment tab, a document entitled, Social Services Assessment and Documentation with an effective date of 7/1/24 was reviewed. On page 3, Item #5 read, Resident Rights/Healthcare Decision Making/Advanced Directives a. Information Provided with regard to resident rights, yes. b. Advanced Directives (e.g. Living Will, Healthcare Power of Attorney, or Healthcare Proxy) in place? yes. b.2. Healthcare agent/Proxy? no. c. Additional conversation regarding advanced care planning provided? no. f. Separate Healthcare order (POST- physician order for scope of treatment, POLST- physician order for life sustaining treatment, MOLST- medical order for life sustaining treatment, etc.) completed? yes. This surveyor was unable to locate any Advanced Directives, POST, POLST, or MOLST documents in the clinical record. The care plan was reviewed. There was a focus that read, Resident/patient established advanced directives: Full code. An intervention read, Advance Directive education and materials, including state forms provided. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 this surveyor asked the Director of Nursing for a copy of resident # 32's Advanced Directives. They were not able to provide a copy. Resident # 32 was interviewed on 8/21/24 at 11:03 AM. When asked if they had an Advanced Directive such as a Living Will or Power of Attorney they stated, No, I don't believe I do. When asked if they had been given any written information about Advanced Directives, they stated, I don't think so. 2. For resident # 44 the facility staff failed to ensure the resident had the opportunity to develop an advanced directive. Resident # 44's diagnoses included but were not limited to, unspecified dementia, malignant neoplasm of colon and essential hypertension. The minimum data set (MDS) assessment with an assessment reference date of 6/12/24 assigned the resident a brief interview for mental status (BIMS) score of 12 out of 15 indicating mild cognitive impairment. During a review of the clinical record an order for a code status of DNR or do not resuscitate was noted. Under the document section of the chart, Durable Do Not Resuscitate Order dated 6/11/24 and signed by a family member was noted. The top section of the order has two paragraphs, and each paragraph has a checkbox beside it. The first one reads, 1. The patient is capable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment. The second paragraph reads, 2. The patient is incapable of making an informed decision about providing, withholding or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decisions, or to make a rational evaluation of the risks and benefits of alternatives to that decision. There is no mark in the box by either statement. The form had signatures but was not complete. Under the Assessment tab, a document entitled, Social Services Assessment and Documentation with an effective date of 7/2/24 was reviewed. On page 3, Item #5 read, Resident Rights/Healthcare Decision Making/Advanced Directives a. Information Provided with regard to resident rights, yes. b. Advanced Directives (e.g. Living Will, Healthcare Power of Attorney, or Healthcare Proxy) in place? no. c. Additional conversation regarding advanced planning provided? no. d. Opportunity to complete advance directives offered? no e. Advance directive educational materials, including state form provided? no f. Separate Healthcare order (POST- physician order for scope of treatment, POLST- physician order for life sustaining treatment, MOLST- medical order for life sustaining treatment, etc.) completed? no. This surveyor was unable to locate any Advanced Directives in the clinical record. The care plan for resident # 44 was reviewed. There was a focus that read, Resident/Patient has an established advanced directive DO NOT RESUSCITATE (DNR). There is no mention of a Living Will, Power of Attorney or other form of advance directives being discussed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This surveyor requested and received the policy entitled, Health Care Decision Making with a review date of 1/8/24. The policy read in part, It is the right of all patients/residents (herein after patient) to participate in their own health care decision-making, including the right to decide whether they wish to request, accept, refuse, or discontinue treatment, and to formulate or not formulate an advance directive. Centers: -Inform and provide written information to all patients concerning the right to accept or refuse medical or surgical treatment and, at the patient's option, formulate and advance directive; -Provide a written description of the Center's policies to implement advance directives and applicable state law;. Under the heading definitions, the document read in part, Advanced Care Planning: An ongoing process of communication between patients and their healthcare decision makers to understand, reflect on, discuss, and plan for future healthcare decisions for a time when patients are not able to make their own healthcare decisions. Advance care planning includes two key parts: 1. Face to face conversations with physician or other healthcare professionals and patients and their health care decision makers to discuss advance directive treatment decisions with or without completing relevant legal forms; and 2. Documenting treatment or wishes preferences. On 8/21/24 at 3:30 PM the survey team met with the Administrator, Director of Nursing and the Regional Nurse Consultant. These concerns were reviewed at that time. No further information was provided to the survey team prior to the exit conference. 34307 3. For Resident #39 the facility staff failed to ensure the resident had the opportunity to develop an advance directive. Resident #39's face sheet listed diagnoses which included but not limited to myeloid leukemia, polyosteoarthritis, and depression. Resident #39's face sheet indicated that the resident has a code status of do not resuscitate (DNR). Resident #39's most recent minimum data set with an assessment reference date of 06/13/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #39's comprehensive care plan was reviewed and contains a plan for Resident/Patient has an established advanced directive, DNR. Resident #39's clinical record was reviewed and contained a Social Services Assessment and Documentation dated 12/19/23 which read in part, 5. Residents Rights/Healthcare Decision Making/Advance Directives b. Advance Directive (e.g. Living Will, Healthcare Power of Attorney, Healthcare Proxy) in place? no. c. Additional conversation regarding advance care planning provided: no. d. Opportunity to complete advance directive offered: no. e. Advance directive educational materials, including state form, provided: no. Resident #39's clinical record contained a Virginia Department of Health Durable Do Not Resuscitate form signed by the resident. Surveyor could not locate any information related to an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested from the director of nursing (DON), information pertaining to Resident #39's advance directive. DON stated they did not have any information. Surveyor requested and was provided with a facility document entitled Health Care Decision Making which read in part, It is the right of all patients/residents (hereinafter patient) to participate in their own health care decision-making, including the right to decide whether they wish to request, accept, refuse, or discontinue treatment, and to formulate or not formulate an advance directive. Centers must: Inform and provide written information to all patients concerning the right to accept or refuse medical or surgical treatment and, at the patient's option, formulate an advance directive; Provide a written description of the Center's policies to implement advance directives and applicable state law; Approach a capable patient who does not have an advance directive upon admission; the patient will be approached by the Social Worker or another designated staff person on admission, quarterly, and with change in condition to discuss whether he/she wishes to consider developing an advance directive .Advance Directive: Written instruction, such as a living will or durable power of attorney for health care, recognized under state law relating to the provision of health care when the patient is incapacitated. Advance directives can be either Instructive or Proxy Directives and are activated in accordance with state requirements .Practice Standards 1.2 If the patient does not have an advance directive: 1.2.1 Inform the patient/patient representative of their rights under state law regarding health care decision making, including the right to prepare advance directive. 1.2.2 Ask whether the patient wishes to formulate an advance directive. 1.2.3 Provide advance directive information. 1.2.4 Document that information has been provided to the patient/patient representative. The concern of not ensuring Resident #39 had the opportunity to formulate an advance directive was discussed with the administrator, director of nursing, and regional nurse consultant on 08/21/24 at 3:30 pm. 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. 34307 Based on staff interview, clinical record and facility document review the facility staff failed to ensure an accurate minimum data set for 1 of 6 closed record reviews, Resident #56. The findings included: For Resident #56 the facility staff coded the minimum data set (MDS) as discharged to critical access hospital, when the resident discharged to the community. Resident #56's face sheet listed diagnoses which included but not limited to urinary tract infection, sepsis, and dementia. Resident #56's discharge MDS with an assessment reference date of 06/21/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section A, subsection A 2105, Discharge Status coded the resident as being discharged to a critical access hospital. Resident #56's clinical record was reviewed and contained a Discharge Plan Documentation dated 06/20/24 which read in part, O. Discharge 1. Estimated/Scheduled discharge date and Time: 06/21/2024 4:00. A. 3. Discharge Destination: Home with family. Surveyor spoke with registered nurse (RN) #4 on 08/21/22 at 2:05 pm regarding Resident #56. RN #4 stated that resident discharged home, and the MDS was coded wrong. RN #4 stated they would modify the assessment to correct it. The concern of not ensuring an accurate MDS for Resident #56 was discussed with the administrator, director of nursing, and regional nurse consultant on 08/21/24 at 3:30 pm. No further information was provided prior to exit.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to ensure a level I preadmission screening and resident review (PASARR) was completed for 2 of 22 residents, Resident #21 and Resident #32. The findings included: 1. For Resident #21 the facility staff failed to ensure a level 1 PASARR was completed. Resident #21's face sheet listed diagnoses which included but not limited to Alzheimer's disease, dementia, and bipolar disorder. Resident #21's most recent minimum data set with an assessment reference date of 06/18/24 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #21's clinical record was reviewed, and surveyor could not locate a level 1 PASARR. Surveyor requested from the director of nursing information regarding Resident #21's PASARR. On 08/21/24 at 9:35 am, the regional nurse consultant (RNC) informed the surveyor that they did not have the PASARR. RNC stated, We don't have that, we are not doing them, and we recognize that it's an issue. Surveyor requested and was provided with a facility policy entitled, Pre-admission Screening for Mental Disorder and/or Intellectual Disability Patient which read in part, 1. Social Services will coordinate and/or inform the appropriate agency to conduct the evaluation and obtain results if: 1.1 It is learned after admission that the Pre-Admission Screening and Resident Review (PASRR) was not completed or is incorrect .3. The PASRR will be placed in the patient's medical record. The concern on not completing a level 1 PASARR for Resident #21 was discussed with the administrator, director of nursing, and RNC on 08/21/24 at 3:30 pm. No further information was provided prior to exit. 47299 2. For resident # 32 the facility staff failed to ensure a Level I PASARR (preadmission screening and resident review) was completed. Resident # 32's diagnoses included but were not limited to, bipolar disorder, anxiety disorder and depression. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 32's minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/2/24 assigns the resident a brief interview for mental status (BIMS) score of 14 out of 15, indicating they are cognitively intact. There were no mood indicators or behaviors captured during the look back period for this assessment. A clinical record review was done. This surveyor was unable to locate a Level I PASARR in the record. On 8/19/24 at 2:09 PM this surveyor asked the Director of Nursing (DON) for a copy of the PASARR for resident # 32. On 8/21/24 at 9:34 AM this surveyor asked the Regional Nurse Consultant about the PASARR for resident # 32. They stated, We don't have it. We recognize it's a problem and we will be working on it going forward, but we don't have it now. This surveyor requested and received the policy entitled, Pre-admission Screening for Mental Disorders and/or Intellectual Disability Patients with an effective date of 6/1/01 and a revision date of 2/16/24. The policy read in part, Center Social Worker or designated staff will assure that all patients with Mental Disorders (MD) and/or Intellectual Disability (ID) receive appropriate pre-admission screenings according to federal and/or state regulations. On 8/21/24 at 3:30 PM the survey team met with the Administrator, the DON and Regional Nurse Consultant. This concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit conference.

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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. 47299 Based on staff interview, clinical record review and facility document review, the facility staff failed to develop and/or implement a comprehensive person-centered care plan for 1 of 6 closed record reviews, Resident #55. The findings included: Resident # 55's diagnoses included but were not limited to Alzheimer's, history of stroke, history of traumatic brain injury and paranoid schizophrenia. The minimum data set (MDS) assessment with an assessment reference date of 7/17/24 assigned the resident a brief interview for mental status score of 5 out of 15 indicating a moderate cognitive impairment. The MDS did not indicate that resident had any swallowing difficulty. During a review of resident # 55's clinical record, an order dated 5/27/24 was noted that read, Regular/liberalized diet Dysphasia Advanced texture for Pt requires feeding assistance. The order was put in by the Speech Therapist. A progress note 5/20/24 at 8:00 PM read in part, Resident was walking down the hallway pushing bedside table CNA (Certified Nursing Assistant) redirected resident back to her room. Resident was helped into bed for ADL (activities of daily living) to be performed, then helped back into the wheelchair. Resident started gasping for air, lips was blue, CNA yelled for south side nurse, nurse came to resident performed the Heimlich maneuver then a finger sweep got small piece of bread out of resident mouth, resident started talking trying to put more of her sandwich in her mouth then turned blue then resident was placed to floor then four back blows was performed then resident went limp rolled to her side resident coughed a large piece of bread came up. Another progress note dated 8/12/24 at 9:15 AM read, This nurse was called to residents room by LPN (name omitted). Upon entering the room the resident was lying on back on bed. This nurse saw no rise or fall of chest, No pulse palpated, No heartbeat auscultated. Confirmed residents code status was a Do Not Resuscitate by nurse (name omitted) LPN. Resident was pronounced at 9:09 am. The care plan was reviewed. An ADL focus with a created date of 5/3/24 read in part, Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Recent illness, fall, hospitalization , etc.) resulting in fatigue, activity intolerance, confusion, etc.), Chronic disease/condition: Dementia TBI, CVA, Schizophrenia Limited range of motion of Left Lower leg with Casting, Mood symptoms. An intervention read, Provide cueing for safety and sequencing to maximize current level of functioning. There was a nutritional care plan. The nutritional care plan did not specify a diet, or that resident required feeding assistance. There was no mention of any limitations to the types of food resident was allowed on meal trays. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 1:24 PM this surveyor interviewed other employee # 3. They stated that they were working with resident # 55 in May when it happened the first time, but only for cognition. (Resident) didn't have a swallowing problem, it was a traumatic brain injury with behaviors. She would eat very fast and just shove everything in her mouth all at once. She needed cuing to slow down. Surveyor asked what Pt requires feeding assistance means, as that is how the order read, they stated, she needed supervision and cuing to not eat so fast. They stated that they did education with the CNA's in May but didn't have them sign anything and could not tell surveyor what CNA's had been present for education. They stated, I know I should have been more specific in my recommendation. On 8/21/24 at 11:05 AM this surveyor interviewed CNA # 5. They stated they were the one who gave resident # 55 their tray on 8/12/24. I didn't know we were supposed to feed her. Nobody knew. When asked how the staff know what residents require assistance they stated, I always check the Kardex but it wasn't on there. On 8/21/24 surveyor met with the Administrator, Regional Nurse Consultant and Director of Nursing (DON). Surveyor asked what the process was for notifying the nursing staff that a resident needs assistance with meals. The Regional Nurse Consultant stated, the order was never transcribed to the Kardex. Usually, the speech therapist will do a diet sheet and put the order in, take the diet sheet to the dietary manager who updates the tray ticket, the orders are reviewed, and the care plan updated which would reflect on the Kardex. The policy entitled, Person-Centered Care Plan with a review date of 10/24/22 read in part, 4. A comprehensive person-centered care plan must be developed for each patient and must describe the following: 4.1 Services that are to be furnished . 6.1 The care plan must be customized to each individual patient's preferences and needs. 7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals. No further information was provided to the survey team prior to the exit conference.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49622 Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team for one (1) of 22 sampled residents, (Resident #5). The findings included: For Resident #5, the facility staff failed to reassess the effectiveness of the interventions and review and revise the resident's activity care plan to meet the resident's needs. Resident #5's diagnosis list indicated diagnoses that included, but were not limited to, Anxiety Disorder, Cirrhosis of Liver, Chronic Embolism and Thrombosis of Unspecified Deep Veins of Lower Extremity-Bilateral (both sides), Depression, Dependence on Renal Dialysis, End Stage Renal Disease, Heart Disease of Native Coronary Artery, Liver Transplant, Type 2 Diabetes Mellitus, Chronic Kidney Disease, and Generalized Edema. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/25/24, assigned the resident a brief interview for mental status (BIMS) summary score of 12 out of 15 for cognitive abilities, indicating Resident #5 was moderately impaired in cognition. On 08/18/24 at 4:30 PM resident stated activities do not offer one-to-one activities in her room. A review of the current care plan revealed a Focus of, .While in the facility, [name omitted] states that it is important that she has the opportunity to engage in daily routines that are meaningful relative to their preferences . With a Goal of, .will have opportunities to make decisions/choices related to/for self-directed involvement in meaningful activities . The Interventions read in part, .Encourage and facilitate [name omitted] activity preferences .enjoys listening to music .would like pet visits .likes to use a phone listen to music, look out the window, lay down/rest, think by myself in my bedroom .It is important for [name omitted] to go outside when the weather is good and enjoy, sitting, talking/visiting, bird watching/wildlife observing .would benefit from accommodation for physical limitations by using adaptive materials/equipment such as gerichair . The care plan revealed an initiated date of 11/16/2023 with a revision date of 08/14/2024. No changes were identified for the Focus, Goal or Interventions during this revision. Surveyor could not locate any Activity Progress notes on the clinical record for Resident #5. An annual activity assessment could not be located in the clinical record for the annual MDS review with an ARD of 6/25/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/24 at 11:16 AM, surveyor interviewed activity director about activity assessments and activity progress notes, and she stated she does not do activity progress notes every ninety days or with care plan reviews. She stated she looks under UDA's (user-defined assessments) for activity assessments for quarterly assessments and nothing shows up. For annual reviews she stated she asks the questions for Section F (preferences for customary routine and activities) on the MDS but does not complete an activity assessment. She stated she did not know what the facility activity policy says about ninety-day activity progress notes. Surveyor inquired what activities she offers to Resident #5, and she stated there is a CD player in Resident #5's room. This concern was discussed at the pre-exit meeting on 8/21/24 at 3:30 PM with the corporate nurse consultant, administrator, and director of nursing. Surveyor requested and received the facility policy titled Recreation Assessment, which read in part, . Patients will have a recreation assessment completed .annually .To plan care that enables the individual to reach his/her highest practicable level of physical, mental, and psychosocial functioning .To obtain information regarding the patient's preferences for their daily routine and activities .1. Complete the appropriate Recreation Comprehensive Assessments .1.3 Annual Assessment: Community Life Assessment .2. Conduct interviews within the lookback period to obtain information about preferences directly from the patient . Surveyor also requested and received a facility policy titled, Quarterly Progress Note and Care Plan Evaluation, that read in part, .Recreation progress notes will be completed as part of the Assessments and Care Plan Process .Progress may be documented in the Recreation Quarterly Progress Note and Care Plan Evaluation .To document the effectiveness of recreation interventions and to review patient's progress .To review the individual's progress and response to care plan interventions . No further information regarding this concern was presented to the survey team prior to the exit conference on 8/21/24.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 34307 Based on observation, resident interview, staff interview, clinical record review and facility document review the facility staff failed to provide activities of daily living (ADL) care for 2 of 22 residents, Resident #39 and Resident #7. The findings included: 1. For Resident #7 the facility staff failed to provide nail care. Resident #7's face sheet listed diagnoses which included but not limited to type 2 diabetes mellitus, anxiety and depression. Resident #7's most recent minimum data set with an assessment reference date of 05/30/24 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Section GG, functional goals and abilities, coded the resident as dependent for personal hygiene. Resident #7's comprehensive care plan was reviewed and contained a care plan for Resident requires assistance/is dependent for ADL care related to HF (heart failure), DM (diabetes mellitus), resp. (respiratory) failure. Interventions for this care plan include Provide resident/patient extensive assist of 1 for personal hygiene (grooming). Surveyor spoke with Resident #7 on 08/18/24 at 4:20 pm. Surveyor observed resident's nails to be long and jagged. Resident stated that they have asked for nails to be cut, but no one has cut them. Resident also stated that they have a nail that it broken into the quick. Surveyor observed fingernail on resident's left hand to be broken along the side of the nail bed. Surveyor spoke with the director of nursing (DON) regarding Resident #7's fingernails on 08/20/24, and DON stated that the facility infection preventionist was checking/trimming fingernails, and that Resident #7's nails have been cut. Surveyor spoke with Resident #7 on 08/21/24 at 9:15 am. Resident stated their nails have been cut and showed surveyor. Surveyor requested and was provided with a facility policy entitled Activities of Daily Living which read in part, 4.2 A patient who is unable to carry out ADL's will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. The concern of not providing nail care was discussed with the administrator, DON, and regional nurse consultant on 08/21/24 at 3:30 pm. No further information was provided prior to exit. 2. For Resident #39 the facility staff failed to provide showers/bed baths to maintain good personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39's face sheet listed diagnoses which included but not limited to myeloid leukemia, polyosteoarthritis, and depression. Resident #39's most recent minimum data set with an assessment reference date of 06/13/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section GG, functional abilities and goals coded the resident as needing substantial/maximal assistance for shower/bathing. Resident #39's comprehensive care plan was reviewed and contained a care plan for Resident/Patient is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Limited mobility, dx of generalized weakness, polyosteoarthritis, chronic pain, depression. Surveyor spoke with Resident #39 on 08/18/24 at 2:30 pm. Resident stated that they had once went 3 weeks without a shower or bed bath and felt as if this has contributed to them having urinary tract infections. Surveyor requested daily shower sheets and bathing records for Resident #39. Review of these forms indicated that resident went from 06/01/24-06/11/24 (total of 10 days), from 06/14/24-06/27/24 (total of 13 days), 06/29/24-07/09/24 (total of 9 days), and 07/19/24-07/29/24 (total of 10 days) without a shower/bed bath. During this time, there were two refusals documented. Surveyor requested and was provided with a facility policy entitled Activities of Daily Living which read in part, 4.2 A patient who is unable to carry out ADL's will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. The concern of not providing Resident #39 with showers/bed baths was discussed with the administrator, director of nursing, and regional nurse consultant on 08/21/24 at 3:30 pm. No further information was provided prior to exit.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 34307 Based on observation, staff interview, clinical record review and facility document review the facility staff follow physician's orders for 2 of 22 residents, Resident #9 and Resident #63. The findings included: 1. For Resident #9 the facility staff failed to administer the medication carvedilol per the physician's order. Resident #9's face sheet listed diagnoses which included but not limited to hypotension, anemia, and anxiety. Resident #9's most recent minimum data set with an assessment reference date of 08/08/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #9's comprehensive care plan was reviewed and contained a plan for Resident exhibits or is at risk for cardiovascular symptoms or complications related to hypertension. Interventions for this care plan include Administer meds as ordered . Resident #9's clinical record was reviewed and contained a physician's order summary which read in part, Carvedilol Tablet 12.5 mg. Give 1 tablet by mouth two times a day for hypertension with meals. Resident #9's electronic medication administration record for the month of August 2024 was reviewed and contained an entry as above. This entry was blank on 08/06/24 at 5 pm and coded HD on 08/10/24 at 5 pm. Chart code HD is equivalent to hold/see nurses notes. Resident #9's nursing progress notes were reviewed and contained a note which read in part, 08/10/2024 17:18:00 Carvedilol Tablet 12.5 mg. Give 1 tablet by mouth two times a day for hypertension with meals. due to low BP (blood pressure), med held. MD and RP (responsible party) notified. This medication did not have parameters to hold for low blood pressure. Surveyor spoke with the director of nursing (DON) on 08/21/24 at 9:45 am regarding Resident #9's carvedilol. DON stated, If it's blank, they didn't give it. On 08/21/24 at 2:45, DON stated to surveyor, I can't say it was given, I talked with the nurse working that day and they can't remember if they gave it or not. Surveyor requested and was provided with a facility policy entitled Medication Administration General Guidelines which read in part, Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber .4. The resident's MAR/TAR (medication administration record/treatment administration record) is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration time. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The concern of not administering Resident #9's medication per the physician's order was discussed with the administrator, DON, and regional nurse consultant on 08/21/24 at 3:30 pm. No further information was provided prior to exit. 49622 2. For Resident #63 the facility staff failed to follow a medical provider's orders to provide a functioning pressure redistribution mattress. Resident #63's diagnosis list indicated diagnoses that included, but were not limited to, Streptococcal Arthritis to Right Knee, Sepsis, UTI (urinary tract infection), Acute Kidney Failure, Hypertensive Chronic Kidney Disease-Stage 4, Peripheral Vascular Disease, Atrial Fibrillation, and Osteoarthritis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of, 8/19/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating Resident #63 was cognitively intact. On 8/18/24 at 3:45 PM, surveyor interviewed Resident #63 and she stated her air mattress was not working. Surveyor observed the mattress and the power button located on the footboard of the bed was in the on position, however the mattress was observed to not be functioning or receiving air. A review of the medical providers orders included an order for, Pressure-redistribution mattress to bed with a start date of 8/13/24. A facility assessment titled, Braden Scale for Predicting Pressure Sore Risk, dated 8/13/24, read in part, .1. Sensory Perception .3. Slightly Limited .Responds to verbal commands but cannot always communicate discomfort or the need to be turned or has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities .3. Activity .Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair .4. Mobility .3. Slightly Limited .Makes frequent though slight changes in body or extremity position independently .6. Friction & Shear .2. Potential Problem . Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets .7. Scoring .SCORING .AT RISK 15-18 . The progress note summary attached to the assessment revealed Resident #63 had a score of 16. On 8/18/24 at 3:55 PM, surveyor requested licensed practical nurse #4 (LPN#4) accompany her to resident's room. LPN#4 checked the power button and stated it was not working and she would check to confirm the bed was plugged into the power outlet. LPN#4 stated it was not plugged-in and she plugged it in and stated it should start building pressure now and she was not sure how it got unplugged. On 8/19/24 at 9:45 AM, surveyor and director of nursing (DON) entered Resident #63's room and the pressure redistribution mattress was on and functioning. The DON stated that she would check the provider orders to make sure staff is checking it (pressure-redistribution mattress). An additional review of the medical providers orders revealed a new order dated 8/18/24 with a start date of 8/19/24, that read in part, .Pressure-redistribution mattress to bed, check function Q (every) shift every day and night shift . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This concern was discussed at the end of day meetings with the corporate nurse consultant, administrator, and director of nursing on 8/19/2024 at 4:30 PM, 8/20/24 at 4:19 PM, and again at the pre-exit meeting on 8/21/24 at 3:30 PM. Surveyor requested and received a facility policy titled, Skin Integrity and Wound Management, that read in part, .6.8 Implement pressure injury prevention for identified, modifiable risk factors. 6.9 Determine the appropriate support surface for the bed . No further information regarding this concern was presented to the survey team prior to the exit conference on 8/21/24.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 47299 Based on staff interview, clinical record review and facility document review facility staff failed to provide treatment and services to prevent and/or heal pressure ulcers for 1 of 22 residents in the survey sample, Resident #44. The findings included: Resident # 44's diagnoses included but were not limited to pressure ulcer of the sacral region, stage IV, muscle weakness, and difficulty walking. The minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/12/24 assigned the resident a brief interview for mental status (BIMS) score of 12 out of 15 which indicates a mild cognitive impairment. The MDS was coded to reflect a stage IV pressure area that was present on admission. The care plan for resident # 44 was reviewed. A problem statement that read, Documented pressure ulcer was noted. Under interventions the care plan read in part, Wound care per treatment order. There was an order dated 6/13/24 that read, Cleanse stage IV to sacrum with wound wash, pat dry, apply honey to wound bed, apply dry dressing, change daily and prn (as needed). This order was discontinued on 8/8/24 and a new order was put in as follows, Cleanse stage IV to sacrum with wound wash, pat dry, apply idsorb, calcium alginate, cover with foam, change daily and PRN. The treatment administration record (TAR) was reviewed. There were blanks or holes on the TAR for 6/18/24, 7/20/24, 8/6/24 and 8/7/24. On 8/20/24 at 1:47 PM the surveyor asked the Director of Nursing (DON) what blanks on the TAR meant for those days. They stated they would have to check into it and let me know. On 8/21/24 at 8:52 the DON stated, The wound nurse was off those days and the floor staff would have been responsible to complete the treatments but apparently did not. They have been educated, they have to do it when she is off. Surveyor clarified that the wound care was not done as ordered for the days listed above and the DON stated, To my knowledge, they weren't, but the wound is improving. On 8/21/24 at 3:30 PM the survey team met with the DON, Administrator and Regional Nurse Consultant. This concern was discussed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47299 Based on observations, staff interview, clinical record review and facility document review, the facility staff failed to provide supervision to prevent accidents for 2 of 6 closed record reviews, Resident #55 and Resident #209. This resulted in actual harm for resident #55 cited at past non-compliance. For resident #209, the facility failed to implement safety measures resulting in an elopement. The findings included: 1. For resident # 55 the facility staff failed to provide supervision as ordered by the physician and based on a recommendation by speech therapy, during meal times. Resident # 55's diagnoses included but were not limited to Alzheimer's Disease, history of a stroke, history of a traumatic brain injury and paranoid schizophrenia. The minimum data set (MDS) assessment with an assessment reference date of 7/17/24 assigned the resident a brief interview for mental status (BIMS) score of 8 out of 15 indicating moderate cognitive impairment. Under Section GG Functional Abilities and Goals, resident # 55 was coded as being independent for eating. Under section K Swallowing/Nutritional Status, there were no swallowing difficulties coded. During a review of resident # 55's clinical record a progress note dated 8/12/24 at 9:05 AM read, CNA set tray up in residents room for breakfast, when CNA returned to pick up tray after breakfast resident was found unresponsive. CNA notified Nurse, Nurse verified DNR orders. Medical Director notified. Notified RP, (name omitted). (name omitted) Funeral home called per son request. Another note dated 8/12/24 at 9:15 AM read, This nurse was called to residents room by LPN (Name omitted). Upon entering the room the resident was lying on back on bed. This nurse saw no rise or fall of chest, No pulse palpated, No heartbeat auscultated. Confirmed residents code status was a Do Not Resuscitate by nurse (name omitted) LPN. Resident was pronounced at 9:09 am. The orders for resident # 55 were reviewed. An order dated 5/27/24 for a diet change was noted. The order was for a regular/liberalized dysphagia advance diet texture and under order summary the order stated, Pt requires feeding assistance. The care plan was reviewed. An ADL focus with a created date of 5/3/24 read in part, Resident/Patient requires assistance/is dependent for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	locomotion, toileting related to: Recent illness, fall, hospitalization , etc.) resulting in fatigue, activity intolerance, confusion, etc), Chronic disease/condition: Dementia TBI, CVA, Schizophrenia Limited range of motion of Left Lower leg with Casting, Mood symptoms. An intervention read, Provide cueing for safety and sequencing to maximize current level of functioning. The nutritional care plan was reviewed. There was no diet order listed and it did not mention resident needing feeding assistance, there was no mention of resident not being allowed certain foods. On 8/20/24 at 1:24 PM this surveyor interviewed other employee # 3. They stated that they were working with resident # 55 in May when it happened the first time, but only for cognition.(Resident) didn't have a swallowing problem, it was a traumatic brain injury with behaviors. She would eat very fast and just shove everything in her mouth all at once. She needed cuing to slow down. Surveyor asked what Pt requires feeding assistance means, as that is how the order read, they stated, she needed supervision and cuing to not eat so fast. They stated that they did education with the CNA's in May but didn't have them sign anything and could not tell surveyor what CNA's had been present for the education. They stated, I know I should have been more specific in my recommendation. Surveyor asked what had happened in May and they stated, She got choked on a sandwich and had to have the Heimlich. That's why the order said no sandwiches. Surveyor asked if they could provide a copy of their recommendation as the order in the electronic medical record didn't include anything about resident not having sandwiches. They provided a form entitled, Food & Nutrition Services Diet Order & Communication Form. The form had resident # 55's name and room number on it and was signed by employee # 3. Under the heading Diet the box for Regular/Liberalized was checked. Under the heading Consistency Modification the box Dysphagia Advanced was checked. Under the heading Preferences a hand written note that read, Assistance with meals. *No sandwiches. was noted. On 8/20/24 at 1:40 PM this surveyor interviewed other staff member # 1. Surveyor asked what a regular liberalized dysphagia advanced diet was. They stated, The meat is ground and the vegetables and everything have to be fork tender, no raw vegetables, no hard bread. Surveyor asked what resident # 55 had been served the morning of 8/12/24 for breakfast, they stated, eggs and oatmeal and then we had a coffee cake too. Surveyor asked if the coffee cake was approved for the diet texture ordered for resident # 55 and they stated yes, I can show you the menu. They provided a document entitled, SNF SS 24 ALG Diet Guide Sheet for Monday (Day 2) breakfast. For the dysphagia advance texture the menu consisted of cinnamon oatmeal, western scrambled egg and peach streusel coffee cake. They stated, That coffee cake is real soft. Surveyor asked if they were aware that resident # 55 was not supposed to have sandwiches and they stated, Yes, we had that on her tray card, no sandwiches. On 8/21/24 at 11:05 AM this surveyor interviewed Certified Nursing Assistant (CNA) # 5. They stated they were the one who gave resident # 55 their tray on 8/12/24. I didn't know we were supposed to feed her. Nobody knew. When asked how the staff know what residents require assistance with feeding or supervision they stated, I always check the Kardex but it wasn't on there. It is now, they've went through and fixed everybody's and gave us lists, made sure we know who needs help and how much help. Surveyor asked to describe what happened, they stated, I took her tray in and sat her up on the side of the bed like we always do. I made sure she had everything and came out to pass more trays. I walked by little bit later and she was still sitting there, it looked like she had already finished with everything, I didn't see anything left on the tray. I didn't hear anything, and I was on the hall the whole time, like no coughing or anything, but when I went back in there, she was laying across the bed with her mouth and her eyes open and she wasn't breathing. I could see food in her mouth. I yelled for the nurse. Nothing was out of place. It was like she just laid down. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/21/24 at 11:28 AM this surveyor interviewed CNA # 4. They stated they weren't assigned to resident # 55 on the 12th but was working on the unit. They stated they came in the room after the nurse. Surveyor asked them to described what they saw, I seen her laying straight back with her mouth full, I think it was coffee cake, everything was in place like she didn't kick her legs out like you would expect or anything. Nothing was knocked off or over. She had ate and drank everything. When asked how they know what residents need help they stated, I usually check the Kardexes but all hers said was encourage fluids. I didn't know she was supposed to be fed or helped. They have went through and checked everybody's and made sure the Kardex and tray cards are right and they have in-serviced us. The ST (speech therapist) brought around a checklist and talked to us about precautions and things we are supposed to do. On 8/21/24 at 11:55 AM this surveyor met with the Director of Nursing (DON), the Administrator, and the Regional Nurse Consultant. Surveyor asked to speak with the Licensed Practical Nurse assigned to resident # 55 on 8/12/24. They stated that the nurse was on Family Medical Leave and could not be reached. The DON stated that they were the one who pronounced resident and had arrived in the room within just a couple minutes of the CNA finding the resident. They had already confirmed the code status as DNR (do not resuscitate), there were no signs of life so I pronounced and we notified the family and the funeral home. This surveyor asked why resident was not being assisted during meal times. The Regional Nurse Consultant stated, The diet change and recommendation was never transcribed to the care plan. If it had been put on the care plan, it would have crossed over to the Kardex. The Regional Nurse Consultant stated a Plan of Correction (POC) had been implemented for the incident and presented it at this time. The POC had a completion date of 8/20/24 and read as follows: Corrective Action: The code status for resident # 55 was verified by the Licensed Practical Nurse and no life sustaining measures were initiated due to resident was a DNR. Root Cause Analysis: Upon record review it was noted that the resident's diet was dysphagia advanced texture. Assistance with all meals. No sandwiches. The order was obtained 5/27/2024 by Speech Therapy and never transcribed to the residents Kardex. The staff were unaware of this recommendation by Speech Therapy. Resident # 55 was unable to feed herself without staff assistance. When LPN entered the room, resident # 55 was unresponsive and was noted to have food in her mouth. The LP attempted to removed the food. Resident # 55 was assessed and had no signs of life with no pulse present. The code status was verified and no life sustaining measures were initiated. Identification of Deficient Practice; How will corrective action be accomplished for those residents having potential to be affected by the same deficient practice: On 8/12/24 an audit of all residents with dysphagia diet orders was performed by the DON to ensure that orders are accurate, on the Kardex and the care plan is current. No issues were identified. On 8/12/24 an audit of all diet orders/tray tickets was performed by the DON/designee to ensure all orders were accurate. No issues were identified. On 8/14/24 all residents with dysphagia diet orders were re-evaluated by Speech Therapist to ensure the diets were appropriate. No issues were identified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/12/24 an audit of all care plans/Kardex was performed by the MDS coordinator/designee to ensure that diets are care planned appropriately and are accurate. Any issues identified were corrected. Systemic Changes: On 8/12/24 the DON/designee began education with all nursing staff on verifying the resident's diet by the Kardex/care plan to ensure if any assistance with feeding is needed. If feeding assistance is needed the resident will not be left unsupervised. On 8/12/24 the DON began education with all nursing staff on verifying the tray tickets are accurate with the appropriate diet prior to serving the resident. If the tray ticket states feeding assistance is needed, the resident will not be left unsupervised. Effective 8/14/24, nursing staff will not be allowed to work until the education is completed. New hires will be provided this education by the Nurse Practice Educator during orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Observation competency for any resident requiring feeding assistance will be completed for 12 weeks with (5) staff to ensure residents who require feeding assistance are not left unsupervised during meals. This will include all meals breakfast, lunch and dinner. All new orders will be reviewed 5x weekly in the Clinical Morning Meeting to ensure any new diet orders/changes are verified and updated on the plan of care/Kardex. New admissions will be reviewed 5x weekly in the Clinical Morning Meeting to ensure diet orders are reviewed for accuracy and the care plan/Kardex are updated. The Dietary Manager will perform audits on all tray tickets weekly for 12 weeks to ensure tickets are accurate. The DON will report the results of the plan of correction audits to the QAPI Committee. The QAPI Committee will review the audits and make recommendations to ensure compliance is sustained and ongoing and determine the need for any further auditing is needed. Completion Date: 8/20/24 Surveyor reviewed the credible evidence for the POC on 8/21/24 and found the audits and education to be complete other than two staff members who are on Family Medical Leave. The Administrator confirmed that the two employees are aware that they must complete education prior to working with patients. Interviews with nursing staff on 8/20/24 and 8/21/24 confirmed that staff are knowledgeable about ensuring diets are accurate and residents who require assistance are identified using the Kardex. No further information was provided prior to the exit conference. This is a past non-compliance deficiency. 49622 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2. For Resident #209, the facility staff failed to provide care and services for a safe environment for prevention of elopement from the facility. This was a closed record review. Resident #209's diagnoses included, but were not limited to, Presence of Left Artificial Hip Joint, Anxiety Disorder, Type 2 Diabetes Mellitus, Congestive Heart Failure, Chronic Kidney Disease-Stage 3, Chronic Obstructive Pulmonary Disease, Depression, Dementia, and Adult Failure to Thrive. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/16/23, assigned the resident a brief interview for mental status (BIMS) summary score of 1 out of 15 for cognitive abilities, indicating Resident #209 was severely impaired in cognition. A review of the clinical record revealed a medical provider's order dated 5/4/23, that read in part, .Wander Guard/Wander Elopement Device due to wandering and elopement risk every night shift check function and document in supplemental documentation . A review of the June 2023 MAR (medication administration record) revealed Resident #209's wander guard was ineffective on 6/1/24 during day shift. A review of the progress notes revealed an elopement assessment note dated 6/1/23 that read in part, . continued wandering, patient eloped from the facility was found still in the parking lot . An encounter progress note dated 6/16/23, read in part, .placed on rounds by staff for exit seeking .Patient was placed on every 15 (fifteen) minute checks due to exit seeking. After review plan exit door has been identified. Wander guard is now working . A review of the Elopement Evaluation dated 6/1/23, revealed resident had a history of actual elopement or attempted elopement and had a history of wandering that placed resident at significant risk of getting to a potentially dangerous place, outside facility. The evaluation also indicated that Resident #209 hovered near exits, had impulsiveness, and restlessness. A review of the comprehensive care plan read in part, .is at risk for elopement related to: Cognitive Loss/Dementia and wandering within the facility, sometimes hovers at exits, history of elopement attempt, impulsiveness . with an initiated date of 12/13/2022 that included an intervention that read in part, .Redirect . away from exit doors . On 8/20/24 at 11:10 AM, surveyor interviewed discharge planner and she stated she was trying to find placement for Resident #209 at a dementia unit. She believes they found Resident #209 by the dumpsters, it was later afternoon/evening, and she was not at the facility when it happened. On 8/20/24 at 11:15 AM, surveyor interviewed admissions director and she remembered the incident being discussed, but she did not witness the incident. On 8/20/24 at 3 PM, surveyor interviewed administrator and director of nursing, neither worked at the facility at the time. Administrator called the former administrator, and she gave permission for surveyor to contact her via telephone. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 8/20/24 at 5:08 PM, surveyor spoke via phone with registered nurse #3 (RN#3) and she stated she remembered them talking about Resident #209 getting out, but she was not directly involved, and she believed the resident went out the mechanical room door by the dock and she did not believe that door had a wander guard. On 8/20/24 at 8:01 PM, surveyor interviewed former administrator-other staff #2 (OS#2) about the elopement and she stated they had challenges with Resident #209 leaving the facility with family when they visited. She stated resident went out of the mechanical room door and the door was located to the left of the administrator's office when you came through the double-doors in the lobby. She believed a therapist had found the resident on that day. On 8/21/24 at 8:45 AM, surveyor interviewed rehab director and she stated she found Resident #209 outside by the dumpsters when she was leaving work for the day. She stated as she was walking resident back towards the front doors of the building, staff came out the mechanical door and took resident back in. She could not recall which staff and did not know which door resident came out of. She stated she observed her walking around by the dumpsters and took surveyor outside and showed surveyor where she found resident by the dumpsters. On 8/21/24 at 10:50 AM, surveyor interviewed environmental services director and he showed surveyor the 2 (two) doors that lead into the laundry room. Both doors had a punch-key code lock (numbers are punched in for entry). Both doors lead to the mechanical room door. Immediately outside the mechanical room door was a sidewalk with a rail that led to the dumpster area approximately 50 (fifty) yards to the right of the door. On 8/21/24 at 1:45 PM, administrator informed surveyor he could not locate the investigation or staff statements from the incident that occurred on 6/1/23 in the files left by the former administrator. He also stated there was no wander guard system on the mechanical room doors. When asked the process for checking the wander guard system, administrator stated nursing sign-off on the MAR that it has been checked. Administrator performed tests on the 2 wander guard doors for surveyor and they were observed to be working correctly. No other staff who cared for Resident #209 were available for interview at the time of the survey. This allegation was discussed with the administrator, corporate nurse consultant, and director of nursing at the pre-exit meeting on 8/21/24 at 3:30 PM. Surveyor requested and received a facility policy titled, Elopement of Patient, that read in part, .Those determined to be at risk will receive appropriate interventions to reduce risk .Elopement is defined as any situation in which a patient leaves the premises or a safe area without the facility's knowledge and supervision . No further information regarding this concern was presented to the survey team prior to the exit conference on 8/21/24.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49622 Based on observation, resident interview, staff interview, clinical record review, and facility document review the facility staff failed to provide adequate respiratory care for 1 of 22 residents in the survey sample, (Resident #63). The findings include: For Resident #63 the facility staff failed to label and date each component of the oxygen extension tubing and failed to provide a new pre-filled humidifier bottle for resident upon utilization of the oxygen concentrator. Resident #63's diagnosis list indicated diagnoses that included, but were not limited to, Streptococcal Arthritis to Right Knee, Sepsis, UTI (urinary tract infection), Acute Kidney Failure, Hypertensive Chronic Kidney Disease-Stage 4, Peripheral Vascular Disease, Atrial Fibrillation, and Osteoarthritis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of, 8/19/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating Resident #63 was cognitively intact. On 8/18/24 at 3:45 PM, surveyor interviewed Resident #63 and observed resident to be on oxygen via nasal cannula. Resident stated she was on 2 (two) liters of oxygen. Surveyor observed the oxygen concentrator to be set at 2 liters and noted the humidification bottle was empty and dated 6/10/24. Surveyor observed the oxygen extension tubing to not be labeled or dated. A review of the medical providers orders included an order dated 8/13/24 which read in part, .Oxygen at 2 L/min (liters per minute) via Nasal Cannula, continuously. Every day and night shift . An additional order dated 8/13/24, read in part, Oxygen tubing .Label each component with date and initials . On 8/18/24 at 3:55 PM, surveyor requested licensed practical nurse #4 (LPN#4) accompany her to resident's room and asked her to look at the oxygen humidification bottle. LPN#4 stated the bottle was dated 6/10/24 and she agreed no water was observed to be in the humidification bottle. Surveyor asked LPN#4 what the date was on the extension tubing and she stated there was no date. On 8/19/24 at 9:45 AM, surveyor and director of nursing (DON) entered Resident #63's room and surveyor informed the DON of the observation of the humidification bottle being dated 6/10/24 yesterday and about the extension tubing having no label or date. The DON agreed and stated, absolutely the resident should have received a new humidification bottle upon admission and that resident was admitted late in the evening and staff must have grabbed a concentrator that was not in use. This concern was discussed at the end of day meetings with the corporate nurse consultant, administrator, and director of nursing on 8/19/2024 at 4:30 PM, 8/20/24 at 4:19 PM, and again at the pre-exit meeting on 8/21/24 at 3:30 PM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received a facility policy titled, Procedure: Oxygen: Concentrator, that read in part, . 1. Verify Order .2. Gather supplies .2.4 Pre-filled humidifier bottle and adapter as needed .9. Label, date and attach pre-filled humidifier bottle .13. After a concentrator is discontinued, place the equipment in the soiled utility room. 13.1 Disinfect the concentrator .13.3 Place in the clean utility room for new set-up .14. Document .14.1 Date and time oxygen started . No further information regarding this concern was presented to the survey team prior to the exit conference on 8/21/24.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34307 Based on observation, staff interview, facility document review and during a medication pass and pour observation the facility staff failed to ensure medications were available for administration for 1 of 22 residents, Resident #43. The findings included: For Resident #43 the facility staff failed to ensure the medication Diltiazem was available for administration. Resident #43's face sheet listed diagnoses which included but not limited to hypertension, congestive heart failure and atrial fibrillation. Resident #43's most recent minimum data set with an assessment reference date of 08/13/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #43's comprehensive care plan was reviewed and contained a care plan for Resident exhibits or is at risk for cardiovascular symptoms or complications related to hypertension, A FIb (atrial fibrillation), CHF (congestive heart failure). Interventions for this care plan included Administer medications as ordered . On 08/20/24 at 8:15 am, surveyor observed licensed practical nurse (LPN) #1 during a medication pass and pour. LPN #1 prepared Resident #43's medications but stated to surveyor that the Idolize was not in the medication cart, and they would have to pull it from the Cubex (emergency medication supply). After administering resident's medications, LPN #1 went to the medication room the pull the Diltiazem, but it was not available in the Cubex. LPN #1 then stated to surveyor that they would have to call the pharmacy to get a stat order. Surveyor told LPN #1 to let them know when the medication arrived from the pharmacy. On 08/20/24 at 9:30 am, LPN #1 informed surveyor that medication would not arrive from pharmacy in time to administer the medication, and they had obtained an order from the physician to hold the medication for one dose. Resident #43's medications were reconciled with the clinical record on 08/20/24. Resident #43's clinical record contained a physician's order summary which read in part, Diltiazem HCl Beads Oral Capsule Extended Release 24 Hour 240 mg orally one time a day for HTN (hypertension). Resident #43's clinical record contained a nurse's progress note which read in part, 08/20/2024 9:05:00 New order received and noted per . (name omitted) to hold Diltiazem 240 mg x 1 dose pharmacy to stat dose . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and was provided with a facility policy entitled Medication Shortages which read in part, The facility nurse must make every effort to ensure that a medication ordered for the resident is available to meet their needs. The concern of not having Resident #43's medication available for administration was discussed with the administrator, director of nursing, and regional nurse consultant on 08/21/24 at 3:30 pm. No further information 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. 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to ensure 2 of 22 residents were free from unnecessary medications, Resident #11 and Resident #29. The finding included: 1. For Resident #11 the facility staff administered insulin outside the physician ordered parameters. Resident #11's face sheet listed diagnoses which included but not limited to type 2 diabetes mellitus, anxiety and depression. Resident #11's most recent minimum data set with an assessment reference date of 06/28/24 as of signed the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #11's comprehensive care plan was reviewed and contained a plan for The resident has a diagnosis of diabetes with potential for hypo/hyperglycemia. Interventions for this care plan include Access and record blood glucose levels as ordered and SS (sliding scale) insulin per MD orders and Administer insulin per MD orders. Resident #11's clinical record was reviewed and contained a physician's order summary which read in part, Humalog KwikPen Subcutaneous Pen-Injector (insulin lispro). Inject 15 unit subcutaneously before meals for DM (diabetes mellitus). Hold for glucose under 150 and Levemir Solution (Insulin Detemir). Inject 37 unit subcutaneously one time a day for diabetes. HOLD IF BLOOD SUGAR IS < = (less than or equal to) 125. Resident #11's electronic medication administration record for the months of July and August were reviewed and contained entries as above. The entry for Humalog was initialed as administered on 07/08/24 at 11:30 am with a blood sugar of 132 and 08/18/24 at 6:30 am with a blood sugar of 115. The entry for Levemir was initialed as administered on 07/02/24 at 9 pm with a blood sugar of 114. Surveyor requested and was provided with a facility policy entitled Medication Administration General Guidelines which read in part, 7.1 General Guidelines. Policy. Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so .1. Medications are administered in accordance with written orders of the prescriber. The concern of not ensuring Resident #11 was free from unnecessary medications was discussed with the administrator, director of nursing, and regional nurse consultant on 08/21/24 at 3:30 pm. No further information was provided prior to exit. 49622 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #29 the facility failed to ensure Resident #29 was free of an unnecessary medication, Novolin. (Novolin is a medication used to treat diabetes.) Resident #29's diagnosis list indicated diagnoses that included, but were not limited to, Lung Cancer, Type 2 Diabetes Mellitus, Atrial Fibrillation, Fibromyalgia, Anxiety Disorder, Depression, and Chronic Kidney Disease-Stage 2. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/14/24, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating Resident #29 was cognitively intact. Resident #29's clinical record included a Nursing Report, that read in part, Includes the following Classifications: MRR (medication regimen review) For Recommendations Created Between 7/25/2024 And 7/25/2024 Includes Routings for: Nursing, IDT (interdisciplinary team) .Consultant Pharmacist .The resident has an order for NovoLIN R (regular) Injection Solution 100 UNIT/ML (milliliters) (Insulin Regular (Human)) Inject 22 (twenty-two) unit subcutaneously (under the skin) before meals for IDDM (insulin-dependent diabetes mellitus) with Hyperglycemia hold if less than 160 that was not administered according to the parameters .Please review the order with nursing and educate the importance of following charting/documentation as per ordered . An active medical provider order dated 5/14/24 read in part, .NovoLIN R Injection Solution 100 UNIT/ML . Inject 22 unit subcutaneously before meals for IDDM with Hyperglycemia (high blood sugar) hold if (blood sugar) less than 160 . A review of the July 2024 MAR (medication administration record) revealed Resident #29 received the medication, Novolin, on the following dates with BS (blood sugar) documented as follows: 7/9/24 with a documented BS of 122 7/18/24 with a documented BS of 131 7/23/24 with a documented BS of 135 7/25/24 with a documented BS of 154 7/31/24 with a documented BS of 154. A review of the August 2024 MAR revealed Resident #29 received the medication, Novolin, on the following date with BS documented as follows: 8/7/24 with a documented BS of 153. On 8/20/24 at 2:48 PM, this surveyor and the director of nursing reviewed the July 2024 MAR and the director of nursing stated she would check into the medication administration. She returned to the surveyor and stated it looks like they did give the medication outside of parameters. This concern was discussed at the pre-exit meeting on 8/21/24 at 3:30 PM with the corporate nurse consultant, administrator and director of nursing. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received a facility policy titled, Medication Administration, that read in part, . Medications are administered as prescribed .Medication Preparation .3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. Compare the medication and dosage schedule on the resident's MAR .if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule .Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber . No further information regarding this concern was presented to the survey team prior to the exit conference on 8/21/24.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to ensure 1 of 22 residents was free from significant medication errors. The findings included: For Resident #9 the facility staff failed to administer the medication, Meropenem per the physician's orders. Meropenem is an antibiotic used to treat bacterial infections. Resident #9's face sheet listed diagnoses which included but not limited to sepsis, severe sepsis with septic shock, necrotizing fasciitis, methicillin resistant staphylococcus aureus (MRSA), extended spectrum beta lactamase (ESBL) resistance, and pseudomonas. Resident #9's most recent minimum data set with an assessment reference date of 08/08/24 assigned the resident brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #9's comprehensive care plan was reviewed and contained a plan for Patient has a suspected/actual infection and is at risk for sepsis, has history of or risk factors for sepsis related to Septic Left Shoulder or has actual sepsis, ESBL, MRSA, Pseudomonas, Necrotizing Fasciitis. Interventions for this care plan include Administer medications as ordered. Resident #9's clinical record was reviewed and contained a physician's order summary which read in part, Meropenem Solution Reconstituted 1 GM. Use 1 gram intravenously every 8 hours for septic L(left) shoulder for 28 days. Resident #9's electronic medication administration record (eMAR) for the month of August 2024 was reviewed and contained an entry as above. This entry was not initialed as being administered on 08/12/24 at 6 am. Surveyor spoke with the director of nursing on 08/20/24 at 4:10 pm regarding Resident #9's meropenem. Looking at the blank on the eMAR, DON stated, It looks like it wasn't given. Maybe they didn't have it to give and should have written a hold order. On 08/21/24 at 8:55 am, DON stated the surveyor that the nurse working night shift on 08/11/24 had tested positive for COVID at 5 am on 08/12/24. DON stated another nurse came in to relieve night shift nurse, but didn't know if the Meropenem had been administered, so they didn't give it. Surveyor requested and was provided with a facility policy entitled Medication Administration General Guidelines which read in part, 7.1 General Guidelines. Policy. Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so .1. Medications are administered in accordance with written orders of the prescriber. The concern of not ensuring Resident #9 was free of significant medication error was discussed with the administrator, DON, and regional nurse consultant on 08/21/24 at 3:30 pm. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47299 Based on observation, staff interview, and facility document review, the facility staff failed to appropriately store, prepare and/or serve resident food items. The findings included: On 8/18/24 at 2:12 PM during the initial tour of the dietary department, this surveyor and other employee # 4 entered the walk-in cooler. Employee # 4 had identified themselves as a cook/aide and stated, I'm second in command. They indicated they were in charge when the dietary manager is off. A plastic jug approximately 1/4 full, labeled peeled garlic was noted on the shelf. There were three dates written on the lid as follows, OP 3/20/24 underneath that 3/15/24 and underneath that was a date of 5/20, but the year was not legible, it had been smeared. Surveyor asked employee # 4 what each date means. They stated, This is the day it was opened pointing to the OP 3/20/24 date, and this would be the date that it came in because it's earlier pointing to the 3/15/24 date. When asked about the 5/20 date, they stated, I think that is 5/20/24. I think I need to throw it away. When surveyor asked what the third date is for, they stated, That's the date we should use it by or throw it away. I'm going to throw it away. The policy entitled, Refrigerated/Frozen Storage with an effective date of 5/1/23 was reviewed and read in part, all foods are labeled with the name of the product and the date received and use by date once opened. Manufacturer use by dates are used until opened. On 8/20/24 at 2:46 PM this surveyor checked the resident refrigerator on the North wing. There was a 6-ounce container of vanilla yogurt noted. On the foil lid was written, E.T. and a date of 7/31/24. There was a factory stamp with an expiration date of 8/14/24 noted on the container. The Dietary Manager was notified, and the yogurt was discarded. The policy entitled, Food brought in for Patients/Residents with an effective date of 11/28/17 was reviewed. Under the heading, Storing Food Brought in that Requires Refrigeration the policy read in, Food will be held in refrigerator for three (3) days following date on label and will be discarded by staff upon notification to patient/resident. The survey team met with the Administrator, Director of Nursing and Regional Nurse Consultant on 8/21/24 at 3:30 PM. This concern was discussed at that time. No further information was provided to the survey team before the exit conference

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 47299 Based on observation, staff interview and facility document review, the facility staff failed to ensure proper disposal and/or containment of the facility's garbage/waste. The findings included: On 8/19/24 at approximately 2:30 PM, this surveyor and other employee # 4 made observations of the facility's garbage disposal area located outside the facility but on the campus. There were two dumpsters noted. All of the doors on the dumpsters were closed, however there was scattered debris noted around each one. Surveyor noted 7 gloves, 4 Styrofoam cups, a large black trash bag with unknown contents, the bag was tied. There were 4 large pieces of brown wood lying on the ground between the dumpsters. The surveyor asked the employee if they knew what the wood was and they stated, It looks like something maintenance would have put there. It looks like it was a cabinet or something. On 8/20/21 at 4:15 PM the survey team met with the Administrator, Director of Nursing and Regional Nurse Consultant. Surveyor requested and received the policy entitled, Waste Management with a review date of 5/1/24. The policy did not speak to the garbage disposal area outside the facility. On 8/21/24 at 3:30 PM the surveyor team met with the Administrator, Director of Nursing, and Regional Nurse Consultant. This concern was reviewed at that time No further information was provided to the survey team prior to the exit conference.