STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495264	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside of Poquoson Health and Rehab	1 Vantage Drive Poquoson, VA 23662

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews the facility staff failed to ensure resident equipment was kept clean for 1 of 12 residents (Resident #7), in the survey sample. The findings included: Resident #7 was originally admitted to the facility 09/17/2021 after an acute care hospital stay. The current diagnoses included advanced dementia, paranoid schizophrenia, and severe protein-calorie malnutrition. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/10/25 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. The resident's person centered care plan with a revision date of 10/25/24 had a problem which stated I am at risk for falls related to cognitive impairment, poor safety awareness, and psychotropic medication use. The goal stated I will not fall and injure myself through next care plan review. The interventions included two mats left and right side of bed for safety/fall risk. On 3/25/25 at 12:50 PM, Resident #7 was observed in a low bed with bilateral mats. The mat between the resident's bed and the roommate's bed was observed with dark stains on it as well as bread crumbs, debris and shoe prints. The fall mats were also observed on 3/26/25 with dark stains, shoe prints, debris and staff standing on the one between the two beds. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and [NAME] President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team. The Director of Nursing stated the mats had been removed and new ones put in place. She also stated that staff had been educated that they were not to be walked on and that the environmental services staff would be paying more attention to the fall mats for all residents with them, for they are to be cleaned and disinfected on a regular schedule and removed when they are no longer in good repair.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, family interview, and staff interviews, the facility staff failed to develop person-centerd care plan for a percutaneous endoscopic gastrostomy (PEG) tube for 1 of 12 residents (Resident #8), in the survey sample. The findings included: Resident #8 was originally admitted to the facility 03/03/2023 after an acute care hospital stay. The current diagnoses included vascular dementia and chronic gastric outlet obstruction status post PEG tube placement. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/01/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were severely impaired. On 3/25/25 at approximately 12:43 PM during the initial tour an interview was conducted with Resident #8's daughter who was visiting. The daughter lifted the resident's top which revealed a PEG tube. The PEG's external bumper was observed to be position too far from the abdominal skin and the insertion site had leakage and presented with small red and raised irritation. The daughter removed gauze from the closet and wiped the site dry, afterwards she applied a split drain sponges around the insertion site. A review of the resident's person centered care plan failed to have a problem secondary to the PEG tube and a review of the current physician's orders failed to reveal an order for the PEG tube, but here were orders for management of the PEG. The orders included one dated 7/15/24 to cleanse and place a dressing to the PEG tube site every day and an order dated 5/08/24 which stated PEG tube - flush with thirty milliliters of water every eight hours for patency. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and [NAME] President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team, and they had no comments and voiced no concerns.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 2. The facility staff failed to provide showers to a dependent resident (Resident #6). Resident #6 was originally admitted to the facility 1/9/25 after an acute care hospital stay. The resident's current diagnoses included a stroke resulting in left hemiplegia, spatial neglect of left side, left visual deficit and obstructive sleep apnea. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/15/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were moderately impaired. In section GG0130 (Self-Care) of the 1/15/25 MDS assessment the resident was coded as requiring substantial/maximal assistance with shower/bathe. An interview was conducted with Resident #6 on 3/26/25 at approximately 2:06 PM. The resident stated he was admitted to the facility in early January, and he had received only one shower since his admission. He stated he was told that two showers were scheduled weekly for each resident. The resident further stated he believed if he showered more he would feel better. The resident also stated he was to be shaved on 3/26/25 but he assumed the staff ran out of time because they did not come back to shave him. The resident stated on 3/27/25 at 10:30 AM that CNA #3 stated she would be giving him a shower and shave later on 3/27/25. A review of the Shower/Bathe documentation on the Documentation Survey Reports revealed no showers were provided in January 2025, one was documented on 2/4/25 and one was documented on 2/18/25 with the resident providing all care after he was set-up and the March documentation stated he received showers 3/3/25, 3/6/25, and 3/10/25. The resident identified CNA #6 as the staff member who provided him with the one shower and denied that CNA #5 had provided him with any showers. All shower/bathe entries by CNA #5 were coded the resident was dependent and a shower was provided. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and [NAME] President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team and they had no comments and voiced no concerns. Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to provide hygiene care for dependent residents for 2 of 12 residents (Residents #2 and #6), in the survey sample. The findings included: 1. The facility staff failed to remove unwanted hair from the neck and chin of Resident #2. Resident #2 was originally admitted to the facility 12/11/24 after an acute care hospital stay. The current diagnoses included; end stage renal disease, type 2 diabetes mellitus with hyperglycemia, essential hypertension, and muscle weakness. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/18/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #2's cognitive abilities for daily decision making were intact. On 3/25/25 at 12:45 PM an interview was conducted with Resident #2. It was observed that Resident # 2's was rubbing her fingers through a large amount of hair on her neck and chin. Resident #2 stated, I wish they would shave this hair off of my neck and chin. Resident #2 also stated, they have never asked me if I want to have this hair shaved off of my neck and chin. On 3/27/25 at 12:05 PM an interview was conducted with Resident #2. It was observed that Resident # 2 still had a large amount of hair on her neck and chin. Resident #2 stated, I wish they would clean me up and shave me. Resident #2 also stated, I feel so dirty and just want them to clean me and shave me. On 3/27/25 at 2:51 PM an interview was conducted with Certified Nursing Assistant (CNA) #1. CNA #1 stated, I saw the hair on her neck and chin. I will be honest with you, I did not ask her if she wanted me to shave her today and I should have. CNA #1 also stated, I should have shaved her today and I will before I leave if you want me too. On 3/27/25 at 6:11 PM an interview was conducted with the Administrator. The Administrator stated, We will be shaving the resident. The Care Plan with an initiated date of 12/23/24 read that Resident #2 has a physical functioning deficit related to: Mobility impairment, Self care impairment. The goal is resident will improve my current level of physical functioning. The intervention for Resident #2 was Personal Hygiene assistance of (dependent) 1 person. In section GG (Functional Abilities) the resident was coded dependent with Personal Hygiene: the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands(excludes baths, showers, and oral hygiene). On 3/27/25 at approximately 8:30 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional Director of Clinical Services, and Regional [NAME] President of Operations. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to assess and monitor a surgical wound on a resident's right breast after a breast biopsy was completed; which contributed to the resident becoming septic and hospitalized for 1 of 12 residents (Resident #1), in the survey sample. The findings included: Resident #1 was initially admitted to the facility on [DATE] and discharged on 11/11/24. The resident did not return to the nursing facility. The current diagnoses included major depressive disorder. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 04/21/24, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. The care plan dated 4/27/24 read Resident #1 had open areas related to dermatitis of the right buttock and perineum. The goal for Resident #1 is open areas will be free of infection and healing state through the next care plan review on 05/01/2024. The interventions for Resident #1 were: Encourage proper nutrition. If a resident refuses a meal, offer an alternative and provide medication/treatment as ordered by the physician, observe for effectiveness, and use pressure-reducing seats/mattresses as necessary. A general note read: A physician visit was conducted by the facility Physician's Assistant (PA) on 11/11/24, the day of transfer from the nursing facility to the hospital admission. The chief complaint was sepsis. The resident had an elevated temperature and was hypotensive (90/60). Fluids and resuscitation were ordered. Although the provider doubted her sacral ulcer as the cause of her fever. No other source was identified at this time. A wound care consult was ordered. And local wound care was continued. According to medical records and Family Member #1, the resident had a biopsy of her right breast on 10/22/24. A review of a general progress note on 11/11/24 at 9:00 AM., read: Resident alert/verbal/responsive with difficulty understanding mumbling of words, eyes dazed in bed, head of bed up no signs and symptoms (s/s) of aspiration, skin clammy, hot/warm to touch, observed not eating breakfast vital signs (v/s) Temperature=100.7, blood pressure (bp)= 93/46, Pulse =93, Respiration =18, Oxygen 02= 83% with return 1min 94% 02 applied as ordered blood sugar (b/s) 86, lung sounds slightly diminished on left, right side clear, cap refill less than 3 seconds, and within normal limits with active bowel sounds large bowel movement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress note dated 11/11/24 at 9:10 AM read: PA in the facility and updated orders given, unable to do Intravenous (IV). At 9:15 AM, the company called, spoke to staff, and requested midline stat confirmation number given at 9:25 AM., Responsible Party (RP) updated per his request wants resident sent to the Emergency Room/ ER/Treatment 9:30 AM., Message left via PA answering machine along with phone number waiting call back. 09:30 AM., 911 called 9:45 AM., Resident left via stretcher going to the hospital. Resident remains alert/verbal/responsive prior to departure, all peri care done Assistant Director of Nursing (ADON)/Unit Manager (UM) updated, at 11:30 AM., RP updated of departure. A review of the hospital records dated 11/11/24 at approximately 2:08 PM., read that the patient expressed concern that she was not getting adequate care and was not feeling safe at the facility. According to the History and Physical (H&P) the patient was diagnosed with Sepsis (mostly due to draining of the right breast). On 3/25/25 at approximately 2:15 PM, an interview was conducted with family member (FM) #1 concerning his loved one. FM #1 said that when his mom came into the hospital, she smelled bad from the infections. He also said that she had had a breast biopsy a few weeks before coming here. On 3/26/25 at approximately 2:50 PM, an interview was conducted with Certified Nursing Assistant (CNA) #1. CNA #1 said that on 11/10/24, before the staff called 911, the resident was seen sleeping a lot. The resident started feeling bad after eating her breakfast. She was nauseated and refused her lunch. CAN#1 said, The next mornings she didn't look herself, she would open her eyes and not speak, she didn't eat breakfast that morning (11/11/24). LPN #3 helped me turn the resident in because she had a foley catheter. While giving her a bath I noticed a small area on her butt cheek. We put a protective cream on it. She would always have a bowel movement when receiving activities of daily living (ADL) care. Other CNAs said she had a milky substance coming from her breast. On 3/27/25 at approximately 3:45 PM, an interview was conducted with the Physician Assistant (PA). The PA said that the right breast drainage had been ongoing for some time. The PA also said that he was not informed the resident had a breast procedure done requiring steri strips. An interview was conducted on 3/27/25 at approximately 4:00 PM with Corporate Staff #2, the DON, and the facility Administrator. The administrator said that Resident #1 had a work-up for a breast mass, intermittent discharge, and an inverted nipple at the diagnostic center on 10/22/24. The Administrator said, We saw no progress notes. We should monitor for s/s of infections. The PA and the Medical Director were contacted via telephone during this interview. The DON said, If they came back with no orders (The Diagnostic Breast Center), you would call the hospital. Corporate Staff #2 asked the PA, Did you see anything? The PA said he wasn't aware at all that the resident had a biopsy until the resident went out to another facility (after hospital admission, the resident was discharged to another facility). The PA was asked what the facility was doing to monitor and care for the resident's right breast. The PA said, That was outpatient. I was not aware of a discharge at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at approximately 4:25 PM, a document was presented by Corporate Staff #2. Corporate staff #2 said that the document could not be found in the Medical Records under Point Click Care (PCC) a cloud-based electronic health records (EHR) system; it could only be found under Point Click Care Connect (Optimize care collaboration by connecting to a national-level health data network with hospitals, active resident and patient records, to exchange timely clinical data). The PA and staff present said they were not aware of this system until now. Corporate Staff #2 said that the staff would be educated on Point Click Care Connect because they can access it. The surveyors were not able to retrieve any notes or documents as they were not informed of this system until 3/27/25. The retrieved document from Point Click Care Connect was presented to the surveyors by Corporate Staff #2, dated 10/29/24 at 9:45 AM, that read: Called patient and gave negative biopsy results. Patient very happy with the results, patient has no signs of infection around the biopsy site. Steri strips on and precautions reviewed per protocol. Post operative Biopsy results-Unspecified lump in right breast, subareolar. Pathology from right breast twelve o'clock radius subareolar margin demonstrates benign squamous epithelium with focal acute and chronic inflammation, including giant cells, suggestive of ruptured cyst. Findings are benign. At minimum suggest a 3 month follow-up. On 3/27/25, at approximately 4:50 PM, Licensed Practical Nurse (LPN) #3 was interviewed. LPN #3 said that she noticed the discharge coming from the resident's right breast and notified the doctor. The above findings were shared with the Administrator, Corporate Consultant, and Regional [NAME] President of Operations on 3/27/25 at approximately 7:45 p.m. The facility's staff was offered an opportunity to present additional information, but no additional information was provided. Steri-Strips (Butterfly Bandage) Steri-Strips and butterfly bandages are thin, sticky bandages that cover small cuts and some surgical incisions. You apply them across your cut (running in the opposite direction) to help the two sides of your skin stay tightly closed. This helps prevent bacteria from getting in. Seek medical care immediately at the first sign of a wound infection. https://my.clevelandclinic.org/health/treatments/steri-strip-butterfly-bandage Incision & Surgical Wound Care An incision is an opening of your skin after surgery. Your surgeon will close this surgical wound with stitches (sutures), staples or adhesives (Steri-Strips). A dressing goes over the closed incision. You'll need to keep your incision clean to prevent infection. Your healthcare provider will give you instructions to take care of your wound. What is incision and surgical wound care? Incision and surgical wound care are instructions that you follow to prevent infections and help your body heal. You get these instructions after a surgery or procedure where a surgeon or healthcare provider made an incision (entry point) to access the inside of your body. You'll need to clean and protect your incision site until it heals completely. If you notice any pain, swelling, warmth around the site, or fluid oozing out of your wound, visit a healthcare provider, as you may have an infection. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Adhesives: Adhesives include special tapes and glues that use their stickiness to hold your skin together. A healthcare provider may choose adhesives to close wounds from needles (percutaneous wounds), pediatric wounds or apply them in addition to deep sutures. Adhesives are painless. A common adhesive tape is Steri-Strips® https://my.clevelandclinic.org/health/treatments/15709-incision-care

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, resident interview, staff interviews, and clinical record review, the facility staff failed to provide required care to prevent complications while utilizing an indwelling catheter for 1 of 12 residents (Resident #4), in the survey sample. The findings included: Resident #4 was originally admitted to the facility 03/01/24 after an acute care hospital stay. The current diagnoses included neurogenic uropathy with urinary retention. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/09/25 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. At section H0100 A - the resident was coded for requiring use of an indwelling catheter. A physician order dated 3/6/24 stated Foley Catheter 16 french with a 5 milliliter balloon every shift related to urinary retention. The person centered care plan dated 9/13/24 had a problem which stated I have a Foley catheter 16 french with a 5 milliliter balloon related to a neurogenic uropathy with urinary retention. The goal stated I will not experience an infection until next review. The interventions included Position catheter below bladder, ensure tubing has no kinks, and secure for safety. On 3/25/25 at 1:37 PM Resident #4 was observed in bed with a bedside drainage bag and yellow urine in the tubing. An interview was conducted with Resident #4 regarding the indwelling catheter. The resident pulled back her linens and revealed the upper indwelling catheter tubing. The stat lock (a device to stabilize an indwelling catheter) was observed wrapped around the catheter tubing at the point of the aspiration port. Again on 3/26/25 at 12:49 PM the resident's tubing was observed unstabilized and the stat lock was observed wrapped around the tubing. This information was obtain from the Internet on 3/31/25 - If urinary catheters are not secured appropriately, they can lead to severe trauma of a patient's urethra, potential damage to bladder neck, infection and inflammation, pain and irritation, possible bypassing, accidental dislodging of a catheter and a cleaving (condition whereby the catheter splits the penile or labial tissues). https://pubmed.ncbi.nlm.nih.gov/24335791/ On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and [NAME] President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team, and the Director of Nursing stated her observation on 3/27/25 also revealed the catheter tubing was unsecured. The Director of Nursing further stated that the stat locks supplied by the facility were not of a good quality and the catheter was likely to become unsecured because of the adhesive on the product, therefore she authorized the central supply personnel to order a different indwelling catheter stabilizer.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, family interview, and staff interviews, the facility staff failed to properly care for a percutaneous endoscopic gastrostomy (PEG) tube for 1 of 12 residents (Resident #8), in the survey sample. The findings included: Resident #8 was originally admitted to the facility 03/03/2023 after an acute care hospital stay. The current diagnoses included vascular dementia and chronic gastric outlet obstruction status post PEG tube placement. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/01/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were severely impaired. On 3/25/25 at approximately 12:43 PM during the initial tour an interview was conducted with Resident #8's daughter who was visiting. The daughter lifted the resident's top which revealed a PEG tube. The PEG's external bumper was observed to be position too far from the abdominal skin and the insertion site had leakage and presented with small red and raised irritation. The daughter removed gauze from the closet and wiped the site dry, afterwards she applied a split drain sponges around the insertion site. A review of the resident's person centered care plan failed to have a problem secondary to the PEG tube and a review of the current physician's orders failed to reveal an order for the PEG tube, but here were orders for management of the PEG. The orders included one dated 7/15/24 to cleanse and place a dressing to the PEG tube site every day and an order dated 5/08/24 which stated PEG tube - flush with thirty milliliters of water every eight hours for patency. On 3/27/25 at approximately 10:14 AM the resident's PEG site was observed again after the resident lifted her shirt, The area was again very wet and the split drain sponge was disheveled around the tubing. An interview was conducted with Certified Nursing Assistant (CNA) #6 on 3/27/25 at approximately 10:21 AM. CNA #6 stated it was not the CNA's responsibility to clean Resident's #8's PEG site and apply the sponges. CNA #6 stated her role was to let the nurse know if changes were observed or if the PEG appeared to need care. On 3/27/25 at approximately 1:37 PM an interview was conducted with Resident #8's hospice nurse. The hospice nurse stated the residents PEG tube insertion site was irritated because of a fungus and an antifungal had been ordered. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and [NAME] President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team. The Director of Nursing stated they had obtained new orders for the residents PEG insertion site.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside of Poquoson Health and Rehab	1 Vantage Drive Poquoson, VA 23662

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, resident interview, and clinical record review, the facility staff failed to necessary respiratory care and services for 1 of 12 residents (Resident #6), in the survey sample. The findings included: Resident #6 was originally admitted to the facility 1/9/25 after an acute care hospital stay. The resident's current diagnoses included a stroke resulting in left hemiplegia, spatial neglect of left side, left visual deficit and obstructive sleep apnea. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/15/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #6's cognitive abilities for daily decision making were moderately impaired. The physician's order summary had an order dated 1/20/25 for a C-PAP at previous home settings at bedtime for acute and chronic respiratory failure with hypercapnia and as needed. The person centered care plan with a problem dated 1/29/25 which stated alteration in respiratory status due to sleep apnea. The goal read the resident will have adequate gas exchange as evidenced by no adventitious breath sounds, absence of respiratory distress, and absence of shortness of breath thru the next review. The interventions included monitor to ensure the C-PAP mask in place at nighttime/sleeping time. An interview was conducted with Resident #6 on 3/26/25 at approximately 2:06 PM. The resident stated he utilized a C-PAP (a machine which keeps your airways open while you sleep). The resident stated some nights the C-PAP is not applied at all and other times it is misapplied. The resident stated that sometimes the staff applies the C-PAP while he is asleep and he is awaken by water entering his nose or splashing all over him. The resident stated as a result of the water splashing he had to remove the mask because he was no longer capable of draining the tubing and repositioning the C-PAP mask himself. The resident stated that no one asked him why he removed the C-PAP, if they had he would explained that it was not applied appropriately to remain in place, for the water should not have been inside the tubing. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and [NAME] President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team and the Corporate Nurse Consultant stated they identified the resident needs to be shaved more often so they can get the good fit of the C-PAP mask.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and staff interview the facility staff failed to secure resident medications on 3/27/25. The findings included: On 3/27/25 at approximately 10:47 AM Licensed Practical Nurse (LPN) #2 was observed passing medications on the 200's hall. LPN #2 went from room to room for seven rooms pulling and administering the medications. In between pulling the medication and administering it to the residents the medication cart was left unlocked making the medications accessible to unauthorized individuals. At 11:06 AM the Administrator was observed coming onto the 200's hall with a visiting male and female to visit a resident. The Administrator observed the unattended, unlocked medication cart in the hallway and went over to it and closed the locking mechanisms without saying anything to LPN #2, who was inside a resident's room. When LPN #2 returned to the medication cart, he pulled at a medication drawer but it did not open, he looked around but said nothing. LPN #2 was observed removing the medication cart key from his pocket, unlocked the medication cart and resumed pulling medications for other residents. On 3/27/25 at approximately 4:05 PM LPN #2 was sought for an interview but he was not located. The Director of Nursing stated he was gone for the day. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and [NAME] President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team, and they had no comments and voiced no concerns.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and in the course of a complaint investigation, it was determined that facility staff failed to maintain a complete record for 1 of 12 residents in the survey sample; Resident #1 The findings included: Resident #1 was originally admitted to the facility on [DATE] and discharged on 11/11/24. The current diagnoses included major depressive disorder. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 04/21/24, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of 15. The care plan dated 4/27/24 read Resident #1 had open areas related to dermatitis of the right buttock and perineum. The goal for Resident #1 is for open areas to be free of infection and in a healing state through the following care plan review on 05/01/2024. The interventions for Resident #1 were: Encourage proper nutrition. If a resident refuses a meal, offer an alternative and provide medication/treatment as ordered by the physician, observe for effectiveness, and provide pressure-reducing seats/mattresses as necessary. According to medical records and Family Member #1, the resident had a biopsy of her right breast on 10/22/24. An interview was conducted on 3/27/25 at approximately 4:00 PM with Corporate Staff #2, the DON, and the Facility Administrator. The administrator said that Resident #1 had a work-up for a breast mass, intermittent discharge, and an inverted nipple at the diagnostic center on 10/22/24. We saw no progress notes. We should monitor for s/s of infections. The PA and the Medical Director were contacted by telephone during this interview. The DON said that if they came back with no orders (The Diagnostic Breast Center) you would call the hospital). Corporate Staff #2, asked the PA did you see anything. The PA said he wasn't aware at all that the resident had a biopsy until the resident went out to another facility (after hospital admission, the resident was discharged to another facility). The PA was asked what the facility was doing to monitor and care for the resident's right breast. The PA said, That was outpatient. I was not aware of a discharge at that time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/27/25 at approximately 4:25 PM, a document was presented by Corporate Staff #2. Corporate Staff #2 said that the document could not be found in the Medical Records under Point Click Care (PCC) a cloud-based electronic health records (EHR) system; (Optimize care collaboration by connecting to a national-level health data network with hospitals, active resident and patient records, to exchange timely clinical data). The PA and staff present said they were not aware of this system until now. Corporate Staff #2 said that the staff would be educated on Point Click Care Connect because they can access it. The surveyors could not retrieve any notes or documents as they had not been informed of this system until 3/27/25. The retrieved document from Point Click Care Connect was presented to the surveyors by Corporate Staff #2, dated 10/29/24 at 9:45 AM, which read: Called patient and gave negative biopsy results. Patient very happy with the results, patient has no signs of infection around the biopsy site. Steri strips on and precautions reviewed per protocol. Post operative Biopsy results-Unspecified lump in right breast, subareolar. Pathology from right breast twelve o'clock radius subareolar margin demonstrates benign squamous epithelium with focal acute and chronic inflammation, including giant cells, suggestive of ruptured cyst. Findings are benign. At minimum suggest a 3 month follow-up. On 3/27/25 at approximately 7:45 p.m., the above findings were shared with the Administrator, Corporate Consultant and the Regional Vice-President of Operations. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation staff interviews and a clinical record review, the facility staff failed to establish/provide collaborative care (Hospice) for 3 of 12 residents (Resident #7, 8, and 12), in the survey sample. The findings included: 1. Resident #7 was originally admitted to the facility 09/17/2021 after an acute care hospital stay. The current diagnoses included advanced dementia, paranoid schizophrenia, and severe protein-calorie malnutrition. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/10/25 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. A physician order dated 2/12/24 stated (name of the hospice agency) to evaluate and treat. A hospice agency document dated 2/14/24 stated the resident elected hospices services 2/14/24. A review of the resident's clinical record failed to reveal collaboration between the facility and the hospice agency in development of a plan of care between the facility and the hospice agency and evidence of the hospice agency's participation in the resident's interdisciplinary care plan meeting. On 3/27/25 at 1:37 PM an interview was conducted with the resident's visiting hospice primary care nurse. The hospice nurse stated she does not participate in the resident care plan meetings at this facility and the facility's staff is not permitted to participate in their biweekly care planning meetings. The hospice nurse further stated she does not combine her care documents and assessments with the facility's documents because hospice documents are kept in a book at the nurse's station. She also stated the facility can call the hospice agency's office and request other documentation they would like. A review of the resident's clinical record revealed some dates the hospice disciplines visited the resident and general forms of what they did such as assessments, case manage, wound care and refill medications, no specifics or details regarding the resident's care was documented. An interview was conducted with the facility's Social Services Director (SSD) on 3/27/25 at approximately 5:20 PM. The SSD stated she had no documentation to support that the hospice agency participated in Resident #7's care plan conferences but she would make sure they were invited and participated going forward. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and [NAME] President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team, and they had no comments and voiced no concerns. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #8 was originally admitted to the facility 03/03/2023 after an acute care hospital stay. The current diagnoses included vascular dementia and chronic gastric outlet obstruction status post PEG tube placement. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/01/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #8's cognitive abilities for daily decision making were severely impaired. A physician's order dated 7/19/24 stated to consult (name of the hospice agency) to evaluate related to unspecified intestinal obstruction, unspecified as to partial versus complete obstruction. A document completed by a hospice agency representative on 7/21/24 titled Hospice IDG comprehensive assessment and Plan of Care Update Report revealed the resident was a new admission for hospice services. The resident's record has no order to be admitted for hospice services. Otherwise there is only a progress note of a care plan meeting dated 7/24/24 which stated the resident recently entered hospice services. The participants did not include a representative from the hospice agency. On 3/27/25 at 1:37 PM an interview was conducted with the resident's visiting hospice primary care nurse. The hospice nurse stated she does not participate in the resident care plan meetings at this facility and the facility's staff is not permitted to participate in their biweekly care planning meetings. The hospice nurse further stated she does not combine her care documents and assessments with the facility's documents because hospice documents are kept in a book at the nurse's station. The hospice nurse also stated until recently she did not provide wound measurements to the facility because they were hospice measurements and not for the facility. The hospice nurse stated the facility's staff requested the wound assessment documents therefore they were provided by the hospice office A review of the resident's clinical record revealed some dates the hospice disciplines visited the resident and general forms of what they did such as assessments, case manage, wound care and refill medications, no specifics or details regarding the resident's care was documented. An interview was conducted with the facility's Social Services Director (SSD) on 3/27/25 at approximately 5:20 PM. The SSD stated she had documentation to support the hospice agency participated in Resident #8's care plan conferences on 1/3/24 and 11/6/24, but the hospice agency did not participate in the care plan conferences in between 1/3/24 and 11/6/24 or the most recent care plan conference on 2/5/25. On 3/27/25 at approximately 5:30 P.M., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and [NAME] President of Operations and Corporate Nurse Consultant. The above findings were conveyed to the administrative team, and they had no comments and voiced no concerns. 3. The facility's staff failed to provide a Hospice Care Plan, nurses notes and other dispositions for Resident #12. Resident #12 was originally admitted to the facility 1/13/23 and readmitted [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; End Stage Renal Disease. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The significant Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/24/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #12 cognitive abilities for daily decision making were severely impaired. The person-centered care plan dated 1/27/25 read Resident #12 is on hospice relating to end of life care. The Goal for Resident #12 Patient will be comfortable and have needs meet. The interventions for Resident #12 were: Evaluate effectiveness of medications/interventions to address comfort and Respect patient and family wishes. In Section O Special Treatments and Programs. K1= Coded resident as receiving Hospice Care. A care plan review note dated 02/05/2025 at 2:31 PM., read: Resident had her care plan meeting. In attendance was the SSD, MDS, and UM. Resident declined to attend. Resident is staying at the facility for LTC and has a code status of DNR. According to the above care plan meeting note. Hospice was not in attendance. On 3/27/25 at 1:37 PM an interview was conducted with the resident's visiting hospice primary care nurse. The hospice nurse stated she does not participate in the resident care plan meetings at this facility and the facility's staff is not permitted to participate in their biweekly care planning meetings. The hospice nurse further stated she does not combine her care documents and assessments with the facility's documents because hospice documents are kept in a book at the nurse's station. She also stated the facility can call the hospice agency's office and request other documentation they would like. An interview was conducted with the facility's Social Services Director (SSD) on 3/27/25 at approximately 5:20 PM. The SSD stated she had no documentation to support that the hospice agency participated in Resident #12's care plan conferences, but she would make sure they were invited and participated going forward. On 3/27/25 at approximately 7:45 p.m., the above findings were shared with the Administrator, Corporate Consultant and the Regional Vice-President of Operations. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.