STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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 - Some	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** 32642 Based on observation, resident interview, facility staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services in a manner to promote resident dignity for four of 50 residents in the survey sample, Residents #96, #31, #67, and #157. The findings include: 1. For Resident #96 (R96), the facility staff failed to treat him with dignity after he vomited. On the most recent MDS (minimum data set), an admission assessment dated [DATE], R96 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring staff assistance for ADLs (activities of daily living). On 8/26/24 at 2:46 p.m., R96 was sitting up in bed. He stated that last Saturday, 8/24/24, he woke up very early in the morning, around 6:00 a.m. LPN (licensed practical nurse) #4 was at his bedside administering a tube feeding. As LPN #4 walked away from his bed towards the bathroom, he experienced severe nausea. He called out to the nurse, then vomited a large amount. He stated he caught some of the emesis in a basin, but much of it landed on his clothing and bed linens. He stated a CNA (certified nursing assistant) came in the room, but he could not remember the CNA's name. He stated the CNA placed a clean towel over his chest, and walked out of the room, along with LPN #4. He stated no one came in to clean him up and change his bed linens until after 9:00 a.m. that morning. He stated this made him feel dirty and humiliated. A review of R96's clinical record revealed no evidence of this incident. On 8/29/24 at 7:30 a.m., LPN #4 were interviewed. She stated she remembered the morning that R96 vomited. She had worked the night shift, and was providing the resident's early morning tube feeding. She stated within about five minutes of finishing administering his tube feeding, he vomited it all back up. She stated the CNA working with her put a towel across the resident's chest, and walked out the door with her. She stated: I thought she was going to get supplies to clean him up. She stated if the resident was left dirty for several hours, the resident was not being treated with dignity. The CNA in question was not available for interview during the survey. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R96's care plan dated 7/12/24 revealed, in part: [R96] has an ADL self-care deficit .Physical assist as needed. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. A review of the facility policy, Dignity, revealed, in part: Each resident shall be cared for in a manner that promotes or enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents will be treated with dignity and respect at all times. No further information was provided prior to exit. 31753 2. For Resident #31 (R31), the facility staff failed to serve lunch in a dignified manner. Other residents seated at the same table as R31 were served a meal and R31 was not served food until 11 minutes later. On 8/26/24 at 12:52 p.m., R31 was observed sitting at a table in the dining room. At this time, two other residents were observed seated at the same table and eating lunch. R31 was not served any food until 1:03 p.m. On 8/27/24 at 1:32 p.m., an interview was conducted with OSM (other staff member) #1 (the dietary manager). OSM #1 stated the dietary aides were responsible for serving meals in the dining room and everyone at the same table should be served food at the same time so no resident is just sitting there waiting. OSM #1 stated that if she was seated at a table where other residents were eating and she was not served, I would be like where is my food? On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Food and Nutrition Services failed to document information regarding a diginified dining experience. No further information was presented prior to exit. 42106 3. For Resident #67 (R67), the facility staff failed to promote dignity on 9/30/23 during the night shift (11:00 p. m. to 7:00 a.m.), the staff failed to provide ADL (activities of daily living) assistance or assist the resident to bed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/3/24, R67 scored seven out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. The resident was assessed as being dependent on staff for toileting, personal hygiene and transfers. The quarterly MDS assessment with an ARD of 12/8/23 documented R67 scoring 15 out of 15 on the BIMS assessment, indicating they were cognitively intact for making daily decisions at that time, and being dependent on staff for toileting, personal hygiene and transfers. On 8/26/24 at 2:13 p.m., an observation was made of R67 in their room. R67 was observed in bed watching videos on an electronic device. A family member was observed sitting at R67's bedside. At that time, an interview was conducted with R67's family member who stated that on R67 had recently declined and been placed under hospice care. R67's family member stated that they had multiple concerns regarding the care that was received at the facility and stated that on 9/30/23, R67 had been left sitting up in the wheelchair all night long after returning to the facility from a leave with family. She stated that R67 had asked the staff to put them back to bed and they had not done it and the staff had told them that it was because R67 was refusing to go to bed. She stated that R67 had been left sitting in the wheelchair in soiled clothing and not assisted back to bed the entire night and not cleaned up until the day shift staff got there the next day. The progress notes for R67 documented in part, - 09/29/2023 07:50 Note Text: Resident went OOF (out of facility) this morning as per his routine, facility aware. Resident had morning meds w/o difficulty before leaving. - 09/30/2023 22:42 (10:42 p.m.) Note Text: Aide offered to put resident down after writer finished medication pass, refused 3x to go to bed and stated wanted to sit on commode for an hour before bed advised that due to pressure sore risks and skin integrity complications that this was strongly advised against. Brief on and intact, offered to help change brief, denied assistance. Passed in report that resident refused help offered to him. The progress notes for R67 failed to evidence documentation of any further attempts to provide care to R67 during the night shift on 9/30/2023 or refusal of care. Review of the ADL documentation report for R67 dated 9/1/23-9/30/23 failed to evidence any ADL care provided, transfer assistance provided, refusal of care or behaviors displayed by R67 on the night shift (11:00 p.m. to 7:00 a.m.) shift of 9/30/23. The comprehensive care plan for R67 documented in part, [Name of R67] has an ADL self-care performance deficit AEB (as evidenced by) spinal stenosis, osteoarthritis, & pain. Date Initiated: 02/01/2024. Revision on: 02/01/2024. Under Interventions it documented in part, .Physical assist as needed with ADLs. Date Initiated: 05/30/2023. Revision on: 06/14/2023 . On 8/28/24 at approximately 8:45 a.m., ASM (administrative staff member) #1, the administrator stated that the RN (registered nurse) who wrote the progress note on 9/30/23 and the CNA (certified nursing assistant) who worked on the unit that R67 resided on 9/30/23, no longer worked at the facility. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/24 at 11:20 a.m., an interview was conducted with CNA #7. CNA #7 stated that residents were rounded on every two hours to check for needs such as incontinence care, water, pain and turning and repositioning. She stated that the care that they provided to the resident was evidenced as done by their documentation in the ADLs each shift in the computer. She stated that she was not aware of any residents who would be left up in their wheelchair all night unless that was what they requested or if it was a behavior and it would be reported to the nurse and documented. She stated that when she worked with R67, they were complaint with care. On 8/30/24 at 10:00 a.m., an interview was conducted with CNA #8. CNA #8 stated that when a resident refused care, they let the nurse know and returned to the resident later with the nurse to re-attempt the care. She stated that if the resident still refused the care it was documented in the medical record in the ADLs and the nurse also documented the refusal and reported it. On 8/29/24 at approximately 3:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit. 27660 4. For Resident #157 (R157), the facility staff failed to treat the resident in a dignified manner, telling the resident to void in her brief. On the most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 8/13/24, the resident scored an 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired for making daily decisions. In Section H - Bladder and Bowel, the resident was coded as being occasionally incontinent of urine and frequently incontinent of bowel. An interview was conducted with R157 on 8/26/24 at 3:55 p.m. When asked if the staff treat her with dignity and respect, R157 stated when she has to go to the bathroom, the staff tell her to pee in your diaper. She stated the staff tell her they are going on break and can't change her at that time. When asked how that makes her feel, R157 stated that it's embarrassing to go in the brief and makes her feel bad. R157 stated that when she has to wait and can't hold her urine any longer, she voids in the brief and many times it goes through to her clothing, so she is soaking wet. She stated that is not a good feeling to be wet. An interview was conducted with CNA (certified nursing assistant) #7 on 8/29/24 at 11:15 a.m. When asked if a resident puts on their call bell for assistance, what does she do, CNA #7 stated if she is available, she will assist the resident, if she is not available she will get someone else to assist the resident. Have you ever told or heard a staff member tell a resident to pee in their diaper, CNA #7 stated, no. CNA #7 was asked if she has ever or heard anyone tell a resident they have to wait for assistance as they are going on break, CNA #7 stated, no. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observations, staff/resident interviews facility document review and clinical record review, it was determined the facility staff failed to accommodate resident needs for three of 50 residents in the survey sample, Resident #92, Resident #50 and Resident #91. The findings include: 1. For Resident #92, the facility staff failed to maintain the call light in a position where they could access it. Resident #92 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CHF (congestive heart failure), Parkinson's disease and dementia. The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 6/12/24, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring supervision for transfer/dressing/toileting and eating. A review of the comprehensive care plan dated 6/17/24 revealed, FOCUS: The resident has an alteration in musculoskeletal status related to fracture right humeral neck. INTERVENTIONS: Anticipate and meet needs. Be sure call light is within reach. On 8/26/24 at 1:30 PM, an observation was made of Resident #92's room. Call bell cord was coiled behind the headboard on the left side of the bed. On 8/27/24 at 8:00 AM, Resident #92 was sitting in the chair by the window on the right side of the bed. The call bell cord was coiled behind the headboard on the left side of the bed. Resident #92 was asked where her call bell was, she stated, they usually come in quite frequently, I do not know where the call bell is. An interview was conducted on 8/27/24 at 8:10 AM with CNA (certified nursing assistant) #1. When asked is she could locate Resident #92's call bell, CNA #1 stated, it is here behind the headboard. When asked if it was accessible to the resident in that location, CNA #1 stated, no, it is not and proceeded to clip the cord to the bedspread. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's Answering the Call Light policy revealed in part, be sure the call light is within easy reach of the patient. No further information was provided prior to exit. 42106 (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #50 (R50), the facility staff failed to maintain the call light in a position where they could access it. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/23/24, the resident was assessed as being severely impaired for making daily decisions. Section GG documented R50 not having any impairment in the upper extremities and requiring substantial/maximal assistance with toileting and personal hygiene. The resident was assessed as always being incontinent of bowel and bladder. The comprehensive care plan for R50 documented in part, [Name of R50] is at risk for injury due to falls r/t impaired mobility. Date Initiated: 05/11/2022. Revision on: 03/24/2023. Under Interventions it documented in part, Call bell in reach . On 8/27/24 at 7:59 a.m., an observation was made of R50 in their room. R50 was observed lying in bed with the call bell observed on the floor beside the right side of the bed. Additional observations on 8/27/24 at 8:49 a.m., revealed the call bell lying on the floor beside the right side of the bed. On 8/27/24 at 12:13 p.m., R50 was observed lying in bed with the call bell clipped to the pillow located under their head. The press button on the call bell was observed to beside their ear out of R50's reach. On 8/28/24 at 9:27 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the call bell should be within reach of the resident and normally was hooked near the resident's lap or hooked to the linens so they could reach it. She stated that the resident should always be able to reach it because it was their way to alert the staff if they needed something. On 8/29/24 at 11:20 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that residents were rounded on every two hours to ensure that the call bell was in reach and to provide care. She stated that the call bell should always be within reach in case the resident needed them for an emergency, had any pain, or anything else they may need. She stated that if the call bell was on the floor the resident would not be able to reach it. On 8/29/24 at approximately 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN (registered nurse) #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was presented prior to exit. 27660 3. For Resident #91(R91), the facility staff failed to assess the resident for the use of grab bars, per the resident request. An interview was conducted with R91 on 8/26/24 at 4:45 p.m. R91 stated she had had sometimes when she has slipped off the side of the bed and would like to have grab bars on one or both sides of the bed to help her with stabilizing herself for standing up. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to evidence a side rail assessment for R91. There was no documented physician order for grab bars. Review of the care plan failed to evidence documentation of grab bars. A request was made for a side rail assessment for R91. On 8/29/24 at 10:47 a.m. ASM (administrative staff member) #2, the director of nursing, stated they do not have a side rail assessment for R91. An interview was conducted with OSM (other staff member) #11, the director of therapy, on 8/29/24 at 2:47 p. m. When asked if a resident can have side rails or grab bars, OSM #11 stated they have to do a grab bar assessment to see if rails would help with the resident's functional abilities. If it is determined that they would help the resident, then the grab bars are put in place. When asked about R91 desire to have grab bars, OSM #11 stated the resident was currently on caseload and was unaware of her desire to have grab bars. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to notify the physician and/or the resident's representative of a change in condition or treatment, for three of 50 residents in the survey sample; Residents #53, #101, and #110. The findings include: 1. For Resident #53, the facility staff failed to evidence that the resident and/or the responsible party was notified of a change in medication on 11/3/23. A review of the clinical record revealed a physician's progress note dated 11/2/23 that documented, Patient seen resting in bed. He reports that his left great toenail has been sore. He would like it examined to make sure there is no acute problem . Cardiovascular: No chest pain, tightness or palpitations Blood Pressure: 100/57 . Heart has a regular rate and rhythm Plan: Recertify. The patient meets criteria for long-term care. Follow blood pressure per facility protocol. Assist with ADLs (activities of daily living) and hygiene as necessary. The patient is at risk for skin breakdown. Monitor the patient to minimize risk . A review of the physician's orders revealed one dated 11/3/23 for Sacubitril-Valsartan (1) Oral Tablet 24-26 MG (milligrams) Give 0.5 tablet by mouth two times a day related to essential hypertension. The above physician's note from the day before did not evidence any discussion and plan to add this medication. Further review of the clinical record failed to evidence any discussion / notification of the addition of this medication by the physician or nursing. On 8/28/24 at 1:00 PM, an interview was conducted with ASM #3 (Administrative Staff Member) an attending physician of the facility, who was not at the facility at the time of this incident. He stated that whenever possible, a medication change should be discussed with the resident and/or the responsible party and should be added to the physician's progress note as part of the plan. On 8/30/24 at 10:45 AM, an interview was conducted with LPN #1 (Licensed Practical Nurse). She stated that notification should have occurred. She stated that the resident has a right to have a say in their treatment plan. The facility policy, Change in a Resident's Condition documented, The facility will promptly notify the resident, his or her physician/practitioner, and representative of changes in the resident's medical/mental condition and/or status 5. Regardless of the resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments .7. The nurse / designee will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/29/24 at the end of day meeting at approximately 3:40 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, ASM #6 a Director of Clinical Operations, ASM #7 a Regional Director of Clinical Operations, ASM #8 a Regional Director of Operations, and RN #4 (Registered Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. References: 1. Sacubitril-Valsartan is used to treat heart failure Information obtained from https://medlineplus.gov/druginfo/meds/a615039.html 27660 2. For Resident #101 (R101), the facility staff failed to notify the physician when transportation did not pick the resident up for dialysis and the resident missed her dialysis treatment on 8/24/24. The nurse's notes dated 8/24/24 at 10:49 a.m. documented, Resident was not picked up for dialysis this morning. Attempted to locate contact information for transportation, unable to locate. Called (initials of company) Dialysis spoke to the nurse, and she was also unable to located contact information for transportation, but there also was no more chair time availability for resident. I updated the resident, nursing supervisor and left a vm (voicemail) for the resident's niece. The physician order dated 8/27/24 documented, Dialysis Tues, Thurs, Sat, at (initials of dialysis center) Farmville 6:10 - 9:40 am chair time. Arrive at 5:40 a.m. Dialysis transport provided by (name of company and phone number). On 8/29/24 at 3:43 p.m., ASM (administrative staff member) #9, the regional director of clinical services) stated the nurse who wrote the above note was an agency nurse and wasn't available for interview. A/n interview was conducted with RN (registered nurse) #5, the unit manager, on 8/29/24 at 12:40 p.m. When asked if a resident refuses or misses dialysis for any reason, what should the nurse do, RN #5 stated she would call the provider and responsible party. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit. 3. For Resident #110, the facility staff failed to notify the responsible party of a fall on 11/2/23. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The eINTERACT SBAR (situation, background, assessment, recommendations) dated 11/2/23 at 6:18 a.m. documented in part, The change in condition reported - falls .Primary Care Provider Feedback: New Testing Orders. There was no documentation of the responsible party being notified. Further review of the clinical record failed to evidence documentation that the responsible party was notified after the fall at 6:18 a.m. An interview was conducted with RN #5 on 8/29/24 at 12:40 p.m. When asked who is notified when a resident falls, RN #5 stated the provider (physician or nurse practitioner) and the responsible party if the resident is not their own responsible party. On 8/30/24 at 10:16 a.m. ASM #2, the director of nursing, reviewed the notes and the care plan for the fall of 11/2/23 and stated there was no notes regarding the notification of the responsible party at the time of the fall. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #8, the regional director of operations and ASM #9, the regional director of clinical services, were made aware of the above concern on 8/30/24 at 11:00 a.m. No further information was provided prior to exit.

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Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to issue a beneficiary notice of non-coverage in a timely manner for one of three beneficiary notice reviews, Resident #257. The findings include: For Resident #257 (R257), the facility staff failed to provide an advance beneficiary notice of non-coverage in a timely manner. A review of a list of residents discharged from a Medicare covered Part A stay with benefit days remaining revealed R257 was discharged from services on 5/22/24. A Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage documented, Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on 5/23/24, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs . The notice was signed by OSM (other staff member) #4 (the discharge planner) on 5/14/24 and signed by R257 on 5/22/24. On 8/27/24 at 8:29 a.m., an interview was conducted with OSM #4. OSM #4 stated she spoke with R257 regarding the beneficiary notice on 5/14/24 but did not obtain the resident's signature until 5/22/24. When asked why she did not obtain R257's signature when she spoke with the resident on 5/14/24, OSM #4 stated she thought she may have left the papers in the resident's room, and she was not sure. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Advanced Beneficiary Notice (ABN) documented, 7. To ensure that the resident, or representative, has enough time to make a decision whether or not to receive the services in question and assume financial responsibility, the notice shall be provided within forty-eight hours of the last anticipated covered day. No further information was presented prior to exit.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence written notification of a facility-initiated hospital transfer was provided to the resident and/or Ombudsman, for five of 50 residents in the survey sample; Residents #52, #69, #22, #45 and #11. The findings include: 1. For Resident #52, the facility staff failed to evidence a written notice was provided to the resident representative for a hospital transfer on 7/11/24. A review of the clinical record revealed a nurse's note dated 7/11/24 that documented, Resident has complaint of shortness of breath and states My chest feels heavy. On call MD notified of current condition and order given to this nurse to send to ER (emergency room) for evaluation and treatment as indicated Further review of the clinical record failed to reveal any evidence of a written noticed being provided to the resident representative regarding the hospital transfer. On 8/30/24 at 8:50 AM an interview was conducted with OSM #4 (Other Staff Member) the Discharge Planner / Social Worker. She stated that she was out with COVID and did not send out the written notification to the resident representative upon her return. The facility policy, Facility Initiated Transfer and Discharge was reviewed. This policy documented, 6. Residents who are sent emergently to the hospital are considered facility-initiated transfers because the resident ' s return is generally expected 8. Before a facility transfers or discharges a resident, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand b. Notice must be made as soon as practicable before transfer or discharge when: .An immediate transfer or discharge is required by the resident ' s urgent medical needs .The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman On 3/29/24 at the end of day meeting at approximately 3:40 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #6 a Director of Clinical Operations, ASM #7 a Regional Director of Clinical Operations, ASM #8 a Regional Director of Operations, and RN #4 (Registered Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #69, the facility staff failed to evidence a written notice was provided to the resident representative and the Ombudsman for a hospital transfer on 7/12/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record revealed a nurse's note dated 7/12/24 that documented, Called NP (nurse practitioner) earlier because resident was tachycardic and had an elevated temp and slightly elevated temps. NP came an assessed resident and stated she will do labs on resident. As the afternoon progressed resident noted to be more confused, restless and difficult to redirect. called Np and she stated ok to transfer resident to hospital. Further review of the clinical record failed to reveal any evidence of a written noticed being provided to the resident representative and Ombudsman regarding the hospital transfer. On 8/30/24 at 8:50 AM an interview was conducted with OSM #4 (Other Staff Member) the Discharge Planner / Social Worker. She stated that she was out with COVID and did not send out the written notification to the resident representative upon her return. She provided the list she submitted to the Ombudsman for July 2024 transfers and discharges, which did not include Resident #69's name. It was noted that the transfer list did not capture the names of residents who went to the emergency room and back on the same day and were not discharged from the system. The facility policy, Facility Initiated Transfer and Discharge was reviewed. This policy documented, 6. Residents who are sent emergently to the hospital are considered facility-initiated transfers because the resident ' s return is generally expected 8. Before a facility transfers or discharges a resident, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand b. Notice must be made as soon as practicable before transfer or discharge when: .An immediate transfer or discharge is required by the resident ' s urgent medical needs .The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman On 3/29/24 at the end of day meeting at approximately 3:40 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #6 a Director of Clinical Operations, ASM #7 a Regional Director of Clinical Operations, ASM #8 a Regional Director of Operations, and RN #4 (Registered Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. 3. For Resident #22, the facility staff failed to evidence a written notice was provided to the Ombudsman for a hospital transfer on 6/26/24. A review of the clinical record revealed a nurse's note dated 6/26/24 that documented, Resident returned from dialysis at 1145 (11:45 AM), nosebleed in progress. Pressure applied continuously; bleeding continued. NP (nurse practitioner) contacted; order received to send to ED (emergency department) at this time Further review of the clinical record failed to reveal any evidence of a written noticed being provided to the Ombudsman regarding the hospital transfer. On 8/30/24 at 8:50 AM an interview was conducted with OSM #4 (Other Staff Member) the Discharge Planner / Social Worker. She provided the list she submitted to the Ombudsman for June 2024 transfers and discharges, which did not include Resident #22's name. It was noted that the transfer list did not capture the names of residents who went to the emergency room and back on the same day and were not discharged from the system. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Facility Initiated Transfer and Discharge was reviewed. This policy documented, 6. Residents who are sent emergently to the hospital are considered facility-initiated transfers because the resident ' s return is generally expected 8. Before a facility transfers or discharges a resident, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand b. Notice must be made as soon as practicable before transfer or discharge when: .An immediate transfer or discharge is required by the resident ' s urgent medical needs .The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman On 3/29/24 at the end of day meeting at approximately 3:40 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #6 a Director of Clinical Operations, ASM #7 a Regional Director of Clinical Operations, ASM #8 a Regional Director of Operations, and RN #4 (Registered Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. 42106 4. For Resident #45 (R45), the facility staff failed to evidence that written notification of transfer was provided to the resident and/or responsible party and the long-term care ombudsman for a facility-initiated transfer on 8/5/24 and failed to evidence notification of transfer provided to the long-term care ombudsman for facility-initiated transfers on 4/29/24 and 6/25/24. A review of R45's clinical record revealed the following progress notes: - 04/29/2024 15:04 (3:04 p.m.) Note Text: Resident complained of pain while urinating at about 9.30 this morning. Informed resident that the NP (nurse practitioner) would be in to see him today. [NAME] [sic] I wrote his name down in the provider book. Around 12pm resident complained that when urinating that his foreskin was Ballooning and he now had blood in his urine. NP notified and orders to send resident to ER for evaluation for possible stricture and hematuria. 911 called, [Name of hospital] notified, RP (responsible party) notified, resident is being transported to ER. - 06/25/2024 06:52 (6:52 a.m.) Note Text: Patient transferred to ED for SOB (shortness of breath), chest pain, chills and fever. Report received from [Name of hospital] from charge nurse [Name of nurse] that patient was admitted for Sepsis, Pneumonia, and possible respiratory failure. RP-sister [Name of RP] was called and made aware. DON (director of nursing) also aware. - 08/05/2024 20:16 (8:16 p.m.) Note Text : while passing medication on hall heard resident yelling upon entering resident room supervisor, second nurse and CNA (certified nursing assistant) was in resident room resident was laying on floor next to bed and w/c (wheelchair) c/o (complains of) back, neck, r/l (right/left) arm and leg pain when ask resident what happened resident stated I passed out while sitting in w/c and fell left resident room to call on call NP and gather paperwork leaving behind with resident supervisor, second nurse and CNA on call NP called spoke with [Name of NP], 911 called, report called in to [Name of hospital] ER resident exit facility with Ems (emergency medical services) to hospital for evaluation. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the clinical record failed to reveal evidence that notification of transfer was provided to the long-term care ombudsman for the transfers on 4/29/24 and 6/25/24. It further failed to evidence that written notification of transfer was provided to the resident and/or the responsible party and the long-term care ombudsman for the transfer on 8/5/24. On 8/27/24 at 3:50 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for evidence of notification of transfer provided to the long-term care ombudsman for the transfers on 4/29/24 and 6/25/24 and written notification of transfer was provided to the resident and/or the responsible party and the long-term care ombudsman for the transfer on 8/5/24. On 8/28/24 at 8:36 a.m., ASM #1 stated that they did not have any evidence to provide. On 8/28/24 at 9:27 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that when a resident was sent out to the emergency room the nurse sent a copy of the physician orders, the care plan, bed hold notice, transfer summary and the change in condition note. She stated that they had transfer folders at the nurse's station that contained a checklist of documents to send out with the resident, so the staff knew what needed to be sent. She stated that nursing did not send anything to the ombudsman. On 8/28/24 at 10:52 a.m., an interview was conducted with OSM (other staff member) #4, discharge planner. OSM #4 stated that they sent out ombudsman notification of transfers monthly from a report they printed out and they kept a copy of it in a file with the email confirmation. She stated that she followed up on transfers the next day and sent out the written notices by certified mail and kept the letter on file afterwards. She stated that she had been out for a while, and some had been missed when she was out. She stated that she did not have evidence of the ombudsman notification or written notices for R45 for the dates listed above. On 8/29/24 at approximately 3:40 p.m., ASM #1, the administrator, ASM #2, director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN (registered nurse) #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit. 5. For Resident #11 (R11), the facility staff failed to evidence notification of transfer provided to the long-term care ombudsman for facility-initiated transfer on 7/28/24. A review of R11's clinical record revealed the following physician order: - Transfer to ED for further evaluation. 07/28/2024. Further review of the clinical record failed to reveal evidence notification of transfer provided to the long-term care ombudsman for facility-initiated transfer on 7/28/24. On 8/27/24 at 3:50 p.m., a request was made to ASM (administrative staff member) #1, the administrator, for evidence of ombudsman notification for the facility-initiated transfer on 7/28/24. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at 8:36 a.m., ASM #1 stated that they did not have any evidence of ombudsman notification to provide. On 8/28/24 at 9:27 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that when a resident was sent out to the emergency room the nurse sent records to the hospital, but they did not send anything to the ombudsman. On 8/28/24 at 10:52 a.m., an interview was conducted with OSM (other staff member) #4, discharge planner. OSM #4 stated that they sent out ombudsman notification of transfers monthly from a report they printed out and they kept a copy of it in a file with the email confirmation. She stated that she had been out for a while, and some had been missed when she was out. She stated that she did not have evidence of the ombudsman notification for R11 for the date listed above. On 8/29/24 at approximately 3:40 p.m., ASM #1, the administrator, ASM #2, director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN (registered nurse) #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 27660 Based on staff interview and clinical record review, it was determined the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for one of 50 residents in the survey sample, Resident # 115. The findings include: The MDS assessment, an admission assessment with an assessment reference date of 5/7/23, in Section B - Hearing, Speech and Vision, coded the resident as usually being understood and usually understands. In Section C - Cognitive Patterns, there were dashed documented in the section for the resident interview and the section for staff interview. Under C0100 - Should Brief Interview for Mental Status Be Conducted, a dash was documented. An interview was conducted with RN (registered nurse) #6, the MDS coordinator, on 8/29/24 at 9:29 a.m. When asked who does Section C, RN #6 stated sometimes she does it but normally it's the social worker that does it. RN #6 was no employed at the facility at the time of the assessment above. The above assessment was reviewed with RN #6. RN #6 stated there shouldn't be dashes, the staff interview should have been done if the resident couldn't do the interview, but the resident was coded as being usually understood and usually understands, it should have been completed. When asked what reference the facility uses to complete the MDS assessments, RN #6 stated, the RAI (Resident Assessment Instrument) manual. The Facility RAI Manual, Version 1.18.11 - October 2023 documented in part, If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard no information code (a dash -) entered in the resident interview items. Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted but was not done. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observations, staff/resident interviews facility document review and clinical record review, it was determined the facility staff failed to develop a baseline care plan for two of 50 residents in the survey sample, Resident #113 and Resident #407. The findings include: 1. The facility failed to develop a baseline care plan to include monitoring of anticoagulation therapy for Resident #113. Resident #113 was admitted to the facility on [DATE] with diagnosis that included fractures and hypertension. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 7/26/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers, dressing, hygiene toileting and independent for eating. A review of the baseline care plan dated 8/3/23 revealed, FOCUS: Resident has actual impairment to skin integrity related to Surgical Wound. INTERVENTIONS: Administer medications, supplements and treatments as ordered. Monitor/document for side effects and effectiveness. A review of the physician order dates 7/21/23 revealed Enoxaparin Sodium Injection Prefilled Syringe Kit 40 MG/0.4ML. Inject 0.4 ml subcutaneously every 12 hours. There is no evidence of the baseline care plan including any focus or interventions related to anticoagulation therapy or monitoring. An interview was conducted on 8/27/24 at 2:45 PM with LPN (licensed practical nurse) #2. When asked what the baseline care plan should include, LPN #2 stated, it should include the initial plan of care for the resident. When asked if a resident is ordered anticoagulation therapy, should it be included on the baseline care plan, LPN #2 stated, yes, it should be included. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's Baseline Care Plan policy revealed in part, will implement a baseline care plan to meet the resident's immediate care needs based on orders, services, medications and treatments. No further information was provided prior to exit. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The facility failed to develop a baseline care plan to include monitoring of CPAP therapy for Resident #407. Resident #407 was admitted to the facility on [DATE] with diagnosis that included fracture right lower leg, OSA (obstructive sleep apnea), asthma and paroxysmal atrial fibrillation. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 8/16/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being max assist for mobility/transfers, dressing, hygiene toileting and independent for eating. Section O-Special Treatments and Procedures coded the resident as non-invasive Bipap-yes. A review of the baseline care plan dated 8/23/24 revealed, FOCUS: Resident has actual impairment to skin integrity related to Surgical Wound. INTERVENTIONS: Administer medications, supplements and treatments as ordered. Monitor/document for side effects and effectiveness. There is no evidence of the baseline care plan including any focus or interventions related to CPAP (continuous positive airway pressure) use or monitoring. A review of the physician order dates 8/13/24 revealed CPAP on at HS at bedtime Per home settings. An interview was conducted on 8/27/24 at 2:45 PM with LPN (licensed practical nurse) #2. When asked what the baseline care plan should include, LPN #2 stated, it should include the initial plan of care for the resident. When asked if a resident is ordered CPAP therapy, should it be included on the baseline care plan, LPN #2 stated, yes, it should be included. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's Baseline Care Plan policy revealed in part, will implement a baseline care plan to meet the resident's immediate care needs based on orders, services, medications and treatments. No further information was provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for nine of 50 residents in the survey sample, Residents #157, #101, #34, #67, #111, #24, #116, #63, and #96. The findings include: 1a. For Resident #157 (R157), the facility staff failed to implement the comprehensive care plan to do the blood sugars per the physician orders. The comprehensive care plan dated 8/21/24, documented in part, Focus: (R157) has Diabetes Mellitus. The interventions documented in part, Fasting Serum Blood Sugar as ordered by doctor. The physician order dated 8/9/24, documented, Humalog Solution 100 units/ML (milliliters) inject as per sliding scale: if (blood sugar) 1-70 = 0 (insulin) notify MD (medical doctor); 150 -199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 + = 5 units Notify MD > (greater than) 400, subcutaneously before meals and at bedtime for diabetes. D/C (discontinue date) 8/18/24. The blood sugars are scheduled for 7:00 a.m., 11:00 a.m., 4:00 p.m. and 9:00 p.m. The physician order dated 8/12/24, documented, Humalog Solution 100 units/ML (milliliters) inject as per sliding scale: if (blood sugar) 1-70 = 0 (insulin) notify MD (medical doctor); 150 -199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 + = 5 units Notify MD > (greater than) 400, subcutaneously before meals for diabetes. The blood sugars are scheduled for 6:30 a.m., 11:00 a.m. and 4:00 p.m. The physician order dated 8/23/24, documented, Humalog Solution 100 units/ML (milliliters) inject as per sliding scale: if (blood sugar) 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units; 451 - 500 = 14 units. subcutaneously before meals for diabetes. The blood sugars are scheduled for 6:30 a.m., 11:00 a.m. and 4:00 p.m. The documented mealtimes for the facility are: Breakfast - 7:30 a.m. Lunch - 12:00 p.m. Dinner - 5:00 p.m. The August 2024 MAR (medication administration record) documented the above orders. On the following dates and times, the blood sugars were taken during or after the meals: 8/10/24 at 5:48 p.m. - scheduled for 4:00 p.m. (continued on next page)

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Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/11/24 at 5:50 p.m. - scheduled for 4:00 p.m. 8/12/24 at 9:20 a.m. - scheduled for 7:00 a.m. 8/12/24 at 5:39 p.m. - scheduled for 4:00 p.m. 8/13/24 at 12:02 p.m. - scheduled for 11:00 a.m. 8/13/24 at 6:41 p.m. - scheduled for 4:00 p.m. 8/21/24 at 6:25 p.m. - scheduled for 4:00 p.m. 8/23/24 at 12:48 p.m. - scheduled for 11:00 a.m. 8/24/24 at 6:60 p.m. - scheduled for 4:00 p.m. 8/26/24 at 10:21 p.m. - scheduled for 4:00 p.m. 8/27/24 at 1:10 p.m. - scheduled for 11:00 a.m. 8/28/24 at 1:41 p.m. - scheduled for 11:00 a.m. An interview was conducted with ASM (administrative staff member) #4, the nurse practitioner, on 8/29/24 at 9:54 a.m. When asked why a resident is on sliding scale insulin, ASM #4 stated, to help cover them when the blood sugars are higher when the resident has eaten sugary snacks. ASM #4 was asked what times they are normally ordered, ASM #4 stated before meals and at bedtime. When asked what would happen if the blood sugar was taken after the resident ate their meal, ASM #4 stated, it depends, if they've only eaten five bites or so, then nothing, but if they've eaten their whole meal, say 30 minutes to an hour later, it would elevate the blood sugar, thus giving them too much insulin and the risk of their blood sugar going too low. An interview was conducted with RN (registered nurse) #5, the unit manager, on 8/29/24 at 12:40 p.m. When asked the purpose of the care plan, RN #5 stated it's to have a conclusive person-centered plan, one area you can go to see what needs to be done for the resident. RN#5 was asked if it should be followed, RN #5 stated, yes. When asked who is responsible for implementing the care plan, RN #5 stated, the whole care team. The facility policy, Care Planning - Comprehensive Person-Centered, documented in part, 2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. 1b. For Resident #157, the facility staff failed to implement the comprehensive care plan to administer insulin per the physician orders. The comprehensive care plan dated 8/21/24, documented in part, Focus: (R157) has Diabetes Mellitus. The interventions documented in part, Diabetes medication as ordered by doctor. The physician order dated 8/23/24 documented, Levemir Flex Pen Subcutaneous Solution Pen- Injector 100 UNIT/ML; Inject 50 units subcutaneously at bedtime for DM (diabetes mellitus). The August 2024 MAR documented the above order. On 8/24/24, there was a blank on the space for the medication to be documented as administered. Review of the nurse's notes failed to evidence documentation of a reason why the medication was not given. An interview was conducted with RN (registered nurse) #5, the unit manager, on 8/29/24 at 12:40 p.m. When asked the purpose of the care plan, RN #5 stated it's to have a conclusive person-centered plan, one area you can go to see what needs to be done for the resident. RN#5 was asked if it should be followed, RN #5 stated, yes. When asked who is responsible for implementing the care plan, RN #5 stated, the whole care team. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #8, the regional director of operations, and ASM #9, the regional director of clinical services, were made aware of the above concern on 8/30/24 at 11:00 a.m. No further information was obtained prior to exit. 1c. For Resident #157, the facility staff failed to implement the comprehensive caer plan to administer antibiotics in a timely manner. The comprehensive care plan dated, 8/23/24, documented in part, Focus: (R157) is on antibiotic therapy r/t (related to) abscess to right buttock. The Interventions documented in part, Administer ANTIBIOTIC medications as ordered by physician. The physician order dated 8/22/24 at 3:42 p.m. documented, Clindamycin HCL (hydrochloride) 150 MG; give 3 capsules by mouth three times a day for abscess to buttocks for 10 days. The medication was scheduled for 7:00 a.m., 11:00 a.m. and 8:00 p.m. The August 2024 MAR documented the above order. The first dose was documented as having been given on 8/23/24 at 7:00 a.m. On 8/24/24 at the scheduled 8:00 p.m. dose, nothing was documented in the space. Review of the contents of the facility, onsite, pharmacy system, documented the Clindamycin 150 mg was available in the system. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with RN #5 on 8/29/24 at 12:40 p.m. When asked if a physician order is written on 8/22/24 for an antibiotic, when would the antibiotic be started, RN #5 stated, on the 22nd, if it was started on the 23rd, it would be a delay in treatment. When asked how she evidenced that she's given a medication, RN #5 stated she documents in on the electronic MAR. When asked the purpose of the care plan, RN #5 stated it's to have a conclusive person centered plan, one area you can go to see what needs to be done for the resident. RN#5 was asked if it should be followed, RN #5 stated, yes. When asked who is responsible for implementing the care plan, RN #5 stated, the whole care team. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #8, the regional director of operations, and ASM #9, the regional director of clinical services, were made aware of the above concern on 8/30/24 at 11:00 a.m. No further information was obtained prior to exit. 2. For Resident #101, the facility staff failed to implement the comprehensive care plan to monitor her fluid restriction. The comprehensive care plan dated, 7/17/24, documented in part, Focus: (R101) is at risk for malnutrition r/t (related to) adenocarcinoma (cancer), new HD (hemodialysis) r/t ESRD. The Interventions documented in part, Fluid Restriction 1200 ml/day (milliliters/day); dietary - 840 ml/day (B [breakfast] - 240 ml, L [lunch] 360 ml, D [dinner]) 240 ml; nursing: 360 ml/day (120 ml Q [every] shift) - ONS (ordered nutritional supplements) not included in fluid restriction. The physician order dated, 7/31/24, documented, Fluid Restriction 1200 ml/day (milliliters/day); dietary - 840 ml/day (B [breakfast} - 240 ml, L [lunch] 360 ml, D [dinner] 240 ml; nursing: 360 ml/day (120 ml Q [every] shift) - ONS (ordered nutritional supplements) not included in fluid restriction. The August 2024 MAR (medication administration record) documented the above physician order. On the following dates there was nothing documented: 8/12/24 - day shift and 8/24/24 - night shift. On the following dates and shift an NA(not applicable) was documented: Day shift on 8/1/14, 8/3/24, 8/4/24, 8/8/24, 8/16/24, 8/17/24, 8/25/24. Evening shift on 8/16/24 and 8/17/24. Night shift on 8/16/24. An interview was conducted with RN (registered nurse) #5, the unit manager, on 8/29/24 at 12:40 p.m. When asked the purpose of the care plan, RN #5 stated it's to have a conclusive person-centered plan, one area you can go to see what needs to be done for the resident. RN#5 was asked if it should be followed, RN #5 stated, yes. When asked who is responsible for implementing the care plan, RN #5 stated, the whole care team. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. 3. For Resident #34, the facility staff failed to implement the comprehensive care plan for the administration of Xarelto. The comprehensive care plan dated 8/18/23 documented in part. Focus: The resident is on anticoagulant therapy. The Interventions documented in part, Administer ANTOCOAGULANT medications as ordered by physician. An interview was conducted with R34 on 8/26/24 at 3:45 p.m. The resident stated that she had missed several doses of her Xarelto. The physician order dated 7/31/23, documented, Xarelto Oral Tablet 20 MG (Rivaroxaban); Give 1 tablet by mouth in the evening for prophylactic related to personal history of other venous thrombosis and embolism; atherosclerosis of aorta. The August MAR (medication administration record) documented the above order. On 8/21/24 and 8/22/24, a 9 was documented in the administration box on the MAR. A 9 indicated, Other/See Progress Note. Review of the progress notes dated 8/21/24 and 8/22/24, documented, Not on hand. for both days. Review of the contents of the facility, onsite, pharmacy system, documented the Xarelto 10 mg tablets were available in the system. An interview was conducted with RN (registered nurse) #5, the unit manager, on 8/29/24 at 12:40 p.m. When asked the purpose of the care plan, RN #5 stated it's to have a conclusive person-centered plan, one area you can go to see what needs to be done for the resident. RN#5 was asked if it should be followed, RN #5 stated, yes. When asked who is responsible for implementing the care plan, RN #5 stated, the whole care team. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit. 42106 4. For Resident #67 (R67), the facility staff failed to implement the comprehensive care plan to provide physical assistance with ADLs (activities of daily living) on 9/30/23 and multiple dates from 6/1/24 through 8/28/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/3/24, the resident scored seven out of 15 on the BIMS (brief assessment for mental status), indicating R67 was severely impaired for making daily decisions. Section GG documented R67 being dependent on staff for toileting, bathing, dressing, bed mobility, transfers, and personal hygiene. On 8/26/24 at 2:13 p.m., an observation was made of R67 in their room. R67 was observed in bed watching videos on an electronic device. A family member was observed sitting at R67's bedside. At that time, an interview was conducted with R67's family member who stated that on R67 had recently declined and been placed under hospice care. R67's family member stated that they had multiple concerns regarding the care that was received at the facility and stated that on 9/30/23, R67 had been left sitting up in the wheelchair all night long after returning to the facility from a leave with family. She stated that R67 had asked the staff to put them back to bed and they had not done it and the staff had told them that it was because R67 was refusing to go to bed. She stated that R67 had been left sitting in the wheelchair in soiled clothing and not assisted back to bed the entire night and not cleaned up until the day shift staff got there the next day. R67's family member further stated that the staff did not come in to turn and reposition every two hours and left the resident soiled for extended periods of time. She stated that R67 could not turn themselves and relied on the staff to come in to turn them, but she often found him lying in one position the entire time she was there to visit. She stated that since hospice had come on board that they had been providing most of the care to R67. The comprehensive care plan for R67 documented in part, [Name of R67] has an ADL self-care performance deficit AEB (as evidenced by) spinal stenosis, osteoarthritis, & pain. Date Initiated: 02/01/2024. Revision on: 02/01/2024. Under Interventions it documented in part, .Physical assist as needed with ADLs. Date Initiated: 05/30/2023. Revision on: 06/14/2023 . Review of the ADL documentation report for R67 dated 9/1/23-9/30/23 failed to evidence any ADL care provided, transfer assistance provided, refusal of care or behaviors displayed by R67 on the night shift (11:00 p.m. to 7:00 a.m.) shift for 9/30/23. Review of the ADL documentation report for R67 dated 6/1/24-6/30/24 failed to evidence assistance with bed mobility provided on day shift on 6/14/24 and 6/30/24, and on evening shift on 6/14/24, 6/17/24, 6/21/24 and 6/23/24. It further failed to evidence assistance with bed mobility on night shift on 6/1/24, 6/4/24, 6/7/24, 6/8/214, 6/11/24, 6/15/24, 6/19/24, 6/22/24, 6/28/24 and 6/30/24. The documentation areas were either blank or documented NA. The report key documented NA-Not Applicable . Review of the ADL documentation report for R67 dated 7/1/24-7/31/24 failed to evidence assistance with bed mobility provided on day shift on 7/4/24, and on night shift on 7/2-7/8/24, 7/10-7/22/24, 7/24-7/27/24, 7/30/24 and 7/31/24. The documentation areas were either blank or documented NA. The report key documented NA-Not Applicable . Review of the ADL documentation report for R67 dated 8/1/24-8/30/24 failed to evidence assistance with bed mobility provided on day shift on 8/17/24, and on evening shift on 8/17/24 and 8/21/24. If further failed to evidence assistance with bed mobility on night shift on 8/2/24, 8/4/24, 8/10-8/12/24, 8/17/24, 8/19/24, 8/21/24, 8/23/24, and 8/28/24. The documentation areas were either blank or documented NA. The report key documented NA-Not Applicable . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The progress notes for R67 documented in part, - 09/29/2023 07:50 Note Text: Resident went OOF (out of facility) this morning as per his routine, facility aware. Resident had morning meds w/O difficulty before leaving. - 09/30/2023 22:42 (10:42 p.m.) Note Text: Aide offered to put resident down after writer finished medication pass, refused 3x to go to bed and stated wanted to sit on commode for an hour before bed advised that due to pressure sore risks and skin integrity complications that this was strongly advised against. Brief on and intact, offered to help change brief, denied assistance. Passed in report that resident refused help offered to him. The progress notes for R67 failed to evidence documentation of any further attempts to provide care to R67 during the night shift on 9/30/2023 or refusal of care. On 8/28/24 at approximately 8:45 a.m., ASM (administrative staff member) #1, the administrator stated that the RN (registered nurse) who wrote the progress note on 9/30/23 and the CNA (certified nursing assistant) who worked on the unit that R67 resided on 9/30/23, no longer worked at the facility. On 8/29/24 at 11:20 a.m., an interview was conducted with CNA #7. CNA #7 stated that residents were rounded on every two hours to check for needs such as incontinence care, water, pain and turning and repositioning. She stated that the care that they provided to the resident was evidenced as done by their documentation in the ADLs each shift in the computer. She stated that she was not aware of any residents who would be left up in their wheelchair all night unless that was what they requested or if it was a behavior and it would be reported to the nurse and documented. She stated that when she worked with R67, they were complaint with care. She stated that R67 required staff to turn and reposition them and they documented the care provided under bed mobility. On 8/29/24 at 12:40 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 stated that the care plan purpose was for the staff to have a complete person-centered plan that showed what needed to be done for the resident. She stated that the care plan should be followed and the whole care team was responsible for making sure the care plan was implemented. On 8/30/24 at 10:00 a.m., an interview was conducted with CNA #8. CNA #8 stated that when a resident refused care, they let the nurse know and returned to the resident later with the nurse to re-attempt the care. She stated that if the resident still refused the care it was documented in the medical record in the ADLs and the nurse also documented the refusal and reported it. She stated that if NA was documented in the ADLs it meant not applicable and usually the resident was out at an appointment or not in the building at that time. On 8/29/24 at approximately 3:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. For Resident #111 (R111), the facility staff failed to implement the comprehensive care plan to provide treatment to a pressure injury (1) as ordered on multiple dates from 9/1/23-12/31/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/2/24, the resident was assessed as having one Stage 2 pressure injury that was not present on admission. The comprehensive care plan for R111 documented in part, [Name of R111] has an unstageable pressure ulcer (see wound nurse note 3/24/2023) on her sacrum r/t decreased mobility, incontinence. Date Initiated: 05/05/2023. Revision on: 11/02/2023. Under Interventions it documented in part, Apply treatments as ordered and monitor for effectiveness. Date Initiated: 05/05/2023. Revision on: 11/02/2023. The progress notes for R111 documented in part, 6/7/2023 16:18 (4:18 p.m.) Weekly wound assessment completed. Unstageable Pressure Ulcer to other: Sacral. Overall impression: new wound- first observation. See wound evaluation weekly for additional details . The physician orders for R111 documented in part, Clean area to sacrum with normal saline or soap and water apply barrier cream cover with foam dressing qday (every day) and prn (as needed) when soiled. every day shift for assessment. Review of the eTAR (electronic treatment administration record) for R111 dated 9/1/23-9/30/23 failed to evidence a treatment completed as ordered to the sacral area on 9/4/23, 9/9/23, 9/11/23, 9/15-9/18/23, 9/21/23, 9/23/23, and 9/28/23. Review of the eTAR for R111 dated 10/1/23-10/31/23 failed to evidence a treatment completed as ordered to the sacral area on 10/6/23, 10/7/23, and 10/24/23. Review of the eTAR for R111 dated 11/1/23-11/30/23 failed to evidence a treatment completed as ordered to the sacral area on 11/17/23. Review of the eTAR for R111 dated 12/1/23-12/31/23 failed to evidence a treatment completed as ordered to the sacral area on 12/1/23, 12/7/23, 12/16/23, 12/17/23, 12/19/23, and 12/22-12/24/23. On 8/28/24 at 9:27 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to show the staff what they were supposed to do for the resident. She stated that it was their treatment plan, and it should be implemented because it was the residents right to have goals and to see the outcomes. She stated that the wound nurse was there during the week and when she was not there the floor nurses were expected to complete the wound care treatments. She stated that the wound care was evidenced by the nurse writing the time, date, and initials on the dressing and signing them off as completed on the eTAR. On 8/28/24 at 11:39 a.m., an interview was conducted with RN (registered nurse) #3, wound care. RN #3 stated that they had been at the facility for about two months and prior to them starting the floor nurses were doing the wound care treatments. She stated that wound care was evidenced as done by the nurse signing off on the eTAR and if not completed or the resident was not available for the wound care it would be documented on the eTAR and the provider would be made aware. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/24 at 12:40 p.m., an interview was conducted with RN #5. RN #5 stated that the care plan purpose was for the staff to have a complete person-centered plan that showed what needed to be done for the resident. She stated that the care plan should be followed and the whole care team was responsible for making sure the care plan was implemented. On 8/29/24 at approximately 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN (registered nurse) #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit. Reference: (1) Pressure injury A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm. 6. For Resident #24 (R24), the facility staff failed to implement the comprehensive care plan to provide catheter care on multiple dates from 6/1/24 through 7/30/24. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/14/24, the resident scored 15 out of 15 on the BIMS (brief assessment for mental status), indicating R24 was cognitively intact for making daily decisions. Section H documented R24 having an indwelling catheter. On 8/26/24 at 2:18 p.m., an interview was conducted with R24 in their room. A urinary catheter bag was observed attached to the bed frame of R24's bed with a privacy cover intact. R24 stated that they had a urinary catheter and had it for a few years now which they saw the urologist for regularly. R24 stated that the staff changed the catheter when it was leaking and emptied the bag every day. R24 stated that the staff kept gauze around the catheter site and changed it when it came off. R24 stated that they were unsure if there was a schedule for catheter care of not. The comprehensive care plan for R24 documented in part, [Name of R24] has Suprapubic (1) Catheter: Obstructive Uropathy. Date Initiated: 07/29/2022. Revision on: 09/07/2022. Under Interventions it documented in part, .Catheter care Q (every) shift and PRN (as needed). Date Initiated: 07/29/2022 . The physician orders for R24 documented in part, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Order Date: 06/06/2022. Cath care every shift and as needed- may be performed by CNA (certified nursing assistant), verified by nurse every shift. End Date: 06/06/2024. - Order Date: 08/02/2024. Foley cath care every shift and prn (as needed). every shift related to Neuromuscular dysfunction of bladder, unspecified. - Order Date: 06/26/2024. regular gauze cut with split to place around suprapubic catheter, Zinc oxide to periwound daily and PRN for soilage and or dislodgement. as needed for soilage and or dislodgement AND every day shift. Review of the eTAR (electronic treatment administration record) for R24 dated 6/1/24-6/30/24 failed to evidence catheter care provided 6/4/24-6/26/24. Review of the eTAR for R24 dated 7/1/24-7/31/24 failed to evidence catheter care provided on 7/26/24 and 7/29/24. On 8/29/24 at 11:20 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that catheter care was provided every shift. She stated that they emptied the catheter bags and cleaned the skin around the catheter unless there was a special treatment ordered and then the nurse did the treatment. On 8/29/24 at 12:40 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 stated that the care plan purpose was for the staff to have a complete person-centered plan that showed what needed to be done for the resident. She stated that the care plan should be followed and the whole care team was responsible for making sure the care plan was implemented. She stated that residents with suprapubic catheters had the site assessed and the care was provided as ordered by the physician. She stated that the orders triggered on the eTAR for the nurse to complete the treatment and document it as completed. She stated that the documentation was how the care was evidenced as completed. She stated that if there were no orders for the catheter the physician should be called to get orders for care. On 8/29/24 at approximately 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit. Reference: (1) A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem. This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000145.htm. 42183 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. The facility staff failed to implement the comprehensive care plan for wound care for Resident #116. Resident #116 was admitted to the facility on [DATE] with diagnosis that included but were not limited to dementia, sacral ulcer and ASCVD (atherosclerotic cardiovascular disease). The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 3/6/23, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/transfer/dressing/toileting and supervision for eating. A review of the comprehensive care plan dated 9/14/22 revealed, FOCUS: Resident has a skin tear to her right shin. INTERVENTIONS: Treatment as ordered. A review of the physician orders dated 12/24/22 revealed, Cleanse wound to right lower leg and Left forearm with wound cleanser, apply xeroform gauze to wound, cover with kerlix, secure with tape. One time a day for skin tear. A review of the December 2022, January 2023 and February 2023 MAR (medication administration record) revealed missing evidence of wound treatments provided on the following dates: 12/28/22, 12/30/22, 12/31/22, 1/2/23, 1/3/23, 1/13/23, 1/16/23, 1/21/23 1/24/23, 1/31/23, and 2/7/23. An interview was conducted on 8/27/24 at 2:45 PM with LPN (licensed practical nurse) #2. When asked what the purpose of the comprehensive care plan is, LPN #2 stated, to develop the plan of care that is individualized for each resident. When asked if a resident's care plan includes wound care and there is no evidence that is has been completed, has the care plan be implemented, LPN #2 stated, no, it has not been. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's Care Planning policy revealed in part, Our Care Planning team is responsible for the development of an individualized comprehensive care plan for each resident. No further information was provided prior to exit. 32642 8. For Resident #63 (R63), the facility staff failed to follow the resident's dialysis care plan for a fluid restriction. A review of R63's clinical record revealed the following order dated 8/23/24: Fluid restriction =1200 ml/day (milliliters per day): dietary 840 ml/day (B [breakfast]: 240 ml, L [lunch]: 360 ml, D [dinner]: 240 ml); nursing - 360 ml/day (120 ml q [each] shift). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of R63's clinical record, including August 2024 MARs (medication administration records), TARs (treatment administration records), and progress notes, revealed no evidence that the fluid restriction had been implemented. A review of R63's care plan revealed, in part: [R63] has nutritional problem or potential nutritional problem r/t (related to) .ESRD (end stage renal disease) .Fluid restriction 1200 ml/day (milliliters per day): d [TRUNCATED]

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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. 42106 Based on observation, resident interview, clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to review and/or revise the comprehensive care plan for three of 50 residents in the survey sample, Residents #11, #114 and #110. The findings include: 1. For Resident #11 (R11), the facility staff failed to revise the comprehensive care plan to include the use of grab bars. On the most recent MDS (minimum data set) assessment, a significant change assessment with an ARD (assessment reference date) of 7/12/24, the resident scored 10 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. On 8/26/24 at 3:00 p.m., an interview was conducted with R11 in their room. R11 was observed in bed with bilateral grab bars on each side of the upper portion of the bed. R11 stated that the bars assisted them to turn and position themselves in the bed. The physician orders for R11 documented in part, Bilateral grab bars applied to the bed. Order Date: 06/13/2024. The side rail & entrapment risk assessment for R11 dated 6/12/24 documented the resident able to safely use both upper grab bars for independent bed mobility. The comprehensive care plan for R11 failed to evidence the use of the grab bars for independent bed mobility. The ADL (activities of daily living) care plan documented, [Name of R11] has an ADL self-care performance deficit r/t muscle weakness, difficulty walking, wound to buttocks. Date Initiated: 02/23/2024. Revision on: 06/19/2024. Under Interventions it documented in part, Bed Mobility: The resident requires assistance by staff. Date Initiated: 07/16/2024 . On 8/28/24 at 9:27 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to show the staff what they were supposed to do for the resident. She stated that it was their treatment plan, and it was revised and reviewed by both nursing staff and the MDS staff in the care plan meetings. On 8/29/24 at 12:40 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 stated that the care plan purpose was for the staff to have a complete person-centered plan that showed what needed to be done for the resident. She stated that the care plan was updated after clinical meetings and done by the interdisciplinary team. She stated that normally bed rails were on the care plan because they required an assessment and an order and if not properly documented they could be considered a restraint. She stated that the MDS team normally added them to the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Care Planning- Comprehensive Person-Centered documented in part, .Each resident's comprehensive care plan will describe the following: a. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: .d. When the goals, needs, and preferences change .f. At least quarterly and after each OBRA MDS assessment . On 8/29/24 at approximately 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was obtained prior to exit. 2. For Resident #114 (R114), the facility staff failed to revise the comprehensive care plan to include treatment for a non-pressure related skin condition. The physician orders for R114 documented in part, - Nystatin External Cream 100000 UNIT/GM (Nystatin (Topical)) Apply to affected areas topically every day and evening shift for redness until healed. Order Date: 06/13/2024. Review of the eTAR (electronic treatment administration record) for R114 dated 8/1/23-8/31/23 failed to evidence the Nystatin treatment completed on day shift on 8/2/23-8/7/23, 8/12/23-8/14/23, 8/19/23-8/21/23, 8/26/23-8/28/23 and 8/31/23. It further failed to evidence the Nystatin treatment completed on evening shift on 8/1/23-8/2/23, 8/5/23-8/6/23, 8/12/23-8/13/23, 8/19/23, 8/27/23 and 8/31/23. Review of the eTAR for R114 dated 9/1/23-9/30/23 failed to evidence the Nystatin treatment completed on day shift on 9/1/23-9/2/23, 9/4/23, 9/9/23, 9/11/23-9/12/23, 9/16/23-9/18/23, and 9/18/23. It further failed to evidence the Nystatin treatment completed on evening shift on 9/1/23-9/2/23, 9/9/23, 9/16/23-9/18/23, 9/21/23, and 9/23/23. Review of the eTAR for R114 dated 10/1/23-10/31/23 failed to evidence the Nystatin treatment completed on day shift on 10/7/23 and 10/20/23. The comprehensive care plan for R114 documented in part, [Name of R114] has potential for impairment of skin integrity r/t bowel and bladder incontinence. Date Initiated: 05/10/2022. Revision on: 03/13/2024. It failed to evidence the skin redness requiring the use of Nystatin from 7/3/23-7/24/23, 7/28/23-10/20/23 and 11/13/23-12/27/23. On 8/28/24 at 9:27 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the purpose of the care plan was to show the staff what they were supposed to do for the resident. She stated that it was their treatment plan, and it was revised and reviewed by both nursing staff and the MDS staff in the care plan meetings. LPN #1 stated that treatments were evidenced as completed by the staff signing them off on the eTAR. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 12:40 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 stated that the care plan purpose was for the staff to have a complete person-centered plan that showed what needed to be done for the resident. She stated that the care plan was updated after clinical meetings and done by the interdisciplinary team. She stated that the nursing staff provided care to any yeast rashes and evidenced the treatment as done by signing it off on the eTAR. On 8/30/24 at approximately 11:39 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #6, the regional director of clinical operations, ASM #9, the regional director of clinical operations, and ASM #8, the regional director of operations were made aware of the concern. No further information was obtained prior to exit. 27660 3. For Resident #110 (R110), the facility staff failed to review and revise the comprehensive are plan after the resident had a fall on 11/2/23. The eINTERACT SBAR (situation, background, assessment, recommendations) dated 11/2/23 at 6:18 a.m. documented in part, The change in condition reported - falls .Primary Care Provider Feedback: New Testing Orders. There was no documentation of the responsible party being notified. The comprehensive care plan dated, 8/4/23, documented in part, Focus: (R110) had an actual fall. The Interventions documented, Lab (laboratory) work as needed. OT (occupational therapy) order placed. X-ray ordered by MD/NP (medical doctor/nurse practitioner). The care plan further documented, dated 5/11/22, Focus: (R110) is at risk for falls. The Interventions documented in part, 10/4/22 - Encourage toileting q (every) 2-3 hours. 10/4/22 - Ensure wheelchair within reach. 10/4/22 - nurse to therapy referral prn (as needed). 8/8/23 - OT consult for treatment and evaluation. 5/11/22 - Provide assist with transfers, ambulation and bed mobility as necessary. 5/11/22 - Call bell within reach. 5/11/22 - Monitor/document/report PRN x 72 h (hours) to MD for s/sx (signs and symptoms): pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. 5/11/22 - neuro-checks as ordered. 5/11/22 - PT (physical therapy) consult for strength and mobility. There was no documented review or revision to the care plan after the fall of 11/2/23. An interview was conducted with RN (registered nurse) #5, the unit manager, on 8/29/24 at 12:40 p.m. When asked who is responsible for updating the care plan after a resident falls, RN #5 stated, the interdisciplinary team comes up with a plan and then it's updated by the MDS (minimum data set) nurse at the clinical meeting. The care plan for R110 was reviewed with ASM (administrative staff member) #2, the director of nursing, on 8/30/24 at 10:16 a.m. ASM #2 stated she did not see any updating of the care plan after the fall of 11/2/23. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #8, the regional director of operations and ASM #9, the regional director of clinical services, were made aware of the above concern on 8/30/24 at 11:00 a.m. No further information was provided prior to exit.

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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. 27660 Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for three of 50 residents in the survey sample, Residents #157, #34 and #72. The findings include: 1. For Resident #157, the facility staff failed to clarify two physician orders for blood sugar checks with insulin coverage in the clinical record at the same time. The physician order dated 8/9/24, documented, Humalog Solution 100 units/ML (milliliters) inject as per sliding scale: if (blood sugar) 1-70 = 0 (insulin) notify MD (medical doctor); 150 -199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 + = 5 units Notify MD > (greater than) 400, subcutaneously before meals and at bedtime for diabetes. D/C (discontinue date) 8/18/24. This order was documented on the MAR (medication administration record) from 8/9/24 through 8/18/24. The physician order dated 8/12/24, documented, Humalog Solution 100 units/ML (milliliters) inject as per sliding scale: if (blood sugar) 1-70 = 0 (insulin) notify MD (medical doctor); 150 -199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 + = 5 units Notify MD > (greater than) 400, subcutaneously before meals for diabetes. This order was documented on the MAR from 8/12/24 through 8/23/24. On the following dates and times, the nurses documented, Duplicate order. 8/13/24 at 6:41 p.m. 8/14/24 at 7:09 a.m. 8/14/24 at 4:14 p.m. 8/15/24 at 6:08 a.m. 8/16/24 at 8:30 a.m. 8/16/24 at 12:03 p.m. 8/16/24 at 5:15 p.m. 8/17/24 at 6:43 a.m. 8/17/24 at 11:00 a.m. 8/17/24 at 4:47 p.m. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/18/24 at 6:17 a.m. 8/18/24 at 12:30 p.m. An interview was conducted with RN (registered nurse) #5 on 8/29/24 at 12:40 p.m. When asked if she, as a nurse, saw a duplicate order on the MAR for a resident, what would she do, RN #5 stated, she would discontinue the duplicate order. RN #5 was asked if she would just document duplicate order at the time of administration, RN #5 stated, she would talk to the provider to make sure which of the orders is the correct one. The facility policy, Medication Administration, did not address when there are duplicate orders on the MAR. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit. 2. For Resident #34 (R34), the facility staff failed to administer medications per the physician orders for Metformin (used to treat diabetes) and Seroquel (used to treat schizophrenia). During an interview with R34 on 8/26/24 at 3:45 p.m. R34 stated that on 7/12/24 she did not get her medications until after 10:00 p.m. The physician order dated, 8/24/23, documented, Seroquel Oral Tablet 100 mg (milligrams); give 1.5 tablet by mouth at bedtime related to schizophrenia. The Seroquel is scheduled for administration at 9:00 p.m. Metformin HCL (hydrochloride) Oral Tablet 500 MG; give 1 tablet by mouth two times a day for diabetes. Give before meals. The scheduled time was 6:00 p.m. Dinner is served at the facility at 5:00 p.m. The MAR (medication administration record) for July 2024 documented the above orders. On 7/12/24 the Seroquel was documented as having been administered at 10:43 p.m., 1 hour and 45 minutes after the scheduled time. The Metformin was documented as having been administered on 7/12/24 at 7:58 p.m., 1 hour and 58 minutes after the scheduled time, which is still after the meal is served. An interview was conducted with RN #5, the unit manager, on 8/29/24 at 12:40 p.m. When asked when medications are to be administered, RN #5 stated, one hour before or one hour after the scheduled time. The facility policy, Medication Administration documented in part, The 5 Rights (right resident, right medication, right dose, right route, right time) must be confirmed at the following stages during medication administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit. 32642 3. For Resident #72 (R72), the facility staff failed to clarify two prn (as needed) orders for pain medication. A review of R72's clinical record revealed the following orders: 7/23/24 Oxycodone (an opioid pain medication) Oral Tablet 10 mg (milligrams) .Give 2 tablets by mouth every 4 hours as needed for pain. 7/16/24 Oxycodone-Acetaminophen (Percocet, an opioid pain medication) 7.5 - 325 mg Give 1 tablet by mouth every 4 hours as needed for pain medication. A review of R72's August 2024 MAR (medication administration record) revealed he received a total of 21 as needed doses of Oxycodone between 8/1/24 and 8/28/24. R72 received 28 doses of Percocet between 8/1/24 and 8/28/24. The review revealed pain level assessments prior to the administration of these pain medications to range primarily between 7 and 10. The as needed medications were administered over the entire range of days, evenings, and nights. The review revealed no clarification for these orders as to under which circumstances or pain rating each medication should be given. On 8/29/24 at 8:01 a.m., LPN (licensed practical nurse) # 5, a unit manager, was interviewed. She stated if a resident has two orders for prn pain medication, each order should specify the circumstances under which each medication should be given. After reviewing R72's August 2024 MAR, she stated: I'm not sure how the nurses know which medication to give (Percocet or Oxycodone). It should have a pain scale. It looks like his pain levels are the same for each [prn medication]. There should have been a parameter. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. No further information was provided prior to exit.

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	495339	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for dependent residents for four of 50 residents in the survey sample, Residents #96, #108, #32, and #67. The findings include: 1. For Resident #96 (R96), the facility staff failed to clean him and his bed linens after he vomited. On the most recent MDS (minimum data set), an admission assessment dated [DATE], R96 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring staff assistance for ADLs (activities of daily living). On 8/26/24 at 2:46 p.m., R96 was sitting up in bed. He stated that last Saturday, 8/24/24, he woke up very early in the morning, around 6:00 a.m. LPN (licensed practical nurse) #4 was at his bedside administering a tube feeding. As LPN #4 walked away from his bed towards the bathroom, he experienced severe nausea. He called out to the nurse, then vomited a large amount. He stated he caught some of the emesis in a basin, but much of it landed on his clothing and bed linens. He stated a CNA (certified nursing assistant) came in the room, but he could not remember the CNA's name. He stated the CNA placed a clean towel over his chest, and walked out of the room, along with LPN #4. He stated no one came in to clean him up and change his bed linens until after 9:00 a.m. that morning. A review of R96's clinical record revealed no evidence of this incident. On 8/29/24 at 7:30 a.m., LPN #4 were interviewed. She stated she remembered the morning that R96 vomited. She had worked the night shift, and was providing the resident's early morning tube feeding. She stated within about five minutes of finishing administering his tube feeding, he vomited it all back up. She stated the CNA working with her put a towel across the resident's chest, and walked out the door with her. She stated: I thought she was going to get supplies to clean him up. The CNA in question was not available for interview during the survey. A review of R96's care plan dated 7/12/24 revealed, in part: [R96] has an ADL self-care deficit .Physical assist as needed. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy, Activities of Daily Living, revealed, in part: Each resident shall be given proper daily personal attention and care, including skin, nails, hair, and oral hygiene, in addition to any specific care ordered by the attending physician .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .Hygiene (bathing, dressing, grooming, and oral care) .Residents will be assisted with dressing and grooming as appropriate. No further information was provided prior to exit. 42183 2.The facility staff failed to provide evidence of incontinence care for dependent Resident #108. Resident #108 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: CAD (coronary artery disease), COPD (chronic obstructive respiratory disease), hyponatremia and asthma. The most recent MDS (minimum data set) assessment, a discharge assessment, with an ARD (assessment reference date) of 5/20/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as being dependent for toileting, bathing and hygiene. A review of the comprehensive care plan with a revision date of 5/16/24, revealed, FOCUS: The resident has bladder incontinence related to decrease mobility weakness. INTERVENTIONS: Physical assist as needed with ADLs. Provide supervision and cuing as needed with ADLs. A review of the May 2024 ADL (activities of daily living) record revealed missing documentation for incontinence care, bathing and dressing on the following shifts and dates: Night: 5/15/24 and 5/19/24. An interview was conducted on 8/27/24 at 8:10 AM with CNA (certified nursing assistant) #1. When asked the process for incontinence care, CNA #1 stated, we round every two to three hours and provide the incontinence care, turning/repositioning at those times. When asked where the incontinence care would be evidenced, CNA #1 stated, we document it in PCC (point click care). On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's Activities of Daily Living policy revealed in part, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal care and oral hygiene. Provision or resident refusal of activities of daily living/personal care shall be documented in the clinical record. No further information was provided prior to exit. 42106 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. For Resident #32 (R32), the facility staff failed to provide ADL (activities of daily living) care to a dependent resident on multiple dates from 6/1/24 through 8/28/24. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/8/24, the resident scored 15 out of 15 on the BIMS (brief assessment for mental status), indicating R32 was cognitively intact for making daily decisions. Section GG documented R32 requiring supervision or touching assistance for toileting hygiene and being frequently incontinent of bowel and bladder. On 8/26/24 at 4:40 p.m., an interview was conducted with R32 in their room. R32 was observed sitting in a wheelchair in their room. R32 stated that they were often left wet and not changed in a timely manner. R32 stated that some of the CNA (certified nursing assistant) staff tell them that they should be able to get the bathroom and should not be incontinent but they could not help it. R32 stated that they could not walk since they had recently had COVID-19 and was working with therapy to get their strength back. R32 stated that they felt that the CNA staff did not believe that they could not help being incontinent and made them wait to be changed on purpose but could not name any specific staff. The comprehensive care plan for R32 documented in part, [Name of R32] has bladder/bowel incontinence. Date Initiated: 09/06/2022. Revision on: 06/02/2023. Review of the ADL documentation report for R32 dated 6/1/24-6/30/24 failed to evidence assistance with toileting provided on day shift on 6/2/24, 6/3/24, evening shift on 6/11/24 and night shift on 6/3/24, 6/9/24, 6/12/24, 6/19/24, 6/23/24 and 6/27/24. The documentation areas were either blank or documented NA. The report key documented NA-Not Applicable . Review of the ADL documentation report for R32 dated 7/1/24-7/31/24 failed to evidence assistance with toileting on evening shift on 7/4/24 and night shift on 7/4/24, 7/6/24, 7/9/24, 7/11/24, 7/12/24, 7/15/24, 7/17/24, 7/19/24, 7/24/24, 7/28/24 and 7/30/24. Review of the ADL documentation report for R32 dated 8/1/24-8/30/24 failed to evidence assistance with toileting on day shift on 8/5/24, 8/7/24-8/12/24, 8/14/24, 8/15/24, 8/18/24, and 8/26/24. If further failed to evidence assistance with toileting on evening shift 8/6/24, 8/16/24, 8/18/24, and 8/22/24, and on night shift on 8/4/24, 8/11/24, 8/12/24, 8/17/24, 8/19/24, 8/21/24, and 8/27/24. The documentation areas were either blank or documented NA. The report key documented NA-Not Applicable . Review of the clinical record failed to evidence documentation of R32 being out of the facility or refusing care on the dates listed above. On 8/29/24 at 11:20 a.m., an interview was conducted with CNA #7. CNA #7 stated that residents were rounded on every two hours to check for needs such as incontinence care, water, pain and turning and repositioning. She stated that the care that they provided to the resident was evidenced by their documentation in the ADLs each shift in the computer under toileting. On 8/30/24 at 10:00 a.m., an interview was conducted with CNA #8. CNA #8 stated that if NA was documented in the ADLs it meant not applicable and usually the resident was out at an appointment or not in the building at that time. She stated that it would be documented that the resident was out of the building in the medical record. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/24 at approximately 3:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit. 4. For Resident #67 (R67), the facility staff failed to provide ADL (activities of daily living) care to a dependent resident on 9/30/23 and multiple dates from 6/1/24 through 8/28/24. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/3/24, the resident scored seven out of 15 on the BIMS (brief assessment for mental status), indicating R67 was severely impaired for making daily decisions. Section GG documented R67 being dependent on staff for toileting, bathing, dressing, bed mobility, transfers, and personal hygiene. On 8/26/24 at 2:13 p.m., an observation was made of R67 in their room. R67 was observed in bed watching videos on an electronic device. A family member was observed sitting at R67's bedside. At that time, an interview was conducted with R67's family member who stated that on R67 had recently declined and been placed under hospice care. R67's family member stated that they had multiple concerns regarding the care that was received at the facility and stated that on 9/30/23, R67 had been left sitting up in the wheelchair all night long after returning to the facility from a leave with family. She stated that R67 had asked the staff to put them back to bed and they had not done it and the staff had told them that it was because R67 was refusing to go to bed. She stated that R67 had been left sitting in the wheelchair in soiled clothing and not assisted back to bed the entire night and not cleaned up until the day shift staff got there the next day. R67's family member further stated that the staff did not come in to turn and reposition them every two hours and left the resident soiled for extended periods of time. She stated that R67 could not turn themselves and relied on the staff to come in to turn them, but she often found him lying in one position the entire time she was there to visit. She stated that since hospice had come on board that they had been providing most of the care to R67. The comprehensive care plan for R67 documented in part, [Name of R67] has an ADL self-care performance deficit AEB (as evidenced by) spinal stenosis, osteoarthritis, & pain. Date Initiated: 02/01/2024. Revision on: 02/01/2024. Under Interventions it documented in part, .Physical assist as needed with ADLs. Date Initiated: 05/30/2023. Revision on: 06/14/2023 . Review of the ADL documentation report for R67 dated 9/1/23-9/30/23 failed to evidence any ADL care provided, transfer assistance provided, refusal of care or behaviors displayed by R67 on the night shift (11:00 p.m. to 7:00 a.m.) shift for 9/30/23. Review of the ADL documentation report for R67 dated 6/1/24-6/30/24 failed to evidence assistance with bed mobility provided on day shift on 6/14/24 and 6/30/24, and on evening shift on 6/14/24, 6/17/24, 6/21/24 and 6/23/24. It further failed to evidence assistance with bed mobility on night shift on 6/1/24, 6/4/24, 6/7/24, 6/8/214, 6/11/24, 6/15/24, 6/19/24, 6/22/24, 6/28/24 and 6/30/24. The documentation areas were either blank or documented NA. The report key documented NA-Not Applicable . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the ADL documentation report for R67 dated 7/1/24-7/31/24 failed to evidence assistance with bed mobility provided on day shift on 7/4/24, and on night shift on 7/2-7/8/24, 7/10-7/22/24, 7/24-7/27/24, 7/30/24 and 7/31/24. The documentation areas were either blank or documented NA. The report key documented NA-Not Applicable . Review of the ADL documentation report for R67 dated 8/1/24-8/30/24 failed to evidence assistance with bed mobility provided on day shift on 8/17/24, and on evening shift on 8/17/24 and 8/21/24. If further failed to evidence assistance with bed mobility on night shift on 8/2/24, 8/4/24, 8/10-8/12/24, 8/17/24, 8/19/24, 8/21/24, 8/23/24, and 8/28/24. The documentation areas were either blank or documented NA. The report key documented NA-Not Applicable . The progress notes for R67 documented in part, - 09/29/2023 07:50 Note Text: Resident went OOF (out of facility) this morning as per his routine, facility aware. Resident had morning meds w/O difficulty before leaving. - 09/30/2023 22:42 (10:42 p.m.) Note Text: Aide offered to put resident down after writer finished medication pass, refused 3x to go to bed and stated wanted to sit on commode for an hour before bed advised that due to pressure sore risks and skin integrity complications that this was strongly advised against. Brief on and intact, offered to help change brief, denied assistance. Passed in report that resident refused help offered to him. The progress notes for R67 failed to evidence documentation of any further attempts to provide care to R67 during the night shift on 9/30/2023 or refusal of care. Review of the clinical record failed to evidence documentation of R67 being out of the facility or refusing care on the dates listed above. On 8/28/24 at approximately 8:45 a.m., ASM (administrative staff member) #1, the administrator stated that the RN (registered nurse) who wrote the progress note on 9/30/23 and the CNA (certified nursing assistant) who worked on the unit that R67 resided on 9/30/23, no longer worked at the facility. On 8/29/24 at 11:20 a.m., an interview was conducted with CNA #7. CNA #7 stated that residents were rounded on every two hours to check for needs such as incontinence care, water, pain and turning and repositioning. She stated that the care that they provided to the resident was evidenced by their documentation in the ADLs each shift in the computer. She stated that she was not aware of any residents who would be left up in their wheelchair all night unless that was what they requested or if it was a behavior and it would be reported to the nurse and documented. She stated that when she worked with R67, they were complaint with care. She stated that R67 required staff to turn and reposition them and they documented the care provided under bed mobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/24 at 10:00 a.m., an interview was conducted with CNA #8. CNA #8 stated that when a resident refused care, they let the nurse know and returned to the resident later with the nurse to re-attempt the care. She stated that if the resident still refused the care it was documented in the medical record in the ADLs and the nurse also documented the refusal and reported it. She stated that if NA was documented in the ADLs it meant not applicable and usually the resident was out at an appointment or not in the building at that time and the nurses documented where the resident was in their notes. On 8/29/24 at approximately 3:40 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN (registered nurse) #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services to promote a resident's highest level of well-being for eight of 50 residents in the survey sample, Residents #157, #34, #114, #113, #108, #112, #117 and #53. The findings include: 1.a. For Resident #157 (R157), the facility staff failed to obtain blood sugars as ordered by the physician. During an interview with R157 on 8/26/24 at 3:55 p.m. the resident stated that the nurses come in to do her blood sugar either while she is eating or after she finishes eating. Then they try to give her insulin and the blood sugar is high due to eating. The physician order dated 8/9/24, documented, Humalog Solution 100 units/ML (milliliters) inject as per sliding scale: if (blood sugar) 1-70 = 0 (insulin) notify MD (medical doctor); 150 -199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 + = 5 units Notify MD > (greater than) 400, subcutaneously before meals and at bedtime for diabetes. D/C (discontinue date) 8/18/24. The blood sugars are scheduled for 7:00 a.m., 11:00 a.m., 4:00 p.m. and 9:00 p.m. The physician order dated 8/12/24, documented, Humalog Solution 100 units/ML (milliliters) inject as per sliding scale: if (blood sugar) 1-70 = 0 (insulin) notify MD (medical doctor); 150 -199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 + = 5 units Notify MD > (greater than) 400, subcutaneously before meals for diabetes. The blood suugars are scheduled for 6:30 a.m., 11:00 a.m. and 4:00 p.m. The physician order dated 8/23/24, documented, Humalog Solution 100 units/ML (milliliters) inject as per sliding scale: if (blood sugar) 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units; 451 - 500 = 14 units. subcutaneously before meals for diabetes. The blood sugars are scheduled for 6:30 a.m., 11:00 a.m. and 4:00 p.m. The documented mealtimes for the facility are: Breakfast - 7:30 a.m. Lunch - 12:00 p.m. Dinner - 5:00 p.m. The August 2024 MAR (medication administration record) documented the above orders. On the following dates and times, the blood sugars were taken during or after the meals: 8/10/24 at 5:48 p.m. - scheduled for 4:00 p.m. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/11/24 at 5:50 p.m. - scheduled for 4:00 p.m. 8/12/24 at 9:20 a.m. - scheduled for 7:00 a.m. 8/12/24 at 5:39 p.m. - scheduled for 4:00 p.m. 8/13/24 at 12:02 p.m. - scheduled for 11:00 a.m. 8/13/24 at 6:41 p.m. - scheduled for 4:00 p.m. 8/21/24 at 6:25 p.m. - scheduled for 4:00 p.m. 8/23/24 at 12:48 p.m. - scheduled for 11:00 a.m. 8/24/24 at 6:60 p.m. - scheduled for 4:00 p.m. 8/26/24 at 10:21 p.m. - scheduled for 4:00 p.m. 8/27/24 at 1:10 p.m. - scheduled for 11:00 a.m. 8/28/24 at 1:41 p.m. - scheduled for 11:00 a.m. The comprehensive care plan dated 8/21/24, documented in part, Focus: (R157) has Diabetes Mellitus. The Interventionsdocumented in part, Fasting Serum Blood Sugar as ordered by doctor. An interview was conducted with ASM (administrative staff member) #4, the nurse practitioner, on 8/29/24 at 9:54 a.m. When asked why a resident is on sliding scale insulin, ASM #4 stated, to help cover them when the blood sugars are higher when the resident has eaten sugary snacks. ASM #4 was asked what times they are normally ordered, ASM #4 stated before meals and at bedtime. When asked what would happen if the blood sugar was taken after the resident ate their meal, ASM #4 stated, it depends, if they've only eaten five bites or so, then nothing, but if they've eaten their whole meal, say 30 minutes to an hour later, it would elevate the blood sugar, thus giving them too much insulin and the risk of their blood sugar going too low. An interview was conducted with RN (registered nurse) #5 on 8/29/24 at 12:40 p.m. When asked when blood sugars are taken for a resident receiving sliding scale insulin, RN #5 stated, before meals and at bedtime. RN #5 was asked if she would take a blood sugar if the resident has started to eat their meal, RN #5 stated, no. When asked the purpose of taking the blood sugar before meals, RN #5 stated the meal would make the blood sugar go up. RN #5 was asked if dinner is at 5:00 p.m. is it appropriate to take the blood sugar at 6:30 p.m., RN #5 stated no, the purpose is to take it before the meal is eaten. The facility policy, Medication Administration, documented in part, 6. Obtain and document any necessary vital signs or monitoring parameters before administration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit. 1.b. For Resident #157, the facility staff failed to administer insulin as ordered by the physician. The physician order dated 8/23/24 documented, Levemir Flex Pen Subcutaneous Solution Pen- Injector 100 UNIT/ML; Inject 50 units subcutaneously at bedtime for DM (diabetes mellitus). The August 2024 MAR documented the above order. On 8/24/24, there was a blank on the space for the medication to be documented as administered. Review of the nurse's notes failed to evidence documentation of a reason why the medication was not given. The comprehensive care plan dated 8/21/24, documented in part, Focus: (R157) has Diabetes Mellitus. The Interventionsdocumented in part, Diabetes medication as ordered by doctor. An interview was conducted with RN #5 on 8/29/24 at 12:40 p.m. When asked how she evidenced that she's given a medication, RN #5 stated she documents in on the electronic MAR. The facility policy, Medication Administratiomn documented in part, 7. After administering the medication, return multi-dose containers to the cart and document the administration in the MAR/TAR, including controlled substances where applicable. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #8, the regional director of operations, and ASM #9, the regional director of clinical services were made aware of the above concern on 8/30/24 at 11:00 a.m. No further information was obtained prior to exit. 1.c. For Resident #157, the facility staff delayed in starting an antibiotic for the treatment of an infection and the 8:00 p.m. dose was not documented as having been given on 8/24/24. The physician order dated 8/22/24 at 3:42 p.m. documented, Clindamycin HCL (hydrochloride)(an antibiotic); 150 MG (milligrams) give 3 capsules by mouth three times a day for abscess to buttocks for 10 days. The medication was scheduled for 7:00 a.m., 11:00 a.m. and 8:00 p.m. The August 2024 MAR documented the above order. The first dose was documented as having been given on 8/23/24 at 7:00 a.m. On 8/24/24 at the scheduled 8:00 p.m. dose, nothing was documented in the space. Review of the contents of the facility, onsite, pharmacy system, documented the Clindamycin 150 mg was available in the system. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan dated, 8/23/24, documented in part, Focus: (R157) is on antibiotic therapy r/t (related to) abscess to right buttock. The Interventions documented in part, Administer ANTIBIOTIC medications as ordered by physician. An interview was conducted with RN #5 on 8/29/24 at 12:40 p.m. When asked if a physician order is written on 8/22/24 for an antibiotic, when would the antibiotic be started, RN #5 stated, on the 22nd, if it was started on the 23rd, it would be a delay in treatment. When asked how she evidenced that she's given a medication, RN #5 stated she documents in on the electronic MAR. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #8, the regional director of operations, and ASM #9, the regional director of clinical services were made aware of the above concern on 8/30/24 at 11:00 a.m. No further information was obtained prior to exit. 2. For Resident #34 (R34), the facility staff failed to administer Xarelto (used to prevent blood clots). An interview was conducted with R34 on 8/26/24 at 3:45 p.m. The resident stated that she had missed several doses of her Xarelto. The physician order dated 7/31/23, documented, Xarelto Oral Tablet 20 MG (Rivaroxaban); Give 1 tablet by mouth in the evening for prophylactic related to personal history of other venous thrombosis and embolism; atherosclerosis of aorta. The August MAR (medication administration record) documented the above order. On 8/21/24 and 8/22/24, a 9 was documented in the administration box on the MAR. A 9 indicated, Other/See Progress Note. Review of the progress notes dated 8/21/24 and 8/22/24, documented, Not on hand. for both days. Review of the contents of the facility, onsite, pharmacy system, documented the Xarelto 10 mg tablets were available in the system. The comprehensive care plan dated 8/18/23 documented in part. Focus: The resident is on anticoagulant therapy. The Interventions documented in part, Administer ANTOCOAGULANT medications as ordered by physician. An interview was conducted with RN #5 on 8/29/24 at 12:40 p.m. When asked what she does if a medication is not on the medication cart at the scheduled time for administration, RN #5 stated she would first call the pharmacy. RN #5 was asked if the facility had a backup system for medications, RN#5 stated, yes, I would check there especially if the pharmacy were not open. When asked if the medication is not in the backup system, does she have to notify anyone, RN #5 stated, yes, we have to notify the provider and the responsible party for the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Unavailable Medications, documented in part, Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, or manufacturer's shortage of an ingredient, or may be permanent situation due to the medication no longer being produced. The facility must make every effort to ensure that medications are available to meet the needs of each resident .The nursing staff shall: 1. Notify the attending physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available. If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit. 42106 3. For Resident #114 (R114), the facility staff failed to provide care and services to a non-pressure related skin condition as ordered on multiple dates in August 2023, September 2023 and October 2023. The physician orders for R114 documented in part, - Nystatin External Cream 100000 UNIT/GM (Nystatin (Topical)) Apply to affected areas topically every day and evening shift for redness until healed. Order Date: 06/13/2024. Review of the eTAR (electronic treatment administration record) for R114 dated 8/1/23-8/31/23 failed to evidence the Nystatin treatment completed on day shift on 8/2/23-8/7/23, 8/12/23-8/14/23, 8/19/23-8/21/23, 8/26/23-8/28/23 and 8/31/23. It further failed to evidence the Nystatin treatment completed on evening shift on 8/1/23-8/2/23, 8/5/23-8/6/23, 8/12/23-8/13/23, 8/19/23, 8/27/23 and 8/31/23. Review of the eTAR for R114 dated 9/1/23-9/30/23 failed to evidence the Nystatin treatment completed on day shift on 9/1/23-9/2/23, 9/4/23, 9/9/23, 9/11/23-9/12/23, 9/16/23-9/18/23, and 9/18/23. It further failed to evidence the Nystatin treatment completed on evening shift on 9/1/23-9/2/23, 9/9/23, 9/16/23-9/18/23, 9/21/23, and 9/23/23. Review of the eTAR for R114 dated 10/1/23-10/31/23 failed to evidence the Nystatin treatment completed on day shift on 10/7/23 and 10/20/23. On 8/28/24 at 9:27 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that non-pressure treatments were completed by the floor nurses assigned each day and they were evidenced as completed by the staff signing them off on the eTAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/24 at 12:40 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 stated that the nursing staff provided care to any yeast rashes as ordered by the physician and evidenced the treatment as done by signing it off on the eTAR. The facility provided policy, Non-Pressure Injury/Ulcer Management documented in part, .Treatments, including preventative interventions, will be documented in the resident's medical record . On 8/30/24 at approximately 11:39 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #6, the regional director of clinical operations, ASM #9, the regional director of clinical operations, and ASM #8, the regional director of operations were made aware of the concern. No further information was obtained prior to exit. 42183 4. The facility failed to administer anticoagulation therapy as ordered for Resident #113. Resident #113 was admitted to the facility on [DATE] with diagnosis that included fractures and hypertension. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 7/26/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers, dressing, hygiene toileting and independent for eating. A review of the baseline care plan dated 8/3/23 revealed, FOCUS: Resident has actual impairment to skin integrity related to Surgical Wound. INTERVENTIONS: Administer medications, supplements and treatments as ordered. Monitor/document for side effects and effectiveness. There is no evidence of the baseline care plan including any focus or interventions related to anticoagulation therapy or monitoring. A review of the physician order dates 7/21/23 revealed Enoxaparin Sodium Injection Prefilled Syringe Kit 40 MG/0.4ML. Inject 0.4 ml subcutaneously every 12 hours. A review of the July and August 2023 MAR (medication administration record) reveals scheduled time for Enoxaparin injection scheduled for 12:00 AM and 12:00 PM. Review of the administration times reveals the following delays in administration of Enoxaparin: 7/22- 3:28 AM and 1:30 PM, 7/24-1:30 PM, 7/31-1:21 AM and 1:37 PM, 8/2-5:00 AM and 1:29 PM, 8/5-2:42 PM, 8/6-1:24 PM, 08/7-1:24 PM, 8/8-2:54 PM, 8/10-1:15 PM, 8/11-3:26 AM and 1:10 PM and 8/12-1:50 AM and 4:17 PM. An interview was conducted on 8/27/24 at 2:45 PM with LPN (licensed practical nurse) #2. When asked where the evidence of anticoagulation injections would be located, LPN #2 stated, it would be on the MAR. When asked if the physician orders for anticoagulation medication administration were not followed, were professional standards followed, LPN #2 stated, no, they would not be followed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's Medication Administration policy revealed in part, This policy establishes the guidelines for the safe and effective administration of medications at Hill Valley Healthcare. All medications administered within the facility are subject to these guidelines. The 5 Rights (right resident, right medication, right dose, right route, right time) must be confirmed at the following stages during medication administration. No further information was provided prior to exit. 5. The facility staff failed to provide respiratory care services per physician orders for Resident #108. Resident #108 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: CAD (coronary artery disease), COPD (chronic obstructive respiratory disease), hyponatremia and asthma. The most recent MDS (minimum data set) assessment, a discharge assessment, with an ARD (assessment reference date) of 5/20/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as being dependent for toileting, bathing and hygiene. A review of the comprehensive care plan with a revision date of 5/16/24, revealed, FOCUS: The resident has altered respiratory status/difficulty breathing related to COPD, acute/chronic respiratory failure with hypoxia. INTERVENTIONS: Monitor/document/report abnormal breathing patterns to MD: increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed-lip breathing and nasal flaring. A review of the physician orders dated 5/15/24 revealed, Respiratory Assessment: Assess lung sounds, respiratory rate, pulse Ox and report any abnormalities to physician (document abnormalities in nursing note). Educate resident on importance of reporting respiratory changes. every shift for 14 Days. A review of the May 2024 TAR (treatment administration record) revealed missing documentation for the respiratory assessment on day shift: 5/16 and 5/18 as well as night shift on 5/17. An interview was conducted on 8/27/24 at 2:45 PM with LPN (licensed practical nurse) #2. When asked where the evidence of respiratory assessments would be located, LPN #2 stated, it would be on the TAR. When asked if the physician orders for respiratory care were not followed, were professional standards followed, LPN #2 stated, no, they would not be followed. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R117's hospital discharge summary dated 1/26/23 revealed, in part: Primary Discharge Diagnosis .Diabetes mellitus .Diabetes mellitus with hyperglycemia (high blood sugar) .Continue glycemic protocol .Consider increasing sliding scale. A review of R117's clinical record revealed the resident was admitted to the facility on [DATE] at approximately 10:00 p.m. This review revealed the following progress notes: 1/28/23 Note text 1903 (7:03 p. m.) .Notified by RP (responsible party) resident is on scheduled insulin and accuchecks (blood sugar checks) four times a day at home. NP (nurse practitioner) made aware and new orders received and RP made aware. This reviewed revealed the provider gave orders for accuchecks and insulin on 1/28/23 at 7:26 p.m. These were the first orders for accuchecks and insulin since the resident's admission on 1/16/23. On 8/29/24 at 9:40 a.m., ASM (administrative staff member) #4, a nurse practitioner, was interviewed. She stated if a resident has been on accuchecks and insulin in the hospital, she would initially order sliding scale insulin before meals and at bedtime. Once the resident's insulin needs have been established, she stated she attempts to get the resident on scheduled insulin rather than a sliding scale. She added: If they are on something at the hospital, they should be on something here. On 8/29/24 at 1:07 p.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated if a resident is discharged with orders for insulin, those orders should be called in to the provider for approval. She stated the whole of the resident's discharge records should be reviewed for accurate medication reconciliation. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. No further information was provided prior to exit. 7.b. For Resident #117 (R117), the facility staff failed to assess a surgical wound. A review of R117's hospital discharge summary dated 1/26/23 revealed, in part: Staples from knee to be removed 1/30/23. Cover with dry dressing for 2 days then discontinue the dressing. Follow up with [name of orthopedic surgeon] 3/1/23. A review of R117's clinical record revealed no evidence of assessment of R117's knee surgical wound between her admission on 1/26/23 and the removal of the staples on 1/30/23. On 8/29/24 at 1:07 p.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated if a resident is admitted with a surgical wound, she would look for orders for wound care on the resident's hospital discharge summary. She stated, If there are orders there, we need to follow them. She stated the facility staff are responsible for assessing the surgical site prior to removal of any stitches or staples. She stated the assessment needs to include skin integrity and any signs or symptoms of infection. She stated if there are no orders on the discharge summary, the wound nurse should be contacted for orders. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42106 Based on observation, resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide care and services to promote healing of pressure injuries for three of 50 residents in the survey sample, Residents #67, #111 and #116. The findings include: 1. For Resident #67 (R67), the facility staff failed to provide treatment as ordered to a pressure injury (1) on multiple dates from 6/1/24 through 8/28/24. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/3/24, the resident scored seven out of 15 on the BIMS (brief assessment for mental status), indicating R67 was severely impaired for making daily decisions. The assessment documented R67 having one Stage II pressure injury that was not present on admission. On 8/26/24 at 2:13 p.m., an observation was made of R67 in their room. R67 was observed in bed watching videos on an electronic device. A family member was observed sitting at R67's bedside. At that time, an interview was conducted with R67's family member who stated that on R67 had recently declined and been placed under hospice care. R67's family member stated that they had multiple concerns regarding the care that was received at the facility. R67's family member stated that the staff did not come in to turn and reposition every two hours and left the resident soiled for extended periods of time. She stated that R67 could not turn themselves and relied on the staff to come in to turn them, but she often found him lying in one position the entire time she was there to visit. She stated that since hospice had come on board that they had been providing most of the care to R67. She stated that the staff were supposed to put a cream on R67's backside for skin breakdown but they did not do it like they were supposed to. The comprehensive care plan for R67 documented in part, [Name of R67] has potential for impairment to skin integrity r/t impaired mobility. Date Initiated: 08/18/2023. Revision on: 08/26/2024. The physician orders for R67 documented in part, - Apply zinc cream to lower back every shift for rash every shift. Order Date: 07/21/2024. - Skin protectant to left heel twice daily two times a day for skin protectant. Order Date: 06/03/2024. - Zinc to bilateral buttock and perianal area q shift and prn as needed. Order Date: 07/02/2024. - Greers goo perianal and buttock daily and PRN every evening shift for MASD (moisture associated skin damage). Start Date: 06/7/2024. - Clean right and left buttock with wound cleanser, skin prep periwound and apply medihoney and cover with foam dressing QD (every day) and prn every day shift. Start Date: 06/07/2024. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cleanse right buttock with wound cleanse, apply medihoney and dry dressing daily and prn every day shift. Start Date: 07/02/2024. Review of the eTAR (electronic treatment administration record) for R67 dated 6/1/24-6/31/24 failed to evidence the Greers goo treatment administered on 6/7/24-6/11/24 and 6/24/24. It further failed to evidence the treatment to the left buttock administered on 6/9/24. Review of the eTAR for R67 dated 7/1/24-7/30/24 failed to evidence the zinc to the bilateral buttocks and perianal area on day shift 7/3/24 and evening shift on 7/5/24. It further failed to evidence treatment to the right buttock medihoney treatment completed on 7/4/24, 7/13/24, and 7/14/24. Review of the eTAR for R67 dated 8/1/24-8/31/24 failed to evidence the zinc to the bilateral buttocks and perianal area on day shift on 8/12/24 and 8/17/24, on evening shift on 8/13/24 and 8/15/24 and on night shift on 8/9/24 and 8/24/24. It further failed to evidence the zinc cream to the lower back administered on day shift 8/12/24 and 8/17/24, on evening shift 8/13/24 and 8/15/24 and on night shift 8/9/24 and 8/24/24. On 8/28/24 at 9:27 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the wound nurse was there during the week and when she was not there the floor nurses were expected to complete the wound care treatments. She stated that the wound care was evidenced by the nurse writing the time, date, and initials on the dressing and signing them off as completed on the eTAR. On 8/28/24 at 11:39 a.m., an interview was conducted with RN (registered nurse) #3, wound care. RN #3 stated that they had been at the facility for about two months and prior to them starting, the floor nurses were doing the wound care treatments. She stated that wound care was evidenced as done by the nurse signing off on the eTAR and if not completed or the resident was not available for the wound care it would be documented on the eTAR and the provider would be made aware. The facility provided policy, Non-Pressure Injury/Ulcer Management documented in part, .Treatments, including preventative interventions, will be documented in the resident's medical record . On 8/29/24 at approximately 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit. Reference: (1) Pressure injury (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website:https://medlineplus.gov/ency/patientinstructions/000740.htm. 2. For Resident #111 (R111), the facility staff failed to provide treatment to a pressure injury (1) as ordered on multiple dates from 9/1/23-12/31/23. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/2/24, the resident was assessed as having one Stage 2 pressure injury that was not present on admission. The comprehensive care plan for R111 documented in part, [Name of R111] has an unstageable pressure ulcer (see wound nurse note 3/24/2023) on her sacrum r/t decreased mobility, incontinence. Date Initiated: 05/05/2023. Revision on: 11/02/2023. Under Interventions it documented in part, Apply treatments as ordered and monitor for effectiveness. Date Initiated: 05/05/2023. Revision on: 11/02/2023. The progress notes for R111 documented in part, 6/7/2023 16:18 (4:18 p.m.) Weekly wound assessment completed. Unstageable Pressure Ulcer to other: Sacral. Overall impression: new wound- first observation. See wound evaluation weekly for additional details . The physician orders for R111 documented in part, Clean area to sacrum with normal saline or soap and water apply barrier cream cover with foam dressing qday (every day) and prn (as needed) when soiled. every day shift for assessment. Review of the eTAR (electronic treatment administration record) for R111 dated 9/1/23-9/30/23 failed to evidence a treatment completed as ordered to the sacral area on 9/4/23, 9/9/23, 9/11/23, 9/15-9/18/23, 9/21/23, 9/23/23, and 9/28/23. Review of the eTAR for R111 dated 10/1/23-10/31/23 failed to evidence a treatment completed as ordered to the sacral area on 10/6/23, 10/7/23, and 10/24/23. Review of the eTAR for R111 dated 11/1/23-11/30/23 failed to evidence a treatment completed as ordered to the sacral area on 11/17/23. Review of the eTAR for R111 dated 12/1/23-12/31/23 failed to evidence a treatment completed as ordered to the sacral area on 12/1/23, 12/7/23, 12/16/23, 12/17/23, 12/19/23, and 12/22-12/24/23. On 8/28/24 at 9:27 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the wound nurse was there during the week and when she was not there the floor nurses were expected to complete the wound care treatments. She stated that the wound care was evidenced by the nurse writing the time, date, and initials on the dressing and signing them off as completed on the eTAR. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at 11:39 a.m., an interview was conducted with RN (registered nurse) #3, wound care. RN #3 stated that they had been at the facility for about two months and prior to them starting the floor nurses were doing the wound care treatments. She stated that wound care was evidenced as done by the nurse signing off on the eTAR and if not completed or the resident was not available for the wound care it would be documented on the eTAR and the provider would be made aware. On 8/29/24 at approximately 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN (registered nurse) #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit. Reference: (1) Pressure injury A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm. 42183 3.The facility failed to evidence wound treatment for Resident #116. Resident #116 was admitted to the facility on [DATE] with diagnosis that included but were not limited to dementia, sacral ulcer and ASCVD (atherosclerotic cardiovascular disease). The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 3/6/23, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for bathing/transfer/dressing/toileting and supervision for eating. A review of the comprehensive care plan dated 9/14/22 revealed, FOCUS: Resident has a skin tear to her right shin. INTERVENTIONS: Treatment as ordered. A review of the physician orders dated 12/24/22 revealed, Cleanse wound to right lower leg and Left forearm with wound cleanser, apply xeroform gauze to wound, cover with kerlix, secure with tape. One time a day for skin tear. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the December 2022, January 2023 and February 2023 MAR (medication administration record) revealed missing evidence of wound treatments provided on the following dates: 12/28/22, 12/30/22, 12/31/22, 1/2/23, 1/3/23, 1/13/23, 1/16/23, 1/21/23 1/24/23, 1/31/23, and 2/7/23. An interview was conducted on 8/29/24 at 2:20 PM with LPN (licensed practical nurse) #3. When asked where evidence of wound treatment would be located, LPN #3 stated, it would be on the TAR. When asked if there is no evidence that is has been completed, has wound care been performed, LPN #3 stated, no, it has not been. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's Non-Pressure Injury/Ulcer Management policy revealed in part, Treatments will be ordered by the physician/practitioner. Treatments including preventive interventions will be documented in the resident's medical record. No further information was provided prior to exit.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42106 Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide care and services for an indwelling catheter for two of 50 residents in the survey sample, Residents #67 and #24. The findings include: 1. For Resident #67 (R67), the facility staff failed to provide urinary catheter care on multiple dates from 6/1/24 through 8/28/24. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 7/3/24, the resident scored seven out of 15 on the BIMS (brief assessment for mental status), indicating R67 was severely impaired for making daily decisions. Section H documented R67 having an indwelling urinary catheter. On 8/26/24 at 2:13 p.m., an observation was made of R67 in their room. R67 was observed in bed watching videos on an electronic device. A family member was observed sitting at R67's bedside. At that time, an interview was conducted with R67's family member who stated that on R67 had recently declined and been placed under hospice care. R67's family member stated that they had multiple concerns regarding the care that was received at the facility. R67's family member stated that the staff emptied the catheter bag but were not sure about what care they provided for the catheter itself. The comprehensive care plan for R67 documented in part, [Name of R67] has a 16Fr foley catheter r/t BPH (benign prostatic hypertrophy), obstructive uropathy. Date Initiated: 12/04/2023. Revision on: 08/26/2024. Under Interventions it documented in part, Catheter care q (every) shift and as needed. Date Initiated: 04/03/2024 . The physician orders for R67 documented in part, Cath care every shift and as needed every shift. Order Date: 12/04/2023. Review of the eTAR (electronic treatment administration record) for R67 dated 6/1/24-6/30/24 failed to evidence catheter care provided on day shift on 6/7/24, and on evening shift 6/7/24 and 6/24/24. Review of the eTAR for R67 dated 7/1/24-7/31/24 failed to evidence catheter care provided on day shift on 7/3/24. Review of the eTAR for R67 dated 8/1/24-8/30/24 failed to evidence catheter care provided on day shift on 8/12/24 and 8/17/24, on evening shift on 8/13/24 and 8/15/24 and on night shift 8/9/24 and 8/24/24. On 8/29/24 at 11:20 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that catheter care was provided every shift. She stated that they emptied the catheter bags and cleaned the skin around the catheter unless there was a special treatment ordered and then the nurse did the treatment. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 12:40 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 stated that the catheter care was provided as ordered by the physician. She stated that the orders triggered on the eTAR for the nurse to complete the treatment and document it as completed. She stated that the documentation was how the care was evidenced as completed. She stated that if there were no orders for the catheter the physician should be called to get orders for care. The facility policy Urinary Catheter Care documented in part, .Documentation- The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given . On 8/29/24 at approximately 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit. 2. For Resident #24 (R24), the facility staff failed to provide catheter care on multiple dates from 6/1/24 through 7/30/24. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 6/14/24, the resident scored 15 out of 15 on the BIMS (brief assessment for mental status), indicating R24 was cognitively intact for making daily decisions. Section H documented R24 having an indwelling catheter. On 8/26/24 at 2:18 p.m., an interview was conducted with R24 in their room. A urinary catheter bag was observed attached to the bed frame of R24's bed with a privacy cover intact. R24 stated that they had a urinary catheter and had it for a few years now which they saw the urologist for regularly. R24 stated that the staff changed the catheter when it was leaking and emptied the bag every day. R24 stated that the staff kept gauze around the catheter site and changed it when it came off. R24 stated that they were unsure if there was a schedule for catheter care of not. The comprehensive care plan for R24 documented in part, [Name of R24] has Suprapubic (1) Catheter: Obstructive Uropathy. Date Initiated: 07/29/2022. Revision on: 09/07/2022. Under Interventions it documented in part, .Catheter care Q (every) shift and PRN (as needed). Date Initiated: 07/29/2022 . The physician orders for R24 documented in part, - Order Date: 06/06/2022. Cath care every shift and as needed- may be performed by CNA (certified nursing assistant), verified by nurse every shift. End Date: 06/06/2024. - Order Date: 08/02/2024. Foley cath care every shift and prn (as needed). every shift related to Neuromuscular dysfunction of bladder, unspecified. - Order Date: 06/26/2024. regular gauze cut with split to place around suprapubic catheter, Zinc oxide to periwound daily and PRN for soilage and or dislodgement. as needed for soilage and or dislodgement AND every day shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the eTAR (electronic treatment administration record) for R24 dated 6/1/24-6/30/24 failed to evidence catheter care provided 6/4/24-6/26/24. Review of the eTAR for R24 dated 7/1/24-7/31/24 failed to evidence catheter care provided on 7/26/24 and 7/29/24. On 8/29/24 at 11:20 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that catheter care was provided every shift. She stated that they emptied the catheter bags and cleaned the skin around the catheter unless there was a special treatment ordered and then the nurse did the treatment. On 8/29/24 at 12:40 p.m., an interview was conducted with RN (registered nurse) #5. RN #5 stated that catheter care was provided as ordered by the physician. She stated that the orders triggered on the eTAR for the nurse to complete the treatment and document it as completed. She stated that the documentation was how the care was evidenced as completed. She stated that if there were no orders for the catheter the physician should be called to get orders for care. On 8/29/24 at approximately 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, RN #4, the assistant director of nursing and infection preventionist, and ASM #8, the regional director of operations were made aware of the concern. No further information was provided prior to exit. Reference: (1) A suprapubic catheter (tube) drains urine from your bladder. It is inserted into your bladder through a small hole in your belly. You may need a catheter because you have urinary incontinence (leakage), urinary retention (not being able to urinate), surgery that made a catheter necessary, or another health problem. This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000145.htm.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 27660 Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to complete nutritional assessments and obtain daily weights for one of 50 residents in the survey sample, Resident #34. The findings include: A. For Resident #34 (R34), the facility failed to obtain physician ordered daily weights. An interview was conducted with R34 on 8/26/24 at 3:45 p.m. R34 stated that she is supposed to have daily weights done. She stated if she didn't go to the scales to get weighed, no one would come get her to do it. She has missed a few weights. The physician order dated, 7/12/24, documented, Daily weights every day shift for sig (significant) weight gain. Use same scale/method for each wt (weight). The MAR (medication administration record) for July 2024 and August 2024 documented the above order. On 7/13/24, 7/14/24 and 7/20/24, there were blanks where the weight was to be documented. The comprehensive care plan dated 8/17/23 and revised on 8/9/24, documented in part, Focus: (R34) is at risk for alteration in nutritional status risk for malnutrition, multiple comorbidities. Regular diet. Res. (resident) has potential for weight gain r/t (related to) enjoying snacks and additional sandwiches with meals. The Interventions documented in part, Daily Weight r/t sig (significant) weight gain. An interview was conducted with RN (registered nurse) #5, the unit manager, on 8/29/24 at 12:40 p.m. When asked how she evidenced the physician ordered daily weights, RN #5 stated, it's documented in the electronic record. The facility policy, Physician Orders did not evidence following the physician orders. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #8, the regional director of operations, and ASM #9, the regional director of clinical services, were made aware of the above concern on 8/30/24 at 11:00 a.m. No further information was obtained prior to exit. B. For Resident #34, the facility staff failed to complete a quarterly nutritional assessment. There was no assessment between 12/6/23 and 5/1/24. The review of the clinical chart revealed a nutritional assessment and note dated, 12/6/23. The nutritional note documented in part, Weight review: Resident 73 yo (year old) F (female) now reporting a sign (significant) wt (weight) gain x 3,6 mos. (months). Wt not taken x 2 mos .no change made at this time. Honor food preferences. Monitor nutrition parameters. Continue POC (plan of care). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The next nutritional assessment was dated, 5/1/24. The assessment documented in part, Plan of Care: Problem Statement: no nutritional concern at this time. Goal: maintain weight through next review date. Interventions/Approaches: Recommend re-weigh to confirm weight change. The Nutritional Note dated, 5/29/24, documented in part, 73 yo F seen for sig (significant) wt gain . Undesirable sig wt gain x 1 mo (month) (12%) from 4/2 wt; r/t multiple psych (psychiatric) medications that may cause app (appetite) stimulation/wt gain .Recommend: Begin weekly weights to monitor wt changes to establish new baseline wt for confirmation of wt change. Recommend using same scale/method of weighing for most accurate wt. Monitor for fluid shift/edema to confirm not fluid retention, continue preventative measures. A request was made for a nutritional assessment between 12/6/23 and 5/1/23. On 8/28/24 at 3:46 p.m. ASM (administrative staff member) #9 stated the resident should have had a nutritional quarterly assessment in March, but it was not completed. An interview was conducted with OSM (other staff member) #12, the current dietician, on 8/29/24 at 2:22 p. m. When asked how often nutritional assessments are to be completed, OSM #12 stated, quarterly, annually on admission and readmission, and if the resident is at high risk, then monthly. Reviewed the above assessments and nutritional notes with OSM #12. OSM #12 was asked if the resident triggered for a weight gain in December of 2023, wouldn't they have an assessment the next month, OSM #12 stated, if the resident triggered again the next month, then, yes, an assessment should have been completed but if the resident didn't trigger in the next month, then their next assessment would be at their next scheduled assessment, either a quarterly or annual assessment. The facility policy, Nutritional Assessment documented in part, POLICY:As part of the comprehensive assessment, a nutritional evaluation, including current nutritional status, risk factors, for impaired nutrition, and resident preferences shall be conducted for each resident. 1. The dietitian, in conjunction with dietary staff, nursing staff, and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition. 2. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. 3.The dietitian/designee will complete the facility approved nutritional assessment tool. Analysis of the collected nutritional data will include: a. An estimate of calorie, protein, nutrient, and fluid needs; b. Whether the resident's current intake is adequate to meet his or her nutritional needs; and c. Special food formulations. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #8, the regional director of operations, and ASM #9, the regional director of clinical services, were made aware of the above concern on 8/30/24 at 11:00 a.m. No further information was provided prior to exit.

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	495339	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observations, staff /resident interviews facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care services for 2 of 50 residents, Resident #108 and #407. The findings include: 1. The facility staff failed to provide respiratory care services per physician orders for Resident #108. Resident #108 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: CAD (coronary artery disease), COPD (chronic obstructive respiratory disease), hyponatremia and asthma. The most recent MDS (minimum data set) assessment, a discharge assessment, with an ARD (assessment reference date) of 5/20/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section G-functional status coded the resident as being dependent for toileting, bathing and hygiene. A review of the comprehensive care plan with a revision date of 5/16/24, revealed, FOCUS: The resident has altered respiratory status/difficulty breathing related to COPD, acute/chronic respiratory failure with hypoxia. INTERVENTIONS: Monitor/document/report abnormal breathing patterns to MD: increased rate, decreased rate, periods of apnea, prolonged inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed-lip breathing and nasal flaring. A review of the physician orders dated 5/15/24 revealed, Respiratory Assessment: Assess lung sounds, respiratory rate, pulse Ox and report any abnormalities to physician (document abnormalities in nursing note). Educate resident on importance of reporting respiratory changes. every shift for 14 Days. A review of the May 2024 TAR (treatment administration record) revealed missing documentation for the respiratory assessment on day shift: 5/16 and 5/18 as well as night shift on 5/17. An interview was conducted on 8/27/24 at 2:45 PM with LPN (licensed practical nurse) #2. When asked where the evidence of respiratory assessments would be located, LPN #2 stated, it would be on the TAR. When asked if the physician orders for respiratory care were not followed, were professional standards followed, LPN #2 stated, no, they would not be followed. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's CPAP-BIPAP guidance policy revealed in part, The facility will implement procedures to ensure that each resident receives necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan and the resident's choice. No further information was provided prior to exit. 2. The facility staff failed to provide respiratory care services per physician orders for Resident #407. Resident #407 was admitted to the facility on [DATE] with diagnosis that included fracture right lower leg, OSA (obstructive sleep apnea), asthma and paroxysmal atrial fibrillation. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 8/16/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being max assist for mobility/transfers, dressing, hygiene toileting and independent for eating. Section O-Special Treatments and Procedures coded the resident as non-invasive Bipap-yes. A review of the baseline care plan dated 8/23/24 revealed, FOCUS: Resident has actual impairment to skin integrity related to Surgical Wound. INTERVENTIONS: Administer medications, supplements and treatments as ordered. Monitor/document for side effects and effectiveness. A review of the physician order dates 8/13/24 revealed CPAP mask cleaning every Morning after removing one time a day. A review of the August 2024 Nursing Task Administration Record revealed no evidence of the CPAP being cleaned from 5/13/24 through 5/27/24. An interview was conducted on 8/28/24 at 2:35 PM with Resident #407. When asked who was cleaning his mask, Resident #407 stated, no one. I usually clean it, but being in this wheelchair with broken bone, I have not cleaned it. An interview was conducted on 8/27/24 at 2:45 PM with LPN (licensed practical nurse) #2. When asked where the evidence of cleaning CPAP mask would be located, LPN #2 stated, it would be on the TAR. When asked if the physician orders for respiratory care were not followed, were professional standards followed, LPN #2 stated, no, they would not be followed. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's CPAP-BIPAP guidance policy revealed in part, The facility will implement procedures to ensure that each resident receives necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan and the resident's choice. No further information was provided prior to exit.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement a complete pain management program for two of 50 residents in the survey sample, Residents #96 and #72. The findings include: 1. For Resident #96 (R96), the facility staff failed to assess the resident's need for an increase in his scheduled pain medication. On the most recent MDS (minimum data set), an admission assessment dated [DATE], R96 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring staff assistance for ADLs (activities of daily living). On 8/26/24 at 2:46 p.m., R96 was sitting up in bed. He stated he was concerned about having to ask so frequently for pain medications. He stated sometimes the staff was too busy to bring the medications in a timely manner, and he did not feel he should have to ask for pain medication so many times during the day and night. A review of R96's clinical record revealed the following orders: 7/31/24 Oxycodone (an opioid pain medication) Oral Tablet 10 mg (milligrams) .Give 2 tablets by mouth every 4 hours as needed for breakthrough pain related to multiple sclerosis. 8/15/24 Oxycodone Oral Tablet 10 mg .Give 2 tablets every 4 hours as needed for breakthrough pain. A review of R96's August 2024 MAR (medication administration record) revealed he received a total of 51 as needed doses of Oxycodone between 8/1/24 and 8/28/24. The review revealed pain level assessments prior to the administration of the Oxycodone to range between 6 and 9. The as needed Oxycodone was administered over the entire range of days, evenings, and nights. On 8/28/24 at 12:38 p.m., ASM (administrative staff member) #4, the attending physician, was interviewed. When asked his role in monitoring prn (as needed) pain medication for residents, he stated a resident's frequent usage of a prn pain medication could be mentioned either by the resident or by the nurse. He stated: Certainly if the prns are being given around the clock, or the resident is frequently requesting a dose, something needs to be adjusted. He stated the resident's maintenance (scheduled) pain medication may need to be increased. He added this decision should take into account the reason for the pain, with the goal of getting the resident off of narcotic pain medications as soon as possible. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/29/24 at 8:01 a.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated when a resident requests a prn pain medication, the nurses try an alternative to the medication first. This could include repositioning or a warm/cold compress, depending on the nature of the pain and the resident's orders. She stated if the alternative interventions are unsuccessful in relieving the resident's pain, the nurse should administer the as needed medication. She stated when the nursing staff notices a trend of the resident being in constant pain, the nurses talk to the nurse practitioner to see if something needs to be scheduled or increased. She added: It is situational. We look for the need and address it. She stated the responsibility for this belongs both to the nurses and to the providers (nurse practitioners and physicians). After reviewing R96's August 2024 MAR, she stated when the prn medications are being used as frequently as R96 was using them, the nurse practitioner or physician should have made an adjustment. On 8/29/24 at 9:40 a.m., ASM #4, the nurse practitioner, was interviewed. She stated she has just started getting to know the residents at this facility. She stated: I'm seeing a lot of people just on prn medications for pain. She stated if residents are requesting frequent prn pain medication, she would try to schedule a one-time nighttime dose. She added: I try to get them on a once or twice a day schedule, and move them to Tylenol instead of the opioids. After reviewing R96's August 2024 MAR, she stated: I would put him on an extended release opioid twice a day, and schedule it. He shouldn't have to ask for that much medication so frequently. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. A review of the facility policy, Pain Management, revealed, in part: Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals .Pain management is a multidisciplinary care process that includes .Monitoring for the effectiveness of interventions .Modifying approaches as necessary .If pain has not been adequately controlled, the multidisciplinary team, including the physician, may reconsider approaches and make adjustment as indicated. No further information was provided prior to exit. 2. For Resident #72 (R72), the facility staff failed to assess the resident's need for an increase in his scheduled pain medication. A review of R72's clinical record revealed the following orders: 7/23/24 Oxycodone (an opioid pain medication) Oral Tablet 10 mg (milligrams) .Give 2 tablets by mouth every 4 hours as needed for pain. 7/16/24 Oxycodone-Acetaminophen (Percocet, an opioid pain medication) 7.5 - 325 mg Give 1 tablet by mouth every 4 hours as needed for pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R72's August 2024 MAR (medication administration record) revealed he received a total of 49 as needed doses of Oxycodone or Percocet between 8/1/24 and 8/28/24. The review revealed pain level assessments prior to the administration of the pain medications to range primarily between 7 and 10. The as needed medications were administered over the entire range of days, evenings, and nights. On 8/28/24 at 12:38 p.m., ASM (administrative staff member) #4, the attending physician, was interviewed. When asked his role in monitoring prn (as needed) pain medication for residents, he stated a resident's frequent usage of a prn pain medication could be mentioned either by the resident or by the nurse. He stated: Certainly if the prns are being given around the clock, or the resident is frequently requesting a dose, something needs to be adjusted. He stated the resident's maintenance (scheduled) pain medication may need to be increased. He added this decision should take into account the reason for the pain, with the goal of getting the resident off of narcotic pain medications as soon as possible. On 8/29/24 at 8:01 a.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated when a resident requests a prn pain medication, the nurses try an alternative to the medication first. This could include repositioning or a warm/cold compress, depending on the nature of the pain and the resident's orders. She stated if the alternative interventions are unsuccessful in relieving the resident's pain, the nurse should administer the as needed medication. She stated when the nursing staff notices a trend of the resident being in constant pain, the nurses talk to the nurse practitioner to see if something needs to be scheduled or increased. She added: It is situational. We look for the need and address it. She stated the responsibility for this belongs both to the nurses and to the providers (nurse practitioners and physicians). After reviewing R72's August 2024 MAR, she stated when the prn medications are being used as frequently as R72 was using them, the nurse practitioner or physician should have made an adjustment. On 8/29/24 at 9:40 a.m., ASM #4, the nurse practitioner, was interviewed. She stated she has just started getting to know the residents at this facility. She stated: I'm seeing a lot of people just on prn medications for pain. She stated if residents are requesting frequent prn pain medication, she would try to schedule a one-time nighttime dose. She added: I try to get them on a once or twice a day schedule, and move them to Tylenol instead of the opioids. After reviewing R72's August 2024 MAR, she stated: I would put him on an extended release opioid twice a day, and schedule it. He shouldn't have to ask for that much medication so frequently. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. No further information was provided prior to exit.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on resident interview, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide care and services related to dialysis for five of 50 residents in the survey sample, Residents #101, #109, #56, #63 and #22. The findings include: 1a. For Resident #101, the facility staff failed to ensure a resident was transported to dialysis, thus the resident did not receive dialysis on 8/24/24. The nurse's notes dated 8/24/24 at 10:49 a.m. documented, Resident was not picked up for dialysis this morning. Attempted to locate contact information for transportation, unable to locate. Called (initials of company) Dialysis spoke to the nurse, and she was also unable to located contact information for transportation, but there also was no more chair time availability for resident. I updated the resident, nursing supervisor and left a vm (voicemail) for the resident's niece. The physician order dated 8/27/24 documented, Dialysis Tues, Thurs, Sat, at (initials of dialysis center) Farmville 6:10 - 9:40 am chair time. Arrive at 5:40 a.m. Dialysis transport provided by (name of company and phone number). An interview was conducted on 8/28/24 at 1:28 p.m. with ASM (administrative staff member) #1, the administrator. ASM #1 stated, the facility transportation takes the residents to dialysis even on the weekend. An interview was conducted with OSM (other staff member) #14, the receptionist/transportation coordinator, on 8/28/24 at 3:08 p.m. When asked who schedules transportation for residents to go to dialysis, OSM #14 stated it's usually herself. When asked who transports R101 to dialysis, OSM #14 stated, the resident goes through Medicaid to dialysis. When asked if that includes weekends, OSM #14 stated, yes. OSM #14 was asked what happens on the weekend if the scheduled transportation doesn't show to take the resident to dialysis, OSM #14 stated, the nurse should contact the backup driver/facility drivers, so they would transport the resident. The nurse's note above was shared with OSM #14. She stated that she was unaware of the resident missing dialysis. When asked who has access to the number for the transportation for R101, OSM #14 stated the number is taped to her desk and anyone has access to the number. OSM #13 was asked fi the staff is aware of a transportation problem, do the staff know who the backup person/transportation is, OSM #13 stated, they should know. The comprehensive care plan dated, 7/13/24, documented in part, Focus: (R101) has ESRD (end stage renal disease) and receives hemodialysis @ (Name and address of dialysis center), Tues. Thurs, Sat @ 6:10 a.m. Goal: The resident will not experience any unavoidable complications from dialysis through the next review dated. The Interventions documented in part, Encourage resident to go for the scheduled dialysis appointments. Resident receives dialysis. The facility policy, End Stage Renal Disease - Care of the Resident., documented in part, The nursing facility will assist the resident requiring hemodialysis with arrangement for safe transportation to and from the hemodialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit. 1b. For Resident #101, the facility staff failed to have communication with the dialysis center when the resident went to dialysis. An interview was conducted with R101 on 8/26/24 at approximately 5:00 p.m. When asked if she takes any paperwork, a binder or folder with her when she goes to dialysis, R101 stated, no, she doesn't take anything like that with her. The physician order dated 8/27/24 documented, Dialysis Tues, Thurs, Sat, at (initials of dialysis center) Farmville 6:10 - 9:40 am chair time. Arrive at 5:40 a.m. Dialysis transport provided by (name of company and phone number). Since admission, the resident should have gone to the dialysis center 19 times between 7/16/24 and 8/27/24. On 8/10/24, the resident refused to go. On 8/24/24, the transportation company did not pick up the resident, so she missed that treatment. Of those 17 times, there was only one Pre and Post Dialysis Review form. Review of the clinical record revealed a Pre and Post Dialysis Review dated, 7/18/24. It documented the resident left the facility at 4:47 a.m. The vital signs documented under the Pre-Dialysis section were dated, 7/16/24. The Post Dialysis section documented the same vital signs as in the Pre-Dialysis section. There were no weights documented Pre or Post Dialysis. There were no other Pre and Post Dialysis Review forms. A request was made for the communication forms for the resident's date of treatments at the dialysis center. On 8/28/24 at 9:53 a.m., ASM #1, the administrator, stated the facility did not have any communication with dialysis for R101. An interview was conducted with RN (registered nurse) #5 on 8/29/24 at 12:40 p.m. When asked what should happen when a resident goes to dialysis, RN #5 stated, normally they have a snack to go with them. The residents should be up and dressed and ready. RN #5 was asked if the residents take any paperwork with them, RN #5 stated, if there is a change in their medications, she would send the medication list. When asked if the residents take a folder or binder with them when they go, RN #5 stated yes. When asked what is in the binder/folder, RN #5 stated, a face sheet, medication list, if the resident is a DNR (do not resuscitate), a copy of that. RN#5 was asked if this should go with the resident each time they go, RN #5 stated, yes. When asked if the paperwork sent with the resident comes back from the dialysis center, RN #5 stated, some centers print them off, most of them will fax over anything that they need to know. RN #5 was asked if the nurse who gets the resident upon return from dialysis should look for paperwork to return, RN #5 stated, yes. When asked how they communicate with the dialysis centers, RN #5 stated they have the centers phone number in the resident's chart, and they can call them if they need to. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, End Stage Renal Disease - Care of the Resident., documented in part, 3. Agreements between this facility and the contracted ESRD facility will include all aspects of how the resident's care will be managed including but not limited to: b. The communication process between the nursing facility and the dialysis center that will reflect on going communication, coordination, and collaboration. ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit. 1c. For Resident #101, the facility staff failed to monitor a physician ordered fluid restriction. The physician order dated, 7/31/24, documented, Fluid Restriction 1200 ml/day (milliliters/day); dietary - 840 ml/day (B [breakfast} - 240 ml, L [lunch] 360 ml, D [dinner] 240 ml; nursing: 360 ml/day (120 ml Q [every] shift) - ONS (ordered nutritional supplements) not included in fluid restriction. The August 2024 MAR (medication administration record) documented the above physician order. On the following dates there was nothing documented: 8/12/24 - day shift and 8/24/24 - night shift. On the following dates and shift an NA(not applicable) was documented: Day shift on 8/1/14, 8/3/24, 8/4/24, 8/8/24, 8/16/24, 8/17/24, 8/25/24. Evening shift on 8/16/24 and 8/17/24. Night shift on 8/16/24. The comprehensive care plan dated, 7/17/24, documented in part, Focus: (R101) is at risk for malnutrition r/t (related to) adenocarcinoma (cancer), new HD (hemodialysis) r/t ESRD. The Interventions documented in part, Fluid Restriction 1200 ml/day (milliliters/day); dietary - 840 ml/day (B [breakfast] - 240 ml, L [lunch] 360 ml, D [dinner]) 240 ml; nursing: 360 ml/day (120 ml Q [every] shift) - ONS (ordered nutritional supplements) not included in fluid restriction. An interview was conducted with RN #5 on 8/29/24 at 12:40 p.m. When asked if a resident is on a fluid restriction, where is that documented, RN #5 stated on the eMAR (electronic medication administration record). RN #5 was asked what NA would mean when documenting under the fluid restriction order, RN #5 stated, normally NA means not applicable but that wouldn't make sense on that order. When asked what should be documented on the eMAR, RN #5 stated, a numerical number. The facility policy, Resident Hydration and Prevention of Dehydration documented in part, Physician orders to limit fluids will take priority over calculated fluid needs. The dietitian may refer calculated needs to the physician if restrictions potentially increase a risk for dehydration. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit. 2. For Resident #109 (R109), the facility staff failed to have communication with the dialysis center when the resident went to dialysis. R109 was admitted to the facility on [DATE]. The physician order dated, 12/13/23, documented, Dialysis at (name and address of dilayss center) on Tues, Thurs, Sat at 10:35 a.m. The resident was scheduled to go to dialysis on 12/14/23. Review of the clinical record, failed to evidence communication with the dialysis center. A request was made for any communication with the dialysis center on 12/14/23. On 8/28/24 at 9:53 a.m. ASM #1, the administrator, stated they had no documentation of communication with the dialysis center for 12/14/23. An interview was conducted with RN (registered nurse) #5 on 8/29/24 at 12:40 p.m. When asked what should happen when a resident goes to dialysis, RN #5 stated, normally they have a snack to go with them. The residents should be up and dressed and ready. RN #5 was asked if the residents take any paperwork with them, RN #5 stated, if there is a change in their medications, she would send the medication list. When asked if the residents take a folder or binder with them when they go, RN #5 stated yes. When asked what is in the binder/folder, RN #5 stated, a face sheet, medication list, if the resident is a DNR (do not resuscitate), a copy of that. RN#5 was asked if this should go with the resident each time they go, RN #5 stated, yes. When asked if the paperwork sent with the resident comes back from the dialysis center, RN #5 stated, some centers print them off, most of them will fax over anything that they need to know. RN #5 was asked if the nurse who gets the resident upon return from dialysis should look for paperwork to return, RN #5 stated, yes. When asked how they communicate with the dialysis centers, RN #5 stated they have the centers phone number in the resident's chart, and they can call them if they need to. ASM #1, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit. 42183 3. The facility failed to provide evidence of communication with dialysis facility for Resident #56. (continued on next page)

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Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #56 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: ESRD (end stage renal disease), CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease) and diabetes. The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 7/2/24, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as being dependent for toileting, bathing and hygiene. A review of the comprehensive care plan dated 9/29/22, which revealed, FOCUS: Resident has ESRD and receives Hemodialysis at Dialysis Center in Farmville M, W, F. Rt. upper chest catheter for dialysis access. INTERVENTIONS: Resident receives dialysis M, W, F. If bleeding from the vascular access is not controlled; apply direct pressure, call the Dialysis team/nephrologist to determine the need for resident to be transported emergently to the ED. A review of the physician's orders dated 8/5/24, revealed, Hemodialysis Mon, Wed, Fri. LogistiCare transport, pick up for 0935 chair time, return to facility 1355. A review of Resident #56's medical record evidenced the only dialysis communication form 7/1/24-8/28/24 was on 7/12/24. No other communication forms located. An interview was conducted on 8/27/24 at 8:25 AM with Resident #56. When asked if they send a binder, folder or notebook with her to dialysis, Resident #56 stated, no, they do not send any paperwork with me. An interview was conducted on 8/29/24 at 2:20 PM with LPN (licensed practical nurse) #3. When asked the purpose of the dialysis communication sheets, LPN #3 stated, it is to provide information to the dialysis center about the resident. We document it in PCC (point click care), print and are to put them in a book or a folder and send with the resident. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. A review of the facility's End Stage Renal Disease-Care of Resident policy revealed in part, Agreements between this facility and the contracted ESRD facility will include all aspects of how the residents care will be managed including but not limited to communication process between the nursing facility and the dialysis center that will reflect ongoing communication, coordination and collaboration. No further information was provided prior to exit. 32642 4. For Resident #63 (R63), the facility failed to provide evidence of implementing a fluid restriction related to dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R63's clinical record revealed the following order dated 8/23/24: Fluid restriction =1200 ml/day (milliliters per day): dietary 840 ml/day (B [breakfast]: 240 ml, L [lunch]: 360 ml, D [dinner]: 240 ml); nursing - 360 ml/day (120 ml q [each] shift). Further review of R63's clinical record, including August 2024 MARs (medication administration records), TARs (treatment administration records), and progress notes, revealed no evidence that the fluid restriction had been implemented. On 8/29/24 at 8:01 a.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated the dietician is responsible for putting an order in for any kind of fluid restriction. It is the nurses' responsibility to document the resident's fluid intake on each shift. After reviewing R63's order, MAR, and TAR, she stated: There is no documentation about this order because it was put in as 'no documentation required.' The dietician put the order in wrong. LPN #5 stated R63 receives dialysis, and the fluid restriction is intended to prevent the resident from becoming fluid overloaded. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. No further information was provided prior to exit. 29125 5. For Resident #22 the facility staff failed to evidence consistent communication with (to and from) the dialysis center. A review of the clinical record revealed the following regarding dialysis services from 6/1/24 through the survey date of 8/28/24: A review of the clinical record revealed physician's orders dated 5/17/24, 7/17/24, 7/31/24, and 8/5/24 that all documented the resident was to receive dialysis services every Monday, Wednesday and Friday. A review of the clinical record revealed a Pre and Post Dialysis Review form completed by the facility, to be printed and sent to the dialysis facility with the resident. The record revealed that this form was not completed on 6/14/24, 6/19/24, 6/21/24, 7/26/24, 8/19/24 and 8/21/24 and therefore could not be provided to the dialysis center. In addition, Post Dialysis Communication forms provided to the facility from the dialysis center were reviewed for the months of June, July and August, 2024. Only eight dates were provided (6/7/24, 6/10/24, 6/17/24, 6/19/24, 6/21/24, 7/12/24, 7/26/24, and 8/7/24). All other dialysis dates from 6/1/24 through 8/28/24 were not provided, evidencing that the dialysis center did not provide post dialysis communication to the facility. These dates were 6/3/24, 6/5/24, 6/12/24, 6/14/24, 6/24/24, 6/26/24, 6/28/24, 7/1/24, 7/3/24, 7/5/24, 7/8/24, 7/10/24, 7/15/24, 7/17/24, 7/19/24, 7/22/24, 7/24/24, 7/29/24, 7/31/24, 8/2/24, 8/5/24, 8/9/24, 8/12/24, 8/14/24, 8/16/24, 8/19/24, 8/21/24, 8/23/24, and 8/26/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/30/24 at 10:53 AM an interview was conducted with LPN #1 (Licensed Practical Nurse). She stated that the nurse does the pre dialysis form which should include information regarding if any meds were given, if resident ate, blood sugar, then print the form and it is put in the binder and goes with them. She stated that the dialysis center is supposed to send post-dialysis information, including pre and post dialysis weight, how much fluid was removed, any medications administered, any effects or complications the resident had, post dialysis vitals, etc., are supposed to be sent back. She stated that has not been happening. The facility policy, End Stage Renal Disease - Care of Resident documented, Agreements between this facility and the contracted ESRD facility will include all aspects of how the resident's care will be managed including but not limited to: b. the communication process between the nursing facility and the dialysis center that will reflect ongoing communication, coordination, and collaboration On 3/29/24 at the end of day meeting at approximately 3:40 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #6 a Director of Clinical Operations, ASM #7 a Regional Director of Clinical Operations, ASM #8 a Regional Director of Operations, and RN #4 (Registered Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 32642 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to perform safety assessments for the use of side rails for one of 50 residents in the survey sample, Resident #93. The findings include: For Resident #93 (R93), the facility staff failed to assess the resident for safe side rail usage. On 8/27/24 at 9:02 a.m., R93 was observed sitting up in bed eating breakfast. Both quarter side rails were up on his bed. A review of R93's clinical record, including assessments, physician orders, and care plan, revealed no evidence of an assessment for R93's need for the use of side rails and for R93's ability to use the side rails safely. On 8/28/24 at 8:41 a.m., ASM (administrative staff member) #2, the director of nursing, stated she could not locate any evidence of a safety assessment for R93's use of side rails. On 8/29/24 at 12:40 p.m., RN (registered nurse) #5, a unit manager, was interviewed. She stated before a resident's bed is equipped with side rails of any kind, PT (physical therapy) and OT (occupational therapy) must perform an assessment for the resident's ability to use the side rails safely, and for the resident's need for the side rails. Once those assessments are completed, it is the responsibility of PT or OT to put the orders in the system. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. No further information was provided prior to exit.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide physician oversight for the care of four of 50 residents in the survey sample, Residents #96, #72, #112, and #117. The findings include: 1. For Resident #96 (R96), the facility physician and/or nurse practitioner (NP) failed to assess the resident's prn (as needed) pain medication usage. For Resident #96 (R96), the facility staff failed to assess the resident's need for an increase in his scheduled pain medication. On the most recent MDS (minimum data set), an admission assessment dated [DATE], R96 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring staff assistance for ADLs (activities of daily living). On 8/26/24 at 2:46 p.m., R96 was sitting up in bed. He stated he was concerned about having to ask so frequently for pain medications. He stated sometimes the staff was too busy to bring the medications in a timely manner, and he did not feel he should have to ask for pain medication so many times during the day and night. A review of R96's clinical record revealed the following orders: 7/31/24 Oxycodone (an opioid pain medication) Oral Tablet 10 mg (milligrams) .Give 2 tablets by mouth every 4 hours as needed for breakthrough pain related to multiple sclerosis. 8/15/24 Oxycodone Oral Tablet 10 mg .Give 2 tablets every 4 hours as needed for breakthrough pain. A review of R96's August 2024 MAR (medication administration record) revealed he received a total of 51 as needed doses of Oxycodone between 8/1/24 and 8/28/24. The review revealed pain level assessments prior to the administration of the Oxycodone to range between 6 and 9. The as needed Oxycodone was administered over the entire range of days, evenings, and nights. On 8/28/24 at 12:38 p.m., ASM (administrative staff member) #4, the attending physician, was interviewed. When asked his role in monitoring prn (as needed) pain medication for residents, he stated a resident's frequent usage of a prn pain medication could be mentioned either by the resident or by the nurse. He stated: Certainly if the prns are being given around the clock, or the resident is frequently requesting a dose, something needs to be adjusted. He stated the resident's maintenance (scheduled) pain medication may need to be increased. He added this decision should take into account the reason for the pain, with the goal of getting the resident off of narcotic pain medications as soon as possible. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 8:01 a.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated when the nursing staff notices a trend of the resident being in constant pain, the nurses talk to the nurse practitioner to see if something needs to be scheduled or increased. She added: It is situational. We look for the need and address it. She stated the responsibility for this belongs both to the nurses and to the providers (nurse practitioners and physicians). After reviewing R96's August 2024 MAR, she stated when the prn medications are being used as frequently as R96 was using them, the nurse practitioner or physician should have made an adjustment. On 8/29/24 at 9:40 a.m., ASM #4, the nurse practitioner, was interviewed. She stated she has just started getting to know the residents at this facility. She stated: I'm seeing a lot of people just on prn medications for pain. She stated if residents are requesting frequent prn pain medication, she would try to schedule a one-time nighttime dose. She added: I try to get them on a once or twice a day schedule, and move them to Tylenol instead of the opioids. After reviewing R96's August 2024 MAR, she stated: I would put him on an extended release opioid twice a day, and schedule it. He shouldn't have to ask for that much medication so frequently. She stated the responsibility for reviewing a resident's as needed medication usage falls to both the nurses and the providers. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. A review of the facility policy, Attending Physician Responsibilities, revealed, in part: The Attending Physicians shall be the primary practitioners responsible for providing medical services and coordinating the healthcare of each resident in the facility .Each Attending Physician will be responsible for .Accepting responsibility for initial and subsequent resident care .Providing appropriate resident care .Providing appropriate, timely medical orders .The Attending Physician will assess new admissions in a timely fashion . The Attending Physician NPP will seek, provide, and analyze information regarding a resident's current status, recent history, and medications and treatments to enable safe, effective continuing care and to support facility compliance with regulations and care standards. No further information was provided prior to exit. 2. For Resident #72 (R72), the facility physician and/or nurse practitioner (NP) failed to assess the resident's prn (as needed) pain medication usage. A review of R72's clinical record revealed the following orders: 7/23/24 Oxycodone (an opioid pain medication) Oral Tablet 10 mg (milligrams) .Give 2 tablets by mouth every 4 hours as needed for pain. 7/16/24 Oxycodone-Acetaminophen (Percocet, an opioid pain medication) 7.5 - 325 mg Give 1 tablet by mouth every 4 hours as needed for pain medication. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R72's August 2024 MAR (medication administration record) revealed he received a total of 49 as needed doses of Oxycodone or Percocet between 8/1/24 and 8/28/24. The review revealed pain level assessments prior to the administration of the pain medications to range primarily between 7 and 10. The as needed medications were administered over the entire range of days, evenings, and nights. On 8/28/24 at 12:38 p.m., ASM (administrative staff member) #4, the attending physician, was interviewed. When asked his role in monitoring prn (as needed) pain medication for residents, he stated a resident's frequent usage of a prn pain medication could be mentioned either by the resident or by the nurse. He stated: Certainly if the prns are being given around the clock, or the resident is frequently requesting a dose, something needs to be adjusted. He stated the resident's maintenance (scheduled) pain medication may need to be increased. He added this decision should take into account the reason for the pain, with the goal of getting the resident off of narcotic pain medications as soon as possible. On 8/29/24 at 8:01 a.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated when the nursing staff notices a trend of the resident being in constant pain, the nurses talk to the nurse practitioner to see if something needs to be scheduled or increased. She added: It is situational. We look for the need and address it. She stated the responsibility for this belongs both to the nurses and to the providers (nurse practitioners and physicians). After reviewing R72's August 2024 MAR, she stated when the prn medications are being used as frequently as R72 was using them, the nurse practitioner or physician should have made an adjustment. On 8/29/24 at 9:40 a.m., ASM #4, the nurse practitioner, was interviewed. She stated she has just started getting to know the residents at this facility. She stated: I'm seeing a lot of people just on prn medications for pain. She stated if residents are requesting frequent prn pain medication, she would try to schedule a one-time nighttime dose. She added: I try to get them on a once or twice a day schedule, and move them to Tylenol instead of the opioids. After reviewing R72's August 2024 MAR, she stated: I would put him on an extended release opioid twice a day, and schedule it. He shouldn't have to ask for that much medication so frequently. She stated the responsibility for reviewing a resident's as needed medication usage falls to both the nurses and the providers. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. No further information was provided prior to exit. 3. For Resident #112 (R112), the facility physician and/or nurse practitioner (NP) failed to identify the resident's need for blood sugar checks and insulin upon admission. A review of R112's hospital discharge summary dated 8/25/23 revealed, in part: Discharge Diagnoses . Diabetes mellitus type 2 .continue current regimen .Medications Inpatient .Insulin lispro .with meals and at bedtime. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R112's clinical record revealed he was admitted to the facility on [DATE]. This review revealed the following progress notes: 8/26/23 at 7:00 p.m. Resident's spouse voiced concerns he didn't have accucheck (test for blood glucose levels) orders nor insulin orders, and that he was [name of medication to treat diabetes] at home .at hospital .he was on insulin. MD (medical doctor) on call made aware and insulin orders given. A review of R112's MAR (medication administration record) revealed he received a one-time dose of Humalog Lispro (short-acting insulin) 15 units on 8/26/23 at 7:00 p.m. This review failed to reveal any blood sugar checks or insulin administration between his admission on 8/25/23 at 8:00 p.m. and 8/27/23 at 7:00 p.m. On 8/29/24 at 9:40 a.m., ASM (administrative staff member) #4, a nurse practitioner, was interviewed. She stated if a resident has been on accuchecks and insulin in the hospital, she would initially order sliding scale insulin before meals and at bedtime. Once the resident's insulin needs have been established, she stated she attempts to get the resident on scheduled insulin rather than a sliding scale. She added: If they are on something at the hospital, they should be on something here. She stated the responsibility for reviewing a resident's admission medications falls to both the nurses and the providers. On 8/29/24 at 1:07 p.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated if a resident is discharged with orders for insulin, those orders should be called in to the provider for approval. She stated the whole of the resident's discharge records should be reviewed for accurate medication reconciliation. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. No further information was provided prior to exit. 4. For Resident #117 (R117), the facility physician and/or nurse practitioner (NP) failed to identify the resident's need for blood sugar checks and insulin upon admission. A review of R117's hospital discharge summary dated 1/26/23 revealed, in part: Primary Discharge Diagnosis .Diabetes mellitus .Diabetes mellitus with hyperglycemia (high blood sugar) .Continue glycemic protocol .Consider increasing sliding scale. A review of R117's clinical record revealed the resident was admitted to the facility on [DATE] at approximately 10:00 p.m. This review revealed the following progress notes: 1/28/23 Note text 1903 (7:03 p. m.) .Notified by RP (responsible party) resident is on scheduled insulin and accuchecks (blood sugar checks) four times a day at home. NP (nurse practitioner) made aware and new orders received and RP made aware. This reviewed revealed the provider gave orders for accuchecks and insulin on 1/28/23 at 7:26 p.m. These were the first orders for accuchecks and insulin since the resident's admission on 1/16/23. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 9:40 a.m., ASM (administrative staff member) #4, a nurse practitioner, was interviewed. She stated if a resident has been on accuchecks and insulin in the hospital, she would initially order sliding scale insulin before meals and at bedtime. Once the resident's insulin needs have been established, she stated she attempts to get the resident on scheduled insulin rather than a sliding scale. She added: If they are on something at the hospital, they should be on something here. She stated the responsibility for reviewing a resident's admission medications falls to both the nurses and the providers. On 8/29/24 at 1:07 p.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated if a resident is discharged with orders for insulin, those orders should be called in to the provider for approval. She stated the whole of the resident's discharge records should be reviewed for accurate medication reconciliation. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. No further information was provided prior to exit.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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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 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. 32642 Based on staff interview and facility document review, the facility failed to provide adequate nursing staff for two of 50 residents in the survey sample, Residents #107 and #112. The findings include: 1. For Resident #107 (R107), the facility failed to provide adequate nursing staff on the resident's unit for night shift (11:00 p.m. through 7:30 a.m.) on multiple nights in September and October 2023. A review of nursing staff records for September and October 2023 revealed one licensed nurse and one CNA (certified nursing assistant) on the night shift on 9/22, 9/24, 9/30, 10.4, 10/5, 10/6, 10/7, 10/8, 10/9, 10/14, and 10/16 's on R107's unit during the resident's stay. The resident census on this unit was between 25 and 30 on each of these nights. On 8/29/24 at 10:21 a.m., CNA #6, the staff scheduler, was interviewed. She stated she assigns staff to units according to a form given to her by corporate. She stated this form tells her how many staff each unit needs according to census and acuity. She stated: We talk to the unit managers about acuity, then we schedule according to acuity within the budget. She stated R107's unit has a total of 30 beds, and requires a minimum of one licensed nurse and two CNAs on the night shift. She stated: The only they work with only one CNA on that unit at night is if we have call outs. Our plan calls for a minimum of two CNAs. On 8/29/24 at 3:20 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated R107's unit is staffed based on acuity and census. She stated: We use our staffing grid provided to us by corporate. She stated the unit can have high acuity residents since it is a skilled nursing unit. It is a 30 bed unit. She added the night shift requires one licensed nurse and a minimum of two CNAs. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. A review of the facility policy, Staffing, revealed, in part: Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services to all residents in accordance with resident care plans and the facility assessment .Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. No further information was provided prior to exit. 2. For Resident #112 (R112), the facility failed to provide adequate nursing staff on the resident's unit for night shift (11:00 p.m. through 7:30 a.m.) on 8/26/23. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of nursing staff records for 8/26, 2023 revealed one licensed nurse and one CNA (certified nursing assistant) on the night shift. The resident census was 26 on this night. On 8/29/24 at 10:21 a.m., CNA #6, the staff scheduler, was interviewed. She stated she assigns staff to units according to a form given to her by corporate. She stated this form tells her how many staff each unit needs according to census and acuity. She stated: We talk to the unit managers about acuity, then we schedule according to acuity within the budget. She stated R107's unit has a total of 30 beds, and requires a minimum of one licensed nurse and two CNAs on the night shift. She stated: The only they work with only one CNA on that unit at night is if we have call outs. Our plan calls for a minimum of two CNAs. On 8/29/24 at 3:20 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated R107's unit is staffed based on acuity and census. She stated: We use our staffing grid provided to us by corporate. She stated the unit can have high acuity residents since it is a skilled nursing unit. It is a 30 bed unit. She added the night shift requires one licensed nurse and a minimum of two CNAs. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the regional director of operations, were informed of these concerns. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide a physician ordered medication for administration to two of 50 residents in the survey sample, Residents #96 and #34. The findings include: 1. For Resident #96 (R96), the facility staff failed to provide Avonex (a medication to treat multiple sclerosis) for timely administration. On the most recent MDS (minimum data set), an admission assessment dated [DATE], R96 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring staff assistance for ADLs (activities of daily living). On 8/26/24 at 2:46 p.m., R96 was sitting up in bed. He stated he was concerned about not receiving a weekly injection to treat his multiple sclerosis weekly on Saturdays. He stated he thought it was important that this medication be given on time, every seven days. A review of R96's clinical record revealed the following physician order dated 7/13/24: Avonex Prefilled Intramuscular Prefilled Syringe Kit 30 mcg/0.5 ml (micrograms per milliliter). Inject 1 syringe intramuscularly one time a day every Sat (Saturday) related to multiple sclerosis. Family to bring from home. A review of R96's progress notes revealed, in part: 8/3/24 [Avonex] not given. Not available. Waiting on family. 8/10/24 [Avonex] not given .waiting on the family to bring in. 8/10/24 [Avonex] not given .waiting on family. A review of R96's August 2024 MAR (medication administration record revealed that R96 did not receive the medication on any of the three Saturdays in August prior to survey entrance. Instead of Saturday, 8/3/24, the resident received the medication on Tuesday, 8/6/24. The resident then received the medication on subsequent Tuesdays 8/13 24 and 8/20/24. This review R96 did not receive Avonex between 7/27/24 and 8/6/24, a total of 10 days between administrations. The clinical record review revealed no evidence of efforts by the facility to communicate with the pharmacy or the family regarding the resident's Avonex availability. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 8:01 a.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. When asked about R96's Avonex injections, she stated: The wife brings it in. There has been an issue with the wife bringing the medication on the day it needs to be given. I know that on one Saturday, it wasn't given because it wasn't here to be given. She stated she is aware the medication is very expensive, and she did not know what to do if the wife did not bring the medication to the facility for the nurses to administer to R96. On 8/29/24 at 11:06 a.m., ASM (administrative staff member) #5, the registered pharmacist, was interviewed. He stated he was not familiar with R96's Avonex, and encouraged conversation with OSM (other staff member) #9, a pharmacy technician at the facility's contract pharmacy. He stated he believed the electronic medical record contained information that the family would provide the medication, adding that the facility would be very expensive for the facility to provide. He added: We did not provide it. That's a facility decision. If the facility tells us the family is going to provide a medication, we say it's okay. On 8/29/24 at 11:35 a.m., OSM #9 was interviewed. She stated the facility gave the pharmacy directions not to fill the physician order for Avonex for R96. She stated: The family was bringing it from home. This is not unusual for the facility. OSM #9 stated she would check with a pharmacist about the directions to be followed if a resident missed a dose. At 11:53 a.m., OSM #9 called the survey team and said the manufacturer's instructions for Avonex say to give the dose as soon as possible, then to get back on the original schedule. According to the manufacturer's instructions, the duration of the medication is only four days, so it needs to be administered regularly. A review of directions for administration of Avonex revealed, in part: If you miss a dose of this medicine, take it as soon as possible. However, if it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not double doses .Avonex(R): If you miss a dose, give it as soon as you can. Go back to your regular schedule the following week. Do not use this medicine 2 days in a row. This information is taken from the website https://www.mayoclinic.org/drugs-supplements/interferon-beta-1a-intramuscular-route-subcutaneous-route/proper-use/drg-20064352 On 8/29/24 at 3:20 p.m., ASM #2, the director of nursing, was interviewed. She stated: The Avonex was priced out. It is a high cost medication. She stated she was aware R96 was on the medication at home, but was not sure what the communication was between the facility staff and the family regarding when the medication would be brought to the facility, and who would bring it. She stated: I don't know if this is an insurance thing. When asked who was responsible for obtaining medications and giving the medications in a timely manner, she stated: We are. On 8/29/24 at 3:40 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, and ASM #8, the A review of the facility policy, Unavailable Medications, revealed, in part: The facility must make every effort to ensure that medications are available to meet the needs of each resident .The nursing staff shall .notify the attending physician .of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available. No further information was provided prior to exit. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	27660 2. For Resident #34(R34), the facility staff failed to ensure Meclizine was available for administration. An interview was conducted with R34 on 8/26/24 at 3:45 p.m. R34 stated that the facility runs out of medications all the time, so she misses doses. The physician order dated, 7/2/24, documented, Meclizine HCL (hydrochloride) 12.5 MG (milligrams); Give 1 tablet by mouth three times a day for vertigo. The July 2024 MAR (medication administration record) documented the above order. On 7/2/24 at the 5:00 p. m. dose, a 5 was documented. A 5 indicates Hold/See Progress Note. The progress note dated 7/2/24 at 6:04 p.m. documented, Not available. The August 2024 MAR documented the above order. On 8/18/24 at the 1:00 p.m. dose a 9 was documented. A 9 indicates Other/See Progress Note. The progress note dated 8/18/24 at 2:07 p.m. documented, not available. Review of the contents of the facility, onsite, pharmacy system, failed to have available, Meclizine. An interview was conducted with RN #5 on 8/29/24 at 12:40 p.m. When asked what she does if a medication is not on the medication cart at the scheduled time for administration, RN #5 stated she would first call the pharmacy. RN #5 was asked if the facility had a backup system for medications, RN#5 stated, yes, I would check there especially if the pharmacy were not open. When asked if the medication is not in the backup system, does she have to notify anyone, RN #5 stated, yes, we have to notify the provider and the responsible party for the resident. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #6, the regional director of clinical operations, ASM #7, the regional director of clinical operations, ASM #8, the regional director of operations and RN (registered nurse) #4, the assistant director of nursing, were made aware of the above findings on 8/29/24 at 3:41 p.m. No further information was provided prior to exit.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure the physician reviewed and acted upon a pharmacy recommendation for one of five residents reviewed for the monthly pharmacy regimen review task. The findings include: For Resident #22, the facility staff failed to ensure the physician reviewed and addressed a pharmacy recommendation on 5/20/24. A review of the clinical record revealed a pharmacy note dated 5/20/24 that documented, See Consultant Pharmacist's Medication Regimen Review. A review of the pharmacy recommendation dated 5/20/24 documented, Resident is currently receiving Ramelteon (1) 8 mg (milligrams) tablets, 1 QHS (every night at bedtime) for hypnotic therapy and has been on it beyond the manufacturer's recommendation for duration of use. Please consider gradual tapering of the medication to ensure Resident is on the lowest dose possible, or continues to need the medication. The physician did not review and address this recommendation. The resident remained on this medication at this higher dose for an additional three months until the pharmacy repeated this recommendation on 8/12/24. The physician decreased the dose on 8/23/24 to 4 mg in response to the 8/12/24 recommendation. On 8/30/24 at 11:03 AM in an interview conducted with ASM #2 (Administrative Staff Member) the Director of Nursing, she stated that she gets the forms from pharmacy and they are provided to the provider who then addresses the recommendations and signs off on it. She stated she did not know why this one was not addressed timely. The facility policy, Medication Regimen Review documented, If the attending physician does not respond within 30 days, the medical director will be asked to review the recommendations and/or contact the attending physician .The attending physician or medical director will document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record On 3/29/24 at the end of day meeting at approximately 3:40 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, ASM #6 a Director of Clinical Operations, ASM #7 a Regional Director of Clinical Operations, ASM #8 a Regional Director of Operations, and RN #4 (Registered Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. References: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Ramelteon is used to help with insomnia Information obtained from https://medlineplus.gov/druginfo/meds/a605038.html

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure residents were free of unnecessary medications for two of 50 residents in the survey sample, Resident #113 and Resident #26. The findings include: 1.The facility staff failed to ensure Resident #113 was free of unnecessary medications by administering anticoagulant as ordered. Resident #113 was admitted to the facility on [DATE] with diagnosis that included fractures and hypertension. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 7/26/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers, dressing, hygiene toileting and independent for eating. A review of the baseline care plan dated 8/3/23 revealed, FOCUS: Resident has actual impairment to skin integrity related to Surgical Wound. INTERVENTIONS: Administer medications, supplements and treatments as ordered. Monitor/document for side effects and effectiveness. There is no evidence of the baseline care plan including any focus or interventions related to anticoagulation therapy or monitoring. A review of the physician order dates 7/21/23 revealed Enoxaparin Sodium Injection Prefilled Syringe Kit 40 MG/0.4ML. Inject 0.4 ml subcutaneously every 12 hours. A review of the July and August 2023 MAR (medication administration record) reveals scheduled time for Enoxaparin injection scheduled for 12:00 AM and 12:00 PM. Review of the administration times reveals the following delays in administration of Enoxaparin: 7/22- 3:28 AM and 1:30 PM, 7/24-1:30 PM, 7/31-1:21 AM and 1:37 PM, 8/2-5:00 AM and 1:29 PM, 8/5-2:42 PM, 8/6-1:24 PM, 08/7-1:24 PM, 8/8-2:54 PM, 8/10-1:15 PM, 8/11-3:26 AM and 1:10 PM and 8/12-1:50 AM and 4:17 PM. An interview was conducted on 8/27/24 at 2:45 PM with LPN (licensed practical nurse) #2. When asked where the evidence of anticoagulation injections would be located, LPN #2 stated, it would be on the MAR. When asked if the physician orders for anticoagulation medication administration were not followed, were professional standards followed, LPN #2 stated, no, they would not be followed. When asked if not administering anticoagulant as ordered every 12 hours was keeping the resident free of unnecessary medications, LPN #2 stated, no, it is not. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Medication Administration policy revealed in part, This policy establishes the guidelines for the safe and effective administration of medications at Hill Valley Healthcare. All medications administered within the facility are subject to these guidelines. The 5 Rights (right resident, right medication, right dose, right route, right time) must be confirmed at the following stages during medication administration. No further information was provided prior to exit. 2.The facility staff failed to ensure Resident #26 was free of unnecessary medications by administering anticoagulant as ordered. Resident #26 was admitted to the facility on [DATE] with diagnosis that included CHF (congestive heart failure), DM (diabetes mellitus) and COPD (chronic obstructive pulmonary disease). The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 6/11/24, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as being dependent for mobility/transfers, dressing, hygiene toileting and independent for eating. A review of the comprehensive care plan dated 4/9/24 revealed, FOCUS: Resident is on anticoagulant therapy related to Atrial fibrillation. INTERVENTIONS: Monitor/document/report PRN adverse reactions of ANTICOAGULANT therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs. A review of the physician order dates 5/14/24 revealed Apixaban Oral Tablet 2.5 MG (Apixaban) Give 1 tablet by mouth two times a day for afib. A review of the June, July and August 2024 MAR-TAR (medication administration record-treatment administration record) found no evidence of the resident being monitored for adverse reactions of anticoagulant therapy as ordered. An interview was conducted on 8/27/24 at 2:45 PM with LPN (licensed practical nurse) #2. When asked where the evidence of anticoagulation monitoring would be located, LPN #2 stated, it would be on the TAR. When asked if the physician orders for anticoagulation medication monitoring were not followed, were professional standards followed, LPN #2 stated, no, they would not be followed. When asked if not monitoring the resident receiving anticoagulants was keeping the resident free of unnecessary medications, LPN #2 stated, no, it is not. On 8/28/24 at 3:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing was made aware of the findings. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Medication Administration policy revealed in part, This policy establishes the guidelines for the safe and effective administration of medications at Hill Valley Healthcare. All medications administered within the facility are subject to these guidelines. The 5 Rights (right resident, right medication, right dose, right route, right time) must be confirmed at the following stages during medication administration. No further information was provided prior to exit.

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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. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure that one of five residents reviewed for the monthly pharmacy regimen review task was free of an unnecessary psychoactive medication; Resident #22. The findings include: For Resident #22, the facility staff failed to ensure the resident was free of an unnecessary psychoactive medication. A review of the clinical record revealed a physician's order dated 5/14/24 for Ramelteon (1) Oral Tablet 8 MG (milligrams) Give 1 tablet by mouth at bedtime for insomnia. A review of the pharmacy recommendation dated 5/20/24 documented, Resident is currently receiving Ramelteon (1) 8 mg (milligrams) tablets, 1 QHS (every night at bedtime) for hypnotic therapy and has been on it beyond the manufacturer's recommendation for duration of use. Please consider gradual tapering of the medication to ensure Resident is on the lowest dose possible, or continues to need the medication. The physician did not review and address this recommendation. The resident remained on this medication at this higher dose for an additional three months until the pharmacy repeated this recommendation on 8/12/24. The physician decreased the dose on 8/23/24 to 4 mg in response to the 8/12/24 recommendation. On 8/30/24 at 11:03 AM in an interview conducted with ASM #2 (Administrative Staff Member) the Director of Nursing, she stated that she gets the forms from pharmacy and they are provided to the provider who then addresses the recommendations and signs off on it. She stated she did not know why this one was not addressed timely. On 3/29/24 at the end of day meeting at approximately 3:40 PM, ASM #1 the Administrator, ASM #2 the Director of Nursing, ASM #6 a Director of Clinical Operations, ASM #7 a Regional Director of Clinical Operations, ASM #8 a Regional Director of Operations, and RN #4 (Registered Nurse) the Assistant Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. References: 1. Ramelteon is used to help with insomnia Information obtained from https://medlineplus.gov/druginfo/meds/a605038.html

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 31753 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to serve palatable food for five of 33 residents in the survey sample, Residents #24, #96, #34, #157, and #32. The findings include: The facility staff failed to serve food with a palatable flavor and at an appetizing temperature. On R24's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 7/14/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 8/26/24 at 2:18 p.m., an interview was conducted with R24. The resident stated the food at the facility was edible but that was all they would say about it. R24 stated that they had lost weight since they were at the facility, but it was desired due to the food quality and the food was usually cold. On R96's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/16/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 8/26/24 at 2:46 p.m., an interview was conducted with R96. The resident stated the food served at the facility lacks in taste and temperature. R96 stated, I would not serve this food to my dog. On R34's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/24/24, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 8/26/24 at 3:45 p.m., an interview was conducted with R34. The resident stated the food at the facility doesn't taste good. On R157's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/13/24, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident was moderately impaired for making daily decisions. On 8/26/24 at 3:55 p.m., an interview was conducted with R157. The resident stated the facility food was cold and did not have any taste. On R32's most recent MDS (minimum data set), a quarterly assessment with an ARD of 6/8/24, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 8/26/24 at 4:40 p.m., an interview was conducted with R32. The resident stated the food at the facility was normally served cold when it was supposed to be hot, and the cold items were normally room temperature. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Manor Rehab and Nursing	2003 Cobb Street Farmville, VA 23901

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at 5:32 p.m., a meal test tray was conducted with OSM (other staff member) #1 (the dietary manager) as the last meal was being served on the last unit. The food did not have a palatable flavor or appetizing temperature. The ground pork was 99 degrees Fahrenheit, the coleslaw was 69 degrees Fahrenheit, the pureed pork was 114 degrees Fahrenheit, and the pureed vegetables were 114 degrees Fahrenheit. OSM #1 stated the ground pork was a little bland and could be a little warmer. OSM #1 stated the coleslaw was a little vinegary. OSM #1 stated the pureed pork was a little bland and did not taste like pork, and the pureed vegetables could be a little warmer. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Food and Nutrition Services documented, 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. No further information was presented prior to exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 31753 Based on observation, staff interview, and facility document review, the facility staff failed to store, prepare, and serve food in a safe and sanitary manner in one of one kitchen, and one of three nourishment rooms (the grace unit), and failed to maintain the dishwasher in good repair in one of one kitchen. The findings include: 1. The facility staff failed to store sugar in a safe and sanitary manner. On 8/26/24 at 12:10 p.m., an observation of the kitchen dry goods storage room was conducted. A container of sugar was observed with the lid open, exposing the sugar to air. On 8/27/24 at 1:32 p.m., an interview was conducted with OSM (other staff member) #1 (the dietary manager). OSM #1 stated the lid should cover the sugar container at all times so nothing will drop into the sugar. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Receiving and Storage of Food documented, Foods shall be received and stored in a manner that complies with safe food handling practices. 2. The facility staff failed to store pots and a pan in a clean and sanitary manner. On 8/26/24 at 12:10 p.m., an observation of a food preparation table with two shelves was conducted. The lower shelf was observed with multiple brown and white stains and food debris. Two pots and one pan were observed upside down on the shelf, making contact with the shelf. On 8/27/24 at 1:32 p.m., an interview was conducted with OSM (other staff member) #1 (the dietary manager). OSM #1 stated the food preparation table should be, wiped down daily and should not have stains and food debris on it. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. 3. The facility staff failed to store an ice scoop in a sanitary manner. On 8/26/24 at 12:10 p.m., an observation of the kitchen ice machine was conducted. The ice scoop was lying on a cart beside the ice machine. On 8/27/24 at 1:32 p.m., an interview was conducted with OSM (other staff member) #1 (the dietary manager). OSM #1 stated the maintenance department had ordered a hanger for the ice scoop and staff was supposed to place the ice scoop in a bag, but they forget. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. 4. The facility staff failed to properly sanitize a bowl per the sanitizer solution manufacturer's instructions in the three-compartment sink. On 8/26/24 at 12:12 p.m., an observation of the three-compartment sink was conducted. A bowl was sitting in sanitizer solution. OSM #5 (a dietary cook) was asked to test the sanitizer solution. OSM #5 tested the sanitizer solution, and the reading was 170 ppm (parts per milliliter). OSM #5 and OSM #6 (another dietary cook) stated that was the appropriate amount of chemicals. On 8/27/24 at 1:32 p.m., an interview was conducted with OSM (other staff member) #1 (the dietary manager). OSM #1 stated the sanitizer solution in the three-compartment sink should be 700 ppm. The sanitizer sink solution manufacturer's instructions documented, Testing solution should be between 0. 27-0.55 oz/gal (ounces per gallon) corresponds to: 272-700 ppm. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. 5. The facility staff failed to ensure the dishwasher ran at a safe temperature, per the manufacturer's instructions. On 8/26/24 at 1:10 p.m., an observation of the dishwasher was conducted while staff were washing facility dishes. The dishwasher temperature was 116 degrees Fahrenheit. On 8/27/24 at 9:15 a.m., an observation of the dishwasher was conducted while staff were washing facility dishes. The dishwasher temperature was 118 degrees. On 8/27/24 at 1:32 p.m., an interview was conducted with OSM (other staff member) #1 (the dietary manager). OSM #1 stated the dishwasher should run between 120 to 123 degrees because it was a low temperature dishwashing machine. OSM #1 stated the staff had to run the dishwasher two or three times to obtain the proper temperature because the water came from a heat pump that was distanced farther away in the building. On 8/27/24 at 2:00 p.m., an observation of the dishwasher was conducted with OSM #1. The dishwasher gauge read 114 degrees. OSM #1 measured water in the dishwasher with a digital thermometer and the reading was 116.4. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The dishwasher manufacturer's instructions documented, WASH-(MINIMUM) 120. 6. The facility staff failed to serve coleslaw at a safe temperature. On 8/26/24 at 5:32 p.m., a meal test tray was conducted with OSM (other staff member) #1 (the dietary manager). OSM #1 measured the temperature of the coleslaw, and the temperature was 69 degrees Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at 1:32 p.m., an interview was conducted with OSM #1. OSM #1 stated the coleslaw was a potentially hazardous food and should be served at a temperature of 40 degrees. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. 7. The facility staff failed to label and store watermelon in a safe manner. On 8/27/24 at 9:20 a.m., an observation of the grace unit nourishment room refrigerator was conducted with RN (registered nurse) #4. A container of mushy dark watermelon pieces in a cloud of juice was observed. The container was not labeled with a date. RN #4 stated the container should have been labeled with a date and the contents in the container looked like old watermelon with an unpleasant odor. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 31753 Based on observation, staff interview, and facility document review, the facility staff failed to maintain the garbage areas in a sanitary manner for one of one trash compactor and two of ten trash bins. The findings include: The facility staff failed to ensure the door/lids on the trash compactor and two trash bins were kept closed when not in use. On 8/26/24 at 4:00 p.m., an observation of the trash compactor was conducted. The side door of the compactor was open and multiple bags of trash were observed in the compactor. On 8/27/24 at 1:52 p.m., an observation of the outside trash bins was conducted. The lids on two bins were open and multiple bags of trash were observed in the bins. On 8/27/24 at 2:43 p.m., an interview was conducted with OSM (other staff member) #2 (the regional director of maintenance) and OSM #3 (the maintenance director). OSM #2 stated the side door on the trash compactor and the lids on the trash bins should be kept closed to keep animals out. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Food-Related Garbage and Refuse Disposal documented, 5. Garbage and refuse containing food waste will be stored in a manner that is inaccessible to pests. No further information was presented prior to exit.

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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. 31753 Based on observation, staff interview, and facility document review, the facility staff failed to maintain a complete infection control program and implement infection control practices for one of 50 residents in the survey sample, Resident #33. The findings include: 1. The facility staff failed to evidence infection surveillance for January 2023 through December 2023. A review of the facility infection control program for January 2023 through December 2023 failed to reveal a system of surveillance. There was only a binder containing multiple Antibiotic Timeout forms for multiple residents. On 8/28/24 at 9:16 a.m., an interview was conducted with RN (registered nurse) #4 (the infection control nurse who was not employed at the facility during 2023). RN #4 stated every day he documents all infections on a tracking log spreadsheet then color codes the infections on a floor plan of rooms so he can evaluate if there is a group of a certain infection and so he knows if there is an infection control challenge that he needs to address. RN #4 was shown the 2023 binder of antibiotic timeout forms and stated it was not possible to track and identify clusters of infections if only those forms were utilized. On 8/28/24 at 11:44 a.m , ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Infection Prevention and Control Program documented, 6. Surveillance- a. Process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incidence and prevalence of healthcare acquired infections) are used as measures of the IPCP (infection prevention and control program) effectiveness. b. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. No further information was presented prior to exit. 2. For Resident #33 (R33), RN (registered nurse) #2 failed to implement infection control practices while preparing and administering medications to the resident. On 8/26/24 at 4:21 p.m., RN #2 was observed preparing medications for R33. RN #2 dropped a 100 mg (milligrams) tablet of bupropion (an antidepressant medication) on top of the medication cart then picked the tablet up with his bare hand and placed the pill in the medication cup. RN #2 placed two other pills in the medication cup then stated the tablet of bupropion was the wrong medication. RN #2 placed his finger in the medication cup to hold the two other pills in the cup while he disposed of the bupropion. RN #2 placed another medication into the medication cup then administered the medications to R33. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/27/24 at 3:01 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a pill is dropped on top of the medication cart, then it should be discarded. LPN #1 stated that if there are multiple pills in a medication cup and one pill needs to be discarded, she would discard all pills and re-pour the medications or a nurse should put on gloves to remove the pill from the cup. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern and the facility did not have a specific policy regarding the above concern. No further information was presented prior to exit.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 31753 Based on observation, staff interview, and facility document review, the facility staff failed to provide a sanitary environment for one of one kitchen. The findings include: The facility staff failed to ensure the floors in the kitchen were clean and free from debris. On 8/26/24 at 12:10 p.m., and 8/27/24 at 9:15 a.m., observations of the kitchen were conducted. Several crumbles of black and brown debris were easily visible and observed on the floor under the three-compartment sink, under shelves, under the dishwasher, and in a gap (approximately 12 inches) between the stove and ovens. Several crumbles of black and brown debris and black and brown stains were observed on the floor in the dry goods storage room. On 8/27/24 at 1:32 p.m., an interview was conducted with OSM (other staff member) #1 (the dietary manager). OSM #1 stated the dietary staff should sweep and mop the kitchen floors after every meal and this should be done under the sink, under shelves, under the dishwasher, and between the stove and ovens. OSM #1 stated the dietary staff could not remove the stains on the floor in the dry goods storage room and she had asked the housekeeping staff to strip and wax the floor. All of the above areas were observed with OSM #1, and she stated the floors needed to be cleaned. On 8/27/24 at 4:21 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Floors documented, Floors shall be maintained in a clean, safe, and sanitary manner. No further information was presented prior to exit.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 31753 Based on staff interview, and facility document review, the facility staff failed to ensure CNAs (certified nursing assistants) completed required in-services trainings for three of five CNA record reviews. The findings include: The facility staff failed to evidence 12 hours of annual training was provided to CNA #3, #4, and #5. CNA #3 was hired on 5/19/22. A review of CNA #3's employee record revealed the CNA only received 10 hours of annual in-service trainings. CNA #4 was hired on 6/22/22. A review of CNA #4's employee record revealed the CNA only received 4.5 hours of annual in-service trainings. CNA #5 was hired on 3/24/23. A review of CNA #5's employee record revealed the CNA only received 2.75 hours of annual in-service trainings. On 8/28/24 at 11:45 a.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing). ASM #2 stated the facility recently began utilizing a computer software for trainings. ASM #2 stated she would have to put something in place to make sure required trainings are being completed by staff. ASM #1 and ASM #2 were made aware of the above concern. The facility policy titled, Nurse Aide In-Service Training Program documented, 4. Annual in-services: b. Are no less than 12 hours per employment year or according to state law. No further information was presented prior to exit.