STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Health & Rehabilitation Center	1004 Independence Blvd Virginia Beach, VA 23455

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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 - Some	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** 34894 Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to maintain the self esteem/dignity of two resident (Resident # 5 and #10) in survey sample of 62 residents. The findings included: 1. For Resident # 5, the facility staff did not provide a dignified experience regarding incontinence care. Resident # 5 was admitted to the facility on [DATE] with diagnoses including but not limited to: Type 2 Diabetes, Chronic Kidney Disease, Glaucoma, hypertension, Osteomyelitis and depression. Resident # 5's MDS review included the MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 4/22/2024 which was a quarterly assessment. The MDS coded Resident # 5 as requiring extensive assistance from one to two staff members with bed mobility, dressing, toileting, hygiene, and bathing. The Resident was also coded as 14 of 15 possible points on a brief interview for mental status (BIMS), indicating no cognitive impairment. The Resident was coded as always incontinent of bladder and frequently incontinent bowel. Review of the clinical record was conducted 6/4/2024-6/7/2024. During an interview on 6/4/2024 at 11:45 a.m., Resident # 4 stated the staff often did not provide incontinence care and she was left soiled for extended periods of time. The room had a pungent odor of urine and feces. Dark brownish colored liquid substance was observed on the bottom sheet with the line of demarcation reaching to level of Resident # 5's hips. The dark substance was noted on the bedspread and top sheet as well. The room was very foul smelling. On 6/4/2024 at 12:10 p.m., Licensed Practical Nurse-1 entered Resident # 5's room and obtained a finger stick blood sugar. LPN-1 was accompanied by a student nurse who stated she was in orientation. LPN-1 and the student nurse did not comment about the pungent odor in the room nor about the brown liquid substance that was evident on the bed sheets and linen. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse removed the lid on the lunch tray, Resident # 5 looked at the food and stated she did not want to eat the food. She said it did not smell good and she did not want an alternate meal. LPN-1 stated that Resident # 5 often ordered food from outside restaurants. Resident # 5 stated she did not want any restaurant food either. On 6/4/2024 at 1:15 p.m., Resident # 5 was observed still lying in bed. The room still had the pungent odor of urine and feces. The line of demarcation of the brownish colored liquid was creeping higher up the sheets to approximately the waist level. On 6/4/2024 at 1:45 p.m. and 2:15 p.m , there were observations of Resident # 5 still lying in bed with dark brown liquid stains on the sheets which had increased in size to reach to the middle of Resident # 5's back. There was a pungent odor of urine and feces in the room. During an interview on 6/4/2024 at 2:15 p.m., Resident # 5 stated they haven't changed me yet. They haven't done it since early this morning. Resident # 5 stated she needed to be changed. There were no nursing staff observed in the hallway. On 6/4/2024 at 2:19 p.m., the Corporate Nurse Consultant was asked to come to Resident # 5's room. The Corporate Nurse Consultant came to the room and immediately stated it was evident that Resident # 5 had not had incontinence care for an extended period of time. The room reeked of urine and feces. There were lines of demarcation indicating the urine and feces had crept up higher at different times. The Corporate Nurse Consultant stated she would get someone to provide are immediately. On 6/4/2024 at 2:30 p.m., Resident # 5's door was closed. One Certified Nursing Assistant was observed coming out of Resident # 5's room carrying two clear bags of soiled linen. Feces and urine stains could be visualized on the linens. The Certified Nursing Assistant was asked what she was doing. She stated she had just helped the other CNAs provide incontinence care to Resident # 5. She stated the resident had been incontinent of both urine and feces and all of the linens were soiled. The odor was pungent. She stated incontinence care should be provided every two hours and as needed. She stated she did not know why incontinence care had not been provided earlier. Review of Resident #5's physician orders, Medication and treatment administration records (MAR's/TAR's), Care plan, and progress notes indicated that the Resident suffered from moisture associated dermatitis (MASD) and had a history of a pressure ulcer on the sacrum. On 6/4/2024, the Director of Nursing (DON), and Administrator were interviewed and asked what their expectation for toileting and incontinence care timing was for this Resident. They stated every 2 hours, and as needed, and that the care must be documented after care. Certified Nursing Assistants (CNA's) were interviewed on all three units during survey, and indicated residents should be checked at least every 2 hours and as needed for incontinence care. On 6/5/2024 at 9:20 a.m., an interview was conducted with Certified Nursing Assistant-3 who stated they turn and reposition residents every 2 hours but sometimes every hour depending on the needs of the resident. CNA-3 stated incontinence care should be given every hour or even 30 minutes if needed. She also stated showers should be given at least twice a week and more often if needed or if the resident requests one. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 5's point of care documentation by primary care staff to indicate care that was given every day was reviewed. The facility instituted 8 hour working shifts for staff, and those 3 shifts were 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. The records indicated that for the months of April 2024, May 2024 and June 2024, Resident # 5 was totally dependent on staff for toileting and incontinence care. The Corporate Nurse Consultant stated the facility did not have a policy on ADL (Activities of Daily Living) care. She stated the expectation was that care would be provided approximately every 2 hours every shift and PRN (as needed). She stated failure to provide timely incontinence care did not show treatment with dignity. Interviews were conducted with staff members by the survey team. Staff members stated that the expectation was to give incontinence care immediately after every incontinent episode. Resident # 5 was not afforded timely incontinence care and was not shown dignity and respect. The facility Administrator and Director of Nursing (DON) were made aware of the above findings at the end-of-day debriefing on 6/5/2024. No further information was provided. 49916 2. For Resident # 10, the facility staff failed to provide dignity related to the care of an indwelling urinary catheter (Foley brand name). Resident # 10 was admitted to the facility on [DATE] with diagnoses including but not limited to: Type 2 Diabetes, Urinary Tract Infections, Aphasia, Muscle Weakness, Need for Assistance with Personal Care, Presence of Coronary Angioplasty Implant, Anemia, and Epilepsy. Resident #10's MDS review included the MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 4/22/2024 which was a quarterly assessment. The MDS coded Resident # 10 as requiring extensive assistance from one to two staff members with bed mobility, dressing, toileting, hygiene, and bathing. The Resident was also coded as 7 of 15 possible points on a brief interview for mental status (BIMS), indicating mild to moderate cognitive impairment. The resident was coded as indwelling catheter always incontinent of bladder and frequently incontinent bowel. During an initial tour on 6/4/2024 at 11:45 a.m., Resident # 10 was observed in the hall sitting in a wheel chair with his foley catheter bag visible with dark amber substance in the foley collection bag and the tubing hanging near the floor. Nursing staff was observed in the hallway during the initial tour. Review of Resident #10's physician orders revealed: that the resident has a Foley (brand name) Catheter. The Foley anchor should be changed each week, and Resident should have a leg bag during waking hours. On 6/5/2024, the Director of Nursing (DON), and Administrator were interviewed and asked what their expectation for foley care for this resident. They stated the indwelling urinary catheter should have a leg bag, bag anchor and cover for privacy and dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Corporate Nurse Consultant stated the facility did not have a policy related to provision of indwelling catheter covers/bags to maintain the resident's dignity. On 5/13/2024 and 5/14/2024 during the end of day debriefings, the Administrator, and the DON (Director of Nursing) were notified the above findings. No further information was provided by the facility prior to survey 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 34894 Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to ensure one Resident (Resident # 5) in a survey sample of 62 residents was clinically appropriate to self-administer medications. The findings included: 1. For Resident # 5, the facility staff allowed prescription eye drops to be kept at the bedside without an order and self administration assessment. On 6/5/2024 at 9:30 a.m., a plastic prescription bag with an affixed label that stated Bremonidine 0.2 % eye gtts (drops) was noted on Resident # 5's overbed table. The eye drops had been opened and still had medication remaining. Resident # 5 stated she kept the eye drops at her bedside because the staff members kept losing her eye drops. Resident # 5 stated that she was diagnosed with glaucoma and she was very concerned about not getting the eye drops on time. Resident # 5 stated she would give the eye drops to the nurses when it was time to administer them. On 6/5/2024 at 10:05 a.m., the bag with the eye drops was still on the overbed table. On 6/5/2024 at 10:20 a.m., the eye drops were still on the overbed table. On 6/5/2024 at 10:30 a.m., an interview was conducted in the conference room with the Director of Nursing and Corporate Nurse Consultant. Both stated that medications should not be kept at the bedside without the resident being assessed for self administration of medications. Both stated that medications should be kept on the medication cart until time for administration. Review of the clinical record revealed an order for Bremonidine 0.2 % eye gtts instill one drop in both eyes Brimonidine Tartrate Solution 0.2 %- Instill 1 drop in both eyes two times a day for glaucoma -Order Date 07/29/2022 1253 There was no documentation of eye drops being administered on 4/21/2024 at 9 a.m. and 4/30/2024 at 5 p. m. Review of the physicians orders revealed no orders for the medication to be left at the bedside. Review of the care plan revealed no documentation of self administration of medications or medications to be left at the bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the end of day debriefing on 6/5/2024, the Administrator and Corporate Nurse Consultant were informed of the findings. They were asked about the risks of medications being left at the bedside. The Corporate Nurse Consultant stated there was a risk of other residents getting the medications and a risk of the resident administering the medication outside of the scheduled times as ordered by the physician. The Corporate Nurse Consultant stated if a resident had a self-administration clearance, the medication would be kept in a locked box at the bedside. They were asked to provide any information about eye drops not being administered by nurses due to the medication not being available. They stated they were unaware of nurses not having the eye drops available at the time of administration. Both stated medications should not be left at the bedside without an order and a self-administration assessment. On 6/6/2024 at 1:40 p.m., an interview was conducted with the Director of Nursing who stated the eye drops were removed from Resident # 5's bedside table and placed in the medication cart. The Director of Nursing stated the maintenance director located a locked box to use if a self administration assessment was done and deemed appropriate. The Director of Nursing stated that there was no assessment done at the time of the survey and interview. No further information was provided prior to survey 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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure one resident (Resident # 5) in the survey sample of 62 residents had the right to make choices about aspects of life in the facility. The Findings included: 1. For Resident # 5, the facility staff often failed to provide more coffee as requested. Resident # 5 was admitted to the facility on [DATE] with diagnoses including but not limited to: Type 2 Diabetes, Chronic Kidney Disease, Glaucoma, hypertension, Osteomyelitis and depression. Resident # 5's MDS review included the MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 4/22/2024 which was a quarterly assessment. The MDS coded Resident # 5 as requiring extensive assistance from one to two staff members with bed mobility, dressing, toileting, hygiene, and bathing. The Resident was also coded as 14 of 15 possible points on a brief interview for mental status (BIMS), indicating no cognitive impairment. The Resident was coded as always incontinent of bladder and frequently incontinent bowel. Review of the clinical record was conducted 6/4/2024-6/7/2024. Review of the Physicians orders revealed an order for a Regular Diabetic Diet. There was no noted restriction on the number of cups of coffee consumed by Resident # 5. During the initial tour of the facility on 6/4/2024 at 11:42 a.m., Resident # 5 stated she enjoyed having more coffee after breakfast but it was hard to get another cup. Resident # 5 stated breakfast was served early at the facility. However, she liked more coffee after breakfast. On 6/5/2024 at 9:00 a.m., Resident # 5 stated she asked for coffee after breakfast. She stated Nobody brought another cup yet but it's probably all gone by now. The breakfast tray was gone and there was no coffee on Resident # 5's bedside table. A beverage cart was observed at the nurses station. There were 3 carafes of coffee, sugar, creamer and cups located on the cart. Nursing staff members were not observed in the hallways. On 6/5/2024 at 9:52 a.m., the Director of Nursing was observed walking in the hallway. She was asked if residents could get more coffee if they desired, to which she responded yes. The Director of Nursing stated the staff members could get more coffee from the Dietary department. The Director of Nursing looked around the hallway, then observed the beverage cart at the Nurses station and determined there was coffee in one of the carafes. One carafe was empty. The Director of Nursing poured two cups of coffee (one for Resident # 5 and the other for the roommate.) The Director of Nursing gave the two cups of coffee to LPN (Licensed Practical Nurse)-1 and asked her to give them to the two residents. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN-1 was observed placing one cup of coffee on the overbed table for Resident # 5 and the other was given to the roommate. The surveyor asked if she received the coffee. Resident # 5 stated she received the coffee but could not pour it into her personal coffee cup with a lid located on the bedside table. CNA (Certified Nursing Assistant)-1 walked into the room while the surveyor was talking with the resident and poured the coffee into Resident # 5's personal coffee cup. CNA-1 stated Resident # 5 could not pour the coffee into her own personal cup so staff members had to provide assistance. Resident # 5 smiled and stated getting the extra coffee made her happy. She stated she was Glad there was some left. During the Group Interview on 6/5/2024 at 11:00 a.m., thirteen alert and oriented residents participated. Surveyor stated several residents complained of not being able to get extra coffee as desired. During the end of day debriefing, the Administrator and Corporate Nurse Consultant were informed of the findings. The Corporate Nurse stated residents should be able to have another cup of coffee without a long delay. No further information was provided prior to survey 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to develop and implement a comprehensive person-centered care plan for 2 (#'s 172 and 165) residents in a survey sample of 62 residents. The findings included: 1. For Resident # 172 the facility staff failed to provide a comprehensive care plan for wounds. Resident #1 was admitted to the facility on [DATE] with diagnoses that included but were not limited to diabetes, hypertension, on anticoagulant therapy, sustained injuries to left foot and leg in car accident. discharged from hospital with multiple wounds requiring sutures to the left leg as well as a lymphatic wound. On 5/1/24 the admitting nurse made the following entry: 5/1/24 at 12:00 AM - Skilled Nursing Focus: pt here for pt and ot he has a wound to the left leg no wound orders present at the moment. On 5/1/24 at 1:05 PM the wound specialist was in to see the Resident and he assessed all 4 wounds and identified 3 of them as lacerations that were sustained during the accident and sutured by the hospital. He put orders in for treatments to the affected areas. The wound doctor assessed and identified one wound as a lymphatic wound ulcer and prescribed treatment for that as well. A review of the comprehensive care plan revealed the following: FOCUS: SKIN IMPAIRMENT: the resident has a skin impairment Created on: 04/30/2024. GOAL: The skin impairment will heal without complications thru review date Created on: 04/30/2024. INTERVENTIONS: Notify MD as indicated Date Initiated: 04/30/2024. Observe area for signs of improvement or decline Date Initiated: 04/30/2024. Treatment as ordered Date Initiated: 04/30/2024 Created on: 04/30/2024. On 6/13/24 at approximately 12:30 PM an interview was conducted with LPN (Licensed Practical Nurse) 1 who stated that the purpose of a care plan is to direct the care of the Resident. When asked if a care plan says skin impairment is that enough information to tell you what the impairment, she stated that it was not. When asked if a care plan should be more specific, she stated that it should be Tailored to the individual needs of each resident. She further stated that it should specifically how to care for each resident, such as ADL(Activities of Daily Living) care, dietary, activities, code status, and plans for discharge. She stated that it should be updated as the needs of the resident change. (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 care plan policy revealed the following excerpt: Policy: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing. On 6/13/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 31199 2. For Resident #165, the facility staff failed to derive a comprehensive care plan for multiple acquired pressure sores. Resident #165 was admitted to the facility on [DATE], and discharged on [DATE] (29 days later) with diagnoses including; Diabetes type 2, acute hip fracture with surgical repair, Foley urinary catheter placement after hip fracture, and congestive obstructive pulmonary disorder (COPD). Resident #165's most recent MDS (Minimum Data Set Assessment) was an admission assessment. The MDS coded Resident #165 as needing extensive to total staff assistance with toileting, hygiene, and bathing. The Resident was also coded as alert and able to make needs known, with some confusion at times. The Resident was coded as frequently incontinent of bowel and a Foley catheter for bladder. The Resident was no longer in the facility and a closed record review was conducted. The Resident had no pressure wounds upon admission. Physician orders were reviewed and revealed that on 3-23-21 after admission the Resident was receiving an Allevyn cushion dressing to the sacrum from the hospital every day for protection, and skin prep wipes to heels every shift for protection prior to the development of the pressure sores. This indicated that the facility staff were aware of the risk potential for skin breakdown for Resident #165. No other preventive measures were put in place for the immobile Resident with a surgical repair for her fractured hip which increased the likelihood of skin impairment. Resident #165's Activity of daily living sheets documented the incontinence/hygiene, and bathing care provided for the Resident. Review of those documents revealed that during the month of April 2021 personal hygiene was not given for the following dates and shifts: On 4-9-21, and 4-14-21, (7am to 3pm) day shift staff documented extensive assistance from 1 staff member required by the Resident for personal hygiene care. No other day shifts were documented as hygiene care having been given on this 8 hour shift during the 20 day period (18 days missed) from 4-1-21 through discharge on 4-20-21. On 4-1-21, 4-2-21, 4-4-21, 4-5-21, 4-13-21, 4-14-21, 4-16-21, and 4-19-21, (3pm to 11pm) evening shift staff documented total dependence from 1 staff member required by the Resident for personal hygiene care. No other evening shifts were documented as hygiene care having been given on this 8 hour shift during the 20 day period (12 evenings missed) from 4-1-21 through discharge on 4-20-21. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Bathing care was documented as being planned for Monday, Wednesday, Friday 7am to 3pm shift (day shift). Those baths did not occur on 4-2-21, 4-5-21, 4-12-21, and 4-19-21, and the Resident was documented as completely dependant on one staff member for bathing. Eight opportunities for baths were planned from 4-1-21

through 4-20-21, and only 4 were given.

Review of Resident #165's physician and nursing progress notes revealed a Resident who was total care. The notes indicated that on 4-13-21 the Resident went out of the facility for an Orthopedic appointment and returned to the facility later in the afternoon. In the nursing progress notes, on 4-13-21 at 3:15 pm, the nurse documented that the Resident returned from her Orthopedic follow up appointment with new orders and that a dressing change was provided to the Resident's sacrum and heels, with some discomfort noted to sites. Will continue to monitor. Which indicated that nursing staff were aware of wounds.

An interview was conducted with family which revealed that they were present when the pressure sores on the sacrum and heels were identified for the Resident at the Orthopedic appointment, and the information was communicated to the staff upon the Resident's return to the facility. This indicates that the unstageable pressure sore of the sacrum was known by the staff on 4-13-21, and a skin assessment was partially completed by nursing staff on that day which documented the unstageable sacral wound.

Weekly skin Evaluation documents were reviewed and revealed that 4 existed in the clinical record. None were complete. Those were as follows:

1. 3-30-21 first weekly assessment skin intact without impairment.

2. 4-6-21 second weekly assessment skin intact without impairment.

3. 4-13-21 third weekly assessment site sacrum pressure 2.5 long, 2.0 wide unstageable, right heel pressure 2.2 long, 2.1 wide suspected deep tissue injury, left heel pressure 3.0 long, 2.5 wide suspected deep tissue injury. No further documentation nor description was given, and it is unknown if these measurements were centimeters or inches.

4. 4-20-21 fourth weekly assessment documented site left gluteal fold pressure, Sacrum pressure no measurements nor description noted, however, the Resident now had a new pressure ulcer added to the document on her left gluteal fold/ischium, and the bilateral heels were not mentioned. The pressure wound found to the right lateral leg was never mentioned. It is referred to later in this investigation.

The physician progress notes and physician's order review further revealed that no orders nor indications that the facility doctor was ever made aware of the unstageable pressure sores on 4-13-21. Not until 4-16-21 (3 days later) did a progress note appear from the wound specialist practice.

On 4-16-21 a wound Advanced Registered Nurse Practitioner (wound NP) completed an assessment and issued new orders after being made aware of the identification of the unstageable pressure sores identified on 4-13-21 at the Orthopedic doctor's appointment. The orders were as follows:

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ordered 4-16-21- (7 items) 1. Prostat 30 milliliters (ml) two times per day supplement. 2. Use pillows and wedges to keep patient off of backside at all times to decrease pressure and aid in healing. 3. Prevalon boots to bilateral heels at all times except when performing morning care. 4. Right ischial ulcer clean with dermal wound cleaner, apply thin duoderm to area change Monday, Wednesday, Friday and as needed if it comes off, keep covered at all times. 5. Sacrum cleanse with dermal wound cleanser apply santyl nickel thick to gauze that is moistened with microcyn hydrogel cover with allevyn life sacral dressing change twice per day and as needed for incontinence episodes. 6. X-ray to sacral ulcer to assess bone condition. 7. Place on group 2 low air loss mattress for unstageable ulcer to sacrum and left ischium. Ordered 4-17-21- (1 item) 1. Left heel deep tissue injury skin prep every other day and cover with allevyn life heel foam to help aid in pressure reduction, Ordered 4-19-21- (1 item) 1. Right lateral leg cleanse with dermal wound cleanser apply iodosorb gel cover with allevyn life foam to help with pressure reduction change on Monday Wednesday Friday necrotic wound. It is notable to mention that the right gluteal/Ichium ulcer and right lateral leg ulcers were never mentioned on the weekly skin assessments, and no treatment for the left gluteal/Ichium ulcer was ever obtained. The Wound NP's progress note dated 4-16-21 at 2:48 pm, included the following: Ulcer to sacral region, wound to right lower extremity, wound to left ischium, skin discoloration (deep tissue injury)to bilateral heels, fall with hip fracture, nonambulatory, deconditioning, .medication currently taking . then listed those medications. The note went on to describe the wounds as follows: Open sacral pressure ulcer unstageable 6 cm long, 7.5 centimeters (cm) wide, 0.1 cm deep, no granulation tissue, 100% black necrotic (dead) tissue within the wound bed Open right ischial pressure ulcer unstageable 1.5 cm long, 1.8 cm wide, 0.1 cm deep, no granulation tissue, 100 % yellow necrotic (dead) tissue within the wound bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Open right lateral leg 10 cm long, 2.0 cm wide, 0.1 cm deep, no granulation tissue, 100% black eschar/necrotic (dead) tissue within the wound bed DTI to (deep tissue injury) bilateral heels. The note continues to state that the Resident's daughter was called and made aware that the Resident may require plastic surgery at some point for the wounds. Resident #165's Treatment Administration Record (TAR) was reviewed and revealed that the physician's orders for wound care treatment were not completed for the following wounds, on the following dates, as listed below: Sacrum - Omitted on 4-11-21, 4-16-21, 4-19-21. Ischium - The order was placed on the TAR, however, never signed as administered. Right lateral Leg - The order was placed on the TAR, however, never signed as administered. Bilateral heels - Omitted on 4-5-21, 4-6-21, 4-11-21, 4-12-21. The facility policies for Skin Assessments, and Wound/Skin Assessments were reviewed and revealed the following: Skin Assessments; 1. A licensed nurse will ensure that a skin risk assessment using the Braden Scale is done upon admission, weekly for four weeks, and quarterly thereafter. 4. Care plan specific interventions will be developed based on skin risk assessment outcomes and individual patient needs. 5. Notify provider with updates and/or changes to skin integrity. 6. Notify responsible party with updates and/or changes to skin integrity.Documented upon admission, weekly, and as needed if the Resident or wound condition deteriorates. Wound/Skin Assessments; 1. A licensed nurse will assess patients for any skin impairments, including surgical wounds, vascular wounds/ulcers, pressure ulcers/injuries, skin tears, etc 2. The skin observation tool will be completed by a licensed nurse at least every 7 days, detailing any wound/skin impairments (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

These policy documents that were provided by the facility were accompanied by training materials from the facility's nursing practice standards (Mosby's and NCLEX) used to train nursing staff in the facility on wound care. The documents described current skin care preventative techniques, assessments, other prevention modalities, care planning, wound identification, measuring, and staging standards, treatment of wounds and required documentation of wounds.

The following elements were notated in the training materials, and accepted as a standard of practice for a complete wound assessment:

a. Type of wound (pressure injury, surgical, etc.) and anatomical location

b. Stage of the wound if pressure injury (stage 1, 2, 3, 4, deep tissue injury, unstageable pressure injury) or the degree of skin loss if non-pressure (partial or full thickness)

c. Measurements: height, width, depth, undermining, tunneling

d. Description of wound characteristics to include the following;

i. Color of the wound bed

ii. Type of tissue in the wound bed (i.e., granulation, slough, eschar/necrosis, epithelium)

iii. Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated)

iiii. Presence, amount and characteristics of wound drainage/exudate

v. Presence or absence of odor

vi. Presence or absence of pain, and wound treatments are also to be documented at the time of each treatment.

No Braden scale skin assessment was completed at the time of admission, nor ever during the entire course of the Resident's stay. The Resident had no pressure wounds upon admission.

The Resident's care plan was reviewed and indicated the only care plan area mentioning skin was potential for skin impairment related to immobility, catheter. admitted with a non-removable dressing to her left hip. This entry described the fractured hip surgical wound dressing. The interventions were keep skin clean and dry, moisture barrier cream as needed for protection of skin, peri care with incontinence episodes, and weekly skin assessment. The Resident had a Foley catheter, so urinary incontinence was not a complicating factor in wound development.

There was no care plan ever completed for the pressure ulcer wounds that developed on Resident #156's Sacrum, ischium, leg, and both heels.

(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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple staff nurses were interviewed by surveyors on 2 shifts. Those interviews indicated that the nursing staff did not complete wound assessments as reported by all of those interviewed. The nurses stated that they contacted the contracted wound doctor's practice to come in and do the assessments. The nursing staff stated all skin assessments were in the computerized record, and they had no paper assessments. The wound physician was onsite during the survey, and was interviewed by surveyors. She stated that No one asked me to teach the nurses how to assess wounds, so I haven't done that. The Director of Nursing (DON) was asked what her expectation was for incontinence rounds and skin breakdown assessment. Her reply was every 2 hours and as often as needed, and skin would be assessed for breakdown during that care. If skin breakdown was found by CNA's (Certified Nursing Assistants), who typically completed incontinence care, they would then immediately report it to the nurse. The nurse would then assess the area, measure it, document a description of it, and seek physician's orders to treat and prevent worsening. The Resident's unstageable pressure wounds were never identified by the facility. No measurements nor descriptions of the wounds were every placed in the clinical record by nursing staff. The 4-13-21 identification of multiple unstageable pressure wounds occurred at an outside orthopedics appointment and not treated until the Resident was seen by the wound NP on 4-16-21, 3 days after identification. Resident #165 was not afforded timely bathing, nor hygiene/incontinence care, multiple unstageable pressure sores were not identified by the facility, orders and treatments were delayed, and not administered as per physician's order. No care plan ever existed for the pressure ulcers after they were identified. On 6-7-24 during the end of day meeting the Administrator and Regional Nurse Consultant were made aware of the above findings. The Administrator stated that this happened before her tenure, and with a different owner. She stated she had no additional information to provide prior to survey exit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to review and revise the care plan for 5 Residents (Residents #45, #359, #36, #161, and #50) in a survey sample of 62 Residents. The findings include: 1. For Resident #45, the facility staff failed to revise the care plan to include Eliquis anticoagulant therapy and assessment after a bilateral lung pulmonary embolus (blood clot) diagnosis in the hospital. Resident #45, was initially admitted to the facility on [DATE], with diagnoses including; Hypothyroidism, ileus, Atrial fibrillation, weakness, falls, gluten intolerance, and obesity. The Resident was discharged on [DATE] back to the emergency room for fever, body ache and change in level of consciousness. The Resident was readmitted on [DATE] after the inpatient hospitalization for bilateral pulmonary embolus (lung blood clots), bilateral pneumonia with sepsis, metabolic encephalopathy, and protein calorie malnutrition. Resident #45's most recent MDS (minimum data set) coded the Resident as having moderate cognitive impairment. Resident #45 was also coded as requiring extensive dependence on one staff member to perform activities of daily living, such as hygiene, transferring, and bed mobility. The Resident's physician orders from the hospital were reviewed and revealed 2 orders for an anticoagulant. The orders were for the following; 1. 3-23-24 Apixaban (Eliquis) 5 mg (milligram) tablets take 2 tablets by mouth twice (20 mg per day) daily for 12 doses (6 days). Dispense 24 tablets. 2. 3-23-24 Apixaban (Eliquis) 5 mg tablets start 3-29-24 take 1 tablet by mouth twice (10 mg per day) daily for 90 days. Dispense 60 tablets with 2 refills. Guidance for the administration of anticoagulant medication is given by The National Institutes of Health (NIH), and is as follows; National Institutes of Health & Medline.gov; Do not discontinue this medication without seeking a doctor's help. Stopping Anticoagulants increases the likelihood of blood clot formation which can be life threatening, to include stroke, heart attack and pulmonary emboli. Assess for signs of bleeding while taking this or any anticoagulant drug therapy. Resident #45's care plan was reviewed and revealed no care plan revision for anticoagulant drug use for pulmonary embolus, nor assessments for potential bleeding. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews conducted from 6-5-24 through 6-12-24 with nursing staff on separate halls and shift revealed that the expectation for all medications is that they are available and administered per physician's order. Nursing staff agreed that administering anticoagulants was to decrease the possibility of blood clots which caused strokes and heart attacks, and could cause bleeding. On 6-7-24, and 6-10-24, the DON (director of nursing) and Administrator were interviewed in the conference room and stated that they had been unaware that nursing care plans were not revised in March of 2024, however did state that interdisciplinary care plan meetings had not been done for a little over a month. The DON was a new staff member and had recently been hired in the last month. On 6-12-24 at approximately 1:30 p.m., at the end of day debrief, the Administrator and DON were again made aware of the failure of staff to review and revise care plans. No further information was provided. 49455 2. For Resident #359, the facility staff failed to revise the resident's care plan to include new interventions to meet goals after learning that the resident had a fall on 6/3/24 shortly after being admitted to the facility and learning that the resident was legally blind. Resident #359 was admitted to the facility on [DATE]. Diagnoses for Resident #359 included but were not limited to acute metabolic encephalopathy, urinary tract infection, end-stage renal disease, and legal blindness. Resident #359's Minimum Data Set (MDS) was not yet complete. An observation was made on 6/4/24 at approximately 1:30 PM of Resident #359 sitting on the side of the bed and the resident's call bell was on the floor under the bed. After asking the resident if he had any concerns, Resident #359 shared that he had slid to the floor shortly after being admitted the day before and his roommate had to call and get staff to help him back to bed. In review of Resident #359's clinical record, there was no documentation supporting his fall. After notifying the Administrator and Regional Nurse Consultant (RNC) #1 of what the resident shared and how there was no documentation of the event, they did an investigation on 6/6/24. Licensed Practical Nurse (LPN) #1, shared during the investigation that she forgot to document that the resident had a fall on her shift on 6/3/24. Resident #359's care plan was revised on 6/7/24 with no changes noted to prevent future falls. 3. For Resident #36, the facility staff failed to develop, review, and revise an Activities of Daily Living (ADLs) care plan. Resident #36 was admitted to the facility originally on 1/16/24 and readmitted last on 5/7/24. Diagnoses for Resident # 36 included but were not limited to pressure ulcers, Diabetes Mellitus, Bilateral Lower Extremity Amputation, and Clostridium Difficile. Resident #36's Minimum Data Set (MDS) with an Assessment Reference Date of 5/7/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 which indicated that Resident #36 was cognitively intact. In section GG (Activities of Daily Living), the resident required partial assistance for eating and oral care, was dependent on toileting and bed mobility, and required substantial maximum assistance for dressing. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 an interview was conducted with Resident #36 and his private caretaker. Resident #36 shared that his wife got a private caretaker after he had fallen twice in the facility. The resident says he could not call for help because due to the neuropathy in his hands, he could not use the call bell. Resident #36 said he shared this information with the Administrator and Admissions Director the prior week, but no action had taken place. Resident #36 indicated the only ADL care he receives is primarily from occupational therapy and they are the only people who have giving him a bath. A review of the clinical record supports Resident #36 falling on 4/27/24 and 5/13/24. On 4/27/24 Resident #36 was sent to the emergency room for a dislodged percutaneous endoscopic gastrostomy (PEG) tube and on 5/13/24 the resident did not sustain any injuries. Resident #36 care plan did not include anything regarding ADL care. The above findings were shared with the Administrator, Corporate Nurse #1, and Corporate Nurse #2 on 6/13/2024 at approximately 11:45 AM. No further information was provided prior to the conclusion of the survey. 40026 4. For Resident #161 the facility staff failed to review and revise the care plan after the development of a stage 2 pressure area. On 6/6/24 a review of the clinical record revealed that Resident #161 was admitted to the facility on [DATE] from an acute care hospital, where he was admitted after sustaining facial injuries after a fall. The document entitled Admission Skin Assessment lists only the facial injuries as skin impairments, no pressure ulcers or other wounds are listed. On 2/14/24 Resident #161 was evaluated by the wound doctor and the following excerpts are from the wound doctor's notes: Wound Evaluation Date: 02/14/2024, Location: Sacrum Measurements: Length: 8.50 cm, Width: 8.00 cm, L x W: 68.00 cm2, Depth: 0.20 cm Observations: Location: Sacrum, Etiology: Pressure, Stage/Severity: Stage 2, Acquired in House: Yes, Date Wound Acquired: 02/11/2024, Wound Status: New. On 6/6/24 a review of the care plan revealed the following for skin / wounds: FOCUS: The resident is at risk for pressure ulcers related to advanced age, chronic health conditions, dry fragile skin, immobility, inability to turn and reposition independently, incontinence Created on: 02/01/2024 Revision on: 05/14/2024. GOAL: the resident will not have a skin impairment thru the review period Created on: 02/01/2024 Revision on: 05/14/2024 (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTION: Assess resident for risk of skin breakdown Date Initiated: 02/01/2024 Keep skin clean and dry as possible Date Initiated: 02/01/2024 Created on: 02/01/2024. Skin assessments as indicated Date Initiated: 02/01/2024 Created on: 02/01/2024. The care plan did not reflect the actual wound development nor the treatment or interventions to prevent further worsening of the wound. On 6/13/24 at approximately 12:30 PM an interview was conducted with LPN (Licensed Practical Nurse) 1 who stated that the purpose of a care plan is to direct the care of the Resident. When asked if a care plan says skin impairment is that enough information to tell you what the impairment, she stated that it was not. When asked if a care plan should be more specific, she stated that it should be Tailored to the individual needs of each resident. She further stated that it should specifically how to care for each resident, from ADL care to dietary, activities code status and plans for discharge. She stated that it should be updated as the needs of the resident change. A review of the care plan policy revealed the following excerpt: Policy: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing. On 6/7/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 34306 5. The facility staff failed to review and revise Resident 50's care plan to include application of TED hose every day and to remove them nightly. Resident #50 was originally admitted to the facility 3/29/2024 after an acute care hospital stay and she had not been discharged from the facility. The resident's diagnoses included bilateral lower extremity edema The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/4/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. In section GG H. as dependent for putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable. During the initial tour with Resident #50 on 6/4/24 at approximately 3:20 PM. The resident stated she experienced swelling in her feet and legs therefore she now required application of TED hose daily and to remove them prior to bed each night. The resident further stated because she can bath, dress and toilet herself she was having a difficult time getting staff to come in and apply the TED hose. The resident further stated she had tried but the TED hose were too tight for her to apply them unassisted. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #50's orders revealed the following order dated 5/23/24 - TED HOSE - Please apply compression stockings every day for bilateral lower extremity edema. Take the TED HOSE off at night. The resident may help apply stockings to bilateral lower extremities. A review of the resident's care plan failed to identify the bilateral lower extremity edema problem and the intervention to apply the TED hose every day and remove them every night. An interview was conducted with Licensed Practical Nurse (LPN) #1 on 6/7/24 11:40 AM. LPN #1 stated Resident #50 comes to the door and tells staff what her needs are and they follow through with her request for she does not require very much. On 6/13/24 at approximately 12:00 P.M., a final interview was conducted with the Administrator, and two Corporate Nurse Consultants. They had no comments and voiced no concerns regarding the above information.

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure services provided by the nursing facility meet professional standards of quality.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 34894

Based on resident interview, staff interview and clinical record review, the facility staff failed to provide care and services in accordance with professional standards for three resident (Resident #5, #173 and #27) in a survey sample of 62 residents.

The findings included:

1. For Resident # 5, facility staff failed to administer, and/or document medications and treatments as administered, as ordered by the physician on several dates including but not limited to: 5/5/2024, 5/13/2024 and 5/30/2024.

Resident # 5 was admitted to the facility on [DATE] with diagnoses including but not limited to: Type 2 Diabetes, Chronic Kidney Disease, Glaucoma, hypertension, Osteomyelitis and depression.

Resident # 5's MDS review included the MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 4/22/2024 which was a quarterly assessment. The MDS coded Resident # 5 as requiring extensive assistance from one to two staff members with bed mobility, dressing, toileting, hygiene, and bathing. The Resident was also coded as 14 of 15 possible points on a brief interview for mental status (BIMS), indicating no cognitive impairment. The Resident was coded as always incontinent of bladder and frequently incontinent bowel.

Review of the clinical record was conducted 6/4/2024-6/7/2024.

Review of Resident #5's clinical record was conducted on 6/4/2024-6/7/2024. Review of the physician orders and medication administration documentation revealed the following:

Review of the facility policy entitled, Administering Medications, revised April 2019, heading Policy read, Medications are administered in a safe and timely manner, and as prescribed and subheading Policy Interpretation and Implementation, item 4 read, Medications are administered in accordance with prescriber's orders, including any required time frame.

Review of the May 2024 Medication Administration Record revealed several medications that were not administered as ordered by the physician. The medications included but were not limited to:

Amlodipine 10 mg (milligrams) - Give 1 tablet by mouth in the

evening for Hypertension

Order Date- 12/08/2023 1601 Scheduled 8 p.m.

not given 5/5/2024, 5/13/2024 and 5/30/2024 at 8 p.m.

Nortriptyline Oral Capsule 10 milligrams-Give 20 mg by mouth at bedtime related to Major Depressive Disorder

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Order Date-11/1/2023 -scheduled at 9:00 p.m. not given 5/5/2024 and 5/30/2024 at 9 p.m. Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (units per milliliter) (Insulin Glargine) Inject 40 unit subcutaneously at bedtime for Diabetes IF PT (patient) REFUSES, DOCUMENT AND NOTIFY PROVIDER. -Order Date-04/05/2024 1648 not given at 9 p.m. on 5/5/2024, 5/13/2024, 5/30/2024 Melatonin Tablet 5 mg-Give 1 tablet by mouth at bedtime for insomnia -Order Date- 05/19/2023 1040 Not given 9 p.m. on 5/5/2024, 5/30/2024 Trazodone HCl (Tablet 50 MG-Give 1 tablet by mouth at bedtime for insomnia GDR (gradual dose reduction) -Order Date- 03/24/2023 1116 Not given 9 p.m. on 5/5/2024, 5/30/2024 Carvedilol Tablet 12.5 MG Give 1 tablet by mouth two times a day for HTN Hold if SBP (systolic blood pressure) < (greater than)100 HR (heart rate) < (less than) 50 -Order Date- 01/10/2024 1624 Not given 9 p.m. on 5/5/2024, 5/30/2024 Eliquis Tablet 5 MG (Apixaban)-Give 1 tablet by mouth two times a day related to personal history of other venous thrombosis and embolism -Order Date- 01/10/2024 1621 (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 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Not given 9 p.m. on 5/5/2024, 5/30/2024

Review of the May 2024 Treatment Administration Record revealed missing documentation of treatments to include but not limited to:

Skin care-sacrum, under bilateral breast, bilateral axilla, abdominal fold, cleanse area with soap and water, pat dry, apply skin prep to surrounding tissues,

ketoconazole Cream 2% and petroleum-based barrier cream together and leave open to air. every day and evening shift for

Treatment

-Order Date-05/03/2024 1339

not administered on 5/5/2024 day and evening, 5/8/2024 day and evening, 5/9/2024 evening, 5/13/2024 evening and 5/17/2024 day shift.

Guidance for nursing standards for the administration of medication provided by Fundamentals of Nursing, 7th Edition, Mosby's/ [NAME]-[NAME], p. 705 stated Professional standards, such as the American Nurses Association's Nursing Scope and Standards of Nursing Practice of (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:

1. The right medication

2. The right dose

3. The right client

4. The right route

5. The right time

6. The right documentation.

Resident 5's care plan was reviewed and revealed a care plan that instructed to administer medications and treatments as ordered by the physician.

Nursing and physician progress notes were reviewed, and revealed no notes documenting that the medications had been omitted, nor that the doctor was made aware of the omissions.

On 6/5/2024 at 10:20 a.m., an interview was conducted with Licensed Practical Nurse-1 who stated the expectation was for nurses to administer medications and treatments as ordered by the physician. She stated that nurses should document immediately after administration of medications and treatments.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Health & Rehabilitation Center	1004 Independence Blvd Virginia Beach, VA 23455

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/6/2024 at 2:25 p.m., an interview was conducted with the Director of Nursing who stated the expectation was for the staff to administer medications and treatments as ordered by the physician. On 6/6/2024, during the end of day debriefing with all surveyors, the Administrator and Corporate Nurse Consultant were made aware of the failure of staff to administer medications as ordered. No further information was provided. 34306 2. The facility staff failed to administer ophthalmic (eye) medications to Resident #173 as ordered. Resident #173 was originally admitted to the facility 6/3/24 after an acute care hospital stay. The resident's diagnoses included alcohol abuse and glaucoma. The resident had not been admitted to the facility long enough for the Minimum Data Set (MDS) to be completed therefore the following information was obtained from the Admission/Readmission Nursing Collection Tool dated 6/3/24. The tool revealed at number 1. Cognitive state that the resident was oriented to person and place, at number 8. Gastrointestinal, the resident was continent of bowels, at number 9. Genitourinary, the resident was continent of bladder, at number 12.GG that the resident required set-up assistance with eating and oral care. The resident was not assessed for toileting hygiene, to move from sitting on side of bed to lying flat on the bed, to come to a standing position from sitting in a chair, and with transfers. An interview was conducted with the resident on 6/10/24 at approximately 1:40 P.M. Resident #173 stated he had not received his eye drops since admission to the facility. The resident further stated that his sister administered his ophthalmic drops when he was home. The resident also stated he had not experienced blurred vision, burning, itching, or a feeling as if something was his eye since he was not being administered the ophthalmic drops. The resident asked, when would he receive the ophthalmic drops. Resident #173 had the following ophthalmic orders dated 6/3/24; Latanoprost Ophthalmic Solution 0.005 % - Instill 1 drop in both eyes at bedtime and Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 % - Instill 1 drop in both eyes two times a day. During the 6/10/24, medication storage task of the Hall 3 medication cart, the Dorzolamide HCl-Timolol Mal ophthalmic drops were not on the medication cart. An interview was conducted with Licensed Practical Nurse (LPN) #6 on 6/10/24 at approximately 1:07 PM. LPN #6 stated she administered the resident's Dorzolamide HCl-Timolol Mal ophthalmic drops that morning and she threw the bottle in the trash afterwards because they were drops sent over from the hospital. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication administration Record (MAR) revealed on 6/6, 6/9 and 6/10 the 9:00 P. M., medication was documented as waiting for pharmacy and on order. A note was also written for the medication on 6/12/24. It stated Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2-0.5 %. Instill 1 drop in both eyes two times a day for one time hold order per the Physician's Assistant because the family was providing the supplies and the resident is his own Responsible Party. An interview was conducted with the Pharmacist on 6/1/24 at 2:30 PM. The Pharmacist stated the Dorzolamide HCl-Timolol Mal ophthalmic drops were delivered to the facility on [DATE] and signed as received by Registered Nurse (RN) #4. The location of the ophthalmic drops which were delivered and signed as delivered was not determined by the facility's staff. On 6/10/24 at 12:40 PM during the medication storage task of the medication refrigerator, a sealed unopened bottle of Latanoprost Ophthalmic Solution 0.005 % was observed in the refrigerator. This ophthalmic drop was scheduled to given each night at bedtime. The bedtime dose was signed off as administered each night except 6/3, 6/6, 6/7 and 6/9. The progress notes regarding the medication read waiting for pharmacy, med not available, on order. At approximately 4:50 PM on 6/12/24 the sealed unopened bottle of Latanoprost Ophthalmic Solution 0.005 % was validated in the refrigerator by Corporate Nurse #1. They were still not in use. On 6/13/24 at approximately 12:00 P.M., a final interview was conducted with the Administrator, and two Corporate Nurse Consultants. They had no new information regarding the missing bottle of Dorzolamide HCl-Timolol Mal ophthalmic drops or comments on why the Latanoprost Ophthalmic Solution 0.005 % remained in the refrigerator unused. 40711 3. For Resident #27 the facility staff failed to follow physicians orders by not ensuring Resident #27 received her necessary wound care treatments. Resident #27 was originally admitted to the facility 11/18/21 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Pressure Ulcer of the Right Ankle and Peripheral Vascular Disease. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/05/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #27 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goal) Requires set up and or clean up assistance with eating, oral hygiene and personal hygiene. Requiring substantial/maximal assistance with toileting hygiene and lower body dressing. In Section M (Skin Conditions) Resident is coded as being at risk for Pressure Ulcers. Resident is coded as not having any unhealed Pressure Ulcers. Resident is coded as having 3 Venous and Arterial Ulcers. The Care Plan dated 11/22/22 and revised on 7/23/23 read that Resident #27 was at risk for Pressure Ulcers related to weakness, impaired mobility and incontinence, Right hemiparesis status post (s/p) Cerebral Vascular Accident (CVA). The Goal for Resident #27 is that the resident will not have a skin impairment thru the review period. assess resident for risk of skin breakdown, assist the resident to turn and reposition often, Keep skin clean and dry as possible. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medication Administration Record (MAR) for May and June 2024 Solosite Wound Gel External Gel (Wound Dressings) Apply to buttocks, R lateral ankle topically every night shift every other day for Stage 4 pressure ulcer -Order Date 05/21/2024 9:41 AM -D/C Date 06/06/2024 10:24 AM. Missed treatment on 6/04/24. WOUND CARE: Buttocks, right lateral ankle: Cleanse and pat dry. Apply scant amount of Solosite to wound and cover with foam dressing. Change Q2 days or PRN for soiling. every night shift every other day -Order Date 05/21/2024 9:38 AM -D/C Date 06/06/2024 10:18 AM. Missed treatment on 6/04/24. WOUND CARE: Please apply betadine-soaked gauze, 4x4s, Kerlix, and a light ACE bandage to right foot every other day every night shift every other day -Order Date 05/21/2024 9:47 AM -D/C Date 06/06/2024 10:13 AM., Missed Treatment on 6/04/24. LEFT BUTTOCK - Cleanse with wound cleanser, pat dry, apply hydrogel, cover with bordered gauze. every night shift for pressure stage 3 wound -Order Date05/09/2024 1315 -D/C Date 05/21/2024 0923. Missed treatments: 5/10/24, 5/12/24, 5/15/24, 5/16/24. Right Lateral ankle: Cleanse with normal saline, Pat dry, skin prep to surrounding tissue, Manuka HD alginate, Honey fiber to wound bed, Bordered foam, NO ACE BANDAGE OR KERLIXNO COMPRESSION OF ANYKIND one time a day for WOUND -Order Date 02/27/2024 4:30 PM. -D/C Date 05/21/2024 9:22 AM. Missed Treatments. 5/01/24, 5/02/24, 5/08/24. On 6/11/24 at approximately 2:55 PM., an interview was conducted with the Director of Nursing (DON) concerning skin assessments and missed wound care treatments. The DON said that it is expected that the nurses perform skin assessments and carry out wound care treatments on their residents. The DON also mentioned that if the CNAs notice any new areas on the residents' skin, they will inform the nurse. On 6/12/24 at approximately 11:00 AM., an interview was conducted with Certified Nursing Assistant (CNA #6) concerning Resident #27. CNA #6 said that the resident didn't have any skin issues in January. On 6/12/24 at approximately 1:35 pm., an interview was conducted with the Wound Care Nurse Practitioner (WCNP). The WCNP said that she was not aware of any missed wound care treatments. On 06/13/24 at approximately 2:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure a complete list of orders were sent to the Home Health Agency upon resident's discharge for 1 of 62 residents (Resident #167), in the survey sample. The findings included: Resident #167 was originally admitted to the facility 10/02/21 and discharged on [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; End stage Renal Disease The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/08/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #167 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goal) the resident was coded as Independent with eating, Requires partial/moderate assistance with toileting hygiene and bathing/showering. The Care Plan dated 10/07/21 read that Resident #167 has infection of the (Osteomylitis left foot). The Goal for Resident #167 was the resident will be free from complications related to infection through the review date. The Interventions for Resident #167 was to administer meds/treatment as ordered. The October 2021 Physicians Order Summary (POS) Read: Zosyn Solution Reconstituted 2.25 (2-0.25) GM (Piperacillin Sod-Tazobactam So) Use 2.25 gram intravenously two times a day for UTI Verbal, Active 10/08/2021. The Medication Administration Record (MAR) for October 2021 read: Zosyn Solution Reconstituted 2.25 (2-0.25) GM (Piperacillin Sod-Tazobactam/Zosyn) Use 2.25 gram intravenously every 12 hours for antibiotic for 42 Days -Order Date-10/02/2021 2:56 PM., -D/C Date- 10/08/2021 6:30 PM. Zosyn Solution Reconstituted 2.25 (2-0.25) GM (Piperacillin Sod-Tazobactam So) Use 2.25 gram intravenously two times a day for UTI for 69 Administrations -Order Date-10/13/2021 2:00 PM., D/C Date- 10/22/2021 6:00 PM. The Ombudsman/Other Staff #17 alleged that the facility staff failed to arrange for continued IV therapy in home. Resident #167 was supposed to continue her therapy of IV Zosyn at home. Resident #167 was able to contact her infectious disease doctor to get orders to continue her IV therapy at home. However, the facility's failure delays her treatment for 6 days. The Ombudsman said that his review of the facility record revealed there were addendum notes dated 10-28-21 with instructions for IV therapy. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Health Status Note on 10/21/21 at approximately 6:34 AM., revealed that Resident #167 was tolerating IV Zosyn for left foot infection with no adverse effects. A review of the discharged Instruction document dated 10/22/21 only shows the signature of Resident #167. The discharge Summary note dated 10/21/21 at approximately 1:00 PM revealed the following: patient received antibiotic (ABX) treatment via IV as scheduled. Patient states that she is doing well and overall looking forward to discharging home to continue with IV abx treatment. The discharge Medication list dated 10/21/21 included but not limited to Piperacillin Sod-Tazobactam So, Zosyn Solution Reconstituted 2.25 (2-0.25) GM, Use 2.25 gram intravenously two times a day for UTI. for 69 Administrations, 2.25 (2-0.25) GM, ACTIVE, 10/13/2021 to 11/17/2021. All written prescriptions to be given to patient upon discharge. Other instructions: Patient will need home health with Home Health Care with same instruction on how to administer IV ABX as it is BID dosing. The above instructions were written on 10/21/21 a day before the resident's discharge. A Discharge Summary Planning Progress Note dated 10/22/21 at approximately 4:30 PM., revealed that Resident #167 was discharged on Friday 10/22/21 around 5:00 PM., Transport home by family. Physician will write handwritten scripts. Home Health Care will provide skilled nursing care-wound care-PT/OT/HHA. Family Medical Supply will provide a wheelchair (w/c) that was delivered to the facility today,10/22/21. No other needs identified. According to the discharge summary dated 10/22/21, the day of discharge does not indicate that Resident #167 received scripts for IV therapy. On 06/12/24 at approximately 1:06 PM., an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 said that she does not remember the resident but normally we would print off all the scripts and give them to the Physician Assistant (PA) We would then go over the scripts with the resident. LPN #1 also mentioned that the PA will call in the scripts to a certain pharmacy. Several phone calls were made throughout the survey to contact the above resident and her emergency contact. No return calls were received. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 a phone call was made at approximately 12:14 PM., to the said Home Health Agency. An interview was conducted with the Director concerning Resident #167. The Director said that the agency only received a referral for rehab., and wound care but did not include IV therapy. We received the referral from the Nursing facility on 10/25/21 saying Wound Care only. The Director also said that on 10/26/21 the Infectious Disease doctor was contacted by the resident to initiate IV therapy. The agency Director also mentioned that the resident started receiving IV therapy services on 10/28/21 from their agency. On 6/12/24 at approximately 12:45 PM., documents were received from the Corporate Consultant Nurse (CCN) #1. The CCN had 2 copies of prescriptions dated 10/15/21: Hydromorphone-Acetaminophen Tablet 10-325 MG, give 1 tablet by mouth every 8 hours as needed. The other copy read the same as above but was dated on 10/06/21. The CCN said that was all she could fine on staff concerning the discharge scripts. Zosyn/Piperacillin/tazobactam Zosyn 2.25 Gram Intravenous Solution - Piperacillin/tazobactam is used to treat a wide variety of bacterial infections. Bacterial Infection- It is a penicillin antibiotic. It works by stopping the growth of bacteria. This medication is given by injection into a vein as directed by your doctor, usually every 6 hours. It should be injected slowly over at least 30 minutes. For the best effect, use this antibiotic at evenly spaced times. To help you remember, use this medication at the same time(s) every day. https://www.webmd.com/drugs/2/drug-16577/zosyn-intravenous/details. On 06/13/24 at approximately 2:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation, the facility staff failed to provide ADL (Activities of Daily Living) care 7 Residents (#'s 13, 161, 258, 7, 171, 5 and 165) in a survey sample of 62 Residents. The findings included: 1. For Resident #13 the facility staff failed to provide incontinence care in a timely manner leaving Resident #13 in brief that was visibly soiled. 6/4/24 at 11:30 AM, Resident #13 was laying in soiled brief notable urine and feces odor in room. Sheets soiled with brownish yellow stain on left side of the bed. Resident #13 asked if the staff have been in to provide incontinence care and she stated that they had not been in since they collected the breakfast trays and had not provided incontinence care since before breakfast. 6/4/24 at 12:00 AM , Resident feces odor remained in room has still not been changed. On 6/4/24 at 1:00 PM, Corporate Employee #1 stated that the facility does not have a policy on ADL Care, she stated they use Mosby's Professional Nursing standards. On 6/4/24 at 2:00 PM, Resident #13 still had not been attended to for incontinence care. Regional nurse consultant came with surveyors to the room and observed the odor in the room and the stains on the sheets. She stated that it was obvious that incontinence care had not been provided timely. When asked the importance of timely incontinence care for dependent Residents she stated that it prevents skin irritation and breakdown and also for the comfort of the Resident. On 6/4/24 during the end of day meeting the Administrator was made aware of the concerns and stated that there was a mix up in the scheduling and the assigned CNA was unaware that Resident #13's room was assigned to them. No further information was provided. 2. For Resident #161 the facility staff failed to ensure adequate bathing and hygiene. On 6/5/24 a review of the clinical record revealed that Resident #161 was admitted to the facility on [DATE] with diagnoses that included but were not limited to muscle weakness, malnutrition, respiratory failure, and history of fall with injury. A review of the closed clinical record revealed that during the time of the admission Resident #161, did not receive scheduled showers on 2/19, 2/27, 3/1, 3/12, 3/16, 3/19, and 3/22. These were not coded nor documented as refusal by the Resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 an interview was conducted with CNA #5 who was asked how often Residents receive showers, CNA #5 responded that all Residents were scheduled for 2 showers a week. When asked what is documented if a Resident refuses, CNA #5 stated if a Resident refuses a shower, We notify the nurse and document in our POC (Point of Care) notes that the Resident refused, and we try to find out if they want to do it another time or if they just don't want shower at all. We also are supposed to try again later and offer a bed bath instead. CNA #5 was asked about documenting Codes in POC. When asked what the codes 1/8/8 meant, CNA #5 stated that the first number is for if the shower was given, # 1 is No the Resident did not get a shower. CNA #5 stated the second number is 8 meaning the activity did not occur and the third number is how much help they required which was also 8 activity did not occur. When asked if the Residents prefer bed baths how often should that occur, CNA #5 stated that if the resident does not like to shower then daily bed baths should be given. A review of the clinical record for the duration of the admission revealed that Resident #161 did not receive daily bed baths. On 6/6/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 3. For Resident #258 the facility staff failed to provide adequate showers and nail care. Resident #258 was admitted to the facility on [DATE] with diagnoses that included but were not limited to malnutrition, dementia, weakness, abnormality of gait, and history of falls, his most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/31/24 coded him as having a BIMS (Brief Interview of Mental Status) score was 7/15, indicating severe cognitive impairment. On 6/4/24 at approximately 11:20 PM, Resident #258 was observed in bed wearing a hospital gown and no socks, sheets pulled over legs feet exposed. Resident #258 appeared disheveled and had long nails. Resident #258 was asked about getting out of bed and he stated that he gets out of bed when his son comes to visit. When asked if he gets up more often than that he stated that he only gets out of bed when family visits. At that time, it was noted that Resident #258's nails were approximately 1/4 -1/2 an inch over the tips of his fingers, they appeared to have dark debris under the nails. When asked about cutting nails Resident #258 stated, Yes I would like my nails cut. On 6/4/24 a review of the clinical record revealed that Resident #258 had been admitted to the facility on [DATE] and since then has only had 1 of the 4 scheduled showers. On 6/5/24 at approximately 12:30 PM Resident #258 was again observed in his bed appearing disheveled and nails continued to be long with debris under the nail. Family member was at the bedside and when asked about Resident #258's care the family member stated that Resident #258 did need his nails cut but was not sure if the facility would do it or if the family was expected to do this. On 6/5/24 at approximately 2:00 PM an interview was conducted with the DON who was asked the expectation of CNA's (Certified Nursing Assistant's) with regard to nail care. The DON stated that routine nail care should be provided on shower days by the CNA unless the Resident has diabetes or PVD (Peripheral Vascular Disease) or some other condition that would make it unsafe for a non-licensed person to do it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 an interview was conducted with Corporate Employee #1 who stated they do not have a policy on ADL Care. On 6/6/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 40711 4. For Resident #7 the facility staff failed to ensure a resident who was unable to carry out activities of daily living (ADL) receive the necessary services to include showers and washing her hair. Resident #7 was originally admitted to the facility 04/29/22 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Need for assistance with personal care and Low back pain unspecified. The Quarterly Revised Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/21/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #7 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goals) the resident was coded as requires partial/moderate assistance with eating, oral hygiene, and personal hygiene. Resident is dependent with toileting hygiene and showers/bathes. The Care Plan dated 3/21/24 for read that resident #7 requires assistance with ADLS relate to CVA with weakness, inability to perform ADL. The Goal for Resident #7 would be to maintain her ADL functionality thru the review period. An intervention for Resident would be to provide a two person assist for bed mobility. The Physicians Order Summary (POS) Read: MUST WASH HAIR WITH NIZORALE SHAMPOO X2/WK. MONITOR FOR IMPROVEMENT OF DANDRUFF. DOCUMENT IN PCC THAT PT'S HAIR WAS WASHED WITH ABOVE SHAMPOO. SEE PCC FOR SPECIFIC ORDER FOR NIZORALE SHAMPOO, one time a day every Tue, Fri for Hair care; dandruff Prescriber Entered Active 04/15/2024. The Medication Administration Record (MAR) read: Nizoral External Shampoo 2 % (Ketoconazole (Topical)) Apply to To scalp topically one time a day every Mon, Thu for Cradle Cap / Dandruff for 8 Weeks until finished APPLY TO SCALP WHEN WASHING HAIR X2/WK -Order Date 06/07/2024. MUST WASH HAIR WITH NIZORALE SHAMPOO X2/WK. MONITOR FOR IMPROVEMENT OF DANDRUFF. DOCUEMENT IN PCC THAT PT'S HAIR WAS WASHED WITH ABOVE SHAMPOO. SEE PCC FOR SPECIFIC ORDER FOR NIZORALE SHAMPOO. one time a day every Tue, Fri for Hair care; dandruff -Order Date 04/15/2024 1533. A review of the shower schedule reveal that Resident #7 is scheduled for showers on Mondays and Thursdays. The 3P-11P shift. A review of the ADL sheet for June 2024 show that Resident #7 missed 1 shower on 6/06/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495213	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Bayside Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 Independence Blvd Virginia Beach, VA 23455	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the ADL sheet for May 2024 show that Resident #7 missed 2 showers on 5/13/24 and 5/27/24. A review of the ADL sheet for June 2024 show that Resident #7 did not get her hair washed shower on 6/06/24. A review of the ADL sheet for May 2024 show that Resident #7 did not get her hair washed 5/13/24 and 5/27/24. A review of the most current order summary dated 6/04/24 at 3:36 PM., read: MUST WASH HAIR WITH NIZORALE SHAMPOO X2/WK. MONITOR FOR IMPROVEMENT OF DANDRUFF. DOCUMENT IN PCC THAT PT'S HAIR WAS WASHED WITH ABOVE SHAMPOO. SEE PCC FOR SPECIFIC ORDER FOR NIZORALE SHAMPOO, One time a day every Mon, Thu for Hair care; dandruff. During the initial on 06/04/24 at approximately 12:51 PM., Resident #7 was observed lying in her bed watching tv. The left side of resident's head/hair had thick, large, brownish/yellowish particles in her hair. The resident said that she would like to get her hair washed but doesn't. The resident also mentioned that she's only getting one shower a week but would like to get more. On 06/05/24 at approximately 11:23 AM., an interview was conducted with Resident #7. Resident #7 said that she gets a shower once a week on Thursday but would like more. Resident #7 also said I don't remember the last time I got my hair washed. Shortly after LPN #1 entered the room said that Resident #7 was refusing her special shampoo. LPN #1 was asked to present any refusal documentations concerning ADL care. On 6/06/24 at approximately 11:36 AM., Resident #7 was observed lying in bed. Hair observed to have thick, brownish/yellowish flakes on the right side of her head. Resident #7 said that she had a bed bath but didn't get her hair washed. On 6/12/24 at approximately 10:40 AM., an interview was conducted with Certified Nursing Assistant (CNA) #6 concerning ADL care. CNA #6 said that asked if a resident refuses showers, baths, ADL care, the nurse should be informed. On 6/12/24 at approximately 11:00 AM., an interview was conducted with CNA #6. CNA #6 said that residents are supposed to get two showers a week and get their hair wash during their showers. CNA #2 also said that if a resident refuses a shower, they will get a bed bath and if a bed bath is refused, they will inform the resident's nurse. On 06/12/24 at approximately 1:06 PM., an interview was conducted with Licensed Practical Nurse (LPN) #1 concerning Resident #7. LPN #7 said that the resident's daughter spoke to her on yesterday to ensure she gets a shower and her hair washed on the 3-11 shift. LPN#1 also stated that Resident #7's shower days are on Monday and Thursdays on the 3-11 shift. She also said that the resident got her hair washed on yesterday and there are no flakes showing in her hair afterwards. LPN #7 also mentioned that the resident ran out of special shampoo, but the Physician Assistant (PA) was recently made aware. (continued on next page)

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 06/13/24 at approximately 2:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

34306

5. The facility staff failed to carry out activities of daily living necessary to maintain good grooming and personal hygiene for a dependent resident, Resident #171.

Resident #171 was originally admitted to the facility 6/3/24 after an acute care hospital stay. The current diagnoses included metastatic cancer involving the liver, lungs, chest wall and the brain.

The resident had not been admitted to the facility long enough for the Minimum Data Set (MDS) to be completed therefore the following information was obtained from the Admission/Readmission Nursing Collection Tool dated 6/3/24.

The tool revealed at number 1. Cognitive state, that the resident was oriented to person, place, and time, at number 8. Gastrointestinal, the resident was incontinent of bowels, at number 9. Genitourinary, the resident was incontinent of bladder, at number 12.GG that the resident required Partial/moderate assistance with eating and oral care, was dependent with toileting hygiene, and the resident was not assessed to move from sitting on side of bed to lying flat on the bed, to come to a standing position from sitting in a chair, and with transfers.

On 6/4/24 at approximately 10:05 A.M., Resident #171 was observed in bed observed in bed unshaven, with dry lips and disheveled. On 6/5/24 at approximately 10:47 A.M., Resident #171 was again observed in bed with a urine saturated drawsheet with multiple brown rings on it. The gown was also noticeable wet through the wet sheet, the resident was unshaven and did not smell clean. He was also in the same position as he was observed in on 6/4/24, facing the door.

The information was reported to Corporate Nurse Consultant #1. Corporate Nurse Consultant #1 and Corporate Nurse Consultant #2 stated they would ensure the resident received the necessary activities of daily services to promote comfort. The Corporate nurses were observed providing the resident's hygienic care.

On 6/13/24 at approximately 12:00 P.M., a final interview was conducted with the Administrator, and two Corporate Nurse Consultants. The above findings were shared with them. An opportunity was offered to the facility's staff to comment but they offered voiced no concerns regarding the conveyed information.

34894

6. For Resident # 5, the facility staff did not provide timely incontinence care.

Resident # 5 was admitted to the facility on [DATE] with diagnoses including but not limited to: Type 2 Diabetes, Chronic Kidney Disease, Glaucoma, hypertension, Osteomyelitis and depression.

(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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 5's MDS review included the MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 4/22/2024 which was a quarterly assessment. The MDS coded Resident # 5 as requiring extensive assistance from one to two staff members with bed mobility, dressing, toileting, hygiene, and bathing. The Resident was also coded as 14 of 15 possible points on a brief interview for mental status (BIMS), indicating no cognitive impairment. The Resident was coded as always incontinent of bladder and frequently incontinent bowel. Review of the clinical record was conducted 6/4/2024-6/7/2024. During an interview on 6/4/2024 at 11:45 a.m., Resident # 4 stated the staff often did not provide incontinence care and she was left soiled for extended periods of time. The room had a pungent odor of urine and feces. Dark brownish colored liquid substance was observed on the bottom sheet with the line of demarcation reaching to level of Resident # 5's hips. The dark substance was noted on the bedspread and top sheet as well. The room was very foul smelling. On 6/4/2024 at 12:10 p.m., Licensed Practical Nurse-1 entered Resident # 5's room and obtained a finger stick blood sugar. LPN-1 was accompanied by a student nurse who stated she was in orientation. LPN-1 and the student nurse did not comment about the pungent odor in the room nor about the brown liquid substance that was evident on the bed sheets and linen. The nurse removed the lid on the lunch tray, Resident # 5 looked at the food and stated she did not want to eat the food. She said it did not smell good and she did not want an alternate meal. LPN-1 stated that Resident # 5 often ordered food from outside restaurants. Resident # 5 stated she did not want any restaurant food either. On 6/4/2024 at 1:15 p.m., Resident # 5 was observed still lying in bed. The room still had the pungent odor of urine and feces. The line of demarcation of the brownish colored liquid was creeping higher up the sheets to approximately the waist level. On 6/4/2024 at 1:45 p.m. and 2:15 p.m , there were observations of Resident # 5 still lying in bed with dark brown liquid stains on the sheets which had increased in size to reach to the middle of Resident # 5's back. There was a pungent odor of urine and feces in the room. During an interview on 6/4/2024 at 2:15 p.m., Resident # 5 stated they haven't changed me yet. They haven't done it since early this morning. Resident # 5 stated she needed to be changed. There were no nursing staff observed in the hallway. On 6/4/2024 at 2:19 p.m., the Corporate Nurse Consultant was asked to come to Resident # 5's room. The Corporate Nurse Consultant came to the room and immediately stated it was evident that Resident # 5 had not had incontinence care for an extended period of time. The room reeked of urine and feces. There were lines of demarcation indicating the urine and feces had crept up higher at different times. The Corporate Nurse Consultant stated she would get someone to provide are immediately. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/2024 at 2:30 p.m., Resident # 5's door was closed. One Certified Nursing Assistant was observed coming out of Resident # 5's room carrying two clear bags of soiled linen. Feces and urine stains could be visualized on the linens. The Certified Nursing Assistant was asked what she was doing. She stated she had just helped the other CNAs provide incontinence care to Resident # 5. She stated the resident had been incontinent of both urine and feces and all of the linens were soiled. The odor was pungent. She stated incontinence care should be provided every two hours and as needed. She stated she did not know why incontinence care had not been provided earlier. Review of Resident #5's physician orders, Medication and treatment administration records (MAR's/TAR's), Care plan, and progress notes indicated that the Resident suffered from moisture associated dermatitis (MASD) and had a history of a pressure ulcer on the sacrum. The Resident was ordered to have moisture barrier cream applied to the sacrum, and the Resident wore incontinence products/briefs. On 6/4/2024, the Director of Nursing (DON), and Administrator were interviewed and asked what their expectation for toileting and incontinence care timing was for this resident. They stated every 2 hours, and as needed, and that the care must be documented after provision of care to the resident. Certified Nursing Assistants (CNA's) were interviewed on all three units during survey, and indicated they documented all care in the Point of Care computerized system for each of their residents at the end of every shift. On 6/5/2024 at 9:20 a.m., an interview was conducted with Certified Nursing Assistant-3 who stated they turn and reposition residents every 2 hours but sometimes every hour depending on the needs of the resident. CNA-3 stated incontinence care should be given every hour or even 30 minutes if needed. She also stated showers should be given at least twice a week and more often if needed or if the resident requests one. Resident # 5's point of care documentation by primary care staff to indicate care that was given every day was reviewed. The facility instituted 8 hour working shifts for staff, and those 3 shifts were 7:00 a.m. to 3:00 p. m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. The records indicated that for the months of April 2024, May 2024 and June 2024, Resident # 5 was totally dependent on staff for toileting and incontinence care. The record further documented the following but not limited to: In May 2024, Resident #5 did not receive toileting and incontinence care every 8 hour shift. There were 25 of 90 shifts with missing documentation during May 2024. In June 2024, there were 5 of 15 shifts with missing documentation. The Corporate Nurse Consultant stated the facility did not have a policy on ADL (Activities of Daily Living) care. She stated the expectation was that care would be provided approximately every 2 hours every shift and PRN (as needed), which included removal of wet incontinent briefs, and cleansing. Interviews were conducted with staff members by the survey team. Staff members stated that the expectation was to give incontinence care immediately after every incontinent episode. Resident # 5 was not afforded timely incontinence care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Administrator and Director of Nursing (DON) were made aware of the above findings at the end-of-day debrief on 6/5/2024. No further information was provided. 31199 7. For Resident #165, the facility staff failed to provide timely ADL care to a dependant Resident. Resident #165 was admitted to the facility on [DATE], and discharged on [DATE] (29 days later) with diagnoses including; Diabetes type 2, acute hip fracture with surgical repair, Foley urinary catheter placement after hip fracture, and congestive obstructive pulmonary disorder (COPD). Resident #165's most recent MDS (Minimum Data Set Assessment) was an admission assessment. The MDS coded Resident #165 as needing extensive to total staff assistance with toileting, hygiene, and bathing. The Resident was also coded as alert and able to make needs known, with some confusion at times. The Resident was coded as frequently incontinent of bowel and a Foley catheter for bladder. The Resident was no longer in the facility and a closed record review was conducted. The Resident had no pressure wounds upon admission. Physician orders were reviewed and revealed that on 3-23-21 after admission the Resident was receiving an Allevyn cushion dressing to the sacrum from the hospital every day for protection, and skin prep wipes to heels every shift for protection prior to the development of the pressure sores. This indicated that the facility staff were aware of the risk potential for skin breakdown for Resident #165. No other preventive measures were put in place for the immobile Resident with a surgical repair for her fractured hip which increased the likelihood of skin impairment. Resident #165's Activity of daily living sheets documented the incontinence/hygiene, and bathing care provided for the Resident. Review of those documents revealed that during the month of April 2021 personal hygiene was not given for the following dates and shifts; On 4-9-21, and 4-14-21, (7am to 3pm) day shift staff documented extensive assistance from 1 staff member required by the Resident for personal hygiene care. No other day shifts were documented as hygiene care having been given on this 8 hour shift during the 20 day period (18 days missed) from 4-1-21 through discharge on 4-20-21. On 4-1-21, 4-2-21, 4-4-21, 4-5-21, 4-13-21, 4-14-21, 4-16-21, and 4-19-21, (3pm to 11pm) evening shift staff documented total dependence from 1 staff member required by the Resident for personal hygiene care. No other evening shifts were documented as hygiene care having been given on this 8 hour shift during the 20 day period (12 evenings missed) from 4-1-21 through discharge on 4-20-21. Bathing care was documented as being planned for Monday, Wednesday, Friday 7am to 3pm shift (day shift). Those baths did not occur on 4-2-21, 4-5-21, 4-12-21, and 4-19-21, and the Resident was documented as completely dependant on one staff member for bathing. Eight (8) opportunities for baths were planned from 4-1-21 through 4-20-21, and only 4 were given. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was asked what her expectation was for incontinence rounds and skin breakdown assessment. Her reply was every 2 hours and as often as needed, and skin would be assessed for breakdown during that care. If skin breakdown was found by CNA's (Certified Nursing Assistants), who typically completed incontinence care, they would then immediately report it to the nurse. The nurse would then assess the area, measure it, document a description of it, and seek physician's orders to treat and prevent worsening. Resident #165 was not afforded timely bathing, nor hygiene/incontinence care. During the course of the survey multiple Residents in the survey sample, and still residing in the facility were found to have not been afforded timely hygiene/incontinence care and bathing. On 6-7-24 during the end of day meeting the Administrator and Regional Nurse Consultant were made aware of the above findings. The Administrator stated that this happened before her tenure, and with a different owner. She stated she had no additional information to provide to the survey team.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0684

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40026

Based on interviews, clinical record review, and facility documentation the facility staff failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan for 2 Residents (#172 and #27) in a survey sample of 62 residents.

The findings included:

1. For Resident #172 the facility staff failed to provide treatments for non-pressure wounds which became infected and resulted in hospitalization , this is harm.

Resident #172 was admitted on [DATE] with 4 wounds and no orders, and when orders were obtained on 5/1/24 they were not transcribed to the MAR until 5/3/24. In addition, the care plan stated wound care as ordered however there were no wound care orders on 4/30/24.

Resident #172's admission diagnoses included but were not limited to diabetes, hereditary lymphedema, non-pressure wound to left leg, Motor Vehicle Accident (MVA) driver resulting in lacerations with sutures to left lower leg and foot, muscle weakness and abnormal gait.

On 6/6/24 a review of the clinical record revealed that on 5/1/24 the admitting nurse made the following entry:

5/1/24 at 12:00 AM (midnight) - Skilled Nursing Focus: Patient here for physical therapy (PT) and occupational therapy (OT) he has a wound to the left leg no wound orders present at the moment.

The clinical record revealed that on 5/1/24 at 1:05 PM, Resident #172 was evaluated by the wound specialist. The wound doctor identified 4 wounds in total. Excerpts from the wound doctor's notes are as follows:

WOUND ASSESSMENT:

Wound 1: Location: Left anterior lower leg Primary Etiology: Skin tear/Laceration s/p suture repair Wound Status: Present on Admission Odor Post Cleansing: None Size: 8.9 cm x 2 cm x 0.1 cm. Calculated area is 17.8 sq cm. Wound Edges: Sutured, Peri-wound: Edema, Fragile Exudate: Moderate amount of Serosanguineous Wound Pain at Rest: 2

Wound 2: Location: Left medial ankle Primary Etiology: Skin Tear/Laceration s/p suture repair Wound Status: Present on Admission Odor Post Cleansing: None Size: 4 cm x 5 cm x 0.1 cm. Calculated area is 20 sq cm. Wound Edges: Sutured Peri wound: Edema, Fragile Exudate: Moderate amount of Serosanguineous Wound Pain at Rest: 2

Wound 3: Location: Left dorsal foot Primary Etiology: Skin Tear/ Laceration s/p suture repair Wound Status: Present on Admission Odor Post Cleansing: None Size: 5 cm x 6 cm x 0.1 cm. Calculated area is 30 sq cm. Wound Edges: Sutured Peri wound: Fragile, Edema Exudate: Moderate amount of Serosanguineous Wound Pain at Rest: 2

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Wound 4: Location: Right posterior lower leg Primary Etiology: Lymphatic Stage/Severity: Full Thickness Wound Status: Present on Admission Odor Post Cleansing: None Size: 4 cm x 8 cm x 0.2 cm. Calculated area is 32 sq cm. Wound Base: 0% epithelial, 100% granulation, 0% slough, 0% eschar Exposed Tissues: Subcutaneous Wound Edges: Attached Peri wound: Fragile, Erythema exudate: Moderate amount of Serous drainage. PLAN: Wound # 1 Left anterior lower leg Skin Tear/Laceration Treatment Recommendations:1. Betadine. 2. apply Bacitracin ointment to base of the wound. 3. secure with ABD, Rolled gauze. 4. change Daily. Wound # 2 Left medial ankle Skin Tear/ Laceration Treatment Recommendations:1. Betadine. 2. apply Bacitracin ointment to base of the wound.3. secure with ABD, Rolled gauze. 4. change Daily. Wound # 3 Left dorsal foot Skin Tear/Laceration Treatment Recommendations:1. Betadine .2. apply Bacitracin ointment to base of the wound.3. secure with ABD, Rolled gauze 4. change Daily. Wound # 4 Right posterior lower leg Lymphatic Treatment Recommendations:1. Cleanse with wound cleanser .2. apply Triamcinolone ointment to peri wound-cover open ulcerations with silver alginate to base of the wound.3. secure with ABD, Rolled gauze 4. change Every other day. A review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) revealed that wound care orders were not transcribed to the TAR until 5/3/24 and were subsequently not signed off as being administered at any point during the admission. Resident #172 subsequently was seen by the wound doctor again on 5/6/24, excerpts from the wound doctor are as follows: WOUND ASSESSMENT: Wound: 1 Location: Left anterior lower leg Primary Etiology: Skin Tear/Laceration Stage/Severity: s/p suture repair Wound Status: Stable Odor Post Cleansing: None Size: 8.9 cm x 2 cm x 0.1 cm. Calculated area is 17.8 sq.cm. Wound Edges: Sutured Peri wound: Edema, Fragile Exudate: Moderate amount of Serosanguineous Wound Pain at Rest: 2 Wound: 2 Location: Left medial ankle Primary Etiology: Skin Tear/Laceration Stage/Severity: s/p suture repair Wound Status: Worsening Odor Post Cleansing: None Size: 4 cm x 5 cm x 0.1 cm. Calculated area is 20 sq cm. Exposed Tissues: Epithelium Wound Edges: Sutured Peri wound: Edema, Fragile Exudate: Moderate amount of Seropurulent Wound Pain at Rest: 2 Wound: 3 Location: Left dorsal foot Primary Etiology: Skin Tear/Laceration Stage/Severity: s/p suture repair Wound Status: Worsening Odor Post Cleansing: None Size: 5 cm x 6 cm x 0.1 cm. Calculated area is 30 sq cm. Wound Edges: Sutured, Unattached Peri wound: Fragile, Edema Exudate: Moderate amount of Seropurulent Wound Pain at Rest: 2 Wound: 4 Location: Right posterior lower leg Primary Etiology: Lymphatic Stage/Severity: Full Thickness (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 0684

Level of Harm - Actual harm

Residents Affected - Few

Wound Status: Improving without complications Odor Post Cleansing: None Size: 4 cm x 8 cm x 0.2 cm. Calculated area is 32 sq cm. Wound Edges: Attached Peri wound: Fragile, Erythema Exudate: Moderate amount of Serous Wound Pain at Rest: 2

ASSESSMENT:

Non-pressure chronic ulcer of unspecified part of the right lower leg with unspecified severity Hereditary lymphedema.

Car driver injured in collision with other nonmotor vehicle in nontraffic accident, subsequent encounter.

Laceration without foreign body, left ankle, subsequent encounter.

Laceration without foreign body, left foot, subsequent encounter.

Laceration without foreign body, left lower leg, subsequent encounter.

5/6/24: Left dorsal foot and left medial ankle wounds have worsened with moderate seropurulent drainage noted. Sutures dehisced with slough noted. Spoke with facility provider with recommendations to send him to the Emergency Department (ED) for evaluation of infection. He is diabetic and has lymphedema and is at an increased risk for wound complications to his feet.

A review of the hospital record dated 5/6/24 revealed that Resident #172 was seen in the ED and was subsequently admitted to the hospital with a diagnosis of infected wounds.

On 6/13/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

40711

2. For Resident #27 the facility staff failed to follow physicians orders by not ensuring Resident #27 received her necessary wound care treatments. Resident #27 was originally admitted to the facility 11/18/21 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included Pressure Ulcer of the Right Ankle and Peripheral Vascular Disease.

The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/05/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #27 cognitive abilities for daily decision making were intact.

In sectionGG(Functional Abilities Goal) Requires set up and or clean up assistance with eating, oral hygiene and personal hygiene. Requiring substantial/maximal assistance with toileting hygiene and lower body dressing. In Section M (Skin Conditions) Resident is coded as being at risk for Pressure Ulcers. Resident is coded as not having any unhealed Pressure Ulcers. Resident is coded as having 3 Venous and Arterial Ulcers.

(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 0684 Level of Harm - Actual harm Residents Affected - Few	The Care Plan dated 11/22/22 and revised on 7/23/23 read that Resident #27 was at risk for pressure ulcers related to weakness, impaired mobility and incontinence, right hemiparesis status post (s/p) Cerebral Vascular Accident (CVA). The Goal for Resident #27 is that the resident will not have a skin impairment thru the review period, assess resident for risk of skin breakdown, assist the resident to turn and reposition often, keep skin clean and dry as possible. The Medication Administration Record (MAR) for May and June 2024: Solosite Wound Gel External Gel (Wound Dressings) Apply to buttocks, R lateral ankle topically every night shift every other day for Stage 4 pressure ulcer -Order Date 05/21/2024 9:41 AM -D/C Date 06/06/2024 10:24 AM. Missed treatment on 6/04/24. WOUND CARE: Buttocks, right lateral ankle: Cleanse and pat dry. Apply scant amount of Solosite to wound and cover with foam dressing. Change Q2 days or PRN for soiling. every night shift every other day -Order Date 05/21/2024 9:38 AM -D/C Date 06/06/2024 10:18 AM. Missed treatment on 6/04/24. WOUND CARE: Please apply betadine-soaked gauze, 4x4s, Kerlix, and a light ACE bandage to right foot every other day every night shift every other day -Order Date 05/21/2024 9:47 AM -D/C Date 06/06/2024 10:13 AM. Missed Treatment on 6/04/24. LEFT BUTTOCK: Cleanse with wound cleanser, pat dry, apply hydrogel, cover with bordered gauze. every night shift for pressure stage 3 wound -Order Date 05/09/2024 1315 -D/C Date 05/21/2024 0923. Missed treatments: 5/10/24, 5/12/24, 5/15/24, 5/16/24. Right Lateral ankle: Cleanse with normal saline, Pat dry, skin prep to surrounding tissue, Manuka HD alginate, Honey fiber to wound bed, Bordered foam, NO ACE BANDAGE OR KERLIX NO COMPRESSION OF ANY KIND one time a day for WOUND -Order Date 02/27/2024 4:30 PM. -D/C Date 05/21/2024 9:22 AM. Missed Treatments: 5/01/24, 5/02/24, 5/08/24. On 6/11/24 at approximately 2:55 PM., an interview was conducted with the Director of Nursing (DON) concerning skin assessments and missed wound care treatments. The DON said that it is expected that the nurses perform skin assessments and carry out wound care treatments on their residents. The DON also mentioned that if the CNAs notice any new areas on the residents' skin they would inform the nurse. On 6/12/24 at approximately 11:00 AM., an interview was conducted with Certified Nursing Assistant (CNA #6) concerning Resident #27. CNA #6 said that the resident didn't have any skin issues in January. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/12/24 at approximately 1:35 pm., an interview was conducted with the Wound Care Nurse Practitioner (WCNP). The WCNP said that she was not aware of any missed wound care treatments. On 06/13/24 at approximately 2:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observations, family interview, staff interviews, clinical record review, and facility document review, the facility staff failed to prevent, identify, assess and treat pressure sores for one (1) resident (Residents #165) resulting in harm in a survey sample of 62 Residents. The findings included: Resident #165's unstageable pressure wounds were never identified by the facility. No measurements nor descriptions of the wounds were ever placed in the clinical record by nursing staff. The 4-13-21 identification of multiple unstageable pressure wounds occurred at an outside orthopedics appointment and was not treated until the Resident was seen by the wound NP on 4-16-21, 3 days after identification. This was identified as harm. Resident #165 was admitted to the facility on [DATE] and discharged on [DATE] (29 days later) with diagnoses including; Diabetes type 2, acute hip fracture with surgical repair, Foley (brand name) urinary catheter placement after hip fracture, and congestive obstructive pulmonary disorder (COPD). Resident #165's most recent MDS (Minimum Data Set Assessment) was an admission assessment. The MDS coded Resident #165 as needing extensive to total staff assistance with toileting, hygiene, and bathing. The resident was also coded as alert and able to make needs known, with some confusion at times. The Resident was coded as frequently incontinent of bowel and a Foley catheter for the bladder. The resident was no longer in the facility and a closed record review was conducted. The resident had no pressure wounds upon admission. Physician orders were reviewed and revealed that on 3-23-21 after admission the Resident was receiving an Allevyn cushion dressing to the sacrum from the hospital every day for protection, and skin prep wipes to heels every shift for protection before the development of the pressure sores. This indicated that the facility staff were aware of the risk potential for skin breakdown for Resident #165. No other preventive measures were put in place for the immobile resident with a surgical repair for her fractured hip which increased the likelihood of skin impairment. Resident #165's Activity of daily living sheets documented the incontinence/hygiene, and bathing care provided for the resident. A review of those documents revealed that during the month of April 2021 personal hygiene was not given for the following dates and shifts; On 4-9-21 and 4-14-21, (7 am to 3 pm) day shift staff documented extensive assistance from 1 staff member required by the Resident for personal hygiene care. No other day shifts were documented as hygiene care having been given on this 8-hour shift during the 20 days (18 days missed) from 4-1-21 through discharge on 4-20-21. On 4-1-21, 4-2-21, 4-4-21, 4-5-21, 4-13-21, 4-14-21, 4-16-21, and 4-19-21, (3 pm to 11 pm) evening shift staff documented total dependence from 1 staff member required by the resident for personal hygiene care. No other evening shifts were documented as hygiene care having been given on this 8-hour shift during the 20 days (12 evenings missed) from 4-1-21 through discharge on 4-20-21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Bathing care was documented as being planned for Monday, Wednesday, Friday 7 am to 3 pm shift (day shift). Those baths did not occur on 4-2-21, 4-5-21, 4-12-21, and 4-19-21, and the Resident was documented as completely dependent on one staff member for bathing. 8 opportunities for baths were planned from 4-1-21. through 4-20-21, and only 4 were given. Review of Resident #165's physician and nursing progress notes were reviewed and revealed a resident who was total care. The notes indicated that on 4-13-21 the resident went out of the facility for an Orthopedic appointment and returned to the facility later in the afternoon. In the nursing progress notes, on 4-13-21 at 3:15 pm, the nurse documented that the resident returned from her Orthopedic follow-up appointment with new orders and that a dressing change was provided to the resident's sacrum and heels, with some discomfort noted to sites. Will continue to monitor. Which indicated that the nursing staff was aware of the wounds. An interview was conducted with the family which revealed that they were present when the pressure sores on the sacrum and heels were identified for the resident at the Orthopedic appointment, and the information was communicated to the staff upon the resident's return to the facility. This indicated that the unstageable pressure sore of the sacrum was known by the staff on 4-13-21, and a skin assessment was partially completed by the nursing staff on that day which documented the unstageable sacral wound. Weekly skin Evaluation documents were reviewed and revealed that 4 existed in the clinical record. None were complete. Those were as follows: 1. 3-30-21 first weekly assessment skin intact without impairment. 2. 4-6-21 second weekly assessment skin intact without impairment. 3. 4-13-21 third weekly assessment site sacrum pressure 2.5 long, 2.0 wide unstageable, right heel pressure 2.2 long, 2.1 wide suspected deep tissue injury, left heel pressure 3.0 long, 2.5 wide suspected deep tissue injury. No further documentation nor description was given, and it is unknown if these measurements were centimeters or inches. 4. 4-20-21 fourth weekly assessment documented site left gluteal fold pressure, sacrum pressure. No measurements nor description were noted, however, the resident now had a new pressure ulcer added to the document on her left gluteal fold/ischium, and the bilateral heels were not mentioned. The pressure wound found on the right lateral leg was never mentioned. It is referred to later in the body of this investigation. The physician's progress notes and physician's order review further revealed that no orders nor indications that the facility doctor was ever made aware of the unstageable pressure sores on 4-13-21. Not until 4-16-21 (3 days later) did a progress note appear from the wound specialist practice. On 4-16-21 a wound Advanced Registered Nurse Practitioner (wound NP) completed an assessment and issued new orders after being made aware of the identification of the unstageable pressure sores identified on 4-13-21 at the Orthopedic doctor's appointment. The orders were as follows: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Ordered 4-16-21- (7 items) 1. Prostat 30 milliliters (ml) two times per day supplement. 2. Use pillows and wedges to keep the patient off of the backside at all times to decrease pressure and aid in healing. 3. Prevalon boots to bilateral heels at all times except when performing morning care. 4. Right ischial ulcer clean with dermal wound cleaner, apply thin duoderm to area change Monday, Wednesday, and Friday and as needed if it comes off, keep covered at all times. 5. Sacrum cleanse with dermal wound cleanser apply santyl nickel thick to gauze that is moistened with microcyn hydrogel cover with allevyn life sacral dressing change twice per day and as needed for incontinence episodes. 6. X-ray of sacral ulcer to assess bone condition. 7. Place on group 2 low air loss mattress for an unstageable ulcer to sacrum and left ischium. Ordered 4-17-21- (1 item) 1. Left heel deep tissue injury skin prep every other day and cover with allevyn life heel foam to help aid in pressure reduction, Ordered 4-19-21- (1 item) 1. Right lateral leg cleanse with dermal wound cleanser apply iodosorb gel cover with allevyn life foam to help with pressure reduction change on Monday, Wednesday, and Friday to necrotic wound. It is notable to mention that the right gluteal/Ichium ulcer and right lateral leg ulcers were never mentioned on the weekly skin assessments, and no treatment for the left gluteal/ischium ulcer was ever obtained. The Wound NP's progress note dated 4-16-21 at 2:48 pm included the following: Ulcer to sacral region, wound to right lower extremity, wound to left ischium, skin discoloration (deep tissue injury)to bilateral heels, fall with hip fracture, nonambulatory, deconditioning, .medication currently taking . then listed those medications. The note went on to describe the wounds as follows: Open sacral pressure ulcer unstageable 6 cm long, 7.5 centimeters (cm) wide, 0.1 cm deep, no granulation tissue, 100% black necrotic (dead) tissue within the wound bed Open right ischial pressure ulcer unstageable 1.5 cm long, 1.8 cm wide, 0.1 cm deep, no granulation tissue, 100 % yellow necrotic (dead) tissue within the wound bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Open right lateral leg 10 cm long, 2.0 cm wide, 0.1 cm deep, no granulation tissue, 100% black eschar/necrotic (dead) tissue within the wound bed DTI to (deep tissue injury) bilateral heels. The note continued to state that the resident's daughter was called and made aware that the resident may require plastic surgery at some point for the wounds. Resident #165's Treatment Administration Record (TAR) was reviewed and revealed that the physician's orders for wound care treatment were not completed for the following wounds, on the following dates, as listed below: Sacrum - Omitted on 4-11-21, 4-16-21, 4-19-21. Ischium - The order was placed on the TAR, however, never signed as administered. Right lateral Leg - The order was placed on the TAR, however, never signed as administered. Bilateral heels - Omitted on 4-5-21, 4-6-21, 4-11-21, 4-12-21. The facility policies for Skin Assessments, and Wound/Skin Assessments were reviewed and revealed the following: Skin Assessments 1. A licensed nurse will ensure that a skin risk assessment using the Braden Scale is done upon admission, weekly for four weeks, and quarterly thereafter. 4. Care plan-specific interventions will be developed based on skin risk assessment outcomes and individual patient needs. 5. Notify provider with updates and/or changes to skin integrity. 6. Notify responsible party with updates and/or changes to skin integrity.Documented upon admission, weekly, and as needed if the Resident or wound condition deteriorates. Wound/Skin Assessments 1. A licensed nurse will assess patients for any skin impairments, including surgical wounds, vascular wounds/ulcers, pressure ulcers/injuries, skin tears, etc 2. The skin observation tool will be completed by a licensed nurse at least every 7 days, detailing any wound/skin impairments (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

These policy documents that were provided by the facility were accompanied by training materials from the facility's nursing practice standards (Mosby's and NCLEX) used to train nursing staff in the facility on wound care. The documents described current skincare preventative techniques, assessments, other prevention modalities, care planning, wound identification, measuring, and staging standards, treatment of wounds, and required documentation of wounds.

The following elements were notated in the training materials, and accepted as a standard of practice for a complete wound assessment:

a. Type of wound (pressure injury, surgical, etc.) and anatomical location

b. Stage of the wound if pressure injury (stage 1, 2, 3, 4, deep tissue injury, unstageable pressure injury) or the degree of skin loss if non-pressure (partial or full thickness)

c. Measurements: height, width, depth, undermining, tunneling.

d. Description of wound characteristics to include the following:

i. Color of the wound bed

ii. Type of tissue in the wound bed (i.e., granulation, slough, eschar/necrosis, epithelium)

iii. Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated)

iiii. Presence, amount, and characteristics of wound drainage/exudate

v. Presence or absence of odor

vi. Presence or absence of pain, and wound treatments are also to be documented at the time of each treatment.

No Braden scale skin assessment was completed at the time of admission, nor ever during the entire course of the resident's stay. The Resident had no pressure wounds upon admission.

The Resident's care plan was reviewed and indicated the only care plan area mentioning skin was potential for skin impairment related to immobility, catheter. admitted with a non-removable dressing to her left hip. This entry described the fractured hip surgical wound dressing. The interventions were keep skin clean and dry, moisture barrier cream as needed for protection of skin, peri care with incontinence episodes, and weekly skin assessment. The Resident had a Foley catheter, so urinary incontinence was not a complicating factor in wound development.

There was no care plan ever completed for the pressure ulcer wounds that developed on Resident #156's sacrum, ischium, leg, and both heels.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Multiple staff nurses were interviewed by surveyors on two (2) shifts. Those interviews indicated that the nursing staff did not complete wound assessments as reported by all of those interviewed. The nurses stated that they contacted the contracted wound doctor's practice to come in and do the assessments. The nursing staff stated all skin assessments were in the computerized record, and they had no paper assessments. The wound physician was onsite during the survey and was interviewed by surveyors. She stated that no one asked me to teach the nurses how to assess wounds, so I haven't done that. The Director of Nursing (DON) was asked what her expectations was for incontinence rounds and skin breakdown assessment. Her reply was every 2 hours and as often as needed, and skin would be assessed for breakdown during that care. If skin breakdown was found by CNA's (Certified Nursing Assistants), who typically completed incontinence care, they would then immediately report it to the nurse. The nurse would then assess the area, measure it, document a description of it, and seek physician's orders to treat and prevent worsening. The Resident's unstageable pressure wounds were never identified by the facility. No measurements nor descriptions of the wounds were ever placed in the clinical record by nursing staff. The 4-13-21 identification of multiple unstageable pressure wounds occurred at an outside orthopedics appointment and was not treated until the Resident was seen by the wound NP on 4-16-21, 3 days after identification. Resident #165 was not afforded timely bathing, nor hygiene/incontinence care, multiple unstageable pressure sores were not identified by the facility, orders and treatments were delayed, and not administered as per physician's order. No care plan ever existed for the pressure ulcers after they were identified. On 6-7-24 during the end of day meeting the Administrator and Regional Nurse Consultant were made aware of the above findings. The Administrator stated that this happened before her tenure and with a different owner. She stated she had no additional information to provide to the survey team before the survey's exit.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure residents receive sufficient fluid intake to maintain proper hydration, and maintain acceptable parameters of nutritional status, and was offered a therapeutic diet when needed for 2 (R #258 and #13) residents in a survey sample of 62 residents. The findings included: 1. For Resident #258, the facility staff failed to ensure the resident was provided a diet that he could eat to maintain adequate nutritional status. Resident #258 was admitted to the facility on [DATE] with diagnoses that included but were not limited to malnutrition, dementia, weakness, abnormality of gait, and history of falls. On 6/5/24 observation made of Resident #258's lunch tray, resident only ate pudding and applesauce. On 6/6/24 observation of breakfast tray Resident #258 ate only hot cereal. On 6/7/24 at approximately 12:15 PM, an observation was made of Resident #258 in his room with his family at his bedside. An interview was conducted with Resident #258's family member who stated that Resident #258 does not eat much because his has no teeth. The family elaborated by saying he has dentures but does not use them because they do not fit right. A review of Resident #258's tray ticket revealed he was on a regular diet with regular texture and thin liquids. 6/7/24 at 4:00 PM a review of the clinical record revealed the following diet order: 5/25/24 Regular diet, Regular texture, Thin Liquids consistency. A review of the clinical record revealed a Malnutrition Universal Screening Tool (MUST) was completed on 5/30/24 and the results were as follows: Patient: [Name redacted] Category: High Risk (Treat) Description: Admission Score: 2.0 Date: 5/30/2024 11:24 The order was place for Med Pass 90 ml a day for prevention of malnutrition. On 6/10/24 an interview was conducted with the Nutritionist who stated she had not yet seen Resident #258 and was unaware of his edentulous status. She stated that some people do better than others without teeth so she would evaluate him later on that day. A review of the clinical record revealed that on admission Resident #258 weighed 122.2 lbs. On 6/10/24 CNA #'s 1, 5 and 6 accompanied the surveyor to check Resident #258's weight. Resident #258 weighed 116 pounds which was a 5.07 % weight loss since his admission (16 days), this represented a significant weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/10/24 at 1:23 PM Note Text: RD was made aware that rsd (sic) has not been consuming much of his meals. RD visited w/ rsd who appears to have impaired dentition. RD spoke w/ rsd's RP (son) who reports he has been visiting the facility to assist rsd with consuming his meals. Son has noticed rsd has trouble with some of the bread items with his meals. RD asked son if he thinks rsd would benefit from some softer food items to which son stated yes. RD spoke w/ DOR about possible SLP screen r/t most recent BIMS of 7. Will downgrade diet to Dysphagia Advanced and refer to therapy for possible SLP evaluation. Rsd continues on Medplus 2.0 supplement Q Day [every day] for additional nutrition w/ good acceptance per staff. Currently awaiting an updated weight at this time. Will cont. to monitor. On 6/11/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #13, the facility staff failed to ensure sufficient hydration and to honor resident's choice for fluids. On 6/4/24 at approximately 2:00 PM an interview was conducted with Resident #13 who stated What I would like to get is some ice water. I can never seem to get them to keep this cup filled. Resident pointed to large Styrofoam cup on the bedside table. When asked if she tried ringing her call bell she stated, I would if I could reach it, they keep it wrapped around my rail and its above my head out of reach I cannot get to it like that. When asked if she had told the staff that it is a problem when they wrap cords around the rail, she stated that she had told them, but they continued to do it anyway. On 6/4/24 at 11:45 a.m., during initial tour of the facility Resident #8 was interviewed. The resident was sitting in bed consuming lunch and complained to the surveyor, Everything is fine here as long as they fill my water container with ice. I just can't drink it room temperature, and they don't fill it but one time a day some days, that's my only problem. The water pitcher was observed to have no ice in it and held approximately 1 quart of water when full. It was found to be half full of room temperature water. On 6/5/24 at approximately 10:30 a.m., Resident # 13's cup was empty of iced water and once again the call bell was observed to be out of her reach. On 6/6/24 at approximately 3:00 p.m., Resident #13 was out of iced water again and the call bell once again was out of her reach. At 3:05 PM on 6/6/24, an interview was conducted with CNA #3 who was asked why call bells would be wrapped around a bed rail, CNA #3 stated the staff sometimes did this to keep the call bell from falling off of the bed and onto the floor, some residents prefer the call bell to be wrapped around the rail so they can reach it. CNA #3 was asked if a call bell should be in the resident's reach at all times, CNA #3 stated that it should always be in reach of the Resident so in case they have an emergency they can reach the nurse. CNA #3 was then asked to view the call bell in Resident #13's room and see if there was a problem with the resident reaching it. CNA #3 came out of the room and stated it was up too high wrapped around the rail and she could not reach it. CNA #3 stated I fixed it for her know I am going to get her some iced water. On 6/10/24 during the end of day meeting the Administrator was made aware of the concerns and no further information as provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 40026 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility staff failed to perform physician ordered pain assessments, topical and oral medications for 1 of 62 residents (Resident 166), in the survey sample. The findings included: Resident #166 was admitted to the facility with diagnoses that included but were not limited to Fracture of scapula, right shoulder, Osteoporosis, aortic valve disorder, history of falls, malignant neoplasm of upper lobe right bronchus, hypertension, bilateral osteoarthritis of knees, history of venous thrombosis, dementia without dementia without behaviors, and abnormality of gait. Resident #166 admitting orders included the following: Pain Assessment using 0-10 scale or non-verbal scoring tool every shift for Monitor -Order Date- 01/04/2024 - D/C (Discontinued) Date-02/20/2024. Acetaminophen Oral Tablet 500 MG Give 2 tablet by mouth three times a day for Pain -Order Date- 01/04/2024 -D/C Date-01/29/2024. Lidocaine Pain Relief External Patch 4 % Apply to Bilateral Knees topically every 12 hours for Pain -Order Date-01/04/2024 -D/C Date- 01/29/2024 A review of Resident #166's care plan read: FOCUS: The resident has a risk for pain related to gout, arthritis, osteoarthritis, fracture right scapula. Created on: 01/06/2024. GOAL: The residents pain will be resolve thru review period Created on: 01/06/2024 INTERVENTION: Administer medications as ordered Date Initiated: 01/06/2024 Notify MD as indicated Date Initiated: 01/06/2024. Observe for physical indicators of pain Date Initiated: 01/06/2024. A review of the MAR (Medication Administration Record) revealed the following dates and times of missed doses of pain medications and treatments as well as missing pain assessments. Pain Assessment - From admission on 1/4/24 until the discharge on 2/16/24 the following pain assessments were not documented: Day Shift - 1/29, 2/5 Evening Shift - 1/20, 1/25, 1/29, 2/7 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Night Shift - 1/22, 1/26, 2/8, 2/9 Acetaminophen - From admission on 1/4/24 until the order was changed on 1/29/24 the following doses were not documented as given: 6:00 AM - 1/23, 1/27 2:00 PM - 1/28, 1/29 9:00 PM - 1/16, 1/20, 1/22, 1/25 Lidocaine Patches - From admission on 1/4/24 until the order was changed on 1/29/24 the following doses were not documented as given: 9:00 AM - 1/4, 1/23 9:00 PM - 1/16, 1/20, 1/22, 1/24, 1/25 On 6/11/24 an interview was conducted with the DON who was asked what the expectation was if a medication is ordered, she stated, It is expected that the Resident will receive all medications as ordered by the physician. When asked what the nurses responsibility was if a medication dose is missed or not given for any reason, the DON stated, If any medications are not administered for any reason the nurse should notify the physician and the Resident or the RP (Responsible Party). When asked what the importance of notifying the physician would be she stated, In case the physician wants to give a onetime order for another med or to give a one-time order to 'give now' if it is outside of the time frames for administration. On 6/10/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided prior to the survey's exit.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49917 Based on staff interviews, clinical record review, and review of facility documents, the facility staff failed to ensure pharmacist reported irregularities to the attending physician, the facility's medical director and the director of nursing, and were acted upon for four (4) of 62 residents (Resident #11, #172, #4 and #25), in the survey sample. The findings included: 1. The facility staff failed to ensure the physician and/or designee received the recommendations from the pharmacy review dated 4/20/24 for Resident #11. Resident #11 was originally admitted to the facility 4/18/24 after an acute care hospital stay. The current diagnoses included type 2 diabetes mellitus, acute bronchitis, hyperlipidemia, depression, muscle weakness, and unspecified dementia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/24/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 6 out of a possible 15. This indicated Resident #11's cognitive abilities for daily decision making were severely impaired. A review of the Consultant Pharmacist Medication Review for Resident #11 dated 4/20/24 at 7:53 PM read: see report for any noted irregularities and/or recommendations. On 6/10/24 at 3:05 PM an interview was conducted with the Corporate Nurse Consultant. The Corporate Nurse Consultant stated that the facility does not have documentation that the Physician and/or designee received the recommendations from the pharmacy review dated 4/20/24 regarding Resident #11. On 6/13/24 at approximately 2:28 p.m., a final interview was conducted with the Administrator, and two Corporate Nursing Consultant's. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information. 40026 2. For Resident # 172 the facility staff failed to document in the resident's medical record that the identified pharmacy recommendation had been reviewed and any actions taken as a result. On 6/10/24 a review of the clinical record revealed that Resident #172 was admitted to the facility on [DATE] with diagnoses that included but were not limited to diabetes, hereditary lymphedema, non-pressure wound to left leg, MVA (Motor Vehicle Accident) driver resulting in lacerations with sutures to left lower leg and foot, muscle weakness and abnormal gait. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the morning of 6/10/14 a review of the clinical record was conducted, and it was found that during the month of May, a pharmacy drug regimen review was conducted, and it was found that the pharmacist made recommendations for Resident #172's drug regimen. The clinical record only revealed that the pharmacy review was done, and the box was checked to See report for Time Sensitive recommendation. On 6/10/24 at approximately 2:00 PM an interview was conducted with the Regional Nurse Consultant who was asked where to find the recommendations that were addressed by the physician, and she stated if they were not in the record, she would have to pull them from the website. On 6/10/24 at 3:10 PM the Clinical Nurse Consultant came back to submit the pharmacy reviews and stated, I will not waste any more of your time, the consults have not been addressed, and I have given them to the Nurse Practitioner to address at this time. Resident #172 was discharged from this facility and the Time Sensitive recommendations were not addressed during his stay. On 6/10/24, during the end of day meeting, the Administrator was made aware of the concerns and no further information was provided prior to the survey's exit. 31199 3. For Resident #4, the facility staff failed to respond and act on the Pharmacy Consultant recommendations identified on Monthly Medication Reviews. Resident #4 was admitted to the facility on [DATE] and was a bed bound Resident with multiple medications. The Resident was cognitively impaired and was fully dependant on staff for all activities of daily living such as hygiene, dressing and eating. On 6-6-24 the Resident's clinical record was reviewed. The review revealed that on 4-8-24, Resident #4's medication regimen was reviewed by the Registered Pharmacist (RPH), and the pharmacy consultant (RPH) documented in the clinical record See report for noted irregularities and/or recommendations. The report could not be found. On 6-6-24, The Director of Nursing (DON) and Administrator were asked to supply the report. They responded an hour later and stated they could not locate the report which denoted irregularities. On 6-6-24, an interview was conducted with the Pharmacy (RPH) (Corporate #3). She stated that she and her colleague did perform monthly medication reviews. She went on to describe that those reviews were completed electronically and uploaded to a web site (name given) where the facility would go in and retrieve the reports and recommendations monthly. She stated that only the DON (Director of Nursing) and Administrator had password access credentials to get into the information. She further stated that the Medical Director for this facility did not have access granted and the Administrator or DON would have to print the report and give it to him to act upon. Both the Administrator and DON stated they had not done that, and so none of the reports nor recommendations had been reviewed nor acted upon by the doctor for approximately 3 months or longer. Review of the clinical record revealed no documentation of the Physician's response to the recommendations. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6-6-24, and 6-7-24 the Administrator and DON were made aware of the non-compliance, and they stated the incident would be rectified immediately. 4. For Resident #25, the facility staff failed to respond and act on the Pharmacy Consultant recommendations identified on Monthly Medication Reviews. Resident #25 was admitted to the facility on [DATE]. The Resident was a recent leg amputee with confusion and psychiatric illness. The Resident was cognitively impaired and was extensively dependant on staff for all activities of daily living such as hygiene, dressing and eating. On 6-6-24 the Resident's clinical record was reviewed. The review revealed that on 4-27-24, Resident #4's medication regimen was reviewed by the Registered Pharmacist (RPH), and the pharmacy consultant (RPH) documented in the clinical record See report for noted irregularities and/or recommendations. The report could not be found. On 6-6-24, The Director of Nursing (DON) and Administrator were asked to supply the report. They responded an hour later and stated they could not locate the report which denoted irregularities. On 6-6-24, an interview was conducted with the Pharmacy (RPH) (Corporate #3). She stated that she and her colleague did perform monthly medication reviews. She went on to describe that those reviews were completed electronically and uploaded to a web site (name given) where the facility would go in and retrieve the reports and recommendations monthly. She stated that only the DON (Director of Nursing) and Administrator had password access credentials to get into the information. She further stated that the Medical Director for this facility did not have access granted and the Administrator or DON would have to print the report and give it to him to act upon. Both the Administrator and DON stated they had not done that, and so none of the reports nor recommendations had been reviewed nor acted upon by the doctor for approximately 3 months or longer. Review of the clinical record revealed no documentation of the Physician's response to the recommendations. On 6-6-24, and 6-7-24 the Administrator and DON were made aware of the non-compliance, and they stated the incident would be rectified immediately.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to prevent significant medication errors for five (5) Residents (Residents #45, #49, #23, #166 and #358) in a survey sample of 62 residents. The findings included: 1. For Resident #45, the facility staff failed to administer Eliquis anticoagulant medication after a bilateral lung pulmonary embolus (blood clot) diagnosis in the hospital with a specialist doctor's ordered dose Resident #45, was initially admitted to the facility on [DATE], with diagnoses including; Hypothyroidism, ileus, Artial fibrillation, weakness, falls, gluten intolerance, and obesity. The Resident was discharged on [DATE] back to the emergency room for fever, body ache and change in level of consciousness. The Resident was readmitted on [DATE] after the inpatient hospitalization for bilateral pulmonary embolus (lung blood clots), bilateral pneumonia with sepsis, metabolic encephalopathy, and protein calorie malnutrition. Resident #45's most recent MDS (minimum data set) coded the Resident as having moderate cognitive impairment. Resident #45 was also coded as requiring extensive dependence on one staff member to perform activities of daily living, such as hygiene, transferring, and bed mobility. The Resident's physician orders from the hospital were reviewed and revealed 2 orders for an anticoagulant. The orders were for the following; 1. 3-23-24 Apixaban (Eliquis) 5 mg (milligram) tablets take 2 tablets by mouth twice (20 mg per day) daily for 12 doses (6 days). Dispense 24 tablets. The original 10 mg dose ordered twice daily for 12 doses (6 days) was only given for 3 days on 3-25-24, 3-26-24, and 3-27-24. The Resident only received once daily 10 mg evening doses on 3-24-24, 3-28-24, and 3-29-24, for a half dose each day. The other 10 mg evening doses were omitted. 2. 3-23-24 Apixaban (Eliquis) 5 mg tablets start 3-29-24 take 1 tablet by mouth twice (10 mg per day) daily for 90 days. Dispense 60 tablets with 2 refills. The Medication and Treatment Administration Records (MAR/TAR) was reviewed for March, April, may, and June 2024, and revealed the absence of nursing signatures on multiple occasions. Those follow; 9:00 am dose - 4-14-24, 4-21-24, 4-25-24. 6:00 pm dose - 3-23-24, 3-24-24, 3-28-24, 3-29-24, 4-7-24, 4-17-24, 6-1-24, and 6-3-24. Nursing medication administration notes do not indicate why the medications were not administered as ordered, and why they were omitted. (continued on next page)

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Guidance for the administration of anticoagulant medication is given by The National Institutes of Health (NIH), and is as follows;

National Institutes of Health & Medline.gov;

Anticoagulant medication must be given as per a doctor's order and on the schedule indicated. If a dose is missed the doctor must be notified. Do not miss doses. Do not discontinue this medication without seeking a doctor's help. Stopping Anticoagulants increases the likelihood of blood clot formation which can be life threatening, to include stroke, heart attack and pulmonary emboli.

Resident #45's care plan was reviewed and revealed no care plan revision for anticoagulant drug use for pulmonary embolus, nor assessments for potential bleeding.

Nursing and physician progress notes were reviewed, and revealed no notes documenting that the medication had been unavailable, omitted, nor that the doctor was made aware of the omissions.

Interviews conducted from 6-5-24 through 6-12-24 with nursing staff on separate halls and shift revealed that the expectation for all medications is that they are available and administered per physician's order. They were in agreement that if there was a hole (no signature), or a 9 or a 5 on the medication administration record (MAR), that the medication was not administered. Nursing staff further agreed that administering anticoagulants was to decrease the possibility of blood clots which caused strokes and heart attacks.

On 6-7-24, and 6-10-24, the DON (director of nursing) and Administrator were interviewed in the conference room and stated that they had been unaware that medications had not been given, and that the doctor and family were not notified of medications being omitted by staff. The DON was a new staff member and had recently been hired.

On 6-12-24 at approximately 1:30 p.m., at the end of day debrief, the Administrator and DON were again made aware of the failure of staff to prevent significant medication errors in omitted medications as ordered. No further information was provided.

2. For Resident # 49, Facility staff failed to Administer Lovenox (anticoagulant) and Keflex (antibiotic) medication.

Resident #49, was admitted to the facility on [DATE], and discharged to the emergency room with an infected wound on 4-19-24. The Resident returned on 4-24-24. Diagnoses included; After care following hip fracture, alzheimers disease, stage 4 sacral pressure sore, hypertension, hypothyroid, stroke, malnutrition, aphasia, dysphagia, and aspiration pneumonia.

Resident #49 was a bed bound patient with severe cognitive impairment. Resident #49 was documented as being totally dependant on staff for all activities of daily living such as hygiene, transferring, and bed mobility. The Resident was incontinent of bowel and bladder.

The Resident's physician orders were reviewed and revealed orders for anticoagulants and antibiotics. The orders were for the following;

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Ordered 4-24-24 at 2:59 pm, Lovenox inject 0.4 milliliters subcutaneously one time per day for 20 days. 2. Ordered 5-13-24 at 9:43 am, Cephalexin/Keflex 500 milligrams tablet every 12 hours at 9:00 am, and 9:00 pm, for urinary tract infection for 8 administrations. The Medication and Treatment Administration Record (MAR/TAR) was reviewed for April and May of 2024 2024, and revealed the absence of nursing signatures on some occasions, and a signature with the number 5 added to it indicating the medications were not administered. Those follow; Lovenox not administered; 4-25-24, 4-26-24, 5-13-24, 5-14-24, 5-15-24, at which time it was discontinued with only 17 doses given omitting 3 doses. Keflex not administered: 5-15-24 at 9:00 am, and it was discontinued on 9-17-24 after the 9:00 am dose having administered 7 of 8 doses. Nursing medication administration notes do not indicate why the Lovenox and Keflex were not administered as ordered, and why they were omitted. Guidance for the administration of Antibiotics and Anticoagulants is given by The National Institutes of Health (NIH), and is as follows; National Institutes of Health & Medline.gov; Antibiotics must be given as per a doctor's order and on the schedule indicated. If a dose is missed the doctor must be notified. Do not miss doses. Do not discontinue this medication without seeking a doctor's help. Stopping Antibiotics increases the likelihood of MDRO's (multi drug resistant organisms) such as Methycillin Resistant Staphyloccocus Aureus (MRSA), and can result in rebound infections which can be life threatening. National Institutes of Health & Medline.gov; Anticoagulant medication must be given as per a doctor's order and on the schedule indicated. If a dose is missed the doctor must be notified. Do not miss doses. Do not discontinue this medication without seeking a doctor's help. Stopping Anticoagulants increases the likelihood of blood clot formation which can be life threatening, to include stroke, heart attack and pulmonary emboli. Resident #49's care plan was reviewed and revealed a care plan for Anticoagulant medications, however, it was not revised to include a care plan for urinary tract infections and antibiotic use. Nursing and physician progress notes were reviewed, and revealed no notes documenting that the medication had been unavailable, omitted, nor that the doctor was made aware of the omissions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews conducted from 6-5-24 through 6-12-24 with nursing staff on separate halls and shift revealed that the expectation for all medications is that they are available and administered per physician's order. They were in agreement that if there was a hole (no signature), or a 9 or a 5 on the medication administration record (MAR), that the medication was not administered. Nursing staff further agreed that administering anticoagulants was to decrease the possibility of blood clots which caused strokes and heart attacks, and withholding antibiotics could cause a rebound infection. On 6-7-24, and 6-10-24, the DON (director of nursing) and Administrator were interviewed in the conference room and stated that they had been unaware that medications had not been given, and that the doctor and family were not notified of medications being omitted by staff. The DON was a new staff member and had recently been hired. On 6-12-24 at approximately 1:30 p.m., at the end of day debrief, the Administrator and DON were again made aware of the failure of staff to ensure medication administration per physician's orders. No further information was provided. 40026 3. For Resident # 23 the facility staff held medications without a physician order and or notification to the physician. Resident #23 was readmitted to the facility on [DATE] with diagnoses that include but are not limited to hypertension, Paroxysmal Atrial Fibrillation, adult failure to thrive, history of Malignant Neoplasm of Prostate Protein -Calorie malnutrition, chronic respiratory failure with hypoxia, dependence on enabling machines or devices and dysphagia. On 6/10/24 a review of the clinical record revealed that Resident #23 had the following orders for blood pressure medications. Atenolol Oral Tablet 50 MG (Atenolol) Give 1 tablet by mouth one time a day for htn -Order Date- 05/07/2024. Diltiazem HCl Oral Tablet 60 MG Give 1 tablet by mouth three times a day for htn -Order Date- 05/07/2024. The medications were being coded as #4 Outside parameters or #9 see progress notes. A review of the progress notes revealed that the Nurses were entering a note that states the medication was held due to low bp, however no documentation was found to support holding the blood pressure medication as the order does not specify parameters. On 6/11/24 at approximately 4 PM an interview was conducted with the NP who stated that she 6/8/24 not given coded as #4 - Outside of parameters. Diltiazem was coded as not given on 5/8, 5/12, 5/21, 6/3 and 6/10/24 at 6 AM and on 5/12/24 at 2 PM and on 5/22, 5/28, 5/30, at 10 PM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the morning of 6/11/24 an interview was conducted with the DON who stated that nurses can hold medications for Nursing Judgement if a blood pressure reading is too low, however, they should be making the physician aware the Resident or Resident Family, and documenting in the nursing notes everything that was done and what the physician response was. On the afternoon of 6/11/24 an interview was conducted with the NP (Nurse Practitioner) who was asked if she was aware of Resident #23's blood pressure medications being held per Nursing Judgement for low blood pressure, the NP stated, I understand they can hold it for nursing judgement but then someone should have notified me so that I can put parameters in place so they know when I consider it too low to give. On 6/11/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 4. For Resident # 166 the facility staff failed to administer anti-coagulant, and anti-hypertensive medications as ordered by physician. Resident #166 was admitted to the facility with diagnoses that included but were not limited to Fracture of scapula, right shoulder, Osteoporosis, aortic valve disorder, history of falls, malignant neoplasm of upper lobe right bronchus, hypertension, bilateral osteoarthritis of knees, history of venous thrombosis, dementia without dementia without behaviors, and abnormality of gait. On 6/6/24 a review of the clinical record revealed that Resident #166 had orders that included: Cozaar Oral Tablet 50 MG Give 50 mg by mouth one time a day for Hypertension. This medication was not given on 1/5/24. Eliquis Oral Tablet 2.5 MG Give 2.5 mg by mouth two times a day for History of DVT [Deep Vein Thrombosis]. This medication was not administered on 1/16/24, 1/20/24, 1/22/24, or 1/25/25 at 9 pm. On 6/11/24 an interview was conducted with the DON who was asked what the expectation is if a medication is ordered, she stated it is expected that the Resident will receive all medications as ordered by the physician. When asked what the nurses responsibility is if a medication dose is missed or not given for any reason, the DON stated that if any medications are not administered for any reason the nurse should notify the physician and the Resident or the RP (Responsible Party). When asked what the importance of notifying the physician would be she stated, In case the physician wants to give a onetime order for another med or to give a one-time order to 'give now' if it is outside of the time frames for administration. A review of the clinical record revealed no adverse outcomes as a result of the missing medications; however, the physician and RP were not documented as being notified. On 6/10/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 49455 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bayside Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1004 Independence Blvd Virginia Beach, VA 23455	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Resident #358 was admitted to the facility on [DATE], status post left knee revision from an acute care hospital. Diagnoses for Resident #358 included but were not limited to hypertension, hypercholesterolemia, left knee revision, and left knee infection. Resident #358 order summary dated 5/22/24 has intravenous (IV) Vancocin (vancomycin) ordered daily until 6/29/24 for a left knee infection. A review of Resident #358 clinical records indicated that due to lack of access or not having vancomycin available, the resident missed doses on June 1,2,6, of 2024. Review of the facility policy, General guidelines for medication administration by Pharmascript effective 9/2018 and revised 8/2020 .Medications are administered in accordance with written orders of the prescriber . The above findings were shared with the Administrator, Corporate Nurse #1, and Corporate Nurse #2 on 6/13/2024 at approximately 11:45 AM. No further information was provided prior to the conclusion of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on observations, resident interview, staff interview and clinical record review, the facility staff failed to ensure medications were stored properly in the refrigerator and on the medication carts. The findings included: 1. On 6/10/24 at approximately 12:40 PM the medication storage task was completed with Licensed Practical Nurse (LPN) #2. In the refrigerator in the medication room along with medication to be administered was an opened vial of purified protein derivative (PPD), which was absent of the date it was opened. There were also four single dose COVID-19 vaccines with expiration dates of April 2024. 2. Also on 6/10/24 at approximately 1:07 PM the medication cart that serviced Hall #3 was inspected with LPN #6. In the medication cart were three opened bottles of Latanoprost ophthalmic drops for Resident #50. The oldest bottle was dated 4/23/24, another 5/11/24 and 5/24/24. LPN #6 left the cart and Registered Nurse (RN) #2 completed the inspection. RN #2 stated that Latanoprost ophthalmic drops could be used for six weeks after they were opened and after six weeks it is recommended to discard the drops, even if there were some still left inside the bottle. That meant that the 4/23/24 bottle of Latanoprost ophthalmic drops should have been discarded on 6/4/24 if they were opened on 4/23/24. On 6/13/24 at approximately 12:00 P.M., a final interview was conducted with the Administrator, and two Corporate Nurse Consultants regarding the above findings. They voiced no concerns regarding the above information. 34894 3. For Resident # 5, the facility staff failed to store eye drops in the medication cart. The resident was allowed to keep them at the bedside. Resident # 5 was admitted to the facility on [DATE] with diagnoses including but not limited to: Type 2 Diabetes, Chronic Kidney Disease, Glaucoma, hypertension, Osteomyelitis and depression. Resident # 5's MDS review included the MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 4/22/2024 which was a quarterly assessment. The MDS coded Resident # 5 as requiring extensive assistance from one to two staff members with bed mobility, dressing, toileting, hygiene, and bathing. The Resident was also coded as 14 of 15 possible points on a brief interview for mental status (BIMS), indicating no cognitive impairment. The Resident was coded as always incontinent of bladder and frequently incontinent bowel. Review of the clinical record was conducted 6/4/2024-6/7/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/2024 at 9:30 a.m., a plastic prescription bag with an affixed label Bremonidine 0.2 % eye gtts (drops) was noted on Resident # 5's overbed table. Resident # 5 stated she kept the eye drops at her bedside because the staff members kept losing her eye drops. Resident # 5 stated that she was diagnosed with glaucoma and she was very concerned about not getting the eye drops on time. Resident # 5 stated she would give the eye drops to the nurses when it was time to administer them. On 6/5/2024 at 10:05 a.m., the bag with the eye drops was still on the overbed table. On 6/5/2024 at 10:20 a.m., the eye drops were still on the overbed table. On 6/5/2024 at 10:30 a.m., an interview was conducted in the conference room with the Director of Nursing and Corporate Nurse Consultant. Both stated that medications should not be kept at the bedside without the resident being assessed for self administration of medications. Both stated that medications should be kept on the medication cart until time for administration. Review of the clinical record revealed an order for Bremonidine 0.2 % eye gtts instill one drop in both eyes Brimonidine Tartrate Solution 0.2 %- Instill 1 drop in both eyes two times a day for glaucoma -Order Date 07/29/2022 1253 There was no documentation of eye drops being administered on 4/21/2024 at 9 a.m. and 4/30/2024 at 5 p. m. Review of the physicians orders revealed no orders for the medication to be left at the bedside. During the end of day debriefing, the Administrator and Corporate Nurse Consultant were informed of the findings. They were asked to provide any information about eye drops not being administered by nurses due to the medication not being available. No further information was provided.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34894 Based on observation, resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure one Resident (Resident # 5) received routine and emergency dental care. The Findings included: For Resident # 5, the facility staff failed to schedule routine and emergency dental care appointments. Resident # 5 was admitted to the facility on [DATE] with diagnoses including but not limited to: Type 2 Diabetes, Chronic Kidney Disease, Glaucoma, hypertension, Osteomyelitis and depression. Resident # 5's MDS review included the MDS (Minimum Data Set Assessment) with an ARD (Assessment Reference Date) of 4/22/2024 which was a quarterly assessment. The MDS coded Resident # 5 as requiring extensive assistance from one to two staff members with bed mobility, dressing, toileting, hygiene, and bathing. The Resident was also coded as 14 of 15 possible points on a brief interview for mental status (BIMS), indicating no cognitive impairment. The Resident was coded as always incontinent of bladder and frequently incontinent bowel. Review of the clinical record was conducted 6/4/2024-6/7/2024. On initial tour, Resident # 5 was observed sitting up in bed. The lower bottom teeth were in obvious need of repair as evidenced by noticeable dental caries. Resident # 5 stated her teeth hurt. Review of the clinical record was conducted 6/4/2024-6/7/2024. Review of the Progress Notes revealed that Resident # 5 complained of tooth pain several times. Review of the April 2024, May 2024 and June 2024 Medication Administration Records revealed documentation of an order written on 4/25/2024 which stated: DENTIST APT (appointment) - Pt (patient) requesting Dentist apt (appointment), 'teeth are hurting' Please schedule apt. Pt thinks that she goes to Dr. __________(name redacted) office. every shift for Teeth are hurting -Order Date- 04/25/2024 1655 (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were initials on most shifts on the MARs indicating that the task was completed. Review of the Progress Notes revealed no documentation of an appointment with a dentist since the order was written on 4/25/2024. There was documentation on 6/2/2024 on 11-7 shift where a nurse wrote : 06/02/2024 00:58 Type: Orders - Administration Note Note Text : Can not make dental appointment 11-7 on a weekend. On 6/6/2024 at 2:10 p.m., the Administrator and Corporate Nurse Consultant were informed of Resident # 5 complaining of tooth pain and no apparent follow up was noted in the clinical record. Review of the care plan revealed documentation of a problem of oral/dental health problems on admission There were 2 interventions to address the problem and goals: Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions. Provide mouth care as per ADL(Activities of daily living) personal hygiene. There was no mention of referring the resident to the Dentist. There were no noted scheduled dental appointments according to the clinical record. Resident # 5 stated she needed to see the dentist. During the end of day debriefing on 6/6/2024, the facility Administrator and Corporate Nurse Consultant were informed of the findings that Resident # 5 had not received Dental services. On 6/7/2024 at 3:10 p.m., a telephone interview was conducted with the Administrator who stated she did not have any information about any dental visits for Resident # 5. The Administrator stated she would immediately send a copy of the facility's policy on Dental care. The policy was submitted to the surveyor. Review of the policy revealed the following documentation: POLICY In the event a patient is in need of routine or emergency dental services, a licensed nurse will initiate and coordinate the necessary care. Under PROCEDURE was written the following: 1. Nursing will notify the provider and obtain a consult recommendation. 2. Nursing will collaborate with the Social Services Department to identify and secure designated and/or centered contracted community available resources for dental services. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Nursing will, if necessary or if requested, assist the patient in making appointments and/or arranging transportation to and from the dental services location. Also. 5. The Social Services Department will coordinate with the business office to assist the patient for dental service associated payments. Patients who are eligible and wish to participate may apply for reimbursement of dental services under the Medicaid Plan. Further review of the clinical record revealed no documentation that an appointment was made for Resident # 5. No further information was provided.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 49455 Based on staff interviews, facility documentation review, the facility staff failed to ensure all staff received mandatory infection control training. The findings include: Review of the staff training records indicated the following facility staff did not have mandatory infection control training: The Director of Nursing (DON), CNA #8, Others #9, Others #10, Others #11, Others #12, Others #13, and Others #14. The above findings were shared with the Administrator, Corporate Nurse #1, and Corporate Nurse #2 on 6/13/2024 at approximately 11:45 AM. No further information was provided prior to the conclusion of the survey.