STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Rehabilitation and Nursing Center	7300 Forest Ave Richmond, VA 23226

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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** Based on observation, staff interview, and facility document review, it was determined the facility staff failed to serve meals in a dignified manner on one of four units, unit two. The findings include: On 11/13/24 at 1:24p.m., an observation was made of the kitchen staff plating and preparing the food carts for delivery. When the kitchen staff got to the last one and a half carts, they started using plastic silverware and styrofoam take out containers to put the food in and placed them on the trays and into the meal carts. When asked why they were using plastic silverware and styrofoam take out containers to serve the food to the residents, the kitchen staff stated they don't have any more pellets (that keep the food warm) or covers to serve the residents to complete the tray line. OSM (other staff member) #15, the director of dietary services, stated she had just come to the facility on [DATE] and was in the process of finding out the needs of the kitchen in order to serve the residents better. The facility policy, The Dining Experience, documented in part, Policy: The dining experience will be person centered with the purpose of enhancing each individual's quality of life and being supportive of each individual's needs during dining. Individuals will be provided with nourishing, palatable, attractive meals that meet daily nutritional, and/or special dietary needs and food preferences and are served at a safe and appetizing temperature. ASM (administrative staff member) #1, the administrator and OSM #15 were made aware of the above findings on 11/19/24 at 2:42 p.m. No further information was provided prior to exit.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff/resident interviews, facility document review and clinical record review, it was determined the facility staff failed to accommodate resident needs for four of 69 residents in the survey sample, Resident (R) #36, R46, R125 and R179. The findings include: 1. For Resident #36, the facility staff failed to accommodate the resident preferences to have access to the outside. R36's room is on Unit 1. The end of Unit 1, there is a door to a covered patio with a ramp, the door is not automatic and requires you to turn handle to open the door. This door is unlocked from 8:00 AM -8:00 PM. The main lobby has 2 sets of double doors all with handles/bars to open them. The outside set of doors when opened put you in between 2 glass doors that then open into the lobby. The end of Unit 2 there is an automatic sliding door with a ramp that requires a code to open the door. R36 was admitted to the facility on [DATE] with diagnosis that included but were not limited to Hepatic Encephalopathy, DM (diabetes), PTSD (post-traumatic stress disorder) and muscle wasting. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/4/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring supervision for locomotion/transfer/dressing/toileting and eating. A review of the comprehensive care plan dated 4/18/24 revealed, FOCUS: Resident is at risk for falls related to muscle weakness, fall, DM neuropathy generalized muscle weakness. INTERVENTIONS: Assist to wheel outside on ramp as needed. On 11/20/24 at 3:34 PM, an interview was conducted with R36. When asked about his ability to go outside on his own. R36 stated, it is not easy to get back into this building. I am either in the manual or motorized wheelchair, I can get out by pushing the doors with my footrest, but cannot easily get back into the building, because I have to reach and pull the door open. I go outside to smoke. I have been assessed as a safe smoker and do not need supervision. I cannot give you the date, but when I was trying to get back into the building, I cut my left forearm on what I think it was the dead bolt part of the door. No scar visible on left forearm, unable to find evidence of cut in R36 medical record or grievance. On 11/19/24 upon entrance to the facility, ASM (administrative staff member) #3, the VP of operations was observed holding the front entrance doors open for resident in wheelchair to enter the building. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 11/19/24 8:18 AM with ASM #3, the VP of operations and ASM #1, the administrator. When asked if the residents were able to enter and exit the building on their own ability. ASM #3 stated, yes, they are able to get in and out. When asked why he was observed holding the door open for a resident in a wheelchair, ASM #3 stated, well, I was there and saw him coming. Every time I work here the receptionist is able to help them open the door. A while ago we worked on getting automated doors. When asked when that was, ASM #3 stated, about 6 months ago. When asked if no access to automated doors is an impediment to a resident's accommodation of needs; ASM #3 stated, no, I do not think so as someone is available to let them in. ASM #1 stated, there is a work order for fixing the door. On 11/19/24 at 8:30 AM an interview was conducted with LPN (licensed practical nurse) #9. When asked about the resident's ability to enter and exit the building independently, LPN #9 stated, the only automatic doors are at the end of Unit 2 and the residents do not have access to the code. The other doors are able to be opened by handle or bar or I have seen residents push the main doors open with their footrest. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. A review of the facility's Resident Rights policy, revealed, Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: A dignified existence; to be honored and respected. Be treated with respect, kindness and dignity. Self-determination. No further information was provided prior to exit. 2. For R46, the facility staff failed to accommodate the resident preferences to have access to the outside. R46 was admitted to the facility on [DATE] with diagnosis that included but were not limited to quadriplegia, colostomy, tobacco use and osteomyelitis. The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 8/30/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bed mobility/transfer/dressing/toileting and eating. A review of the comprehensive care plan dated 1/19/24 revealed, FOCUS: Resident is a Quadriplegic. Uses seatbelt in wheelchair to aid in positioning due to lack of core strength, no restriction to normal movement. INTERVENTIONS: wheelchair for ambulation and transfers. R46 was observed using wheelchair to move throughout the facility. Wheelchair is able to be moved by R46's head movement. On 11/14/24 at approximately 10:30 AM R46 was observed exiting main lobby doors . R46 used his wheelchair footrests to push open the lobby doors to exit building. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 11/18/24 at 10:27 AM with R46. When asked how he was able to exit the building, R46 stated, I can get out of the building by pushing the door off of the main lobby with my footrest. I cannot get back in on my own. I have to wait for someone to open the door. The exit door on Unit 1 hall, I can push that open with footrest also, but same problem with getting back in on my own. The automatic door on the Unit 2 hall, that has the ramp, they will not give us the code to that door. When I first was admitted here within the first month, I had cut my left forearm on the door off of the main lobby, getting back in. If there were automatic doors, that would not have happened. No scar visible on left forearm, unable to find evidence of cut in R46 medical record or grievance. On 11/19/24 upon entrance to the facility, ASM (administrative staff member) #3, the VP of operations was observed holding the front entrance doors open for resident in wheelchair to enter the building. An interview was conducted on 11/19/24 8:18 AM with ASM #3, the VP of operations and ASM #1, the administrator. When asked if the residents were able to enter and exit the building on their own ability. ASM #3 stated, yes, they are able to get in and out. When asked why he was observed holding the door open for a resident in a wheelchair, ASM #3 stated, well, I was there and saw him coming. Every time I work here the receptionist is able to help them open the door. A while ago we worked on getting automated doors. When asked when that was, ASM #3 stated, about 6 months ago. When asked if no access to automated doors is an impediment to a resident's accommodation of needs; ASM #3 stated, no, I do not think so as someone is available to let them in. ASM #1 stated, there is a work order for fixing the door. An interview was conducted on 11/19/24 at 8:30 AM with LPN (licensed practical nurse) #9. When asked about the resident's ability to enter and exit the building independently, LPN #9 stated, the only automatic doors are at the end of Unit 2 and the residents do not have access to the code. The other doors are able to be opened by handle or bar or I have seen residents push the main doors open with their footrest. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. A review of the facility's Resident Rights policy, revealed, Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to: A dignified existence; to be honored and respected. Be treated with respect, kindness and dignity. Self-determination. No further information was provided prior to exit. 3. For Resident #125 (R125), the facility staff failed to accommodate the resident's preference to have access to the outside. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 8/19/24, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 at 10:03 a.m., an interview was conducted with OSM (other staff member) #8 (the director of maintenance). OSM #8 stated residents have access to three doors in the facility but the only automatic door, on unit two, is locked and requires a code to open. OSM #8 stated the door in the front lobby and the door on unit one must be manually opened. An interview was conducted with R125 on 11/18/24 at approximately 12:25 p.m. R125 stated the residents can't go outside after 8:00 p.m. They tell them that all assisted residents have to go in at 8:00 p.m. She doesn't need assistance to go in and out. They lock the door at 8:00 p.m. and if you open the door after that an alarm goes off. R125 stated she feels trapped inside and it affects her anxiety. She stated they used to be able to sit outside until 9:00 p.m. and sometimes 10:00 p.m. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #3, the assistant director of nursing, were made aware of the above concern on 11/20/24 at 4:00 p.m. No further information was provided prior to exit. 4. For Resident #179, the facility staff failed to accommodate the resident's preference to have access to the outside. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 9/13/24, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. On 11/14/24 at 10:03 a.m., an interview was conducted with OSM (other staff member) #8 (the director of maintenance). OSM #8 stated residents have access to three doors in the facility but the only automatic door, on unit two, is locked and requires a code to open. OSM #8 stated the door in the front lobby and the door on unit one must be manually opened. An interview was conducted with R179 on 1/18/24 at approximately 1:30 p.m. R179 stated she likes to be outside. She isn't happy being in the nursing home. R179 needs help to open the doors to go outside. She has tried to go out the front door, but they are not handicapped accessible. She must push the door with the front of her foot rests on the wheelchair. It's very difficult, she wants to be able to go out independently. R179 stated, once outside the ramp has broken or loose bricks on it, that's dangerous for someone in a wheelchair. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #3, the assistant director of nursing, were made aware of the above concern on 11/20/24 at 4:00 p.m. No further information was provided prior to exit.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility's documentation and staff interview, it was determined that the facility failed to evidence resolution of resident council concerns. The findings included: During the review of the Resident Council Minutes from 12/2022-10/2024, there was no evidence of resolution of resident concerns, regarding food/menus/alternate meals and missing belongings. On 11/21/24 at 9:15 AM an interview was conducted With ASM #2, the director of nursing. When asked where the resolution of concerns from Resident Council were documented and shared with the residents, ASM #2 stated, we do not have evidence of that. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. A review of the facility's Resident Council policy reveals, The Administrator is responsible for reviewing and signing the company Resident Council Meeting Minutes and responding in writing to concerns presented by the council on the Administrative Response to Resident Council Form. No further information was provided prior to exit

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and facility document review, it was determined the facility staff failed to provide beneficiary notification for one of three residents in the beneficiary notification facility task, Resident #25. The findings include: During the facility task of beneficiary notification review on 11/20/24. The list of discharges for the last six months was provided at 4:30 PM on 11/19/24. Resident #25 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: neoplasm of breast, dementia and unsteadiness on feet. Resident #25 was a current resident in the facility during the survey period. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 9/21/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the social services progress note dated 6/18/24 at 2:21 PM, revealed the following, Jumpstart meeting held on this day with resident daughter on phone. Resident admitted to the facility on [DATE] for skilled services. Resident's primary insurance is Medicare. Prior to hospitalization, resident was in a nursing home with 24-hour care. Resident completed her ADLs with assistance. Resident does own a rollator and wheelchair. Resident does report having prior history with home health agency. Residents PCP is unknown. Resident plans to LTC at Westport This writer verified resident's demographic information and contacts with resident. No concerns expressed. Resident provided with welcome packet including resident rights, contact information for facility department heads and important facility information. Social services will continue to provide support as needed. On 11/20/24 at approximately 10:00 AM, the three beneficiary notices were returned. Resident #25's Beneficiary Protection Notification Review form revealed the following: Under #1. Was a SNF ABN Form CMS-10055 provided to the resident the box was checked next to 'NO'. Explanation: No Form Found. An interview was conducted on 11/21/24 at 9:15 AM with OSM (other staff member) #18, the director of social services. When asked if she was responsible for the beneficiary notices being performed, OSM #18 stated, yes, however, I just started 3 days ago. When asked about the ABN (beneficiary notice), OSM #18 stated, with managed care plans we get a 3 day window and notify the resident or family that a NOMNC was issued, if the resident can sign and if they cannot we get telephone verification from RP and document that. There was no form for this resident. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Advance Beneficiary Notice policy, revealed, The advanced beneficiary notice is to be used to comply with federal guidelines for notifying a beneficiary or the responsible party the care the patient is receiving will not be covered by Medicare B. No further information was provided prior to exit.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain confidentiality of resident information for three of 69 residents in the survey sample, Residents #249, #250 and #182. The findings include: 1. For Resident #249 (R249), the facility staff failed to maintain confidentiality of the resident information, A copy of text messages sent to the state agency were reviewed. The text messages documented in part, (R249) I admitted her to room (#) and (name of former administrator) ended up putting up somewhere else where a room was not ready because of housekeeping and so her arrival was very unwelcoming and not good. So, I went to put together a care package for her and her daughter and gave that to both of them that put a smile on her face. I set with them for 20 mins (minutes) answered all the question both of them had. They met with the unit manager and kitchen manager. Still, nobody checked on this lady since her arrival. An interview was conducted with OSM (other staff member) #7, the clinical liaison, on 11/14/24 at 9:36 a.m. When asked if she is allowed to text a resident's name to another staff member's phone, OSM #7 stated, no. OSM #7 stated she did once, years ago, text by mistake but now uses an application on her phone, that encrypts the messages while she is in the hospital and has another application she uses for internal use, with other staff members in the building. An interview was conducted with OSM #13, the director of activities, on 11/14/24 at 10:23 a.m. When asked if he is allowed to text a resident's name in a text message, OSM #13 stated hesitantly, yes. OSM #13 was asked if he used a secured application to text resident's name between staff members, OSM #13 stated, no. The text message above was reviewed with OSM #13. OSM #13 stated the text messages were not done on a secured text message application. When asked if he had had training in confidentiality of resident information, OSM #13 stated, yes. OSM #13 stated he was not aware that a staff member cannot text resident names in an unsecured text message. An interview was conducted with OSM #19 on 11/14/24 at 11:38 a.m. The above text message was reviewed with OSM #19. When asked if they were through a protected application on the phone, OSM #19 stated, no there were not. When asked why staff should not text resident names to other staff members in an unsecured application, OSM #19 stated, it's a HIPAA (Health Information Portability and Accountability Act) violation. The facility policy, Confidentiality of Patient Information, documented in part, POLICY The company will comply with the Health Insurance Portability and Accountability Act (HIPAA) which protects the security and confidentiality of medical information. All patient and employee protected health information will be safeguarded according to HIPAA. Employees are prohibited from viewing, accessing, using, or disclosing protected medical information (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to anyone, outsiders, or other employees, except where necessary to the job, or as allowed by law. PROCEDURE 1. Any employee who has a question on whether any action is in violation of this policy should seek guidance from the center Administrator or from the compliance hotline at [PHONE NUMBER] 2. All employees will receive training on HIPAA upon hire and annually thereafter. All employees are required to sign and follow the company ' s Privacy/Security Training Acknowledgement. 3. All employees, regardless of position, are required to safeguard protected health information according to the Act. Examples of potential violations of the Act include, but are not limited to, knowingly and improperly disclosing PHI, accessing PHI when not authorized to do so, or leaving EPHI on an unencrypted external device. Employees who violate the Act either intentionally or accidentally are subject to corrective action, up to and including termination, depending on the nature and severity of the violation. Punishment for severe offenses can result in large federal fines, and even prison sentences for serious offense ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #3, the assistant director of nursing, were made aware of the above findings on 11/21/24 at 1:51 p.m. No further information was provided prior to exit. 2. For Resident #250 (R250), the facility staff failed to maintain confidentiality of the resident information. A copy of text messages sent to the state agency were reviewed. The text messages documented in part, (R250) room (#) - Our (initials of hospital) left ama (against medical advice) just now. No, that one the other (first name of resident). She did not receive any care nor her meds (medications) and (name of staff member) and I both spoke to (name of administrator) about this and I was going back up to the building but was told not too(sic) when the family member called. On 11/14/24 at 9:36 a.m. an interview was conducted with OSM (other staff member) #7, the clinical liaison. When asked if she is allowed to text a resident's name to another staff member's phone, OSM #7 stated, no. OSM #7 stated she did once, years ago, text by mistake but now uses an application on her phone, that encrypts the messages while she is in the hospital and has another application she uses for internal use, with other staff members in the building. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 at 10:23 a.m. an interview was conducted with OSM #13, the director of activities. When asked if he is allowed to text a resident's name in a text message, OSM #13 stated hesitantly, yes. OSM #13 was asked if he used a secured application to text resident's name between staff members, OSM #13 stated, no. The text message above was reviewed with OSM #13. OSM #13 stated the text messages were not done on a secured text message application. When asked if he had had training in confidentiality of resident information, OSM #13 stated, yes. OSM #13 stated he was not aware that a staff member cannot text resident names in an unsecured text message. On 11/14/24 at 11:38 a.m. an interview was conducted with OSM #19 The above text message was reviewed with OSM #19. When asked if they were through a protected application on the phone, OSM #19 stated, no there were not. When asked why staff should not text resident names to other staff members in an unsecured application, OSM #19 stated, it's a HIPAA (Health Information Portability and Accountability Act) violation. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #3, the assistant director of nursing, were made aware of the above findings on 11/21/24 at 1:51 p.m. No further information was provided prior to exit. 3. For Resident #182 (R182), the facility staff failed to maintain confidentiality of the resident information. A copy of text messages sent to the state agency were reviewed. The text messages documented in part, (R182), Room (#), Let's start with (first name of R182). He was admitted on Friday, the weekend was really horrible for him. They left this man in feces for 5 hours he said, they didn't feed him and he's a feeder also the nurse told him to shut up and closed his door on him and told him we have 20 patients, and we short we can send your ass out if you don't want to be here. Then shoved his meds down his throat and told him here take this. He's very scared because he said they are going to kill so (name of staff member), and I been down there all day sitting and checking on him and again still no nurse or CNA(certified nursing assistant) came and check on him. On 11/14/24 at 9:36 a.m. an interview was conducted with OSM (other staff member) #7, the clinical liaison, When asked if she is allowed to text a resident's name to another staff member's phone, OSM #7 stated, no. OSM #7 stated she did once, years ago, text by mistake but now uses an application on her phone, that encrypts the messages while she is in the hospital and has another application she uses for internal use, with other staff members in the building. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Rehabilitation and Nursing Center	7300 Forest Ave Richmond, VA 23226

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 at 10:23 a.m. an interview was conducted with OSM #13, the director of activities, When asked if he is allowed to text a resident's name in a text message, OSM #13 stated hesitantly, yes. OSM #13 was asked if he used a secured application to text resident's name between staff members, OSM #13 stated, no. The text message above was reviewed with OSM #13. OSM #13 stated the text messages were not done on a secured text message application. When asked if he had had training in confidentiality of resident information, OSM #13 stated, yes. OSM #13 stated he was not aware that a staff member cannot text resident names in an unsecured text message. On 11/14/24 at 11:38 a.m. an interview was conducted with OSM #19. The above text message was reviewed with OSM #19. When asked if they were through a protected application on the phone, OSM #19 stated, no there were not. When asked why staff should not text resident names to other staff members in an unsecured application, OSM #19 stated, it's a HIPAA (Health Information Portability and Accountability Act) violation. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #3, the assistant director of nursing, were made aware of the above findings on 11/21/24 at 1:51 p.m.

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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 - Some	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, staff interview, and facility document review, the facility staff failed to maintain a clean, comfortable, homelike environment for one of 69 residents in the survey sample, Resident #121, and in one of one reception area outside of the kitchen. The findings include: 1. For Resident #121 (R121), the facility staff failed to maintain the resident's tube feeding pole and floor in a clean and homelike manner. On 11/18/24 at 11:26 a.m., 11/19/24 at 7:40 a.m., and 11/20/24 at 9:25 a.m., R121 was observed lying in bed. Puddles of a dried light brown substance were observed on the base of the resident's tube feeding pole and on the floor. On 11/20/24 at 10:15 a.m., an interview was conducted with OSM (other staff member) #4 (the director of housekeeping). OSM #4 stated residents' rooms are cleaned daily and substances on the base of the tube feeding poles and floors should be cleaned. OSM #4 stated if certified nursing assistants or nurses see substances on the base of tube feeding poles or the floor, they should clean up the substances or notify the housekeeping department. OSM #4 was shown the substance on R121's tube feeding pole and floor. OSM #4 stated the substance was dried tube feeding formula and should have been cleaned up. OSM #4 stated the tube feeding pole and floor were not clean or homelike. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility environmental services operations manual documented, Offices, Resident/Patient Rooms, and Restrooms: Remove all debris from floors, counters, and edges. No further information was presented prior to exit. 2. The facility staff failed to maintain the hallway outside the kitchen in a homelike environment. Observation was made of the hallway outside the door to the kitchen on 11/13/24 at approximately 11:30 a.m. accompanied by OSM (other staff member) #15, the dietary manager. There were two holes it the drywall. Each hole was approximately 12 inches long by six inches in height. When asked what happened, she stated she did not know. On 11/21/24 at 8:11 a.m. an observation was made of the area with OSM #8, the Maintenance Director. The walls had been patched up and a piece of furniture had been placed in front of the patched holes. OSM #8 stated that the holes were caused by the food carts coming from the kitchen. He stated he patches the holes about twice a month. When asked how staff inform him of any concerns for him to fix, he stated they use the Reqqer system that staff can enter concerns into, and he gets them electronically. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 11/21/24 at 1:41 p.m. No further information was provided prior to exit.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility document review, and staff interview, it was determined that the facility staff failed to resolve a grievance in a timely manner for 1 of 69 residents in the survey sample, Resident #397. The findings include: For Resident #397 (R397), the facility staff failed to resolve a grievance regarding missing personal belongings in a timely manner. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/8/24, the resident was assessed as being severely impaired for making daily decisions. On 11/12/24 at 11:17 a.m., an interview was conducted with R397's responsible party (brother) who stated that R397 had recently passed away at the facility. He stated that when R397 was hospitalized the facility had packed up all their belongings and moved them out of the room. He stated that no one contacted him to ask if he wanted to pick them up and when R397 came back to the facility there were no belongings in the room, and no one could find them. He stated that he spoke to the floor supervisor, the housekeeping supervisor, the admissions director, the social worker, and the former administrator regarding the belongings being missing but no one found anything or followed up with him. He stated that he emailed the former administrator multiple times and was told that they had filed the report in New Jersey for reimbursement, but they never received any follow up until the current administrator spoke with him after R397 passed away in October 2024. He stated that R397 had belongings that included shoes, multiple pairs of jogging pants, shirts, undershirts, socks, a jacket and several hats missing. He stated that when he met with the new administrator in October 2024, she offered him a gift card for $150 which he accepted because he felt that at the present, there was not much left to do because his brother had passed away, but he wanted to help others who may be in the same situation. He stated that the housekeeping director told him that a trainee had gone in and cleaned R397's room when he went to the hospital and threw everything away by mistake. He stated that the former administrator was a piece of work, and he still felt that the items may have been stolen because they were name brand and most of them were new. A service concern form dated 4/26/24 for R397 documented a concern received by the former administrator at the facility from R397's brother. It documented a phone call received from the brother demanding $600. The form documented an attached email however no email was attached. Under Action Taken to Resolve Concern it documented, Since call & email, [Name of brother] has been asked to provide proof of items. He has not. He claims to have photos of items in facility. He has not provided them. He states in email a value of $340, yet in person is demanding $600. If he feels something was stolen, he was told to report to law enforcement & offered assistance. Instead, he became threatening & was asked to leave. Under Follow up it documented, 5/22/24 [Name of brother] was again in facility and made physical threats, including referencing a gun. Police were called, but he had left prior to law enforcement's arrival. The service concern form documented Resolution Ongoing with no date and the former administrator's signature. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An email dated 4/26/24 provided to the state agency addressed to the former administrator of the facility, the director of nursing and the director of admissions at the facility from R397's brother documented in part, Subject: Will be filing a formal complaint related to the Theft of [Name and room number of R397] clothes (6 newly purchased outfits from Sam's Club, Adidas socks, under clothes, black Sketchers slip-on shoes, & Kansas City Chiefs Super bowl team Cap) & $340 . An additional email dated 5/13/24 from R397's brother to the former administrator of the facility, the director of nursing and the director of admissions at the facility documented in part, .This is my 2nd written e-mail request directly to [Name of former administrator], administrator at [Name and address of facility] to provide reimbursement for all items stolen in the THEFT of my oldest brothers clothing from [Room number] . Review of the clinical record for R397 failed to evidence documentation of a personal belonging inventory list or any concerns regarding missing personal belongings voiced by the family. It documented R397's brother being the responsible party and emergency contact. The clinical record documented R397 being hospitalized from [DATE]-[DATE] and returning to the same room at the facility. On 11/12/24 at 11:57 a.m., a request was made to ASM (administrative staff member) #1, the current administrator for a copy of the personal inventory list for R397. ASM #1 stated that the former administrator no longer worked for the company and was not available for interview. On 11/12/24 at 1:37 p.m., ASM #2, the director of nursing stated that they did not have a personal inventory list for R397 to provide. On 11/12/24 at 12:31 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated that he worked with R397 at the facility. He stated that R397 had a lot of clothing at one point and then everything went missing all at once. He stated that he remembered telling R397's brother that he did not know what had happened to the clothing. CNA #1 stated that when a resident or family reported missing clothing, he checked with the head of laundry first because sometimes they were down there to be washed. He stated that if it was not located there, he was not sure what happened and who took over from there. CNA #1 stated that he did not think that they found the missing clothing and the family had brought in new clothing for the resident. On 11/12/24 at 12:37 p.m., an interview was conducted with OSM (other staff member) #3, laundry aide. OSM #3 stated that if a resident or family member reported missing clothing, they went through the cart for that unit to see if things were mixed in by mistake. She stated that if clothing was found and was not labeled, she took it up to the resident if it matched the description given. She stated that they had an outside contracted agency that washed linens and towels and if clothing got mixed in with those bags by mistake it was not returned. She stated that if she was not able to find the missing clothing items, she reported it to her supervisor and was not sure what happened after that. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 12:39 p.m., an interview was conducted with OSM #4, the director of housekeeping and laundry. OSM #4 stated that in April of 2024 when a resident went out to the hospital the housekeeping staff packed up the clothing and personal belongings until recently when they changed the process and now the nursing staff packed everything. He stated that the boxes were labeled with the resident's name and brought down to his office and placed in a storage room. OSM #4 stated that when the resident came back to the facility the staff were able to come down and pick up the resident's belongings. He stated that the office was always unlocked, and the storage room was unlocked so all staff could access it. He stated that as far as he knew all staff were aware of this. He stated that he remembered R397 and talking with R397's brother. He stated that it was about a week or so after the clothes went missing when the brother came to the facility and the former administrator paged him because the brother was acting erratically. He stated that he came upstairs and took him downstairs, and they searched the storage room together but could not find any of R397's belongings. OSM #4 stated that he was unable to resolve the grievance. He stated that when they were not able to find the missing belongings that they notified the resident or family, tried to find an alternate resolution, the value of the missing items and then he went to the administrator to see if they could replace the items. He stated that the expectation was to find the missing items or resolve the grievance within two days. On 11/12/24 at 12:50 p.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that they did not recall any concerns regarding missing personal belongings for R397 when they came back from the hospital, but they rarely worked with them. LPN #6 stated that when a resident went out to the hospital, they boxed up all their belongings and put a name on the boxes. She stated that they took the boxes down to storage in the housekeeping supervisors office. She stated that when the resident returned to the facility the housekeeping staff brought the belongings back to the residents' room. LPN #6 stated that if the resident came in on the weekend there were housekeeping staff there but not as late. She stated that if needed they had access to reach the housekeeping supervisor to tell them how to get to the belongings. She stated that everything was locked up and they would have to tell them how to access the key. On 11/12/24 at 12:59 p.m., an interview was conducted with OSM #5, the current business office manager and former admissions director that was copied on the emails referenced above. OSM #5 stated that they did not recall being in any meeting with the former administrator and R397's brother regarding missing personal belongings. She stated that she only remembered being copied on the emails from the residents' brother regarding the missing personal belongings that were sent to the former administrator. She stated that she was not aware of the resolution to the concerns. On 11/12/24 at 1:04 p.m., an interview was conducted with ASM #1, the current administrator. ASM #1 stated that she had spoken to R397's brother when he came in to pick up their belongings after the resident passed away. She stated that she had given the brother a $150 gift card to reimburse them for the missing belongings. ASM #1 stated that her practice was to reach out and try to reimburse if possible and it did not sound like any resolution was made with the former administrator. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 1:20 p.m., an interview was conducted with OSM #6, social services assistant. OSM #6 stated that they had worked at the facility since 6/4/24 and the former social worker no longer worked at the facility. She stated that when a resident reported missing belongings, they took a description, wrote up a service concern and gave it to the admissions director. She stated that they directed the service concern to the appropriate department and missing clothing went to the laundry department. She stated that the appropriate department investigated the concern and signed off as resolved or if not resolved gave it to the administrator for follow-up. She stated that she was not aware of R397 missing personal belongings. On 11/12/24 at 1:37 p.m., an interview was conducted with ASM #2, director of nursing. ASM #2 stated that she was copied on the emails with R397's brother to the former administrator. She stated that there was discussion between the brother and former administrator regarding what was missing, they had searched the rooms, and the former administrator had reached out to the brother offering to replace what he had. She stated that the brother came back with more than what he could prove and was upset that they had given R397 more clothing from the lost and found. ASM #2 stated that there were personal conversations, and the emails sent between the former administrator and the brother and was not sure if there was any additional documentation of any attempts of resolution. She stated that if the concern were resolved it would be on the grievance form and if it had been reimbursed it would have been if the former administrator decided that the things were to be replaced. She stated that the inventory sheet was part of the policy, and they would use that to compare it with what was reported as missing however they were unable to find an inventory sheet on R397. She stated that nursing completed the inventory sheet. ASM #2 stated that she was not involved in any meetings with R397's brother and the former administrator regarding the missing personal belongings. She stated that the expectation to investigate and resolve a grievance was within 48-72 hours and the follow up was normally a verbal interaction or by email with the brother. On 11/12/24 at 1:47 p.m., an interview was conducted with RN #2. RN #2 stated that on admission an inventory of personal belongings was done by the nurse and the CNA. She stated that only valuables like electronics and jewelry were documented and sent to the admissions office. She stated that they reviewed the clothing brought in with the resident and/or family but did not write down a physical list of items. She stated that if a resident or family member reported missing personal belongings, they went to the unit manager and reported it. She stated that she was not sure where it went from there. The facility policy Service Concerns/Grievances dated 1/23/2020 documented in part, The patient has the right to voice/file grievances/complaints (orally, in writing or anonymously) without fear of discrimination or reprisal. The Administrator serves as the grievance official of the Center and is responsible for overseeing the grievance process and for receiving and tracking to their conclusion. Procedure: 1. Patient grievances/complained filed with the Administrator will be processed and tracked via the company Grievance Form. The Administrator will make every reasonable effort to resolve grievances/complaints regarding the rights of the patient as promptly as possible. The review process by the Administrator is anticipated to be complete no later than five (5) business days from the Administrator receiving the filed grievance. 2. The company Grievance Form will be completed by the Administrator. The patient will be provided a written response from the Administrator regarding his or her grievance via the completed company Grievance Form . On 11/12/24 at 4:42 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to protect one of 69 residents from abuse and/or neglect, R447. The findings include: The facility failed to protect R447 from verbal abuse from another resident, R450 based on grievance form, 11/1/23. R447 was admitted to the facility on [DATE] with diagnosis that included but were not limited to arthropathy, muscle wasting, ankle effusion and arthrodesis. The most recent MDS (minimum data set) assessment, a five-day assessment, with an ARD (assessment reference date) of 11/6/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for bed mobility/transfers, dressing, hygiene/toileting; and set up for eating. A review of the comprehensive care plan dated 11/2/23 revealed, FOCUS: Resident is at risk for complications related to psychoactive medication use secondary to diagnoses of: anxiety disorder, depressive disorder. INTERVENTIONS: Observe for signs and symptoms of adverse side effects related to medication use and notify MD as indicated. There is no progress note in R447's medical record. A review of the progress notes in R450's medical record revealed, Type of Behavior: Writer observed the resident cursing and being verbally abusive towards roommate, A-bed, and staff members. Non-pharmacological intervention: Writer listened to the resident and gave the scheduled meds. Effect: Resident continues to tell roommate, A-bed, You talk too fucking much! That nurse [NAME] with the deep voice can get on a boat back to [NAME] for all I care! That aide [NAME] has jacked up teeth need to shut up too. PRN Medication: n/a. Outcome: Resident eventually calmed down on her own and was observed laughing and talking with roommate again. R447 was in bed 121-A and R450 was in bed 121-B An interview was conducted on 11/14/24 at 2:30 PM with LPN (licensed practical nurse) #11. When asked to define abuse, LPN #11 stated, it is acts that are physical, verbal, sexual, financial, emotional or other and is reported up the chain of command. An interview was conducted on 11/14/24 at 3:35 PM with ASM (administrative staff member) #2, the director of nursing. When asked what constitutes abuse, ASM #2 stated, it can be physical, verbal, sexual, financial, emotional and should be reported to administration. If the abuse is resident to resident, we have up to 24 hours to report. If staff to resident allegation of abuse should be reported within 2 hours. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. A review of the facility's Patient Protection policy reveals, Patients of the Center have the legal right to be free from verbal, sexual, mental and physical abuse. Any and all suspected or witnessed incidents of patient abuse, neglect, theft against a patient should be brought to the attention of the Center's administration and will result in internal investigation, timely reporting to the State Survey Agency (SSA) and other legally designated agencies, as well as staff corrective action, suspension, and/or termination as necessary. No further information was provided prior to exit.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to prevent misappropriation of resident's property for one of 69 residents, R451. The findings included: Observations during survey period of 11/6/24-11/21/24 revealed no missing narcotics. A review of the final report from the facility dated 11/14/24 revealed, Oxycodone 5 mg, 30 tablet card for R451 remains missing. Three nurses were suspended pending investigation, LPN (licensed practical nurse) #12 had a negative drug screen, LPN #21 had a negative drug screen and LPN #22 has a prescription for Oxycodone and will test positive. Narcotics were not counted per policy and standards of practice. R451 was credited for the 30 tablets of Oxycodone and the facility will be responsible for payment. Audit of all narcotics books, carts and narcotic returns did not locate the missing 30 tablet Oxycodone card. Police investigated on 11/12/24. Review of Resident Council Minutes 1/24-11/24: There were no concerns regarding misappropriation of narcotics. Review of the facility event synopsis and grievance log 12/22-11/2024 revealed multiple concerns regarding missing clothing. R451 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: COVID, DM (diabetes mellitus) and infection internal fixation device of humerus. The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 11/9/24, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as mod assist for bed mobility, transfer, hygiene and set up for eating. A review of the comprehensive care plan dated 11/2/24 revealed, FOCUS: The resident has a risk for pain related to sec to chronic health conditions, chronic pain, right shoulder, compression fracture. INTERVENTIONS: administer medications as ordered. A review of the physician orders dated 11/3/24 revealed Oxycodone HCl ER Tablet 12 Hour Abuse-Deterrent 5 MG Give 1 tablet by mouth every 12 hours for moderate to severe pain for 14 Days. A review of the November 2024 MAR (medication administration record) revealed no Oxycodone 5 mg administered 11/3/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Rehabilitation and Nursing Center	7300 Forest Ave Richmond, VA 23226

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/24 at 8:30 AM, an interview was conducted with ASM #2, the director of nursing, who revealed, On 11/10/24, the supervisor notified me that there was a discrepancy on unit 3. The unit 2 nurse -LPN #12 walked the card to nurse -LPN #21 on unit 3. Resident transferred on Saturday 11/9. Supervisor went through the carts and did a facility audit to ensure all narcotics were accounted for. Supervisor unable to find the missing card of 30 Oxycodone 5 mg tablets. Next steps; verified with pharmacy that Oxycodone 5 mg tablets had been delivered and was not returned. Contacted police on 11/11-Monday, police came on 11/12, we continued to do audits, 3 nurses suspended sent for urine testing at outside place. LPN #22 was the nurse that LPN #21 would have counted with at 7:00 PM, LPN #22 was night nurse. LPN #21 and LPN #22 failed to count the sheets and the cards both at 7 PM on 11/10 and 7 AM on 11/11. LPN #21 counted with supervisor and realized count was off. We use Concentra for drug testing. LPN #22 did not respond back till 5 PM, Concentra was closed, Patient first would not do test, sent to hospital but wouldn't do because wasn't workers comp. went to Concentra, informed me that she had gotten refill on 11/11, she has chronic back issues and on Oxycodone 10 mg. Concentra then checks on if valid prescription with physician. LPN #12 and LPN #21 urine drug test negative and are back to work. Waiting for LPN #22's urine results to report to DHP. When we had previous diversion, we had an audit in place and have reimplemented that. An interview was conducted on 11/19/24 at 8:25 AM with LPN #12. When asked about the missing Oxycodone, LPN #12 stated, they moved the resident due to COVID and she had 6 narc cards and I put them in the narc box, did not give them. I counted with LPN #21. Overnight we counted but did not count each page and card, next morning, we did not count the pages and card. When I went to count with Berry, the full card of oxycodone and the narcotic page related to oxycodone was missing. I immediately reported to the nursing supervisor that the card and the page were missing. I had to have drug test and investigation, everything was fine and I'm back at work now. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. According to the facility's Responding to abuse/neglect/misappropriation policy, A licensed nurse will immediately respond to all allegations and/or reasonable suspicions of staff to patient, patient to patient, and/or visitor to patient, neglect, abuse, injuries of unknown source, mistreatment, exploitation, misappropriation of patient property or crime against a patient. 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to implement a policy for reporting abuse for two of 69 residents, R447 and R397. The findings include: 1. The facility failed to implement their abuse policy to report occurrences according to regulations. A review of the facility grievance form, dated 11/1/23, revealed Resident 450 overheard verbally abusing roommate R447. R447 was admitted to the facility on [DATE] with diagnosis that included but were not limited to arthropathy, muscle wasting, ankle effusion and arthrodesis. The most recent MDS (minimum data set) assessment, a five-day assessment, with an ARD (assessment reference date) of 11/6/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for bed mobility/transfers, dressing, hygiene/toileting; and set up for eating. A review of the comprehensive care plan dated 11/2/23 revealed, FOCUS: Resident is at risk for complications related to psychoactive medication use secondary to diagnoses of: anxiety disorder, depressive disorder. INTERVENTIONS: Observe for signs and symptoms of adverse side effects related to medication use and notify MD as indicated. There is no progress note in R447's medical record. There is no evidence of a facility event synopsis of this abuse being reported to State Survey Agency (SSA), VDH-OLC (Virginia Department of Health-Office Licensure Certification). A review of the progress notes in R450's medical record revealed, Type of Behavior: Writer observed the resident cursing and being verbally abusive towards roommate, A-bed, and staff members. Non-pharmacological intervention: Writer listened to the resident and gave the scheduled meds. Effect: Resident continues to tell roommate, A-bed, You talk too fucking much! That nurse [NAME] with the deep voice can get on a boat back to [NAME] for all I care! That aide [NAME] has jacked up teeth need to shut up too. PRN Medication: n/a Outcome: Resident eventually calmed down on her own and was observed laughing and talking with roommate again. R447 was in bed 121-A and R450 was in bed 121-B. On 11/14/24 at 2:30 PM an interview was conducted with LPN (licensed practical nurse) #11. When asked to define abuse, LPN #11 stated, it is acts that are physical, verbal, sexual, financial, emotional or other and is reported up the chain of command. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 11/14/24 at 3:35 PM with ASM (administrative staff member) #2, the director of nursing. When asked what constitutes abuse, ASM #2 stated, it can be physical, verbal, sexual, financial, emotional and should be reported to administration. If the abuse is resident to resident, we have up to 24 hours to report. If staff to resident allegation of abuse should be reported within 2 hours. When asked if they had reported this verbal abuse from R450, ASM #2 stated, no, we did not. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. A review of the facility's Patient Protection policy reveals, Patients of the Center have the legal right to be free from verbal, sexual, mental and physical abuse. Any and all suspected or witnessed incidents of patient abuse, neglect, theft against a patient should be brought to the attention of the Center's administration and will result in internal investigation, timely reporting to the State Survey Agency (SSA) and other legally designated agencies, as well as staff corrective action, suspension, and/or termination as necessary. No further information was provided prior to exit. 2. For Resident #397 (R397), the facility staff failed to implement the facility abuse policy to report and investigate an allegation of misappropriation of property. The facility policy Abuse/Neglect/Misappropriation/Crime dated 1/29/2024 documented in part, .In response to all allegations of neglect, abuse, injuries of unknown source, mistreatment, exploitation, misappropriation of patient property, or crime against a patient, a licensed nurse will assure safety .The Administrator and/or Director of Nursing will promptly initiate the investigation and follow guidelines for reporting . Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury . The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, Interviewing alleged victims and witnesses, and involving other appropriate individuals, agents or authorities to assist in the process and determinations . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 11:17 a.m., an interview was conducted with R397's responsible party (brother) who stated that R397 had recently passed away at the facility. He stated that when R397 was hospitalized the facility had packed up all their belongings and moved them out of the room. He stated that no one contacted him to ask if he wanted to pick them up and when R397 came back to the facility there were no belongings in the room, and no one could find them. He stated that he spoke to the floor supervisor, the housekeeping supervisor, the admissions director, the social worker, and the former administrator regarding the belongings being missing but no one found anything or followed up with him. He stated that R397 had belongings that included shoes, multiple pairs of jogging pants, shirts, undershirts, socks, a jacket and several hats missing. He stated that the housekeeping director told him that a trainee had gone in and cleaned R397's room when he went to the hospital and threw everything away by mistake. He stated that the former administrator was a piece of work, and he still felt that the items may have been stolen because they were name brand and most of them were new. A service concern form dated 4/26/24 for R397 documented a concern received by the former administrator at the facility from R397's brother. It documented a phone call received from the brother demanding $600. The form documented an attached email however no email was attached. Under Action Taken to Resolve Concern it documented, Since call & email, [Name of brother] has been asked to provide proof of items. He has not. He claims to have photos of items in facility. He has not provided them. He states in email a value of $340, yet in person is demanding $600. If he feels something was stolen, he was told to report to law enforcement & offered assistance. Instead, he became threatening & was asked to leave. Under Follow up it documented, 5/22/24 [Name of brother] was again in facility and made physical threats, including referencing a gun. Police were called, but he had left prior to law enforcement's arrival. The service concern form documented Resolution Ongoing with no date and the former administrator's signature. An email dated 4/26/24 provided to the state agency from R397's brother to the former administrator of the facility, the director of nursing and the director of admissions at the facility documented in part, Subject: Will be filing a formal complaint related to the Theft of [Name and room number of R397] clothes (6 newly purchased outfits from Sam's Club, Adidas socks, under clothes, black Sketchers slip-on shoes, & Kansas City Chiefs Super bowl team Cap) & $340 . An additional email dated 5/13/24 from R397's brother to the former administrator of the facility, the director of nursing and the director of admissions at the facility documented in part, .This is my 2nd written e-mail request directly to [Name of former administrator], administrator at [Name and address of facility] to provide reimbursement for all items stolen in the THEFT of my oldest brothers clothing from [Room number] . On 11/12/24 at 11:57 a.m., a request was made to ASM (administrative staff member) #1, the current administrator for a copy of the personal inventory list for R397. ASM #1 stated that the former administrator no longer worked for the company and was not available for interview. On 11/12/24 at 1:37 p.m., ASM #2, the director of nursing stated that they did not have a personal inventory list for R397 to provide. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 12:39 p.m., an interview was conducted with OSM (other staff member) #4, the director of housekeeping and laundry. OSM #4 stated that in April of 2024 when a resident went out to the hospital the housekeeping staff packed up the clothing and personal belongings until recently when they changed the process and now the nursing staff packed everything. He stated that the boxes were labeled with the resident's name and brought down to his office and placed in a storage room. OSM #4 stated that when the resident came back to the facility the staff were able to come down and pick up the resident's belongings. He stated that the office was always unlocked, and the storage room was unlocked so all staff could access it. He stated that as far as he knew all staff were aware of this. He stated that he remembered R397 and talking with R397's brother. He stated that it was about a week or so after the clothes went missing when the brother came to the facility and the former administrator paged him because the brother was acting erratically. He stated that he came upstairs and took him downstairs, and they searched the storage room together but could not find any of R397's belongings. OSM #4 stated that he was unable to resolve the grievance. He stated that when they were not able to find the missing belongings that they notified the resident or family, tried to find an alternate resolution, the value of the missing items and then he went to the administrator to see if they could replace the items. He stated that the expectation was to find the missing items or resolve the grievance within two days. On 11/12/24 at 12:59 p.m., an interview was conducted with OSM #5, the current business office manager and former admissions director that was copied on the emails referenced above. OSM #5 stated that they did not recall being in any meeting with the former administrator and R397's brother regarding missing personal belongings. She stated that she only remembered being copied on the emails from the residents' brother regarding the missing personal belongings that were sent to the former administrator. She stated that she was not aware of the resolution to the concerns. On 11/12/24 at 1:04 p.m., an interview was conducted with ASM #1, the current administrator. ASM #1 stated that she had spoken to R397's brother when he came in to pick up their belongings after the resident passed away. She stated that she had given the brother a $150 gift card to reimburse them for the missing belongings. ASM #1 stated that her practice was to reach out and try to reimburse if possible and it did not sound like any resolution was made with the former administrator. On 11/12/24 at 1:37 p.m., an interview was conducted with ASM #2, director of nursing. ASM #2 stated that she was copied on the emails with R397's brother to the former administrator. She stated that there was discussion between the brother and former administrator regarding what was missing, they had searched the rooms, and the former administrator had reached out to the brother offering to replace what he had. She stated that the brother came back with more than what he could prove and was upset that they had given R397 more clothing from the lost and found. ASM #2 stated that there were personal conversations, and the emails sent between the former administrator and the brother and was not sure if there was any additional documentation of any attempts of resolution. She stated that if the concern were resolved it would be on the grievance form and if it had been reimbursed it would have been if the former administrator decided that the things were to be replaced. She stated that the inventory sheet was part of the policy, and they would use that to compare it with what was reported as missing however they were unable to find an inventory sheet on R397. She stated that nursing completed the inventory sheet. ASM #2 stated that she was not involved in any meetings with R397's brother and the former administrator regarding the missing personal belongings. She stated that the expectation to investigate and resolve a grievance was within 48-72 hours and the follow up was normally a verbal interaction or by email with the brother. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 3:38 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that when a resident or family member reported personal belongings possibly being stolen, they would report it and investigate it. She stated when the word stolen was used from her perspective it was reportable and was something that they would investigate. She stated that they would investigate this because it was possible misappropriation, and they had to rule that out. She stated that the investigation would include checking the inventory sheet, interviewing the staff, and checking in the laundry. She stated that she as the administrator had the decision making for reimbursement for missing personal belongings and sent very expensive items to corporate for review. She stated that it was her understanding is that it was a new CNA who put R397's belongings in the wrong bag and they had begun a process to keep linen in-house to prevent loss. On 11/12/24 at 4:02 p.m., ASM #2 stated that they did not have a reported facility synopsis of events for the allegation of misappropriation of R397's property. On 11/12/24 at 4:42 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. A review of the facility grievance form, dated 11/1/23, revealed Resident 450 overheard verbally abusing roommate R447. R447 was admitted to the facility on [DATE] with diagnosis that included but were not limited to arthropathy, muscle wasting, ankle effusion and arthrodesis. The most recent MDS (minimum data set) assessment, a five-day assessment, with an ARD (assessment reference date) of 11/6/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assistance for bed mobility/transfers, dressing, hygiene/toileting; and set up for eating. A review of the comprehensive care plan dated 11/2/23 revealed, FOCUS: Resident is at risk for complications related to psychoactive medication use secondary to diagnoses of: anxiety disorder, depressive disorder. INTERVENTIONS: Observe for signs and symptoms of adverse side effects related to medication use and notify MD as indicated. There is no progress note in R447's medical record. There is no evidence of a facility event synopsis of this abuse being reported to State Survey Agency (SSA), VDH-OLC (Virginia Department of Health-Office Licensure Certification). A review of the progress notes in R450's medical record revealed, Type of Behavior: Writer observed the resident cursing and being verbally abusive towards roommate, A-bed, and staff members. Non-pharmacological intervention: Writer listened to the resident and gave the scheduled meds. Effect: Resident continues to tell roommate, A-bed, You talk too fucking much! That nurse [NAME] with the deep voice can get on a boat back to [NAME] for all I care! That aide [NAME] has jacked up teeth need to shut up too. PRN Medication: n/a Outcome: Resident eventually calmed down on her own and was observed laughing and talking with roommate again. R447 was in bed 121-A and R450 was in bed 121-B An interview was conducted on 11/14/24 at 2:30 PM with LPN (licensed practical nurse) #11. When asked to define abuse, LPN #11 stated, it is acts that are physical, verbal, sexual, financial, emotional or other and is reported up the chain of command. An interview was conducted on 11/14/24 at 3:35 PM with ASM (administrative staff member) #2, the director of nursing. When asked what constitutes abuse, ASM #2 stated, it can be physical, verbal, sexual, financial, emotional and should be reported to administration. If the abuse is resident to resident, we have up to 24 hours to report. If staff to resident allegation of abuse should be reported within 2 hours. When asked if they had reported this verbal abuse from R450, ASM #2 stated, no, we did not. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. A review of the facility's Patient Protection policy reveals, Patients of the Center have the legal right to be free from verbal, sexual, mental and physical abuse. Any and all suspected or witnessed incidents of patient abuse, neglect, theft against a patient should be brought to the attention of the Center's administration and will result in internal investigation, timely reporting to the State Survey Agency (SSA) and other legally designated agencies, as well as staff corrective action, suspension, and/or termination as necessary. No further information was provided prior to exit. 3. For Resident #397 (R397), the facility staff failed to report an allegation of misappropriation of property. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/8/24, the resident was assessed as being severely impaired for making daily decisions. On 11/12/24 at 11:17 a.m., an interview was conducted with R397's responsible party (brother) who stated that R397 had recently passed away at the facility. He stated that while R397 was hospitalized the facility had packed up all their belongings and moved them out of the room. He stated that no one contacted him to ask if he wanted to pick them up and when R397 came back to the facility there were no belongings in the room, and no one could find them. He stated that he spoke to the floor supervisor, the housekeeping supervisor, the admissions director, the social worker, and the former administrator regarding the belongings being missing but no one found anything or followed up with him. He stated that he emailed the former administrator multiple times and was told that they had filed the report in New Jersey for reimbursement, but they never received any follow up until the current administrator spoke with him after R397 passed away in October 2024. He stated that R397 had belongings that included shoes, multiple pairs of jogging pants, shirts, undershirts, socks, a jacket and several hats missing. He stated that when he met with the new administrator in October 2024, she offered him a gift card for $150 which he accepted because he felt that at the present, there was not much left to do because his brother had passed away, but he wanted to help others who may be in the same situation. He stated that the housekeeping director told him that a trainee had gone in and cleaned R397's room when he went to the hospital and threw everything away by mistake. He stated that the former administrator was a piece of work, and he still felt that the items may have been stolen because they were name brand and most of them were new. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A service concern form dated 4/26/24 for R397 documented a concern received by the former administrator at the facility from R397's brother. It documented a phone call received from the brother demanding $600. The form documented an attached email however no email was attached. Under Action Taken to Resolve Concern it documented, Since call & email, [Name of brother] has been asked to provide proof of items. He has not. He claims to have photos of items in facility. He has not provided them. He states in email a value of $340, yet in person is demanding $600. If he feels something was stolen, he was told to report to law enforcement & offered assistance. Instead, he became threatening & was asked to leave. Under Follow up it documented, 5/22/24 [Name of brother] was again in facility and made physical threats, including referencing a gun. Police were called, but he had left prior to law enforcement's arrival. The service concern form documented Resolution Ongoing with no date and the former administrator's signature. An email dated 4/26/24 provided to the state agency from R397's brother to the former administrator of the facility, the director of nursing and the director of admissions at the facility documented in part, Subject: Will be filing a formal complaint related to the Theft of [Name and room number of R397] clothes (6 newly purchased outfits from Sam's Club, Adidas socks, under clothes, black Sketchers slip-on shoes, & Kansas City Chiefs Super bowl team Cap) & $340 . An additional email dated 5/13/24 from R397's brother to the former administrator of the facility, the director of nursing and the director of admissions at the facility documented in part, .This is my 2nd written e-mail request directly to [Name of former administrator], administrator at [Name and address of facility] to provide reimbursement for all items stolen in the THEFT of my oldest brothers clothing from [Room number] . Review of the clinical record for R397 failed to evidence documentation of a personal belonging inventory list or any concerns regarding missing personal belongings voiced by the family. It documented R397's brother being the responsible party and emergency contact. The clinical record documented R397 being hospitalized from [DATE]-[DATE] and returning to the same room at the facility. On 11/12/24 at 11:57 a.m., a request was made to ASM (administrative staff member) #1, the current administrator for a copy of the personal inventory list for R397. ASM #1 stated that the former administrator no longer worked for the company and was not available for interview. On 11/12/24 at 1:37 p.m., ASM #2, the director of nursing stated that they did not have a personal inventory list for R397 to provide. (continued on next page)

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	495227	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Rehabilitation and Nursing Center	7300 Forest Ave Richmond, VA 23226

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 12:39 p.m., an interview was conducted with OSM (other staff member) #4, the director of housekeeping and laundry. OSM #4 stated that in April of 2024 when a resident went out to the hospital the housekeeping staff packed up the clothing and personal belongings until recently when they changed the process and now the nursing staff packed everything. He stated that the boxes were labeled with the resident's name and brought down to his office and placed in a storage room. OSM #4 stated that when the resident came back to the facility the staff were able to come down and pick up the resident's belongings. He stated that the office was always unlocked, and the storage room was unlocked so all staff could access it. He stated that as far as he knew all staff were aware of this. He stated that he remembered R397 and talking with R397's brother. He stated that it was about a week or so after the clothes went missing when the brother came to the facility and the former administrator paged him because the brother was acting erratically. He stated that he came upstairs and took him downstairs, and they searched the storage room together but could not find any of R397's belongings. OSM #4 stated that he was unable to resolve the grievance. He stated that when they were not able to find the missing belongings that they notified the resident or family, tried to find an alternate resolution, the value of the missing items and then he went to the administrator to see if they could replace the items. He stated that the expectation was to find the missing items or resolve the grievance within two days. On 11/12/24 at 12:59 p.m., an interview was conducted with OSM #5, the current business office manager and former admissions director that was copied on the emails referenced above. OSM #5 stated that they did not recall being in any meeting with the former administrator and R397's brother regarding missing personal belongings. She stated that she only remembered being copied on the emails from the residents' brother regarding the missing personal belongings that were sent to the former administrator. She stated that she was not aware of the resolution to the concerns. On 11/12/24 at 1:04 p.m., an interview was conducted with ASM #1, the current administrator. ASM #1 stated that she had spoken to R397's brother when he came in to pick up their belongings after the resident passed away. She stated that she had given the brother a $150 gift card to reimburse them for the missing belongings. ASM #1 stated that her practice was to reach out and try to reimburse if possible and it did not sound like any resolution was made with the former administrator. On 11/12/24 at 1:37 p.m., an interview was conducted with ASM #2, director of nursing. ASM #2 stated that she was copied on the emails with R397's brother to the former administrator. She stated that there was discussion between the brother and former administrator regarding what was missing, they had searched the rooms, and the former administrator had reached out to the brother offering to replace what he had. She stated that the brother came back with more than what he could prove and was upset that they had given R397 more clothing from the lost and found. ASM #2 stated that there were personal conversations, and the emails sent between the former administrator and the brother and was not sure if there was any additional documentation of any attempts of resolution. She stated that if the concern were resolved it would be on the grievance form and if it had been reimbursed it would have been if the former administrator decided that the things were to be replaced. She stated that the inventory sheet was part of the policy, and they would use that to compare it with what was reported as missing however they were unable to find an inventory sheet on R397. She stated that nursing completed the inventory sheet. ASM #2 stated that she was not involved in any meetings with R397's brother and the former administrator regarding the missing personal belongings. She stated that the expectation to investigate and resolve a grievance was within 48-72 hours and the follow up was normally a verbal interaction or by email with the brother. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 3:38 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that when a resident or family member reported personal belongings possibly being stolen, they would report it and investigate it. She stated when the word stolen was used from her perspective it was reportable and was something that they would investigate. She stated that they would investigate this because it was possible misappropriation, and they had to rule that out. She stated that the investigation would include checking the inventory sheet, interviewing the staff, and checking in the laundry. She stated that she as the administrator had the decision making for reimbursement for missing personal belongings and sent very expensive items to corporate for review. She stated that it was her understanding is that it was a new CNA who put R397's belongings in the wrong bag and they had begun a process to keep linen in-house to prevent loss. On 11/12/24 at 4:02 p.m., ASM #2 stated that they did not have a facility synopsis of events for the allegation of misappropriation of R397's property. The facility policy Abuse/Neglect/Misappropriation/Crime dated 1/29/2024 documented in part, .In response to all allegations of neglect, abuse, injuries of unknown source, mistreatment, exploitation, misappropriation of patient property, or crime against a patient, a licensed nurse will assure safety .The Administrator and/or Director of Nursing will promptly initiate the investigation and follow guidelines for reporting . Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury . The facility was previously found to be out of compliance for reporting alleged violations and provided an accepted plan of correction with a date of compliance of 10/25/2024. There were no current concerns regarding reporting of alleged violations. On 11/12/24 at 4:42 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit. PAST NONCOMPLIANCE Based on staff interview, facility document review, and clinical record review, the facility staff failed to report allegations of abuse to the state agency in a timely manner for three of 69 residents in the survey sample, Residents #182, #447, and #397. The findings include: 1. For Resident #182 (R182), the facility staff failed to report an allegation of abuse within two hours. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility synopsis of events submitted to the state agency on 9/25/24 documented, On 9/23/2024 Resident reported to the Director of Admissions that the 11-7 shift was mean, told him 'to shut up, as closing his door, just die.' He also stated that they did not feed him nor change him with feces for 5 [sic] and reported to Administrator. On 11/14/24 at 10:23 a.m., an interview was conducted with OSM (other staff member) #13 (the former director of admissions). OSM #13 stated that on 9/23/24 at approximately 10:00 a.m., he spoke with R182, and the resident reported he was left in feces for five hours, the night shift nurse told him to shut up because staff were working short, and the night shift nurse told him if he wanted to stay alive then he would be quiet. OSM #13 stated he immediately reported R182's allegations to the administrator and director of nursing at approximately 10:15 a.m. on that same day. The former administrator was no longer employed at the facility. On 11/14/24 at 3:34 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated an allegation of abuse should be reported to the state agency within two hours. ASM #2 stated she usually reports allegations of abuse to the state agency as soon as she is made aware, and she did not recall when OSM #13 reported R182's allegation of abuse. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 were made aware of the above concern. The facility abuse policy titled, Reporting Requirements/Investigations documented, 1. Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility corrective action plan dated 9/25/24 documented, Immediate Response- what was done at the time: Upon knowledge RDCS (regional director of clinical services) submitted FRI (facility reported incident) on 9/24/2024 for 1st identified resident, staff member was sent home pending investigation. Upon knowledge on 9/25/2024 FRI submitted for allegations of abuse/neglect with 2 staff members suspended. How to Identify other residents that might be impacted: All resident have the potential to be affected. An audit conducted by DON (director of nursing) or designee to interview other residents on the staff assignment to identify any concerns. Residents that cannot be interviewed had skin assessments completed. Findings will have the abuse policy followed. What Measures were put in place to prevent reoccurrence: Education by SDC (staff development coordinator) or designee to facility staff on the abuse policy, all employees are mandated reporters. Must protect residents, report to DON or Administrator. The accused staff member will be immediately removed from resident care area, sent home pending investigation to protect the resident and/or other residents from further risk for actual alleged abuse. The DON or Administrator or designee will submit FRI, in include state agencies, notifications of MD/RP (medical doctor/responsible party) as applicable with initiation of investigation. How to monitor to ensure the problem does not reoccur: Audits by the DON or Administrator to review weekly x 4 the 24-hour report, service concerns and/or reported suspected or allegation of abuse to verify the abuse policy/process was followed with resident was protected, staff member suspended pending investigation and reported to the DON or Administrator with submission of FRI and investigation. QA (Quality Assurance): The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance is sustained. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. Date of compliance: 10/25/2024. All credible evidence regarding this corrective action plan was verified during the survey. PAST NON-COMPLIANCE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility document review, and staff interview, it was determined that the facility staff failed to investigate an allegation of misappropriation of property for 1 of 69 residents in the survey sample, Resident #397. The findings include: For Resident #397 (R397), the facility staff failed to investigate an allegation of misappropriation of property. On 11/12/24 at 11:17 a.m., an interview was conducted with R397's responsible party (brother) who stated that R397 had recently passed away at the facility. He stated that while R397 was hospitalized the facility had packed up all their belongings and moved them out of the room. He stated that no one contacted him to ask if he wanted to pick them up and when R397 came back to the facility there were no belongings in the room, and no one could find them. He stated that he spoke to the floor supervisor, the housekeeping supervisor, the admissions director, the social worker, and the former administrator regarding the belongings being missing but no one found anything or followed up with him. He stated that he emailed the former administrator multiple times and was told that they had filed the report in New Jersey for reimbursement, but they never received any follow up until the current administrator spoke with him after R397 passed away in October 2024. He stated that R397 had belongings that included shoes, multiple pairs of jogging pants, shirts, undershirts, socks, a jacket and several hats missing. He stated that when he met with the new administrator in October of 2024, she offered him a gift card for $150 which he accepted because he felt that at the present, there was not much left to do because his brother had passed away, but he wanted to help others who may be in the same situation. He stated that the housekeeping director told him that a trainee had gone in and cleaned R397's room when he went to the hospital and threw everything away by mistake. He stated that the former administrator was a piece of work, and he still felt that the items may have been stolen because they were name brand and most of them were new. A service concern form dated 4/26/24 for R397 documented a concern received by the former administrator at the facility from R397's brother. It documented a phone call received from the brother demanding $600. The form documented an attached email however no email was attached. Under Action Taken to Resolve Concern it documented, Since call & email, [Name of brother] has been asked to provide proof of items. He has not. He claims to have photos of items in facility. He has not provided them. He states in email a value of $340, yet in person is demanding $600. If he feels something was stolen, he was told to report to law enforcement & offered assistance. Instead, he became threatening & was asked to leave. Under Follow up it documented, 5/22/24 [Name of brother] was again in facility and made physical threats, including referencing a gun. Police were called, but he had left prior to law enforcement's arrival. The service concern form documented Resolution Ongoing with no date and the former administrator's signature. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An email dated 4/26/24 provided to the state agency addressed to the former administrator of the facility, the director of nursing and the director of admissions at the facility from R397's brother documented in part, Subject: Will be filing a formal complaint related to the Theft of [Name and room number of R397] clothes (6 newly purchased outfits from Sam's Club, Adidas socks, under clothes, black Sketchers slip-on shoes, & Kansas City Chiefs Super bowl team Cap) & $340 . An additional email dated 5/13/24 from R397's brother to the former administrator of the facility, the director of nursing and the director of admissions at the facility documented in part, .This is my 2nd written e-mail request directly to [Name of former administrator], administrator at [Name and address of facility] to provide reimbursement for all items stolen in the THEFT of my oldest brothers clothing from [Room number] . On 11/12/24 at 12:39 p.m., an interview was conducted with OSM (other staff member) #4, the director of housekeeping and laundry. OSM #4 stated that in April of 2024 when a resident went out to the hospital the housekeeping staff packed up the clothing and personal belongings until recently when they changed the process and now the nursing staff packed everything. He stated that the boxes were labeled with the resident's name and brought down to his office and placed in a storage room. OSM #4 stated that when the resident came back to the facility the staff were able to come down and pick up the resident's belongings. He stated that the office was always unlocked, and the storage room was unlocked so all staff could access it. He stated that as far as he knew all staff were aware of this. He stated that he remembered R397 and talking with R397's brother. He stated that it was about a week or so after the clothes went missing when the brother came to the facility and the former administrator paged him because the brother was acting erratically. He stated that he came upstairs and took him downstairs, and they searched the storage room together but could not find any of R397's belongings. OSM #4 stated that he was unable to resolve the grievance. He stated that when they were not able to find the missing belongings that they notified the resident or family, tried to find an alternate resolution, the value of the missing items and then he went to the administrator to see if they could replace the items. He stated that the expectation was to find the missing items or resolve the grievance within two days. On 11/12/24 at 12:59 p.m., an interview was conducted with OSM #5, the current business office manager and former admissions director that was copied on the emails referenced above. OSM #5 stated that they did not recall being in any meeting with the former administrator and R397's brother regarding missing personal belongings. She stated that she only remembered being copied on the emails from the residents' brother regarding the missing personal belongings that were sent to the former administrator. She stated that she was not aware of the resolution to the concerns. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/24 at 1:37 p.m., an interview was conducted with ASM #2, director of nursing. ASM #2 stated that she was copied on the emails with R397's brother to the former administrator. She stated that there was discussion between the brother and former administrator regarding what was missing, they had searched the rooms, and the former administrator had reached out to the brother offering to replace what he had. She stated that the brother came back with more than what he could prove and was upset that they had given R397 more clothing from the lost and found. ASM #2 stated that there were personal conversations, and the emails sent between the former administrator and the brother and was not sure if there was any additional documentation of any attempts of resolution. She stated that if the concern were resolved it would be on the grievance form and if it had been reimbursed it would have been if the former administrator decided that the things were to be replaced. She stated that the inventory sheet was part of the policy, and they would use that to compare it with what was reported as missing however they were unable to find an inventory sheet on R397. She stated that nursing completed the inventory sheet. ASM #2 stated that she was not involved in any meetings with R397's brother and the former administrator regarding the missing personal belongings. She stated that the expectation to investigate and resolve a grievance was within 48-72 hours and the follow up was normally a verbal interaction or by email with the brother. On 11/12/24 at 3:38 p.m., an interview was conducted with ASM #1, the current administrator. ASM #1 stated that when a resident or family member reported personal belongings possibly being stolen, they would report it and investigate it. She stated when the word stolen was used from her perspective it was reportable and was something that they would investigate. She stated that they would investigate this because it was possible misappropriation, and they had to rule that out. She stated that the investigation would include checking the inventory sheet, interviewing the staff, and checking in the laundry. She stated that she as the administrator had the decision making for reimbursement for missing personal belongings and sent very expensive items to corporate for review. She stated that it was her understanding is that it was a new CNA (certified nursing assistant) who put R397's belongings in the wrong bag and they had begun a process to keep linen in-house to prevent loss. On 11/12/24 at 4:02 p.m., ASM #2 stated that they did not have a facility synopsis of events for the allegation of misappropriation of R397's property. The facility policy Abuse/Neglect/Misappropriation/Crime dated 1/29/2024 documented in part, .In response to all allegations of neglect, abuse, injuries of unknown source, mistreatment, exploitation, misappropriation of patient property, or crime against a patient, a licensed nurse will assure safety .The Administrator and/or Director of Nursing will promptly initiate the investigation and follow guidelines for reporting . The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, Interviewing alleged victims and witnesses, and involving other appropriate individuals, agents or authorities to assist in the process and determinations . On 11/12/24 at 4:42 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 4. The facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for R67. R67 was transferred to the hospital on [DATE]. R67 was identified through the closed record review. R67 was admitted to the facility on [DATE] with diagnosis that included paraplegia, post hemorrhagic anemia and pseudomonas. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/25/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring max assistance for mobility/transfers, dressing, hygiene toileting and independent for eating. A review of the baseline care plan dated 7/19/24 revealed, FOCUS: The resident is at risk for bleeding, hemorrhage, excessive bruising and complications related to anticoagulant use secondary to: history of DVT. INTERVENTIONS: Observe for signs and symptoms of bleeding, bruising, and complications and notify MD as indicated. A review of the progress note dated 11/15/24 at 9:22 AM revealed, Resident was noted to have increased bloody drainage from his sacral/buttocks/ischial wounds. Status post debridement at the wound clinic. Wound team present & evaluated area, MD/NP were updated & order received to send out to ER for further evaluation & treatment. The transfer form's Acute Care Document Transfer List was not completed. No evidence of documents sent with R67 to the hospital. No provider note post transfer to hospital was located. On 11/20/24 at 10:05 a.m., an interview was conducted with ASM (administrative staff member) #5 (a nurse practitioner). ASM #5 stated she does not necessarily document a note each time a resident is sent to the hospital. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that when a resident is discharged to the hospital, the nurses should complete and send a transfer and discharge report that contains a list of the resident's medications, the resident's care plan, and a progress note. LPN #3 stated the nurses should also complete and send a bigger packet of forms that's called an unplanned discharge and the packet should be scanned into the resident's electronic clinical record. LPN #3 stated she has never known the physicians or nurse practitioners to document a note regarding the basis for discharge and the resident needs that could not be met when residents are discharged to the hospital. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the 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 - Some	Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement facility-initiated transfer/discharge requirements for four of 69 residents in the survey sample, Residents #121, #130, #108, and #67. The findings include: 1.a. For Resident #121 (R121), the facility staff failed to evidence required information was provided to hospital staff when the resident was discharged to the hospital on 7/25/24 and 8/31/24. A review of R121's clinical record revealed a nurse's note dated 7/25/24 that documented the resident was transferred to the hospital for shortness of breath and a low oxygen level, and a nurse's note dated 8/31/24 that documented the resident was transferred to the hospital for an elevated temperature and low blood pressure. Further review of R121's clinical record failed to reveal evidence of information that was provided to the hospital staff on both dates. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that when a resident is discharged to the hospital, the nurses should complete and send a transfer and discharge report that contains a list of the resident's medications, the resident's care plan, and a progress note. LPN #3 stated the nurses should also complete and send a bigger packet of forms that's called an unplanned discharge, and the packet should be scanned into the resident's electronic clinical record. LPN #3 reviewed R121's electronic clinical record and could not find evidence of information that was provided to the hospital staff when R121 was sent to the hospital on 7/25/24 and 8/31/24. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Patient Transfer documented, 3. Generate the chart for the last 7 days and provide information to the receiving facility. No further information was presented prior to exit. 1.b. For Resident #121 (R121), the facility staff failed to ensure the physician documented the basis for discharge and the resident needs that could not be met when the resident was discharged to the hospital on 7/25/24 and 8/31/24. A review of R121's clinical record revealed a nurse's note dated 7/25/24 that documented the resident was transferred to the hospital for shortness of breath and a low oxygen level, and a nurse's note dated 8/31/24 that documented the resident was transferred to the hospital for an elevated temperature and low blood pressure. Further review of R121's clinical record failed to reveal the physician (or nurse practitioner) documented the basis for discharge and the resident needs that could not be met when R121 discharged on both dates. On 11/20/24 at 10:05 a.m., an interview was conducted with ASM (administrative staff member) #5 (a nurse practitioner). ASM #5 stated she does not necessarily document a note each time a resident is sent to the hospital. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Rehabilitation and Nursing Center	7300 Forest Ave Richmond, VA 23226

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated she has never known the physicians or nurse practitioners to document a note regarding the basis for discharge and the resident needs that could not be met when residents are discharged to the hospital. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not provide a specific policy regarding physician documentation and discharges. No further information was presented prior to exit. 2. For Resident #130 (R130), the facility staff failed to evidence the comprehensive care plan was sent to the hospital upon transfer on 8/3/24. The nurse's note dated. 8/3/24 at 11:16 a.m. documented, Resident observed with an oxygen level of 94%. Resident c/o (complained of) sob (shortness of breath). Resident observed with using accessory muscles to breathe. Resident c/o chest pain and upper right and left abdominal pain. Resident rate pain 10/10. Resident was placed on non-breather oxygen improved to 99%. NP (nurse practitioner) notified of change of condition. New order to transfer to hospital. Resident is own rp (responsible party). Resident was made aware of the transfer. Resident was sent to (name of hospital) ED (emergency department) via ems (emergency medical services) with face sheet, med (medication) list and transfer form. The Acute Care Transfer Document Checklist dated 8/3/24 failed to evidence what documents were sent to the hospital upon transfer. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that when a resident is discharged to the hospital, the nurses should complete and send a transfer and discharge report that contains a list of the resident's medications, the resident's care plan, and a progress note. LPN #3 stated the nurses should also complete and send a bigger packet of forms that's called an unplanned discharge, and the packet should be scanned into the resident's electronic clinical record. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 11/20/24 at 4:00 p.m. No further information was provided prior to exit. 3. For Resident #108 (R108), the facility staff failed to provide evidence the physician and/or nurse practitioner wrote a progress note for the reason of the transfer to the hospital on 9/21/24. The eINTERACT note dated 9/21/24 at 3:20 a.m. documented in part, Evaluation: nausea/vomiting shortness of breath .Recommendations: Send pt (patient) to ER (emergency room) for evaluation. Further review of the clinical record failed to evidence a physician and/or nurse practitioner wrote a progress note related to the reason for the transfer and why the resident's needs could not be met at the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 10:05 a.m., an interview was conducted with ASM (administrative staff member) #5 (a nurse practitioner). ASM #5 stated she does not necessarily document a note each time a resident is sent to the hospital. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated she has never known the physicians or nurse practitioners to document a note regarding the basis for discharge and the resident needs that could not be met when residents are discharged to the hospital. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 11/20/24 at 4:00 p.m. No further information was provided prior to exit.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 5. The facility staff failed to evidence written notification to RP at the time of discharge for R67. R67 was transferred to the hospital on [DATE]. R67 was identified through the closed record review. R67 was admitted to the facility on [DATE] with diagnosis that included paraplegia, post hemorrhagic anemia and pseudomonas. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/25/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring max assistance for mobility/transfers, dressing, hygiene toileting and independent for eating. A review of the baseline care plan dated 7/19/24 revealed, FOCUS: The resident is at risk for bleeding, hemorrhage, excessive bruising and complications related to anticoagulant use secondary to: history of DVT. INTERVENTIONS: Observe for signs and symptoms of bleeding, bruising, and complications and notify MD as indicated. A review of the progress note dated 11/15/24 at 9:22 AM revealed, Resident was noted to have increase d bloody drainage from his sacral/buttocks/ischial wounds. Status post debridement at the wound clinic. Wound team present & evaluated area, MD/NP were updated & order received to send out to ER for further evaluation & treatment. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated a written notice of transfer should be provided to a resident/resident representative when a resident is sent to the hospital. LPN #3 stated evidence that a written notice of transfer was provided to a resident/resident representative should be documented under the assessment tab in the electronic clinical record and a paper form should be scanned into the electronic clinical record. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. No further information was provided prior to exit. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide a written notice of transfer to the resident/resident representative and/or ombudsman for five of 69 residents in the survey sample, Residents #121, #130, #108, #74, and #67. The findings include: 1. a. For Resident #121 (R121), the facility staff failed to provide a written notice of transfer to the resident/resident representative when the resident was transferred to the hospital on 7/25/24 and 8/31/24. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R121's clinical record revealed a nurse's note dated 7/25/24 that documented the resident was transferred to the hospital for shortness of breath and a low oxygen level, and a nurse's note dated 8/31/24 that documented the resident was transferred to the hospital for an elevated temperature and low blood pressure. Further review of R121's clinical record failed to reveal a written notice of transfer, including the reason for the transfer, was provided to the resident/resident representative on both dates. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated a written notice of transfer should be provided to a resident/resident representative when a resident is sent to the hospital. LPN #3 stated evidence that a written notice of transfer was provided to a resident/resident representative should be documented under the assessment tab in the electronic clinical record and a paper form should be scanned into the electronic clinical record. R121's record was reviewed with LPN #3. LPN #3 stated she did not see evidence that a written notice of transfer was provided to R121 or the resident's representative when the resident was sent to the hospital on 7/25/24 or 8/31/24. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not provide a specific policy regarding written notice of transfer to the resident/resident representative and/or ombudsman. No further information was presented prior to exit. 1.b. For Resident #121 (R121), the facility staff failed to provide a written notice of transfer to the ombudsman when the resident was transferred to the hospital on 8/31/24. A review of R121's clinical record revealed a nurse's note dated 8/31/24 that documented the resident was transferred to the hospital for an elevated temperature and low blood pressure. Further review of R121's clinical record failed to reveal a written notice of transfer was provided to the ombudsman. On 11/20/24 at 11:23 a.m., an interview was conducted with OSM (other staff member) #6 (the social services assistant/discharge planner). OSM #6 stated the social services director was responsible for ombudsman notification and a fax that documented all resident discharges was supposed to be sent to the ombudsman each month. OSM #6 stated a new social services director just began employment on the previous Monday. A review of the facility ombudsman fax book failed to reveal any faxes regarding August 2024 resident discharges. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 2. For Resident #130 (R130) the facility staff failed to evidence the resident and/or responsible party was provided a written notice for the reason of the need for transfer to the hospital on 8/3/24 and failed to notify the ombudsman of the transfer in a timely manner. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nurse's note dated. 8/3/24 at 11:16 a.m. documented, Resident observed with an oxygen level of 94%. Resident c/o (complained of) sob (shortness of breath). Resident observed with using accessory muscles to breathe. Resident c/o chest pain and upper right and left abdominal pain. Resident rate pain 10/10. Resident was placed on non-breather oxygen improved to 99%. NP (nurse practitioner) notified of change of condition. New order to transfer to hospital. Resident is own rp (responsible party). Resident was made aware of the transfer. Resident was sent to (name of hospital) ED (emergency department) via ems (emergency medical services) with face sheet, med (medication) list and transfer form. Review of the clinical record failed to evidence documentation of a written notice provided to the resident and/or responsible party for the transfer on 8/3/24. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated a written notice of transfer should be provided to a resident/resident representative when a resident is sent to the hospital. LPN #3 stated evidence that a written notice of transfer was provided to a resident/resident representative should be documented under the assessment tab in the electronic clinical record and a paper form should be scanned into the electronic clinical record. Documentation was provided that the ombudsman was notified of the 8/3/24 transfer on 11/18/24. On 11/20/24 at 11:23 a.m., an interview was conducted with OSM (other staff member) #6 (the social services assistant/discharge planner). OSM #6 stated the social services director was responsible for ombudsman notification and a fax that documented all resident discharges was supposed to be sent to the ombudsman each month. OSM #6 stated a new social services director just began employment on the previous Monday. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 11/20/24 at 4:00 p.m. No further information was provided prior to exit. 3. For Resident #108, the facility staff failed to evidence the resident and/or responsible party was provided a written notice for the reason of the need for transfer to the hospital on 7/19/24 and 8/31/24 and failed to notify the ombudsman of the transfer in a timely manner for a transfer on 8/31/24 and 9/21/24. The eINTERACT note dated 9/21/24 at 3:20 a.m. documented in part, Evaluation: nausea/vomiting shortness of breath .Recommendations: Send pt (patient) to ER (emergency room) for evaluation. The facility staff provided a document dated, 7/19/24 that documented in part, Deliverance of Notice: this notice was given/communicated telephonically to the resident/resident representative on 7/19/24 by (name of nurse). (R108) and (name of responsible party) in agreement for transfer 7/19/24. The facility staff provided a document dated, 8/31/24 that documented in part, Deliverance of Notice: this notice was given/communicated telephonically to the resident/resident representative on 8/31/24 by (name of nurse). Message left for brother 8/31/24. ER (emergency room) export (911) took to ER unresponsive - full code. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated a written notice of transfer should be provided to a resident/resident representative when a resident is sent to the hospital. LPN #3 stated evidence that a written notice of transfer was provided to a resident/resident representative should be documented under the assessment tab in the electronic clinical record and a paper form should be scanned into the electronic clinical record. Documentation was provided the ombudsman was notified of the transfers on 8/31/24 and 9/21/24 on 11/18/24. On 11/20/24 at 11:23 a.m., an interview was conducted with OSM (other staff member) #6 (the social services assistant/discharge planner). OSM #6 stated the social services director was responsible for ombudsman notification and a fax that documented all resident discharges was supposed to be sent to the ombudsman each month. OSM #6 stated a new social services director just began employment on the previous Monday. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 11/20/24 at 4:00 p.m. No further information was provided prior to exit. 4. For Resident #74 (R74), the facility staff failed to evidence a written notification was provided to the resident and/or responsible party upon transfer to the hospital on [DATE]. The eINTERACT form dated 11/18/24 documented in part, :6. Abdominal/GI (gastrointestinal) Evaluation. A check mark was documented next to: GI bleeding (blood in stool or vomitus) and Nausea and/or vomiting. Further review of the clinical record failed to evidence a written notice was provided to the resident and/or responsible party. On 11/21/24 at 7:50 a.m. ASM (administrative staff member) #2, the director of nursing stated it was documented the responsible party was notified but stated they did not have documentation that a written notice was provided. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 11/20/24 at 4:00 p.m. No further information was provided prior to exit.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4.The facility staff failed to evidence provision of bed hold notification at the time of discharge for R67. R67 was transferred to the hospital on [DATE]. R67 was identified through the closed record review. R67 was admitted to the facility on [DATE] with diagnosis that included paraplegia, post hemorrhagic anemia and pseudomonas. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/25/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring max assistance for mobility/transfers, dressing, hygiene toileting and independent for eating. A review of the baseline care plan dated 7/19/24 revealed, FOCUS: The resident is at risk for bleeding, hemorrhage, excessive bruising and complications related to anticoagulant use secondary to: history of DVT. INTERVENTIONS: Observe for signs and symptoms of bleeding, bruising, and complications and notify MD as indicated. A review of the progress note dated 11/15/24 at 9:22 AM revealed, Resident was noted to have increase d bloody drainage from his sacral/buttocks/ischial wounds. Status post debridement at the wound clinic. Wound team present & evaluated area, MD/NP were updated & order received to send out to ER for further evaluation & treatment. The transfer form's Acute Care Document Transfer List was not completed. No evidence of documents sent with R67 to the hospital including bed hold. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated a bed hold agreement should be sent with a resident when he or she is transferred to the hospital. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. No further information was provided prior to exit. Based on staff interview, and clinical record review, the facility staff failed to provide a written notice of the bed hold policy upon hospital transfer for four of 69 residents in the survey sample, Residents #121, #130, #108, and #67. The findings include: 1. For Resident #121 (R121), the facility staff failed to provide the resident/resident representative a written notice of the bed hold policy when the resident was transferred to the hospital on 7/25/24 and 8/31/24. (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R121's clinical record revealed a nurse's note dated 7/25/24 that documented the resident was transferred to the hospital for shortness of breath and a low oxygen level, and a nurse's note dated 8/31/24 that documented the resident was transferred to the hospital for an elevated temperature and low blood pressure. Further review of R121's clinical record failed to reveal the resident/resident representative was provided a written notice of the bed hold policy on both dates. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated a bed hold agreement should be sent with a resident when he or she is transferred to the hospital. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not provide a specific policy regarding written notice of the bed hold policy upon hospital transfer. No further information was presented prior to exit. 2. For Resident #130 (R130), the facility staff failed to provide evidence that a bed hold notice was provided upon transfer to the hospital on 8/3/24. The nurse's note dated. 8/3/24 at 11:16 a.m. documented, Resident observed with an oxygen level of 94%. Resident c/o (complained of) sob (shortness of breath). Resident observed with using accessory muscles to breathe. Resident c/o chest pain and upper right and left abdominal pain. Resident rate pain 10/10. Resident was placed on non-breather oxygen improved to 99%. NP (nurse practitioner) notified of change of condition. New order to transfer to hospital. Resident is own rp (responsible party). Resident was made aware of the transfer. Resident was sent to (name of hospital) ED (emergency department) via ems (emergency medical services) with face sheet, med (medication) list and transfer form. Further review of the clinical record failed to evidence documentation of a bed hold notice provided upon transfer on 8/3/24. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated a bed hold agreement should be sent with a resident when he or she is transferred to the hospital. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 11/20/24 at 4:00 p.m. No further information was provided prior to exit. 3. For Resident #108 (R108), the facility staff failed to provide evidence that a bed hold notice was provided upon transfer to the hospital on 9/21/24. The eINTERACT note dated 9/21/24 at 3:20 a.m. documented in part, Evaluation: nausea/vomiting shortness of breath .Recommendations: Send pt (patient) to ER (emergency room) for evaluation. Further review of the clinical record failed to evidence documentation of a bed hold notice provided upon transfer on 9/21/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated a bed hold agreement should be sent with a resident when he or she is transferred to the hospital. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 11/20/24 at 4:00 p.m. No further information was provided prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide an accurate MDS (minimum data set) assessment for one of 69 residents in the survey sample, R34. The findings include: The facility staff failed to complete an accurate MDS (minimum data set), a quarterly assessment for Resident #34. Resident #34 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: traumatic brain injury (TBI), muscle wasting and depression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/4/24, coded the resident as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for bed mobility, transfer, hygiene and supervision for eating. A review of Section P-Restraints and Alarms: P0100. Physical Restraints: Limb restraints coded as used less than once daily. A review of the comprehensive care plan dated 11/16/22 revealed, FOCUS: The resident has potential to display the following behaviors related to depression and TBI. INTERVENTIONS: Assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately. Resident not observed in restraints 11/12/24 to 11/19/24. Orders from 5/1/24 to 11/19/24 reviewed, no orders for restraint. MDS 11/4/24 Section P: restraints coded limb restraint-use less than once daily. On 11/20/24 at 1:50 PM an interview was conducted with OSM (other staff member) #16, the MDS Coordinator. When asked about the restraint coding for Resident #34, OSM #16 stated, no, that is coded incorrectly. There is no evidence of any order for restraint or it being on the care plan. We are modifying the MDS now. When asked what standard is followed for MDS, OSM #16 stated, we use the RAI (resident assessment instrument). On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. According to the RAI (resident assessment instrument) MDS Section P0100. Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look-back period. Any manual method or physical or mechanical device, material, or equipment that meets the definition of a physical restraint must have: a physician's documentation of a medical symptom that supports the use of the restraint, a physician's order for the type of restraint and parameters of use, and a care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence an accurate PASARR (preadmission screening and resident review) screening for one of 69 residents in the survey sample, R88. The findings include: The facility failed to ensure a PASARR was completed upon admission for R88. Resident #88 was admitted to the facility on [DATE]. Resident #88's diagnoses included but were not limited to: quadriplegia, neurogenic bowel/bladder and delusional disorders. Resident #88's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/3/24, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. MDS Section G-Functional Status: coded the resident as max assist in bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene/bathing; independent for eating. A review of Resident #88's comprehensive care plan dated 9/19/24, revealed the following, FOCUS: The resident has signs and symptoms of depression. INTERVENTIONS: Activities of resident choice. PHQ9 screening as indicated. A review of Resident #88's clinical record failed to reveal evidence of completion of a PASARR either prior to or on admission on [DATE]. A PASARR dated 11/18/24 was provided when asked for this document. On 11/21/24 at 9:15a.m an interview was conducted with OSM (other staff member) #18, the social services director. When asked who is responsible for ensuring the resident has a PASARR, OSM #18 stated, social services do them. They should be done on admission, not done annually, unless there is a change to be switched to a level 2 or they have been discharged for more than 6 months. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. A review of the facility's PASRR policy, which revealed, Prior to admission, review the transferring hospitals' preadmission paperwork to determine if the transferring hospital has completed a Level I PASRR. If the Level I PASRR is missing from the preadmission paperwork, collaborate with admissions to determine if/why the admitting patient is exempt from the hospital screening in order to initiate completion of the Level PASRR internally. In the absence of a Social Work and Discharge Planner, the Administrator will appoint a designee who has access to the relevant medical information necessary to conduct the Level I PASRR. No further information was provided prior to exit.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop a complete baseline care plan for two of 22 residents in the survey sample, Resident #112 and #113. The findings include: 1. For Resident #112 (R112), the facility staff failed to develop a complete baseline care plan that included a continuous IV (intravenous) Milrinone (1) drip for CHF (congestive heart failure) (2). R112 was admitted to the facility on [DATE]. The MDS (minimum data set) assessment was not due at the time of the survey. The admission nursing assessment dated [DATE] documented the resident being alert and oriented to person, place, time and situation. It further documented R112 having a PICC (peripherally inserted central catheter) line intravenous access on admission in the right upper extremity. On 1/22/25 at 11:01 a.m., an observation was made of R112 in their room at the facility with an intravenous infusion pump at the bedside. A double lumen PICC line was observed to the right upper arm with the intravenous medication tubing infusing into one port of the PICC line. At that time, an interview was conducted with R112 who stated that they received the medication continuously for their heart and that the nurses changed the bags when they were low and took care of the PICC line. The baseline care plan for R112 failed to evidence documentation of the Milrinone Lactate continuous infusion for CHF. The physician orders for R112 documented in part, Milrinone Lactate in Dextrose Intravenous Solution 40-5 MG/200ML-% (Milrinone Lactate in Dextrose). Use 15.9 milliliter intravenously every shift for heart failure. Order Date: 1/18/2025. The hospital discharge instructions for R112 dated 1/17/25 documented in part, Start taking these medications . milrinone (Primacor) IV infusion. Infuse 0.375 mcg/kg/min x 157kg (Order-specific weight) into a venous catheter continuous . On 1/22/25 at 2:51 p.m., an interview was conducted with RN (registered nurse) #1 who stated,That the purpose of the care plan was basically to dictate the residents care, their preferences and show the things they were at risk for and things that they needed to monitor them for. She stated, That the baseline care plan was developed by the admission nurse during the admission assessment and was driven by the information that was put in during the assessment. She state,That the system automatically created the baseline care plan based on the nursing admission assessment and anything that was not included on the admission assessment that needed to be included in the care plan was added in by the admission nurse. RN #1 stated, That a resident who was receiving a continuous intravenous cardiac drip should have that included on their baseline care plan because it was a vital drip, and that information would be important to know in how to take care of the resident and how to monitor the resident. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Care Planning effective 11/1/19, documented in part, 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 practical physical, mental, and psychosocial well-being of the patient. PROCEDURE 1. The baseline care plan is initiated and activated within 48 hours of admission . The facility policy Intravenous Inotropic Support effective 1/29/24 documented in part, Patients requiring intravenous inotropic support will be cared for in accordance with current standards of practice and per provider's orders . Include intravenous inotropic therapy on the care plan . On 1/22/25 at 4:32 p.m., ASM (administrative staff member) #1, administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, consultant vice president and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (1) Milrinone is a vasodilator that is used as a short-term treatment for life-threatening heart failure. This information was obtained from the website: https://www.drugs.com/mtm/milrinone.html (2) Heart failure means that your heart can't pump enough oxygen-rich blood to meet your body's needs. Heart failure doesn't mean that your heart has stopped or is about to stop beating. But without enough blood flow, your organs may not work well, which can cause serious problems. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 2. For Resident #113 (R113), the facility staff failed to develop a baseline care plan that included a continuous IV (intravenous) Dobutamine (1) drip for CHF (congestive heart failure) (2). R113 was admitted to the facility on [DATE]. The MDS (minimum data set) assessment was not due at the time of the survey. The admission nursing assessment dated [DATE] documented the resident being alert and oriented to person, place, time and situation. It further documented R113 having intravenous access on admission in the right chest with a Dobutamine drip infusing. On 1/22/25 at 1:12 p.m., an observation was made of R113 in their room at the facility with an intravenous infusion pump at the bedside. At that time, an interview was conducted with R113 who stated, That they received medication continuously into an IV access that they had and that the nurses changed the bags. The baseline care plan for R113 failed to evidence documentation of the Dobutamine intravenous infusion. The physician orders for R113 documented in part, Dobutamine-Dextrose Intravenous Solution 2-5 MG/ML-% (Dobutamine in Dextrose) Use 7.5 milliliter intravenously every shift for heart failure. Order Date: 1/15/2025. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital discharge instructions for R113 dated 1/14/25 documented in part, Expected Medication List at Discharge . Dobutamine (Dobutrex) IV Infusion. Infuse 2.5 mcg/kg/min x 95.4kg (Order specific weight) into a venous catheter continuous . On 1/22/25 at 2:51 p.m., an interview was conducted with RN (registered nurse) #1 who stated, 'That the purpose of the care plan was basically to dictate the residents care, their preferences and show the things they were at risk for and things that they needed to monitor them for. She stated, That the baseline care plan was developed by the admission nurse during the admission assessment and was driven by the information that was put in during the assessment. She stated, That the system automatically created the baseline care plan based on the nursing admission assessment and anything that was not included on the admission assessment that needed to be included in the care plan was added in by the admission nurse. RN #1 stated, That a resident who was receiving a continuous intravenous cardiac drip should have that included on their baseline care plan because it was a vital drip, and that information would be important to know in how to take care of the resident and how to monitor the resident. On 1/22/25 at 4:32 p.m., ASM (administrative staff member) #1, administrator, ASM #2, assistant administrator, ASM #3, director of nursing, ASM #4, consultant vice president and ASM #5, regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: (1) Dobutamine stimulates heart muscle and improves blood flow by helping the heart pump better. Dobutamine is used short-term to treat cardiac decompensation due to weakened heart muscle. Dobutamine is usually given after other heart medicines have been tried without success. This information was obtained from the website: https://www.drugs.com/mtm/dobutamine.html (2) Heart failure means that your heart can't pump enough oxygen-rich blood to meet your body's needs. Heart failure doesn't mean that your heart has stopped or is about to stop beating. But without enough blood flow, your organs may not work well, which can cause serious problems. This information was obtained from the website: https://medlineplus.gov/heartfailure.html

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 6. The facility staff failed to implement the comprehensive care plan for incontinence care for Resident #138. R138 was admitted to the facility on [DATE] with diagnosis that included but were not limited to cerebral infarction, hemiplegia, aphasia and muscle wasting. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/8/24, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/transfer/dressing/toileting and supervision for eating. A review of the comprehensive care plan dated 8/7/23 revealed, FOCUS: Resident has incontinence of bladder and/or bowels: due to impaired mobility, and cognitive impairment. INTERVENTIONS: Check and change briefs frequently as needed. Provide toileting hygiene with brief changes. A review of the November 2024 ADL (activities of daily living) form reveals missing documentation on day shift 11/17, and night shift 11/2, 11/6, and 11/16. On 11/14/24 at 11:05 AM, an interview was conducted with LPN (licensed practical nurse) #9. When asked the purpose of the care plan, LPN #9 stated, the purpose of the care plan is to know what is needed for long term and short-term goals. This is how we can plan our care for this individual. On 11/21/24 at 9:56 AM, an interview was conducted with CNA (certified nursing assistant) #4. When asked the process for incontinence care, CNA #4 stated, we do incontinence care at least every two hours. It is documented in PCC (point click care) it turns green and you can go in multiple times to document the frequency you have provided it. When asked if there was no documentation of incontinence care, could evidence of it being done be provided and CNA #4 stated, no. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. No further information was provided prior to exit. 5. For Resident #48 (R48), the facility staff failed to implement the resident's comprehensive care plan for respiratory medication administration. R48's comprehensive care plan dated 2/13/24 documented, RESPIRATORY: the resident is at risk for respiratory complications secondary to COPD (chronic obstructive pulmonary disease [lung disease]). Administer medications as ordered. A review of R48's clinical record revealed the following physician's orders: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5/20/24- Incruse Ellipta 62.5 micrograms, one inhalation by mouth one time a day for chronic obstructive pulmonary disease. -10/18/24- Advair Diskus 250 micrograms, one inhalation by mouth every 12 hours for chronic obstructive pulmonary disease. Rinse mouth after use. Wait five minutes between different inhalers. R48's November 2024 MAR (medication administration record) documented the above orders. On 11/13/24 at 7:51 a.m., an observation of LPN (licensed practical nurse) #13 administering medications to R48 was conducted. LPN #13 administered one inhalation of Incruse Ellipta then immediately administered one inhalation of Advair Diskus. LPN #13 failed to wait five minutes in between administering the inhalers and failed to assist R48 with rinsing his mouth. On 11/13/24 at 10:34 a.m., an interview was conducted with LPN #13. LPN #13 reviewed R48's physician's orders. LPN #13 stated she should have waited five minutes in between administering R48's Advair and Incruse Ellipta, and she should have had R48 rinse his mouth after the Advair administration. On 11/14/24 at 10:59 a.m., an interview was conducted with LPN #9. LPN #9 stated the purpose of the care plan is, to know their (residents') health care. What is their plan? Long term goals, short term goals, so we know how to care for this individual. LPN #9 stated nurses have access to review residents' care plans to ensure they are being implemented. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. Based on observation, resident interview, staff interview, facility document review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for six of 69 residents in the survey sample, Residents #5, #248, #74, #179, #48 and #138. The findings include: 1. For Resident #5 (R5), the facility staff failed to develop a care plan to address activities. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 10/2/24, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The Activities assessment dated [DATE] documented in part, 2d. How important is it to you to keep up with the news? Somewhat important. (R5) enjoys watching TV shows, games shows and news .2f. How important is it to you to do your favorite activities? Very important. (R5) prefers 1:1 visits, watching TV, and good conversation .2g. How important is it to you to go outside to get fresh air when the weather is good? Somewhat important. (R5) enjoys the weather when it's not raining .C.1. Does the patient wish to participate in activities while in the center? Yes .7. a. Large print items and One to One activity was checked. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan dated, 9/25/24, failed to evidence documentation related to activities. An interview was conducted with OSM (other staff member) #13, the activities director, on 11/21/24/at 9:11 a. m. OSM #13 stated when a resident is admitted to the facility, an activities assessment is completed, signed and then locked. The activities director is responsible for developing the care plan for each of the residents. The above care plan was reviewed with OSM #13. OSM #13 stated there is no care plan for activities, there should be one. The facility policy, Care Planning documented in part, 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 practical physical, mental, and psychosocial well-being of the patient. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #3, the assistant director of nursing, were made aware of the above concern on 11/21/24 at 1:51 p.m. No further information was provided prior to exit. 2. For Resident #248, the facility staff failed implement the care plan to administer medications to treat neuropathic pain. The comprehensive care plan dated, 5/14/24, documented in part, Focus: The resident has a risk for pain related to Neuropathy pain, arthritis pain. The Interventions, documented in part, Administer medications as ordered. R248 was admitted to the facility on [DATE]. The physician order dated 5/14/24 at 6:53 p.m. documented, Gabapentin Oral Capsule (1) 300 mg (milligrams); Give 1 capsule by mouth at bedtime related to diabetes mellitus with diabetic neuropathy. The May 2024 MAR (medication administration record) documented the above order. The Gabapentin was scheduled to be given at 9:00 p.m. There was a blank for the 5/14/24 at 9:00 p.m. dose. Review of the Omnicell (on site back up medication storage system) contents list documented Gabapentin 300 mg capsule. An interview was conducted with LPN (licensed practical nurse) #6 on 11/21/24 at 9:54 a.m. LPN #6 stated the purpose of the care plan is to know the specific needs of the resident. The care plan should be always followed and updated as needed. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #3, the assistant director of nursing, were made aware of the above concern on 11/21/24 at 1:51 p.m. No further information was provided prior to exit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	References: (1) Gabapentin capsules, tablets, and oral solution are used along with other medications to help control certain types of seizures in people who have epilepsy and neuropathic pain. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a694007.html. 3.a. For Resident #74 (R74), the facility staff failed to develop a care plan to address activities. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 10/29/24, the resident scored a 3 out of 15 on the BIMS(brief interview for mental status) score, indicating the resident was severely impaired for making daily decisions. The Activities assessment dated [DATE], documented the resident was interviewed. The assessment documented in part, How important is it to you to listen to music you like? Somewhat important. How important is it to you to keep up with the news? Very Important. How important is it to you to do your favorite activities? Somewhat important. Pt (patient) report she likes to be able to participate in things she likes to do. How important is it to you to go outside to get fresh air when the weather is good? Somewhat important . Does the patient wish to participate in activities while in the center? No. No activities were check for the resident. The comprehensive care plan dated, 10/22/24, failed to evidence documentation related to activities. An interview was conducted with OSM (other staff member) #13, the activities director, on 11/21/24/at 9:11 a. m. OSM #13 stated when a resident is admitted to the facility, an activities assessment is completed, signed and then locked. The activities director is responsible for developing the care plan for each of the residents. The above care plan was reviewed with OSM #13. OSM #13 stated a resident with dementia should have a care plan to address activities and we would try to involve them in activities and do 1:1 visit with them. 3.b. For Resident #74, the facility staff failed to develop interventions for the care area on the care plan for Care Needs. The comprehensive care plan dated, 10/23/24, documented in part, Focus: CARE NEEDS: resident has the following care needs due to Alzheimer's disease, HTN (high blood pressure) HLD (hyperlipidemia), bronchitis, osteoarthritis, gout, long term anticoagulants, mood disorder, depression, presence prosthetic heart valve. Under Interventions it was blank. No interventions were documented. An interview was conducted with LPN (licensed practical nurse) #16, the MDS Coordinator, on 11/21/24 at 10:53 a.m. The above care plan was reviewed with LPN #16. She stated the care plan should have interventions for what type of assistance is needs, what adaptive equipment is required, and general care needs. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #3, the assistant director of nursing, were made aware of the above concern on 11/21/24 at 1:51 p.m. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. 4. For Resident #179, the facility staff failed to implement the comprehensive care plan to administer medications per the physician orders. The comprehensive care plan dated, 9/6/24, documented in part, Focus: The resident is at risk for pain related to chronic conditions. Interventions: Administer medications as ordered. Focus: The resident is at risk for constipation related to pain medication use, reduced physical mobility. Interventions: administer medications as ordered. Focus: Anticoagulant: the resident is at risk for bleeding, hemorrhage, excessive bruising and complications related to anticoagulant use secondary to: proph (prophylaxis) r/t (related to) immobility. Interventions: administer medications as ordered. Psychoactive medications: the resident is at risk for complications related to psychoactive medication use secondary to diagnoses of: depressive disorder, PTSD (post-traumatic stress disorder). Interventions: administer medications as ordered. Focus: Antiplatelets: The resident is at risk for bleeding, hemorrhage, excessive bruising, and complications due to antiplatelet use secondary to: proph r/t immobility. Interventions: administered medications as ordered. Focus: Opioids: the resident is at risk for complications related to the use of opioids secondary to chronic pain unrelieved by analgesics, neuropathy. Interventions: administer medications as ordered. A review of the Medication Administration Audit Report documented the following: 11/1/24 - Sennosides Tablet 8.6 mg (milligrams) 2 tablets by mouth in the afternoon for constipation - due at 1:00 p.m. - administered at 2:59 p.m. On 11/2/24, the following medications were due to be given at 8:00 a.m. and were not documented as being administered until 11:01 a.m. Pregabalin Oral Capsule 200 mg - 1 capsule three times a day for neuropathy Doxycycline Hyclate Oral Capsule 100 mg - give 1 capsule by mouth two times a day for acne. Midodrine HCL Oral Tablet 10 mg - give 10 mg three times a day for orthostatic hypotension. Acetaminophen (Tylenol) Oral Tablet 325 mg - give 3 tablets three times a day for pain. Baclofen Oral Tablet 10 mg - give 1 tablet three times a day for spasms. Pantoprazole Sodium Oral Tablet Delayed Release 40 mg - give 1 tablet one time a day for GERD (gastroesophageal reflux disease). On 11/1/24 the following medication was scheduled for 5:00 p.m. - it was documented as being administered at 11:41 p.m. Doxycycline. On 11/2/24 the following medication was scheduled for 12:00 p.m. - it was documented as being administered at 1:34 p.m. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Midodrine On 11/2/24 the following medication was scheduled for 4:00 p.m. - it was documented as being administered at 5:28 p.m. Midodrine On 11/3/24 the following medications were scheduled to be given at 8:00 a.m. - they were documented as being administered at 9:22 a.m. Acetaminophen, Baclofen, Midodrine, Doxycycline, and Pregabalin. On 11/3/24 the following medications were scheduled to be given at 5:00 p.m. - they were documented as being administered at 6:24 p.m. Naproxen, Doxycycline, Midodrine. on 11/5/24 the following medications were scheduled to be given at 9:00 p.m. - they were documented as being administered at 11:05 p.m. Trazadone HCL Oral Tablet 100 mg - give 1 tablet by mouth at bedtime for depression. Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP (grams per scoop) - give 1 scoop by mouth at bedtime for bowel regimen. On 11/6/24 the following medications were scheduled to be given at 8:00 a.m. - they were documented as being administered at 9:25 a.m. Acetaminophen, Baclofen, Doxycycline, and Pregabalin. On 11/6/24 the following medication was scheduled to be given at 9:00 p.m. - it was documented as being administered at 11:41 p.m. Cefpodoxime. On 11/8/24 the following medications were scheduled to be given at 9:00 p.m. - they were documented as being administered at 11:09 p.m. Trazadone, Melatonin, and Polyethylene Glycol. On 11/9/24 the following medications were scheduled to be given at 8:00 a.m. - they were documented as being administered at 11:44 a.m. Acetaminophen, Baclofen, Doxycycline, and Pregabalin. On 11/9/24 the following medications were scheduled to be given at 9:00 a.m. - they were documented as being administered at 11:46 a.m. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sertraline HCL Oral Tablet 50 mg - give 3 tablets by mouth one time a day for depression. Aspirin Low Dose Oral tablet 81 mg Cymbalta Capsule Delayed Release Particles 30 mg - give 1 capsule by mouth one time a day for depression. Cefpodoxime Proxetil Oral Tablet 200 mg - give 1 tablet by mouth two times a day for UTI (urinary tract infection) Fludrocortisone Acetate Oral Tablet 0.1 mg - give 0.5 tablet by mouth one time a day for orthostatic hypotension Naproxen Oral Tablet Delayed Release 375 mg - give 1 tablet by mouth two times a day for neck and back pain. Midodrine, and Pantoprazole. On 11/17/24 the following medication was to be given at 5:00 p.m. - it was documented as being administered at 7:06 p.m. Midodrine. On 11/18/24 the following medications were scheduled to be given at 9:00 p.m. - they were documented as being administered at 11:54 p.m. Melatonin and Trazadone. On 11/19/24 the following medication was scheduled to be given at 9:00 a.m. - it was documented as administered at 1:06 p.m. Midodrine HCL Oral Tablet 10 mg - give 1.5 tablets by mouth three times a day for hypotension - Hold for SBP (systolic blood pressure) greater than 140 (please give medication before 9am). An interview was conducted with LPN (licensed practical nurse) #6 on 11/21/24 at 9:54 a.m. LPN #6 stated the purpose of the care plan is to know the specific needs of the resident. The care plan should be always followed and updated as needed. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN (registered nurse) #3, the assistant director of nursing, were made aware of the above concern on 11/21/24 at 1:51 p.m. 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 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** 2. For Resident #147 (R147), the facility staff failed to review and revise the resident's comprehensive care plan for the use of bed rails. R147's comprehensive care plan dated 1/30/24 failed to document information regarding bed rails. On 11/18/24 at 11:21 a.m., and 11/19/24 at 9:05 a.m., R147 was observed lying in bed with bilateral quarter bed rails in the upright position. On 11/20/24 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #7 (the regional director of clinical reimbursement). ASM #7 stated the purpose of the care plan is to structure the framework for the care that the resident receives, identify risks, strengths, and deficits, and plan for residents' care. ASM #7 stated the care plan should be reviewed and revised for the use of bed rails to assess for risk, identify if the bed rails are an enabler, and identify how the bed rails are used to assist the resident. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. For Resident #182 (R182), the facility staff failed to review and revise the resident's comprehensive care plan for the use of bed rails. R182's comprehensive care plan dated 9/20/24 failed to document information regarding bed rails. On 11/18/24 at 12:00 p.m., R182 was observed lying in bed with bilateral quarter bed rails in the upright position. On 11/20/24 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #7 (the regional director of clinical reimbursement). ASM #7 stated the purpose of the care plan is to structure the framework for the care that the resident receives, identify risks, strengths, and deficits, and plan for residents' care. ASM #7 stated the care plan should be reviewed and revised for the use of bed rails to assess for risk, identify if the bed rails are an enabler, and identify how the bed rails are used to assist the resident. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the comprehensive care plan for three of 69 residents in the survey sample, Residents #130, #147 and #182. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings include: 1. For Resident #130, the facility staff failed to remove from the care plan, the infection and use of a PICC (1) line after it was discontinued. The comprehensive care plan dated, 8/25/24, documented in part, Focus: The resident has a PICC line venous access to the left arm. The care plan further documented, Focus: GENERAL INFECTION: (R130) was admitted to facility with MRSA (2) bacteremia, IV (intravenous) ABT(antibiotics) therapy in place. This entry was dated 8/21/24. The last documented dose of Daptomycin (3) was administered on 9/8/24. The physician order dated 9/10/24 documented, DC (discontinue) PICC line, one time only for IV abx (antibiotic therapy complete for 2 days. The MAR (medication administration record) documented the above orders. An interview was conducted with RN (registered nurse) #1 on 11/21/24 at 10:38 a.m. RN #1 stated the care plans are updated accordingly in our clinical meetings. The facility policy, Care Planning, documented in part, 5. Care Plans will be updated on an ongoing basis as changes in the patient occurs and reviewed quarterly with the quarterly assessment. The most recent MDS (minimum data set) assessment, a quarterly assessment, was completed, with an assessment reference date of 9/24/24. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN #3, were made aware of the above findings on 11/20/24 4:00 p.m. No further information was provided prior to exit. References: (1) According to the glossary in [NAME], [NAME] & [NAME], Fundamental of Nursing, 5th edition, 2007, page 1423, the definition is Peripherally inserted central catheter is a long-line catheter made of soft silicone or Silastic material that is placed peripherally but delivers medications and solutions centrally. (2) MRSA stands for methicillin-resistant Staphylococcus aureus. It causes a staph infection (pronounced staff infection) that is resistant to several common antibiotics. This information was obtained from the following website: https://medlineplus.gov/mrsa.html. (3) Daptomycin injection is used to treat certain blood infections or serious skin infections caused by bacteria in adults and children. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a608045.html.

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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** 2.The facility staff failed to meet professional standards by administering medications as ordered for R449. R449 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: COPD (chronic obstructive pulmonary disease), diabetes mellitus (DM) and sleep apnea. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 7/9/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring total dependence for transfer, bathing, bed mobility, dressing, hygiene, toileting and supervision for eating. A review of the comprehensive care plan dated 11/11/21 revealed, FOCUS: Resident has Congestive Heart Failure. INTERVENTIONS: Give cardiac medications as ordered. A review of the physician orders dated 5/16/23 revealed, Trulicity Subcutaneous Solution Pen-injector 1.5 MG/0.5ML (Dulaglutide) Inject 0.5 ml subcutaneously in the morning every Sunday and physician orders dated 6/1/23 revealed, Humalog Solution 100 UNIT/ML (Insulin Lispro (Human)) Inject 10 unit subcutaneously before meals for DM. A review of the June 2023 MAR (medication administration record) reveals, Trulicity Pen-injector 1.5 MG/0.5ML Inject 0.5 ml subcutaneously in the morning every Sunday- administered 6/25/23 at 1:02 PM. Humalog Solution 100 UNIT/ML, inject 10 unit subcutaneously before meals for DM administered 6/6/23 11:54 PM, 6/11/23 11:56 PM, 6/14/23 9:37 PM and 6/15/23 9:53 PM. On 11/14/24 at 2:25 PM an interview was conducted with LPN (licensed practical nurse) #11, when asked medication administration process, LPN #11 stated, we are to administer the medication within 1 hour, either before or after, of the time identified. When asked if it was professional standard to administer within this time frame, LPN #11 stated, yes, this was professional standards. On 11/21/24 at 10:05 AM an interview was conducted with LPN #6, when asked if medication administered outside of the 1 hour before or after the time identified for administration, are the professional standards being upheld, LPN #6 stated, no, it is not being upheld. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. According to the facility's Nursing Services policy, Nursing staff will provide nursing care and services following current standards of practice recognized by state boards of nursing as informed by national nursing organizations. The facility follows clinical guidelines for Nursing skills and techniques from [NAME] and [NAME]. No further information was provided prior to exit. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for two of 69 residents in the survey sample, Residents #179 and #449. The findings include: 1. For Resident #179 (R179), the facility staff failed to administer medications in the prescribed time frame. An interview was conducted with R179 on 11/18/24 at approximately 1:00 p.m. R179 stated she doesn't get her morning medications until sometimes after 11:00 a.m. Also, some of her other medications are being given late. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 9/13/24, the resident scored a 15 out of 15, indicating the resident was not cognitively impaired for making daily decisions. A review of the Medication Administration Audit Report documented the following: 11/1/24 - Sennosides Tablet 8.6 mg (milligrams) 2 tablets by mouth in the afternoon for constipation - due at 1:00 p.m. - administered at 2:59 p.m. On 11/2/24, the following medications were due to be given at 8:00 a.m. and were not documented as being administered until 11:01 a.m. Pregabalin Oral Capsule 200 mg - 1 capsule three times a day for neuropathy Doxycycline Hyclate Oral Capsule 100 mg - give 1 capsule by mouth two times a day for acne. Midodrine HCL Oral Tablet 10 mg - give 10 mg three times a day for orthostatic hypotension. Acetaminophen (Tylenol) Oral Tablet 325 mg - give 3 tablets three times a day for pain. Baclofen Oral Tablet 10 mg - give 1 tablet three times a day for spasms. Pantoprazole Sodium Oral Tablet Delayed Release 40 mg - give 1 tablet one time a day for GERD (gastroesophageal reflux disease). On 11/1/24 the following medication was scheduled for 5:00 p.m. - it was documented as being administered at 11:41 p.m. Doxycycline. On 11/2/24 the following medication was scheduled for 12:00 p.m. - it was documented as being administered at 1:34 p.m. Midodrine (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/2/24 the following medication was scheduled for 4:00 p.m. - it was documented as being administered at 5:28 p.m. Midodrine On 11/3/24 the following medications were scheduled to be given at 8:00 a.m. - they were documented as being administered at 9:22 a.m. Acetaminophen, Baclofen, Midodrine, Doxycycline, and Pregabalin. On 11/3/24 the following medications were scheduled to be given at 5:00 p.m. - they were documented as being administered at 6:24 p.m. Naproxen, Doxycycline, Midodrine. on 11/5/24 the following medications were scheduled to be given at 9:00 p.m. - they were documented as being administered at 11:05 p.m. Trazadone HCL Oral Tablet 100 mg - give 1 tablet by mouth at bedtime for depression. Polyethylene Glycol 3350 Oral Powder 17 GM/SCOOP (grams per scoop) - give 1 scoop by mouth at bedtime for bowel regimen. On 11/6/24 the following medications were scheduled to be given at 8:00 a.m. - they were documented as being administered at 9:25 a.m. Acetaminophen, Baclofen, Doxycycline, and Pregabalin. On 11/6/24 the following medication was scheduled to be given at 9:00 p.m. - it was documented as being administered at 11:41 p.m. Cefpodoxime. On 11/8/24 the following medications were scheduled to be given at 9:00 p.m. - they were documented as being administered at 11:09 p.m. Trazadone, Melatonin, and Polyethylene Glycol. On 11/9/24 the following medications were scheduled to be given at 8:00 a.m. - they were documented as being administered at 11:44 a.m. Acetaminophen, Baclofen, Doxycycline, and Pregabalin. On 11/9/24 the following medications were scheduled to be given at 9:00 a.m. - they were documented as being administered at 11:46 a.m. Sertraline HCL Oral Tablet 50 mg - give 3 tablets by mouth one time a day for 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aspirin Low Dose Oral tablet 81 mg Cymbalta Capsule Delayed Release Particles 30 mg - give 1 capsule by mouth one time a day for depression. Cefpodoxime Proxetil Oral Tablet 200 mg - give 1 tablet by mouth two times a day for UTI (urinary tract infection) Fludrocortisone Acetate Oral Tablet 0.1 mg - give 0.5 tablet by mouth one time a day for orthostatic hypotension Naproxen Oral Tablet Delayed Release 375 mg - give 1 tablet by mouth two times a day for neck and back pain. Midodrine, and Pantoprazole. On 11/17/24 the following medication was to be given at 5:00 p.m. - it was documented as being administered at 7:06 p.m. Midodrine. On 11/18/24 the following medications were scheduled to be given at 9:00 p.m. - they were documented as being administered at 11:54 p.m. Melatonin and Trazadone. On 11/19/24 the following medication was scheduled to be given at 9:00 a.m. - it was documented as administered at 1:06 p.m. Midodrine HCL Oral Tablet 10 mg - give 1.5 tablets by mouth three times a day for hypotension - Hold for SBP (systolic blood pressure) greater than 140 (please give medication before 9am). Review of the nurse's notes failed to evidence notification to the medical doctor or nurse practitioner, the reasons for the medications not being given at the prescribed times. The above Medication Administration Audit Report was reviewed with RN (registered nurse) #3 on 11/21/24 at 9:46 a.m. RN#3 stated that medications are to be given within one hour before or one hour after the prescribed time. The facility policy, General Guidelines for Medication Administration, documented in part, 12. Medications are administered within 60 minutes of the scheduled administration time, except before, with, or after meal orders, which are administered based on mealtimes. Unless otherwise specified by a prescriber, routine medications are administered according to the established medication administration schedule for the facility. ASM (Administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN #3, the assistant director of nursing, were made aware of the above findings on 11/21/24 at 1:51 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident/staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for dependent residents for three of 69 residents, R138, R448 and R55. The findings include: 1. The facility staff failed to provide ADL care for a dependent resident, R138. R138 was admitted to the facility on [DATE] with diagnosis that included but were not limited to cerebral infarction, hemiplegia, aphasia and muscle wasting. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/8/24, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/transfer/dressing/toileting and supervision for eating. A review of the comprehensive care plan dated 8/7/23 revealed, FOCUS: Resident has incontinence of bladder and/or bowels: due to impaired mobility, and cognitive impairment. INTERVENTIONS: Check and change briefs frequently as needed. Provide toileting hygiene with brief changes. A review of the October 2024 ADL (activities of daily living) form reveals missing incontinence care documentation on night shift 10/5, 10/11, 10/15, 10/17, 10/19, 10/21, 10/26 and 10/29. A review of the November 2024 ADL form reveals missing incontinence care documentation on day shift 11/17, and night shift 11/2, 11/6, and 11/16. On 11/21/24 at 9:56 AM an interview was conducted with CNA (certified nursing assistant) #4. When asked the process for incontinence care, CNA #4 stated, we do incontinence care at least every two hours. It is documented in PCC (point click care) it turns green and you can go in multiple times to document the frequency you have provided it. When asked if there was no documentation of incontinence care, could evidence of it being done be provided and CNA #4 stated, no. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. According to the facility's Incontinence brief policy, reveals Post-procedure: Reported and recorded your observations. No further information was provided prior to exit. 2. The facility staff failed to provide ADL care for a dependent resident, R448. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R448 was admitted to the facility on [DATE] with diagnosis that included but were not limited to afib, chronic respiratory failure with hypoxia and cutaneous abscess. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/14/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/transfer/dressing/toileting and supervision for eating. A review of the comprehensive care plan dated 12/15/22 revealed, FOCUS: The resident is frequently/almost always incontinent of bladder and continent of bowels due to cognitive impairment, decreased mobility. INTERVENTIONS: Check and change frequently as tolerated. Provide toileting hygiene as needed for incontinent episodes. A review of the March, April and May 2023 ADL (activities of daily living) form reveals missing documentation on day shift: 3/5, 3/14, 4/3, 4/6, 4/16, 4/19, 5/12, 5/13, 5/14, 5/17, 5/21; Evening shift: 3/10, 3/12, 3/17, 3/29, 4/1, 4/3, 4/6, 4/12, 4/16, 4/24, 5/7, 5/8, 5/10, 5/12, 5/13, 5/14 and Night shift: 3/5, 3/6, 3/18, 3/19, 3/20, 3/26, 3/29, 3/30, 3/31, 4/7, 4/17, 4/27, 5/9, 5/11, 5/13, 5/15, 5/19 and 5/20. An interview was conducted on 11/21/24 at 9:56 AM with CNA (certified nursing assistant) #4. When asked the process for incontinence care, CNA #4 stated, we do incontinence care at least every two hours. It is documented in PCC (point click care) it turns green and you can go in multiple times to document the frequency you have provided it. When asked if there was no documentation of incontinence care, could evidence of it being done be provided and CNA #4 stated, no. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. According to the facility's Incontinence brief policy, reveals Post-procedure: Reported and recorded your observations. No further information was provided prior to exit. 3. For Resident #55 (R55), the facility staff failed to provide personal hygiene, oral hygiene, and showers on multiple dates in October 2024 and November 2024. A review of R55's ADL (activities of daily living records) for October 2024 and November 2024 failed to reveal the resident was provided a shower. Further review of R55's ADL records failed to reveal personal hygiene, and oral hygiene was provided during the 7:00 p.m. to 7:00 a.m. shift on 10/3/24, 10/8/24, 10/10/24, 10/14/24, 10/17/24, 10/21/24, 10/26/24, 11/4/24, and 11/8/24 (as evidenced by blank spaces on the records). On 11/14/24 at 2:11 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated personal hygiene consists of washing the resident's body, mouth care, and hair care. CNA #4 stated residents should receive showers twice a week. CNA #4 stated care such as personal hygiene and showers is evidenced as being done by documentation in the ADL records. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 9:48 a.m., an interview was conducted with CNA #3. CNA #3 stated personal hygiene, and oral hygiene depends on residents' preferences but should be offered during the day and evening. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to administer medications per physician's orders for five of 69 residents in the survey sample, Residents #55, #106, #130, #248, and #500. The findings include: 1. For Resident #55 (R55), the facility staff failed to administer the medication buspirone (used to treat anxiety) per physician's orders twice on 3/12/23. A review of R55's clinical record revealed a physician's order dated 2/7/23 for buspirone 10 mg (milligrams)- one tablet by mouth three times a day for anxiety. A review of R55's March 2023 MAR (medication administration record) revealed the same physician's order. On 3/12/23 at 8:00 a.m. and 2:00 p.m., the nurse documented buspirone was not administered as evidenced by the code, 5=Hold/See Progress Notes on the MAR. A review of progress notes for 3/12/23 failed to reveal why the buspirone was not administered. On 11/14/24 at 10:59 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that if a medication is not available for administration, nurses should check to see if the medication is available in the Omnicell (a machine containing various medications that can be accessed if a resident's specific medication is not available), and if so, pull the medication from the Omnicell and administer the medication to the resident. A review of the Omnicell list revealed 10 tablets of buspirone 5 mg were available in the machine. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Medication Unavailability documented, A licensed nurse discovering a medication on order that in unavailable will initiate appropriate steps to ensure medical treatment is provided as ordered. No further information was presented prior to exit. 2. For Resident #106 (R106), the facility staff failed to administer the medication oxycodone (used to treat pain) per physician's orders on 8/10/24 and failed to administer the medication gabapentin (used to treat pain) per physician's orders on 8/11/24. A review of R106's clinical record revealed the following physician's orders: -4/24/23- gabapentin 100mg (milligrams), one capsule by mouth three times a day for pain. -4/22/24- oxycodone/acetaminophen 7.5-325 mg (milligrams), one tablet by mouth three times a day for pain. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R106's August 2024 MAR (medication administration record) revealed the same physician's orders. Further review of the August 2024 MAR revealed the oxycodone/acetaminophen was not administered on 8/10/24 at 6:00 a.m. and the gabapentin was not administered on 8/11/24 at 6:00 a.m. as evidenced by the code, 9=Other/ See Progress Notes. Progress notes dated 8/10/24 and 8/11/24 documented, Awaiting pharmacy delivery. On 11/14/24 at 10:59 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that if a medication is not available for administration, nurses should check to see if the medication is available in the Omnicell (a machine containing various medications that can be accessed if a resident's specific medication is not available), and if so, pull the medication from the Omnicell and administer the medication to the resident. A review of the Omnicell list revealed eight tablets of oxycodone/acetaminophen 7.5-325 mg were available in the machine and 15 tablets of gabapentin 100 mg were available in the machine. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. For Resident #130, the facility staff failed to administer an intravenous (IV) antibiotic, Daptomycin (1), per the physician orders. The Hospital IV Antibiotic Orders, dated 8/19/24, documented, Daptomycin 1250 mg (milligrams) IV Q (every) 24 hours. The physician orders dated 8/20/24 documented, Daptomycin Solution; Reconstituted; Use 1250 mg intravenously STAT for IV every 24 hours. The August MAR (medication administration record) documented the above order. On 8/21/24 there was a blank in the space for it to be administered. The first dose was documented as given on 8/22/24, 48 hours after admission. An interview was conducted with LPN (licensed practical nurse) #9 on 11/14/24 at 11:04 a.m. When asked how she evidenced that she has given a medication, LPN #9 stated it is documented on the MAR in the space for the date and time of administration for each medication given. An interview was conducted with RN (registered nurse) #3, on 11/21/24 at 8:14 a.m. RN #3 stated she had investigated the missed dose of Daptomycin and found the nurse failed to enter the physician orders into the computer until the end of her shift at 8:00 a.m. on 8/21/24. When asked if the resident missed a dose of antibiotics, RN #3 stated, yes. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN #3, were made aware of the above findings on 11/21/24 at 1:51 p.m. No further information was provided prior to exit. References: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Daptomycin injection is used to treat certain blood infections or serious skin infections caused by bacteria in adults and children. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a608045.html. 4. For Resident #248 (R248), the facility staff failed to administer Gabapentin (1) per the physician order. R248 was admitted to the facility on [DATE]. The physician order dated 5/14/24 at 6:53 p.m. documented, Gabapentin Oral Capsule 300 mg (milligrams); Give 1 capsule by mouth at bedtime related to diabetes mellitus with diabetic neuropathy. The May 2024 MAR (medication administration record) documented the above order. The Gabapentin was scheduled to be given at 9:00 p.m. There was a blank for the 5/14/24 at 9:00 p.m. dose. Review of the Omnicell (on site back up medication storage system) contents list documented Gabapentin 300 mg capsule. An interview was conducted with LPN (licensed practical nurse) #9 on 11/14/24 at 11:04 a.m. When asked how she evidenced that she has given a medication, LPN #9 stated it is documented on the MAR in the space for the date and time of administration for each medication given. LPN #9 was asked for medications for a new admission, how do they get the medications to administer, LPN #9 stated the medications are normally here the next day but if they are due for medications in the evening, I would go to the Omnicell and pull whatever medications were available and if not available I'd contact the pharmacy and the physician for further instructions. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN #3, were made aware of the above findings on 11/21/24 at 1:51 p.m. No further information was provided prior to exit. References: (1) Gabapentin capsules, tablets, and oral solution are used along with other medications to help control certain types of seizures in people who have epilepsy and neuropathic pain. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a694007.html. 5. For Resident #500, the facility staff failed to administer Norvasc (1) according to the physician orders. The physician order dated, 11/4/24, documented, Norvasc Oral Tablet 5 mg (milligrams) (amlodipine besylate); give 1 tablet by mouth one time a day for HTN (high blood pressure) Take only if Systolic Blood pressure is Higher than 130. The November MAR (medication administration record) documented the above order. On the following dates the medication was given when the blood pressure was lower than 130: 11/5/24 - 127/69 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/9/24 - 107/75 11/10/24 - 114/67 11/11/24 - 121/70 11/13/24 - 105/80 11/14/24 - 118/84 11/17/24 - 121/68 11/19/24 - 126/70 On 11/21/24 at 9:46 a.m. an interview was conducted with RN (registered nurse) #3, the assistant director of nursing. The above order and MAR were reviewed with RN #3. RN #3 stated the nurse shouldn't have given the medication. ASM (Administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN #3, the assistant director of nursing, were made aware of the above findings on 11/21/24 at 1:51 p.m. No further information was provided prior to exit. (1) Amlodipine (Norvasc) is used alone or in combination with other medications to treat high blood pressure in adults and children. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a692044.html

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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 resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide services for a contracture for one of 69 residents in the survey sample, Resident #140. The findings include: For Resident #140 (R140), the facility staff failed to provide palm guard/splinting for a left-hand contracture. An interview was conducted with R140 on 11/18/24 at approximately 12:20 p.m. R140 was observed to have a contracture of her left hand and wrist. R140 stated she needed a brace as she can't move her hand, they were supposed to be working on it. She stated she had one before and it was red but has been missing for quite some time. Review of the physician orders failed to evidence any documentation related to a brace/splint. A request was made for any therapy note for the past six months. On 11/19/24 at 1:30 p.m. ASM (administrative staff member) #1, the administrator, stated the resident has not have any occupational therapy for over six months. An interview was conducted with OSM (other staff member) #20, the occupational therapist that last worked with R140. OSM #20 stated when he last worked with R140, he did passive range of motion and exercises to her upper left extremity. He stated it was very painful for the resident to stretch out her hand and fingers. When asked if the resident had a brace or splint, OSM #20 stated when she was discharged from therapy services she had a palm guard with a piece of red foam. On 11/20/24 at 2:34 p.m. observation of R140's left hand was conducted with LPN (licensed practical nurse) #17. When asked if she has seen a splint, braces or palm guard for this resident, LPN #17 stated, no. When asked for a policy related to contracture management, the facility provided a policy, Device Assessment. This policy documented in part, The Device Assessment is used to evaluate and document patient needs for any devices, establish the intended purpose, and identify whether any device in use is considered a restraint. Procedure: 1. The Device Assessment will be completed on admission, quarterly, and as needed. 2. The specific type of device and the purpose will be documented on the Device Assessment . 5. Notify the responsible party of all devices in use, along with their intended purpose, benefits, and potential risk associated. 6. Devices will be added to the patient's care plan. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN #3, were made aware of the above findings on 11/21/24 at 1:51 p.m. No further information was provided prior to exit.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on staff interview, and clinical record review, the facility staff failed to provide Foley catheter care and services for one of 69 residents in the survey sample, Resident #300. The findings include: For Resident #300 (R300), the facility staff failed to provide Foley catheter care per physician's orders on multiple dates in April 2023 and May 2023. A review of R300's clinical record revealed physician's orders dated 11/28/22 and 4/26/23 for a Foley catheter due to urinary retention every shift and to provide Foley catheter care. A review of R300's April 2023 and May 2023 TARs (treatment administration records) failed to reveal Foley catheter care was provided during the day shift on 4/5/23, 4/24/23, 4/30/23, and 5/9/23 (as evidenced by blank spaces on the TARs). On 11/14/24 at 10:59 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated nurses evidence Foley catheter care is provided per physician's orders by signing the care off on the TAR. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not provide a specific policy regarding Foley catheter care. No further information was presented prior to exit.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on staff interview, and clinical record review, the facility staff failed to provide colostomy care and services for one of 69 residents in the survey sample, Resident #300. The findings include: For Resident #300 (R300), the facility staff failed to change the resident's colostomy pouch per physician's orders on multiple dates in April 2023 and May 2023. A review of R300's clinical record revealed a physician's order dated 11/19/22 to change the resident's colostomy pouch every two to three days and as needed. A review of R300's April 2023 and May 2023 TARs (treatment administration records) revealed the same physician's order and a schedule for the resident's colostomy pouch to be changed every three days. Further review of R300's April 2023 and May 2023 TARs failed to reveal the resident's colostomy was changed during both months (as evidenced by blank spaces on the TAR). On 11/14/24 at 10:59 a.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated nurses' evidence the changing of a colostomy pouch by signing it off on the TAR. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not provide a specific policy regarding colostomy pouches. No further information was presented prior to exit.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for a PICC line for one of 69 residents in the survey sample, Resident #130. The findings include: For Resident #130 (R130) the facility staff failed to measure the PICC (1) line for 13 days after admission on [DATE]. The physician order dated 8/20/24, documented, PICC line - measure external portion of PICC line catheter weekly with dressing changes every night shift every Mon (Monday). PICC line dressing changes on admission, then Q (every) week and PRN. The MAR (medication administration record) for August and September 2024 were reviewed. The MAR documented the above orders. For the dressing change on admission, the dressing was documented as completed on 8/21/24. The order for the measure external portion of the PICC line was dated on 8/20/24 and nothing was signed off until 9/2/24. An interview was conducted with RN (registered nurse) #3, on 11/21/24 at 8:15 a.m. When asked the process for caring for a PICC line upon admission and then while resident has the PICC line inserted, RN #3 stated the PICC line and dressing should be assessed upon admission. The nurse should assess for redness, swelling any signs and symptoms of infection, and the date on the dressing. RN #3 stated the PICC line should be measured upon admission. RN #3 stated we take the measurement to monitor if the line starts to come out. The facility policy, IV (intravenous) Therapy documented in part, 1. License nurses will demonstrate IV competence in initialing/managing IV therapy .5. License nurses may provide central line care: a. Dressing change. b. Flush as per MD (medical doctor) orders. c. IV tubing change. d. Licensed Practical Nurses (LPNs) may not reposition or discontinue a central line. The policy did not address the measuring of the PICC line. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and RN #3, were made aware of the above findings on 11/21/24 at 1:51 p.m. No further information was provided prior to exit. References: 1. According to the glossary in [NAME], [NAME] & [NAME], Fundamental of Nursing, 5th edition, 2007, page 1423, the definition is Peripherally inserted central catheter is a long-line catheter made of soft silicone or Silastic material that is placed peripherally but delivers medications and solutions centrally.

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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, facility document review and clinical record review, it was determined the facility staff failed to maintain respiratory equipment in a sanitary manner for one of 69 residents in the survey sample, Resident #130. The findings include: For Resident #130 (R130), the facility staff failed to store a CPAP (1) mask in a sanitary manner. Observation was made on 11/12/24 at 2:35 p.m. of R130 in her bed. The CPAP mask was on the nightstand, behind where resident could not reach, uncovered, sitting on the nightstand. A second observation was made on 11/19/24 at 3:45 p.m. of the CPAP mask sitting on the nightstand, behind the CPAP machine, not stored in a bag. A third observation was made of the CPAP mask sitting on the nightstand on 11/20/24 at 11:41 a.m. The physician dated, 10/31/24, documented, CPAP - specify setting: Rate: 16; Inspiratory: 14; Expiratory: 8; *Use sterile H2O only* every evening shift apply CPAP. On 11/20/24 at 11:41 a.m. LPN (licensed practical nurse) #17 was asked to observe the CPAP machine mask for R130. LPN #17 stated, it's not covered, it should be in a plastic bag. When asked why is needed to be in a plastic bag, LPN #17 stated, it's because of infection control and germs. The facility policy, Respiratory Care & Oxygen Equipment, documented in part, 2. Store tubing/masks/yankers, etc. in plastic storage bag when not in use. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 11/20/24 at 4:00 p.m. No further information was provided prior to exit. References: (1) Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was taken from the following website: https://medlineplus.gov/ency/article/001916.htm

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide dialysis care and services for one of 69 residents in the survey sample, R155. The findings include: The facility failed to provide evidence of communication with dialysis facility and providing meal for R155. R155 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: ESRD (end stage renal disease), COPD (chronic obstructive pulmonary disease) and left above the knee amputation. The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 8/5/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as being dependent for toileting, bathing and hygiene. A review of the comprehensive care plan dated 7/31/24, which revealed, FOCUS: The resident is at increased risk for complications secondary to requiring hemodialysis secondary to ESRD. INTERVENTIONS: Observe for signs and symptoms of complications related to ESRD including but not limited to fluid overload, hemorrhage, infection to the access site, hypotension, respiratory and/ or cardiac distress and notify MD as indicated. Therapeutic diet as ordered. A review of the physician's orders dated 8/30/24, revealed, Hemodialysis Mon, Wed, Fri. Dialysis 3x weekly. A review of R155's medical record evidenced missing dialysis communication form 10/1/24-11/18/24 for 10/4, 10/11 and 11/15/24. An interview was conducted on 11/19/24 at 8:30 AM with R155. When asked if she received dialysis pre and post care, R155 stated, yes, they take care of the port. When asked if she takes a bagged lunch, R155 stated, no, they do not always give me a bagged lunch. I leave here between 9:30 AM and 10:00 AM to go to dialysis, I did not get a bagged lunch yesterday. An interview was conducted on 11/19/24 at 11:51 AM with LPN (licensed practical nurse) #12. When asked the purpose of the dialysis communication book, LPN #12 stated, it is to send information with the resident to update the dialysis facility on any labs, vital signs, medications. it is to go with the resident each time they go to dialysis. When asked if a meal is provided to the resident to take with them, LPN #12 stated, it should be given to them prior to them leaving. The kitchen brings us bagged meals to give them. On 11/20/24 at approximately 8:50 AM, R155 was asked if she had received her bagged lunch for dialysis, R155 stated, no, I do not have it. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 9:00 AM an interview was conducted with OSM (other staff member) #15, the dietary manager. When asked how the dialysis residents are identified, OSM #15 stated, there is a list, but this resident is not on the list for those that need a bagged lunch, I will make a bagged lunch up now. Bagged lunch with sandwich, chips, juice and apple sauce provided to the resident. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. A review of the facility's Hemodialysis policy revealed in part, The dialysis communication form will be initiated prior to sending patient for dialysis. No further information was provided prior to exit.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, staff interview, and clinical record review, the facility staff failed to implement bed rail requirements for four of 69 residents in the survey sample, Residents #147, #55, #182, and #106. The findings include: 1. For Resident #147 (R147), the facility staff failed to offer/attempt appropriate alternatives prior to the use of bed rails and failed to assess the resident for risk of entrapment. On 11/18/24 at 11:21 a.m., and 11/19/24 at 9:05 a.m., R147 was observed lying in bed with bilateral quarter bed rails in the upright position. A review of R147's clinical record failed to reveal documentation that the facility staff offered/attempted appropriate alternatives prior to the use of bed rails and failed to assess R147 for risk of entrapment. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated appropriate alternatives to bed rails, such as one bed rail, a grab bar, or wedges should be attempted prior to the use of bed rails and should be documented in progress notes. LPN #3 stated she was not aware of the facility having an assessment for risk of entrapment. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not provide a specific policy regarding offering/attempting appropriate alternatives prior to the use of bed rails and assessing the resident for risk of entrapment. No further information was presented prior to exit. 2. For Resident #55 (R55), the facility staff failed to offer/attempt appropriate alternatives prior to the use of bed rails and failed to assess the resident for risk of entrapment. On 11/18/24 at 11:14 a.m., and 11/19/24 at 9:31 a.m., R55 was observed lying in bed with bilateral quarter bed rails in the upright position. A review of R55's clinical record failed to reveal documentation that the facility staff offered/attempted appropriate alternatives prior to the use of bed rails and failed to assess R55 for risk of entrapment. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated appropriate alternatives to bed rails, such as one bed rail, a grab bar, or wedges should be attempted prior to the use of bed rails and should be documented in progress notes. LPN #3 stated she was not aware of the facility having an assessment for risk of entrapment. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. For Resident #182 (R182), the facility staff failed to offer/attempt appropriate alternatives prior to the use of bed rails and failed to assess the resident for risk of entrapment. On 11/18/24 at 12:00 p.m., R182 was observed lying in bed with bilateral quarter bed rails in the upright position. A review of R182's clinical record failed to reveal documentation that the facility staff offered/attempted appropriate alternatives prior to the use of bed rails and failed to assess R182 for risk of entrapment. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated appropriate alternatives to bed rails, such as one bed rail, a grab bar, or wedges should be attempted prior to the use of bed rails and should be documented in progress notes. LPN #3 stated she was not aware of the facility having an assessment for risk of entrapment. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 4. For Resident #106 (R106), the facility staff failed to offer/attempt appropriate alternatives prior to the use of a bed rail and failed to assess the resident for risk of entrapment. On 11/18/24 at 11:46 a.m. and 11/19/24 at 9:05 a.m., R106 was observed lying in bed with a quarter bed rail in the upright position. A review of R106's clinical record failed to reveal documentation that the facility staff offered/attempted appropriate alternatives prior to the use of a bed rail and failed to assess R106 for risk of entrapment. On 11/20/24 at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated appropriate alternatives to bed rails, such as one bed rail, a grab bar, or wedges should be attempted prior to the use of bed rails and should be documented in progress notes. LPN #3 stated she was not aware of the facility having an assessment for risk of entrapment. No further information was presented prior to exit. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on resident interview, staff interview and facility document review, it was determined the facility staff failed to follow up on a psychiatric consult for one of 69 residents in the survey sample, Resident #500. The findings include: For Resident #500 (R500), the facility staff failed to follow up on a psychiatric consult recommendation to increase the resident's antidepressant, Zoloft. An interview was conducted with R500 on 11/19/24 at 9:54 a.m. R500 stated that her antidepressant, Zoloft, was to be increased after she saw the psychiatric nurse practitioner, and it hadn't been increased. The psychiatric nurse practitioner note dated 11/4/24, documented in part, Recommendation: Pt (patient) admits to significant depression with passive death wishes in the setting of further decline in functioning and tension at home. She is also having difficulty adjusting to being here. She is amenable to dose increase of Zoloft. 1. Increase Zoloft to 100 mg (milligrams) po (by mouth) QD (every day) for moderate depression. The physician order dated, 11/1/24, documented, Sertraline HCl (hydrochloride) Tablet 50 mg; Give 1 tablet by mouth one time a day for depression. The November 2024, MAR (medication administration record) documented the above order. It documented the resident was receiving 50 mg not the 100 mg that the psychiatric nurse practitioner recommended. An interview was conducted with RN (registered nurse) #3, the assistant director of nursing, on 11/21/24 at 8:14 a.m. When asked how the recommendation from the psychiatric nurse practitioner gets acted upon, RN #3 stated that sometimes, she (psychiatric nurse practitioner) puts them in the computer but sometimes the unit managers will do that. We need to reach out to the resident's physician to get their approval for the increase in the medication dose. Reviewed the above with RN #3, she stated she didn't know about the above. The facility policy, Consulting Provider Services, documented in part, 4. Consulting providers may make recommendations for patient specific orders/care/treatment, which will be reviewed by the patient's in-house provider(s) for approval/denial. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on 11/21/24 at 1:41 p.m. No further information was provided prior to exit.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure a medication error rate less than five percent for one of five residents observed during the medication administration observation, Resident #48. During the medication administration observation, two errors out of 25 opportunities occurred, resulting in an eight percent medication error rate. The findings include: For Resident #48 (R48), the facility staff failed to administer inhalers per physician's orders. LPN #13 failed to assist the resident with rinsing his mouth after Advair use and failed to wait five minutes between administering inhalers. A review of R48's clinical record revealed the following physician's orders: -5/20/24- Incruse Ellipta 62.5 micrograms, one inhalation by mouth one time a day for chronic obstructive pulmonary disease (lung disease). -10/18/24- Advair Diskus 250 micrograms, one inhalation by mouth every 12 hours for chronic obstructive pulmonary disease. Rinse mouth after use. Wait five minutes between different inhalers. R48's November 2024 MAR (medication administration record) documented the above orders. On 11/13/24 at 7:51 a.m., an observation of LPN (licensed practical nurse) #13 administering medications to R48 was conducted. LPN #13 administered one inhalation of Incruse Ellipta then immediately administered one inhalation of Advair Diskus. LPN #13 failed to wait five minutes in between administering the inhalers and failed to assist R48 with rinsing his mouth. On 11/13/24 at 10:34 a.m., an interview was conducted with LPN #13. LPN #13 reviewed R48's physician's orders. LPN #13 stated she should have waiting five minutes in between administering R48's Advair and Incruse Ellipta, and she should have had R48 rinse his mouth after the Advair administration. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, General Guidelines for Medication Administration documented, Medications are administered as prescribed in accordance with good nursing principles and practices . No further information was presented prior to exit.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide a meal tray for one of 69 residents in the survey sample, Resident #500. The findings include: For Resident #500 (R500), the facility staff failed to offer the resident a lunch tray on 11/19/24. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 11/8/24, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The physician order dated, 11/1/24, documented, Diabetic diet; regular texture, thin liquids consistency. An interview was conducted with R500 on 11/19/24 at 2:29 p.m. R248 stated she had never got a lunch tray today. An interview was conducted with CNA (certified nursing assistant) #8, who was assigned to R500, on 11/19/24 at approximately 2:32 p.m. When asked if she offered R500 a lunch tray today, CNA #8 stated the nursing students passed the trays. CNA #8 further stated the resident refuses it all the time. She, the resident, never eats the food from our kitchen. When asked if the resident should be offered a meal tray, CNA #8 stated, yes. The facility policy, Therapeutic Diets, documented in part, Policy: When necessary, the facility will provide a therapeutic diet that is individualized to meet the clinical needs and desires of a patient/resident to achieve outcomes/goals of care. Available therapeutic diets should coincide with the therapeutic diets on the facility's menu extensions. ASM (administrative staff member) #1, the administrator, and OSM (other staff member) #15, the dietary manager, were made aware of the above concerns on 11/19/24 at 2:42 p.m. No further information was provided prior to exit.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. The facility staff failed to provide alternate menu selection for R46. R46 was admitted to the facility on [DATE] with diagnosis that included but were not limited to quadriplegia, colostomy, tobacco use and osteomyelitis. The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 8/30/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bed mobility/transfer/dressing/toileting and eating. A review of the comprehensive care plan dated 1/19/24 revealed, FOCUS: Resident is a Quadriplegic. Uses seatbelt in wheelchair to aid in positioning due to lack of core strength, no restriction to normal movement. INTERVENTIONS: wheelchair for ambulation and transfers. A review of the physician order dated 8/23/24 revealed, Regular diet, Regular texture, Thin Liquids consistency. A review of the 7/12/24 Nutrition Assessment revealed, Significant undesirable weight loss x3 months (4/12/2024, 208.5 Lbs., -9.5%, -19.8 Lbs RP/MD/IDT aware. Weight 188.7 pounds. Weight loss is desirable related to recent hospitalization with L BKA and diuretics treatment, however, undesirable related to decreased appetite and increased metabolic needs for wound healing. Resident currently meets criteria for malnutrition related to suboptimal po intake, significant weight loss, and muscle wasting/atrophy. Initiate: Mighty Shake 6oz with meals (900kcals, 27gm pro) for supplement. Initiate: Pro-stat BID, zinc, and MVI-M for wound healing. 11/6/24 weight 198.5 lbs A review of the dietician note dated 11/15/24 at 9:52 AM revealed, Resident is receiving Mighty Shake 6oz with meals (900kcals, 27gm pro) for supplement. Resident is receiving pro-stat BID to provide an additional 200 kcal and 30 g pro. Resident with various pressure ulcers in different areas, resident has received vit/minerals in the past, no further vit/min necessary as wounds are stable. Resident currently meets criteria for malnutrition related to suboptimal po intake, history of significant weight loss, and muscle wasting/atrophy. POC updated. RD to follow. Recommendations: -Continue current diet: Regular diet, Regular texture, Thin Liquids consistency. -Continue Mighty Shake 6oz with meals (900kcals, 27gm pro) for supplement. -continue pro-stat BID (200 kcal, 30 g pro) for wound healing. Encourage to eat/drink. Honor food preferences as able, in place. On 11/18/24 at 10:27 A M ,an interview was conducted with R46. When asked about the food, R46 stated, you never know what you are getting as the menu they post is not correct with what is delivered. If you choose something from the alternate menu, they are often out of the item or the wrong item is delivered. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at approximately 8:30 AM, an interview was conducted with OSM (other staff member) #!5, the dietary manager. When asked about consistency in menus posted and what is delivered, OSM #15 stated, we are having some issues and working on that. I have only been here a few days. When asked what residents need to do to receive food from alternate menus, OSM #15 stated, the aides can call us. When asked if the resident should be able to choose items off of the alternate menu, OSM #15 stated, yes, they should. On 11/20/24 at 9:56 AM, an interview was conducted with CNA (certified nursing assistant) #4. When asked how residents are able to obtain food from the alternate menu, CNA #4 stated, we call the kitchen to tell them. Often, they have not had the food the resident has requested, so we have to ask the resident to pick something else. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. A review of the facility's Offering Food Replacements at Mealtimes policy which revealed, If an individual is not eating a food served, the nursing staff will be responsible for asking why and for verbally offering a suitable food replacement. If the individual dislikes the food that was offered, the director of food and nutrition services should be notified to maintain an accurate list of food preferences. No further information was provided prior to exit. Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow the menus and provide alternate menu selection for one of one kitchen and for one of 69 residents in the survey sample, Resident #46. The findings include: 1. The facility staff failed to follow the menus on 11/13/24, 11/18/24 and 11/19/24. Observation was made of the kitchen on 11/13/24 at 11:33 a.m. The cook was preparing baked fish, when asked why he was cooking fish, he stated hamburgers were supposed to be the alternate, but they didn't have any in stock. The cook was observed boiling a pot of water and adding dry pasta. He proceeded to drain the pasta then mix it with paprika. When asked why he did that, the cook stated it was for an alternate starch for the meal. The staff were cutting up a sheet cake and putting it in individual containers. When asked why there was no icing on the cake, OSM (other staff member) #15, the dietary manager, stated they didn't have any icing to put on the cake. Review of the menus for the week failed to document fish or pasta cooked with paprika. On 11/17/24, the menus stated there was to be sloppy joes served for dinner. On 11/18/24 the menu posted for the residents documented chicken salad sandwiches for lunch and turkey deli sandwiches for dinner. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The menu for 11/18/24 documented the lunch was to be Spaghetti and meatballs with sauce, Italian green beans and cake with icing. On 11/19/24 the menu documented beer battered fish, sweet potato fries and Capri vegetables. Observation was made of several lunch trays on 11/19/24, there were regular French fries, not sweet potato fries. An interview was conducted with OSM #15 on 11/20/24 at 9:46 a.m. When asked why sandwiches were served for two meals on 11/18/24, OSM #15 stated they didn't have any ground beef in the building. OSM #15 was asked why sloppy joes were not served on Sunday evening, 11/17/24, OSM #15 stated again, they didn't have the ground beef to cook. OSM #15 stated for 11/19/24, they didn't have any sweet potato fries in the building so they substituted regular French fries. OSM #15 stated she just got here and has adjusted the ordering to match the menus. The facility policy, Menu Substitutions, documented in part, Menu substitutions will be made after discussion with the director of food and nutrition services whenever possible. Last-minute substitutions may need to be made for uncontrollable situations (i.e. inventory emergency when a food item is temporarily unavailable). Procedure: 1. Kitchen staff will consult with the director of food and nutrition services or designee on any needed menu substitutions. 2. If the director of dining services is unavailable, the designated staff (i.e. assistant supervisor, cook/chef) will refer to the Menu Substitution Lists. ASM (administrative staff member) #1, the administrator, and OSM #15 were made aware of the above findings on 11/19/24 at 2:42 p.m. 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview and facility document review, it was determined the facility staff failed to served food at a palatable taste and temperature for one of one meals tasted. The findings include: On 11/18/24 at 11:40 a.m., an interview was conducted with Resident #301. The resident stated he does not like the taste of the facility food and the meals are on the cool side. On 11/18/24 at 12:43 p.m. an interview was conducted with Resident #247. The resident stated the food is nasty and is cold most of the time. Observation was made of the kitchen 11/13/24 at 11:33 a.m. The food temperatures were as followed: Zucchini - 200 degrees Green beans - 205 degrees Mixed vegetables - 194 degrees Veal patties - 205 degrees [NAME] fish - 174 degrees Rice - 177 degrees Puree chicken - 189 degrees Thickened gravy - 145 degrees Pureed mixed vegetables - 191 degrees Pasta mixed with paprika - 185 degrees Mechanical chicken - 172 degrees Baked chicken - 173 degrees Mashed potatoes - 165 degrees On 11/13/24 at 1:42 p.m. the tray line staff ran out of silverware, pellets and dome lids and started using plastic silverware and Styrofoam take out containers to plate the food. At 1:59 p.m. the last cart left the kitchen with the test trays on top of the cart as there was no more room in the cart for the trays. The last resident was served their tray at 2:07 p.m. The test tray temperatures and taste were completed by two surveyors and OSM (other staff member) #15, the dietary manager. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fish - 81.6 degrees - cool to taste Rice - 115 degrees - dry to taste Mixed vegetables - 120 degrees - okay Puree chicken - 100 degrees - tasted too much of the thickener Puree mixed vegetables - 112 - okay Mashed potatoes - 102 degrees - tasted too much of the thickener Veal patty with gravy - 89.4 degrees - taste good but cool to taste. Chicken 130.4 degrees - okay Pasta with paprika - 92 degrees - cool to taste and didn't really have any taste, dry. Green beans - 118 degrees - okay Cauliflower - 108 degrees - okay OSM #15 agreed with the two surveyors of the above findings. The facility policy, Timely Meal Service, documented in part, Policy: Food will be delivered promptly to assure safe, palatable, and high-quality food served at the proper temperature. ASM (administrative staff member) #1, the administrator, and OSM #15, were made aware of the above findings on 11/19/24 at 2:42 p.m. No further information was provided prior to exit.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview and facility document review, it was determined the facility staff failed to provide a diet according to the resident's preferences for one of 69 residents in the survey sample, Resident #173. The findings include: For Resident #173 (R173), the facility staff failed to serve food according to his preferences. On the most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 10/25/24, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. An interview was conducted with R173 on 11/18/24 at approximately 12:15 p.m. R173 stated he can't eat bread, and the menu posted for the residents today has sandwiches for both lunch and dinner. R173 went and retrieved the menu that is posted. The menu posted documented chicken salad sandwiches for lunch and turkey deli sandwiches for dinner. A second interview was conducted with R173 on 11/19/24 at 3:45 p.m. Resident had a carry out bag from a local restaurant on the nightstand. He stated he had to order out food on Sunday, 11/17/24, as the food was not edible to eat. The menu for 11/17/24 was reviewed with R173. The menu documented roasted chicken for lunch and Sloppy Joes for dinner. R173 stated neither of those were served on Sunday. R173 stated that he would have eaten the Sloppy [NAME] if it had been on the tray as he likes that. R173 stated he did speak with the dietary manager yesterday and they did cook him up two hamburgers for dinner on 11/18/24, when sandwiches were on the dinner menu. An interview was conducted with OSM (other staff member) #15, the dietary manager on 11/20/24 at 9:46 a.m. When asked what did R173 eat on 11/18/24 as his preference is no bread, OSM #15 stated she had cooked him a hamburger for dinner. She stated there was no ground beef in the building to make Sloppy Joes with. When asked if this was following the resident's preferences, OSM #15 stated, no. The facility policy, Select Menus, documented in part, Policy: If select menus are offered, selections will be provided within allowed dietary modifications. A non-select menu will be available for anyone who does not make meal choices on his or her own. If an individual is unable to make their own choices, a family member may make the selection, or staff will choose based on known food preferences and diet order. Procedure:1. Select menus will be provided to all individuals who choose to make their own menu selections. Assistance from family or staff is encouraged for those who cannot make their own choices. a. Food and nutrition services staff will label menus with the individual's name, room number and diet, and deliver the menus. ASM (administrative staff member) #1, the administrator, and OSM #15, were made aware of the above findings on 11/21/24 at 1:51 p.m. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide meals at times comparable to normal mealtimes for two of 69 residents in the survey sample, Residents #301 and #247. The findings include: For Residents #301 (R301) and Resident #247 (R247), the facility staff failed to serve meals in a timely manner. On 11/12/24 at 1:47 p.m., staff were observed passing lunch trays to residents on the 300 unit. On 11/13/24 at 9:43 a.m., a meal cart was observed being delivered to the 200 unit. On 11/18/24 at 11:40 a.m., an interview was conducted with R301. The resident stated meals arrive late and he is hungry when they arrive. On 11/18/24 at 12:43 p.m., an interview was conducted with R247. The resident voiced concern regarding mealtimes. R247 stated breakfast can arrive as late as 10:00 a.m., and sometimes she does not receive dinner until 7:00 p.m. The facility mealtimes were documented as: Breakfast: Unit 1: 8:00 a.m. Unit 4 8:30 a.m. Unit 3 9:00 a.m. Unit 2 9:30 a.m. Lunch: Unit 1: 12:15 p.m. Unit 4 12:45 p.m. Unit 3: 1:15 p.m. Unit 2: 1:30 p.m. Dinner: Unit 1: 5:15 p.m. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Unit 4: 5:45 p.m. Unit 3: 6:15 p.m. Unit 2: 6:45 p.m. On 11/20/24 at 9:41 a.m., an interview was conducted with OSM (other staff member) #15 (the dietary manager). OSM #15 stated normal community mealtimes are 7:30 a.m., 11:30 a.m., and 4:30 p.m. and the facility meals are delivered according to the above list. OSM #15 meals are not delivered severely late but approximately 15 to 20 minutes late. OSM #15 stated she was working with the dietary staff to ensure meal deliveries are timelier. On 11/20/24 at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Menu Planning documented, 2.a. Menus will include at least three meals daily at regular times comparable to the normal mealtimes in the community or in accordance with the individual's needs and preferences. No further information was presented prior to exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and facility document review it was determined the facility staff failed to store, prepare and serve food in a sanitary manner in one of one kitchens. The findings include: Observation was made of the kitchen on 11/13/24 at 7:51 a.m. accompanied by OSM (other staff member) #15, the dietary manager. The following was found: Freezer - two wrapped package with no label as to contents, no date when opened or no use by date. On the table by the food processor, there were tortillas, cake mix, box of corn flake crumbs, three bags of dry pasta and a box of lasagna noodles. When asked why these things were there, OSM #15 stated they should be in the pantry. On top of the table next to this were two clear plastic storage bins with parchment paper in the bottom. Both storage bins had food/powder in them, the one bin was cracked. An uncovered container of thickener was observed on this table. OSM #15 stated, it should be covered when not in use. Steamer - top steamer had food debris in the bottom of it. and there were splashes of food substances down the front. Ovens - the top oven had black crusted debris on the bottom and the racks were brown with caked on food debris. The bottom oven had large flakes of burned on food debris or possible, parchment paper that had burned. There were splashes of food on the outside of both ovens. Tilt Griddle - had food debris inside the griddle. Stove - there was black charred food debris on the top surface of the stove. The oven door of the stove was very difficult to open. There was food debris on the floor under the steamer, tilt griddle, ovens and stove. Food prep table - there was an empty jar of peanut butter sitting on the shelf under the table with the buckets of sanitizer solution. Rack with paper products - on the top shelf there were three bottles of eye wash solution. There was a sleeve of Styrofoam cups on the floor under the rack. Also under the rack were six plastic cups, unwrapped. Ice machine room - there were three towels sitting in front of the machine on the floor, empty pack of cigarettes on the floor behind the ice machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The dry storage area - there were two backpacks on the shelf as you enter the room. There were five pairs of shoes, sitting next to a box of wax paper, in the storage room. The office part of the storage room contained another backpack and a pair of Croc shoes. The shelves store the emergency food supplies. The were vacuum attachments stored on the shelf with the food. The graham crackers and saltine crackers had been opened. At 11:32 a.m. the kitchen was again observed. There were pots on the stove. The front of the stove had a brown liquid running down the front of it onto the floor. At 11:40 a.m. OSM #15 was asked for documentation of the cleaning schedule as to when the above equipment had been cleaned, OSM #15 stated there was no cleaning schedule in place that she was aware of. At 1:27 p.m. the afternoon cook washed equipment in the three-compartment sink. The cook did not put the washed equipment into sanitizing solution prior to use as there was no sanitizing solution in any of the sinks. There was a small red bucket sitting in one of the sinks. At 1:42 p.m. two staff members were making sandwiches at the food prep table. The one staff member stopped making sandwiches and grabbed a fast-food style cup from under the food prep table and started drinking it, while talking to the other staff member continuing to make sandwiches. This observation was shared with OSM #15, she stated that that was not allowed. The facility policy, Policy and Procedure Manual, documented in part, 13. Frozen Foods: c. All foods should be covered, labeled and dated. The facility policy, Cleaning and Sanitizing of Dining and Food Service Areas, documented in part, Policy: The food and nutrition services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. Procedure: 1. The director of food and nutrition services will determine all cleaning and sanitation tasks needed for the department. 2. Tasks shall be designated to be the responsibility of specific positions in the department. 3. Staff will be trained on the frequency of cleaning as necessary. 4. The methods and guidelines to be used and agents used for cleaning shall be developed for each task or piece of equipment to be cleaned. 5. A cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks as completed. 6. Staff will be held accountable for cleaning assignments. The facility policy, Cleaning Instructions: Ovens, documented in part, Policy: Ovens will be cleaned as needed and according to the cleaning schedule (at least once every two weeks). Spills and food particles will be removed after each use. Procedure: 1. Remove the oven racks, and place on a newspaper in a ventilated area. 2. Apply oven cleaner and let the racks stand per the oven cleaner directions. 3. Wipe off any loosened grease and particles with paper towels. Place the racks in a sink with the drain open. 4. Run water over the racks to remove the oven cleaner, dirt, grease and grease particles. Let the water rundown the drain. 5. Wash and rinse the racks. Air dry. 6. Remove large particles from the inside of the oven. Apply oven cleaner to the inside of the oven and oven door. Let it stand per oven cleaner directions. 7. Wipe off any loosened grease and particles from inside the oven and oven door. 8. Rinse thoroughly. 9. Replace the racks inside the oven. 10. Remove spills and food particles after each oven use as needed (before re-heating the oven). The facility policy, Cleaning Instructions: Floors, Tables and Chairs, documented in part, Policy: Kitchen and dining room floors, tables and chairs will be cleaned and sanitized regularly. Procedure: 1. Sweep and clean kitchen floors after each meal. Sanitize at least once daily. Move major appliances at least once a month (as appropriate) in order to facilitate cleaning behind and underneath them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM (administrative staff member) #1, the administrator, and OSM #15, were made aware of the above findings on 11/19/24 at 2:42 p.m. 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 - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 5. The facility staff failed to evidence complete and accurate documentation for incontinence care for R167. R167 was admitted to the facility on [DATE] with diagnosis that included but were not limited to encephalopathy, dementia and seizures. R167's most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of [DATE], coded the resident as scoring a 02 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as moderate assist for bed mobility/transfer, eating/hygiene. A review of R167's comprehensive care plan dated [DATE] revealed, FOCUS: The resident is at risk for weight loss or malnutrition related to advanced age, chronic disease. INTERVENTIONS: weights as ordered. A review of the physician orders revealed Monthly weights. A review of R167 weights revealed weight [DATE] 127 pounds. weight [DATE] 236.5 pounds. No additional weight obtained, till Registered Dietician requested new weight on [DATE]. R167 weight on [DATE] was 144 pounds. On [DATE] at 9:56 AM, an interview was conducted with CNA (certified nursing assistant) #4. When asked the process if there was a difference in the resident weight, CNA #4 stated, you would reweigh the resident if there was a weight change of 5 pounds more or less you would reweigh. We document on paper and then give the paper to the nurse to enter into PCC. A 100-pound weight difference had to be a typo. On [DATE] at 10:05 AM, an interview was conducted with LPN (licensed practical nurse) #6. When asked the process if there is a difference in the resident's weight, LPN #6 stated, if there is more than 5 pounds one way or the other, then we get a reweigh. This looks like an incorrect entry in the medical record. When asked if the resident's medical record was complete and accurate, LPN #6 stated, no, it is not. On [DATE] at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. No further information was provided prior to exit. Based on staff interview, clinical record review, and facility document review, the facility staff failed to protect a resident's rights to confidentiality of his medical record for one of 69 residents in the survey sample, Resident #303; and failed to maintain a complete and accurate clinical record for four of 69 residents in the survey sample, Residents #247, #250, #55, and #167. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The findings include: 1. For Resident #303 (R303), the facility staff released the deceased resident's medical record to an individual who had not provided legal evidence that he was the resident's next of kin. This constituted a violation of releasing a confidential medical record to the individual, or their resident representative where permitted by applicable law. A review of R303's face sheet revealed Individual #1 was listed as the resident's responsible party. Individual #1 was identified on the face sheet as the R303's brother. A review of R303's admission MDS (minimum data set) with an ARD (assessment reference date) of [DATE], R303 was coded as being severely cognitive impaired, scoring zero out of 15 on the BIMS (brief interview for mental status). He was coded as having a diagnosis of intellectual disability. A review of R303's hospital Discharge summary dated [DATE] revealed, in part: At this time, legal decision-maker is Siblings. First contact: [Individual #1] (brother) .Capacity: Patient does not have capacity to make decisions at this time .No understanding of the relevant information. No responses are consistent over time, when questions are asked a different way and by different people. No appreciation of the significance of information as it is applied to the person's situation. No ability to reason with relevant information, logically weighing options. No ability to express a choice. Further review of R303's clinical record failed to reveal any evidence of any legal paperwork verifying Individual #1's status as the R303's brother or next of kin or executor of estate. A review of a letter from Individual #1 dated [DATE] and addressed to OSM (other staff member) #1, the medical records clerk, revealed, in part: My brother, [R303], was a resident of your facility from [DATE] until his death, [DATE] .I am requesting a copy of his medical records, inclusive of all documentations by physicians, nurse practitioners, nursing staff, medication records, and administrative staff who were involved with the care and treatment of [R303] .This is my second request for this information .If there is a cost for providing me with the records, please provide me with the cost of preparing and submitting the aforementioned documents to me, in accordance with allowable charges under federal law, as well as when such documents will be sent to me. I will accept the records electronically. If, for whatever reason, you believe you do not have to comply with this request, please inform me within seven (7) days of receipt of this request the basis for your denial. A review of a facility email dated [DATE] from OSM #1 to Individual #1 revealed two attachments and a link to a digital drop box accessible by Individual #1. The email contained the following text: This was the link used to submit the records. Attached are the same files submitted along with the request. On [DATE] at 8:33 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were interviewed. ASM #1 stated there is a corporate compliance company who reviews all requests for medical records. She stated this third party company reviews all requests and makes the decision about releasing the records. ASM #1 stated designations of resident representatives/decision makers are made according to competency. She stated if a resident is competent, that resident is designated as the decision maker unless the resident defers that to someone else. She stated the facility would get that deferment in writing. ASM #2 stated the facility does a BIMS assessment on admission, and that would be used to determine the resident's decision making capacity. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM #1 and ASM #2 were asked to provide evidence that Individual #1 was designated legally as either R303's next of kin, or executor of estate after R303 was deceased . On [DATE] at 12:18 p.m., OSM #1 was interviewed. He stated he becomes aware of requests for records to be released by email or fax. He stated he scans the requests into an email, and sends the email request to the administrator and corporate compliance representative for clearance to release the records. Once he receives permission from the corporate compliance representative, he releases the records. He stated he received two requests for R303's records at about the same time at the end of September/early [DATE]. The initial request was from another state agency. The second was from Individual #1. He stated he communicated the state agency's request to the corporate compliance representative, but did not communicate Individual #1's request. He stated he received permission to release R303's records to the state agency, and then he released the records to both the state agency and Individual #1. He stated he knows he did not have permission from the corporate compliance representative to release the records to Individual #1, but stated he knew Individual #1 was R303's brother. On [DATE] at 9:04 a.m., ASM #1 stated state law allowed Individual #1 to be designated as R303's decision maker. She stated she was not aware until [DATE] that R303's records had been released to Individual #1. She stated she did not believe the facility has any verification that Individual #1 was legally entitled to a copy of R303's record, but that she would continue looking. At this time, ASM #1 and ASM #2 were made aware of the concerns regarding the violation of R303's confidentiality of his clinical record. A review of the facility policy, Medical Record Access, revealed, in part: Staff must follow the guidelines and policies of the Company in order to safeguard the rights of our patients .Release of information should only be processed by those trained and qualified to do so .Authorization - Special : Patient is deceased or Mentally incapacitated .If the records are for a deceased patient, the personal representative must sign the authorization. Under the Code of Virginia Section 1-234, the personal representative is the executor of a will or the administrator of the estate of a decedent or a curator of the estate, or other curators or committee appointed by a court. Either a copy of the will or a letter of qualification from a court must be annexed to the signed authorization .If the Center receives a request for records from an individual who was involved in the care of the deceased patient and the required records are related to that care, the Center may provide those records. No further information was provided prior to exit. Reference 12VAC5-371-360. Clinical records. A. The nursing facility shall maintain an organized clinical record system in accordance with recognized professional practices. Written policies and procedures shall be established specifying content and completion of clinical records. B. Clinical records shall be confidential. Only authorized personnel shall have access as specified in §§ 8.01-413 and 32.1-127.1:03 of the Code of Virginia § 64.2-1608. Termination of power of attorney or agent's authority. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. A power of attorney terminates when: 1. The principal dies; 2. The principal becomes a vulnerable adult, if the power of attorney is not durable; 3. The principal revokes the power of attorney; 4. The power of attorney provides that it terminates; 5. The purpose of the power of attorney is accomplished; or 6. The principal revokes the agent's authority or the agent dies, becomes a vulnerable adult, or resigns, and the power of attorney does not provide for another agent to act under the power of attorney. 4. For Resident #55 (R55), the facility staff failed to document why the medication buspirone (used to treat anxiety) was held twice on [DATE]. A review of R55's clinical record revealed a physician's order dated [DATE] for buspirone 10 mg (milligrams)-one tablet by mouth three times a day for anxiety. A review of R55's [DATE] MAR (medication administration record) revealed the same physician's order. On [DATE] at 8:00 a.m. and 2:00 p.m., the nurse documented buspirone was held as evidenced by the code, 5=Hold/See Progress Notes on the MAR. A review of progress notes for [DATE] failed to reveal why the buspirone was held. On [DATE] at 10:52 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 reviewed R55's [DATE] MAR and nurses' notes. LPN #3 stated the nurse who held the buspirone on [DATE] should have documented the reason the medication was held. On [DATE] at 4:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 2. For Resident #247, the facility staff failed to complete a Trauma Informed Screen. The Resident was admitted on [DATE] with a diagnosis of PTSD (post-traumatic stress disorder). The Trauma Informed Screen dated [DATE], failed to document any answers to any questions on the form. The comprehensive care plan dated, [DATE], documented in part, Focus: The resident reported trauma during their trauma screening related to PTSD. A/n interview was conducted with OSM (other staff member) #18, the director of social services, on [DATE] at 9:30 a.m. The above trauma informed screen dated [DATE], was reviewed with OSM #18. OSM #18 stated the form should be filled out so that the facility knows how to address the resident's needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Rehabilitation and Nursing Center	7300 Forest Ave Richmond, VA 23226

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Medical Records Management - Initiation & Continuation, documented in part, The medical record is initiated upon the patient's first admission and is continued for each episode of care. An episode of care begins at admission and ends at discharge. If there is a readmission within 30 days, the medical record may be continued but all assessment requirements remain the same. The medical record number (not the ID), is the official number for the chart. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on [DATE] at 1:41 p.m. No further information was provided prior to exit. 3. For Resident #250, the facility staff failed to accurately document the date and time the resident left AMA (against medical advice). Resident #250 (R250) was admitted to the facility on [DATE] at 12:25 p.m. Review of the Medication Administration Record for September revealed blanks for where medications should have been signed off as given for [DATE] at 9:00 p.m. and [DATE] at 9:00 a.m. Further review of the clinical record revealed documented on [DATE] at 10:46 p.m. documented, Pt (patient) family expressed discontent with care and desire to transfer patient back to the hospital. Nurse explained to the family about the admission process and the importance of allowing provider to make decisions bout transfer. Family called 911 against medical advice. Family refused to sign against medical advice form. Supervisor aware. An interview was conducted on [DATE] at 8:07 a.m. with RN (registered nurse) #3, the assistant director of nursing. RN #3 stated that after she researched the clinical record, she found out that the resident had left the facility, via 911, on [DATE] at approximately 8:30 p.m. An interview was conducted with RN #7, the supervisor, on [DATE] at 8:07 a.m. RN #7 stated he was called to (R250)'s room by the night shift nurse around 7:30 p.m. The family of the resident were there. They were all upset and wanted to take (R250) out of the facility, they were not satisfied. there was a concern expressed by the family for a room change, related to COVID. The family didn't like that the facility had COVID. They wouldn't have chosen the facility to come to. The family felt the mother might get more sick at this facility. He stated he asked if he could do anything, he offered a room on another unit without COVID. The family had decided. He was not aware that they had already called 911 prior to him coming into the room. When asked if he should have written a note, RN #7 stated he had to go to another concern on another unit. He stated it is the facility procedure that the nurse assigned to the resident will write the note. RN #7 stated wasn't able to recheck if the note was written or not. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the assistant director of nursing, were made aware of the above concern on [DATE] at 4:00 p.m. 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
	495227	A. Building B. Wing	11/21/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly The facility staff failed to evidence medical director participation in four of four 2023 QAPI (quality assurance process improvement) meetings. The findings include: During the facility QAPI task, a review of the QAPI committee rosters from 11/2022 to 10/2024 revealed the there was no evidence of medical director participation for four of four 2023 QAPI meetings, 3/21/23, 6/29/23, 8/28/23 and 11/28/23. 11/20/24 QAPI rosters were reviewed as well as the plan. on 11/21/24 at 8:49 AM, an interview was conducted with ASM (administrative staff member) #1, the administrator. When asked the meeting schedule for QAPI, ASM #1 stated, when this corporation acquired this facility, they decided we needed to focus on quality and meet monthly in order to enhance quality. Monthly we expect attendance from the administrator, director of nursing, safety, maintenance, nursing leaders, IP, clinical rehab and dietary. Quarterly we expect attendance from the medical director and pharmacy. When ASM #1 was asked to review the 2023 QAPI attendance rosters for medical director participation, ASM #1 stated, no, I do not see that the medical director participated. I do not see evidence that he called into the meeting. On 11/21/24 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and RN (registered nurse) #3, the assistant director of nursing, were made aware of the findings. A review of the facility's QAPI policy revealed in part, The Administrator serves as the Chairperson to the QAPI committee to oversee committee activities. The committee membership includes the Administrator, Director of Nursing, Medical Director, Infection Preventionist, and at least two other Center designated employees. No further information was provided prior to exit.