STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wayland Nursing and Rehabilitation Center	730 Lunenburg Highw Keysville, VA 23947

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide education and the opportunity to refuse the implementation of psychoactive medications for one of 19 residents in the survey sample, Resident #41. The findings include: For Resident #41 (R41) the facility staff failed to provide education for and the opportunity to refuse the implementation of the use of Risperidone (1) and Sertraline (2). A review of R41's clinical record revealed an order for Risperidone 0.5 mg (milligrams) daily and Sertraline 50 mg daily. A review of R41's MARs (medication administration records) for March and April 2025 revealed these medications were administered as ordered. Further review of the record failed to reveal any evidence that the facility provided the resident (and/or resident representative) education about the risks versus benefits of these medications or offered the opportunity to refuse the administration of these medications. On 4/15/25 at 3:36 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated: We are supposed to get consent and provide education. She stated psychoactive medications carry a specialized risk for side effects which can be pretty bad. On 4/15/25 at 4:00 p.m., ASM #1, the administrator, ASM #2, ASM #3, the facility nurse consultant, and ASM #4, an administrator colleague, were informed of these concerns. A review of the facility policy, Psychotropic Drug Therapy, revealed, in part, The resident has the right to accept or decline the initiation or increase of a psychotropic medication. To demonstrate compliance, the resident's medical record must include documentation that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options, and was able to choose the option he or she preferred. No additional information was provided prior to exit. References (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Risperidone (generic for Risperdal) is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers [AGE] years of age and older. It is also used to treat episodes of mania (frenzied, abnormally excited, or irritated mood) or mixed episodes (symptoms of mania and depression that happen together) in adults and in teenagers and children [AGE] years of age and older with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). Risperidone is also used to treat behavior problems such as aggression, self-injury, and sudden mood changes in teenagers and children 5 to [AGE] years of age who have autism (a condition that causes repetitive behavior, difficulty interacting with others, and problems with communication). Risperidone is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information is taken from the website https://medlineplus.gov/druginfo/meds/a694015.html. (2) Sertraline is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). This information is taken from the website https://medlineplus.gov/druginfo/meds/a697048.html#:~:text=Sertraline%20is%20in%20a%20class,that%20helps%20maintain%20mental%20balance.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to maintain a homelike environment for 1 of 19 residents in the survey sample, Resident #9. The findings include: For Resident #9 (R9), the facility staff failed to maintain the resident's wheelchair cushion in good repair. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/6/25, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. On 4/14/25 at 1:24 p.m., an observation was made of R9 in their room eating lunch. R9 was observed sitting in a manual wheelchair. The black cushion underneath R9 was observed to be torn on both corners exposing the yellow foam underneath. On 4/14/25 at 1:34 p.m., an interview was conducted with R9 who stated that he had the wheelchair cushion for a long time and the holes in the cushion had started very small but had gotten larger over time. He stated that the cushion had lost its padding from age, and he needed a new one, but no one had ever offered one. Additional observation of R9's wheelchair cushion with the tears on both sides exposing the yellow foam underneath was made on 4/15/25 at 8:10 a.m. On 4/15/25 at 12:42 p.m., an interview was conducted with LPN (licensed practical nurse) #1 who stated that if they saw that a residents wheelchair cushion was torn or damaged, they contacted therapy to replace it. She stated that normally it was a conversation with them to replace the cushion. On 4/15/25 at 12:58 p.m., LPN #1 observed R9's wheelchair cushion with the torn areas on both sides exposing the yellow foam underneath and stated that the cushion should be replaced She stated that she would let R9's nurse know so that therapy could order him a replacement. The facility policy titled, Environment and Property dated 8/2019, documented in part, .The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely . On 4/15/25 at 3:59 p.m., ASM #1, (administrator), ASM #2, (director of nursing), ASM #3, (facility nurse consultant) and ASM #4, (administrator colleague from another facility) were made aware of the findings. No further information was presented prior to exit.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For R1, the facility staff failed to evidence required documentation was provided to the receiving facility for a transfer to the hospital on [DATE] and 04/06/2025. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/26/2025, R1 scored an 8 (eight) out of 15 on the BIMS (brief interview for mental status), indicating R1 was moderately impaired of cognition for making daily decisions. The facility's nursing progress noted for R1 dated 02/25/2025 documented, Note Text: Resident complaining that she can't breathe. O2 (oxygen) concentrator, tubing, and all working properly. Nasal spray administered and neb (nebulizer) tx (treatment) given without relief. Md (medical doctor) notified and received order to send to ER (emergency room) for workup. The facility's nursing progress noted for R1 dated 04/06/2025 at 8:00 p.m. documented, Note Text: Writer call to resident room observed resident yelling out, I can`t breathe, Writer observed resident O2 at 4L/M (four liters per minute) intact via (by) nasal canula. Resident observed having difficulty breathing using abdominal muscle. Writer placed POSAT (pulse oximeter) (1) on resident finger an notice her SATS (saturation) was 85 (85 percent). Writer immediately started resident on breathing treatment and notice SATS increase to 90 then went back down to 85. Writer notified (Name of Director of Nursing), DON (director of nursing) as ordered to do so, suggested to writer to contact MD (medical doctor) and see what he advises. The facility's nursing progress noted for R1 dated 04/06/2025 at 8:15 p.m. documented, Note Text: Writer notified (Name of Doctor) and received order to send resident to [NAME] (emergency room department). Writer notified 911 rescue gave report to dispatcher who told me that he has recue in route. Writer notifies (Name of Hospital) [NAME] gave report to (Name of Nurse), RN Registered Nurse). Review of the EHR (electronic health record) failed to evidence documentation of required information provided to the hospital on [DATE] and 04/06/2025 for R1. On 04/15/2025 at approximately 2:55 p.m., an interview was conducted with ASM (administrative staff member) #1, administrator regarding evidence that the required documentation sent to the receiving facility for a resident's transfer. He stated that the nurse's notes document what information is provided to the receiving facility. When asked about the evidence of the documentation that was sent to the hospital on [DATE] and 04/06/2025 for R1's transfer, ASM #1 stated that that there was no evidence of any documentation was sent for the transfers on 02/25/2025 and 04/06/2025 for R1. On 04/15/2025 at approximately 4:05 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, facility nurse consultant and ASM #4, administrator colleague, were made aware of the above findings. No further information was provided prior to exit. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on clinical record review, facility document review, and staff interview, it was determined the facility staff failed to evidence required documents were sent to the receiving facility at the time of a facility-initiated transfer for two of 19 residents in the survey sample, Residents #38 and #1. The findings include: 1. For Resident #38 (R38), the facility staff failed to evidence that clinical documentation pertaining to the continuity of care was sent to the receiving hospital on 2/2/25 for a facility-initiated transfer. The progress notes for R38 documented in part, - 02/02/2025 14:02 (2:02 p.m.) Note Text: Resident reassessed for temp, increased to 103.7 after Tylenol administered. VS (vital signs) obtained and relayed to MD. Per MD send out to ER for further eval and tx. RR (resident representative), [Name of RR] called and made aware. She agreed to send to ER. - 02/02/2025 14:04 (2:04 p.m.) Note Text: Emergency transport in at this time to transport to [Name of hospital]. - 02/02/2025 18:28 (6:28 p.m.) Note Text: Called ER to check on resident's status. Resident is being admitted with Influenza, UTI (urinary tract infection) and Sepsis. Further review of the clinical record failed to evidence that the resident's representative and physician contact information, advance directive information, instructions for ongoing care, medication list, or care plan goals were sent to the receiving facility. On 4/15/25 at 11:45 a.m., a request was made to ASM (administrative staff member) #1 for evidence of the clinical documentation sent to the receiving hospital on 2/2/25 for R38. On 4/15/25 at 12:42 p.m., an interview was conducted with LPN (licensed practical nurse) #1 who stated that when they transferred a resident to the hospital, they sent a copy of the face sheet, the DNR (do not resuscitate) form if applicable, medication list, transfer form and bed hold policy. She stated that they had sent the care plan in the past, but they had stopped because some were over 50 pages, so she did not think they did that anymore. On 4/16/25 at 10:17 a.m., ASM #1 stated that they did not have any evidence to provide of the clinical documentation sent to the receiving hospital on 2/2/25 for R38. A review of the facility policy, Discharge and Transfer dated 8/2012, documented in part, .When a resident is transferred or discharged to a hospital or to a nursing home, a copy of an approved transfer and referral record and a copy of any additional medical information, as required by the facility receiving the resident, will accompany him/her . On 4/16/25 at 3:38 p.m., ASM #1, (administrator), ASM #2, (director of nursing), ASM #3, (facility nurse consultant) and ASM #4, (administrator colleague from another facility) were made aware of the findings. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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(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. Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to develop and/or implement the comprehensive care plan for two of 19 residents in the survey sample, Resident #1 (R1) and R3 The findings include: 1. For R1, the facility staff failed to follow the comprehensive care plan for the administration of oxygen. R1 was admitted to the facility with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease) (1) and respiratory failure (2). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/26/2025, R1 scored an 8 (eight) out of 15 on the BIMS (brief interview for mental status), indicating R1 was moderately impaired of cognition for making daily decisions. Section O Special Treatments, Procedures and Programs coded R1 as receiving oxygen therapy while a resident. On 04/14/25 at approximately 1:15 p.m., an observation revealed R1 in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between two and three liters per minute. On 04/15/25 at approximately 8:56 a.m., an observation revealed R1 in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between two and three liters per minute. On 04/15/25 at approximately 1:50 p.m., an observation revealed R1 in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between two and three liters per minute. The physician's order for R1 dated 04/10/2025 documented in part, Oxygen flow is 2 (two) L/min (liters per minute): Type of administration used nasal cannula. The comprehensive care plan dated 12/28/2023 for R1 documented in part, Focus: Potential for or Actual Ineffective Breathing Pattern R/T (related to): COPD and Respiratory failure. Date Initiated: 12/28/2023. Created on: 12/28/2023. Under Interventions it documented in part, Oxygen therapy (specify rate) via (specify device) as ordered. Date Initiated: 02/27/2025. On 04/15/2025 at approximately 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the purpose of a resident's care plan she stated that it provides direction for providing care to the resident. When asked if the care plan was followed if the if the oxygen was not set according to the physician's orders, she stated no. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy Guidelines For Documentation By Interdisciplinary Care Team documented in part, The care team should develop appropriate interventions for the prevention of negative outcomes. Potential negative outcomes may include but not limited to incontinence, skin breakdown, decreased range of motion, decrease ability to ambulate, loss of bone and muscle strength, increase risk of injury, loss of appetite, increased risk of infection, agitation, symptoms of withdrawal, depersonalization, dependency, feelings of entrapment, depression or reduced social contact. The care plan team should design interventions that minimize or eliminate the medical symptom . On 04/15/2025 at approximately 4:05 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, facility nurse consultant and ASM #4, administrator colleague, were made aware of the above findings. No further information was provided prior to exit. References: (1) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 2. For Resident #3 (R3), the facility staff failed to develop a care plan for the resident's contractures. On the following dates and times, R3 was observed lying supine in bed, with her head elevated. At each observation, both R3's hands and feet were contracted: 4/14/25 at 12:35 p.m. and 3:36 p.m.; 4/15/25 at 7:49 a.m. and 9:52 a.m. At no time was any contracture related device observed. A review of R3's comprehensive care plan failed to reveal information related to prevention of worsening of R3's contractures. On 4/15/25 at 10:21 a.m., RN (registered nurse) #1, the wound nurse, and ASM (administrative staff member) #2, the director of nursing, were interviewed as they completed R3's wound care. RN #1 and ASM #2 identified R3's bilateral feet and hands as being contracted. On 4/15/25 at 2:16 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated there was nothing required for R3's contractures as far as she knew. On 4/15/25 at 3:09 p.m., RN #2, the MDS (minimum data set) coordinator, was interviewed. She stated R3's most recent comprehensive MDS did not include consideration of R3's contractures as a concern needing interventions or a care plan. She stated ordinarily, a new therapy screening or intervention, or a physician's order for interventions, would trigger an entry on the resident's care plan. She said contractures should definitely be captured in a resident's care plan. On 4/15/25 at 4:00 p.m., ASM #1, the administrator, ASM #2, ASM #3, the facility nurse consultant, and ASM #4, an administrator colleague, were informed of these concerns. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided prior to exit.

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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. Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for 1 of 19 residents in the survey sample, Resident #9. The findings include: For Resident #9 (R9), the facility staff failed to provide routine fingernail care. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/6/25, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. The assessment documented R9 being independent for personal hygiene and bathing. On 4/14/25 at 1:34 p.m., an observation was made of R9's fingernails. The fingernails on both hands were observed to be approximately 1/4 inch long. At that time an interview was conducted with R9 who stated that the staff came around at times and would ask them if they needed their nails trimmed but had not been in recently. R9 stated that they had needed their nails trimmed for a while and was not able to do it himself. Additional observation of R9's fingernails was made on 4/15/25 at 8:10 a.m. and 11:57 a.m. The diagnosis information for R9 did not document a diagnosis of diabetes. The comprehensive care plan for R9 documented in part, Activities of Daily Living/ Personal Care related to dementia, OA (osteoarthritis), edema. Date Initiated: 01/10/2020. The goal of the care plan documented, Activities of Daily Living/Personal Care will be completed with staff support as appropriate to maintain or achieve highest practical level of functioning through the next review. Date Initiated: 01/10/2020. Created on: 01/10/2020. Revision on: 05/15/2024. Target Date: 06/03/2025. On 4/15/25 at 12:42 p.m., an interview was conducted with LPN (licensed practical nurse) #1 who stated that usually the CNA (certified nursing assistant) staff trimmed the residents' fingernails unless the resident was diabetic and then the nurse did it. She stated that the nails were checked every so often and if they noticed that they were long they trimmed them. On 4/15/25 at 12:58 p.m., LPN #1 observed R9's fingernails and stated that they were long and needed to be trimmed. On 4/15/25 at 2:14 p.m., an interview was conducted with CNA #1 who stated that the CNA staff trimmed residents' fingernails unless the resident was diabetic. She stated that the fingernails were assessed every day and especially on shower days when it was the time to give the most attention to the resident for things like shaving and nail care. The facility policy titled, Grooming dated 8/2012, documented in part, Grooming will be performed daily and PRN (as needed) as needed. This includes shampooing, shaving, nail care, and mouth care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 3:59 p.m., ASM #1, (administrator), ASM #2, (director of nursing), ASM #3, (facility nurse consultant) and ASM #4, (administrator colleague from another facility) were made aware of the findings. No further information was presented prior to exit.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement interventions for contractures for one of 19 residents in the survey sample, Resident #3. The findings include: For Resident #3 (R3), the facility staff failed to implement interventions to prevent worsening of contractures. On the following dates and times, R3 was observed lying supine in bed, with her head elevated. At each observation, both R3's hands and feet were contracted: 4/14/25 at 12:35 p.m. and 3:36 p.m.; 4/15/25 at 7:49 a.m. and 9:52 a.m. At no time was any contracture related device observed. On 4/15/25 at 10:21 a.m., RN (registered nurse) #1, the wound nurse, and ASM (administrative staff member) #2, the director of nursing, were interviewed as they completed R3's wound care. RN #1 and ASM #2 identified R3's bilateral feet and hands as being contracted. RN #1 stated, We float her heels, and it brings her feet back. She stated the staff also puts something in both hands, as the resident tolerates. ASM #2 stated if the staff attempted to implement an intervention to prevent contractures and the resident did not tolerate the intervention, there should be a progress note. A review of R3's clinical record, including therapy notes and screenings, failed to reveal evidence that the resident's contractures had been assessed or that interventions to prevent worsening of the contractures had been implemented. On 4/15/25 at 2:16 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated there was nothing required for R3's contractures as far as she knew. On 4/15/25 at 2:27 p.m., OSM (other staff member) #3, a certified occupational therapy assistant, was interviewed. She stated R3 has bilateral contractures in both hands and both feet, but she could not find any evidence of assessment or treatment for R3's contractures in the therapy records. She stated the facility had undergone several changes of therapy providers, and all previous therapy notes are not available to the current staff. She stated therapy screenings occur approximately every three months, and that the therapy staff should be screening for contractures. She stated the therapy staff will be assessing R3's contractures and making a treatment plan this week. On 4/15/25 at 4:00 p.m., ASM #1, the administrator, ASM #2, ASM #3, the facility nurse consultant, and ASM #4, an administrator colleague, were informed of these concerns. A review of the facility policy, Range of Motion, revealed, in part: Range of motion is performed daily with bath. Because of this daily care, range of motion exercises will not be documented. No additional information was provided prior to exit.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide respiratory care and services for one of 19 residents in the survey sample, Resident #1 (R1). For R1, the facility staff failed to maintain the oxygen (O2) flow rate at two liters per minute according to the physician's orders. The findings include: R1 was admitted to the facility with diagnoses that included but were not limited to COPD (chronic obstructive pulmonary disease) (1) and respiratory failure (2). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/26/2025, R1 scored an 8 (eight) out of 15 on the BIMS (brief interview for mental status), indicating R1 was moderately impaired of cognition for making daily decisions. Section O Special Treatments, Procedures and Programs coded R1 as receiving oxygen therapy while a resident. On 04/14/25 at approximately 1:15 p.m., an observation revealed R1 in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between two and three liters per minute. On 04/15/25 at approximately 8:56 a.m., an observation revealed R1 in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between two and three liters per minute. On 04/15/25 at approximately 1:50 p.m., an observation revealed R1 in bed receiving oxygen by nasal cannula. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate between two and three liters per minute. The physician's order for R1 dated 04/10/2025 documented in part, Oxygen flow is 2 (two) L/min (liters per minute): Type of administration used nasal cannula. The comprehensive care plan dated 12/28/2023 for R1 documented in part, Focus: Potential for or Actual Ineffective Breathing Pattern R/T (related to): COPD and Respiratory failure. Date Initiated: 12/28/2023. Created on: 12/28/2023. Under Interventions it documented in part, Oxygen therapy (specify rate) via (specify device) as ordered. Date Initiated: 02/27/2025. On 04/15/2025 at approximately 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked to describe how to read the flow meter on the oxygen concentrator she stated the bottom of the float ball inside the flow meter should be on the liter line. The (Name of Manufacturer's) Oxygen Concentrator Instruction Guide documented in part, Check the flow meter to make sure the flow meter ball is centered on the line next to the prescribed number of your flow rate. The facility's policy Oxygen Therapy documented in part, 5. Adjust flow meter to prescribe rate. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/2025 at approximately 4:05 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, facility nurse consultant and ASM #4, administrator colleague, were made aware of the above findings. No further information was provided prior to exit. References: (1) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post daily nurse staffing information prior to the start of the shift on one of three dates observed and post daily nurse staffing information in a prominent place readily accessible to residents and visitors on three of three dates observed. The findings include: The facility staff failed to post daily nurse staffing information prior to the start of the shift on 4/14/25 and post daily nurse staffing information in a prominent place readily accessible to residents and visitors on 4/14/25, 4/15/25 and 4/16/25. On 4/14/25 at 11:28 a.m., an observation was made of the facility. There was no daily nurse staffing information posted. Observation at 12:50 p.m. revealed a daily nurse staffing posted on the wall inside a plastic page protector. The posting was observed to be hanging on the wall inside the nurses' station on the interior wall not readily accessible to residents or visitors. On 4/15/25 at 8:02 a.m., an observation was made of daily staff posting hanging inside the nurses' station located on the interior wall inside a plastic page protector not readily accessible to residents or visitors. On 4/16/25 at 8:18 a.m., an observation was made of daily staff posting hanging inside the nurses' station located on the interior wall inside a plastic page protector not readily accessible to residents or visitors. On 4/14/25 at 11:44 a.m., an interview was conducted LPN (licensed practical nurse) #2 who stated that the night nurse posted the daily staffing and that it normally hung beside them at the nurses' station. LPN #2 pointed to an empty plastic page protector hanging on the wall on the inside of the nurses' station and stated that she could print one out. On 4/16/25 at 9:53 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing, who stated that the night nurse posted the daily staffing. She stated that they had not posted it on 4/14/25 so she had posted it later that day. ASM #2 stated that residents and visitors did not go in the nurses' station for privacy reasons. She stated that the posting probably could not be seen from a wheelchair or if someone had bad eyesight from where it was hanging on the wall inside the nurses' station. On 4/16/25 at 3:38 p.m., ASM #1, (administrator), ASM #2, (director of nursing), ASM #3, (facility nurse consultant) and ASM #4, (administrator colleague from another facility) were made aware of the findings. No further information was provided prior to exit. On 4/16/25 at 5:02 p.m., ASM #1 stated via email that the facility did not have a policy regarding daily staff posting and that they followed the federal regulations.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to monitor residents for the administration of unnecessary psychoactive medications for two of 19 residents in the survey sample, Residents #41 and #17. The findings include: 1. For Resident #41 (R41) the facility staff failed to monitor for side effects for the use of Risperidone (1) and Sertraline (2). A review of R41's clinical record revealed an order for Risperidone 0.5 mg (milligrams) daily and Sertraline 50 mg daily. A review of R41's MARs (medication administration records) for March and April 2025 revealed these medications were administered as ordered. Further review of the record failed to reveal any evidence that the facility was monitoring for the side effects of the medications. On 4/15/25 at 3:36 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated the facility is responsible for monitoring for side effects of all psychoactive meds. She stated psychoactive medications have the potential for pretty bad side effects for residents, including tardive dyskinesia. She stated the facility's software sometimes automatically triggers for staff to monitor for side effects, but in R41's case, the software had not triggered. On 4/15/25 at 4:00 p.m., ASM #1, the administrator, ASM #2, ASM #3, the facility nurse consultant, and ASM #4, an administrator colleague, were informed of these concerns. A review of the facility policy, Psychotropic Drug Therapy, failed to reveal specific steps to be taken for monitoring for side effects of psychoactive medications. No additional information was provided prior to exit. References (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Risperidone (generic for Risperdal) is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers [AGE] years of age and older. It is also used to treat episodes of mania (frenzied, abnormally excited, or irritated mood) or mixed episodes (symptoms of mania and depression that happen together) in adults and in teenagers and children [AGE] years of age and older with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). Risperidone is also used to treat behavior problems such as aggression, self-injury, and sudden mood changes in teenagers and children 5 to [AGE] years of age who have autism (a condition that causes repetitive behavior, difficulty interacting with others, and problems with communication). Risperidone is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information is taken from the website https://medlineplus.gov/druginfo/meds/a694015.html. (2) Sertraline is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). This information is taken from the website https://medlineplus.gov/druginfo/meds/a697048.html#:~:text=Sertraline%20is%20in%20a%20class,that%20helps%20maintain%20mental%20balance. 2. For Resident #17 (R17), the facility staff failed to for side effects for the use of Seroquel (1) A review of R17's clinical record revealed an order for Seroquel 50 mg (milligrams) nightly. A review of R17's MARs (medication administration records) for March and April 2025 revealed this medication was administered as ordered. Further review of the record failed to reveal any evidence that the facility was monitoring for the side effects of the medications. On 4/15/25 at 3:36 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated the facility is responsible for monitoring for side effects of all psychoactive meds. She stated psychoactive medications have the potential for pretty bad side effects for residents, including tardive dyskinesia. She stated the facility's software sometimes automatically triggers for staff to monitor for side effects, but in R17's case, the software had not triggered. On 4/15/25 at 4:00 p.m., ASM #1, the administrator, ASM #2, ASM #3, the facility nurse consultant, and ASM #4, an administrator colleague, were informed of these concerns. No additional information was provided prior to exit. Reference (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Quetiapine tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release tablets are also used along with other medications to treat depression. Quetiapine tablets may be used as part of a treatment program to treat bipolar disorder and schizophrenia in children and teenagers. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information is taken from the website https://medlineplus.gov/druginfo/meds/a698019.html.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility document review, facility staff failed to prepare store and serve food in a sanitary manner in one of one facility kitchens. The findings include: On 04/14/2025 at approximately 11:30 a.m., an observation of the facility's kitchen revealed the following: On 04/14/2025 at approximately 11:25 a.m., an observation of the facility's kitchen revealed a 26-inch fan sitting on a cart blowing into the kitchen and onto a metal shelving unit with four shelves. Observations of the shelves revealed, the top shelf contained 25 clean meal tray covers, the second from the top shelf contained 12 clean tray bottoms, the third from the top shelf contained 30 clean eight-ounce bowls and the bottom shelf contained three racks of clean cups and glasses. Observation of the fan revealed the fan blades, and the front and back fan guards were coated in dust. Observation of the inside of the facility's walk-in refrigerator revealed a ladder rack containing two sheet pans with a combined total of 40, eight-ounce bowls containing mixed fruit. Further observation revealed that the fruit bowls were uncovered. Observation of the top, right hand shelf inside the facility's walk-in refrigerator revealed a Ziploc bag containing three one-half pound stacks of sliced Swiss cheese. Observation of one of the stacks of cheese revealed it was open to the environment. Observation of the Ziploc bag revealed it was open to the environment. Observation of a shelf, second from the top, on the right-hand side inside the facility's walk-in refrigerator revealed a sandwich wrapped in a paper wrap. Further observation failed to evidence a name or date on the sandwich. Observation of the food processor located in the facility's kitchen on a food preparation table was conducted with OSM #1. When asked if the food processor was cleaned and ready for use OSM #1stated, Yes. Observation of the inside of the food processor lid revealed it was wet, standing water inside the bowl and a wet blade. After observing the food processor bowl OSM #1 verbally agreed that the inside of the lid, bowl and blade were wet. On 04/14/2025 at approximately 2:20 p.m., an interview was conducted with OSM (other staff member) #1. When asked about the fruit on the ladder rack in the walk-in refrigerator being uncovered, she stated the bowls should have been covered to keep any debris from falling on them. OSM #1 stated the Swiss cheese in the Ziploc bag should have been closed, the sandwich found on the shelf in the walk-in refrigerator should have been labeled with a resident's name and dated. Regarding the food processor, she stated it should have been air dried to prevent the development of bacteria or mold. After being informed of the observation of the fan blowing on the clean items on metal shelving, OSM #1 observed the fan and verbally agreed the fan blades, and front and rear fan guards were coated in dust. She further stated the fan should not have been blowing into the kitchen and it was blowing dust onto the clean items on the metal shelving. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy Cleaning Procedures. Warewashing documented in part, Dishes and other reusable components of metal service, pots and pan, will be washed using the proper temperature, correct chemicals, and then air-dried. On 04/15/2025 at approximately 4:05 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, facility nurse consultant and ASM #4, administrator colleague, were made aware of the above findings. No further information was provided prior to exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for two of 19 residents in the survey sample, Residents #35 and #197. The findings include: 1. For Resident #35 (R35), the facility staff failed to document care they provided for the resident's indwelling urinary catheter each shift. On the following dates and times, R35 was observed utilizing an indwelling urinary catheter: 4/14/25 at 12:44 p.m. and 1:14 p.m.; 4/15/25 at 7:51 a.m. and 11:17 a.m. On 4/15/25 at 11:17 a.m., R35 was interviewed about routine care for his indwelling urinary catheter. He stated the staff (especially CNAs [certified nursing assistants]) do a wonderful job of caring for his catheter. He stated they clean the catheter at least every shift. A review of R35's clinical record revealed no orders for catheter care, and no evidence that routine catheter care was being provided to R35. On 4/15/25 at 2:16 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated she regularly cares for R35, and that she always provides catheter care each morning when she gives the resident a bath. She stated it is important to keep the catheter as clean as possible to prevent a possible urinary tract infection. She stated she is not aware of any place to document the care she gives in the clinical record. On 4/15/25 at 4:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, ASM #3, the facility nurse consultant, and ASM #4, an administrator colleague, were informed of these concerns. A review of the facility policy, Rules for Medical Records Documentation, revealed, in part: The resident's medical record is used to plan continuous care; coordinate clinical care contributions; communicate ad keep apprised of the resident medical condition; and provide clinical data for continuing education and research. A resident's medical record is legal proof of the quality of care provided .Document any action taken in response to a resident's problem. No additional information was provided prior to exit. 2. For Resident #197 (R197), the facility staff failed to maintain a complete medical record documenting observed swelling and redness to the residents left knee on 3/6/24. R197 no longer resided at the facility and could not be observed or interviewed. The record was reviewed as a closed record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility synopsis of events for R197 dated 3/8/24 documented in part, .Swelling & redness noted to LT (left) knee. MD in to see. X-ray of knee ordered- found acute appearing distal femur fx (fracture) proximal to LT knee replacement. Resident sent to ER. See attached summary . The attached summary documented in part, Resident was noted with redness and swelling to LT knee on 3/6/24. Primary nurse was made aware. Primary nurse assessed resident and found redness and swelling to LT knee and decision was made to notify MD. Resident had no complaints of pain when asked. MD saw resident on 3/7/24 and order given for x-ray. [Name of x-ray service] in on 3/8/25 and performed x-ray. Radiology reading of x-ray states resident had an acute-appearing fracture of the distal femur proximal to her knee replacement. Resident sent to the ER for evaluation. The hospital attributed the fracture to her fall on 2/25/24. Orthopedic surgeon felt that surgical intervention could cause more harm to resident than nonsurgical intervention. States knee was already starting to heal. Knee immobilizer placed in hospital to help with keeping fracture in alignment during healing. Resident has a diagnosis of osteopenia, osteoarthritis, Vitamin B and D deficiencies. The physician progress note for R197 dated 3/7/24 documented in part, .Chief complaint/reason for this visit: Left knee pain. HPI (history of present illness) relating to this visit: [age and sex of R197] with history of CAD (coronary artery disease), Dementia, Chronic A. (atrial) fibrillation, CVA (cerebrovascular accident) and OA (osteoarthritis) is seen today for evaluation of pain in her left knee with swelling that she complained about this morning. This knee has had joint replacement in 2011. There were no reports of any trauma. She does complain of pain with moving the knee .Musculoskeletal: Joint Swelling/Inflammation, Mobility, Painful Movement, Left knee tender . Assessment and Plan: 1. left knee pain has had surgery 2021. 1: Obtain x-ray. Tylenol prn (as needed) pain. 2. Dementia: Continue safety precautions. Reorient as necessary . The clinical record failed to evidence documentation regarding the swelling and redness of the left knee first observed on 3/6/24. On 4/15/25 at 10:27 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing who stated that R197 had been assisted to the floor during care by a former CNA on 2/25/24 and had only complained of some back pain the day after the fall which was addressed by the physician. She stated that the physician assessed R197 on 2/26/24 and started Tylenol for back pain. She stated that when she had investigated the incident, she had found that R197 had only complained of generalized pain when turning and had not knee pain or swelling until 3/6/24 when the CNA observed it and reported it to the LPN (licensed practical nurse). ASM #2 stated that the LPN had assessed R197's knee and notified the physician by placing it in the physician communication book. She stated that the physician saw R197 on 3/7/24 and ordered the x-ray which was obtained on 3/8/24 and the resident was sent out when the results came in. She stated that in hindsight the nurse should have documented the assessment and findings in the medical record. On 4/15/25 at 12:42 p.m., an interview was conducted with LPN #1 who stated that the physician book was used to communicate anything non-urgent that they needed to address when they came in the next day. She stated that the physician came in twice a week and the nurse practitioner came in three days a week and someone was on call on the weekends. LPN #1 stated that the observed swelling and redness in the knee should have been documented in the medical record of R197 to cover them and show what was going on. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/16/25 at 3:38 p.m., ASM #1, (administrator), ASM #2, (director of nursing), ASM #3, (facility nurse consultant) and ASM #4, (administrator colleague from another facility) were made aware of the findings. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. Building B. Wing	04/16/2025

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interview and facility document review it was determined that the facility staff failed to evidence a continuous Quality Assurance and Performance Improvement (QAPI) program that monitored its performance and ensured that improvements were sustained, which had the ability to affect all residents within the facility for nine of ten quarters reviewed. The findings included: The facility staff failed to evidence QAPI sign-in sheets for meetings held between Q4 of 2022 and Q4 of 2024. On 4/14/25 at 11:28 a.m., during entrance conference a request was made to ASM (administrative staff member) #1, the administrator for QAPI meeting attendance records from 7/28/22 to the present. On 4/16/25 at 12:38 p.m., ASM #1 provided QAPI meeting attendance records and stated that he was not able to find all the sign-in sheets going back to the last survey and what was provided was all that he had. ASM #1 stated that he was not able to identify the dates that the meetings took place, and they did not have dates on the sign-in sheets or any documentation identifying when the meetings took place. Review of the provided QAPI meeting attendance records documented a meeting completed in Q1 of 2025. A QAPI meeting attendance record dated 10/24/24 documented the medical director, administrator and director of nursing attending with no additional staff members. Three undated QAPI meeting attendance records documented three meetings with the required attendees, one meeting with the infection preventionist not attending and one meeting with the director of nursing not attending. On 4/16/25 at 3:49 p.m., an interview was conducted with ASM #1 who stated that since he had been at the facility the QAPI team met monthly with a minimal of a quarterly meeting to discuss subjects that they identified through audits, tracking, morning meetings, the clinical team and resident suggestions. He stated that they worked as a team to determine performance improvement projects, tracked progress of ongoing projects and perform root cause analysis of identified problems. The facility policy, Quality Assurance and Performance Improvement (QAPI) Plan revised 10/15/2022, documented in part, . The QAPI Committee will meet on a regular basis, and at least quarterly . On 04/16/25 at 3:38 p.m., ASM #1, (administrator), ASM #2, (director of nursing), ASM #3, (facility nurse consultant) and ASM #4 (administrator colleague from another facility) were made aware of the concern. No further information was provided prior to exit.