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	08/29/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure a resident's right to a dignified existence and self-determination for 1 Resident (#21) in a survey sample of 35 Residents. The findings included: For Resident #21, the facility staff failed to appropriately dress the resident, supply a top sheet and blanket and respond to his request to wear something other than an incontinent brief. Resident #21 was admitted to the facility on [DATE] with diagnoses that included but were not limited to dysphagia after stroke, Diabetes Type II, dialysis-dependent end-stage renal disease, hypertension, congestive heart failure, lack of coordination, major depressive disorder, muscle weakness (generalized) hemiplegia and hemiparesis following stroke affecting the right dominant side, contracture of the right hand and contracture of the right elbow. Resident #21's most recent MDS (Minimum Data Set), dated 7/7/24, coded Resident #21 as having a BIMS (Brief Interview of Mental Status) score of 15/15, indicating no cognitive impairment. On 8/26/24 at approximately 7:00 p.m., the resident was heard yelling out. Resident #21's door was closed, but he could be heard yelling, Hey! Resident #21 was observed dressed only in an incontinent brief with no top sheet or blanket. He had a right elbow splint and right palm guard in place; the call bell was wrapped around the bed rail on the right side of the bed; however, upon closer look, it was disconnected from the wall. The bed was elevated to the highest position, and the foot of the bed was elevated. Resident #21 said, Hey, are you going to get me some clothes? I don't want to be here like this. I can't get nobody to help me. When asked if he had utilized the call bell, the resident said someone had come in, turned it off, and said they would be back. When asked how long that was, he said, A long time ago. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the above observation, CNA #1 was asked if the bed was the appropriate height, and she stated that it was not the proper height for safety. When asked if the call bell should be on the right side of the bed (the stroke-affected side where the Resident has splints and a palm guard), she stated it was the Resident's choice. Resident #21 was asked where he preferred the call bell, and he said, Over here, indicating the left side of the bed (his unaffected side). When asked if the call bell should ever be left unplugged from the wall, she said it should not, and it was the only way residents could call for assistance. When asked why Resident #21's door was shut, she stated it was the resident's preference. CNA #1 asked Resident #21 how she could help him, and he replied I got no clothes on I want some clothes. Why y'all leave me here like this? CNA #1 responded that it was nighttime, and he was getting ready for bed, to which the Resident responded, I still need something on. CNA#1 was asked why the Resident did not have a top sheet and blanket CNA #1 stated she did not know and would get them. On 8/29/24, during the end-of-day meeting, the Administrator was made aware of the concerns, but no further information was provided.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 40711 Based on observations and interviews, the facility staff failed to ensure the survey results book was readily accessible during the initial entrance of the facility. The findings included: On 8/26/24 at approximately 7:05 PM., during the facility entrance of the main lobby a sign was noticed on a table in the main lobby that read Survey Book is kept in the main lobby. No Survey Book was observed. 08/26/24 at approximately, 7:09 PM., an interview was conducted with the administrator concerning the survey book whereabout. The administrator pulled the survey book from a table in his office, saying that he had the survey book since Friday (8/23/24) because he was expecting us to come in at any time to survey the facility. The above findings were shared with the Administrator, The Director of Nursing (DON) and corporate staff on 8/28/24 at approximately 1:30 PM., during the final interview.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, and clinical record review, the facility staff failed to provide a clean, comfortable, home-like environment for 3 of the 14 Resident rooms in Hall 100. The findings included: For the Residents who resided in rooms [ROOM NUMBERS], the facility staff failed to make repairs to the walls by the head of the bed, where there were gouges in the drywall from the bed impacting the wall. For the Residents in rooms [ROOM NUMBERS], the facility staff failed to provide linens that were in good repair and without holes or stains. On 8/26/24 at approximately 6:45 p.m. during the initial tour of the facility, the following observations were made: room [ROOM NUMBER] A & B - Deep gouges in the drywall by the head of the bed were observed and had not been repaired. room [ROOM NUMBER] A Bed - Resident asleep and the blanket was noted to have brownish colored stain at foot of bed room [ROOM NUMBER] A Bed - Small hole in bottom sheet and no top sheet on bed. room [ROOM NUMBER] A Bed - Large gouges in drywall near head of bed, hole in bottom sheet and no top sheet or blanket and the resident visibly lying in bed wearing a brief with no blanket or top sheet. On 8/26/24, an interview was conducted with CNA #1, who stated that the resident was ready for bed, which is why he did not have any clothes on. When asked why the Resident did not have a top sheet and blanket, she stated she did not know and would get them. On 8/27/24, an interview was conducted with LPN #1, who stated that repairs are put in for maintenance to complete, but if they are not reported, maintenance cannot do the repairs. When asked if she knew if the gouges in the drywall were reported, she stated that she did not. When asked if holes in the stained sheets and blankets are acceptable for Resident use, she stated that when the beds are made, the CNAs should not be using stained or torn linens; they should let the laundry know so they can remove them. A review of the maintenance logs did not reveal any reports of damaged drywall in rooms. On 8/28/24 during the end of day meeting the Administration was made aware of the findings and no further information was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observation, staff interview, clinical record review and facility documentation review, the facility failed to review and revise the care plan for 2 Residents (Residents #2, and #21) in a survey sample of 35 Residents. The findings included: 1. For Resident #2, the the facility staff failed to document resident specific measurable goals, and failed to derive and implement a behavioral modification care plan for a Resident with documented brain injury and behaviors. Resident #2 was initially admitted to the facility on [DATE], and most recently readmitted on [DATE]. Diagnoses included; hypertension, seizure disorder, dementia, depression, pulmonary embolus, and traumatic brain injury with behaviors, stroke and convulsions/movement disorders/muscle weakness. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7-17-24. He was coded with a Brief Interview of Mental Status score of 15 indicting no cognitive impairment. He required assistance with activities of daily living care. He was unable to walk and self propelled slowly in a manual wheel chair. The Resident was interviewed upon entrance to the facility and found to be non-verbal, with a communication deficit. He was pleasant, welcoming and smiling throughout the exchange. He used a writing pad successfully to communicate, although it was difficult for him to write and hold the pad as he he exhibited weakness in his upper extremities, and a tremor which resulted in involuntary shakiness and scribbled shaky writing, though mostly legible. Resident #2 had current physician's orders for the following; Seroquel 25 milligrams (mg) once per day at 9:00 PM Depakote 250 mg once per day at 9:00 PM Depakote 500 mg once per day at 9:00 PM Aricept 10 mg once per day at 9:00 PM The Resident's care plan was reviewed and revealed Focus statements and interventions as follows; FOCUS: Swung at another Resident after being hit by wheel chair (3-15-2019). Resident continues to have outbursts with other Residents (11-16-2019), (11-18-2019). (name) and his room mate had an angry episode over the doorway being blocked by a wheel chair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another (female) Resident thought (Resident #2) was her husband and followed and yelled at him. He tried to get away from her. He did not hit her. He had an altercation with another resident over a woman. Resident to Resident verbal altercation (date unknown) (6-17-19?) per interventions in the careplan dates. INTERVENTION: Encourage Resident to not hit other residents, when another Resident is agitated with me remove me from the situation, offer something I like as a diversion 4-17-19. Resident will not talk with the other Resident, and will stay away from the woman in the incident 6-17-19. If I don't like what I'm doing let me choose something else, if I'm upset please redirect the conversation or task. New focuses were not care planned for 2020 through 2023, however interventions were added. Those follow below; please avoid things that make me more anxious 8-16-22. One to one observation 2-27-23. Velcro stop sign across Residents door per his request 5-15-23. Medication review, psyche referral, and one to one observation 8-3-23. two to one staff observation 11-7-23. On 2-27-23 the psychiatric evaluation was completed by a physician and notes from the physician revealed that the Resident did remember the altercations and felt justified in his self preservation. The doctor further documented that the Resident seemed unconcerned that striking out at a demented person was morally wrong, and that the psychotherapeutic techniques used were attempts to alleviate the emotional disturbances, and attempts to reverse or change maladaptive patterns of behavior. The session lasted 23 minutes. There was no behavior management program ever instituted for this Resident. Interventions for the Resident were not defined nor measurable, and not Resident specific. The Psychiatric evaluation entered into the care plan on 8-3-23 was never obtained. FOCUS: Resident to resident (2-15-2024) Resident attempted to yell and point at another resident during bingo (3-20-24) Resident to Resident altercation (4-13-24) Resident to Resident altercation when a wandering female with dementia was in his room. (progress notes 6-18-24). INTERVENTIONS: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	One on one observation for 5 days 2-16-24. Resident will sit away from other residents during activities 3-20-24. Observe for triggers for physically abusive episodes and intervene at first sign of trigger(s) 4-15-24. No triggers were defined. Redirect resident and remove from area to provide calm 4-15-24. The behaviors follow a pattern of other residents entering his space or blocking his escape. There appears no evaluation of the Resident's behaviors with regard to his specific triggers, and fears. The Resident has known depression and a brain injury, and supervision of other residents with dementia entering his space and or his desire to protect himself, reveals a potential fear for his well being. Progress notes and the care plan document refusing care, refusing therapy, refusing weights being taken, non-compliance with staff, and refusing skin assessments, which is his right, and staff convenience is not a reason for a behavioral care plan. The care plan documents cursing at staff, however, since the Resident only speaks in a whisper or has to write it on a pad of paper, cursing at staff should not impact others around him. There was an addition to the careplan on Focus which stated that this cursing behavior is not his usual. The entire clinical record was reviewed and no documentation was found that a Registered Pharmacist (RPH) had completed the required monthly Medication Regimen Review (MRR) form for Resident #2, who was administered Psychotropic medications with a diagnosis of dementia. The Director of Nursing (DON) was interviewed by surveyors in the conference room and asked to provide the missing documents. The DON stated that she had some in a binder in her office which were not available to staff in her absence. She further stated that she was a new employee who started November of 2023. She went on to state that the MRR reviews had not yet been scanned into the Resident's electronic healthcare clinical record. The binder was reviewed and no MRR records for 2024 could be found for this Resident. No recommendations for gradual dose reductions for Psychotropic medications were made. Further no evaluations nor recommendations regarding a Resident with dementia being administered psychotropic medications were made, and no Laboratory blood tests were recommended by the RPH. On 8-28-24 at 4:00 PM during a meeting with the Administrator and DON they were informed of the failure to adequately care plan the Resident's documented behaviors, and the failure of medication oversight by a Registered Pharmacist for dementia with behaviors while taking psychotropic medications. On 8-29-24 at the time of exit they stated they had no further documents to provide. 40026 2. For Resident #21, the facility staff failed to review and revise the care plan to discontinue fall mats, including a splint and palm guard for right elbow and hand contractures. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #21 was admitted to the facility on [DATE] with diagnoses that included but were not limited to dysphagia after stroke, Diabetes Type II, dialysis-dependent end-stage renal disease, hypertension, congestive heart failure, lack of coordination, major depressive disorder, muscle weakness (generalized) hemiplegia and hemiparesis following stroke affecting the right dominant side, contracture of the right hand and contracture of the right elbow. Resident #21's most recent MDS (Minimum Data Set), dated 7/7/24, coded Resident #21 as having a BIMS (Brief Interview of Mental Status) score of 15/15, indicating no cognitive impairment. On 8/26/24, at approximately 7:00 p.m., Resident #21 was observed in bed with an elbow splint to the right elbow and palm guard to the right hand in place. There were no floor mats at the bedside. On 8/27/24, the resident was out to dialysis, and no floor mats were observed in his room. On 8/27/24, a review of the clinical record revealed the following: FOCUS: Falls- [Resident name redacted] is at risk for falls related to poor sense of safety awareness and possible sedation due to use of psychoactive medication. Date Initiated: 09/18/2019 GOAL: [Resident name redacted] risk for falls will be minimized through next review. Date Initiated: 09/18/2019 Revision on: 05/02/2024 Target Date: 07/24/2024 INTERVENTIONS: 3/1/2023- Bilateral floor Mats Date Initiated: 03/01/2023 Assess for pain. Date Initiated: 09/18/2019 Revision on: 09/18/2019 Call light and personal items available and in easy reach. Date Initiated: 09/18/2019 Revision on: 09/18/2019 Keep environment well-lit and free of clutter. Date Initiated: 09/18/2019 Revision on: 09/18/2019 Observe for side effects of Medications. Date Initiated: 09/18/2019 Revision on: 09/18/2019 On 8/27/24 at approximately 11:45 a.m., Other Staff #1 was interviewed. She was asked if she knew whether Resident # 21 had any adaptive equipment. She stated that they were using an elbow splint and palm guard to manage his contractures. When asked about floor mats, she stated that he was not a high fall risk; he could not turn himself, so they did not use them with him. She stated that she thought they used them in the past. On 8/27/24, at approximately 2 p.m., CNA #1 was interviewed. She was asked if Resident #21 used floor mats in his room, and she stated that he did not. On 8/28/24 at approximately 3:00 p.m., an interview was conducted with the DON, who was asked the purpose of the care plan, and she stated that it was to outline all the resident's care needs. When asked when it should be updated, she stated quarterly and with any changes in resident care. When asked if this included discontinuing interventions that were no longer used and updating to add new interventions, she stated that it should. When asked if this should consist of splints, palm guards, and fall mats, she said that it should. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24, during the end-of-day meeting, the Administrator was made aware of the findings, and no further information was provided.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on resident interview, staff interview, clinical record review, and review of facility documents, The facility staff failed to follow a physician's order to ensure two resident received physician ordered medications for two (2) of 35 residents (Resident #38, #21), in the survey sample. The findings included: 1. Resident #38 was originally admitted to the facility on [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Essential (Primary) Hypertension. The quarterly revised Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/13/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #38 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities and Goals) the resident was coded as being independent with eating, dependent with personal hygiene, showers/bathing, dressing, and toileting. In Section GG (Mobility) the resident was coded as requiring partial/moderate assistance with toilet transfers. The May 2024 Physician's Order Summary read: Senna S Oral Tablet 8.6-50 MG (Sennosides-Docusate Sodium) Give 2 tablet by mouth every 24 hours as needed for constipation. According to the Medication Administration Record (MAR) Resident #38 received her prescribed Docusate Sodium Capsule 100 MG one time a day for constipation every day at 9:00 AM. According to the August 2024 Medication Administration Record (MAR), no prn Senna was administered. On 08/27/24 at approximately 12:56 PM., during the initial tour Resident #38 said that she has not had a bowel movement in a week. Resident #38 also said that she's had issues with her bowel movements for [AGE] years. A review of Bowel Elimination Report showed that Resident #38 had a large Bowel Movement (BM) on 8/21/24 at 6:51 PM. According to the Bowel Elimination Report, Resident #38 had a medium BM on 8/27/24 at 2:59 PM. A review of the above Bowel elimination report show that Resident #38 had not had a BM in 6 days. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/28/24 at approximately 10:43 AM., an interview was conducted with Licensed Practical Nurse (LPN) #4 concerning Resident #38. LPN #4 said that there's usually a dashboard that will alert nursing if a resident hasn't had a Bowel Movement (BM) in 3 days but they did not receive an alert. LPN #4 also said that 3 days of having no BM is the facility cut off time. LPN #4 also mentioned the resident would be given an as needed (prn) medication or if there's no prn order, the physician should be notified. On 08/29/24 at approximately 10:00 AM., an interview was conducted with Certified Nursing Assistant (CNA) #4. CNA #4 said that the facility has a tracking system that will notify nursing if a resident hasn't had a BM in 3 days. CNA #4 also mentioned that she would have alerted the nurse if she was aware that a resident hadn't had a BM in 3 days. The above findings were shared during the Pre-exit, with the Administrator, The Director of Nursing (DON) and corporate staff on 8/29/24 at approximately 1:30 PM., The DON said they (nurses) should have been notified and checked the dashboard and called the physician for an as needed (prn) medication if not available. 40026 2. For Resident #21, the facility staff failed to give the ordered medication, gabapentin. On 8/27/24, a review of the clinical record revealed that Resident #21 had an order that read: Gabapentin Oral Capsule 100 MG - Give 100 mg by mouth one time a day for Neuropathy-Order Date-08/26/2024 On 8/29/24 at approximately 1 p.m., a review of the EMAR (Electronic Medication Administration Record) revealed that the gabapentin ordered on 8/26/24 was not given on 8/27, 8/28, and 8/29/24. The EMAR was coded as #7, which meant see nurse's notes. The nurse's notes reflected that the medication was unavailable on order from the pharmacy, causing the Resident to miss three doses. A review of the stat box contents revealed that gabapentin was available in the 100 mg capsule form in the stat box. On 8/29/24, an interview was conducted with the ADON, who stated that when nurses get an order, they are to check the stat box for availability if the medication is not in the Residents' drawer. When asked if gabapentin is available in the stat box but nurses write unavailable, what would that signify? She stated that it signified they did not check the stat box. On 8/29/24, during the end-of-day meeting, the Administrator was made aware of the findings, and no further information was provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on interview, clinical record review and facility documentation the facility staff failed to provide necessary services to maintain good grooming and personal hygiene for 1 Resident in a survey sample of 35 Residents. The findings included: For Resident #21 the facility staff failed to provide 2 showers per week for Resident who is unable to provide self-care. Resident #21 was admitted to the facility on [DATE] with diagnoses that included but were not limited to dysphagia after stroke, Diabetes Type II, dialysis-dependent end-stage renal disease, hypertension, congestive heart failure, lack of coordination, major depressive disorder, muscle weakness (generalized) hemiplegia and hemiparesis following stroke affecting the right dominant side, contracture of the right hand and contracture of the right elbow. Resident #21's most recent MDS (Minimum Data Set), dated 7/7/24, coded Resident #21 as having a BIMS (Brief Interview of Mental Status) score of 15/15, indicating no cognitive impairment. On the morning of 8/28/24, Resident #21 was observed in the room. He had finished his breakfast tray and was still in the room. Resident #21 had a strong body odor present. Resident #21 was asked about his showers he stated that he did not like getting showers late at night. When asked if he sometimes refuses showers, he said yes; if it's late and he is already in bed, he will refuse. When asked if he was offered showers at a different time, he said he was not. Reviewing the bathing schedule revealed that Resident #21's bath days were Mon. and Thurs on the 3-11 shift. A review of the POC (Point of Care) documentation in the electronic health record revealed that Resident #21's baths were coded as follows: 8/01/24 - 01, 1 (01 means Resident is dependent, and 1 means Shower given) at 9:08 pm 8/05/24 - NA at 11:46 p.m. 8/08/24 - 02, 03 (02 means max assist, 03 means bed bath) 5:52 p.m. 8/12/24 - NA at 11:59 p.m. 8/15/24 - 03, 03 (03 means partial or mod assist, and 03 means bed bath) at 4:42 p.m. 8/19/24 - NA at 11:44 p.m. 8/22/24 - 01, 1 (01 means Resident is dependent, and 1 means Shower given) at 7:23 p.m. 8/26/24 - NA at 10:59 p.m. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the afternoon of 8/27/24, an interview was conducted with LPN #1, who was asked how many showers residents receive each week. She stated that Residents are scheduled for two showers a week but can have more if requested. When asked if they could switch shower days and times, she said they could if requested. When asked what should happen when a Resident refuses a shower, she stated they should be offered another time or a bed bath. When asked what NA means in the POC documentation, she said she was unsure. When asked if there is a code for resident refusal in the POC documentation, she stated that RR is resident refused. On 8/29/24, during the end-of-day meeting, the Administrator was made aware of the findings, and no further information was provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31199 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed for two residents (Residents #2, and #49) to ensure pharmacy recommendations were obtained and acted upon, in the survey sample of 35 Residents. The findings included: 1. For Resident #2, the pharmacist recommendations were not obtained, nor acted upon, and not in the clinical record, in the preceding 8 months of 2024. Resident #2 was initially admitted to the facility on [DATE], and most recently readmitted on [DATE]. Diagnoses included; hypertension, seizure disorder, dementia, depression, pulmonary embolus, and traumatic brain injury with behaviors, stroke and convulsions/movement disorders/muscle weakness. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 7-17-24. He was coded with a Brief Interview of Mental Status score of 15 indicting no cognitive impairment. He required assistance with activities of daily living care. He was unable to walk and self propelled slowly in a manual wheel chair. The Resident was interviewed upon entrance to the facility and found to be non-verbal, with a communication deficit. He was pleasant, welcoming and smiling throughout the exchange. He used a writing pad successfully to communicate, although it was difficult for him to write and hold the pad as he he exhibited weakness in his upper extremities, and a tremor which resulted in involuntary shakiness and scribbled shaky writing, though mostly legible. Resident #2 had current physician's orders for the following: Seroquel 25 milligrams (mg) once per day at 9:00 PM Depakote 250 mg once per day at 9:00 PM Depakote 500 mg once per day at 9:00 PM Aricept 10 mg once per day at 9:00 PM The Resident's care plan was reviewed and revealed Focus statements and interventions as follows: FOCUS: Swung at another Resident after being hit by wheel chair (3-15-2019). Resident continues to have outbursts with other Residents (11-16-2019), (11-18-2019). (name) and his room mate had an angry episode over the doorway being blocked by a wheel chair. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another (female) Resident thought (Resident #2) was her husband and followed and yelled at him. He tried to get away from her. He did not hit her. He had an altercation with another resident over a woman. Resident to Resident verbal altercation (date unknown) (6-17-19?) per interventions in the careplan dates. INTERVENTION: Encourage Resident to not hit other residents, when another Resident is agitated with me remove me from the situation, offer something I like as a diversion 4-17-19. Resident will not talk with the other Resident, and will stay away from the woman in the incident 6-17-19. If I don't like what I'm doing let me choose something else, if I'm upset please redirect the conversation or task. New focuses were not care planned for 2020 through 2023, however interventions were added. Those follow below: Please avoid things that make me more anxious 8-16-22. One to one observation 2-27-23. Velcro stop sign across Residents door per his request 5-15-23. Medication review, psyche referral, and one to one observation 8-3-23. two to one staff observation 11-7-23. On 2-27-23 the psychiatric evaluation was completed by a physician and notes from the physician revealed that the Resident did remember the altercations and felt justified in his self preservation. The doctor further documented that the Resident seemed unconcerned that striking out at a demented person was morally wrong, and that the psychotherapeutic techniques used were attempts to alleviate the emotional disturbances, and attempts to reverse or change maladaptive patterns of behavior. The session lasted 23 minutes. There was no behavior management program ever instituted for this Resident. Interventions for the Resident were not defined nor measurable, and not Resident specific. The Psychiatric evaluation entered into the care plan on 8-3-23 was never obtained. FOCUS: Resident to resident (2-15-2024) Resident attempted to yell and point at another resident during bingo (3-20-24) Resident to Resident altercation (4-13-24) Resident to Resident altercation when a wandering female with dementia was in his room. (progress notes 6-18-24). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS: One on one observation for 5 days 2-16-24. Resident will sit away from other residents during activities 3-20-24. Observe for triggers for physically abusive episodes and intervene at first sign of trigger(s) 4-15-24. No triggers were defined. Redirect resident and remove from area to provide calm 4-15-24. The behaviors follow a pattern of other residents entering his space or blocking his escape. There appears no evaluation of the Resident's behaviors with regard to his specific triggers, and fears. The Resident has known depression and a brain injury, and supervision of other residents with dementia entering his space and or his desire to protect himself, reveals a potential fear for his well being. Progress notes and the care plan document refusing care, refusing therapy, refusing weights being taken, non-compliance with staff, and refusing skin assessments, which is his right, and staff convenience is not a reason for a behavioral care plan. The care plan documents cursing at staff, however, since the Resident only speaks in a whisper or has to write it on a pad of paper, cursing at staff should not impact others around him. There was an addition to the careplan on Focus which stated that this cursing behavior is not his usual. The entire clinical record was reviewed and no documentation was found that a Registered Pharmacist (RPH) had completed the required monthly Medication Regimen Review (MRR) form for Resident #2 who was receiving psychotropic medications. The Director of Nursing (DON) was interviewed by surveyors in the conference room and asked to provide the missing documents. The DON stated that she had some in a binder in her office which were not available to staff in her absence. She further stated that she was a new employee who started November of 2023. She went on to state that the MRR reviews had not yet been scanned into the Resident's electronic healthcare clinical record. The binder was reviewed and no MRR records for 2024 could be found for this Resident. No recommendations for gradual dose reductions for Psychotropic medications were made. Further no evaluations nor recommendations regarding a Resident with dementia being administered psychotropic medications were made, and no Laboratory blood tests were recommended. The facility policy was reviewed and stated in the document that the MRR's would be completed at least monthly and placed in the Resident's clinical chart. They would be available in an easily retrievable format to nurses, physician's, and the care planning team within 48 hours of MRR completion for review. The recommendations and findings will be documented and acted upon by the nursing care center and/or physician. On 8-28-24 at 4:00 PM during a meeting with the Administrator and DON they were informed of the missing MRR documents. On 8-29-24 at the time of exit they stated they had no further documents to provide. 40026 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 8/27/24 during clinical record review it was discovered that Resident #49 had no record of pharmacy medication regimen review since 4/2023 available in the electronic health record. On 8/27/24 at approximately 4 p.m. the DON was asked about the pharmacy review and recommendations, and she stated they are in a book in my office. The DON then produced the book that contained the pharmacy review and recommendations for 2024. The DON was asked if she was aware of any irregularities noted by the pharmacist during their review and if so, could she show documentation of it being acted on by facility physician. The DON opened the book pulled a pharmacy recommendation out for Resident #49 and showed where it had been signed off by the physician and showed where the order had been changed in the EMAR (Electronic Medication Administration Record) however the document was kept in the book not scanned into the electronic health record. On 8/28/24 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on the interviews, clinical record review, and facility documentation, the facility staff failed to ensure they were free from unnecessary psychotropic medications for 1 Resident (#49) in a survey sample of 35 Residents. The findings included: For Resident # 49, the facility staff failed to ensure that the PRN (as needed) anti-anxiety drug Lorazepam was no more than 14 days duration without proper documentation. Resident # was admitted to the facility on [DATE] with diagnoses that included but were not limited to dementia, without behavioral disturbance, psychotic disturbance and anxiety, acute kidney failure, generalized anxiety disorder, unspecified dementia with severe agitation, Alzheimer's disease with late onset, prediabetes and history of falls. On 8/26/24, a review of the clinical record revealed that on 5/3/24, Resident # 49 received an order for Lorazepam (Ativan) 0.5 mg PO tabs, to be taken one tablet every 6 hours as needed for anxiety. There was no stop date for this order. A review of the MAR (Medication Administration Record) revealed the medication was utilized on 5/12, 6/5, and 6/12/24, and the order was current as of 8/27/24. On 8/27/24, during the end-of-day meeting, the DON was asked if she was aware of any regulations regarding PRN psychotropic medications. She stated that there were, and psychotropic drugs are limited to 14 days unless the physician provides proper documentation as to the specific diagnosis and duration of treatment. The DON was unable to provide the supporting documentation. On 8/27/24, during the end-of-day meeting, the Administrator was made aware of the concerns, but no further information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40711 Based on inspection of medications on one medication cart and the facility's Stat box, facility staff failed to ensure medications for resident administraton were not expired. The findings included: 1. A medication cart audit was conducted on 8/29/24 at approximately 11:57 AM., with Licensed Practical Nurse (LPN) #5. Stored inside the medication cart was 1 opened Humalog insulin pen with no open date, 1 opened Lantus insulin pen with no open date and 1 opened vial of mixed Humalog insulin with no resident name/identification. LPN #5 said that the dates should be written on the insulin pens because they expire in 28 days and that a name should be written on the vial. The above findings were shared during the Pre-exit with the Administrator, the Director of Nursing (DON) and corporate staff on 8/29/24 at approximately 1:30 PM. The DON said that drugs and biologicals should be labeled with a date and resident name. 40026 2. For the facility, the facility staff failed to ensure that all medications available for use in the Stat box were not expired. On 8/27/24, a review of the stat box contents revealed that the facility had five (5) tablets of Lorazepam 0.5 mg (milligrams) on-site and available for use that expired on 4/2024. On 8/27/24, an interview was conducted with LPN #2, who stated that the pharmacy changed the stat box regularly. When asked if the pharmacy is responsible for keeping up with expired medications, she noted that the pharmacy usually knows when they have sent the stat box out and when it should be changed, but it is up to the nurses to check it. When asked when this was usually done, she said it was on the night shift. When asked to look at the Lorazepam expiration date, she said it expired four (4) months ago. On 8/28/24 at approximately p.m., an interview was conducted with the DON, who was asked who should be checking for three (3) expired medications, and she stated it is the responsibility of all the nurses who pass medications to check for expiration dates when passing meds or counting meds. She noted the pharmacy regularly changes out the box, but this does not negate the nurses' duty to check for expired medications and report to the pharmacy any medications needing replacement. On 8/28/24, during the end-of-day meeting, the Administrator was made aware of the findings, and no further information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31199 Based on observation and staff interview the facility staff failed to maintain a clean and sanitary food preparation area in accordance with professional standards for food service safety. The findings included; On 8-26-24 at approximately 6:40 PM, the kitchen area of the facility was inspected with the dining services manager. A metal drawer was observed under a long counter where food prep was conducted on the back wall of the kitchen. The drawer did not close under the counter, and was rusty, off of the track, and littered with food debris which could not be removed by simply wiping, as the debris was adhered with a sticky greasy substance. The inspection observations continued in the walk in freezer, dry storage room, and refrigerator. The dry storage food room contained canned goods, pasta, boxed goods, bagged cereals, and pantry storage of shelf stable items. Three large rolling bins of flour, sugar, and rice were observed open, which were dirty with a dried film on them and presumably a white food debris substance in the crevices of the sliding tops. The floor had food debris and a black sticky substances around the base boards and in the corners of the room. Mouse droppings (excrement) were on the floor of the room close to a mouse trap with a dead mouse in it. Behind the main door into the room was a Sticky trap which captures everything crawling across it, and the insect or animal would be trapped in the glue covered top to die as they are unable to escape. The sticky trap was covered in insect and spider carcasses, some of which were dried and dessicated, indicating the trap had been in place for a substantial amount of time. A black mildew substance was found covering the backside of a closet door in the dry storage room, and empty cardboard boxes, a broken shelf, and more food debris on the floor was found within the closet. The Dining Services Manager stated that they would begin to clean the kitchen immediately, and that she had forgotten to ask anyone to take care of the mouse trap, and stated Yes there was a problem with mice I will admit, and so the maintenance director was unaware of the situation. On 8-27-24 the Regional manager and Dining Services Manager were made aware of the issues, and had no further information to provide. On 8-29-24 prior to exit, the same sticky trap full of insects remained as unchanged in it's location behind the door of the dry food storage room, the mouse droppings were gone, however, either the same mouse trap, or an identical one was in the same location also. No further information was provided.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 31199 Based on observation and interview, the facility staff failed to implement an effective pest control program affecting dining services and as a result the facility as a whole. The findings included: For the Residents of the facility the facility staff failed to ensure the facility was free of pests to include mice. On 8-26-24 at approximately 6:40 PM, the kitchen area of the facility was inspected with the dining services manager. The inspection observations continued in the dry storage room of the kitchen which contained canned goods, pasta, boxed goods, bagged cereals, and general pantry storage of shelf stable items. Three large rolling bins of flour, sugar, and rice were observed open, which were dirty with a dried film on them and presumably a white food debris substance in the crevices of the sliding tops. The floor had food debris and a black sticky substances around the base boards and in the corners of the room. Mouse droppings (excrement) were on the floor of the room close to a mouse trap with a dead mouse in it. Behind the main door into the room was a Sticky trap which captures everything crawling across it, and the insect or animal would be trapped in the glue covered top to die as they are unable to escape. The sticky trap was covered in insect and spider carcasses, some of which were dried and dessicated, indicating the trap had been in place for a substantial amount of time. A black mildew substance was found covering the backside of a closet door in the dry storage room, and empty cardboard boxes, a broken shelf, and more food debris on the floor was found within the closet. The Dining Services Manager stated that they would begin to clean the kitchen immediately, and that she had forgotten to ask anyone to take care of the mouse trap, and stated Yes there was a problem with mice I will admit, and so the maintenance director was unaware of the situation. On 8-27-24 the Regional manager and Dining Services Manager were made aware of the issues, and had no further information to provide. On 8-29-24 prior to exit, the same sticky trap full of insects remained as unchanged in it's location behind the door of the dry food storage room, the mouse droppings were gone, however, either the same mouse trap, or an identical one was in the same location also. No further information was provided.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 34306 Based on staff interviews and review of facility documents, the facility staff failed to ensure that twelve hours of in-service education/training within twelve months was completed by five of five sampled Certified Nurse Aides (CNA) #7, 6, 3, 8 and 9. The findings included: A review of the five CNA training transcripts and education records revealed that they had not completed the mandatory 12- hours of in-service education/training including dementia management and resident abuse prevention training. An interview was conducted with CNA #7 on 8/28/24 at 10:05 AM. CNA #7 stated she did not recall if she had completed twelve hours of in-service training to include working with residents with dementia and resident abuse prevention training. An interview was also conducted with CNA #3 on 8/28/24 at 10:17 AM. CNA #3 stated she could not remember if she had received twelve hours of training within the last year. On 8/28/24 at 11:24 AM, an interview was conducted with the Director of Nursing (DON) regarding CNAs mandatory training. The DON stated that training and education were areas they had not focused a lot of attention on, but there was an ongoing plan for all CNAs to become compliant with mandatory training. On 8/29/24 at approximately 2:00 PM, a final interview was conducted with the Administrator, DON and two Corporate Consultants. They had no comments and voiced no concerns regarding the above findings.