STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495236	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chelsea Rehabilitation and Healthcare Center	2715 Dogtown Road Goochland, VA 23063

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 27660 2. For Resident #74, the facility staff failed to maintain dignity of the resident while doing a dressing change. Observation was made on 9/10/24 at 12:15 p.m. of LPN (licensed practical nurse) #2, the wound care nurse administering a treatment for Resident #74 on his buttock. The physician order dated, 8/22/24, documented, Right Buttock: Cleanse with wound cleanser, pat dry, apply silver alginate, border gauze, every day shift for wound care. LPN #2 performed the dressing change as ordered. At the end of the dressing change, LPN #2 took her black marker out of her pocket and wrote on the dressing after the dressing, border gauze, had been applied to the resident's buttock. An interview was conducted with LPN #2 on 9/10/24 at 3:53 p.m. The dressing change was discussed with LPN #2. LPN #2 stated immediately that she wrote her date and initials on the dressing while the dressing was on the resident's buttock. She stated she normally writes on the dressing before she begins her treatments but got distracted with the new wound care provider that morning. When asked why we don't write on a dressing while it's on the resident's bottom, LPN #2 stated, it doesn't feel good to them. The facility policy, Dressing - Dry/Clean, documented in part, 10. Label tape or dressing with date, time and initials. Place on clean field. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above finding on 9/11/24/ at 1:09 p.m. No further information was provided prior to exit. 31753 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to maintain dignity for two of 32 residents in the survey sample, Residents #72 and #74. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The findings include: 1. For Resident #72 (R72), the facility staff failed to provide dignity for the resident's indwelling urinary Foley catheter bag (1). A review of R72's clinical record revealed a physician's order dated 8/26/24 for an indwelling Foley catheter for urinary retention. On 9/9/24 at 7:17 p.m., R72 was observed lying in bed. The resident's indwelling urinary Foley catheter bag was attached to the bed frame. There was no privacy cover on the bag, urine was observed in the bag, and the bag was visible from the hall. On 9/10/24 at 4:09 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated there should be a privacy bag on residents' indwelling urinary Foley catheter bags to maintain residents' dignity. On 9/10/24 at 4:39 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, Catheter Care, Urinary documented, Dignity 1. Use a drainage bag cover when the resident is in common areas. The facility policy titled, Dignity documented, 1. Residents are treated with dignity and respect at all times. Reference: (1) A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 31753 Based on observation, resident interview, staff interview, and facility document review, the facility staff failed to accommodate a resident's needs for one of 32 residents in the survey sample, Resident #72. The findings include: For Resident #72 (R72), the facility staff failed to maintain the resident's call bell within the resident's reach. On 9/9/24 at 7:11 p.m., an observation of R72 lying in bed was conducted. R72 asked where his call bell was and stated he needed it in case he needed something. R72's call bell was observed lying on the floor beside the resident's roommate's bed and was not within R72's reach. There was no clip on the cord so the call bell could not be attached to the resident's bed sheets. On 9/10/24 at 4:09 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated staff should clip call bells to residents' bed sheets and ensure call bells are within residents' reach when they round every hour or two hours. On 9/10/24 at 4:39 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, Answering the Call Light failed to document information regarding maintaining the call bell within a resident's reach. No further information was presented 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 0600 Level of Harm - 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. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to protect a resident from abuse by another resident, resulting in harm, a fractured wrist, for one of 32 residents in the survey sample, Residents #32 and #16. The findings include: The facility synopsis of the event, dated, 3/22/24, documented, Resident to Resident, separated, abut policy initiated. Residents involved: (Resident #32 and Resident #16). The facility synopsis of the event, dated 3/29/24, documented in part, (R32) was in the dining room on the evening of March 22nd around 5:10 p.m. He was watching a program in the dining room, as he often does. When (R16) came into the dining room, he changed the TV channel without first, communicating with (R32). This upset (R32). (R32) stood and aggressively approached (R16), who then pushed (R32); (R32) lost his footing due to the push and fell to the ground attempting to catch himself with his right arm. Resident (R32) sent out for evaluation following complaints of pain in the right wrist and with bruising and swelling. Resident (R32) sent to (Name of hospital) ED (emergency department), returned the same night with diagnoses of right wrist fracture. Findings: Statements resident (R32) and (R16) were reviewed. This was an unwitnessed event that took place in the dining room. Immediately following resident to resident incident, both residents were separated, and room change initiated, before the incident residents were roommates. Skin assessments of (R32) and (R16) were completed, with swelling and bruising noted to (R32) right wrist, there were no new skin impairments for (R16). A pain evaluation was completed for (R32), resulting in him being sent to ER for an X-ray of his wrist, which revealed a fracture to the right wrist. Resident care plans were reviewed (and subsequently updated based on incident), care plan updated to reflect triggers and identification for staff for (R34) aggression. (R34) care plan was also updated to reflect the right wrist fracture. (R16) care plan was updated to reflect the potential for aggression towards other residents. Staff responded appropriately when notified of the incident, able to calm residents and assess the situation. The Nurse Practitioner has noted in resident file, that (R32) behaviors can pose a risk for others when he is unable to get his way, he has unpredictable triggers. Medications reviewed by the Medical Director and adjusted his (R32) Latuda in relation to his schizophrenia. Both residents have low BIM scores and a history of traumatic brain injury which can cause impaired decision making. Screening for potential PTSD completed by Director of Social Services, for (R32) and (R16) following incident, for three days, with no indications of both trauma due to incident. Referral to psych services through (name of company) was also sent for both residents, with (R16) seeing (name of mental health nurse practitioner) on 3/26/24, for an initial evaluation and (R16) had no recollection of the resident-to-resident incident. Resident #32 (R32) (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The MDS (minimum data set) assessment, closest to the time of the incident, a significant change assessment, with an assessment reference date (ARD) of 3/26/24, the resident scored a 5 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired for making daily decisions. In Section E - Behaviors, the resident was coded as having verbal behavioral symptoms directed towards others one to three days of the look back period. The comprehensive care plan dated, 2/21/2019, documented in part, Focus: (R32) can be resistive to care, refusal of showers, yells at staff/other residents, cursing at staff and can be aggressive to staff/residents. the resident is/has potential to be physically aggressive will posture towards staff when angry or upset, is non-compliant with diet, referring sandwiches. Resident has a fear that if he does not have Lomotil then he will have diarrhea again - demands med with angry posturing and foul language. Can demand any meds with angry posturing and foul language when not ready when he requests. Resident #16 (R16) The MDS assessment, closest to the time of the incident, a quarterly assessment, with an ARD of 3/22/24, the resident scored a 4 out of 15 on the BIMS score, indicating the resident was severely impaired for making daily decisions. In Section E - Behaviors, the resident was not coded as having any behavioral symptoms. The comprehensive care plan dated, 3/22/24, documented in part, Focus: I have behavior problem r/t (related to) TBI (traumatic brain injury), I will resist help with ADLs (activities of daily living) and mobility, I will refuse therapy services, I will push other resident in their wheelchair within the building and outside, I will refuse meds and lab draws, I will push other residents. The witness statements were reviewed. This was an unwitnessed incident. The staff stated there didn't notice anything between the two residents. They stated they were getting along like they normally do. An interview was conducted with RN (registered nurse) #2 on 9/10/24 at approximately 4:00 p.m. When asked what she would do if a resident pushes another resident causing the resident to go down to the floor, RN #2 stated she would immediately separate the residents, assess for injury, notify the administrator and the director of nursing. When asked if this is a reportable incident, RN #2 stated, yes. When asked if this was abuse, RN #2 stated, yes. RN #2 was asked if she had received education on abuse, she stated they have received it after the above incident. An interview was conducted with ASM administrative staff member) #1, the administrator, on 9/11/24 at 9:28 a.m. When asked what happens when a resident strikes another resident, ASM #1 stated they would separate the resident, evaluate each resident, try and figure out if there was a cause behind the incident. Start the abuse policy which entails re-education, will do screening of all residents for abuse. The residents answer five questions the social worker asks. ASM #1 further stated that the residents involved in the incident would receive a PTSD screening. When asked if anything was put in place at the time of the above incident, ASM #1 presented an action plan. The Action Plan dated 3/22/24 documented: Problem Statement: Area of opportunity identified o 3/29/24 due to resident-to-resident abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Goal: Resident will have necessary oversight to prevent abuse. Objective: The facility will establish a system to routinely evaluate residents and develop a plan of care to aid in the prevention of abuse and to ensure resident to resident altercations are minimized. Goals/Tasks - Resident involved in resident-to- resident altercations assessed. One resident sustained a fractured right wrist. Monitor resident for no other adverse effects. - Target date - 3/22/24. Statements obtained from residents involved. Target date - 3/24/24. Social Services will meet with the involved resident daily x 3 days to address psycho-social needs. - Target date - 3/27/24. The Medical Director was made aware of the allegations of abuse. Target date - 3/22/24. Department of Health was notified of the allegations of abuse. - Target date - 3/22/24. Current employees will receive education regarding prevention, recognizing, identifying triggers and deescalating abuse. Target date - 3/30/24. Newly hired employees will receive education regarding preventing, recognizing, and reporting abuse prior to assuming any assignment. Target date - 3/30/24. Ensure residents with possible aggression are intellectually and physically stimulated daily through group or 1:1 activities of interest to the resident. Target date - 3/30/24. Educate staff on residents involved updated care plan identifying triggers and de-escalation tactics. Target date - 3/29/24. Dining Room to be closed to residents in not in use for meals or for activities. When residents conjugate in the day room, staff will provide q 15 min checks. Target date - 3/29/24. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation for the audits. Target date - 3/30/24. The credible evidence for the above action plan was reviewed. Resident and staff interviews were conducted to verify the educations and plan. No further concerns were found in the area of F600. This deficiency is being cited at past non-compliance. PAST NON-COMPLIANCE

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that written notification of a hospital transfer was provided to the resident representative for one of 32 residents in the survey sample; Resident #28. The findings include: For Resident #28, the facility staff failed to evidence written notification of a hospital transfer on 7/14/24 was provided to the resident representative. A review of the clinical record revealed a progress note dated 7/14/24 that documented, writer at bedside w/ (with)resident to give evening medication, resident unarousable to voice and touch, noted labored breathing which is a change of condition from baseline call placed to (name of physician) by (licensed practical nurse), recommendations from MD (medical doctor) to send resident to ED (emergency department) for evaluation, RP (responsible party) (name) notified of coc (change of condition) and transfer to hospital @ (at) 1650 (4:50 PM) , ADON (Assistant Director of Nursing) (name) made aware via telephone. Further review failed to reveal any evidence of a written notice of this hospital transfer being provided to the resident representative. On 9/11/24 at 11:58 AM, evidence of the written notice to the resident representative was requested from ASM #2 (Administrative Staff Member) the Director of Nursing. On 9/11/24 at 12:39 PM, ASM #2 stated they did not have evidence that a written notification was provided to the resident representative. She was only able to provide evidence of what documentation was sent to the hospital, which did not include any document that was identified as a written notice to the resident representative. The facility policy, Transfer or Discharge, Facility-Initiated documented, Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) (long term care) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content equirements) No further information was provided by the end of the survey.

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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. 31753 Based on observation, staff interview, and clinical record review, the facility staff failed to implement a resident's comprehensive care plan for one of 32 residents in the survey sample, Resident #72. The findings include: For Resident #72 (R72), the facility staff failed to implement the resident's comprehensive care plan for the resident's indwelling urinary catheter (1). R72's comprehensive care plan dated 8/16/24 documented, I have an indwelling urinary catheter r/t (related to) urinary retention .Maintain dignity bag/privacy cover over urinary collection bag when in social settings and when visible to others. On 9/9/24 at 7:17 p.m., R72 was observed lying in bed. The resident's indwelling urinary catheter bag was attached to the bed frame. There was no privacy cover on the bag, urine was observed in the bag, and the bag was visible from the hall. On 9/10/24 at 4:09 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of the care plan is to provide individualized care for each patient. RN #2 stated nurses have access to residents' care plans to review and ensure the care plans are being implemented. RN #2 stated there should be a privacy bag on indwelling urinary catheter bags to maintain dignity. On 9/10/24 at 4:39 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 staff did not provide a policy regarding care plans. Reference: (1) A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm

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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** 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of care for one of 32 residents in the survey sample, Resident #19. The findings include: 1.a. For Resident #19 (R19), the facility staff failed to document progress notes in a timely manner A review of R19's clinical record revealed three progress notes related to R19 with an effective date between two to four days prior to when the note was actually written. These notes were: On 8/26/24, LPN (licensed practical nurse) #2 wrote a note about what she observed and assessed on 8/22/24. She documented this as a Late Entry. On 8/26/24, RN (registered nurse) #1 wrote a note about what she observed and assessed on 8/23/24. She documented this as a Late Entry. On 8/26/24 at 1:35 p.m., ASM (administrative staff member) #2, the director of nursing, wrote a note about R19 being sent to the emergency roiagnom on [DATE]. The effective date of this note was 8/24/24 at 9:00 p. m. She documented this as a Late Entry. On 9/10/24 at 9:53 a.m., LPN #2 was interviewed. When asked why she did not enter a note about R19's 8/22/24 fall until 8/26/24. She stated: At the time of the fall I did not put a note in. I don't know why I didn't. She added: Nobody asked me to put the note in. I did a witness statement on [R19's fall], and then realized I had not written the note. She stated she knows she had documented the fall and her assessment findings at the time of the resident's fall. On 9/10/24 at 11:20 a.m., RN #1 was interviewed. When asked why she assessed R19 on 9/23/24 but did not document any of her findings until 9/26/24, she stated she had 13 other residents receiving skilled nursing services who needed detailed charting from her on 9/23/24. She stated she habitually manually writes notes in her own notebook so I can remember, then comes in another day to document her findings in the resident's clinical record. She stated she lets the oncoming nurse know what has happened with the resident during her shift. She added: We have to chart on skilled residents and residents on antibiotics, and it takes time. On 9/10/24 at 12:32 p.m., ASM #2 was interviewed. When asked the facility policy about timely documentation by nursing staff, she stated she did not know if there was a policy dictating a specific amount of time that would be considered as timely. She stated some facility staff get overwhelmed by the end of a shift and have to return to the facility on another day to complete their documentation. She stated she would prefer that nurses finish all documentation before they leave the facility after a shift, but understands things get busy with resident care. She stated: Patient care comes first, as long as the documentation gets done. She stated a nurse's charting will likely be more accurate if it is completed as close as possible in time to when an actual event or assessment occurred. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/10/24 at 4:40 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the regional director of operations were informed of these concerns. A review of the facility policy, Charting and Documentation, failed to reveal any information related to timeliness of documentation. No further information was provided prior to exit. High quality documentation is .Accurate, relevant, and consistent .Timely, contemporaneous, and sequential. This information is taken from the American Nurses Association website http://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf 1.b. For R19, the facility staff failed to perform complete neurological assessments by checking the resident's pupil response. A review of R19's clinical record revealed a Neurological Assessment Flow Sheet with the following dates and times: 8/22/24 at 1:30 p.m., 1:45 p.m., 2:00 p.m., 2:15 p.m., 3:15 p.m., 4:15 p.m., 5:15 p.m., 6:15 p.m., and 10:15 p.m.; and 8/23/24 at 2:15 a.m., 6:15 a.m., 10:15 a.m., 2:15 p.m., 6:15 p.m. and 10:15 p.m. The flow sheet included a column to report the assessment findings of the resident's pupil response. All boxes in this column were blank for the 15 neurological assessments performed by the facility staff following R19's fall on 8/22/24. On 9/10/24 at 10:12 a.m., ASM (administrative staff member) #4, a nurse practitioner, was interviewed. She stated a neurological assessment includes pupils, arm and leg strength, changes in mentation, and the resident's ability to talk. She stated it is important to check for changes in a resident's pupils for consistency and changes. When asked if a thorough neurological assessment has been performed if a nurse has not assessed a resident's pupils, she stated: It would appear not. On 9/10/24 at 11:20 a.m., RN (registered nurse) #1 was interviewed. She stated neurological assessments always included the level of consciousness and the pupil response. She stated an abnormal pupil might signal insufficient brain function, and might require further assessment. On 9/10/24 at 12:12 p.m., LPN (licensed practical nurse) #3, a unit manager, was interviewed. She stated pupils should always be checked because a change in function can signal some possible changes in the brain. On 9/10/24 at 1:21 p.m., ASM #5, the attending physician, was interviewed. He stated a thorough neurological assessment should include pupil response to light. On 9/10/24 at 4:40 p.m., ASM #1, the administrator, ASM #2, and ASM #3, the regional director of operations were informed of these concerns. A review of the facility policy, Indications for Neurological Assessment, failed to reveal any information related to elements of a thorough neurological assessment. 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	Routine neurological exams performed by registered nurses during their daily clinical practice include assessing mental status and level of consciousness, pupillary response, motor strength, sensation, and gait. This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/books/NBK593206/.

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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. 42106 Based on observation, resident interview, clinical record review, staff interview and facility document review it was determined that the facility staff failed to provide ADL (activities of daily living) care to a dependent resident for one of 32 residents in the survey sample, Resident #2. The findings include: For Resident #2 (R2), the facility staff failed to maintain trimmed fingernails. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/23/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section GG documented R2 requiring substantial/maximal assistance for personal hygiene and having impairment on one side in the upper extremities. Section I documented R2 having diagnoses including but not limited to Diabetes Mellitus (1). On 9/9/24 at 7:45 p.m., an interview was conducted with R2 in their room. R2 was observed lying in bed with the left hand observed to be contracted with the fingers closed in towards the palm of their hand. R2 stated that they did not have use of their left arm and hand and limited use of the right hand. Observation of R2's fingernails revealed the free edge of the nail approximately three sixteenths of an inch long. When asked about nail care, R2 stated that their nails grew quickly, and they had to beg the staff to trim their nails. R2 stated that the CNA (certified nursing assistants) were not allowed to trim their nails because they were diabetic and only the RN (registered nurses) were allowed to trim their nails. R2 stated that the RN's were always passing medications and never had the time to trim their nails, so they just had to wait until someone had time. R2 stated that they had asked several nurses to trim their nails and they had not been trimmed yet. Additional observations of R2 on 9/10/24 at 9:00 a.m., revealed R2's fingernails remained untrimmed. The comprehensive care plan for R2 documented in part, I have an ADL Self Care Performance Deficit r/t (related to) weakness and debility. Date Initiated: 08/16/2023, On 9/10/24 at 4:23 p.m., an interview was conducted with RN #2. RN #2 stated that the CNA staff were responsible for trimming fingernails unless the resident was diabetic and then it was the responsibility of the licensed nurse. She stated that the CNA staff should be observing the fingernails with their daily care and reporting to the nurse when the nails needed trimming. On 9/10/24 at 4:31 p.m., RN #2 observed R2's fingernails. RN #2 stated that the fingernails were long and needed to be trimmed. RN #2 asked R2 if they would like to have the nails trimmed and R2 stated that they would. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Fingernails/Toenails, Care of dated February 2018, documented in part, Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin . On 9/10/24 at 4:40 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern. No further information was provided prior to exit. Reference: (1) Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high. Glucose comes from the foods you eat. Insulin is a hormone that helps the glucose get into your cells to give them energy. With type 1 diabetes, your body does not make insulin. With type 2 diabetes, the more common type, your body does not make or use insulin well. Without enough insulin, the glucose stays in your blood. You can also have prediabetes. This means that your blood sugar is higher than normal but not high enough to be called diabetes. Having prediabetes puts you at a higher risk of getting type 2 diabetes. Over time, having too much glucose in your blood can cause serious problems. It can damage your eyes, kidneys, and nerves. Diabetes can also cause heart disease, stroke and even the need to remove a limb. This information was obtained from the website: https://medlineplus.gov/diabetes.html

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 31753 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services for an indwelling urinary catheter for one of 32 residents in the survey sample, Resident #72. The findings include: For Resident #72 (R72), the facility staff failed to maintain the resident's indwelling urinary Foley catheter bag (1) in a sanitary manner. A review of R72's clinical record revealed a physician's order dated 8/26/24 for an indwelling Foley catheter for urinary retention. On 9/9/24 at 7:17 p.m., R72 was observed lying in a low bed. The resident's indwelling urinary Foley catheter bag was attached to the bed frame and was lying on the floor. On 9/10/24 at 4:09 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated indwelling urinary Foley catheter bags should be kept off the floor for infection control. On 9/10/24 at 4:39 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, Catheter Care, Urinary documented, Be sure the catheter tubing and drainage bag are kept off the floor. Reference: (1) A urinary catheter is a tube placed in the body to drain and collect urine from the bladder. This information was obtained from the website: https://medlineplus.gov/ency/article/003981.htm

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a complete pain management program for one of 32 residents in the survey sample, Resident #32. The findings include: For Resident #32, the facility staff failed to clarify the physician order to obtain parameters for two PRN (as needed) pain medications and administered pain medication for a pain scale rating of zero. Resident #32 suffered a fracture of his wrist on 3/22/24. The physician order dated, 3/27/24, documented, Ibuprofen Oral Tablet 200 MG (milligrams); Give 3 tablets by mouth every 6 hours as needed for breakthrough pain. The physician order dated, 4/25/24, documented, Oxycodone HCL (hydrochloride) Tablet 10 MG; Give 1 tablet by mouth every 8 hours as needed for pain. The June 2024 MAR (medication administration record) documented the above orders. The Ibuprofen was administered on the following dates, time and pain scale. (Pain scale is rated 0 - 10; zero indicating no pain and 10 indicating the worse pain the resident has ever been in): 6/2/24 at 2:11 a.m. - pain scale of 6. 6/3/24 at 1:50 a.m. - pain scale of 8. 6/12/24 at 2:46 a.m. - pain scale of 0. 6/18/24 at 4:45 a.m. - pain scale of 6. 6/19/24 at 1:16 a.m. - pain scale of 7. 6/23/24 at 4:42 a.m. - pain scale of 6. 6/26/24 at 2:05 a.m. - pain scale of 6. 6/27/24 at 3:30 a.m. - pain scale of 6. 6/28/24 at 4:05 a.m. - pain scale of 8. The Oxycodone was documented as administered on the following dates, time and pain scale: 6/1/24 at 9:03 a.m. - pain scale of 7, at 10:09 p.m. for pain scale of 8. 6/2/24 at 6:19 a.m. - pain scale of 8. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/3/24 at 6:09 a.m. - pain scale of 2; 2:00 p.m. - pain scale of 5; 10:00 p.m. - pain scale of 8. 6/4/24 at 6:00 a.m. - pain scale of 8; 2:00 p.m. - pain scale of 3. 6/5/24 at 12:47 a.m. - pain scale of 4; 12:22 p.m. - pain scale of 10; 10:16 p.m. - pain scale of 10. 6/6/24 at 12:47 a.m. - pain scale of 8; 10:02 p.m. - pain scale of 6. 6/7/24 at 6:48 a.m. - pain scale of 4. 6/8/24 at 12:15 a.m. - pain scale of 8; 10:18 a.m. - pain scale of 8. 6/9/24 at 4:30 p.m. - pain scale of 7. 6/10/24 at 5:01 p.m. - pain scale of 9. 6/11/24 at 9:12 a.m. - pain scale of 9; 5:23 p.m. - pain scale of 9. 6/12/24 at 2:45 a.m. - pain scale of 6; 9:25 a.m. - pain scale of 8; 5:26 p.m. - pain scale of 7. 6/13/24 at 6:18 a.m. - pain scale of 0, 4:30 p.m. - pain scale of 8. 6/14/24 at 1:14 p.m. - pain scale of 5; 11:03 p.m. - pain scale of 5. 6/15/24 at 7:31a.m. - pain scale of 4; 3:35 p.m. - pain scale of 5; 11:53 p.m. - pain scale of 10. 6/16/24 at 8:07 a.m. - pain scale of 5; 5:30 p.m. - pain scale of 5. 6/17/24 at 5:15 p.m. - pain scale of 7. 6/18/24 at 6:18 a.m. - pain scale of 0; 2:58 p.m. - pain scale of 7; 9:30 p.m. - pain scale of 7. 6/19/24 at 12:46 p.m. - pain scale of 10. 6/21/24 at 1:06 a.m. - pain scale of 5. 12:00 p.m. - pain scale of 7; 8:13 p.m. - pain scale of 8. 6/22/24 at 4:30 a.m. - pain scale of 6; 9:59 p.m. - pain scale of 8. 6/23/24 at 5:00 a.m. - pain scale of 0; 4:11 p.m. - pain scale of 8. 6/24/24 at 8:34 a.m. - pain scale of 5; 6:38 p.m. - pain scale of 5. 6/25/24 at 3:04 a.m. - pain scale of 5; 10:27 p.m. - pain scale of 4. 6/26/24 at 10:11 p.m. - pain scale of 0. 6/27/24 at 6:40 a.m. - pain scale of 0; 2:41 p.m. - pain scale of 5. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/29/24 at 2:20 a.m. - pain scale of 9; 10:59 a.m. - pain scale of 5; 7:00 p.m. - pain scale of 7. 6/30/24 at 5:37 a.m. - pain scale of 9; 2:02 p.m. - pain scale of 5; 10:53 p.m. - pain scale of 9. The July 2024 MAR documented the order for Ibuprofen. The Ibuprofen was administered on the following dates, time and pain scale: 7/11/24 at 3:17 a.m. - pain level of 7. 7/13/24 at 4:06 a.m. - pain level of 5. 7/26/24 at 3:25 a.m. - pain level of 8. The July 2024 MAR documented the order for Oxycodone. The Oxycodone was administered on the following dates, times and pain scale: 7/1/24 at 11:30 a.m. - pain scale of 10. 7/3/24 at 10:38 p.m. - pain scale of 0. 7/4/24 at 11:18 a.m. - pain scale of 5; 11:21 p.m. - pain scale of 0. 7/5/24 at 11:16 a.m. - pain scale of 5; 10:03 p.m. - pain scale of 7. 7/8/24 at 10:51 a.m. - pain scale of 5; 9:45 p.m. - pain scale of 5. 7/12/24 at 10:11 p.m. - pain scale of 9. 7/13/24 at 9:52 p.m. - pain scale of 9. 7/14/24 at 12:01 p.m. - pain scale of 5; 11:41 p.m. - pain scale of 5. The physician order dated, 7/24/24, documented, Oxycodone HCL Tablet 10 MG; Give 1 tablet by mouth every 24 hours as needed for pain. The July 2024 MAR documented this order. The Oxycodone was administered on the following dates, time and pain scale: 7/24/24 at 12:36 p.m. - pain scale of 7. 7/25/24 at 7:55 p.m. - pain scale of 7. 7/26/24 at 8:53 a.m. - pain scale of 8. The August 2024 MAR documented the order for Ibuprofen. The Ibuprofen was administered on the following dates, time and pain scale: 8/4/24 at 13:35 a.m. - pain scale of 6. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The August 2024 MAR documented the order for Oxycodone. The Oxycodone was administered on the following dates, time and pain scale: 8/1/24 at 5:07 p.m. - pain scale of 5. 8/4/24 at 5:40 p.m. - pain scale of 10. 8/7/24 at 9:06 a.m. - pain scale of 7. 8/8/24 at 4:51 p.m. - pain scale of 5. 8/11/24 at 9:10 a.m. - pain scale of 5. 8/12/24 at 5:04 p.m. - pain scale of 9. 8/13/24 at 5:50 p.m. - pain scale of 6. 8/17/24 at 12:39 p.m. - pain scale of 5. 8/18/24 at 1:30 p.m. - pain scale of 9. 8/25/24 at 1:23 p.m. - pain scale of 9. 8/26/24 at 3:44 p.m. - pain scale of 8. 8/27/24 at 5:17 p.m. - pain scale of 6. 8/31/24 at 6:07 p.m. - pain scale of 8. An interview was conducted with RN (registered nurse) #4 on 9/11/24 at 11:14 a.m. The above orders for Oxycodone and Ibuprofen were reviewed with RN #4. When asked how she would know which medication to give, RN #4 stated it depended on the pain level. RN #4 was asked if the orders documented which medication to give for pain levels, RN #4 stated, that would need to be clarified with the doctor. When asked if a pain mediation should be given for a pain level of zero, RN #4 stated, no. [NAME] interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 9/11/24 at 11:46 a.m. The above orders were reviewed with ASM #2. When asked how the nurse would know what to give, ASM #2 stated the Ibuprofen would be given for a milder pain. ASM #2 explained the resident had a fractured wrist in March 2024 and the emergency room prescribed Oxycodone. She further explained the resident has a history of drug abuse. When asked if the orders tell the nurse which medication to give, ASM #2 stated, no. When asked what should be done with these orders, ASM #2 stated, they should have parameters. The above MARS were reviewed with ASM #2. When asked if a pain medication should be given for a pain level of zero, ASM #2 stated, no, she doesn't think the pain levels are accurate but that is what is documented. The facility policy, Pain Assessment and Management documented in part, 5. The following are considered when establishing the medication regimen: a. Starting with lower doses and titrating upward as necessary; b. Administering medications around the clock rather than PRN. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Combining long-acting medications with PRNs for breakthrough pain; d. Combining non-narcotic analgesics with narcotic (opioid) analgesics; and e. Reducing or preventing anticipated adverse consequences of medications (e.g., bowel regimen to preventing constipation related to opioid analgesics). 6. The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications .Documentation: 1. Document the resident's reported level of pain with adequate detail (i. e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program. ASM #1, the administrator, and ASM #2 were made aware of these findings on 9/11/24 at 1:09 p.m. No further information was obtained prior to exit.

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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. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to receive the pharmacy recommendations, after the pharmacist completed the medication regimen review, for two of 32 residents in the survey sample, Residents #37 and #76. The findings include: 1. For Resident #37(R37), the pharmacy failed to provide the facility with the pharmacy recommendations, after the medication regimen review (MRR) was completed on 4/24/24 until 5/30/24. The Pharmacy Consultant note in the clinical record, dated 4/24/24 at 9:22 p.m. documented, See report for recommendations. A request was made on 9/11/24 at 10:55 a.m. for the Pharmacy Recommendation of 4/24/24. On 9/11/24 at 11:27 a.m. ASM (administrative staff member) #2, the director of nursing, presented the, Note to Attending Physician/Prescriber, dated 4/24/24, documented in part, This resident has been taking the antipsychotic, Paliperidone ER (extended release) (used to treat schizophrenia) (1) 3 mg (milligrams) daily, for bipolar disorder. IF CLINICALLY APPROPRIATE, please consider a dose reduction (GDR) (gradual dose reduction), perhaps decreasing the paliperidone ER to 1.5 mg daily. ASM #2 presented the email that the pharmacist sent on 4/25/24 that had no attachments to it. The email dated 5/30/24 at 4:04 p.m. from the pharmacist to ASM #2, documented six attachments. The attachments included the pharmacy review for R37 from 4/24/24. The doctor responded to the above recommendation on 6/5/24. An interview was conducted on 9/11/24 at 12:06 p.m. with ASM #7, the consulting pharmacist. When asked why the facility did not receive their pharmacy recommendations completed on 4/24/24 until 5/30/24, ASM #7 stated it was 100% user error on his part. He did not attach them to the email that he sent to the director of nursing and didn't go back to ensure that they were sent. The facility policy, Medication Regimen Review and Reporting documented in part, 7. The record for the consultant pharmacist's observation and recommendations is made available in an easily retrievable format to nurses, physicians and the care planning team within 48 hours of MRR completion. ASM #1, the administrator and ASM #2, the director of nursing, were made aware of the above findings on 9/11/24 at 1:09 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a615032.html (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	29125 2. For Resident #76, the facility staff failed to obtain the recommendations from the pharmacy within 48 hours of the completion of the pharmacy monthly medication regimen review completed on 8/30/24. A review of the clinical record revealed that the pharmacy completed a monthly medication review on 8/30/24. A progress note dated 8/30 24 documented, This individual's medication regimen was reviewed on the date listed here - _____ See report for recommendation(s). _____ Based on information available in the medical record at the time of review, it is my professional judgment that this medication regimen contained no new irregularities as defined in (the regulation set for long term care facilities) at that time. The box for See report for recommendation(s) was marked with an X Further review of the clinical record failed to reveal any evidence of the recommendation report that was referenced as marked by an X in the above note. On 9/11/24 at 11:58 AM, a copy of the pharmacy recommendation was requested from ASM #2 (Administrative Staff Member) the Director of Nursing. On 9/11/24 at 12:19 PM, ASM #2 stated that she has not received the recommendation yet from the pharmacist. ASM #2 was asked what is the time frame that the pharmacy has to provide the recommendations. She stated she would have to check the policy. On 9/11/24 at 12:42 PM in an follow up interview, ASM #2 stated that the pharmacy was to provide the recommendations within 48 hours of the review. The recommendation was not provided from the pharmacy to the facility within 48 hours. As of this survey, it had been 12 days thus far. No further information was provided by the end of the survey.