STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495328	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrington Place of Tappahannock	1150 Marsh Street Tappahannock, VA 22560

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents receive services in the facility with reasonable accommodation of resident needs for 1 Resident (Resident #9) in a survey sample of 33 Residents. The findings included: For Resident # 9 the facility staff failed to ensure the Resident had a bed that was suitable for his size and weight, comfortable and allowed him enough space to turn safely. On 7/9/24 at approximately 1:00 PM Resident was observed in a regular hospital bed. Resident #9 was interviewed and stated that his bed was uncomfortable. When asked to elaborate he stated I can feel the bed frame digging into my hips in this bed and it is hard to turn over there isn't much room. When asked if he had told the staff he was uncomfortable he stated that he had. When asked what their response was, he stated that they don't have any different beds. When asked if he would like a bariatric bed and mattress, he stated that he would. On 7/9/24 a review of the clinical record revealed that Resident #9 weighed 450 lbs. and had a bariatric wheelchair, a bariatric raised commode seat but was put in a regular sized bed with a regular mattress. On 7/9/24 at 3:00 PM an interview was conducted with the Administrator who stated that if a resident requires bariatric equipment such as wheelchair and walker that is ordered through therapy. When asked about beds she stated that would have to come through the Administrator. The Administrator was asked for the manufacturer instructions for the bed and mattress. On 7/10/24 the corporate Nurse was asked to accompany surveyor to Resident #9's room and assess if the Resident was in an appropriate bed. The corporate nurse stated that he has room on either side he is not touching the rails when he is in the bed. The corporate nurse was asked if a resident qualifies for a bariatric wheelchair and commode seat would he not also qualify for the bed as well? She stated that he could probably use a bariatric bed. On 7/12/24 a review of the email from the manufacturer of the bed revealed that the max weight on that particular model is 450 lbs. and the max weight for the mattress he had was 350 lbs. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/12/24 an interview was conducted with the Resident who stated he has not gotten any pressure areas or sores from the bed or mattress however he is uncomfortable in the bed. A review of the weekly skin assessments revealed no pressure areas or injury on Resident #9. On 7/12/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to act promptly upon the grievances arising from Resident Council. The findings included: Resident council continues to have complaints of the same nature with no improvement month after month, the facility has not effectively addressed the concerns of the Residents regarding menus, timeliness of CNA rounding, cleanliness of the building and issues with patio and temperatures in the building. A review of the Resident Council minutes revealed the following: December 2023- Residents complained there was not enough housekeeping staff on weekends. January 2024 - Housekeeping - Dining room is dirty / filthy. February 2024 - meeting was rescheduled for March due to Covid outbreak. March 7, 2024 - Fixing up the patio putting the umbrellas back so they can enjoy the weather. March 20, 2024 (rescheduled from February) - Collective agreement about the dining room being unclean - as well as resident bathrooms. Fixing up the patio umbrellas for shade. April 2024 - Residents stated they would like someone to help the shower aid with showers. Deep cleanings are not being done like they should. Residents are getting tired of the same meals over and over again. May 2024 - No CNA rounding at night, Residents would like their wheelchairs cleaned and inspected. Food is horrible same repeated menus. June 2024 - Still having issues with cleanliness of resident bathrooms. Resident council expressed issue with repeated menus same meals, Dietary Mgr. explained the process of winter menus and summer menus. Residents complained there are no snacks available at night. CNA's should be making rounds every 2 hours. July 2024 - Air conditioning in the dining room. Administrator talked about process pertaining to fixing the issue. Dietary Mgr. is working on changing the menus changes to the meals adding fresh fruit and vegetables. Residents would like the patio tables and umbrellas back. CNA rounding is not happening on 3-11 shift. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the afternoon of 7/12/24 an interview was conducted with the Activities Director who stated that each department is given the feedback from Resident Council to address within their department. When asked if she saw the same issues keep arising month after month, she stated that she did see a pattern. On 7/12/24 during the end of day meeting the Administrator was made aware of the concerns and no further information as provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40026 Based on observation, interview, clinical record review and facility documentation, the facility staff failed to ensure a Residents right to a safe clean, comfortable homelike environment for Residents in a survey sample of 33 Residents. The findings included: The facility staff has failed to ensure the facility was in good repair, temperatures were comfortable, and failed to ensure the cleanliness of the dining room, and resident bathrooms. On 7/9/24 at approximately 12:30 PM the following observations were made in the dining room: The large table near the windows had puzzles, books, a plastic tub of markers and pens in the center while Residents were eating their meal. The dining room has shelves for activity supplies however they were not put on the shelves in preparation for noon meal. The dining room was warm there was one fan blowing in the front of the dining room and a portable a/c unit vented to the outside at the rear of the dining room however the temperature was still too warm for comfort. There was no thermostat / thermometer in the dining room. Staff did not have access to maintenance equipment to check the temps in the dining room at that time. ** Please note the Resident Rooms have individual PTAC wall units. Residents can stay cool if they remain in their rooms. The air conditioning that is broken is the main central air for the facility. This central air unit affects the halls, common areas, kitchen, laundry, lobby, and the second floor where the physical therapy gym is located. The Residents cannot access the second floor at this time due to the elevator also being out of service. *** The following observations were made in Resident Rooms: 7/9/24 at 11:35 Resident #9 complained that his bathroom light was not working, and he has to leave his door open to be able to see. Resident #9's bathroom smelled strongly of urine. Surveyor stepped into [NAME] and [NAME] style bathroom (that is a bathroom located between 2 resident rooms where occupants of both rooms share a bathroom.) When the door was closed the only light visible was the light shining in the crack at the bottom of the door. Resident #9 stated that if he closes the door, he cannot see but if he leaves it open anyone can see him. On 7/9/24 at approximately 11:45 Resident #3 was observed in bed dressed in hospital gown sheet covering body. Interview was conducted and Resident #3 was conducted and he stated he was hot and sweaty. There was a white sheet of notebook paper taped to the PTAC (Packaged Thermal Air Conditioner) unit that read, Do Not Turn On A/C Leaks. There were several dirty towels and a bath blanket shoved under the unit stained with yellowish stains and obviously wet. When asked how long the air conditioner had been broken Resident #3 stated that the Maintenance Man said he would fix it a week ago. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**Please note Maintenance Director (who is the only maintenance person employed by the facility) has been gone since 6/28/24 quit without notice and has not been replaced as of the end of survey (7/15/24). ** On 7/10/24 at 9:45 AM Resident #3 was observed in his bed dressed in a hospital gown and covered with a sheet. Resident #3 expressed being hot and sweaty. On the morning of 7/11/24 the Administrator was asked about the repairs to the air conditioning unit in Resident #3's room and she stated that she was not aware of a problem with the air conditioning unit in his room. Administrator walked to the room with the surveyor and observed the sign on the unit and the felt how warm it was in the room. The Administrator stated that she would handle it immediately and stated that had she been aware of the issue she would have handled it sooner. When asked who put the signage up about the air conditioner being broken she stated that she did not know. When asked about the process for handling maintenance issues she stated that the nurses fill out a slip and put it in the box for maintenance director to handle. When asked who is doing maintenance now, she stated that the Maintenance Director was the only maintenance staff and he left on 6/28/24 without notice. She stated that she was conducting interviews this week to fill the position, however, currently there was no interim person filling in. On the afternoon of 7/10/24 during the Group Interview, Resident # 16 complained about the sink in his room being stopped up. On 7/10/2024 at 4:15 p.m., when the cold water was turned on, there was noted delay in the water draining from the sink. There was a slow drain time. When interviewed, Resident # 16 stated the sink had been stopped up for a while. Resident # 16 stated staff members were informed of the clogged sink previously. During the end of day debriefing on 7/10/2024, the administrator was informed of the issue with the sink in Resident # 16's room. The Administrator stated she was unaware of the sink being clogged. Resident # 16 also reported that there was a screw missing in the footboard of his bed and it was wobbly. The Administrator and Director of Nursing were informed of the complaint during the end of day debriefing. The Director of Nursing stated she would check into it. On 7/15/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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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 - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents received the necessary services to maintain good grooming, and personal hygiene for 4 Resident (#'s 3, 9, 56 & 44) in a survey sample of 33 Residents. The findings included: 1. For Resident #3 the facility staff failed to cut nails and wash Resident's hair. On 7/9/24 at approximately 11:45 Resident #3 was observed in bed dressed in hospital gown sheet covering body. Resident #3 has a dx of a traumatic brain injury and has a BIMS (Brief Interview of Mental Status) score of 7/15 indicating severe cognitive impairment. Resident #3 appeared unkempt hair uncombed and greasy looking, nails were not cut about 1/4 inch over tip of fingers and had debris visible under the nail. Interview with Resident #3 was conducted, and he stated he was hot and sweaty. When asked if he had a shower recently, he stated he does not like showers. When asked how he bathes he stated, They wash me up in bed. When asked about his hair being washed and nails being cut, he stated It's been a while since they did that. A review of the clinical record revealed hair and nail care done on 6/1/24 by DON. On 7/10/24 at 9:45 AM Resident #3 was observed in his bed dressed in a hospital gown and covered with a sheet. Resident #3 expressed being sweaty. Resident appeared unkempt hair was greasy, and nails had not yet been cut. Resident had noticeable body odor. When asked if he had been washed up this morning he stated not yet. On the afternoon of 7/10/24 during the group interview it was stated that there was no shower aide to give showers while Employee B (the shower aid) was on vacation. 14/14 Residents representing both units agreed on this statement. The group agreed that CNA G was the only one who gave showers, and she gave them only to residents on her assignment list. They stated the facility did not assign anyone to take over the shower aide assignments, therefore no showers were done by other staff. The group also stated that showers are given only during the time the shower aide is on duty 7-3 this meant Residents could not get showers in the evening or night. A review of the assignment sheets for the week of 7-1-24 through 7-7-24 revealed that there was no one assigned to give showers, and there was no indication that all CNA's must do their own showers for the week CNA B was off. On 7/15/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 2. For Resident #9 the facility staff failed to ensure showers were given twice a week as scheduled. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/29 at approximately 10:00 a.m. an interview was conducted with Resident #9 who was asked about receiving showers and or baths during the week of 6/30/24 - 7/6/24. Resident #9 stated that he did not receive a shower because that was the week the shower aide was on vacation. Resident #9 stated he washed as best he could at the sink. On 7/11/24 a review of the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/26/24 revealed that Resident #9 required a Maximum Assistance of 2-person physical assistance for showers. On the afternoon of 7/12/24 an interview was conducted with the DON and Administrator. The DON was asked if they had a CNA that was assigned to give showers, and she stated that there was, and she named CNA B. When asked who was assigned to take her place when she went on vacation? She stated that the CNA's can-do showers. When told what the resident council attendees stated about no one getting showers except those on Employee G's assignment, she stated that the CNA's can do it when the shower aide is not here. A review of the assignment sheets for the week of 7-1-24 through 7-7-24 revealed that there was no one assigned to do showers, and there was no indication that all CNA's must do their own showers for the week CNA B was off. On 7/15/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. 3. For Resident #56 the facility staff failed to ensure bathing and nail care was provided while the shower aide was on vacation. On 7/11/24 during the group meeting Resident #56 stated that he did not get his nails cut and showed the surveyor that his nails were indeed at least 1/4 inch over the tips of his fingers. Resident #40 told Resident #56 the CNA's should do your nails on your shower day. Resident #56 stated, I didn't get a shower last week because the shower aid was on vacation. The group agreed that this was an issue. The 14 attendees all agreed that only 1 CNA gave showers last week while the shower aid was on vacation. That CNA only gave showers to the residents on her assignment. When asked if the CNA's assigned to them offered them showers they agreed collectively that they were not offered showers and when they were asked, they were told the shower aid is on vacation. On the afternoon of 7/12/24 an interview was conducted with the DON and Administrator. The DON was asked if they had a CNA that was assigned to give showers, and she stated that there was, and she named CNA B. When asked who was assigned to take her place when she went on vacation? She stated that the CNA's can-do showers. When told what the resident council attendees stated about no one getting showers except those on Employee G's assignment, she stated that the CNA's can do it when the shower aide is not here. A review of the assignment sheets for the week of 7-1-24 through 7-7-24 revealed that there was no one assigned to do showers, and there was no indication that all CNA's must do their own showers for the week CNA B was off. On 7/15/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. For Resident #44 the facility staff failed to ensure twice weekly showers while shower aide was on vacation. During the group meeting Resident #44 stated that she had not had a shower last week and stated that she usually gets her hair washed as well and that did not happen because the shower aide was on vacation. On the afternoon of 7/12/24 an interview was conducted with the DON and Administrator. The DON was asked if they had a CNA that was assigned to give showers, and she stated that there was, and she named CNA B. When asked who was assigned to take her place when she went on vacation? She stated that the CNA's can-do showers. When told what the resident council attendees stated about no one getting showers except those on Employee G's assignment, she stated that the CNA's can do it when the shower aide is not here. A review of the assignment sheets for the week of 7-1-24 through 7-7-24 revealed that there was no one assigned to do showers, and there was no indication that all CNA's must do their own showers for the week CNA B was off. On 7/15/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 40026 Based on observation, interview, clinical record review and facility documentation the facility staff failed to provide an ongoing program to support residents in their choice of activities for 4 Residents (#'s 9, 16, 34, & 36) in a survey sample of 33 Residents. The findings included: For Resident #9 the facility staff failed to conduct an activity assessment to ensure Residents were receiving services from the activities dept that met their interest and personal preferences. Resident #9's most recent Activity Assessment was on 7/14/2023 it read as follows: Reason for Assessment: Initial assessment Orientation: Comments - No change in resident's level of participation since last assessment. Please see 06/26/2023. Progress Summary Note: Quarterly late entry for ARD 07/14/2023: No change in resident's level assessment. Please see assessment dated for ARD 06/26/2023. Proceed with POC. Will monitor. [Former Activities Director name redacted] Resident # 16 did not have an activity assessment. Resident # 34's Activity Assessment read as follows. Reason for Assessment: Initial assessment Orientation: Comments - Resident alert and oriented to person, disoriented to all other spheres. Please see last assessment dated for ARD 05/17/2023. Progress Summary Note: Quarterly for ARD 06/13/2023: No change in resident's level of participation since last assessment. Please see last assessment dated for ARD 05/17/2023. Proceed with POC. Will monitor and follow up on next review. [Former Activities Director name redacted]. Resident # 36 had an initial assessment on 2/15.2024, however, there was no quarterly assessment in the record. On the afternoon of 7/15/24 an interview was conducted with the DON and the Administrator, and they stated if the assessment was not in the electronic medical records, then there was none. When asked when the Assessments should be done and she stated that they should be done on admission, quarterly and yearly. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/15/24 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 40026 Based on staff interviews, clinical record reviews, and review of facility documents, the facility staff failed to ensure the activities program was directed by a qualified professional who could direct the provision of activities to the residents which resulted in substandard quality of care. The findings included: During the recertification survey conducted 7/9/2024 through 7/11/2024 and an extended survey conducted through 7/15/2024, residents were identified who could benefit from meaningful and individualized activity programs. For the Activities Director, the facility has hired an activities director who does not meet the qualifications set forth in the regulations. On 7/9/24 at approximately 2:00 PM an interview was conducted with Employee E the Activities Director who stated that she had been in that role since September 2023. When asked about her credentials she stated that she did not have any certification or attend a program or training course. She indicated that she would be willing to attend any training necessary to ensure her job security and further her career as she enjoyed the job and enjoys working with the Residents. On the morning of 7/12/24 an interview was conducted with the Administrator who acknowledged that the Employee E did not yet have the qualifications for the position of activities director. On 7/15/24 during the end of day meeting the Administrator was made aware that the Activities Director did not have the mandatory requirements for training to serve in that role. No further information was provided.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40026 Based on interview, clinical record review and facility documentation, the facility staff failed to ensure sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being, for 14 out of 14 Residents that attended the group meeting. The findings included: For Residents attending the group meeting, the facility staff failed to assign a shower aid during the time that CNA B (the shower aid) was on vacation, resulting in no showers being given to 14 out of 14 Residents attending the group meeting. On the afternoon of 7/10/24 during the group interview it was stated that there was no shower aid to give showers while Employee B (the shower aid) was on vacation. Fourteen out of 14 Residents representing both units agreed on this statement. The group agreed that CNA (Certified Nursing Assistant) G was the only one who gave showers, and she gave them only to residents on her assignment list. They stated the facility did not assign anyone to take over the shower aid assignments, therefore no showers were done by other staff. The group also stated that showers are given only during the time the shower aid is on duty 7-3 this meant Residents could not get showers in the evening or night shift. On the afternoon of 7/12/24 an interview was conducted with the DON and Administrator. The DON was asked if they had a CNA that was assigned to give showers, and she stated that there was, and she named CNA B. When asked who was assigned to take her place when she went on vacation. She stated that the CNA's can-do showers. When to what the resident council stated about no one getting showers except those on Employee G's assignment, she stated that the CNA's can do it when she is not here. A review of the assignment sheets for the week of 7-1-24 through 7-7-24 revealed that there was no one assigned to do showers, and there was no indication that all CNA's must do their own showers for the week CNA B was off. On 7/15/24 during the end of day meeting the Administrator was made aware of the concerns 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. 40026 Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents who use psychotropics receive gradual dose reduction and are free from unnecessary psychotropic medications for 1 Resident #9 in a survey sample of 33 Residents. The findings included: For Resident #9 the facility staff failed to act on a recommendation from the pharmacy to reduce one or both of the Resident's psychotropic medications. On 7/11/24 a clinical record review was conducted on Resident #9's electronic health record. The record showed that on a pharmacy recommendation dated over a year ago (5/29/23), had not been addressed until 7/18/23 and then was not acted on. The pharmacy recommendation read as follows: The resident receives the following medications that may significantly prolong QT interval and increase risk for arrhythmias and or torsade's (TdP): Citalopram 30 mg QHS and doxepin 50 mg Q PM. Rationale: QT intervals in apparently normal older individuals when combined with expected QT interval changes induced by medications is associated with significantly prolonged QT intervals. Women, older adults, those with heart failure or preexisting arrhythmias may be at increased risk. Please consider decreasing one or both of the above agents and / or consider changing to alternatives. The physician signed and checked the box that said Agree and wrote Resident is male on the form. Resident #9 has diagnoses that include but are not limited to morbid obesity, sleep apnea, type II diabetes, hypertension, high cholesterol, kidney failure and atrial fibrillation (an arrhythmia). A review of the clinical record revealed that Resident #9's dosages had not been decreased nor had medications been changed, in fact the Resident's dose of Citalopram was increased to 40 mg. per day and the Doxepin was still 50 mg. A review of the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/23/24 revealed that the facility had not attempted a GDR (Gradual Dose Reduction) since admission on 12/20/22. On the morning of 7/15/24 an interview was conducted with the DON (Director of Nursing) who was asked about the expectation for GDR's. The DON was able to verbalize understanding that Federal regulations require that a GDR of a psychotropic medication is attempted twice in the first year of admission or initiation of the medication, then annually, however she stated that she did not know why the GDR was not attempted, A review of the clinical record did not reveal any notes that said GDR is contraindicated in this Resident. The DON stated that she the doctor that signed the pharmacy recommendation is no longer working at this facility but that she would bring this to the attention of the Nurse Practitioner in house. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/24 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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. 34894 Based on staff interview and facility documentation review, the facility staff failed to maintain an effective Quality Assurance and Performance Improvement (QAPI) program, having the potential to affect all 58 residents residing in the facility. The findings included: 1. The facility staff failed to maintain an effective QAPI program regarding the residents receiving showers at least twice per week. On 07/09/2024 during the initial tour, the survey team interviewed alert and oriented residents who stated they had did not receive baths or showers when the assigned Shower Aide was not on duty. During the Group Interview/Resident Council Meeting conducted on 07/10/2024, there were fourteen alert and oriented residents in attendance. The residents stated they only received showers when the Shower Aide (Certified Nursing Assistant -B) was on duty. But when she was off, they did not get showers. The residents stated one other Certified Nursing Assistant (Certified Nursing Assistant-G) did give showers to those residents on her assignment during the previous week when the Shower Aide was off. They stated the other staff members did not give showers to the residents on their assignments. Review of the facility's grievances revealed concerns expressed by Residents of showers not being provided. Review of the Resident Council minutes for 6 months (January 2024- June 2024) revealed complaints about showers not being provided. Review of the QAPI information revealed documentation of the concern being addressed in May 2024. Review of the Inservice Education Records revealed documentation of education being provided on January 5, 2024 about showers being provided as scheduled and the right of refusal. The facility staff failed to ensure showers were provided to the residents while the Shower Aide was off for a week. On 7/11/2024 at 1:20 p.m., an interview was conducted with the Director of Nursing who stated the facility did use a Shower Aide who worked 5 days a week and on the Day Shift. When asked if Residents could receive showers on the evening shifts, night shifts or weekends, the Director of Nursing stated other Certified Nursing Assistants could provide showers. She stated the showers were usually done by the Shower Aide who worked on day shift Monday through Friday. Review of the QAPI notes and in-services from January 5, 2024, May 5, 2024 and May 8, 2024 revealed documentation that facility staff members were educated on the importance of and expectation of showers to be provided to residents even when the Shower Aide was off or not available. Review of clinical records of residents in the survey sample revealed showers were not provided two times per week as scheduled. During the week that the Shower Aide was off on leave, there were no showers provided to most of the residents. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/12/2024 at 11:10 a.m., the Administrator was informed that the interview for QAPI would be conducted on Monday, 07/15/2024. Review of the Survey Ready Binder revealed a sheet of paper that stated QAPI Plan: Please see QAPI plan. On 07/15/2024 at 1:58 p.m., an interview was conducted with the facility Administrator. The QAPI program/plan was reviewed during the interview. The Administrator stated the purpose of the QAPI program was to identify anything from the previous month and implement system changes to bring the facility into compliance. She stated the QAPI Committee met monthly to identify issues and address them. The Administrator stated they were expected to monitor ongoing compliance. The Administrator stated she did not have the policies and procedures for QAPI. The Administrator stated the facility staff members should ensure residents receive showers when the Shower Aide was off and on whatever shift they desired. The Administrator stated clearly it's broken. We need to readdress this. We need to make sure someone is scheduled to provide showers. The facility's policy on QAPI was not presented to the survey team prior to the end of survey During the end of day debriefing on 07/15/2024, the Administrator, Director of Nursing and Corporate Nurse Consultant were informed of the findings that the facility staff failed to maintain an effective QAPI program regarding provision of showers to residents at least twice per week. It was noted the facility did not ensure a staff member was assigned to provide showers when the Shower Aide was off on leave. Also, Residents were not offered the option of showers on the other shifts or the weekends. They stated the facility should make sure all residents receive at least two showers per week and document any refusals. No further information was provided.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 34894 Based on Observation, staff interview, Resident interview, clinical record review, and facility documentation review, the facility staff failed to measure the success, and track, performance in their Quality Assurance and Process Improvement (QAPI) program for the provision of showers to residents. The findings included; The facility failed to implement their plan to ensure all residents received a shower as scheduled when the Shower Aide was out on leave. As part of the facility's plan to correct the problem regarding showers, the QAPI committee was tasked with monitoring, measuring, tracking data, and sustaining compliance performance. The facility staff failed to implement measures to ensure Residents received showers as evidenced by their failure to assign the task of Showers/bathing when the Shower Aide was off on leave during July 1- July 7, 2024. Surveyor D documented the following observations: On 7/10/24 at 9:45 AM Resident #3 was observed in his bed dressed in a hospital gown and covered with a sheet. Resident #3 expressed being sweaty. Resident appeared unkempt hair was greasy, and nails had not yet been cut. Resident had noticeable body odor. When asked if he had been washed up this morning he stated not yet. On the afternoon of 7/10/24 during the group interview it was stated that there was no shower aide to give showers while Employee B (the shower aid) was on vacation. Fourteen out of 14 Residents representing both units agreed on this statement. The group agreed that CNA G was the only one who gave showers, and she gave them only to residents on her assignment list. They stated the facility did not assign anyone to take over the shower aide assignments, therefore no showers were done by other staff. The group also stated that showers are given only during the time the shower aide is on duty 7-3 this meant Residents could not get showers in the evening or night. A review of the assignment sheets for the week of 7-1-24 through 7-7-24 revealed that there was no one assigned to give showers, and there was no indication that all CNA's must do their own showers for the week CNA B was off. During the end of day debriefing on 7/15/2024, the Administrator was made aware of the concerns. The Administrator stated residents should be able to receive showers when scheduled. No further information was provided

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 34894 Based on staff interview and facility documentation review, the facility staff failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections with the potential to affect all residents in the facility. The Findings included: The facility staff failed to develop and implement a Legionnaire's water policy or program or Quality Assurance and Process Improvement (QAPI) program . During the entrance conference, the facility's Administrator stated the previous Maintenance Director had quit on 6/28/2024 and had not been replaced at the time of the survey on 7/9/2024. Surveyor C informed the Administrator that she would review the Legionnaires program with the person in charge of the program. The Administrator stated the Maintenance Director was in charge of the testing for Legionnaires. Review of the facility's documentation revealed no records of testing the water for Legionella. There was no documentation of the Facility's Legionnaires policy. Review of the QAPI records revealed no documentation of the issue of testing the water for Legionella . On 7/11/2024, Surveyor C conducted an interview with the Administrator who stated the facility had not established an effective program for the detection of Legionella. She also stated the issue had not been discussed in the QAPI meetings. During the end of day debriefing, the Administrator, Director of Nursing and Corporate Nurse Consultant were informed of the findings. No further information was provided.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **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 provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public The findings included: For the residents, staff and the public the facility staff failed to maintain a working elevator, working air conditioning in the common areas (not Resident Rooms), dining area that clean and free of clutter, and Resident bathrooms that were clean. On 7/9/24 observations were made: 11:30 a.m. - Entrance to facility the lobby area was very warm apparent that there was an issue with the air conditioning. 11:45 a.m. - Sign on elevator in lobby Do not use elevator is broken. 11:55 p.m. - The large table near the windows had puzzles, books, a plastic tub of markers and pens in the center while Residents were eating their meal. The dining room has shelves for activity supplies however they were not put on the shelves in preparation for noon meal. The dining room was warm there was one fan blowing in the front of the dining room and a portable a/c unit vented to the outside at the rear of the dining room however the temperature was still too warm for comfort. There was no thermostat / thermometer in the dining room. On 07/09/2024, at approximately 12:30 p.m., during the initial tour of the facility, it was observed that the South Hall, nursing station and the resident dining room was very warm. The Hall thermostat was set at 63 degrees Fahrenheit and was reading a temperature of 79 degrees Fahrenheit. An interview was conducted with Residents #39 and #40. When asked about the temperatures Resident #40 stated that the main air condition unit for the facility has been broken for over a month and the facility staff is using the air-condition units in the residents room to cool the halls. On 7/9/24 at 1:35 p.m. Resident #9 complained that his bathroom light was not working, and he has to leave his door open to be able to see. Resident #9's bathroom smelled strongly of urine. Surveyor stepped into [NAME] and [NAME] style bathroom (that is a bathroom located between 2 resident rooms where occupants of both rooms share a bathroom.) When the door was closed the only light visible was the light shining in the crack at the bottom of the door. Resident #9 stated that if he closes the door, he cannot see but if he leaves it open anyone can see him. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/12/2024 at approximately 10:50 a.m., the Director of Nursing toured the hallways with surveyors. The hallways felt very hot. Residents were sitting in the hallway some were propelling their wheelchairs in the hallways, and some were just standing in the doorways. On the North Hall, the wall mounted fans at the end of the hall were not blowing. The cord to a motorized wheelchair was plugged in the outlet. The Director of Nursing stated the wheelchair could be unplugged. A review of the Resident Council minutes for the previous 6 months revealed the following: December 2023- Residents complained there was not enough housekeeping staff on weekends. January 2024 - Housekeeping - Dining room is dirty / filthy. March 7, 2024 - Fixing up the patio putting the umbrellas back so they can enjoy the weather. March 20, 2024 (rescheduled from February) - Collective agreement about the dining room being unclean - as well as resident bathrooms. Fixing up the patio umbrellas for shade. April 2024 - Deep cleanings are not being done like they should. May 2024 -Residents would like their wheelchairs cleaned and inspected. June 2024 - Still having issues with cleanliness of resident bathrooms. July 2024 - Air conditioning problems in the dining room. On the afternoon of 7/12/24 an interview was conducted with the Administrator who provided timelines for the air conditioning and elevator repairs. The timelines provided stated that the elevator had broken down 3 times. The first breakdown occurred on 5/9/24 and was running again 5/16/24 the second break down occurred on 5/30/24 and was repaired and running again on 6/6/24, the final break down of the elevator occurred on 6/14/24 as of the end of survey is still out of service. The Air Conditioning that is out of service is not in the Resident rooms it affects only the common areas, lobby, hallways, kitchen, dining area, second floor including physical therapy gym and the laundry and staff areas as well. The HVAC unit has been down since 5/24/24. On 7/12/24 during the end of day meeting the Administrator was made aware of the concerns and no further information as provided.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 49916 Based on facility staff interview, and facility documentation, the facility failed to implement and maintain an effective training program for all new and existing staff. The findings included: The facility failed to maintain an effective training program for 7 employees in the survey sample of 7 employees: 2 Certified Nursing Assistants (CNA's) #B and #F, 3 Licensed Practical Nurses (LPN's) #E, #F, and #G, 1 Registered Nurse, RN #D, and the Administrator. Review of the Medline University Training Transcripts and Staff Education files revealed that none of the direct care staff employees in the survey sample had maintained an effective training program. On 07/12/2024 at 2:00 p.m. an interview was conducted with the Human Resource (HR) Manager who was asked about, an effective training program, she stated that training and education are recorded by Medline University and was initiated in January 2024. The HR Manager went on to say that they have no documentation of trainings completed prior to this date. On 07/15/2024 during the end of day meeting, the Administrator and the Director of Nursing (DON) were made aware of the findings. No further information was provided.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 49916 Based on facility staff interview, and facility documentation, the facility failed to ensure that all direct care staff complete mandatory Effective Communication training. The findings included: The facility failed to ensure that all direct care staff complete mandatory Effective Communication training for 7 employees in a survey sample of 7 employees: 2 Certified Nursing Assistants (CNA's) #B and #F, 3 Licensed Practical Nurses (LPN's) #E, #F, and #G, 1 Registered Nurse, RN #D, and the Administrator. Review of the Medline University Training Transcripts and Staff Education files revealed that none of the direct care staff has documented completion of mandatory Effective Communication training. On 07/12/2024 at 2:00 p.m., an interview was conducted with the Human Resource (HR) Manager who was asked about, direct care staff having completed mandatory Effective Communication training, she stated that training and education are recorded by Medline University and was initiated in January 2024. The HR Manager went on to say that they have no documentation of trainings completed prior to this date. On 07/15/2024 during the end of day meeting, the Administrator and the Director of Nursing (DON) were made aware of the findings. No further information was provided.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. 49916 Based on facility staff interview, and facility documentation, the facility failed to ensure that all staff members had completed the mandatory Ethics and Compliance Training. The findings included: The facility failed to ensure that all staff members had completed the mandatory Ethics and Compliance Training for 7 employees in a survey sample of 7 employees: 2 Certified Nursing Assistants (CNA's) #B and #F, 3 Licensed Practical Nurses (LPN's) #E, #F, and #G, 1 Registered Nurse, RN #D, and the Administrator. Review of the Medline University Training Transcripts and Staff Education files revealed that none of the direct care staff in the survey sample had completed the mandatory Ethics and Compliance Training. On 07/12/2024 at 2:00 p.m. an interview was conducted with the Human Resource (HR) Manager who was asked about staff training regarding, Ethics and Compliance Training, and she stated that training and education are recorded by Medline University and was initiated in January 2024. The HR Manager went on to say that they have no documentation of trainings completed prior to January 2024. On 07/15/2024 during the end of day meeting, the Administrator and the Director of Nursing (DON) were made aware of the findings. No further information was provided.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49916 Based on facility staff interview, and facility documentation, the facility failed to ensure that the nurse aides had 12 hours of in-service training including dementia, abuse preventions and facility assessments, and special needs of residents in a year. The findings included: The facility failed to ensure that all Certified Nursing Assistants (CNA's) had performance evaluations, and regular in-service education every 12 months for 2 CNA's #B and #F, in a survey sample of 7 employees. The facility failed to ensure that the ensure Certified Nursing Assistants (CNA's) have a performance evaluation every 12 months and have regular in-service education. Review of the Medline University Training Transcripts and Staff Education files revealed that the CNA's, in the staff survey did not have the mandatory in-services education and training. On 07/12/2024 at 2:00 p.m. an interview was conducted with the Human Resource (HR) Manager, and the Director of Nursing (DON) who were asked about staff training regarding, the CNA's, mandatory in-services education and training. The DON stated that they provide some in-services for the CNA's and other Licensed staff but that the training and education program was revamped in January 2024, and mainly maintained and recorded by Medline University. The DON went on to say that they have no documentation of trainings completed prior to this January 2024. On 7/15/2024 during the end of day meeting, the Administrator and the Director of Nursing (DON) were made aware of the findings. No further information was provided.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 49916 Based on facility staff interview, and facility documentation, the facility failed to ensure that all staff members had completed the mandatory Behavioral Health Training. The findings included: The facility failed to ensure that all staff members had completed the mandatory Behavioral Health Training for 7 employees in a survey sample of 7 employees: 2 Certified Nursing Assistants (CNA's) #B and #F, 3 Licensed Practical Nurses (LPN's) #E, #F, and #G, 1 Registered Nurse, RN #D, and the Administrator. Review of the Medline University Training Transcripts and Staff Education files revealed that none of the direct care staff in the survey sample had completed the mandatory Behavioral Health Training. On 07/12/2024 at 2:00 p.m. an interview was conducted with the Human Resource (HR) Manager who was asked about staff training regarding mandatory Behavioral Health Training, she stated that training and education are maintained and recorded by Medline University and was initiated in January 2024. The HR Manager went on to say that the Behavioral Health Training is scheduled for later this year, but that they have no documentation of trainings completed prior to January 2024. On 07/15/2024 during the end of day meeting, the Administrator and the Director of Nursing (DON) were made aware of the findings. No further information was provided.