STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495355	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Health and Rehab Center	700 Randolph Street Radford, VA 24141

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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 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. 47299 Based on staff interview, record review and facility document review, the facility staff failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) to one of 3 residents sampled for ABN review, resident #49 (R49). The findings included: R49's diagnoses included but were not limited to; chronic kidney disease stage IV, vascular dementia, iron deficiency anemia, peripheral vascular disease and unsteadiness on feet. The minimum data set (MDS) assessment assigned the resident a brief interview for mental status (BIMS) score of 13 out of 15 which indicates intact cognition. During the SNF Beneficiary Protection Notification Review, the Regional Director of Social Work provided this surveyor with a worksheet for R49 that indicated a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) should have been issued for the residents October 2024 discharge from SNF services but was not. On 2/5/25 at 9:54 AM this surveyor interviewed the Regional Director of Social Work. When asked if the form was correct they stated it was. When asked if the resident should have been issued a SNF ABN they sated, Yes. This would have been the responsibility of the social worker who was here at the time and it wasn't done. The policy entitled, Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 (2018) with a reviewed/revised date of 9/2021 was provided. The document read in part, Medicare requires SNF's (skilled nursing facilities) to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial. On 2/5/25 at 10:30 this surveyor interviewed R49 who had no concerns. On 2/5/25 at 4:19 PM the survey team met with the Administrator, Director of Nursing, the Clinical Services Specialist and the Regional Director of Social Work. This concern was discussed with the team at that time. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided to the survey team prior to the exit conference.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49622 Based on staff interview, employee record review, and facility document review, the facility staff failed to implement their policy regarding new hires for 2 of 25 new hires. New hire #3 and New hire #13. The findings included: The facility staff failed to follow their abuse prevention policy regarding screening of new hires. On 2/5/25, surveyor completed the employee record reviews. New hire #3 was a licensed practical nurse (LPN), and the facility staff provided surveyor with an initial hire date of 9/1/20, a termination of employment date of 1/23/23, and a rehire date of 2/13/23. The facility staff failed to provide surveyor with evidence of a reference check(s) being completed for new hire #3 on either hire date reviewed in the employee file. New hire #13 was a speech language pathologist (SLP), and the facility staff provided surveyor with a hire date of 1/23/25. The facility staff failed to provide surveyor with evidence of a reference check(s) being completed for new hire #13. On 2/5/25 at 12:10 PM, the administrator informed surveyor that reference checks could not be located for new hire #3. She stated at that point in time (2020), the reference checks would have been done on paper. On 2/5/25 at 1:36 PM, the administrator informed surveyor the therapy contract company, Quality Care Rehab, does not require for the company to share reference checks with the facility. Administrator agreed that no reference checks could be obtained for therapy staff, but she would attempt to receive them. On 2/6/25 at approximately 10:15 AM, administrator confirmed that reference check(s) could not be obtained for new hire #13. Surveyor discussed this concern on 2/5/25 at 3:23 PM at the end-of-day meeting with the administrator, director of nursing, clinical services specialist, and regional social worker and again at the pre-exit meeting on 2/6/25 at 1:15 PM, with the above-mentioned staff and the assistant director of nursing. Surveyor requested and received a facility policy titled, Abuse Prevention, that read in part, .I. Screening A. Potential employees will be screened including .at least one reference will be checked . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor also requested and received a facility policy titled, Hiring Process Policy, that read in part, .The Hiring Process .3 .d. The HR (human resources) Manager will ensure that one reference is completed by the vendor .7. Employees who are rehired within one (1) month do not have to complete new hire requirements and will have original hire dates restored . No further information regarding this issue was provided to the survey team prior to the exit conference on 2/6/25.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide a copy of the notification of reasons for transfer or discharge to the representative of the Office of the State Long-Term Care Ombudsman for one (1) of twenty-nine (29) sampled residents. Resident #67. The findings include: For Resident #67, the facility staff failed to send a copy of the notification of reason for transfer or discharge to the Office of the State Long-Term Care Ombudsman for an emergency transfer that occurred on 12/27/24 to the hospital. Resident #67's diagnosis list indicated diagnoses that included, but were not limited to, Non-displaced Fracture of Right Tibial Tuberosity, Non-displaced Zone 1 Fracture of Sacram, Pneumonia, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease-Stage 3, Repeated Falls, Insomnia, and Atrial Fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/8/25, assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating Resident #67 was cognitively intact. A review of the clinical record revealed the following progress note: 12/27/2024 14:04 (2:04 PM) .Alert Note .Resident seen by [name omitted] NP (nurse practitioner) and sent to ED (emergency department at hospital) for evaluation On 2/05/25 at 3:46 PM, administrator informed surveyor that they could not locate any evidence of the ombudsman being notified of Resident #67's transfer/discharge to the hospital on 12/27/24. Surveyor discussed this concern on 2/5/25 at 3:23 PM at the end-of-day meeting with the administrator, director of nursing, clinical services specialist, and regional social worker and again at the pre-exit meeting on 2/6/25 at 1:15 PM, with the above-mentioned staff and the assistant director of nursing. Surveyor requested and received a facility policy, titled, Notification of Discharge with a revision date of 11/2022, that read in part, .Copies of notices for emergency transfers must also be sent to the ombudsman . No further information regarding this concern was presented to the survey team prior to the exit conference on 2/6/25.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21227 Based on interviews and clinical record review, the facility staff failed to ensure accurate Minimum Data Set (MDS) assessments for three (3) of 29 sampled residents (Resident #52, Resident #61, and Resident #67). The findings include: 1. Resident #52's Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 1/23/25, had the resident incorrectly documented for experiencing dehydration. Resident #52's MDS assessment, with an ARD of 1/23/25, was signed as completed on 1/27/25. Resident #52 was assessed as able to make self understood and as able to understand others. Resident #52's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Review of Resident #52's clinical records failed to reveal documentation to support the aforementioned MDS assessment including dehydration as a problem/condition. On 2/4/25 at 10:32 a.m., the MDS Coordinator reported that Resident #52 was assessed with dehydration in error. The MDS Coordinator provided the surveyor with evidence of the incorrect MDS being modified to remove dehydration as a problem/condition. On 2/6/25 at 1:14 p.m., the survey team met with the facility's Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Services Specialist, and Regional Social Worker. During this meeting, Resident #52's MDS assessment incorrectly capturing dehydration as a problem/condition was discussed for a final time. 28169 2. For Resident #61, facility staff inaccurately indicated the resident had one (1) stage 3 pressure ulcer in the minimum data set (MDS) upon admission. The resident had no pressure ulcers upon admission. Section C (cognitive patterns) of Resident #61's minimum data set (MDS) with an assessment reference date of 01/23/25, coded a brief interview for mental status score a 15 out of 15 indicating intact cognition. One surveyor met Resident #61 in his private room on 02/04/25. The resident was alert and pleasant with hearing difficulty during the interview. When asked about having any pressure ulcers, the resident did not answer and kept repeating the staff were great at the facility. Resident #61's clinical record contained an MDS which coded the resident had one Stage 3 (three) pressure ulcer and a surgical wound. The clinical record's skin and wound documentation referred to a surgical wound on the lower extremity with pictures. There was no pressure ulcer referenced on any of the skin and wound assessments. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/25 at 9:45 a.m., the MDS coordinator was interviewed regarding Resident #61's MDS skin condition coding (Section M). On 02/05/25 at 10:59 a.m., the MDS coordinator stated Resident #61's MDS was coded incorrectly for a stage 3 pressure ulcer and the resident's MDS would be modified that day and schedule a significant correction of prior full assessment. The MDS coordinator acknowledged Resident #61 had no pressure ulcer, only a surgical wound and reported being unsure of how the inaccurate coding happened. On 02/05/25 at 1:40 p.m., a modified MDS (Section M - skin conditions) was noted in the clinical record with no pressure ulcer coded. On 02/05/25 at 4:20 p.m., during an end of day meeting, Resident #61's incorrectly coded MDS was discussed with the director of nursing (DON), administrator, regional social worker, and clinical services specialist. The clinical services specialist acknowledged being aware of the inaccuracy and reported the MDS had been modified. No further information was provided prior to the exit conference. 49622 3. For Resident #67, the facility staff failed to accurately complete Section K (Swallowing/Nutritional Status) to indicate an 8.37% weight loss on an admission minimum data set (MDS) assessment dated [DATE]. Resident #67's diagnosis list indicated diagnoses that included, but were not limited to, Non-displaced Fracture of Right Tibial Tuberosity, Non-displaced Zone 1 Fracture of Sacram, Pneumonia, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease-Stage 3, Repeated Falls, Insomnia, and Atrial Fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/8/25, assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating Resident #67 was cognitively intact. A review of section K (Swallowing/Nutritional Status) under section K0300. Weight Loss of 5% or more in the last month or loss of 10% or more in the last 6 months, was coded as 0 indicating no or unknown of a weight loss having occurred. A review of the clinical record revealed the following documentation: A progress note dated 1/7/25 that read in part, .Weight Change Note .LATE ENTRY .WEIGHT WARNING: Value: 92.0 (ninety-two pounds)Vital Date: 2025-01-06 (date weight obtained) .-5.0% change [8.4% , 8.4] . Significant weight loss 8.4% from previous admission .Has dx (diagnosis) protein calorie malnutrition . A Nutrition assessment dated [DATE] read in part, .Weight changes .2. wt (weight) loss >5% (greater than five percent) in 30 days .Wt loss from prev. (previous) admission r/t (related to) acute illness, hosp. (hospital) . A review of the comprehensive, person-centered care plan revealed a focus and interventions that read in part, .has nutritional Concerns: dx (diagnosis) protein calorie malnutrition. Low BMI (body mass index-a ratio of a person's weight to their height) .Revision on: 01/08/2025 .Report unplanned/unexpected weight changes for further assessment . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #67's weights and vitals revealed on 12/25/24, the resident weighed 100.4 lbs. On 1/06/25, the resident weighed 92 pounds, which is an 8.37 % weight loss. On 2/5/25 at 2:00 PM, surveyor reviewed the MDS dated [DATE] with registered nurse #4 (RN#4). She stated they would have referenced Resident #67's weight from the weight obtained on 1/6/25 in the seven-day look-back period. RN#4 stated she was unclear but thought the admission MDS was a subsequent MDS due to the resident discharging back to the hospital within two days of admission and a prior admission MDS could not be completed. RN#4 believed the actual admission MDS was 1/8/25 after the resident returned from the hospital. At 2:40 PM, RN#4 returned to surveyor and stated after speaking with the regional mds coordinator, she was informed the MDS from 1/8/25 was coded incorrectly and was informed to complete a correction MDS for the 1/8/25 assessment to include the resident's significant weight loss. RN#4 agreed the weight loss for Resident #67 should have been coded on the 1/8/25 admission MDS as it was greater than a 5% loss. Surveyor discussed this concern on 2/5/25 at 3:23 PM at the end-of-day meeting with the administrator, director of nursing, clinical services specialist, and regional social worker and again at the pre-exit meeting on 2/6/25 at 1:15 PM, with the above-mentioned staff and the assistant director of nursing. Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.11 with a revision date of October 2024, read in part, on page K-1 .The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition .This section covers .weight loss .The assessor should collaborate with the dietician and dietary staff to ensure that items in this section have been assessed and calculated accurately . on page K-4 .K0300: Weight Loss .Steps for Assessment .This item compares the resident's weight in the current observation period with their weight at two snapshots in time: At a point closest to 30-days preceding the current weight . on page K-5 .For a New Admission .3. If the admission weight is less than the previous weight, calculate the percentage of weight loss . on page K-6 .Code 2, yes .if the resident has experienced a weight loss of 5% or more in the past 30 days . No further information regarding this concern was presented to the survey team prior to the exit conference on 2/6/25.

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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 21227 Based on staff interviews, clinical record review, and facility document review, the facility staff failed to develop and implement a baseline care plan to address specific resident concerns for one (1) of 29 sampled residents (Resident #80). The findings include: Resident #80's baseline care plan did not address the resident being a hospice patient admitted to the facility for respite care. Resident #80 was a respite patient at the facility. Resident #80's length of stay at the facility did not require the completion of an admission Minimum Data Set (MDS) assessment. Resident #80's admission nursing assessment indicated the resident was oriented to self, time, and place. Resident #80 was documented as able to follow directions. Resident #80 was assessed as having adequate hearing but impaired vision. Resident #80's clinical documentation failed to provide evidence of a care plan addressing the resident's needs related to receiving care at the facility as a hospice respite patient. The following information was found in a facility policy titled Baseline Care Plan Summary (with a reviewed/revised date of 10/2024): Interdisciplinary [sic] team identifies the resident's immediate needs through assessments, interviews and observations beginning at admission. On 2/5/25 at 9:17 a.m., the Administrator reported being unable to find a hospice care plan as part of Resident #80's clinical documentation. On 2/6/25 at 1:14 p.m., the survey team met with the facility's Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Services Specialist, and Regional Social Worker. During this meeting, the failure of the facility staff to address Resident #80's hospice respite care in the resident's baseline care plan was discussed for a final time.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47299 Based on observation, interviews, facility document review and clinical record review the facility staff failed to ensure a foley catheter was care planned for 1 of 29 residents in the survey sample, resident #330 (R330). The findings included: R330's diagnoses included but were not limited to; acute cystitis without hematuria, obstructive and reflux uropathy, and unspecified dementia. The minimum data set (MDS) assessment with an assessment reference date of 12/26/24 assigned the resident a brief interview for mental status (BIMS) score of 99 meaning the resident was unable to complete the interview. R330 was coded as having short and long-term memory impairment and impaired decision making. Under section H Bladder and Bowel, the resident was coded as having a foley catheter. On 2/4/25 at 10:20 AM this surveyor observed resident in bed with a foley catheter bag hanging on the bed frame. On 2/5/25 at 9:20 AM R330 was observed lying in bed with a foley catheter bag hanging on the bed frame. The clinical record for R330 was reviewed. There was no mention of a foley catheter on the comprehensive care plan. On 02/05/25 3:49 PM this surveyor interviewed the Director of Nursing (DON). When asked if R330's foley catheter should be on the care plan they stated it should. The DON stated they would look for it and get back to me. When they returned, they stated, the foley catheter had been discontinued in January and the care plan for it was resolved on 1/10/25. We put it back in today though. They provided a copy of the revised care plan that included a focus that read, (name omitted) has an indwelling catheter due to obstructive uropathy and is on enhanced barrier precautions. This surveyor requested and received the policy entitled, Comprehensive Care Planning Process with an implementation date of 2017. The document read in part, The facility must develop a comprehensive care plan for each patient that includes measurable objectives and timetables to meet a patient's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Under the heading, Policy Explanation item #3, the document read, Additionally, the care plan is a fluid document and shall be reviewed and updated at any time the resident, family or representative or member of the ID (interdisciplinary) team determines a need for additional interventions or care areas to be addressed. On 2/5/25 at 4:19 PM the survey team met with the Administrator, DON, Clinical Services Specialist and the Regional Social Worker. This concern was discussed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42353 Based on staff interview and clinical record review, the facility staff failed to ensure residents receive treatment and care in accordance with the comprehensive person-centered care plan and medical provider orders for 1 of 29 sampled residents, Resident #65. The findings included: For Resident #65, the facility staff failed to administer medications as ordered due to the resident being asleep and failed to notify and/or consult the medical provider. Resident #65's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction, Atrial Fibrillation, Nonrheumatic Aortic Valve Insufficiency, Essential Hypertension, and Vascular Dementia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 12/05/24 assigned the resident a brief interview for mental status (BIMS) summary score of 0 out of 15 indicating the resident was severely cognitively impaired. Resident #65's current comprehensive person-centered care plan included a focus area dated 12/03/24 stating [Resident #65] has had a Cerebral Vascular Accident (Stroke) with an intervention to Give medications as ordered by the physician. Resident #65's current medical provider orders included orders for Cozaar 100 mg by mouth in the morning for hypertension and Verapamil Extended Release 180 mg by mouth in the morning for hypertension. A review of Resident #65's January and February 2025 Medication Administration Records (MARs) on 2/04/25 revealed the resident's Cozaar and Verapamil were not administered due to the resident sleeping on 1/04/25, 1/05/25, 1/09/25, 1/14/25, 1/15/25, 1/17/25, 1/18/25, 1/23/25, 1/27/25, 1/28/25, 1/31/25, and 2/01/25. A nursing progress note dated 1/04/25 at 3:31 PM read Pt [patient] is often stuporous in the morning and will not wake up, even to painful stimulation. This is normal for [him/her] but makes it difficult to give [him/her] medications every day. On days safe to do so within policies time range, the pt gets [his/her] medicines. However, some days pt is not capable of safely taking [his/her] morning medications. Surveyor reviewed Resident #65's clinical record and was unable to locate provider notification and/or discussion to adjust medication administration times to accommodate the resident's typical sleep cycle. On 2/05/25 at 12:13 PM, surveyor spoke with the Director of Nursing (DON) who acknowledged the provider had not been notified of Resident #65 not receiving medications as ordered due to sleeping. DON further stated staff will be in-serviced on this concern. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/05/25 at 4:20 PM, the survey team met with the Administrator, DON, and the Clinical Service Specialist and discussed the concern of Resident #65's medication administrations and failure to notify the provider. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/06/25.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 42353 Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide assistance to the resident in making an appointment with an outside provider to address bilateral cataracts for 1 of 29 sampled residents, Resident #29. The findings included: For Resident #29, the facility staff failed to schedule an outside consult for bilateral cataract surgery as ordered by the medical provider. Resident #29's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Respiratory Failure with Hypercapnia, and Paroxysmal Atrial Fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/03/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. On 2/04/25 at 9:00 AM, surveyor spoke with Resident #29 who stated they had cataracts in both eyes and their vision was getting worse. Resident #29's was seen by the optometrist on 4/16/24, the progress note read in part .Physicians Orders: 1) Please schedule cataract surgery evaluation with [name omitted] .Age-related nuclear cataract, bilateral . Moderate becoming visually significant .Had consultation in [name omitted] August 2023 for cataract surgery but surgery was not scheduled yet; please contact [name omitted] for scheduling surgery . Resident #29's current medical provider orders included an order dated 4/16/24 to schedule cataract surgery evaluation with [name omitted]. Resident #29 was again seen by the optometrist on 10/15/24, the progress note read in part .Physicians Orders: 1) Please schedule cataract surgery evaluation with [name omitted] .Age-related nuclear cataract, bilateral .Moderate becoming visually significant .Had consultation in [name omitted] August 2023 for cataract surgery but surgery was not scheduled yet; please contact [name omitted] for scheduling surgery . Resident #29's current medical provider orders included an additional provider order dated 10/16/24 to schedule cataract surgery evaluation with [name omitted]. On 2/04/25 at 3:05 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, and the Clinical Service Specialist and discussed the concern of Resident #29 awaiting a consult appointment regarding cataract surgery. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #29's clinical record included a progress note by the Unit Coordinator (UC) dated 2/04/25 4:56 PM which read in part Patient has an appointment with Dr. [name omitted] for Cataract Surgery Consultation on 4/09/25 . On 2/05/25 at 10:50 AM, surveyor spoke with the UC who stated she had spoken with Resident #29 last Thursday and the resident asked to see a doctor for cataract surgery. The UC denied being notified of the resident needing an appointment scheduled regarding cataract surgery prior to speaking with the resident last week. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/06/25.

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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. 42353 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a resident who is fed by enteral means receives the appropriate, provider ordered tube feeding formula for 1 of 29 sampled residents, Resident #35. The findings included: For Resident #35, the facility staff failed to follow the medical provider's order for tube feeding formula. Resident #35's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Chronic Obstructive Pulmonary Disease, and Stage 4 Sacral Pressure Ulcer. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 11/06/24 coded Resident #35 as being severely impaired in cognitive skills for daily decision making with long-term and short-term memory problems. The resident was coded as receiving 51% or more of total calories through parenteral or tube feeding and 501 cc per day or more of average fluid intake by IV or tube feeding during the last seven (7) days. Resident #35's current comprehensive person-centered care plan included a focus area stating in part [Resident #35] is at risk for nutritional decline [secondary to] hx [history] stroke, dysphagia, need for modified diet. [He/She] has a feeding tube to provide supplemental enteral feedings. Hx significant wt [weight] loss .at risk for malnutrition with an intervention to provide enteral feedings as ordered. Resident #35's current medical provider orders included an enteral feeding order dated 1/09/25 for Isosource 1.5 or equivalent at 20 ml/hr. On 2/04/25 at 8:25 AM surveyor observed Resident #35 in bed receiving a tube feeding formula via pump at 20 ml/hour. The tube feeding formula was present in a fillable formula bag; however, the bag had not been labeled with the name of the formula or the date and time the formula was placed in the bag and started via pump. Surveyor observed two unopened containers of Osmolite 1.5 on Resident #35's overbed table. On 2/04/25 at 2:54 PM, surveyor observed Resident #35 in their room receiving tube feeding via pump. 2/04/25 0500 had been written on the tube feeding formula bag, however the name of the contents had not been added. Surveyor spoke with the resident's nurse, Licensed Practical Nurse (LPN) #1, who stated Resident #35 was receiving Osmolite 1.5 and they were they only resident receiving tube feeding on the unit. Surveyor then spoke with other staff member (OSM) #12 in the unit's stock room who stated Resident #35 received Osmolite 1.5 and surveyor observed an open box of Osmolite 1.5 on a shelf. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received the facility enteral feeding nutrition formulary cross reference which indicated the temporary replacement option for Isosource 1.5 was Jevity 1.5. The formulary indicated Isosource 1.5 was calorically dense, high nitrogen with fiber. According to the Osmolite 1.5 nutritional content guide, it contains no fiber. On 2/04/25 at 3:05 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, and the Clinical Service Specialist and discussed the concern of Resident #35's tube feeding formula. Surveyor requested and received the facility policy titled Care of the Patient with a Feeding Tube with a reviewed/revised date of 2/07/23 which read in part .ensure tube feeding formulas are maintained according to the manufacturer's recommendations and administered per physician/physician orders . No further information regarding this concern was presented to the survey team prior to the exit conference on 2/06/25.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 42353 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a resident who is fed by enteral means receives the appropriate treatment to prevent complications for 1 of 29 sampled residents, Resident #35. The findings included: For Resident #35, the facility staff failed to label the enteral feeding formula and water with the name of the formula being provided and the date and time initiated. Resident #35's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Chronic Obstructive Pulmonary Disease, and Stage 4 Sacral Pressure Ulcer. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 11/06/24 coded Resident #35 as being severely impaired in cognitive skills for daily decision making with long-term and short-term memory problems. The resident was coded as receiving 51% or more of total calories through parenteral or tube feeding and 501 cc per day or more of average fluid intake by IV or tube feeding during the last seven (7) days. Resident #35's current comprehensive person-centered care plan included a focus area stating in part [Resident #35] is at risk for nutritional decline [secondary to] hx [history] stroke, dysphagia, need for modified diet. [He/She] has a feeding tube to provide supplemental enteral feedings. Hx significant wt [weight] loss .at risk for malnutrition with an intervention to provide enteral feedings as ordered. Resident #35's current medical provider orders included an enteral feeding order dated 1/09/25 for Isosource 1.5 or equivalent at 20 ml/hour. On 2/04/25 at 8:25 AM surveyor observed Resident #35 in bed receiving a tube feeding formula via pump at 20 ml/hour. The tube feeding formula was present in a fillable formula bag; however, the bag had not been labeled with the name of the formula or the date and time the formula was placed in the bag and started via pump. On 2/04/25 at 2:54 PM, surveyor observed Resident #35 in their room receiving tube feeding via pump. 2/04/25 0500 had been written on the tube feeding formula bag, however the name of the contents had not been added. Surveyor requested and received the facility policy titled Care of the Patient with a Feeding Tube with a reviewed/revised date of 2/07/23 which read in part .Properly label feeding equipment/accessories with the patient's name, date, type of feeding, rate, and start time as indicated . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/04/25 at 3:05 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, and the Clinical Service Specialist and discussed the concern of Resident #35's tube feeding formula. On 2/06/25 at 9:46 AM, surveyor observed Resident #35 in bed receiving enteral feeding via pump. The enteral formula was labeled with the contents and date and time initiated; however, the water was not labeled with the date and time initiated. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/06/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42353 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to provide respiratory care consistent with the comprehensive person-centered care plan and the medical provider orders for 1 of 29 sampled residents, Resident #35. The findings included: For Resident #35, the facility staff failed to administer supplemental oxygen at the rate ordered by the medical provider. Resident #35's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Chronic Obstructive Pulmonary Disease, and Stage 4 Sacral Pressure Ulcer. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 11/06/24 coded Resident #35 as being severely impaired in cognitive skills for daily decision making with long-term and short-term memory problems. Resident #35's current comprehensive person-centered care plan included a focus area stating in part [Resident #35] has impaired or potentially impaired cardiovascular status r/t [related to] CAD [coronary artery disease], HTN [hypertension], Aortic Valve Insufficiency . with an intervention to Administer O2 [oxygen] per MD orders. Resident #35's current medical provider orders included an order for Oxygen at 2 l/m (liters per minute) via nasal cannula continuously for hypoxemia (low blood oxygen). On 2/04/25 at 8:30 AM and 1:40 PM surveyor observed Resident #35 in bed receiving oxygen via nasal cannula at the delivery rate of 2.5 l/m per the oxygen concentrator setting. The following day, on 2/05/25 at 10:34 AM, surveyor again observed Resident #35 in bed receiving oxygen via nasal cannula at the delivery rate of 2.5 l/m per the oxygen concentrator setting. Surveyor notified Registered Nurse (RN) #5 and Licensed Practical Nurse (LPN) #1 of the resident's current oxygen setting and RN #1 acknowledged the current order was 2 l/m and stated the nurses may adjust oxygen settings accordingly with changes and she assumed Resident #35's oxygen setting needed to be adjusted this morning. Surveyor reviewed Resident #35's clinical record and was unable to locate documentation indicating the resident required an increase in oxygen on 2/04/25 or 2/05/25. On 2/05/25 at 10:43 AM, surveyor spoke with the Director of Nursing (DON) and inquired if nurses were allowed to adjust oxygen delivery rates within an acceptable range as needed and she stated no, there must be an order for the exact setting. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received the facility policy titled Oxygen Administration with a reviewed/revised date of 12/28/23 which read in part Oxygen is administered to patients who need it, consistent with professional standards of practice, the comprehensive person-centered care plans . On 2/05/25 at 4:20 PM, the survey team met with the Administrator, DON, and Clinical Service Specialist and discussed the concern of Resident #35 receiving oxygen at the rate of 2.5 l/m instead of the ordered rate of 2 l/m. On 2/06/25 at 11:40 AM, surveyor spoke with the DON who acknowledged Resident #35's oxygen was set at 2.5 l/m and stated she has reiterated to the facility department heads to observe oxygen settings while rounding and discuss in daily meetings. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/06/25.

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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. 47299 2. For resident # 33 (R33), the facility staff failed to ensure the resident received intravenous antibiotics per provider order. R33's diagnoses included but were not limited to; other acute osteomylitis (infection in the bone) of left ankle and foot, Type II diabetes with skin ulcer and chronic obstructive pulmonary disorder. During a review of R33's clinical record a hospital discharge summary with a date of service of 1/21/25 was reviewed. Under the heading Continue taking these medications the discharge summary included, pipercillin-tazobactam in dextrose (iso-osm) premix 4.5 gram/100ml pgbk commonly known as Zosyn 100 ml every 8 (eight) hours by intravenous (IV) route. Continue until end of 1/28/25. The Medication Administration Record (MAR) for January 2025 was reviewed. On 1/22/25 the MAR was coded with an x for the midnight dose, a 9 for the 8:00 AM dose and a 9 for the 4:00 PM dose. On 1/23/25 the MAR had an x for the midnight dose, 9 for the 8:00 AM dose and 9 for the 4:00 PM dose. On 1/23/25 each dose was coded the same way as the day before. According to the MAR, a code of 9 means, see nurse notes. The progress notes were reviewed. A note dated 1/22/25 at 9:16 AM read, Coming from the pharmacy today. A note dated 1/23/25 at 7:54 PM read, Pharmacy delivering tonight. On 2/6/25 at 10:07 AM this surveyor met with the Director of Nursing (DON) and the Clinical Services Specialist to discuss this concern. This surveyor asked if the notes above were in reference to the pipercillin IV order. The DON stated she would need to look at it and let me know. On 2/6/26 at 11:57 AM the DON stated that the pipercillin was not available and was started two days later than it should have been. On 2/6/25 at 1:15 PM the survey team met with the Administrator, Director of Nursing, Clinical Services Specialist and Regional Director of Clinical Services. This concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference. 34307 Based on staff interview, clinical record review and facility document review the facility staff failed to ensure medications were available for administration for 1 of 29 residents, Resident #38. The findings included: 1. For Resident #38 the facility staff failed to ensure the medication, Humira, was available for administration. Per Drugs.com, Humira is an antirheumatic used to treat inflammatory conditions, such as Crohn's disease. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #38's clinical record listed diagnoses which included but not limited to Crohn's disease, unspecified, without complications. Resident #38's most recent minimum data set with an assessment reference date of 12/12/24 assigned the resident a brief interview for mental status score of 8 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Resident #38's comprehensive care plan was reviewed and contained a plan for . has GERD (gastroesophageal reflux disease) and Crohn's. Interventions for this plan includes Give medications as ordered . Resident #38's clinical record was reviewed and contained a physician's order summary which read in part, Humira Subcutaneous Pen-Injector Kit 40 mg/0.4 ml. Inject 40 mg subcutaneously q (every) week every Fri(day) for inflammation. Resident #38's electronic medication administration record for the month of January 2025 was reviewed and contained an entry as above. This entry was coded 9 on 01/24/25 and 01/31/24. Chart code 9 is equivalent to other/see nurses notes. Resident #39's nurse's progress notes were reviewed and contained notes which read in part, 1/24/2025 19:02 Note Text: Humira (2 Pen) Subcutaneous Pen-Injector Kit 40 mg/0.4 ml. Inject 40 mg subcutaneously q week every Fri for inflammation. Family having problems getting med. prescription runned out, 1/31/2025 15:36 Note Text: Humira (2 Pen) Subcutaneous Pen-Injector Kit 40 mg/0.4 ml. Inject 40 mg subcutaneously q week every Fri for inflammation. The medication is brought in by resident's . (family member). Called . (family member) but only got voicemail, left message about needing medications and 2/4/2025 19:21 Note Text: Call back was received from . (family member) with regards to Humera med of . (Resident #38). (family member) stated that original prescribing gastro entorologist (sic) is not longer practicing in the area. Attempt was made by . (family member) to have other providers in the group fill up the grant form for medication. (family member) was advised that while she is still in the process of requesting new grant, . (name omitted) FNP (family nurse practitioner) can review other options with her. (family member) was in agreement and very appreciative of call made. (FNP name omitted) was given an update of conversation with resident's . (family member). During a meeting with the administrator, director of nursing, assistant director of nursing and clinical services specialist on 02/025/25 at 3:30 pm, surveyor informed these staff of Resident's Humira not being available for two doses. Surveyor spoke with the FNP on 02/05/25 at 11:40 am. Surveyor asked FNP if they had been notified prior to 02/04/25 that Resident #38's Humira was not available, and FNP stated they had not. Surveyor spoke with registered nurse (RN) #3 on 02/05/25 at 2:10 pm. Surveyor asked RN #3 if they had notified anyone of Resident #38's Humira not being available for administration, and RN #3 stated they called resident's family member that usually brings the medication and left a message that the medication was not available. Surveyor asked RN #3 if they had notified the physician/FNP, and RN #3 stated they had not. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and was provided with a facility policy entitled Medication Ordering and Receipt: Use of Outside Pharmacy which read in part, As permitted by State regulations, residents have the right to choose their pharmacy provider as long as Federal, Stated, and Local regulatory requirements are met, and facility policies are followed. 1. When a resident or a resident's family indicates that medications are to be obtained from an outside pharmacy, the Facility should review the policy and procedures for medication distribution with family. Medications must be delivered directly to the Facility by the chosen pharmacy's agent (not including family members) and follow Federal and State requirements as well as established facility policy. The facility must complete an fax the Notice of Intent to Use Outside Pharmacy to . (pharmacy name omitted). The concern of not ensuring medications were available for administration was discussed with the administrator, director of nursing and clinical services specialist on 02/05/25 at 4:20 pm. No further information was provided prior to exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 42353 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure each resident's drug regimen was free from unnecessary drugs for 1 of 29 sampled residents, Resident #22. The findings included: For Resident #22, the facility staff administered the oral antihistamine, Loratadine without a medical provider order. Resident #22's diagnosis list indicated diagnoses, which included, but not limited to Pneumonia, Type 2 Diabetes Mellitus with Diabetic Neuropathy, and Chronic Kidney Disease Stage 4. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/22/25 assigned the resident a brief interview for mental status (BIMS) summary score of 7 out of 15 indicating the resident was severely cognitively impaired. On 2/05/25 at 8:58 AM during a medication pass and pour observation, surveyor observed Licensed Practical Nurse #6 administer a Loratadine 10 mg tablet to Resident #22. Surveyor reviewed Resident #22's medical provider orders and was unable to locate a current order for Loratadine. According to the clinical record, Loratadine was ordered on 1/17/25 and discontinued the same day on 1/17/25. On 2/05/25 at 9:40 AM, surveyor returned to LPN #6 and inquired about the Loratadine. LPN #6 and surveyor observed Loratadine was prepackaged in the pharmacy morning medications that were administered and Loratadine was also prepackaged in the following day's package for administration. LPN #6 confirmed there was no current order for Loratadine. Surveyor requested and received the facility policy titled Paxit Med-Pass Procedure which read in part .5) Verify that the following information for each medication in the bag (1st med check) matches the information on the MAR (medication administration record): a. Med name b. Med strength c. Med quality . On 2/05/25 at 4:20 PM, the survey team met with the Administrator, Director of Nursing, and the Clinical Service Specialist and discussed the concern of staff administering Loratadine to Resident #22 without an order. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/06/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 28169 Based on observation, staff interviews, resident interview, and clinical record review the facility staff failed to ensure a physician ordered medication was kept under direct observation by the nursing staff until consumed by the resident for 2 of 29 residents in the survey sample (Resident #181 and Resident #22). The findings were: 1. For Resident #181, the medication nurse failed to remain with the resident while he consumed all prescribed medications. Resident #181's minimum data set with an assessment reference date of 01/06/25 assigned the resident a brief interview for mental status summary score of 13 out of 15 in Section C (cognitive patterns) indicating the resident was cognitively intact. On 02/04/25 at 9:45 a.m., one surveyor met Resident #181 who was alone in a private room. The surveyor observed the resident attempting to pick up a pill that was lying on the overbed table. When the surveyor asked why the resident had not taken that one pill, he reported preferring to space his pills out. Resident #181 stated he took 6 (six) pills in the morning. When the surveyor asked whether the medication nurse stayed with him until he swallowed all his medications, the resident said no. The resident stated, I think she's supposed to, but she trusts me. On 02/04/25 at 9:55 a.m., Resident #181's medication nurse, licensed practical nurse (LPN #4) was interviewed. The nurse explained her process for administering medications by mouth was that if the resident was not alert and oriented, LPN #4 would wait while the resident took the medications. If the resident was alert and oriented, the nurse left the medications sometimes because there were residents who preferred to take their time swallowing their medications. LPN #4 stated that regarding Resident #181, his wife was generally present all day and night and she made sure the resident took his medications. If his wife was not present, the nurse would crush Resident #181's medications to make sure he got them. The nurse reported she stayed with Resident #181 today while he drank a new medication (Megace, a medication used to treat loss of appetite and weight loss in people with chronic conditions). On 02/04/25 at 3:00 p.m. during an end of day meeting, the concern regarding LPN #4 leaving one of Resident #181's oral medications unconsumed by the resident was discussed with the administrator, director of nursing (DON), assistant director of nursing (ADON), and clinical services specialist. The DON reported the nurse should have stayed with Resident #181 until all the medications were taken. The clinical services specialist stated the resident should be assessed for self-administered medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #181's clinical record contained a progress note written by the ADON on 02/04/25 at 7:36 p.m. which read the ADON spoke with Resident #181 about whether the resident would like to be assessed for possibly self-administering his medications since the facility staff could not leave his medications with him in the room for him to take at his own pace. Resident #181 decided he preferred to have his medications crushed in pudding/applesauce/yogurt since he had difficulty swallowing them and needed to take breaks. No further information was provided prior to the exit conference. 42353 2. For Resident #22, the facility staff left the medication, Nystatin Oral Suspension with the resident to be taken at a later time unsupervised. Resident #22's diagnosis list indicated diagnoses, which included, but not limited to Pneumonia, Type 2 Diabetes Mellitus with Diabetic Neuropathy, and Chronic Kidney Disease Stage 4. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/22/25 assigned the resident a brief interview for mental status (BIMS) summary score of 7 out of 15 indicating the resident was severely cognitively impaired. On 2/05/25 at 8:58 AM during a medication pass and pour observation, surveyor observed Licensed Practical Nurse (LPN) #6 prepare Nystatin Oral Suspension and provide to Resident #22. Resident #22 was eating breakfast at the time of medication administration and LPN #6 administered the resident's oral tablets and left the Nystatin to be taken by the resident after finishing breakfast. LPN #6 asked the resident what they were going to do with the Nystatin after swishing it around in their mouth and Resident #22 stated they would swallow it. LPN #6 exited the room with the Nystatin sitting on Resident #22's overbed table beside their breakfast tray. Resident #22's current medical provider orders included an order dated 1/16/25 for Nystatin Mouth/Throat Suspension 100,000 unit/ml give 5 ml by mouth four times a day for yeast. Surveyor reviewed the resident's clinical record and was unable to locate an order for self-administration of Nystatin. On 2/05/25 at 4:20 PM, the survey team met with the Administrator, Director of Nursing (DON), and the Clinical Service Specialist and discussed the concern of LPN #6 leaving Nystatin unsupervised in Resident #22's room. On 2/06/25 at 11:38 AM, surveyor spoke with the DON who stated the nurse had been educated and would be written up. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/06/25.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 28567 Based on staff interview and clinical record review, the facility staff failed to ensure provider ordered laboratory tests were obtained for 1 of 29 residents, Resident #79. The findings included: The facility staff failed to obtain the provider ordered laboratory tests basic metabolic panel (BMP) and urinalysis (UA). Resident #79's diagnoses included, but were not limited to, multiple sclerosis (MS), chronic kidney disease stage 4, diabetes, and anorexia. Section C (cognitive patterns) of Resident #79's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 09/27/22 included a brief interview for mental status (BIMS) score of 14 out of a possible 15 points. Per the MDS manual a score of 15=cognitively intact. Resident #79's clinical record included the following provider orders. 07/05/22 obtain UA. 07/26/22 obtain BMP 07/27/22. 09/01/22 obtain UA. Resident #79 was seen by the family nurse practitioner (FNP) on 07/26/22. On 09/01/22 the FNP transcribed plan BMP 07/27/22 and on 09/01/22 will obtain UA. During the clinical record review, the surveyor was unable to find the results of these laboratory tests. The missing laboratory tests results were reviewed with the Director of Nursing (DON), Administrator, and Clinical Service Specialist during an end of the day meetings on 02/05/25 at 4:20 p.m. and again on 02/06/25 at 1:15 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 21227 Based on staff interviews, clinical record review, and facility document review, the facility staff failed to ensure complete and/or accurate clinical records for five (5) of 29 sampled residents (Resident #13, Resident #46, Resident #67, Resident #79, and Resident #81). The findings include: 1. The facility staff failed to ensure Resident #13's clinical documentation accurately captured the medications administered to the resident by facility staff members. Resident #13's clinical documentation incorrectly indicated that two Ozempic injections had been administered to Resident #13 in June of 2024. This medication had not been sent to the facility for Resident #13, therefore it was not available to have been administered. Resident #13's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/4/24, was signed as completed on 12/5/24. Resident #13 was assessed as able to make self understood and as able to understand others. Resident #13's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #13's diagnoses included diabetes. Resident #13 was documented as receiving both Ozempic and Trulicity on the mornings of 6/12/24 and 6/19/24; both medications were documented on the resident's medication administration orders (MARs) as being scheduled for 9:00 a.m. (Ozempic and Trulicity are Glucagon-like Peptide-1 (GLP-1) agonist medications used to treat conditions including diabetes.) Pharmacy documentation indicated that Resident #13 was only sent Trulicity for the month of June 2024. No evidence was found to indicate that the pharmacy had sent Ozempic for Resident #13 for the month of June 2024. During a telephone interview with a Consultant Pharmacist on 2/6/25 at 11:30 a.m., the pharmacist confirmed that only one of the aforementioned medications had been sent for Resident #13 for June 2024. The pharmacist stated the medication sent to the facility would have been labeled with the name of the resident for whom it was ordered. On 2/6/25 at 11:34 a.m., the Director of Nursing confirmed that only one of the medications would have been available to administer to Resident #13 in June of 2024. The following information was found in a facility policy titled Documentation in Medical Records (with an implementation date of 6/1/21): Each resident's medical record should contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. On 2/6/25 at 1:14 p.m., the survey team met with the facility's Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Services Specialist, and Regional Social Worker. During this meeting, the aforementioned incorrect documentation, of the administration of GLP-1 agonist medications, was discussed for a final time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28567 2. For Resident #79, the facility staff failed to document meal and fluid intakes. This was a closed record review. Resident #79's diagnoses included, but were not limited to, multiple sclerosis (MS), chronic kidney disease stage 4, diabetes, anorexia, and gastro esophageal reflux disease. Section C (cognitive patterns) of Resident #79's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 09/27/22 included a brief interview for mental status (BIMS) score of 14 out of a possible 15 points. Per the MDS manual a score of 15=cognitively intact. Section GG (functional abilities and goals) was coded to indicate this resident required supervision or touching assistance with meals. Resident #79's comprehensive care plan included the focus areas demonstrates the need for activity of daily living assistance related to MS and decreased mobility. Interventions included, but were not limited to, provide assistance for eating and drinking as needed. At risk for nutritional decline provide diet as ordered, encourage to eat, provide nutritional supplements as ordered, report unplanned/unexpected weight changes for further assessment. A review of Resident #79's meal and fluid intake documentation was completed on 02/06/25. The surveyor was unable to find any documentation for the residents meal intake on 11/06/22, 11/10/22, and 11/19/22. For 11/05/22 the facility staff had only documented intake for 2 of 3 meals and on 11/24/22 the facility staff had documented for 1 of 3 meals. For 11/01/22-11/06/22, 11/08/22-11/10/22, 11/13/22, 11/15/22, 11/18/22-11/20/22, and 11/23/22 the facility staff had documented Resident #79's fluid intake for 1 12-hour shift. There was no documentation of Resident #79's fluid intake for 11/24/22. During an interview with Certified Nursing Assistant (C.N.A.) #5 on 02/06/25 at 10:12 a.m., this staff stated for fluid intake documentation there should be an entry for each shift, and they worked 12-hour shifts. The facility staff provided the survey team with a copy of their policy titled, Documentation in Medical Record date of policy 06/01/21. This policy read in part, Each resident's medical record should contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation .Licensed staff .shall document all assessments, observations, and services provided in the resident's medical record . On 02/06/25 at 1:15 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Service Specialist, and Regional Social Worker the issue with the missing documentation were reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42353 3. For Resident #81, the facility staff failed to document fluid intake, meal intake, bladder continence, and bowel movements each shift. Resident #81's diagnosis list indicated diagnoses, which included, but not limited to Surgical Aftercare, Malignant Neoplasm of Prostate, Hypertensive Chronic Kidney Disease, Diverticulosis of Intestine, and Morbid Obesity. The minimum data set (MDS) with an assessment reference date (ARD) of 8/19/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Surveyor reviewed Resident #81's clinical record for August 2023 which revealed the following documentation omissions: Fluid Intake - 8/13/23 7P-7A, 8/15/23 7P-7A, 8/16/23 7A-7P, 8/16/23 7P-7A, 8/17/23 7A-7P, 8/17/23 7P-7A, 8/19/23 7P-7A Meal Intake - 8/16/23 all meals and 8/17/23 all meals Bowel Movements 8/13/23 7P-7A, 8/15/23 7P-7A, 8/16/23 7A-7P, 8/16/23 7P-7A, 8/17/23 7P-7A, 8/19/23 7P-7A Bladder Continence - 8/13/23 7P-7A, 8/15/23 7P-7A, 8/16/23 7A-7P, 8/16/23 7P-7A, 8/17/23 7P-7A, 8/19/23 7P-7A Surveyor requested and received the facility policy titled Documentation in the Medical Record with an implemented date of 6/01/21 which read in part Each resident's medical record should contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation .1. Licensed staff and interdisciplinary team members shall document all .observations .in the resident's medical record in accordance with state law and facility policy . On 2/05/25 at 3:40 PM, surveyor met with the Clinical Service Specialist and the Director of Nursing and discussed the concern of staff failing to consistently document Resident #81's fluid intake, meal intake, urinary output, and bowel movements. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/06/25. 47299 4. For resident # 46 (R46) the facility staff failed to ensure that insulin administration was accurately documented in the clinical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R46's diagnoses included but were not limited to; type 2 diabetes, morbid obesity due to excess calories, acquired absence of left leg above knee, diabetic retinopathy and generalized anxiety disorder. On 2/4/25 during initial tour, R46 stated to this surveyor, I don't feel like my diabetes is being controlled right. They don't give me my insulin like they should. R46s minimum data set (MDS) assessment with an assessment reference date of 1/5/25 assigned the resident a brief interview for mental status (BIMS) score of 15 out 15 indicating intact cognition. There was no memory or decision making impairments noted and no signs of delirium. The medication orders in clinical record were reviewed. R46 had an order that read, Basaglar KwikPen subcutaneous solution pen-injector 100 units/ml (insulin glargine) Inject 25 units subcutaneously two times a day for dm (diabetes mellitus). The medication administration record (MAR) was reviewed for January 2025. This insulin was coded with a 2 which means drug refused for the night dose of this insulin on 1/3, 1/8, 1/13, 1/17 and 1/18. On 1/22 the night dose was coded with 8 which means nauseated/vomiting. On 1/27 the insulin was coded with 9 for the night dose which means, other, see nurses notes. The nurses notes for 1/27/25 were reviewed an entry for 10:08 PM read, Basaglar KwikPen Subcutaneous Solution Pen-injector 100 UNIT/ML Inject 25 unit subcutaneously two times a day for dm bs 65. This surveyor was unable to locate an order to hold insulin. Another order read, Novolog FlexPen subcutaneous solution pen-injector 100 units/ml (insulin aspart) Inject 40 units subcutaneous three times a day for dm. The MAR was reviewed. The MAR was coded with 11 which means No coverage required per ss (sliding scale) for the 9:00 AM dose on 1/21 and 1/26, the 1:00 PM dose on 1/7, 1/15, 1/21, 1/22, 1/23, 1/27, 1/29, and 1/30 and the 5:00 PM dose on 1/1/, 1/2, 1/6, 1/7, 1/9, 1/12, 1/15, 1/20, 1/21, 1/22, 1/23, 1/25, and 1/30. On 1/13 for the 1:00 PM dose the code 5 was used which means, Hold, see nurse notes and on 1/16 for the 5:00 PM dose the code 9 for Other, see nurse notes was used. The nurse notes were reviewed. On 1/13/25 at 1:43 PM the note read, NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML Inject 40 unit subcutaneously three times a day for dm Bs 87. The note on 1/16/25 at 4:39 PM read, NovoLOG FlexPen Subcutaneous Solution Pen-injector 100 UNIT/ML Inject 40 unit subcutaneously three times a day for dm Hold due to BS of 75. This surveyor was unable to locate an order to hold the insulin. On 2/5/25 at 2:56 PM this surveyor interviewed the Director of Nursing (DON) about the codes on the MAR for R46's insulin. They stated, (resident) frequently refuses all insulin and the codes when the insulin wasn't given should have been 2s. She refuses it all the time. On 2/5/25 at 3:10 PM this surveyor interviewed R46. When asked if they frequently refuse their insulin they stated, If my blood sugar is low, I won't take it. This surveyor read off several of the blood sugar readings for the dates and times that insulin was not administered according to the MAR and resident stated, I wouldn't have taken insulin for those readings. I know my body and I am no going to take all that insulin if I know I haven't eaten much or I'm not going to eat any more. Sometimes if I am going to have my son bring me food in, I might go ahead and take it but it's my choice whether to take it or not. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/05/25 04:01 PM this surveyor spoke with the Nurse Practitioner (NP) who cares for R46. They sated, I'm not sure if I have documented about her refusing her insulin. She is basically managing her insulin just as she would be doing at home. She's alert and oriented and perfectly capable to make her own decisions about whether or not to take her medications. On 2/5/25 at 4:19 PM the survey team met with the Administrator, DON, Clinical Services Specialist and Regional Social Worker. This concern was discussed at that time. No further information was provided to the survey team prior to the exit conference. 49622 5. For Resident #67, the facility staff failed to maintain an accurately documented clinical record by inaccurately documenting a TLSO (thoracolumbar sacral orthosis-a medical device that limits movement in the spine) brace as being on the resident when the resident was out of bed. Resident #67's diagnosis list indicated diagnoses that included, but were not limited to, Non-displaced Fracture of Right Tibial Tuberosity, Non-displaced Zone 1 Fracture of Sacram, Pneumonia, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease-Stage 3, Repeated Falls, Insomnia, and Atrial Fibrillation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/8/25, assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating Resident #67 was cognitively intact. A review of the clinical record revealed the following documentation: A medical provider's order with a start date of 12/25/24 and an end date of 12/27/24, read in part, .TLSO brace anytime resident is out of bed every shift . A medical provider's order with a start date of 1/2/25 and an end date of 1/13/25, read in part, .TLSO brace on when out of bed every shift . A review of the December 2024 TAR (treatment administration record) revealed the TLSO brace was applied to Resident #67 on 12/26/24 and the morning of 12/27/24. A review of the January 2025 TAR revealed the TLSO brace was applied to Resident #67 daily January 3, 2025, through January 12, 2025. A progress note dated 12/26/24, read in part, .Alert Note .TLSO brace not sent with resident from hospital upon admission to our facility. This nurse spoke with PT (physical therapy) dept (department) and was told this would need to come from her Orthopedic surgeon as these were not kept on hand in facility . A progress note dated 1/13/25, read in part, .PT Daily Note .Niece [name omitted] stated that patient cannot get out of bed without back brace .PTA (physical therapy assistant) reported concern to [name omitted] Director of Therapy and instructed therapist to treat patient and that no brace is needed according to medical records . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated 1/14/25 read in part, .Health Status Note .Called [name omitted] ortho (orthopedics) regarding TLSO brace noted in d/c (discharge) summary. Unclear if resident needs it from summaries, no brace here at our facility . A progress note dated 1/15/25 read in part, .PT Daily Note .Patient has no order for TLSO . On 2/05/25 at 3:20 PM, surveyor interviewed rehab manager-other staff #7 (OS#7) and she stated Resident #67 did not have a TLSO brace when she admitted to the facility. She stated ortho stated resident did not require a TLSO brace and agreed that Resident #67 never had a TLSO brace. OS#7 stated she would look for documentation from ortho stating the TLSO brace was not needed. At 3:40 PM, OS#7 provided surveyor with an ortho consultation report dated 1/2/25. An Orthopaedic consult report, dated 1/2/25, read in part, .Reportedly there was a TLSO brace that was ordered. I have not seen this .she (Resident #67) probably does not need the brace . On 2/6/25 at 9:11 AM, surveyor interviewed the director of nursing (DON) and administrative staff #3 (AS#3). The DON stated when Resident #67 readmitted to the facility, the nurse's put the order in for a TLSO brace. AS#3 stated nurses were inaccurately documenting in the clinical record that resident was receiving the TLSO brace. On 2/6/25 at 9:24 AM, surveyor interviewed physical therapy assistant-other staff #9 (OS#9) and she informed surveyor that she did not order a TLSO brace for Resident #67. She spoke with the rehab director and the unit manager informed her that the brace was ordered. OS#9 agreed she was never able to apply a TLSO brace to the resident because there was no brace. On 2/6/25 at 9:42 AM, surveyor interviewed unit manager, registered nurse #6 (RN#6) and she stated she never discussed ordering a TLSO brace and she was out of the facility for a while and the issue with the TLSO brace was reported to the assistant director of nursing. RN#6 denied knowing why the nurses were documenting that a TLSO brace was being applied to Resident #67. Surveyor discussed this concern on 2/5/25 at 3:23 PM at the end-of-day meeting with the administrator, director of nursing, clinical services specialist, and regional social worker and again at the pre-exit meeting on 2/6/25 at 1:15 PM, with the above-mentioned staff and the assistant director of nursing. Surveyor requested and received a facility policy titled, Documentation in the Medical Record, with an implementation date of 6/1/21, that read in part, .Each resident's medical record should contain an accurate representation of the actual experiences of the resident .3. Principles of documentation include, but are not limited to: a. Documentation shall be factual .i. False information shall not be documented .b. Documentation shall be accurate, relevant, and complete . No further information regarding this concern was presented to the survey team prior to the exit conference on 2/6/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42353 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to maintain an infection prevention and control program to provide a safe and sanitary environment and help prevent the development and transmission of infections for 1 of 23 current residents (Resident #35) and 1 of 2 nursing care units (Dogwood). The findings included: 1. For Resident #35, the facility staff failed to perform hand hygiene during treatment administrations and placed soiled items from the treatments in the resident's floor. Resident #35's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Chronic Obstructive Pulmonary Disease, and Stage 4 Sacral Pressure Ulcer. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 11/06/24 coded Resident #35 as being severely impaired in cognitive skills for daily decision making with long-term and short-term memory problems. On 2/04/25 at 1:50 PM, surveyor observed Registered Nurse (RN) #1 and RN #2 provide wound treatment to Resident #35's enteral tube site and Stage 4 sacral ulcer. Surveyor observed RN #2 clean Resident #35's enteral tube site and then apply Zinc Oxide, the nurse failed to change gloves and perform hand hygiene between cleaning the site and applying Zinc Oxide. RN #2 then removed a pen from her pocket and dated the dressing after application to the site. RN #1 then removed the sacral dressing and cleaned the resident's sacral area and buttocks with a wet washcloth and then proceeded to discard the washcloth into the floor. RN #2 cleaned the area with gauze-soaked wound cleanser, patted dry with gauze, applied Dakins Solution with gauze and placed all soiled gauze in the floor. RN #2 then removed the foil seal from a new tube of Medi-Honey ointment and applied the Medi-Honey to the area with a cotton swab. RN #2 then discarded the cotton swab in the floor. RN #2 then removed a pen from her pocket and dated the dressing and applied to the resident's sacrum. RN #2 continued to wear the same gloves throughout the sacral treatment and did not perform hand hygiene. RN #2 then changed gloves but failed to perform hand hygiene and applied cream to Resident #35's gluteal fold and peri-area with gloved fingers. RN #2 then changed gloves but failed to perform hand hygiene and proceeded to reposition the resident in bed and reapply the resident's oxygen nasal cannula. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495355	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Health and Rehab Center	700 Randolph Street Radford, VA 24141

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #2 then removed gloves, performed hand hygiene, and picked up the wound cleanser, Dakin's Solution, and Medi-Honey from Resident #35's overbed table and placed on the treatment cart in the hall. RN #2 then cleaned each container with disinfectant wipes. RN #2 stated the wound cleanser and Dakin's Solution belonged to Resident #35, but the tube of Medi-Honey was shared among other residents. Immediately following the observation, surveyor notified the Administrator and Director of Nursing of RN #2 removing the foil seal from a community supply of Medi-Honey with soiled gloves. On 2/04/25 at 3:05 PM, the survey team met with the Administrator, DON, Assistant DON, and the Clinical Service Specialist (CSS) and discussed the concerns identified with Resident #35's treatment observations. The CSS returned at 3:40 PM and stated the staff had been instructed to dispose of the tube of Medi-Honey as the facility does not use shared Medi-Honey. Surveyor requested and received the facility policy titled Hand Hygiene with a reviewed/revised date of 1/04/24 which read in part .The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . No further information regarding this concern was presented to the survey team prior to the exit conference on 2/06/25. 2. For the Dogwood Unit, the nurse touched an oral medication tablet with their bare hand prior to resident administration. On 2/05/25 at 8:31 AM during a medication pass and pour observation, surveyor observed Licensed Practical Nurse (LPN) #1 remove a Gabapentin oral tablet from a blister pack into their bare palm and then place into a medication cup. LPN #1 then administered the medication to a resident. Surveyor requested and received the facility policy titled Paxit Med-Pass Procedure with an effective date of 6/21/27 which read in part .8) Proceed through the resident's MAR [medication administration record], checking each order with the blister and popping the blister into a medication cup . On 2/05/25 at 4:20 PM, the survey team met with the Administrator, Director of Nursing, and the Clinical Service Specialist and discussed the concern of LPN #1 touching a resident's medication with their bare hand. No further information regarding this concern was presented to the survey team prior to the exit conference on 2/06/25.