STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495230	A. Building B. Wing	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 49456 Based on observation and staff interview the staff failed to ensure the survey results were readily accessible. Findings included: Survey result book was not in a place that was visible and easily accessible for the resident, staff or family members to be able to view. On 2/21/24 at 10:00 a.m., a Resident Council meeting was conducted. When the asked if they knew where the survey results were located, the residents voiced uncertainty regarding the location of the survey result book. On 02/22/24 8:36 a.m., observations were conducted to locate the survey result book but was not found in any of the common areas accessible to residents or the public. On 02/22/24 at 8:40 a.m, an interview with the director of nursing (DON) about the survey book. When questioned about the location, the DON stated being unaware of where the survey result book was kept. On 2/22/24 at 8:45 a.m., an interview was conducted with the Administrator about the location of the survey result book. The Admininstrator then went to the front lobby and was observed searching the area, before finding the survey book under the receptionist's desk. When questioned further, the Administrator verbalized that the book was usually up front in the lobby, on a shelf, beside the receptionist desk. When questioned about the posted notice, the Administrator verbalized that there used to be a sign about the location of the survey result book, but does not know what happened to the sign. Signage noting the location of the survey result book was not observed in any place, throughout the facility. On 2/22/24 at 12:38 p.m., the above findings was presented to the Administrator, Assistant Director of Nursing, and nurse consultants. No other information provided prior to exit conference.

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

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident interview, facility staff interviews, and facility documentation review, the facility staff failed to maintain a safe, comfortable, and homelike environment on 1 of 4 nursing units and in the main dining room. The findings included: 1. On the 300 unit of the nursing facility, the facility staff failed to ensure a safe and homelike environment, affecting multiple residents. 1a. For resident #58 (R58), the facility failed to maintain the room furnishings of a bedside table that was in good operating condition, which resulted in an environment that was not homelike. On 2/20/24, in the late morning, it was observed that R58's bedside table was missing 2 of the 3 drawers. R58 was not in the room at the time of this observation. On 2/21/24 at 9:28 AM, R58's bedside table was noted to still have only 1 drawer, the other 2 were missing. When questioned, R58 reported that it had been like that for weeks. On 02/22/24 at 08:53 a.m., an interview was conducted with CNA #5. CNA #5 confirmed the surveyor's observation that R58's bedside table was missing 2 drawers. CNA #5 confirmed that the drawers had been like that for weeks and stated, I think since he was going home, they just decided to not fix it. During the above interview with CNA #5, the CNA confirmed that everyone has access to a system on the computer where they can put in maintenance work orders for items that need repairs. On 02/22/24 at 8:30 a.m., an interview was conducted with the maintenance director (Other Employee #6-OE #6). OE #6 said he was unaware of the cabinet and could immediately replace it with a spare one that he has out back of the facility. 1b. For the bathroom shared between four residents residing in rooms [ROOM NUMBERS], the baseboard left a large, exposed hole in the wall. On 2/20/24, in the late morning, during facility observations, it was noted that the bathroom which was shared among the four residents residing in rooms [ROOM NUMBERS], there was a rather large, exposed hole in the wall behind the toilet. On 2/21/24 at 9:30 a.m., the hole in the bathroom wall was still noted. On 2/22/24 at approximately 8:45 a.m., the shared bathroom between rooms [ROOM NUMBERS], was still noted with no repairs having been made. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/22/24 at 08:53 a.m., an interview was conducted with CNA #5. CNA #5 stated that everyone has access to a system on the computer where they can put in maintenance work orders for items that need repairs. On 02/22/24 at 8:30 a.m., an interview was conducted with the maintenance director (Other Employee #6-OE #6). OE #6 was shown the bathroom noted above. OE #6 said no one had made him aware of it. OE #6 said he would be able to make repairs which would require him cutting a piece of sheet rock to repair the hole and then he could re-glue the baseboard. 1c. For the bathroom shared between the four residents residing in rooms [ROOM NUMBERS], there was a dislodged access panel cover, which left a large, exposed hole in the wall, and cold air was coming into the bathroom as a result. On 2/20/24, in the late morning, during facility observations, it was noted that the bathroom which was shared among the four residents residing in rooms [ROOM NUMBERS], there was a rather large, exposed hole in the wall behind the toilet. On 2/21/24 at 9:30 a.m., the access panel in the bathroom wall was still noted to be out of place and unsecured. On 2/22/24 at approximately 8:50 a.m., the bathroom between rooms [ROOM NUMBERS] was still noted to have the access panel out of place. On 02/22/24 at 8:30 a.m., an interview was conducted with the maintenance director (Other Employee #6-OE #6). OE was shown the bathroom and stated he had not been aware of the problem. He made multiple attempts to put the access panel back in place but was not able to make immediate repairs and reported to the surveyor that he would have to come back to it. 2. In the main dining room, the facility staff failed to maintain an environment in good repair and homelike, due to the cove baseboard being damaged and exposing holes in the wall. On 2/20/24 at approximately 12 noon, during observation of the lunch meal, it was noted that on the far back wall of the dining room which adjoined the kitchen, the cove baseboard was damaged and left large, exposed holes in the wall. Throughout the remaining days of survey, 2/21/24 and 2/22/24, the above was noted with no repairs having been made. On 02/22/24 at 8:12 a.m., an interview was conducted with the maintenance director (Other Employee #6-OE #6). OE #6 explained that the facility uses an electronic system for maintenance work orders. Any staff member can access it at any computer in the facility, enter what needs repairs and it will send an alert directly to OE #6's phone. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	OE #6 was asked about preventive maintenance and facility rounds. OE #6 said, I do an audit once a week. When asked about the wall in the main dining room, the maintenance director said, with that wall, we are in the process of getting a renovation, so I am waiting to see what they are going to do. When asked, how long has the wall been like that? OE #6 said, It is an ongoing issue, the staff push the food carts against the wall, and it causes the damage. The current damage has been like this for multiple weeks and repairs are not being made due to the upcoming renovation of the room. On the morning of 2/22/24, a review was conducted of the current maintenance work orders since January 1, 2024. None of the identified areas noted above were listed in the work order system to notify maintenance of repairs being needed. On 2/22/24 at approximately 9 a.m., the facility administrator was made aware of the above concerns. The administrator confirmed that the facility was going to be undergoing renovations and this would include replacing all the furniture in the resident rooms. No further information was provided.

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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** 21875 Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to complete an accurate minimum data set (MDS) assessment for one of twenty-two residents in the survey sample (Resident #44). The findings include: Resident #44's admission MDS (an assessment tool) dated 1/18/24 inaccurately assessed the resident with having no dental problems, when the resident was edentulous (no natural teeth). Resident #44 (R44) was admitted to the facility with diagnoses that included osteoarthritis, depressive disorder, Parkinson's disease, heart failure and spinal stenosis. The MDS dated [DATE] assessed R44 as cognitively intact. On 2/20/24 at 11:21 a.m., R44 was interviewed about quality of life/care in the facility. R44 stated during this interview that she had pulled all teeth prior to admission to the facility and was waiting to get full dentures. R44 was observed with no natural teeth and stated she was on a soft diet because she was unable to chew some food items because she had no teeth. R44's clinical record documented an admission nursing assessment dated [DATE]. This assessment documented R44 had no natural teeth. The dental section (L0200) of R44's MDS dated [DATE] inaccurately documented the resident with no dental issues. Item B. for indicating no natural teeth or tooth fragment(s) (edentulous) was not checked. On 2/21/24 at 1:08 p.m., the registered nurse MDS coordinator (RN #1) was interviewed about the inaccuracy of R44's MDS dental assessment. RN #1 stated, To my knowledge, the MDS is correct. RN #1 stated she would review R44's dental assessment. On 2/21/24 at 1:55 p.m., RN #1 stated that R44 did not have natural visible teeth. RN #1 stated R44 had ridges on her gums and when she palpated R44's gums she could feel something. When asked about the MDS not indicating the resident was edentulous, RN #1 stated that she felt that edentulous would not be marked because she felt something on the exam. When asked how the assessment would indicate teeth when the resident's teeth had been pulled, RN #1 stated again that R44 had no visible teeth but that she felt something when she palpated the gums. On 2/21/24 at 3:10 p.m., the director of nursing (DON) was interviewed about R44's dental status. The DON stated R44 did not have any teeth as they had been pulled in preparation for dentures. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual on page L-1 documents that the dental section was intended to record any dental problems present in the 7-day look-back period. Edentulous was defined on page L-1 as, Having no natural permanent teeth in the mouth. Complete tooth loss. Coding instructions on page L-2 included, Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous/lacks all natural teeth or parts of teeth. (1) (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This finding was reviewed with the administrator, director of nursing, and nurse consultant during a meeting on 2/21/24 at 4:15 p.m. with no further information provided prior to the end of the survey. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.18.11, Centers for Medicare & Medicaid Services, Revised October 2023.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on observation, staff interview, and clinical record review, the facility failed to develop a care plan for three of twenty two residents. 1. Resident #49 (R49) was not care planned for the use of a hoyer lift (hydraulic equipment used to safely transfer residents). 2. R21 had an admitting diagnoses of PTSD (Post Traumatic Stress Disorder) and a care plan had not been developed. 3. R44 did not have a care plan for dental issues. The Findings Include: Diagnoses for R49 included; Acquired absence or right hip joint, osteoporosis, pathological left femur fracture, right knee replacement, and rheumatoid arthritis. The most current MDS (minimum data set - an assessment tool) was a quarterly assessment with an ARD (assessment reference date) of 1/11/24. R49 was assessed with a cognitive score of 9 out of 15, indicating moderately impaired cognition. Section GG Functional Abilities indicated R49 was impaired on all extremities and was totally dependant on staff with sit to stand and chair/bed to chair. On 2/20/24 at 12:17 PM, R49 was observed in a wheelchair with a hoyer lift sling underneath her. When asked about using a hoyer lift, R49 verbalized that staff use a hoyer for transfers from the bed to the chair, but sometimes staff are able to stand R49 up and pivot to the chair or bed. Review of R49 care plan did not indicate the use of a hoyer lift, the size of the sling needed, or the degree of assistance needed. On 2/21/24 at 1:53 PM, certified nursing assistant (CNA#1, assigned to R49) was interviewed. CNA #1 verbalized that R49 is transferred with the use of a hoyer lift and is assisted by 2 staff members when the hoyer lift is used. When asked how do the CNA's know which residents use a hoyer lift, and how many staff are needed for transfers, CNA #1 verbalized that the CNA's get their information from other CNA's or nurses. On 2/21/24 at 2:05 PM, registered nurse (RN #1, MDS coordinator) was interviewed regarding hoyer lift interventions on the care plan. RN #1 reviewed R49's care plan and verbalized having seen hoyer lift interventions being care planned at other facilities, but wasn't sure what the requirement is at this facility as only being employed for 4 weeks. On 2/21/24 at 2:08 PM, the director of nursing (DON) was interviewed. The DON reviewed R49's care plan and verbalized that R49 can assist with transfers at times, but the hoyer lift should be care planned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/21/24 at 4:08 PM the above finding was presented to the DON and administrator. No other information was presented prior to exit conference on 2/22/24. 49371 2. The facility failed to develop a plan of care that addressed Resident #21's (R21's) history of PTSD, the specific trauma that caused the PTSD and triggers that may cause re-traumatization. R21 was admitted with diagnoses that include Alzheimer's disease, cerebral infarction, schizophrenia, dementia, bipolar disorder, post-traumatic stress disorder, anxiety, and major depressive disorder. According to the clinical record, R21 was assessed on 12/30/23 as having moderate cognitive impairment. Review of R21's care plan, initiated 12/14/22 with the most recent revision date of 5/19/23, did not address the diagnosis of post-traumatic stress disorder (PTSD). The care plan revealed that R21 had a behavior problem due to diagnosis of PTSD but did not include the specific cause of the PTSD, what the behaviors were, or what R21's triggers were. On 2/22/24 at 8:31 AM, the social worker, other staff #1 (OS#1), was interviewed regarding cause and triggers of R21's PTSD. OS#1 stated, We never talked about what the triggers were, but smoking schedule changes would make him nervous . if meals were late, we assured him they were coming, he would calm down. If not able to reach his family, he would get upset. On 2/22/24 at 9:37 AM, registered nurse #2 (RN#2), who cared for R21, was interviewed regarding the cause and triggers of R21's PTSD. RN#2 stated that she did not know the specifics of his trauma, but family dynamics played a part. When questioned further, RN#2 stated that R21 was .mostly anxious and one day he thought a family member was a sniper outside his room. On 2/22/24 at 9:46 AM, the minimum data set (MDS) coordinator RN#1 was interviewed regarding R21's care plan for PTSD. RN#1 stated that she was not aware of the specific trauma or triggers for R21's PTSD and then stated, They should be on the care plan. On 2/22/24 at 12:40 PM, a meeting was held with the facility administrator and regional nurse consultants to inform them of the above findings and concerns. No additional information was provided. 21875 3. Resident #44 (R44) had no plan of care developed for dental problems related to having no natural teeth or R44's need for dentures. Resident #44 (R44) was admitted to the facility with diagnoses that included osteoarthritis, depressive disorder, Parkinson's disease, heart failure, and spinal stenosis. The minimum data set (MDS - an assessment tool), dated 1/18/24, assessed R44 as being cognitively intact. R44's clinical record documented an admission nursing assessment dated [DATE]. This assessment documented that R44 had no natural teeth and that R44's dentures that did not fit. R44's admission MDS dated [DATE] inaccurately listed the resident as having no dental problems and failed to reflect that the resident was edentulous. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/24 at 11:21 a.m., R44 was interviewed about quality of life/care in the facility. R44 stated that she had all teeth pulled prior to admission to the facility and was waiting for dentures. R44 demonstrated having no natural teeth and stated she was on a soft diet because she was unable to chew some food items. R44's plan of care (revised 1/31/24) included no problems, goals, and/or interventions regarding the resident's edentulous status or the need for dentures. On 2/21/24 at 1:55 p.m., the registered nurse MDS coordinator (RN #1) responsible for care planning was interviewed about R44's plan of care. RN #1 stated R44 was not assessed with any dental issues, that dental was not triggered on the MDS, and therefore no care plan for dental was developed. On 2/21/24 at 3:10 p.m., the director of nursing (DON) was interviewed about R44's dental status. The DON stated R44 did not have any teeth as they had been pulled in preparation for dentures. This finding was reviewed with the administrator, director of nursing, and nurse consultant during a meeting on 2/21/24 at 4:15 p.m., with no further information provided prior to the end of the survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49371 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility failed to review and revise the care plan for 2 of 22 residents (Resident #9 and #32) in the survey sample and failed to invite/involve 2 residents (Resident #6 and #25) in their care plan meeting. The findings included: 1. A review of Resident #9 (R9's) care plan dated 9/6/23 revealed that the care plan had not been revised to indicate a code status change from full code to Do Not Resuscitate (DNR). R9 had diagnoses that included nontraumatic intracerebral hemorrhage, dementia, atrial fibrillation, epilepsy, major depressive disorder, Alzheimer's disease and anxiety disorder. The most current minimum data set (MDS) was an annual assessment dated [DATE], which assessed R9 with severe cognitive impairment. Review of R9's clinical record revealed that R9's power of attorney signed a DNR form on 1/7/24 and the physician placed the DNR order on 1/8/24. R9's care plan, which was revised on 9/6/23, documented the resident's resuscitation status as full code and had not been revised with the change to DNR status. On 2/21/24 at 3:17 PM, the MDS coordinator, registered nurse #1 (RN#1) responsible for updating care plans was interviewed regarding R9's code status on the care plan. RN#1 stated that the care plan should have been updated 24-48 hours after the new order was received. RN#1 had no explanation as to why the care plan had not been updated. 2. R32's care plan initiated 8/17/23 had not been revised to indicate that a fluid restriction had been ordered. R32 had diagnoses that included congestive heart failure, chronic kidney disease, hypertension. The most current MDS (minimumdata set - the assessment tool) was a quarterly assessment dated [DATE], which assessed R32 as being cognitively intact. Review of R32's clinical record revealed a physician's order written on 2/5/24 for R32 to be placed on a 1500 ml fluid restriction per day. Review of R32's care plan dated 8/17/23 included no mention of the fluid restriction. Review of R32's medication administration record, treatment administration record, and activity of daily living record showed no documentation of a fluid restriction. On 2/21/24 at 3:17 PM, RN#1 was interviewed regarding updating and revising care plans. RN#1 stated that there were three opportunities to update a care plan: when the new order is written, during the morning meeting, and when the care plan was scheduled to be updated. When questioned about a change in orders, RN#1 stated the care plan should be updated within 24 to 48 hours after the order is received and is mostly based on nursing knowledge. When questioned about R32's fluid restriction, RN#1 agreed that the fluid restriction should have been added to the care plan but offered no explanation as to why it was not. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/21/24 at 3:35 PM, licensed practical nurse #2 (LPN#2), who was assigned to work with R32 on 2 /21/24, was interviewed regarding updating care plans. LPN#2 stated that both nurses and the MDS coordinator can update care plans. LPN#2 offered no explanation as to why R32's care plan had not been updated to include the order for the fluid restriction. On 2 22/24 at 8:25 AM, LPN #2 was interviewed regarding the documentation of fluid intake for residents on fluid restrictions. LPN #2 stated, We just give verbal report at each shift change, telling what the intake was for our shift. On 2/22/24 at 9:37 AM, registered nurse #2 (RN #2), who worked on the same unit that R32 resided, was questioned about documentation of fluid intake for residents on fluid restrictions. RN #2 stated that the intake is not documented, but verbal report is given at shift changes. On 2/22/24 at 12:40 PM, during the end of day meeting the facility administrator and regional nurse consultants were made aware of the above concerns. No additional information was provided. 41449 3. For Resident #6 (R6), the facility staff failed to hold quarterly care plan meetings and involve the resident in the development and review of the plan of care. On 02/20/24 at 10:48 a.m., an interview was conducted with R6. During this interview, R6 expressed that he was not aware of care plan meetings and was not invited to attend them. On 2/21/24, a clinical record review was conducted., which revealed no information with regards to care plan meetings being held or R6 being invited to and involved in them. On 02/21/24 at 01:37 p.m., an interview was conducted with Other Employee #1, the Social Worker (SW). The SW stated that the MDS (minimum data set - an assessment tool) nurse, sends out a MDS calendar and SW notifies the resident and family. The SW said, If the resident is their own representative, I let them know, and the ones who have legal guardians, I send a letter or email them. When asked if this information was documented, the SW said, I usually call them. When asked about the timing of the call and if they are notified ahead of time, the SW said, I try my best but sometimes my printer goes down or they don't answer their phone. When asked again, how this information is documented, the SW pulled out a folder that dated back to the summer of 2023, stating, Yes, I try to document it but I am trying to get it put into the computer. Every time I will sit to do it, I get interrupted or now I am doing appointments and just haven't gotten to them. During the above interview, the SW was asked when R6's last care plan meeting was. The SW looked through the file and noted that the last meeting was held on 7/19/23. There was no evidence that R6 was invited to attend or involved in the development of the plan of care. The SW was asked to provide any evidence of when R6 had care plan meetings from January 2023-present. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Later on the afternoon of 2/21/24, when asked to explain the purpose of the care plan meeting, the SW said, To talk about their progress, if they have any needs, if there are any concerns, ask about their weight, if they are compliant with dietary and taking their meds, if they still meet criteria for long-term care, find out what they are able to do, talk of discharge or request for discharge, we talk about that as well. When asked why is it important for the resident and/or their representative to be involved, the Social Worker said, for self-care and so they can be patient directed and they can let us know what they want and preferences. On 2/21/24 at 02:02 p.m., an interview was conducted with RN #1, who was the MDS coordinator. When asked about the care plan meetings, RN #1 said, They are held every 90 days based on the date due, typically every 90 days unless there is a significant change. Asked who attends the care plan meetings, RN#1 stated, To my knowledge, therapy, social services, dietary activities and families, the resident and if hospice, a representative from hospice. When asked why is it important for the resident and family to be involved, RN #1 said, I feel it is important because you want the care plan to represent and encourage the resident to have their autonomy and voice is important so they can be reflected. The MDS coordinator stated, I set the schedule and then she [the social worker] sends the invites to everyone. On 2/21/24, during an end of day meeting, the facility Administrator was made aware of the above findings. On the morning of 2/22/24, the SW was again interviewed. The SW provided the surveyor with evidence that R6 had care plan meetings held on 2/21/23, 4/17/23 and 7/19/23. The SW also provided a letter that indicated R6 would have a care plan meeting on 7/19/23. It did not indicate when the resident was given this letter or any specific details at to the time or location of the meeting. There was no evidence that R6 had been invited to the care plan meetings held in February or April. A review of the facility policy titled, Care Planning- Comprehensive Person-Centered was reviewed. The policy read in part, . 6. The resident/resident representative [s] is encouraged to participate in the development of and revisions to the resident's care plan. a. An explanation will be included in the resident's medical record if the participation of the resident/resident representative is determined not practicable for the development of the resident's care plan . 10. Every effort will be made to schedule care plan discussions at the best time of the day for the resident/resident representative . No additional information was provided. 4. For Resident #25 (R25), the facility staff failed to provide quarterly care plan meetings and involve the resident and a representative from nursing in the meetings. On 02/20/24 at 11:37 a.m., R25 stated they were unaware of when care plan meetings were held and were not involved in the development of their plan of care. On 2/21/24, a clinical record review was conducted. This review revealed no information with regards to care plan meetings being held or R25 being invited to and involved in them. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/21/24 at 01:37 p.m., an interview was conducted with Other Employee #1, the Social Worker (SW). The SW stated that the MDS (minimum data set - an assessment tool) nurse, sends out a MDS calendar, and then SW notifies the resident and family. The SW said, If the resident is their own representative, I let them know and the ones who have legal guardians I send a letter or email them. When asked if this information is documented, the SW said, I usually call them. When asked about the timing of the call and if they are notified ahead of time, the SW said, I try my best but sometimes my printer goes down or they don't answer their phone. When again asked how this information is documented, the SW pulled out a folder that dated back to the summer of 2023, and stated, Yes, I try to document it but I am trying to get it put into the computer. Every time I will sit to do it, I get interrupted or now I am doing appointments and just haven't gotten to them. The SW was asked to provide information of when R25 had care plan meetings from January 2023-present. During the interview on the afternoon of 2/21/24, the SW was asked to explain the purpose of the care plan meeting. The SW said, To talk about their progress, if they have any needs, if there are any concerns, ask about their weight, if they are complaint with dietary and taking their meds, if they still meet criteria for long-term care, find out what they are able to do, talk of discharge or request for discharge, we talk about that as well. When asked, why is it important for the resident and/or their representative to be involved? The Social Worker said, for self-care and so they can be patient directed and they can let us know what they want and preferences. On 2/21/24 at 02:02 p.m., an interview was conducted with RN #1, who was the MDS coordinator. RN #1 was asked about the care plan meetings. RN #1 said, They are held every 90 days based on the date due, typically every 90 days unless there is a significant change. RN #1 was asked who attends the care plan meetings, and she stated, To my knowledge therapy, social services, dietary activities and families, the resident and if hospice, a representative from hospice. When asked why is it important for the resident and family to be involved, RN #1 said, I feel it is important because you want the care plan to represent and encourage the resident to have their autonomy and voice is important so they can be reflected. The MDS coordinator stated, I set the schedule and then she [the social worker] sends the invites to everyone. On 2/21/24, during an end of day meeting, the facility Administrator was made aware of the above findings. On the morning of 2/22/24, the surveyor was again questioned, met with the SW again. The SW provided the surveyor with evidence that R25 had care plan meetings held on 2/2/23, 7/12/23 and 9/27/23. The SW also provided a letter that indicated R25 was invited to the care plan meetings on 7/12/23 and 9/27/23. However, during the meeting held in July, there were notes that R25 was suspected of having COVID and the meeting needed to be rescheduled. There was no evidence the meeting was rescheduled at a time the Resident could attend. There were notes to indicate the meeting had proceeded to take place without R25. The care plan meeting held 9/27/23, noted that R25 did not attend and there was no one present to represent nursing. There were notes that the meeting was held but needed to be rescheduled. There was no evidence of the meeting being rescheduled. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Care Planning- Comprehensive Person-Centered was reviewed. The policy read in part, . 6. The resident/resident representative [s] is encouraged to participate in the development of and revisions to the resident's care plan. a. An explanation will be included in the resident's medical record if the participation of the resident/resident representative is determined not practicable for the development of the resident's care plan . 10. Every effort will be made to schedule care plan discussions at the best time of the day for the resident/resident representative . No additional information was provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to follow professional standards of nursing practice for one resident (Resident #22- R22) in a survey sample of 22 residents. The findings included: For R22, who refused lab work, the facility staff failed to notify the physician that the order was not able to be carried out. On 2/20/24 and 2/21/24, a clinical record review was conducted of R22's chart. This review revealed that on 1/26/24, the physician entered an order that read, LAB- Valproic Acid [Valproic acid level], CMP [complete metabolic panel], CBC [complete blood count], LFT [liver function tests] on [DATE] and July 26 every night shift every 6 month(s) starting on the 26th for 1 day(s). According to the treatment administration record, R22 refused the lab draw on 1/26/24. There was no documentation within the progress notes, nor elsewhere, that indicated the physician was made aware that the order for labs was unable to be carried out. On 2/21/24, during an end of day meeting, the facility administration was made aware of the above findings. On 2/22/24 at 8 a.m., another review of the progress notes revealed an entry dated 2/21/24 at 5:48 p.m., that read, Resident refused first set of labs. MD [medical doctor] notified. New orders to redraw labs. On 02/22/24 at 10:00 a.m., an interview was conducted with the assistant director of nursing (ADON). The ADON was asked to explain and describe the process when a resident refuses labs. The ADON said, When they refuse, we are supposed to notify the doctor to see if they want to order something else, update chart, and RP's [responsible party's] accordingly .[R22's name redacted] is a little more particular about who does his lab draws, he will allow an in-house nurse. We notified the doctor and got an order to redraw everything this Friday, when the nurse he will allow to draw them is working. When asked if the refusal was documented in the chart, the ADON confirmed that previously it was not. On 2/22/24, mid-morning, the Corporate Director of Clinical Services (CDCS) stated that the facility follows [NAME] and [NAME] Standards for nursing practice. According to [NAME] and [NAME], Fundamentals of Nursing, Eighth Edition, it read in part on page 302, . Common Negligent Acts . Failure to notify the health care provider of problems, failure to follow orders ., failure to follow policies and procedures . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review was conducted of the facility policy titled, Requesting, Refusing and/or Discontinuing Care or Treatment. The policy read in part, . 6. If a resident requests, discontinues or refuses care or treatment, the licensed nurse or appropriate interdisciplinary team member will meet with the resident to: a. determine why the resident is requesting, refusing, or discontinuing care or treatment; b. try to address the resident's concerns and discuss alternative options; and c. discuss the potential outcomes or consequences (positive and negative) of the resident's decision .13. The healthcare practitioner will be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request . No further information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 21875 Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for two of twenty-two residents in the survey sample (Residents #1 and #3). The findings include: 1. Resident #3 (R3), assessed as needing help with personal hygiene, was observed with long, uneven fingernails. R3 was admitted to the facility with diagnoses that included diabetes, hypertension, chronic pain syndrome, ischemic heart disease, chronic kidney disease, vascular dementia, anemia, and anxiety. The minimum data set (MDS - assessment tool) dated 1/31/24 assessed R3 as cognitively intact and requiring help with self-care. On 2/20/24 at 3:00 p.m., R3 was observed seated in a wheelchair at the doorway of his room. R3 had long fingernails on both hands. The nails extended beyond R3's fingertips, with several nails having uneven/jagged edges. On 2/21/14 at 12:57 p.m., R3 was interviewed about his fingernails. R3 stated that his fingernails were long and needed to be cut. R3 stated, I'd like to have them [fingernails] clipped. On 2/21/14 at 12:58 p.m., certified nurses' aide (CNA #2) caring for R3 was interviewed about the long fingernails. CNA #2 stated she would have to check so see if it was ok to cut R3's nails. When asked if R3 needed help with cutting his fingernails, CNA #3 stated R3 was kind of independent but required assistance with bathing and personal care. On 2/21/24 at 1:01 p.m., the licensed practical nurse (LPN #1) caring for R3 was interviewed. LPN #1 stated that it was ok for the aides to cut R3's fingernails. When questioned further, LPN #1 stated nail care was usually performed as needed during baths and/or showers. LPN #1 stated R3 required assistance with personal care/hygiene. R3's plan of care (revised 2/9/24) documented the resident had ADL self-care deficits due to limited mobility and impaired balance. The plan of care included in interventions to maintain ADLs, .Check nail length and trim and clean on bath day and as necessary . This finding was reviewed with the administrator, director of nursing, and nurse consultant during a meeting on 2/21/24 at 4:15 p.m., with no further information provided prior to the end of the survey. 41449 2. For Resident #1 (R1), who required staff's assistance with activities of daily living (ADLs), the facility staff failed to provide showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/21/24, during a group resident council meeting R1 expressed concerns regarding the lack of showers. On 02/21/24 at 03:09 p.m., R1 was interviewed regarding showers. R1 said, showers are overlooked, if you get a shower, you are lucky, they are not every week. Showers are not just a luxury, they are a necessity, they act like it is a burden. R1 went on to say, I use a wash strap and glove, not a washcloth, so they need to wash me early in the morning so the wash strap and glove can be washed and brought back before laundry leaves. On 02/21/24 at 03:23 p.m., an interview was conducted with CNA #4. CNA #4 stated that showers are given twice weekly and are scheduled and on the CNA's assignment sheet. CNA #4 showed the surveyor the assignment sheet, which indicated R1 was scheduled to receive a shower on Wednesday and Saturdays, on the 11 p.m., to 7 a.m., shift. CNA #4 explained that showers are documented in the computer on the ADL (activities of daily living) for each resident to indicate if it was given or if the resident refused. On 02/21/24 at 03:26 p.m., an interview was conducted with other staff #5 (OS#5), who worked in laundry. OS#5 stated that he was aware R1 had a strap and glove that was used in the shower and when it came to laundry, he would wash it and immediately return it to the resident since it could not be put in the dryer. OS#5 said that it is not a problem, but it has only come to laundry for him to wash about 2 times since he has worked there. On 02/21/24 at 03:37 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated, Showers are at least twice a week and they document if they refuse. On 2/21/24, a review of R1's clinical record, to include ADL sheets revealed that from January 1, 2024-February 20, 2024, R1 did not receive a shower on 8 of their scheduled shower days. Review of the nursing notes revealed no documentation with regards to why showers were not given as scheduled. R1 had a quarterly MDS (minimum data set) (an assessment) completed 2/1/24, which indicated R1 had impaired range of motion of her upper and lower extremities on one side. R1 was depedent upon facility staff for assistance with bathing. On 2/21/24, in the afternoon end of day meeting, the facility administrator was made aware of the above findings. On the morning of 2/22/24, the facility administration provided the survey team with forms titled, Skin Care Alert for R1. The administrator stated that those forms were indicative of when R1 received showers. The form had the following directions: Complete this form daily during usual care, bath care and repositioning or per facility policy. Circle the location of any red, open, dry areas and/or other skin concerns on the diagram below. On the Skin Care Alert forms, it was noted that 3 of the forms were completed at 8 p.m., on two occasions and at 10 p.m., on one occasion. R1 was adamant that she is scheduled for showers early in the morning and if they are not offered in the morning she won't take it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/22/24, an interview was conducted with the administrator, and she was asked where on the Skin Care Alert form indicated that R1 had been showered on the days the form was completed. The administrator confirmed that it was not indicated on the form, it was just their protocol that the form is completed when a shower is done. Review of the facility policy titled, Shower/Tub Bath, read in part, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. General Guidelines: 1. Qualified nursing staff will provide a bed bath to the resident as needed. At a minimum, the resident will be offered at least 2 full baths or showers per week. No further information was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 49371 Based on observation, staff interview, and clinical record review, the facility failed to administer medication according to physician orders for 1 of 22 residents (Resident #27). The findings included: The facility staff failed to follow physician orders during administration of artificial tears for Resident #27 (R27). On 2/20/24 at 3:52 PM, during the task of medication administration, licensed practical nurse #3 (LPN#3) was observed administering one drop of artificial tears to the left eye of R27, with no artificial tears applied to the right eye. Review of R27's clinical record revealed an order (dated 1/29/24) for artificial tears ophthalmic solution, instill 1 drop in both eyes three times a day for eye lubrication, related to acute angle closure glaucoma. On 2/20/24 at 4:52 PM, when questioned about the order for artificial tears for R27, LPN #3 stated that the right eye drop was missed during med administration. On 2/22/24 at 12:40 PM, during the end of day meeting the facility administrator and regional nurse consultants were made aware of the above concern. No additional information was provided.

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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. 28106 Based on observation, staff interview, and clinical record review, the facility failed to ensure parameters were put in place for supplemental oxygen for one of 22 residents. An oxygen order for resident #49 (R49) did not have a rate of delivery. The Findings Include: Accorning to the clinical record, diagnoses for R49 included Respiratory failure, asthma, chronic obstructive pulmonary disease, emphysema, and supplemental oxygen dependant. The most current MDS (minimum data set - an assessment tool) was a quarterly assessment with an ARD (assessment reference date) of 1/11/24. R49 was assessed with a cognitive score of 9 indicating moderately cognitively impaired. On 2/20/24 at 12:17 PM, R49 was observed with oxygen via nasal cannula being delivered at 2 liters per minute (LPM). When asked about the oxygen, R49 verbalized using it all the time. Review of R49's physician order for oxygen dated 11/23/23 and revised on 2/5/24 read Oxygen Continuous. There was no information regarding how much and what route to administer the oxygen. On 2/21/24 at 1:25 PM, registered nurse (RN #2) was interviewed. RN #2 reviewed R49's oxygen orders and verbalized that there should have been parameters set regarding the delivery of oxygen and would make the physician aware. On 2/21/24 at 4:08 PM, the above finding was presented to the administrator and director of nursing. No other information was presented prior to exit conference on 2/22/24.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49371 Based on observation, resident interview, staff interview, and clinical record review the facility staff failed to identify the specific trauma or triggers regarding post-traumatic stress disorder (PTSD) for 1 of 22 residents in the survey sample (Resident #21). The findings included: The facility staff failed to identify and document the experiences that caused Resident #21 (R21)1 to develop PTSD or preferences to eliminate or mitigate triggers that may cause re-traumatization. Review of the clinical record revealed that R21 was admitted with diagnoses that include PTSD, Alzheimer's disease, schizophrenia, bipolar, anxiety, major depressive disorder and cerebral infarction. It was also documented that R21 was assessed on 12/30/23 as having moderate cognitive impairment. Review of R21's care plan, initiated 12/14/22 with a revision date of 5/19/23, revealed that R21 had a behavior problem due to diagnosis of PTSD but did not include the specific cause of the PTSD, what the behaviors were, or what triggers caused the PTSD. Review of R21's physician progress notes, dated 6/13/23, 7/18/23, 8/29/23 10/10/23 and 1/2/24, documented R21's history of PTSD but did not identify the specific trauma or triggers of the PTSD. Psychiatry notes from 8/23/23, 1/9/24, 1/23/24 and 2/13/24 were reviewed. The initial assessment dated [DATE] documented R21's history of PTSD. There was no documentation of the specific cause or triggers for R21's PTSD found in any of the notes. On 2/22/24 at 8:31 AM, the social worker, other staff #1 (OS#1) was interviewed regarding R21's cause and triggers of PTSD. OS#1 stated, We never talked about what the triggers were, but smoking schedule changes would make him nervous. If meals were late, we assured him they were coming, he would calm down. If not able to reach his family, he would get upset. On 2/22/24 at 9:37 AM, registered nurse #2 (RN#2) who cared for R21 was interviewed regarding the cause and triggers of his PTSD. RN#2 stated that she did not know the specifics of his trauma, but family dynamics played a part. RN#2 stated R21 was mostly anxious. On 2/22/24 at 9:46 AM, the minimum data set (MDS) coordinator RN#1 was interviewed regarding R21's care plan for PTSD. RN#1 stated she was not aware of the specific trauma or triggers for R21's PTSD and stated, they should be on the care plan. On 2/22/24 at 12:40 PM, during the end of day meeting the facility administrator and regional nurse consultants were made aware of the above concerns. No additional information was provided.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 49371 Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide social services to assist with obtaining glasses for 1 of 22 residents (Resident #32). The findings include: The facility staff failed to assist resident #32 (R32) with obtaining glasses that were prescribed on 12/13/23. Review of the clinical record revealed that R32 had diagnoses that included congestive heart failure, schizophrenia, chronic kidney disease, hypertension, depression and anxiety. It was also documented that R32 was assessed on 12/2/23 as cognitively intact. On 2/20/24 at 3:08 PM, an interview was conducted with R32, during which R32 voiced concerns that she had attended an appointment with an .eye doctor and had not received the glasses yet. Review of R32's clinical record documented an appointment with an optometrist on 12/13/23, in which R32 received a prescription for glasses. On 2/22/24 at 8:31 AM, the social worker, other staff #1 (OS#1) was interviewed regarding glasses for R32. OS#1 stated that R32 has no funds available and that R32 was .supposed to talk to her daughter about paying for the glasses. WHen questioned further, OS#1 stated that she .forgot to follow up. On 2/22/24 at 10:22 AM, the facility administrator and regional nurse consultant (OS#3) were interviewed regarding obtaining glasses for R32. The administrator stated that she did not remember being told about the glasses and stated that .normally the facility would just cover the cost. On 2/22/24 at 12:40 PM, during the end of day meeting the facility administrator and regional nurse consultants were made aware of the above concern. No additional information was provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49371 Based on staff interview, facility document review, and clinical record review, the facility staff failed to respond to pharmacy recommendations for 1 of 22 residents in the survey sample (Resident #9). The findings included: The facility staff failed to respond to a pharmacist recommendation to attempt a gradual dose reduction of Seroquel for Resident #9 (R9). Acording to the clinical record, R9 had diagnoses that included nontraumatic intracerebral hemorrhage, dementia, major depressive disorder, Alzheimer's disease, and anxiety disorder. The most current minimum data set (MDS - an assessment tool), an annual assessment dated [DATE], assessed R9 with severe cognitive impairment. Review of R9's clinical record documented a physician's order for Seroquel 100 mg tablet, give 1 tablet by mouth at bedtime that started on 11/25/22. Review of R9's psychiatric assessments, dated 9/22/23 and 12/20/23, documented the most recent attempt for a gradual dose reduction for Seroquel was on 8/14/22. On 1/18/24, the consulting pharmacist recommended a gradual dose reduction (GDR) of Seroquel. The pharmacist wrote: This resident has been taking Seroquel 100 mg at bedtime since (11/25/22) without a GDR. Could we attempt a dose reduction at this time to perhaps 75 mg at bedtime to verify this resident is on the lowest possible dose? If not, please indicate response below. No physician response was documented for this recommendation. On 2/22/24 at 11:09 AM, the director of nursing (DON) and the regional nurse consultant, other staff #4 (OS #4), were interviewed regarding R9. The DON stated that the medical doctor had deferred the dose reductions for psychiatric medications to psychiatric services. The DON stated that she .checks the pharmacist recommendation sheets and the psychiatric nurse practitioner documents in her notes if ongoing treatment is needed. Review of the facilities policy for Medication Regimen Review dated 8/2020 stated, The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly . Recommendations are acted upon and documented by the facility staff and/or the prescriber. On 2/22/23 at 12:40 PM, during the end of the day meeting, the facility administrator and regional nurse consultants were made aware of the above concerns. No further information was provided.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49371 Based on staff interview, and clinical record review, the facility staff failed to ensure one of 22 residents in the survey sample was free of unnecessary medications (Resident #9). The findings included: The facility staff failed to attempt a gradual dose reduction of Seroquel for Resident #9 (R9). According to the clinical record, R9 had diagnoses that included nontraumatic intracerebral hemorrhage, dementia, major depressive disorder, Alzheimer's disease and anxiety disorder. The most current minimum data set (MDS - an assessment tool), an annual assessment dated [DATE], assessed R9 with severe cognitive impairment. Review of R9's clinical record documented a physician's order for the antipsychotic Seroquel 100 mg tablet, give 1 tablet by mouth at bedtime that started on 11/25/22. Review of R9's psychiatric assessments dated 9/22/23 and 12/20/23 documented the last attempt for a gradual dose reduction for Seroquel was on 8/14/22. Psychiatric notes also documented nursing reports patient can be irritable at times, no aggression .No significant mood changes. Psychiatric documentation did not include any references to a gradual dose reduction (GDR) or that a reduction was contraindicated. On 1/18/24 the consulting pharmacist recommended a GDR of Seroquel. The pharmacist wrote: This resident has been taking Seroquel 100 mg at bedtime since 11/25/22 without a GDR. Could we attempt a dose reduction at this time to perhaps 75 mg at bedtime to verify this resident is on the lowest possible dose? If not, please indicate response below. No provider response was documented for this recommendation. The clinical record documented no attempted dose reduction for R9's Seroquel or clinical justification for not performing or attempting a reduced dose. On 2/22/23 at 11:06 AM, certified nursing assistant #4 (CNA #4), who regularly cared for R9, was interviewed regarding R9's behaviors. CNA #4 stated that R9 was easy going, verbal when he wants to be, pleasant, quiet, friendly and will swat at your hands at times while cleaning him, but after explaining what you are doing, he allows care. R9 was observed laying calmly in bed, but was verbally unresponsive to any questions, merely smiling. On 2/22/24 at 11:09 AM, the director of nursing (DON) and the regional nurse consultant, other staff #4 (OS #4) were interviewed regarding R9. The DON stated that the medical doctor had deferred the dose reductions for psychiatric medications to psychiatric services. The DON also stated that she .checks the pharmacist recommendation sheets and the psychiatric nurse practitioner documents in her notes if ongoing treatment is needed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/22/23 at 12:40 PM, during the end of the day meeting the facility administrator and regional nurse consultants were made aware of the above findings. No further information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49456 Based observation, facility documentation, and staff interview, the facility failed to accurately label open medication to ensure safe administration and storage. The Findings Include: The facility failed to ensure that a multi-dose vial of medication was labeled with a open date. On 2/21/24 at 11:16 a.m., an observation of the medication storage room was conducted on the nursing unit, in the presence of license practical nurse (LPN1), who provided access. An opened, multidose vial of the influenza vaccine was observed in the refrigerator. No open date was noted on the label. When questioned about this, LPN1 examined the medication, verbalized not seeing an opened date, and removed the medication from the refrigerator. On 2/21/24 at 11:30 a.m., when questioned further, LPN1 stated that an open date should be placed on the vial when medication is opened. A facility policy titled, Medication Storage, read in part, Medications requiring refrigeration must be stored in a refrigerator and medications must be labeled accordingly. On 2/21/24 at 4:05 p.m., the above information was presented to the Director of Nursing, Administrator, and to two Regional Nurse Consultants. No further information was provided prior to exit conference.

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F 0772 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided. 28106 Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered laboratory (Lab) services for one of 22 residents (Resident #38 - R38) in the survey sample; a CBC (Complete Blood Count) and A1C (Glycated Hemoglobin Test) were not collected as ordered for R38. The Findings Include: According to the clinical record, diagnoses for R38 included Diabetes, and kidney failure. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/19/24. R38 was assessed with a cognitive score of 6 out of 15, indicating moderately impaired cognition. Review of R38's physician order set documented an order, dated 6/24/23, for a CBC and A1C to be collected every three months on March 27th, June 27th, September 27th, and December 27th. Review of lab results did not evidence the lab was collected on December 27th, 2023. Review of R38's treatment administration record (TAR) for December showed a blank box (where a nurse would sign off that the order was completed) for December 27th. On 2/21/24 at 1:17 PM, an interview was conducted with registered nurse (RN #2) to explain the lab documentation. RN#2 reviewed the lab order, then reviewed the TAR, verbalizing that the lab was not signed off on the TAR. RN #2 verbalized being unable to find the results and stated intention to call the Lab. While on the phone, RN#2 stated that the lab verified that there were no results for that date, indicating the labs were not collected. RN #2 got off the telephone and verbalized that the labs were missed. On 2/21/24 at 4:08 PM, the above finding was presented to the administrator and director of nursing (DON). No other information was provided prior to exit conference on 2/22/24.

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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. 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain an accurate clinical record for one resident (Resident #25- R25) in a survey sample of 22 residents. The findings included: For R25, the facility staff failed to maintain a complete and accurate clinical record with regards to documentation of when showers were provided. On the afternoon of 02/21/24, during interview with R25's roommate, R25 expressed concerns with not getting showers. On 2/21/24, a review of R25's clinical record was conducted, which included review of ADL (activities of daily living) records. Bathing documentation revealed that R25 had 4 occurrences of showers being provided in January 2024 and 2 showers being provided in the month of February 2024. On 02/21/24 at 03:23 p.m., an interview was conducted with Certified Nursing Assistant #4 (CNA #4), who stated that showers are given twice weekly and are scheduled, which is on the CNA's assignment sheet. CNA #4 showed the surveyor the assignment sheet, which indicated R1 was scheduled to receive a shower on Wednesdays and Saturdays, on the 11 p.m. to 7 a.m. shift. When questioned further, CNA #4 explained that showers are documented in the computer, in the ADL (activities of daily living) section, for each resident, to indicate that the shower was given or if the resident refused. On 02/22/24 at 08:57 a.m., an interview was conducted with CNA #5. CNA #5 reported that showers are given twice weekly in accordance with a shower schedule. On the morning of 2/22/24, the facility administrator was made aware of the above concerns with regards to R25's absent shower documentation. On 2/22/24, the administrator provided the survey team with Skin Care Alert forms for R25. Each of the forms had written across it, Showered, to indicate R25 had received a shower on those dates. The dates were, 1/2/24, 1/9/24, 1/16/24, 1/20/245, 2/6/24, 2/9/24, and 2/13/24. The administrator was asked if this is the facility's protocol for documenting showers and if the provided forms were included in the clinical record. The Corporate Director of Clinical Services (CDCS) agreed that it is the company's protocol that showers be documented on the ADL sheets and the skin care alert forms were not part of the clinical record. During the above interview with the administrator and CDCS, it was discussed that R25's clinical record was incomplete and inaccurate. They both stated they would speak with the director of nursing and follow-up with the surveyor. On 02/22/24 at 11:10 a.m., the Assistant Director of Nursing (ADON) stated the skin care alerts do indicate that they the staff gave R25's showers and it was a documentation issue. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled; Shower/Tub Bath was reviewed. The policy read, in part, . Documentation- 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. 4. How the resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data . No additional information was provided.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide education and offer the COVID-19 spike vaccine booster for the 2023-2024 season, to 5 of 5 residents (Resident #6, 31, 3, 55, and 14) and 5 of 5 staff (RN #3, CNA #6, Other Employee #1, Other Employee #5, and Other Employee #7) sampled. The findings included: 1. For five residents (R6, R31, R3, R55 and R14), the facility staff failed to provide education and offer the COVID-19 spike vaccine booster for the 2023-2024 season. On 2/20/24 and 2/21/24, clinical record reviews were conducted of R6, R31, R3, R55 and R14's charts. This review revealed no evidence that any of the sampled residents had been offered the COVID-19 spike vaccine. On 02/21/24 at 10:11 a.m., an interview was conducted with the Director of Nursing (DON), who was the facility's Infection Preventionist (IP). During this interview, the DON accessed each of the sampled resident's charts, confirmed their immunization status, and then stated that none of them had been offered the COVID-19 spike vaccine. The review revealed the following: a. R6 had received the COVID primary series and a bivalent booster but had not received the spike vaccine. b. R31 had not received any COVID immunizations. When asked if R31 had been offered any of the COVID vaccines, the DON said, No. c. R3 had received the COVID primary series and bivalent booster. d. R55's records indicated he had not received any immunizations for COVID-19, and again the DON confirmed the facility had not offered any. e. R14 had received the COVID primary series immunization, as well as 2 booster doses, that included the bi-valent. R14 had not been offered or received the spike booster for the 2023-2024 season. During the above interview, the DON said, We can get our covid vaccines through our pharmacy now, I just found this out the other day. We haven't given the current boosters; we were supposed to get a local pharmacy to come but they don't do that. On 02/21/24 at 10:51 a.m., the CDCS (corporate director of clinical services) joined in the interview and stated, I just found out we can get the vaccine so we will start that process. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/21/24 at 4:00 p.m., the surveyor spoke with an employee working in the quality assurance department of the contracted pharmacy (Other Employee #9- OE #9), who reported that this has been the contracted pharmacy of this facility since 12/1/22. OE #9 also confirmed that the pharmacy has had available multi-dose vials and single dose vials of the 2023-2024 COVID spike immunization since November 20, 2023, when it was approved. OE #9 went on to say that prior to 11/20/23, it was available under the Emergency Authorization in place, and has always been available for the facility to order. OE #9 also confirmed that the pharmacy had not received any orders from this nursing facility for any of the COVID 2023-2024 spike immunization. Review of the facility policy titled; COVID-19 Vaccination for Residents was conducted. The policy read in part, . 1. Prior to admission, the facility will validate COVID-19 vaccination status. 2. Resident/resident representatives will be educated on: a. risk/benefits of COVID-19 vaccination. b. current CDC guidelines for vaccination of residents for COVID-19 and c. Symptoms, risks and benefits associated with the COVID-19 virus. 3. Residents will be encouraged to accept COVID-19 vaccinations in accordance with CDC guidance. 4. Residents will be screened prior to offering the vaccination for prior immunization, medical precautions, and contraindications as necessary for determining whether they are appropriate candidates for vaccination at any given time. 5. prior to the administration of the COVID-19 vaccine, consent will be obtained . and will be documented in the resident's medical record. 6. If the resident/resident representative declines administration of the COVID-19 vaccine, education will be provided, and declination form will be signed and placed in the resident's medical record . 7. COVID-19 vaccines will be administered according to the CDC, ACIP, FDA, and manufacturer guidelines. 8. Administration of the COVID-19 vaccination will be documented in the resident's medical record . The FDA (Food and Drug Administration) gives information about the 2023-2024 spike vaccine on their website, accessed at:https://www.fda.gov/vaccines-blood-biologics/coronavirus-covid-19-cber-regulated-biologics/novavax-covid-19-vaccine-adjuvanted. The guidance read, On October 3, 2023, the Food and Drug Administration amended the emergency use authorization (EUA) of Novavax COVID-19 Vaccine, Adjuvanted to include the 2023-2024 formula. The Novavax COVID-19 Vaccine, Adjuvanted, a monovalent vaccine, has been updated to include the spike protein from the SARS-CoV-2 Omicron variant lineage XBB.1.5 (2023-2024 formula). The Novavax COVID-19 Vaccine, Adjuvanted (Original monovalent) is no longer authorized for use in the United States. Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is authorized for use in individuals [AGE] years of age and older as follows: Individuals previously vaccinated with any COVID-19 vaccine: one dose of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) is administered at least 2 months after receipt of the last previous dose of an original monovalent (Original) or bivalent (Original and Omicron BA.4/BA.5) COVID-19 vaccine. Individuals not previously vaccinated with any COVID-19 vaccine: two doses of Novavax COVID-19 Vaccine, Adjuvanted (2023-2024 Formula) are administered three weeks apart . On 2/21/24, during an end of day meeting the facility administration was made aware of the above findings. No additional information was received. 2. For 5 of 5 staff (RN #3, CNA #6, Other Employee #1, Other Employee #5, and Other Employee #7) sampled, the facility staff failed to provide education and information regarding the 2023-2024 COVID spike vaccine. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/21/24 at 10:11 a.m., an interview was conducted with the Director of Nursing (DON), who was also the facility's infection preventionist. When asked about COVID vaccines for employees, the DON said, HR [human resources] asks for immunization cards upon hire but it is not a requirement to work with [facility's corporate name redacted]. When asked if they were providing any education to staff regarding the COVID immunizations, the DON said, No. During the above interview, the DON said, We can get our covid vaccines through our pharmacy now, I just found this out the other day. We haven't given the current boosters; we were supposed to get a local pharmacy to come but they don't do that. On 2/21/24 at 2:38 p.m., an interview was conducted with the human resources manager (HRM), Employee #4. The employees selected for review were given to the HR manager and she pulled each employee's file. There was no information with regards to any of them being educated on or given information with regards to the 2023-2024 COVID booster. None of the employees selected had any record of having received the current COVID-booster. The HR manager was asked if the facility gives the employees any information on the COVID vaccine or offers the COVID vaccine. The HR manager said, I thought we moved away from that, so I am not too sure about that. On 2/21/24, in the afternoon, an interview was conducted with Other Employee #1, Other Employee #5, and Other Employee #7. All three stated that they had not received any information or education from the facility with regards to the current COVID booster. On 2/21/24, during an end of day meeting, the facility administration was made aware of the above findings. On 2/22/24, the facility staff provided the survey team with declination forms that Other Employee #5 and RN #3. Across the top of the form it read, 2023_2024 Staff Vaccine Acceptance/Declination Form. The form that RN #3 had signed was dated 10/27/22, which was prior to the 2023-2024 vaccine becoming available. The facility policy titled, Employee Infection and Vaccination Status was reviewed. The policy read in part, . Vaccinations: 1. Employees will be current with mandated vaccinations (i.e., TST, COVID-19) prior to performing direct resident care. 2. Employees will also be offered vaccinations per state or local agency policies/regulations. Employees will be provided with educational materials to make informed decisions for non-mandated vaccinations. If declined, a declination form will be completed and placed in the employee's health record . No additional information was provided.