STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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, staff interview, facility document review, and clinical record review, the facility staff failed to treat residents with dignity for five of 68 residents in the survey sample, Residents #119, #39, #47, #48 and #148. The findings include: 1. For Resident #119, the facility staff failed to provide the resident with dignity by leaving him in a soiled incontinence brief for the entire day shift on 2/4/24; and failed to ensure his wheelchair was clean. 1. a. For Resident #119, the facility staff failed to provide the resident with dignity by leaving him in a soiled incontinence brief for the entire day shift on 2/4/24. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/27/23, R119 was coded as being cognitively intact for making daily decisions, and as being always incontinent of bowel and bladder. On 2/4/24 at 2:35 p.m., R119 was interviewed and stated the facility staff does not take care of the patients. He stated: There is not enough staff, people go 16 or 17 hours without being changed. He stated he had not had his incontinence brief changed since 10:30 p.m. the night before (2/3/24). R119 agreed to allow the surveyor to observe his brief change. R119 traveled back to his room. CNA (certified nursing assistant) #14 was nearby, and stated she was assigned to R119 during that day shift. She stated: It is a little hectic when I am the only aide for 22 residents. No. I have not changed [R119] all day. I am still making my rounds. At 3:00 p.m., CNA #14 assisted R119 to position himself on the bed for incontinence care. CNA #14 removed the incontinence brief. The brief was full of both stool (smeared and dried) and urine. After the resident's brief was changed, he began to cry. He stated: I feel like I am trapped here. There is not enough people to take care of me. I go all day in dirty underpants. I stink. I am not crying because I am weak. I am crying because I am sad and so mad. A review of R119's care plan dated 1/23/23 and updated 8/15/23 revealed, in part: [R119] has an ADL self-care performance deficit .Toilet use .the resident requires supervision to extensive assistance by one staff .[R119] has bowel and bladder incontinence. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/24 at 3:15 p.m., CNA #14 was interviewed. She stated she ordinarily does a walk through first thing when she arrives on the floor. She states she looks in each room to make sure all residents are safe. She stated she next tries to provide morning care to residents who like to get up and move around. She stated morning care includes washing the resident up, assisting them to get dressed, and to assist them to a bedside chair or wheelchair, all depending on the resident's preference. She stated after she serves and assists with feeding residents breakfast, she finishes morning care before lunchtime normally. After lunch, she provides incontinence care a second time for residents who need assistance. She stated on this day (2/4/24), she was assigned to 22 residents. She stated she had tried to get to all her residents at least once a shift, but had not yet gotten to R119. She stated she understood the risks of not providing incontinence care included skin breakdown or the development of urinary tract infections. She stated she was sorry she had not yet gotten to change R119. When asked how she would feel if she were dependent on staff to be changed, and had gone all day without a change, she stated: Well, it wouldn't feel very good. On 2/6/24 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the Market Lead, and ASM #5, the vice president of risk management, were informed of these concerns. A review of the policy, Resident Rights, revealed, in part: It is the policy of the company to .ensure that residents' rights are known to staff .Ongoing training on resident rights will be given to staff members as required by state and/or federal regulations. No further information was provided prior to exit. 1. b. The facility staff failed to provide the resident with dignity by leaving his wheelchair dirty. On the following dates and times, R119 was observed sitting in his wheelchair. At all of these observations, the lower front panel was covered with debris and food particles: 2/4/24 at 2:35 p.m., 2/5/23 at 8:30 a.m., and 2/9/23 at 9:52 a.m. On 2/4/24 at 3:18 p.m., R119 was interviewed. He stated he was aware that his wheelchair was dirty. He stated he knew he dropped food and other particles on the wheelchair, but he had no way of cleaning the wheelchair himself. When asked if the facility staff had ever offered to clean the wheelchair, he stated they had not. He stated he would not have an item this dirty in his own home because it did not have a home like appearance. He stated the dirty wheelchair did not provide him with dignity. On 2/8/24 at 8:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated if a resident's wheelchair is visibly dirty, it should be cleaned. She stated all the debris and food particles should be washed away. She stated a dirty wheelchair does not contribute to a dignified environment for the resident. On 2/8/24 at 10:52 a.m., CNA (certified nursing assistant) #7 was interviewed. She stated if she noticed a resident's wheelchair was dirty, she would assist the resident back to bed, then clean the wheelchair. She stated a dirty wheelchair does not promote a resident's dignity. (continued on next page)

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Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 2/8/24 at 4:22 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns.

No further information was provided prior to exit.

2. For Resident #39 (R39), the facility staff failed to maintain her dignity by offering her the opportunity to use the toilet for urination.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/12/24, R39 was coded as being cognitively intact for making daily decisions. She was coded as being always incontinent of urine. On the preceding MDS, an admission assessment with an ARD of 10/12/23, R39 was also coded as being incontinent of urine. On both assessments, she was coded as being completely dependent on staff for transferring from surface to surface, and as not having attempted to move from the bed to the toilet.

A review of the clinical record, including all ADL (activities of daily living) records for January and February 2024, revealed R39 was incontinent of urine and not toileted on any occasion. This review failed to reveal evidence that a bladder retraining evaluation had been performed for R39.

A review of R39's care plan dated 1/23/24 revealed, in part: [R39] has bowel and bladder incontinence .[R39] has an ADL self-care deficit .The resident is totally dependent on 1 staff for toileting/incontinence care .The resident requires Mechanical Lift with 2 staff assistance for transfers.

On 2/8/24 at 10:52 a.m., CNA (certified nurse aide) #7 was interviewed. She stated she takes care of R39 on most days. She stated: [R39] is incontinent. She is [mechanical] lift right now. I can't transfer her safely to the toilet. She doesn't like the bedpan. She could use the toilet if I could get her there, but she needs the lift, so that's why we don't put her on the toilet. She added the lift sling available on the unit was not structured to allow for a resident to use the toilet while in the sling.

On 2/8/24 at 2:10 p.m., R39 was interviewed. When asked about her urinary continence status, she stated she is usually aware when she needs to urinate, but the staff has not offered to help her get to the toilet. She stated she hates to sit in wet briefs while waiting to be changed. She stated it makes her feel embarrassed and upset.

On 2/8/24 at 2:15 p.m., LPN (licensed practical nurse) #11 was interviewed. She stated if a resident is able to be toileted, then the staff should make sure the resident has that opportunity. She stated she did not know about the availability of a mechanical lift sling to accommodate a resident's toileting while utilizing the lift. She stated the opportunity to urinate in a toilet would add to a resident's sense of dignity.

On 2/8/24 at 4:22 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns.

No further information was provided prior to exit.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024

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Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

3. For Resident #47 (R47) the facility failed to provide dignity to the resident when the staff member stood over the resident to feed her.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/10/23, R47 was coded as being severely cognitively impaired for making daily decisions. She was coded as being completely dependent on staff for eating. On 8/24/21, R47 was diagnosed with dysphagia (difficulty swallowing).

On 2/5/24 at 8:41 a.m., R47 was lying on her right side, with the head of the bed elevated approximately 30 degrees. The bed was pushed up against the bedroom wall. CNA (certified nursing assistant) #9 stood next to the resident's bed and was feeding the resident breakfast. The CNA reached from the resident's left side, over and around to the right side, to put the spoon at the resident's mouth. CNA #9 repeated this action until the resident would not take any more food by mouth.

On 2/7/24 at 12:58 p.m., CNA (certified nursing assistant) #8 was interviewed. When asked how an aide should position themselves when they are feeding a dependent resident, she stated: We should sit down to feed a resident. When asked why this is important, she stated the aide needs to be at eye level with the resident and the resident will not feel rushed to finish. When asked if a resident's dignity is promoted when an aide stands to feed the resident, she stated: No, it's not.

On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns.

29843

4. For Resident #48 (R48), the facility staff failed serve a meal using the facility's standard everyday place settings.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/14/2023, R48 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R48 was cognitively intact for making daily decisions.

On 02/04/24 at approximately 5:14 p.m., an interview was conducted with R48 regarding the facility's meals. R48 stated he did not get breakfast until after 9:00 a.m. this morning, and it was served on Styrofoam. R48 further stated it was not dignified.

On 02/05/24 at approximately 3:13 p.m., an interview was conducted with OSM (other staff member) #1, dining services manager, regarding the use of Styrofoam place settings for breakfast on 02/04/2024. OSM #1 stated Styrofoam place setting are only used when a resident is sick or if there is an outbreak in the facility. When asked if and why Styrofoam place settings were used during breakfast on 2/4/24, OSM #1 stated Styrofoam place settings were used because there was not enough staff, breakfast was late, and the kitchen wanted to get lunch out on time so Styrofoam place settings were used as a short cut. OSM #1 further stated that she was not in the facility on 02/04/2024. When asked if was dignified to serve a resident's meal on Styrofoam when it was not indicated she stated no.

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NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/06/2024 at approximately 4:30 p.m., ASM (administrative staff member) #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM 4, lead for marketing and ASM #5, vice president of risk management, were informed of the above findings. No further information was provided prior to exit. 42183 5. For Resident #148, the facility failed to provide dignity related to incontinence care. Resident #148 was admitted to the facility on [DATE] with diagnosis that included but were not limited to acute respiratory failure with hypoxia, severe morbid obesity and venous thrombosis. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 11/15/23, 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 bed mobility/transferring/toileting and set up for eating. On 2/4/24 at approximately 2:00 PM, an interview was conducted with Resident #148. When asked about incontinence care, Resident #148 stated, Well, for instance last evening [2/3/24], I rang the call bell at 9:30 PM and the nurse came in at 10:00 PM. I told her I needed to be cleaned up and she said she would get help and be back. At 11:30 PM, I called again and she came back in and said they never came back, I said no and she was going to get someone. I did not get cleaned up till day shift. Resident #148 stated, It was uncomfortable being wet that whole time. I did not feel good about it. Resident #148 stated, they are very short staffed here, they do not have enough aids to clean us up. When asked if she felt she was treated with dignity, Resident #148 stated, No, how can you let someone lay in wet cold urine for that long? A review of the ADL (activities of daily living) documents for February 2024 reveals the missing documentation for bladder incontinence care for February 2024 in part: evening shift: 2/3 and night shift 2/3 and 2/4. On 2/5/24 at approximately 6:05 AM, an interview was conducted with CNA #4 on Wing 2. When asked if she had been able to provide incontinence care to Resident #148 on 2/3/24 night shift, CNA #4 stated, Not sure that I was able to. She usually lets us know. When asked where bladder incontinence care is documented, CNA #4 stated on the ADL form. When asked how incontinence care can be evidenced if there is no documentation, CNA #4 stated, it cannot be and it probably was not done. When asked if Resident #148 was treated with dignity, CNA #4 stated, no, she was not. On 2/5/24 at 6:10 AM, an interview was conducted with LPN (licensed practical nurse) #1, when asked if a resident is treated with dignity when they lay in urine overnight, LPN #1 stated, no, they are definitely not treated with dignity. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Resident Rights policy reveals, It is the policy of The Company to make residents and their legal representatives aware of residents' rights, ensure that residents' rights are known to staff. Residents and/or their representative will be made aware of their rights upon admission to the nursing home. Residents' rights will be explained in a language understandable to the resident or representative and printed in a clear, easy to read format. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to inform a resident/resident representative of the risks and benefits of medication treatment in a timely manner for one of 68 residents in the survey sample, Resident #63. The findings include: For Resident #63 (R63), the facility staff failed to inform the resident/resident representative of the risks and benefits for the use of the anti-psychotic medication Seroquel (1), when the medication was ordered on 9/22/23. R63 was admitted to the facility on [DATE] with a diagnosis of schizophrenia. A review of R63's clinical record revealed a physician's order dated 9/22/23 for Seroquel 25 milligrams every 12 hours. Further review of R63's clinical record failed to reveal the facility staff informed the resident or the resident's representative of the risks and benefits for the use of Seroquel until 12/20/23. An informed consent for use of psychotropic medication form signed by R63's representative on 12/20/23 documented the clinical indication for the medication use, benefits, and possible side effects. On 2/7/24 at 12:30 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated consent for antipsychotic medication use should be obtained before the medication is administered. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, Medication Management- Psychotropic Medications documented, 2. Resident(s) receiving psychotropic medication to have the risk/benefits reviewed and consent competed prior to initiation of the medication. Reference: (1) Seroquel is used to treat schizophrenia, bipolar disorder and depression. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 42183 Based on observation, resident/staff interview, facility document review, and clinical record review, it was determined the facility staff failed to accommodate needs for one of 68 residents, Resident #62. The findings include: For Resident #62, the facility staff failed to maintain the call light in a position where they could access it. A review of the comprehensive care plan dated 11/26/19 revealed, FOCUS: Resident has had an actual fall. INTERVENTIONS: Educate resident to use call bell for assistance when getting out of bed. On 2/4/24 at 2:50 PM, Resident #62 was observed sitting on the side of her bed with the call bell under the bed near the headboard, with the cord caught under the bedside cabinet. On 2/5/24 at 7:30 AM, the call bell was under the bed near the headboard with the cord caught under the bedside cabinet. On 2/5/24 at 8:00 AM, an interview was conducted with Resident #62. When asked where her call bell was, Resident #62 stated she did not know where it was. On 2/5/24 at 8:05 AM, an interview was conducted with CNA (certified nursing assistant) #1. When asked to locate Resident #62's call bell, CNA #1 stated, Here it is, it was caught under the bedside cabinet. Sometimes the resident just flings it around. CNA #1 clipped the call bell to the bedspread. On 2/8/24 at 4:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. There was no policy regarding call bells provided by the facility. 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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide required notification of a room change for one of 68 residents in the survey sample, Resident #22. The findings include: For Resident #22 (R22), the facility staff failed to notify the resident and/or responsible party (RP) of a room change. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/6/23, R22 was coded as being severely cognitively intact for making daily decisions. A review of R22's clinical record revealed the following nurse's note dated 1/25/24: Resident adjusting well to room change, no problems or complaints voiced. The nurse who wrote this note was not available for interview during the survey. Further review of the clinical record revealed no evidence that the resident or RP received written notice of the reasons for the room change, and that the room change was happening. On 2/6/24 at 3:25 p.m., OSM (other staff member) #10, the director of social services was interviewed. When asked who is responsible for notifying the resident or their RP in writing of a room change, she stated: The nurses have been doing it. On 2/7/24 at 1:40 p.m., LPN (licensed practical nurse) #10 was interviewed. When asked about resident/RP notice about room changes, she stated ASM (administrative staff member) #2, the director of nursing (DON), usually comes to the floor nurses and informs them of a change. She stated the DON does not normally give the reason for the change. She stated: As far as I know, there is not written notification of the resident or family. On 2/7/24 at 3:46 p.m., LPN #4, a unit manager, was interviewed. She stated she tries to call the resident's family if a room change is going to be made. She stated: I try to call my people who have an RP. She added sometimes she provides a written notice, and sometimes she does not. On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Room Changes, revealed, in part: Team members should consider the pros and cons of the room change with input from the resident and/or interested party whenever feasible .2. Prior to the room change, the team should give the resident/legal representative notice to allow the resident/legal representative time to prepare for the room change. 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 49369 Based on staff interview, facility document review, and clinical record review, the facility staff failed to notify the physician about a change in condition for four of 68 sampled residents, Resident #32, #46, #114 and #22. The findings include: 1. For Resident #32 (R32), the facility staff failed to notify the physician that the resident did not receive medications on 10/8/24. A review of R32's provider's orders from October 2023 revealed the following: 8/9/2023 Carvedilol Oral Tablet (1) 12.5 MG (milligram) (Carvedilol) Give 1 tablet by mouth ever 12 hours for HTN (hypertension). A review of R32's October 2023 MAR (medication administration record), revealed that they did not receive Carvedilol as ordered on 10/8/24. A review of R32's progress notes for October 2023 failed to reveal any evidence that staff notified a provider (either a nurse practitioner or physician) that the resident did not receive their medication on 10/8/24. On 2/7/24 at 11:40 p.m., LPN (licensed practical nurse) #8 was interviewed. She stated that medications should be given on time as ordered. She stated that it is important because they could really need that medication at a certain time or before or after a meal. If the medication is not given the doctor and family should be notified and it should be documented on a nurses note in the clinical record. She also stated that it is important for a resident to receive their Coreg medication because it can affect their blood pressure and they would have to notify the doctor. On 2/7/24 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Notification of Change in Condition, revealed, in part: The Center [is] to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. No further information was provided prior to exit. Reference: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) Carvedilol is used alone or in combination with other medications to treat heart failure (condition in which the heart cannot pump enough blood to all the parts of the body) and high blood pressure. It is also used to improve survival after a heart attack. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697042.html. 2. For Resident #46 (R46), the facility staff failed to notify the physician that the resident did not receive medications on 10/8/24. A review of R46's provider's orders revealed the following: 8/24/2023 Ferrous Sulfate Oral Tablet (1) 325 (65 Fe) MG (Ferrous Sulfate) Give 1 tablet by mouth two times a day for anemia. 8/18/2023 Gabapentin Oral Capsule (3) (Gabapentin) Give 300 mg by mouth every 8 hours for pain mgt (management). 8/18/2023 Hydralazine HCL Oral Tablet (2) 50 MG (Hydralazine HCL) Give 1 tablet by mouth every 8 hours for htn (hypertension). 8/23/2023 Saline Nasal Spray Solution 0.65% (Saline) (4) 2 spray in both nostrils every 8 hours for nasal dryness. A review of R46's October 2023 MAR, revealed that she did not receive the above medications on 10/8/23 on the evening shift. A review of R46's progress notes for October 2023 failed to reveal any evidence that any staff notified a provider (either a nurse practitioner or physician) that the resident did not receive their medication on 10/8/24. On 2/7/24 at 11:40 p.m., LPN (licensed practical nurse) #8 was interviewed. She stated that medications should be given on time as ordered. She stated that it is important because they could really need that medication at a certain time or before or after a meal. If the medication is not given the doctor and family should be notified and it should be documented on a nurses note in the clinical record. On 2/7/24 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit. References: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) Iron (ferrous fumarate, ferrous gluconate, ferrous sulfate) is used to treat or prevent anemia (a lower than normal number of red blood cells) when the amount of iron taken in from the diet is not enough. Iron is a mineral that is available as a dietary supplement. It works by helping the body to produce red blood cells. This information is taken from the website https://medlineplus.gov/druginfo/meds/a682778.html#:~:text=Iron%20(ferrous%20fumarate%2C%20ferrous%20gluconate,available%20as%20a%20dietary%20supplement. (2) Hydralazine is used to treat high blood pressure It works by relaxing the blood vessels so that blood can flow more easily through the body. This information is taken from the website https://medlineplus.gov/druginfo/meds/a682246.html. (3) Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles. This information is taken from the website https://medlineplus.gov/druginfo/meds/a694007.html. (4) Saline Nasal wash helps flush pollen, dust, and other debris from your nasal passages. It also helps remove excess mucus (snot) and adds moisture. This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000801.htm#:~:text=A%20saline%20nasal%20wash%20helps,passages%20before%20entering%20your%20lungs. 3. For Resident #114 (R114), the facility staff failed to notify the physician that the resident did not receive medications on 10/8/24. A review of R114's provider's orders from October 2023 revealed the following: 8/7/2023 Melatonin Tablet (1) 3 MG (milligram) Give 1 tablet by mouth at bedtime for Insomnia. 8/26/2023 Mirtazapine Oral Tablet (2) 15 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for depression. 8/7/2023 Sertraline HCL Oral Tablet (3) 50 MG (Sertraline HCL) Give 1 tablet by mouth at bedtime for Depression. 8/7/2023 Trazadone HCL Oral Tablet (4) 150 MG (Trazadone HCL) Give 1 tablet by mouth at bedtime for Depression. A review of R114's October 2023 MARs, revealed she did not receive the following medications on 10/8/23: Melatonin, Mirtazapine, Sertraline and Trazadone. A review of R114's progress notes for October failed to reveal any evidence that any staff notified a provider (either a nurse practitioner or physician) that the resident did not receive their medication on 10/8/24. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/7/24 at 11:40 p.m., LPN (licensed practical nurse) #8 was interviewed. She stated that medications should be given on time as ordered. She stated that it is important because they could really need that medication at a certain time or before or after a meal. If the medication is not given the doctor and family should be notified and it should be documented on a nurses note in the clinical record. On 2/7/24 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit. References: (1) Melatonin is a hormone made in the body. It regulates night and day cycles or sleep-wake cycles .People most commonly use melatonin for insomnia and improving sleep in different conditions, such as jet lag. It is also used for depression, chronic pain, dementia, and many other conditions. This information is taken from the website https://medlineplus.gov/druginfo/natural/940.html. (2) Mirtazapine is used to treat depression. Mirtazapine is in a class of medications called antidepressants. It works by increasing certain types of activity in the brain to maintain mental balance. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697009.html. (3) Sertraline is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). This information is taken from the website https://medlineplus.gov/druginfo/meds/a697048.html. (4) Trazadone is used to treat depression. Trazadone is in a class of medications called serotonin modulators. It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance. This information is taken from the website https://medlineplus. gov/druginfo/meds/a681038.html. 32642 4. For Resident #22, the facility staff failed to notify the provider of a resident's significant weight loss. A review of R22's clinical record revealed the following weights (in pounds): 11/29/23=180.3 12/5/23=170.4 12/12/23=169.8 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/3/24=170.6 Between 11/29/2023 and 1/03/2024, the resident experienced a 5.38 % weight loss. While a review of R22's progress notes revealed that the dietician was aware of and addressed the weight loss, the review of the provider's notes failed to reveal evidence the physician was notified of the weight loss. On 2/7/23 at 1:40 p.m., LPN (licensed practical nurse) #10 was interviewed. She stated the physician should be notified whenever a resident experiences a significant weight loss. She stated the electronic medical record provides alerts to nursing staff about significant weight changes. On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 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 personal privacy for one of 68 residents in the survey sample, Resident #45. The findings include: For Resident #45 (R45), the facility failed to accommodate personal privacy in their room from wandering residents. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/14/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. On 2/4/2024 at 3:14 p.m., an interview was conducted with R45 in their room. R45 stated that they got along well with their roommate but had concerns with a female resident who wandered around the hallways. She stated that the resident was in the room next door and they shared a bathroom. Observation of R45's room revealed a shared bathroom separating two semi-private rooms. Observation of the bathroom revealed two doors, one opening into each semi-private resident room with a hand-written sign on one door (the other resident room) stating [Name of other resident] room. R45 stated that every time the other resident went to the bathroom they came out into their room and started going through their belongings and they had found the resident in their bed a couple of times. R45 stated that the staff would take them out sometimes but sometimes she would just yell at her to get out of her room. R45 stated that the staff told her that there was nothing they could do because the resident had dementia and didn't know what they were doing. R45 stated that she did not feel that it was fair that there was nothing that they could do about it and that the other resident could wander in and mess with her things. During the interview with the resident an observation was made of the resident in the adjoining room entering R45's room after using the restroom. R45 immediately began yelling at the other resident to get out of their room and the resident went back into the bathroom. R45 stated See, that is what I am talking about. On 2/6/2024 at 1:10 p.m., an interview was conducted with CNA (certified nursing assistant) #10. CNA #10 stated that they attempted to re-direct wandering residents to their rooms if they went into other resident rooms. She stated that she would report any concerns from residents regarding other residents wandering in their rooms and tell the resident that they could close their door to keep them out. She stated that she was not sure what could be done when they shared a bathroom. On 2/6/2024 at 1:33 p.m., an interview was conducted with OSM (other staff member) #8, assistant social worker. OSM #8 stated that at times they moved wandering residents to different rooms. She stated that it was difficult because they could not tell them to stay out of the room because they did not understand so they would re-direct them out of the room. She stated that they would attempt to re-direct the resident to an activity. She stated that it was hard when there were cognitively intact and impaired residents sharing rooms and bathrooms. She stated that she would say that it affects the resident right to privacy having someone coming into their room that is not welcomed and invading their space. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the staff monitored wandering residents as much as possible. She stated that they had put signs up on the bathroom door hoping that it would prompt the other resident not to enter R45's room. She stated that the other resident still entered R45's room with the sign up and she had just removed her from the room not long ago. She stated that they tried to prevent the residents from wandering as much as possible and it was better when there were more staff on the floor to have more eyes on them. She stated that it did affect the other residents privacy to have wandering residents coming in their rooms but they did their best to re-direct the residents that wandered or kept them close to the nurses station. A review of the facility policy, Privacy effective 11/30/2014, documented in part, .It is the policy of The Company to give all residents the opportunity for privacy . The nursing home staff will recognize that residents and their families need a place of privacy . On 2/6/2024 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator market lead, and ASM #5, the vice president of risk management were made aware of the concern. No further information was provided prior to exit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 29125 Based on observation, resident interview, staff interview, and clinical record review, it was determined that the facility staff failed to provide a clean, comfortable, homelike environment for two of 68 residents (Residents #21 and #119) in the survey sample; and for one of three facility shower rooms (Unit 1). The findings include: 1. For Resident #21, the facility staff failed to maintain a clean and comfortable homelike environment. There were seven tiles missing from the bathroom wall. On 2/04/24 at 3:45 PM, an observation was made of Resident #21's room. The bathroom was noted to have seven tiles missing on the lower wall, near the floor, between the sink and toilet. On 2/7/24 at 12:53, an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that Resident #21 was her resident but that she does not always go into the bathrooms. She stated that if she noticed something she would report it to maintenance. She stated that housekeeping should also be noticing things when they are in the rooms. She stated she was not aware if anyone else knew about the missing tiles because no one had reported it to her. On 2/7/24 at 1:31 PM, an interview was conducted with LPN #4, the unit manager. She stated that she had put notification of the repair into the (electronic maintenance reporting system) sometime in December I think. She stated that maintenance reported that they no longer had those type of tiles available and was going to be removing tiles and replace with sheet rock. When it was noted that it was now February, and she reported it in December, was that an extensive amount of time for the repair, she stated Yes, it is. On 2/7/24 at 2:54 PM, an interview was conducted with OSM #2 (Other Staff Member) the Director of Maintenance. He stated that he has had a problem getting the tile, that he cannot find it anymore. He stated that when they can, they move the residents and redo the bathrooms. He stated that they have done about 12 bathrooms like that. When asked about Resident #21's bathroom, he stated that he was not aware of it. When asked, if the nurse reported it in December, and it was now February, was that an extensive period of time for the repair to not be completed, he stated, If we are aware of it, it would be extensive time but that is the thing. He stated that he reviewed the (electronic maintenance reporting system) from October 2023 to the date of survey (2/7/24) and there was nothing reported about the missing tile. On 2/7/24 at 3:15 PM, an interview was conducted with OSM #13, the Director of Housekeeping. She stated that when housekeeping identifies concerns, that they will let her know and and she reports it to maintenance, or they will notify her that they already reported it to maintenance. When asked if she was aware of the missing tiles in Resident #21's bathroom, she stated that she was. When asked when was she made aware, she stated that she could not recall the date. She stated that she reported it to maintenance in the morning meetings. She stated that she did not have any evidence it was reported to maintenance at any morning meeting. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A request was made for a policy regarding a clean, comfortable and homelike environment. None was provided that addressed this concern. On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided. 32642 2. For Resident #119 (R119), the facility staff failed to maintain his wheelchair in a clean, home like manner. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/27/23, R119 was coded as being cognitively intact for making daily decisions. On the following dates and times, R119, was observed sitting in the seat of his wheelchair. At all of these observations, the lower front panel (where legs would normally rest) was covered with debris and food particles: 2/4/24 at 2:35 p.m., 2/5/23 at 8:30 a.m., and 2/9/23 at 9:52 a.m. On 2/4/24 at 3:18 p.m., R119 was interviewed. He stated he was aware that his wheelchair was dirty. He stated he knew he dropped food and other particles on the wheelchair, but he had no way of cleaning the wheelchair himself. When asked if the facility staff had ever offered to clean the wheelchair, he stated they had not. He stated he would not have an item this dirty in his own home. On 2/8/24 at 8:43 a.m., LPN (licensed practical nurse) #11 was interviewed. She stated if a resident's wheelchair is visibly dirty, it should be cleaned. She stated all the debris and food particles should be washed away. She stated a dirty wheelchair does not contribute to a home like environment for the resident. On 2/8/24 at 10:52 a.m., CNA (certified nursing assistant) #7 was interviewed. She stated if she noticed a resident's wheelchair was dirty, she would assist the resident back to bed, then clean the wheelchair. She stated a dirty wheelchair is not home like for the resident. On 2/8/24 at 4:22 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit. 31753 3. The facility staff failed to maintain the unit one shower room in a clean and homelike manner. On 2/7/24 at 3:00 p.m., observation of the unit one shower room was conducted. A wet towel and two gloves rolled into each other was observed on the shower stretcher. A rolled-up glove was observed on the sink, and two wet washcloths, a plastic bag containing a brief, an opened, folded wound dressing, and a rolled-up brief were observed on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/24 at 3:03 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated the shower room should be cleaned after each resident use, and trash and dirty linens should be placed in bins in the unit alcove. The shower room was observed with LPN #8. LPN #8 stated the above observed items were used. LPN #8 stated someone had received a shower and the CNA (certified nursing assistant) had not cleaned the shower room. LPN #8 stated she knew a CNA had used the shower room before lunch and maybe she got busy doing something else. LPN #8 stated the items should not have been on the stretcher, sink and floor, and the CNA could have bagged the items before she left the shower room. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, resident interview, facility document review, and clinical record review, it was determined the facility staff failed to protect three of 68 residents from abuse and/or neglect, Residents #129, #148 and #119. The findings include: 1. The facility failed to protect Resident #129 from physical abuse from another resident, Resident #111. A review of a facility synopsis of event with incident date of 1/13/24 revealed, (Resident #111) slapped (Resident #129) on the left side of her face due to (Resident #129) trying to open the back door. Residents separated. Resident to Resident incident substantiated. Resident #129 was admitted to the facility on [DATE] with diagnoses that included but were not limited to unspecific dementia, cognitive communication deficit and anxiety disorder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 12/30/23, coded the resident as scoring a 99 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 independent for eating, extensive assistance for bed mobility/transfers and dependent for toileting. A review of the comprehensive care plan dated 4/21/23 revealed, FOCUS: Resident has behaviors of moving wheelchair up and down the hall almost running over residents with no awareness. INTERVENTIONS: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Revised interventions as of 1/19/24: Ombudsman, APS, Physician and RP notified. Skin/pain assessment conducted. Psychosocial review conducted. A review of the progress note dated 1/13/24 at 11:00 PM revealed, Writer heard alarm at the back door when going down the hall resident was coming up the hallway holding the left side of her face. When asked what happened she was unable to tell writer so writer asked the resident who was standing at the door what had happened, he stated he slapped her for trying to open the door. RP was called and made aware of the issues. A review of the progress note dated 1/14/24 at 7:11 AM revealed, Resident ambulating on unit, attempting to take another patient's walker. Resident placed on 1:1 during shift. A review of the progress note dated 1/14/24 at 9:02 PM revealed, Resident alert and verbal, continues to pace the hallway and pushing on the doors. Resident not easily redirected. Continues to push and pull-on others and grab walkers/chairs. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Resident #111 was admitted to the facility on [DATE] with diagnoses that included but were not limited to vascular dementia, PTSD (post traumatic stress disorder), DM (diabetes mellitus) and COPD (chronic obstructive pulmonary disease).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/26/23, coded the resident as scoring a 12 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 GG-functional abilities and goals coded the resident as being independent for mobility/transfers and eating. Section P: Restraints/Alarms Wander/elopement: daily use.

A review of the comprehensive care plan dated 7/3/22 revealed, FOCUS: Resident has behaviors related to wandering and exit seeking. INTERVENTIONS: Assess elopement risk. Wander guard as ordered. Check placement and function as ordered and as needed.

An interview was conducted on 2/5/24 at 9:48 AM with Resident #111. When asked if he remembered the issue with Resident #129, Resident #111 stated I remember hitting someone because they were trying to get out.

No abusive behaviors were observed during the survey period of 2/4/24 to 2/9/24 by Resident #111.

An interview was conducted on 2/7/24 at 12:50 PM with LPN (licensed practical nurse) #8. When asked what happens after a resident-to-resident altercation, LPN #8 stated they immediately separate the residents. Assess the residents for any injuries and put the aggressor on every 15-minute checks. Inform the physician, RP, director of nursing and unit manager.

An interview was conducted on 2/7/24 at approximately 1:50 PM with OSM (other staff member) #10, the director of social services. When asked happens after a resident-to-resident altercation, OSM #10 stated, social services would do a psychosocial review and the care plan would be updated. When asked why these interventions would be implemented, OSM #10 stated, to prevent further abuse and assess that the residents are receiving appropriate care.

On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns.

A review of the facility's Abuse/Neglect/Exploitation and Misappropriation policy reveals, It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. Protection: The resident will be evaluation for any signs of injury, including a physical exam and/or psychosocial assessment, as appropriate. Increased supervision of the alleged victim and residents. Room or staffing changes, if necessary, to protect the resident (s) from the alleged perpetrator. Protection from retaliation. Provide the resident with emotional support and counseling during and after the investigation, if needed.

No further information was provided prior to exit.

2. For Resident #148, the facility failed to protect the resident from neglect on 2/3/24.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 11/15/23, 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 bed mobility/transferring/toileting and set up for eating. A review of the comprehensive care plan dated 11/21/23 revealed, FOCUS: Resident has an ADL self-care performance deficit related to shortness of breath (SOB) and morbid obesity. INTERVENTIONS: The resident is totally dependent on 1 staff for toileting/incontinent care. The resident is totally dependent on 1 staff for repositioning and turning in bed. On 2/4/24 at approximately 2:00 PM, an interview was conducted with Resident #148. When asked about incontinence care, Resident #148 stated, Well, for instance last evening [2/3/24], I rang the call bell at 9:30 PM and the nurse came in at 10:00 PM. I told her I needed to be cleaned up and she said she would get help and be back. At 11:30 PM, I called again and she came back in and said they never came back, I said no and she was going to get someone. I did not get cleaned up till day shift. It was uncomfortable being wet that whole time. I did not feel good about it. Resident #148 stated, they are very short staffed here, they do not have enough aids to clean us up. A review of the ADL (activities of daily living) documents for February 2024 revealed the following missing documentation for bladder incontinence care in part: February 2024-evening shift: 2/3; night shift 2/3 and 2/4. On 2/5/24 at approximately 6:05 AM, an interview was conducted with CNA #4. When asked about staffing, CNA #4 stated, It is very short staffed here. I try to do my best but it is impossible to provide care to this many residents. I make rounds, but in addition to trying to provide incontinence care, am managing wanders, call lights and getting water/snacks for the residents. When asked if she had been able to provide incontinence care to Resident #148 on 2/3/24 night shift, CNA #4 stated, Not sure that I was able to. She usually lets us know. When asked where bladder incontinence care is documented, CNA #4 stated on the ADL form. When asked how incontinence care can be evidenced if there is no documentation, CNA #4 stated, It cannot be. It probably was not done. When asked to define neglect, CNA #4 stated, not taking care of resident's needs. When asked if it is neglect if the residents are not receiving incontinence care in a timely manner, CNA #4 stated, yes, it is neglect. On 2/5/24 at 6:10 AM, an interview was conducted with LPN (licensed practical nurse) #1, when asked if there was sufficient staff to meet resident needs, LPN #1 stated, No, there is not. I have come on duty and I am the only one scheduled, with no aide. It is impossible to give care to all these residents and meet their needs. There are anywhere from zero to three aides scheduled on this unit on nights. When asked if it is neglect if the residents needs are not met, LPN #1 stated, Yes, it is neglect and it is why I have given my two weeks' notice. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Abuse/Neglect/Exploitation and Misappropriation policy reveals, It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. Neglect is the failure of the center, its employees or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include but are not limited to; failure to provide adequate nutrition and fluids, failure to take precautionary measures to protect the health and safety of the resident. Intentional lack of attention to physical needs including, but not limited to, toileting and bathing. No further information was provided prior to exit. 32642 3. For Resident #119 (R119), the facility staff failed to prevent the resident from experiencing neglect on 2/4/24. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/27/23, R119 was coded as being cognitively intact for making daily decisions, and as being always incontinent of bowel and bladder. On 2/4/24 at 2:35 p.m., R119 was observed sitting in a wheelchair in his room. He stated he wanted to go to a more private place to be interviewed. R119 stated the facility staff does not take care of the patients. He stated: There is not enough staff, people go 16 or 17 hours without being changed. He stated he had not had his incontinence brief changed since 10:30 p.m. the night before (2/3/24). R119 agreed to allow the surveyor to observe his brief change. R119 traveled back to his room. CNA (certified nursing assistant) #14 was nearby, and stated she was assigned to R119 during that day shift. She stated: It is a little hectic when I am the only aide for 22 residents. No. I have not changed [R119] all day. I am still making my rounds. At 3:00 p. m., CNA #14 assisted R119 to position himself on the bed for incontinence care. CNA #14 removed the incontinence brief. The brief was full of both stool (smeared and dried) and urine. After the resident's brief was changed, he began to cry. He stated: I feel like I am trapped here. There is not enough people to take care of me. I go all day in dirty underpants. I stink. I am not crying because I am weak. I am crying because I am sad and so mad. A review of R119's care plan dated 1/23/23 and updated 8/15/23 revealed, in part: [R119] has an ADL self-care performance deficit .Toilet use .the resident requires supervision to extensive assistance by one staff .[R119] has bowel and bladder incontinence. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/24 at 3:15 p.m., CNA #14 was interviewed. She stated she ordinarily does a walk through first thing when she arrives on the floor. She states she looks in each room to make sure all residents are safe. She stated she next tries to provide morning care to residents who like to get up and move around. She stated morning care includes washing the resident up, assisting them to get dressed, and to assist them to a bedside chair or wheelchair, all depending on the resident's preference. She stated after she serves and assists with feeding residents breakfast, she finishes morning care before lunchtime normally. After lunch, she provides incontinence care a second time for residents who need assistance. She stated on this day (2/4/24), she was assigned to 22 residents. She stated she had tried to get to all her residents at least once a shift, but had not yet gotten to R119. She stated she understood the risks of not providing incontinence care included skin breakdown or the development of urinary tract infections. She stated she was sorry she had not yet gotten to change R119. On 2/6/24 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the Market Lead, and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit.

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Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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.

29125

Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement policies and procedures for the investigation and reporting of abuse for two of 68 residents in the survey sample; Residents #115 and #93.

The findings include:

The facility submitted a synopsis of an event on 7/28/23 to the required state agency. After the initial submission of the event, the facility failed to follow policy to investigate the event and submit a five-day follow up report of the event to the required state agency.

The facility policy, Abuse, Neglect, Exploitation & Misappropriation was reviewed. This policy documented, It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property. The management of the facility recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse 4. Identification: All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Nursing/designee. Patterns or trends will be identified that might constitute abuse. This information will be forwarded to the Executive Director, who will serve as the facility's Abuse Coordinator, and an abuse investigation will be conducted in the absence of the Executive Director, the Director of Nursing will serve as Abuse Coordinator. 5. Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents .7. Reporting/Response: Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Nursing is the designated abuse coordinator. Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply their individual requirements and responsibilities for reporting as required by law. In all cases, the Executive Director or Director of Nursing will ensure notification to the resident's legal guardian, family member, or responsible party or significant other of the alleged, suspected or observed abuse, neglect or mistreatment, and the resident's attending physician Review of Report: Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident and if the alleged violation is verified appropriate corrective action must be taken The Abuse Coordinator will refer any or all incidents and reports of resident abuse to the appropriate state agencies.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #115 was coded on the quarterly MDS (Minimum Data Set) dated 7/5/23 which was the MDS conducted closest to the time of the event (7/28/23) as being cognitively impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #93 was coded on the quarterly MDS (Minimum Data Set) dated 7/31/23 which was the MDS conducted closest to the time of the event (7/28/23) as being cognitively intact in ability to make daily life decisions, scoring a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. A review of the nurse's notes for Resident #115 revealed one dated 7/28/23 that documented, Resident got into a physical altercation with (Resident #93). Small bruise left wrist. Provider, RP (responsible party) aware. Redirected no further issues. Continue to check on frequently by staff. Resident interviewed has no recollection of event. Will monitor. A review of the nurse's notes for Resident #93 revealed one dated 7/28/23 that documented, Resident got into a physical altercation with (Resident #115). No injuries. Provider, RP (responsible party) aware. Redirected no further issues. Continue to check on frequently by staff. Resident interviewed has no recollection of event. Will monitor. On 7/28/23, the facility submitted a synopsis of an event dated 7/28/23 that occurred on 7/28/23 between Resident #115 and Resident #93. This synopsis documented, (Resident #115) initiated argument with (Resident #93) and they began to have a physical altercation in the hallway. Both residents on the Memory care unit, both were immediately separated and investigation to begin. As of the survey start on 2/4/24, there was no follow up reported to the required state agency. On 2/4/24 during the entrance conference, the facility investigations for all events was requested. The boxes provided contained folders, each with separate reportable incidents with their associated investigations, in chronological order. A folder for the above 7/28/23 investigation could not be located. On 2/6/24 at 4:30 PM an end-of-day meeting was held with ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing (DON). They were notified that the investigation could not be located and it was requested if they can locate this investigation to provide it to the survey team. On 2/7/24 at 9:00 AM, ASM #2 stated there was no follow up and no evidence of an investigation. On 2/7/24 at 4:49 PM at the end of day meeting, ASM #1 stated that the incident was not investigated, that it got missed during a time when a former DON left.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to report findings regarding an allegation of abuse for two of 68 residents in the survey sample; Residents #115 and #93. The findings include: The facility submitted a synopsis of an event on 7/28/23 to the required state agency involving Residents #115 and #93. After the initial submission of the event, the facility failed to report a five-day follow up report of the event to the required state agency. Resident #115 was coded on the quarterly MDS (Minimum Data Set) dated 7/5/23 which was the MDS conducted closest to the time of the event (7/28/23) as being cognitively impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #93 was coed on the quarterly MDS (Minimum Data Set) dated 7/31/23 which was the MDS conducted closest to the time of the event (7/28/23) as being cognitively intact in ability to make daily life decisions, scoring a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. A review of the nurse's notes for Resident #115 revealed one dated 7/28/23 that documented, Resident got into a physical altercation with (Resident #93). Small bruise left wrist. Provider, RP (responsible party) aware. Redirected no further issues. Continue to check on frequently by staff. Resident interviewed has no recollection of event. Will monitor. A review of the nurse's notes for Resident #93 revealed one dated 7/28/23 that documented, Resident got into a physical altercation with (Resident #115). No injuries. Provider, RP (responsible party) aware. Redirected no further issues. Continue to check on frequently by staff. Resident interviewed has no recollection of event. Will monitor. On 7/28/23, the facility submitted a synopsis of an event dated 7/28/23 that occurred on 7/28/23 between Resident #115 and Resident #93. This synopsis documented, (Resident #115) initiated argument with (Resident #93) and they began to have a physical altercation in the hallway. Both residents on the Memory care unit, both were immediately separated and investigation to begin. As of the survey started on 2/4/24, there was no investigation and follow up reported to the required state agency. On 2/4/24 at 1:00 PM, during the entrance conference, the facility investigations for all events was requested. The boxes provided contained folders, each with separate reportable incidents with their associated investigations, in chronological order. A folder for the above 7/28/23 investigation could not be located. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/24 at 4:30 PM an end-of-day meeting was held with ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing (DON). They were notified that this investigation could not be located and it was requested if they can locate this investigation to provide it to the survey team. On 2/7/24 at 9:00 AM, ASM #2 stated there was no follow up and no evidence of an investigation. On 2/7/24 at 4:49 PM at the end of day meeting, ASM #1 stated that the incident was not investigated, that it got missed during a time when a former DON left. The facility policy, Abuse, Neglect, Exploitation & Misappropriation was reviewed. This policy documented, 7. Reporting/Response: Any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of Nursing is the designated abuse coordinator. Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply their individual requirements and responsibilities for reporting as required by law. In all cases, the Executive Director or Director of Nursing will ensure notification to the resident's legal guardian, family member, or responsible party or significant other of the alleged, suspected or observed abuse, neglect or mistreatment, and the resident's attending physician Review of Report: Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident and if the alleged violation is verified appropriate corrective action must be taken The Abuse Coordinator will refer any or all incidents and reports of resident abuse to the appropriate state agencies.

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Respond appropriately to all alleged violations.

42183

Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to investigate an allegation of abuse and report the finding to the State Agency for two of 68 residents in the survey sample, Resident #115 and Resident #93.

The findings include:

29125

The facility submitted a synopsis of an event on 7/28/23 to the required state agency involving Residents #115 and #93. After the initial submission of the event, the facility failed to investigate the event.

Resident #115 was coded on the quarterly MDS (Minimum Data Set) dated 7/5/23 which was the MDS conducted closest to the time of the event (7/28/23) as being cognitively impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

Resident #93 was coed on the quarterly MDS (Minimum Data Set) dated 7/31/23 which was the MDS conducted closest to the time of the event (7/28/23) as being cognitively intact in ability to make daily life decisions, scoring a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam.

A review of the nurse's notes for Resident #115 revealed one dated 7/28/23 that documented, Resident got into a physical altercation with (Resident #93). Small bruise left wrist. Provider, RP (responsible party) aware. Redirected no further issues. Continue to check on frequently by staff. Resident interviewed has no recollection of event. Will monitor.

A review of the nurse's notes for Resident #93 revealed one dated 7/28/23 that documented, Resident got into a physical altercation with (Resident #115). No injuries. Provider, RP (responsible party) aware. Redirected no further issues. Continue to check on frequently by staff. Resident interviewed has no recollection of event. Will monitor.

On 7/28/23, the facility submitted a synopsis of an event dated 7/28/23 that occurred on 7/28/23 between Resident #115 and Resident #93. This synopsis documented, (Resident #115) initiated argument with (Resident #93) and they began to have a physical altercation in the hallway. Both residents on the Memory care unit, both were immediately separated and investigation to begin.

As of the survey started on 2/4/24, there was no follow up reported to the required state agency.

On 2/4/24 at 1:00 PM, during the entrance conference, the facility investigations for all events was requested. The boxes provided contained folders, each with separate reportable incidents with their associated investigations, in chronological order. A folder for the above 7/28/23 investigation could not be located.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/24 at 4:30 PM an end-of-day meeting was held with ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing (DON). They were notified that this investigation could not be located and it was requested if they can locate this investigation to provide it to the survey team. On 2/7/24 at 9:00 AM, ASM #2 stated there was no follow up and no evidence of an investigation. On 2/7/24 at 4:49 PM at the end of day meeting, ASM #1 stated that the incident was not investigated, that it got missed during a time when a former DON left. On 2/8/24 at 12:41 PM a follow up interview was conducted with ASM #1 who stated that when an incident is initially reported to him, he will find out what happened and then immediately report to required state agency and then begin an investigation. He stated that after the investigation is concluded a 5-day report will be sent to the required state agency and all the documents are held in a file. ASM #1 stated that reporting is extremely important and he did not have an answer why that did not happen. He stated that at the time of the incident, he was brand new at the facility and that ultimately it would be him as the Administrator [responsible] for investigations and reporting. ASM #1 stated that the process was not followed. The facility policy, Abuse, Neglect, Exploitation & Misappropriation was reviewed. This policy documented, 4. Identification: All reported events (bruises, skin tears, falls, inappropriate or abusive behaviors) will be investigated by the Director of Nursing/designee. Patterns or trends will be identified that might constitute abuse. This information will be forwarded to the Executive Director, who will serve as the facility's Abuse Coordinator, and an abuse investigation will be conducted in the absence of the Executive Director, the Director of Nursing will serve as Abuse Coordinator. 5. Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents .

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NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that all required documentation was provided for hospital transfers for three out of 68 residents in the survey sample; Residents #21, #61, and #160. The findings include: 1. For Resident #21, the facility staff failed to evidence what, if any, documents were provided to the receiving facility upon a hospital transfer on 10/12/23; and that the comprehensive care plan goals were provided to the receiving facility upon a hospital transfer on 11/1/23. 10/12/23: A physician's progress note dated 10/12/23 documented, Resident is being assessed for change in condition per staff. The resident is currently sitting in the wheelchair. She is alert but nonverbal she is staring to the left side she is not following any commands at this time looks like she may be having a stroke Plan: Stroke send to ED (emergency department) for evaluation now. Further review of the clinical record failed to reveal any evidence of what, if any, documentation was provided to the receiving facility upon this 10/12/23 hospital transfer, to include but not limited to contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, the comprehensive care plan goals, and any other necessary information as applicable to ensure a safe and effective transition of care. 11/1/23: A nurse's note dated 11/1/23 documented, Resident reported to writer she had a fall last evening, bruise noted to right ischium. Resident reports mild discomfort. Resident noted ambulating on Wing 1 with rolling walker. NP (nurse practitioner, name) notified. Ordered STAT x-ray. A second nurse's note dated 11/1/23 documented, Upon entering residents' room, swelling to right hip noticeable through clothing. Patient reported more pain to right hip, resident still able to move right leg. RP (responsible party, name) notified and expressed concern, writer called MD (medical doctor, name) and gave orders to have resident sent out due to delay in STAT x-ray, residents increased pain and families (sic) reports of concerns. Resident left facility with DNR (Do Not Resuscitate form), medication summary and face sheet via stretcher at 1901 (7:01 PM). Further review failed to reveal any evidence that the comprehensive care plan goals were provided to the receiving facility. (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 0622

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 2/8/24 at 10:53 AM, an interview was conducted with LPN (Licensed Practical Nurse) #15. She stated that when a resident is transferred to the hospital that the facility sends the facesheet and the orders. When asked if it is just the face sheet and orders and no other documents are sent, including the care plan goals, she stated that was correct. When asked how does the facility evidence that all the required documents were sent, she stated that it is documented in a nurse's note that they were sent. She stated that if it was not documented in the progress note what was sent, the facility is unable to evidence it was sent.

The facility policy, Transfer/Discharge Notification & Rights to Appeal was reviewed. This policy documented, Information provided to the receiving provider must include but is not limited to: Contact information of the practitioner responsible for the care of the resident; Resident representative information including contact information; Advance Directives; Special care instructions or precautions for ongoing care as indicated; Comprehensive care plan goals; All other necessary information, including copies of the resident's discharge summary and other documentation, as applicable to ensure safe and effective transition of care.

On 2/8/24 at 12:41 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided by the end of the survey.

2. For Resident #61, the facility staff failed to evidence what, if any, documents were provided to the receiving facility upon a hospital transfer on 10/28/23; and that the comprehensive care plan goals were provided to the receiving facility upon a hospital transfer on 11/1/23.

10/28/23:

A nurse's note dated 10/28/23 documented, Resident complained of severe chest pain at 11pm. Resident own RP (Responsible Party) requested to go out to the hospital for evaluation. Resident got out at 11:30 and came back at 5 am with no new orders.

Further review of the clinical record failed to reveal any evidence of what, if any, documentation was provided to the receiving facility upon this 10/28/23 hospital transfer, to include but not limited to contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, the comprehensive care plan goals, and any other necessary information as applicable to ensure a safe and effective transition of care.

11/1/23:

A nurse's note dated 11/1/23 documented, Patient reports to writer of not being able to hold down anything PO (by mouth). Patient informed writer of vomiting AM medications. Writer notified NP (nurse practitioner, name), new orders obtained to provide fluids via IV (intravenous) .

A second nurse's note dated 11/1/23 documented, writer informed resident of MD orders obtained, resident refused to have IV placed and fluids pushed in house. Resident requested to be sent to ED (emergency department), writer spoke to RP (responsible party) and agreed with resident about being sent out. Resident exited facility at 1755 (5:55 PM) via stretcher with DNR (Do Not Resuscitate form), face sheet and medication summary.

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F 0622

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Further review failed to reveal any evidence that the comprehensive care plan goals were provided to the receiving facility.

On 2/8/24 at 10:53 AM, an interview was conducted with LPN #15 (Licensed Practical Nurse). She stated that when a resident is transferred to the hospital that the facility sends the facesheet and the orders. When asked if it is just the face sheet and orders and no other documents are sent, including the care plan goals, she stated that was correct. When asked how does the facility evidence that all the required documents were sent, she stated that it is documented in a nurse's note that they were sent. She stated that if it was not documented in the progress note what was sent, the facility is unable to evidence it was sent.

The facility policy, Transfer/Discharge Notification & Rights to Appeal was reviewed. This policy documented, Information provided to the receiving provider must include but is not limited to: Contact information of the practitioner responsible for the care of the resident; Resident representative information including contact information; Advance Directives; Special care instructions or precautions for ongoing care as indicated; Comprehensive care plan goals; All other necessary information, including copies of the resident's discharge summary and other documentation, as applicable to ensure safe and effective transition of care.

On 2/8/24 at 12:41 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided by the end of the survey.

42183

3. For Resident #160, the facility staff failed to evidence provision of required resident information to a receiving facility at the time of discharge for Resident #160. Resident #160 was transferred to the hospital on 10/30/23.

A review of the progress note dated 10/30/23 at 10:37 AM revealed, Received critical lab value for potassium (K) of 1.9. Nurse Practitioner called and received orders for stat oral potassium chloride 40 meq (milliequivalent) and send patient out for IV (intravenous) runs of K. 911 called to send patient to ER (emergency room) for critical K level that could cause cardiac arrythmias.

There was no evidence of a transfer form or clinical documents sent to the hospital with the resident.

An interview was conducted on 2/8/24 at 11:15 AM with LPN (licensed practical nurse) #15. When asked what documents are sent with a resident to the hospital, LPN #15 stated, the care plan, orders, advanced directives and MAR (medication administration record). When asked where this is documented, LPN #15 stated, usually in the progress note. When asked if there is no documentation or clinical records sent, is there evidence that the records were sent, LPN #15 stated, no, there is not.

On 2/8/24 at 4:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the facility's Transfer/Discharge Notification policy, which revealed, When the center transfers or discharges a resident under any circumstances listed above the facility will ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Documentation in the medical record to include contact information of the practitioner responsible for the care of the resident, resident representative information, advance directives, comprehensive care plan and special care instructions for continuing ongoing care. No further information was provided prior to exit.

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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.

42106

Based on staff interview, clinical record review, and facility document review, it was determined the facility staff failed to evidence written notification of transfer provided to the resident and/or responsible party at the time of transfer and/or ombudsman notification of transfer for three of 68 residents in the survey sample, Residents #25, #45 and #42.

The findings include:

1. For Resident #25 (R25), 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 1/4/2024.

The progress notes for R25 documented in part, 1/04/2024 10:26 Resident was sent out to [Name of hospital] via EMT's (emergency medical technicians) @ 10am to r/o (rule out) internal bleeding from unwitness [sic] fall, per NP (nurse practitioner) [Name of NP], request CT (computerized tomography) scan, nurse sent all paperwork and bed hold with EMT's, report given to EMT's and ER (emergency room) nurse. RP (responsible party) brother notified, unit manager and DON (director of nursing) [Name of DON] made aware.

Review of the clinical record failed to reveal evidence that written notification of transfer was provided to the resident and/or responsible party and the long-term care ombudsman for the transfer on 1/4/2024.

On 2/6/2024 at 1:33 p.m., an interview was conducted with OSM (other staff member) #8, the assistant social worker. OSM #8 stated that they did not have any role in providing a written notification of transfer to the resident or responsible party when they went to the hospital. OSM #8 stated that they were not sure who was responsible for the written notification. She stated that the director of social services handled the ombudsman notification.

On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the nursing staff did not provide any written notification of transfer to the resident or the responsible party when they went to the hospital. LPN #4 stated that they spoke with the responsible party over the telephone to notify them that the resident was going to the hospital but sent nothing in writing.

On 2/6/2024 at 3:22 p.m., an interview was conducted with OSM #10, the director of social services. OSM #10 stated that they sent a list of residents that were discharged or sent to the hospital to the ombudsman at least weekly. She stated that she kept a record of what was sent. She stated that she did not provide any written notification of transfer to the resident or responsible party at the time of transfer and nursing notified the family at the time of transfer. OSM #10 was asked to provide evidence of ombudsman notification of transfer for R25 for the transfer on 1/4/2024.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/2024 at approximately 9:00 a.m., OSM #10 provided a fax confirmation dated 1/11/2024 for ombudsman notification for additional requested residents. The list of residents failed to evidence ombudsman notification for R25's transfer on 1/4/2024. The facility policy, Transfer/Discharge Notification & Right to Appeal revised on 10/24/2022 documented in part, . Notice before Transfer: Before a center transfers or discharges a resident the center must: Notify the resident and resident representative(s) of the transfer or discharge and the reason for the move in writing (in a language and manner they understand). The Center must send a copy of the notice to a representative of the Office of the State Long-Term Ombudsman . On 2/7/2024 at 2:00 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit. 2. For Resident #45 (R45), the facility staff failed to evidence that written notification of transfer was provided to the resident and/or responsible party for a facility-initiated transfer on 1/7/2024. The progress notes for R45 documented in part, 1/07/2024 08:18 Residents blood pressure was 60/34 on both arms as of this morning. Resident stated to be lightheaded and dizzy. Resident has been experiencing nausea and vomiting for the past 48 hours that hasn't gotten better. Residents blood sugar is currently 88. Resident is having a new onset of behavior and was having hallucinations stating that they are seeing children out their window. Resident has been discharged to hospital for further care. NP (nurse practitioner) aware. The SNF/NH (skilled nursing facility/nursing home) to hospital transfer form dated 1/7/2024 for R45 documented in part, Sent to [Name of hospital]; Date of Transfer: 01/07/2024 . Review of the clinical record failed to reveal evidence that written notification of transfer was provided to the resident and/or responsible party for the transfer on 1/7/2024. On 2/6/2024 at 1:33 p.m., an interview was conducted with OSM (other staff member) #8, the assistant social worker. OSM #8 stated that they did not have any role in providing a written notification of transfer to the resident or responsible party when they went to the hospital. OSM #8 stated that they were not sure who was responsible for the written notification. On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the nursing staff did not provide any written notification of transfer to the resident or the responsible party when they went to the hospital. LPN #4 stated that they spoke with the responsible party over the telephone to notify them that the resident was going to the hospital but sent nothing in writing. On 2/6/2024 at 3:22 p.m., an interview was conducted with OSM #10, the director of social services. OSM #10 stated that she did not provide any written notification of transfer to the resident or responsible party at the time of transfer and nursing notified the family at the time of transfer. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/2024 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator market lead, and ASM #5, the vice president of risk management were made aware of the concern. No further information was provided prior to exit. 3. For Resident #42 (R42), the facility staff failed to evidence that written notification of transfer was provided to the resident and/or responsible party for a facility-initiated transfer on 9/3/2023. Review of the clinical record for R42 revealed in part, Change in Condition dated 9/3/2023. It documented in part, . Resident was notice [sic] sitting on the chair, blu [sic] color appearance, cold to touch and hard to wake up, cold touch and clear secretions coming out from her mouth. BS (blood sugar) 368. Resident was sent to hospital for eval, MD (medical doctor) and RP (responsible party) notified . Review of the clinical record failed to reveal evidence that written notification of transfer was provided to the resident and/or responsible party for the transfer on 9/3/2023. On 2/6/2024 at 1:33 p.m., an interview was conducted with OSM (other staff member) #8, the assistant social worker. OSM #8 stated that they did not have any role in providing a written notification of transfer to the resident or responsible party when they went to the hospital. OSM #8 stated that they were not sure who was responsible for the written notification. On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the nursing staff did not provide any written notification of transfer to the resident or the responsible party when they went to the hospital. LPN #4 stated that they spoke with the responsible party over the telephone to notify them that the resident was going to the hospital but sent nothing in writing. On 2/6/2024 at 3:22 p.m., an interview was conducted with OSM #10, the director of social services. OSM #10 stated that she did not provide any written notification of transfer to the resident or responsible party at the time of transfer and nursing notified the family at the time of transfer. On 2/6/2024 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator market lead, and ASM #5, the vice president of risk management 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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that a written bed hold notice was provided to the resident representative upon hospital transfers for three out of 68 residents in the survey sample; Residents #21, #61, and #160. The findings include: 1. For Resident #21, the facility staff failed to evidence that a written bed hold notice was provided to the resident representative upon a hospital transfer on 10/12/23 and 11/1/23. 10/12/23: A physician's progress note dated 10/12/23 documented, Resident is being assessed for change in condition per staff. The resident is currently sitting in the wheelchair. She is alert but nonverbal she is staring to the left side she is not following any commands at this time looks like she may be having a stroke Plan: Stroke send to ED (emergency department) for evaluation now. Further review of the clinical record failed to reveal any evidence of a written bed hold notice being provided to the resident representative upon the hospital transfer. 11/1/23: A nurse's note dated 11/1/23 documented, Resident reported to writer she had a fall last evening, bruise noted to right ischium. Resident reports mild discomfort. Resident noted ambulating on Wing 1 with rolling walker. NP (nurse practitioner, name) notified. Ordered STAT x-ray. A second nurse's note dated 11/1/23 documented, Upon entering residents' room, swelling to right hip noticeable through clothing. Patient reported more pain to right hip, resident still able to move right leg. RP (responsible party, name) notified and expressed concern, writer called MD (medical doctor, name) and gave orders to have resident sent out due to delay in STAT x-ray, residents increased pain and families (sic) reports of concerns. Resident left facility with DNR (Do Not Resuscitate form), medication summary and face sheet via stretcher at 1901 (7:01 PM). Further review of the clinical record failed to reveal any evidence of a written bed hold notice being provided to the resident representative upon the hospital transfer. On 2/8/24 at 10:48 AM, an interview was conducted with OSM #10 (Other Staff Member) the Director of Social Services. When asked about sending a written bed hold notice to the resident's representative upon a hospital transfer, she stated that the nurse's do it. On 2/8/24 at 10:53 AM, an interview was conducted with LPN #15 (Licensed Practical Nurse). She stated that the facility does not send any written notice that she is aware of. (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Transfer/Discharge Notification & Rights to Appeal was reviewed. This policy did not include any requirement for the provision of a written bed hold notice upon a hospital transfer. On 2/8/24 at 12:41 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #61, the facility staff failed to evidence that a written bed hold notice was provided to the resident representative upon a hospital transfer on 11/1/23. A nurse's note dated 11/1/23 documented, .Resident requested to be sent to ED (emergency department), writer spoke to RP (responsible party) and agreed with resident about being sent out. Resident exited facility at 1755 (5:55 PM) via stretcher with DNR (Do Not Resuscitate form), face sheet and medication summary. Further review of the clinical record failed to reveal any evidence of a written bed hold notice being provided to the resident representative upon this hospital transfer. On 2/8/24 at 10:48 AM, an interview was conducted with OSM #10 (Other Staff Member) the Director of Social Services. When asked about sending a written bed hold notice to the resident's representative upon a hospital transfer, she stated that the nurse's do it. On 2/8/24 at 10:53 AM, an interview was conducted with LPN #15 (Licensed Practical Nurse). She stated that the facility does not send any written notice that she is aware of. The facility policy, Transfer/Discharge Notification & Rights to Appeal was reviewed. This policy did not include any requirement for the provision of a written bed hold notice upon a hospital transfer. On 2/8/24 at 12:41 PM, ASM #1 (Administrative Staff Member) the Administrator was made aware of the findings. No further information was provided by the end of the survey. 42183 3. For Resident #160, the facility staff failed to evidence provision of bed hold notification at the time of discharge. Resident #160 was transferred to the hospital on 10/30/23. A review of the progress note dated 10/30/23 at 10:37 AM revealed, Received critical lab value for potassium (K) of 1.9. Nurse Practitioner called and received orders for stat oral potassium chloride 40 meq (milliequivalent) and send patient out for IV (intravenous) runs of K. 911 called to send patient to ER (emergency room) for critical K level that could cause cardiac arrythmias. There was no evidence of bed hold being provided to the resident or RP (responsible party). An interview was conducted on 2/8/24 at 10:48 AM with OSM #10, the director of social services. When asked who provides the bed hold to the resident, OSM #10 stated, the nurses do the bed hold. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 2/8/24 at 11:15 AM with LPN (licensed practical nurse) #15. When asked who provides the bed hold to the resident, LPN #15 stated, maybe social services. On 2/8/24 at 4:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024

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Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42106 Based on clinical record review and staff interview it was determined that the facility staff failed to evidence completion of a Level 1 PASRR (preadmission screening and resident review) for one of 68 residents, Resident #55. The findings include: For Resident #55 (R55), the facility staff failed to complete a Level 1 PASRR, who was admitted to the facility on [DATE]. R55 was admitted to the facility with diagnoses that included but were not limited to post traumatic stress disorder, unspecified dementia, depression and anxiety. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/27/2023, the resident scored four out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely impaired for making daily decisions. Review of R55's clinical record failed to evidence a Level 1 PASRR. On 2/5/2024 at approximately 8:30 a.m., a request was made to ASM (administrative staff member) #1, the executive director, for the Level 1 PASRR for R55. On 2/5/2024 at approximately 4:00 p.m., ASM #1 provided a Level 1 PASRR for R55 with a completion date of 2/5/2024. On 2/6/2024 at 3:22 p.m., an interview was conducted with OSM (other staff member) #10, the director of social services. OSM #10 stated that the PASRR was supposed to be completed prior to the resident being admitted to the facility and normally was obtained from the hospital by the admissions department. She stated that if the PASRR was not completed at the hospital it was completed on the day of admission. She stated that the purpose of the PASRR was to screen the resident to see if any additional services were needed and determine if the Level II PASRR was needed. She stated that the screening should be completed on all residents prior to admission to the facility. The facility policy, Preadmission Screening and Resident Review (PASRR) revised 11/8/2021 documented in part, .It is the responsibility of the center to assess and ensure that the appropriate preadmission screenings, either Level I or Level II, are conducted and results obtained prior to admission and placed in the appropriate section of the resident's medical record . On 2/6/2024 at 4:40 p.m., ASM #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator market lead, and ASM #5, the vice president of risk management were made aware of the concern. 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 - Some	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** 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide services for a baseline care plan for four of 68 residents in the survey sample, Residents #312, #160, #165, and #362. The findings include: 1. For Resident #312 (R312), the facility staff failed to develop a baseline care plan to address the resident's pressure injuries. R312 was admitted to the facility on [DATE]. A nurse's note dated 1/26/24 documented R312 presented with an unstageable pressure injury (1) on the right lateral lower leg and a stage three pressure injury (1) on the left buttock. R312's baseline care plan initiated on 1/31/24 failed to document any information regarding pressure injuries. On 2/7/24 at 2:10 p.m., an interview was conducted with LPN (licensed practical nurse) #12 (A minimum data set nurse). LPN #12 stated the baseline care plan should be opened by the admission nurse and the baseline care plan should contain the resident's initial disease processes and things staff needs to generally take care of, until the comprehensive care plan is completed. LPN #12 stated she would think a resident's pressure injuries should be included on a baseline care plan. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, Plans of Care documented, Develop and implement an Individualized Person-Centered baseline care plan within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR (pre-admission screening and resident review) recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed. Reference: (1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss (continued on next page)

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F 0655

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue). This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

42183

2. For Resident #160, the facility failed to develop a baseline care plan to include monitoring of left hip incision and signs/symptoms of infection.

Resident #160 was admitted to the facility on [DATE] with diagnoses that included left hip replacement.

A review of the baseline care plan dated 10/30/23 revealed, FOCUS: Resident wishes to discharge home with son. INTERVENTIONS: Encourage the resident to discuss feelings and concerns with impending discharge. Monitor for and address episodes of anxiety, fear and distress.

A review of the physician order dates 10/24/23 revealed Consult wound care PRN (as needed). Change dressing left hip incision site twice a day.

A review of the progress note dated 10/27/23 at 8:00 PM revealed, Dressing to left hip incision changed twice this shift, heavily soiled with yellowish/clear drainage. No signs/symptoms of infection identified.

There was no evidence that the baseline care plan included any focus or interventions related to her hip replacement, surgical incision and signs/symptoms of infection.

An interview was conducted on 2/8/24 at 11:15 AM with LPN (licensed practical nurse) #15. When asked what the baseline care plan should include, LPN #15 stated, it should include the initial plan of care for the resident. When asked if a resident is admitted post op, what should the baseline care plan include, LPN #15 stated, it should include monitoring the incision site and watching for signs/symptoms of infection. When asked who initiates the baseline care plan, LPN #15 stated, nursing and the unit manager.

On 2/8/24 at 4:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns.

No further information was provided prior to exit.

42106

3. For Resident #165 (R165), the facility staff failed to develop a baseline care plan that addressed the resident's person-centered care needs.

R165 was admitted to the facility on [DATE] and discharged on [DATE]. The admission MDS (minimum data set) assessment was completed on 6/15/2023 and the comprehensive care plan had not been completed at the time of the discharge.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician order summary dated 6/1/2023-6/30/2023 documented in part, - Daily weight one time a day for Heart Failure Notify MD (medical doctor) if weight gain is 2lbs in a day or 3-5 lbs in 1 wk (week). Order Date: 06/09/2023. - IVs: Type of access PICC (peripherally inserted central catheter). Order Date: 06/09/2023. - Strict contact isolation r/t (related to) MRSA (methicillin-resistant staphylococcus aureus) in urine. Resident to have rehab services, meals and nursing services delivered to their room. Order Date: 06/08/2023. - Insulin Lispro Injection Solution 100 Unit/ML (milliliter) Inject 6 unit subcutaneously three times a day for diabetes. Order Date: 06/08/2023. - Vancomycin HCL Intravenous Solution 1500MG/15ML (milligram/milliliter) Use 157 ml/hr intravenously every 24 hours for intra-abdominal infection . Order Date: 06/09/2023. On 2/5/2024 at approximately 8:30 a.m., a request was made to ASM (administrative staff member) #1, the executive director for the care plan for R165. On 2/5/2024 at approximately 4:00 p.m., ASM #1 provided a care plan which documented behaviors that was initiated on 6/15/2023, discharge planning initiated 6/16/2023 and code status initiated 6/16/2023. The care plan provided failed to evidence any person-centered care needs. At this time a request was made for the baseline care plan. On 2/7/2024 at 8:50 a.m., ASM #2, the director of nursing stated that they were not able to locate a baseline care plan for R165. On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the purpose of the care plan was to provide a baseline of care that was to be provided in the facility. LPN #4 stated that the nurses completed the baseline care plan. On 2/6/2024 at 3:25 p.m., an interview was conducted with OSM (other staff member) #10, the director of social services. OSM #10 stated that nursing went over the baseline care plan during the journey home meeting, had the resident sign it and gave them a copy of it. She stated that all of the staff came in and introduced themselves and during the meeting she was responsible for going over the resident's code status and making sure that their discharge was correct. She stated that the DON (director of nursing), ADON (assistant director of nursing), the nurse assigned that day, or the unit manager attended and provided the summary. On 2/7/2024 at 12:27 p.m., an interview was conducted with LPN #8. LPN #8 stated that they did not participate in the initial journey home meeting or have anything to do with the baseline care plan. She stated that she would expect catheters, falls, antibiotics, isolation precautions, infections and PICC (peripherally inserted central catheter) to all be addressed on the baseline care plan because it was addressing the residents care to be provided. (continued on next page)

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F 0655

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 2/7/2024 at 1:48 p.m., an interview was conducted with LPN #10. LPN #10 stated that the floor nurses did not attend the journey home meetings. She stated that she was not involved in developing the baseline care plan.

On 2/7/2024 at 2:00 p.m., ASM #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the concern.

No further information was provided prior to exit.

32642

4. For Resident #362 (R362), the facility staff failed to provide evidence that the resident was given a written summary of the baseline care plan.

R362 was admitted to the facility on [DATE]. On 2/4/24 at 2:28 p.m., R362 was interviewed. She stated she did not remember having been given a written summary or copy of her baseline care plan.

A review of R362's clinical record revealed no evidence that she was provided a written summary or copy of her baseline care plan.

On 2/6/24 at 3:25 p.m., OSM (other staff member) #10, the director of social services, was interviewed. She stated nurses are supposed to over the baseline care plan at the initial meeting of interdisciplinary team with the resident (also called the Journey Home) meeting. She stated the floor nurse, the director of nursing, the assistant director of nursing, or unit manager, who gives the resident the summary of the meeting and a copy of the baseline care plan.

On 2/7/24 at 12:27 p.m., LPN #8 was interviewed. She stated she is a floor nurse, and she does not participate in the initial Journey Home meetings with resident. She added: I do not have anything to do with giving residents their baseline care plan.

On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns.

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 42183

Based on observations, staff /resident interviews facility document review and clinical record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for 20 of 68 residents in the survey sample, Residents #75, #111, #62, #148, #141, #145, #78, #21, #54, #6, #41, #42, #45, #55, #119, #47, #10, #3, #73 and #46.

The findings include:

1. a. For Resident #75, the facility staff failed to implement the comprehensive care plan for a wander guard.

Resident #75 was admitted to the facility on [DATE] with diagnoses that included but were not limited to dementia, bipolar, and neurocognitive disorder with Lewy Bodies.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/6/23, 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 requiring supervision for toileting/eating and independent for mobility/transfers. Section P: Restraints/Alarms Wander/elopement: daily use.

A review of the comprehensive care plan dated 5/6/18 revealed, FOCUS: Resident is an elopement risk/wanderer. INTERVENTIONS: Electronic monitoring device, check for placement and function as ordered.

On 2/5/24 at 6:30 AM, Resident #75 was observed with wander guard to right ankle.

A review of the physician orders dated 3/13/22 revealed, Wander guard check every shift for placement.

A review of the physician orders dated 10/17/23 revealed, Wander guard check function daily, night shift.

A review of the Elopement Risk Evaluation dated 5/7/23 and 10/16/23, Resident is determined to be AT RISK for elopement.

A review of the TAR (treatment administration record) from October 2023-February 2024 revealed missing Wander guard check function daily, night shift and Wander guard check every shift for placement documentation:

October 2023: Wander guard check every shift for placement: Day shift: 10/8, 10/17 and 10/31.

November 2023: Wander guard check function daily, night shift: 11/12. Wander guard check every shift for placement: Day shift: 11/1, 11/3, 11/9; Evening shift: 11/3, 11/10 and 11/24 and night shift 11/12.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	December 2023: Wander guard check function daily, night shift: 12/16, 12/17, 12/30 and 12/31. Wander guard check every shift for placement: Day shift: 12/10, 12/12 and 12/26; evening shift: 12/15, 12/17 and 12/28; night shift 12/16, 12/17, 12/30 and 12/31. January 2024: Wander guard check function daily, night shift: 1/2/24, 1/4/24 and 1/9. Wander guard check every shift for placement: Day shift: 1/12 and 1/13; evening shift 1/12 and night shift 1/2/24 and 1/4/24. February 2024: Wander guard check every shift for placement: Day shift: 2/1 and evening shift 2/3. On 2/5/24 at 6:10 AM, an interview was conducted with LPN (licensed practical nurse) #1, when asked if there is no evidence of documentation on the TAR, what does that indicate, LPN #1 stated, it means that it was not checked. When asked if the care plan had been implemented, LPN #1 stated, no, it was not implemented. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. A review of the facility's Plan of Care policy, which revealed, Develop and implement a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The individualized person-centered plan of care may include but is not limited to the following: Resident strengths/ needs and services to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required by state and federal regulatory requirements. No further information was provided prior to exit. 1. b. For Resident #75, the facility staff failed to implement the comprehensive care plan for ADL (activities of daily living) care. A review of the comprehensive care plan dated 10/24/19 revealed, FOCUS: Resident has bowel and bladder incontinence. INTERVENTIONS: Clean peri-area with each incontinence episode. A review of the ADL (activities of daily living) documents from December 2023-February 2024 revealed missing documentation for bladder incontinence care: December 2023- day shift: 12/2, 12/3, 12/4, 12/5, 12/6, 12/7, 12/8, 12/9, 12/10, 12/11, 12/15, 12/16, 12/25, 12/28, 12/29, 12/30 and 12/31; evening shift: 1/2, 12/2, 12/3, 12/4, 12/5, 12/6, 12/7, 12/8 12/9, 12/10, 12/16, 12/17, 12/21, 12/22, 12/23, 12/25, 12/26, 12/27, 12/30 and 12/31; night shift 12/1, 12/3, 12/4, 12/5, 12/6, 12/8, 12/20, 12/22, 12/23, 12/24, 12/25, 12/26, 12/27, 12/30 and 12/31. January 2024-day shift: 1/1, 1/5, 1/8, 1/11, 1/12, 1/13, 1/14, 1/19, 1/22, 1/23, 1/24, 1/26, 1/27, 1/28; evening shift: 1/1, 1/9, 1/11, 1/12, 1/13, 1/14, 1/16, 1/18, 1/19, 1/20, 1/24, 1/25, 1/26, 1/27, 1/28, 1/30; and night shift: 1/1, 1/2, 1/4, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/15, 1/16, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30 and 1/31. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	February 2024-evening shift: 2/1, 2/2, 2/3, 2/4 and 2/5; night shift 2/1, 2/2, 2/3, 2/4 and 2/5. Resident #75 did not verbalize any answers in multiple attempts to interview her on 2/5, 2/6 and 2/7/24. On 2/5/24 at approximately 6:05 AM, an interview was conducted with CNA (certified nursing assistant) #4. When asked where bladder incontinence care is documented, CNA #4 stated, on the ADL form. When asked how incontinence care can be evidenced if there is no documentation, CNA #4 stated, It cannot be. It probably was not done When asked if incontinence care was not provided, was the care plan followed, CNA #4 stated, no. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. No further information was provided prior to exit. 2. a. For Resident #111, the facility staff failed to develop the comprehensive care plan for trauma informed care. Resident #111 was admitted to the facility on [DATE] with diagnoses that included but were not limited to vascular dementia, and PTSD (post-traumatic stress disorder). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/26/23, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the comprehensive care plan dated 7/29/22 revealed, FOCUS: Resident has potential nutritional problem related to cerebral infarction, vascular dementia and PTSD. Resident has impaired cognitive communication function, related to dementia, behaviors and poor nutrition. INTERVENTIONS: RD (registered dietician to evaluate and make diet change recommendations as needed. Document/report as needed any changes in cognitive function, specifically changes in decision making ability, memory, recall/general awareness, difficulty expressing self or understanding others. There was no evidence of a trauma informed care plan for Resident #111. A review of the facility's Psychosocial Evaluation dated 1/4/24 and 1/24/23 revealed, Have you ever been through anything life threatening or traumatic? Answer-when went to Vietnam. Are you aware of any particular 'triggers' that may make this worse for you? Answer-Messy roommates. An interview was conducted on 2/5/24 at 9:48 AM with Resident #111. When asked if he is provided with counseling for PTSD, Resident #111 stated, There is someone I talk with but I do not know if it is a counselor. An interview was conducted on 2/7/24 at 12:50 PM with LPN (licensed practical nurse) #8, when asked the purpose of the care plan, LPN #8 stated, it is everything about the residents and the care. It is to be used to direct their care. When asked if trauma informed care should be on the care plan when a resident has a diagnosis of PTSD, LPN #8 stated, yes, it should be. (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 on 2/7/24 at approximately 1:50 PM with OSM (other staff member) #10, the director of social services. When asked the purpose of the care plan, OSM #10 stated, it is to have the goals and needs of the resident outlined so care can be provided. When asked if trauma informed care should be on the care plan, OSM #10 stated, yes, it is supposed to be on there. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. No further information was provided prior to exit. 2. b. For Resident #111, the facility staff failed to implement the comprehensive care plan for a wander guard. A review of the comprehensive care plan dated 7/3/22 revealed, FOCUS: Resident has behaviors related to wandering and exit seeking. INTERVENTIONS: Assess elopement risk. Wander guard as ordered. Check placement and function as ordered and as needed. On 2/4/24 at 4:00 PM and 2/5/24 at 9:00 AM, Resident #111 was observed with a wander guard to RLE (right lower extremity) ankle. A review of the physician orders dated 7/31/22 revealed, Wander guard to RLE, check function daily, night shift. A review of the Elopement Risk Evaluation dated 2/5/23 and 5/6/23, Resident is determined to be AT RISK for elopement. A review of the TAR (treatment administration record) from October 2023-January 2024 revealed missing Wander guard to RLE, check function daily, night shift documentation: October 2023: 10/19, 10/23, 10/24, 10/25, 10/28, 10/29 and 10/30. November 2023: 11/3, 11/6, 11/11, 11/22 and 11/29. December 2023: 12/25. January 2024: 1/25. On 2/5/24 at 6:10 AM, an interview was conducted with LPN (licensed practical nurse) #1, when asked if there is no evidence of documentation on the TAR, what does that indicate, LPN #1 stated, it means that it was not checked. When asked if the care plan had been implemented, LPN #1 stated, no, it was not implemented. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. 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	3. The facility staff failed to implement the comprehensive care plan for a wander guard for Resident #62. Resident #62 was admitted to the facility on [DATE] with diagnoses that included but were not limited to, dementia. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/4/24, 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 comprehensive care plan dated 5/6/18 revealed, FOCUS: Resident has impaired behaviors related to wandering. INTERVENTIONS: Check wander guard for function/placement/expiration as ordered and PRN (as needed). On 2/5/24 at 8:00 AM, Resident #62 was observed with wander guard to left ankle. A review of the physician orders dated 8/16/23 revealed, Wander guard to LLE (left lower extremity), check function daily, night shift. Wander guard check every shift for placement. A review of the Elopement Risk Evaluation dated 8/16/23, Resident is determined to be AT RISK for elopement. A review of the TAR (treatment administration record) from October 2023-February 2024 revealed missing Wander guard check function daily, night shift and Wander guard check every shift for placement documentation: October 2023: Wander guard check every shift for placement: Day shift: 10/24. November 2023: Wander guard check function daily, night shift: 11/23. Wander guard check every shift for placement: Evening shift: 11/15, 11/21 and 11/23 and night shift 11/15 and 11/23. December 2023: Wander guard check function daily, night shift: 12/16, 12/17, 12/30 and 12/31. Wander guard check every shift for placement: Day shift: 12/12 and 12/26; evening shift: 12/15, 12/17 and 12/28; night shift 12/16, 12/17, 12/30 and 12/31. January 2024: Wander guard check function daily, night shift: 1/2/24, 1/4/24 and 1/9. Wander guard check every shift for placement: Day shift: 1/12 and 1/13; evening shift 1/12 and night shift 1/2/24, 1/4/24 and 1/9/24. February 2024: Wander guard check every shift for placement: Day shift: 2/1 and evening shift 2/3. On 2/5/24 at 6:10 AM, an interview was conducted with LPN (licensed practical nurse) #1, when asked if there is no evidence of documentation on the TAR, what does that indicate, LPN #1 stated, it means that it was not checked. When asked if the care plan had been implemented, LPN #1 stated, no, it was not implemented. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 906 Thompson Street Ashland, VA 23005	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. No further information was provided prior to exit. 4. a. For Resident #138, the facility staff failed to develop the comprehensive care plan for oxygen and anticoagulant therapy. Resident #148 was admitted to the facility on [DATE] with diagnosis that included but were not limited to acute respiratory failure with hypoxia, severe morbid obesity and venous thrombosis. A review of the physician orders dated 11/8/23 revealed, Oxygen continuous at 2L (liters) via nasal cannula. A review of the physician orders dated 11/15/23, revealed Warfarin Sodium 3 mg (milligram) tablet, give 1 tablet by mouth every evening. Anticoagulants-check for bleeding and bruising every shift. A review of the comprehensive care plan dated 11/21/23 revealed, FOCUS: Resident has an ADL self-care performance deficit related to shortness of breath (SOB) and morbid obesity. INTERVENTIONS: The resident is totally dependent on 1 staff for toileting/incontinent care. The resident is totally dependent on 1 staff for repositioning and turning in bed. There was no mention of oxygen or anticoagulation therapy on the care plan. An interview was conducted on 2/7/24 at 12:50 PM with LPN #8, when asked the purpose of the care plan, LPN #8 stated, it is everything about the residents and the care. It is to be used to direct their care. When asked if oxygen therapy should be on the care plan, LPN #8 stated, yes, it should. When asked if anticoagulant therapy should be on the care plan, LPN #8 stated, yes, it should be on the care plan with the signs and symptoms to look for. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. No further information was provided prior to exit. 4. b. For Resident #148, the facility staff failed to implement the comprehensive care plan for ADL (activities of daily living) care. A review of the comprehensive care plan dated 11/21/23 revealed, FOCUS: Resident has an ADL self-care performance deficit related to shortness of breath (SOB) and morbid obesity. INTERVENTIONS: The resident is totally dependent on 1 staff for toileting/incontinent care. The resident is totally dependent on 1 staff for repositioning and turning in bed. A review of the ADL (activities of daily living) documents from December 2023-February 2024 revealed the missing documentation for bladder incontinence care: (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

December 2023- day shift: 12/8, 12/11, 12/15, 12/16, 12/25, 12/28, 12/30 and 12/31; evening shift: 12/7, 12/8 12/9, 12/10, 12/16, 12/17, 12/21, 12/22, 12/23, 12/25, 12/26, 12/30 and 12/31; night shift 12/8, 12/9, 12/10, 12/11, 12/18, 12/20, 12/22, 12/23, 12/24, 12/25, 12/26, 12/27, 12/30 and 12/31.

January 2024-day shift: 1/1, 1/5, 1/8, 1/11, 1/12, 1/14, 1/19, 1/22, 1/23, 1/26, 1/27, 1/28; evening shift: 1/1, 1/4, 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/16, 1/18, 1/19, 1/20, 1/24, 1/25, 1/26, 1/27, 1/28 and 1/30; and night shift: 1/2, 1/3, 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/16, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30 and 1/31.

February 2024-evening shift: 2/1, 2/2, 2/3, 2/4 and 2/5; night shift 2/1, 2/2, 2/3, 2/4 and 2/5.

On 2/5/24 at approximately 6:05 AM, an interview was conducted with CNA (certified nursing assistant) #4. When asked where bladder incontinence care is documented, CNA #4 stated, on the ADL form. When asked how incontinence care can be evidenced if there is no documentation, CNA #4 stated, it cannot be. It probably was not done. When asked if incontinence care was not provided, was the care plan followed, CNA #4 stated, no.

On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns.

No further information was provided prior to exit.

31753

5. For Resident #141 (R141), the facility staff failed to develop a comprehensive care plan for activities.

R141's comprehensive care plan dated 8/14/23 failed to reveal any documentation regarding activities.

On 2/7/24 at 2:10 p.m., an interview was conducted with LPN (licensed practical nurse) #12 (a minimum data /MDS nurse). LPN #12 stated activities should be included in residents' care plans because the staff want to take into account the residents' preferences and the type of activities they would like to attend, as well as if residents are not attending activities. On 2/7/24 at 5:35 p.m., LPN #12 stated activities were not addressed on R141's care plan.

On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern.

6. For Resident #145 (R145), the facility staff failed to develop a comprehensive care plan based on several care areas that triggered on the resident's annual MDS (minimum data set) assessment with an assessment reference date of 12/19/23.

(continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section V of R145's admission MDS assessment with an assessment reference date of 12/19/23 revealed the following care areas triggered and would be included on the resident's care plan: cognitive loss/dementia, visual function, communication, urinary incontinence and indwelling catheter, nutritional status, feeding tube, dehydration/fluid maintenance, pressure ulcer, psychotropic drug use, and return to community referral. A review of R145's comprehensive care plan dated 12/3/23 revealed the following care areas were not included: cognitive loss/dementia, visual function, communication, urinary incontinence and indwelling catheter, nutritional status, feeding tube, dehydration/fluid maintenance, and psychotropic drug use. On 2/7/24 at 2:10 p.m., an interview was conducted with LPN (licensed practical nurse) #12 (an MDS nurse). LPN #12 stated the purpose of the care plan is to lay out a personalized framework to assist staff in caring for residents and looking at them as a whole person, and being able to take their individual preferences and needs into account and into consideration. In regard to the process for developing the comprehensive care plan, LPN #12 stated the staff generally use the discharge documentation from the hospital or previous facility, look at all orders, speak with the resident, and obtain input from the interdisciplinary team. LPN #12 stated the comprehensive care plan should be developed by day 21 from admission and the care areas that staff checks they are going to care plan on the MDS should be included on the care plan. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. On 2/7/24 at 5:35 p.m., LPN #12 stated all triggered care areas were not addressed on R145's care plan. 49369 7. For Resident #78 (R78), the facility staff failed to develop and implement a comprehensive care plan regarding the antipsychotic medication, Quetiapine (1). R78 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A review of R78's clinical record revealed the following order dated 2/2/24: Quetiapine Fumarate Oral Tablet 50 MG (milligram) (Quetiapine Fumarate) Give 1 tablet by mouth two times a day for mood disorder related to neurocognitive disorder with Lewy bodies (G31.83); unspecified dementia; unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (F03.90). A review of R78's MARs (medication administration records) for January and February 2024 revealed the resident had been receiving the Quetiapine as ordered. A review of R78's care plan failed to reveal evidence of monitoring behaviors and side effects while on an antipsychotic medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/7/24 at 2:10 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated if a resident is taking this type of medication that it would be categorized as an antipsychotic, making it necessary to monitor for effectiveness and if the medications caused any adverse effects. She stated that when a resident is admitted that they should have a whole care plan formulated for them and then reviewed quarterly and revised quarterly or as needed. On 2/7/24 at 5:38 p.m., LPN#12, the MDS (Minimum Data Set) coordinator, was interviewed. She stated that as the MDS coordinator they are responsible for the MDS. She also stated that for this resident, Quetiapine was not addressed on the care plan. She stated that it should be on the care plan. On 2/7/24 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Medication Management- Psychotropic Medications, revealed, in part: Psychotropic Medications is any medications that affects brain activities associated with mental process and behavior .Care plan to include person centered goals and non-pharmaceutical interventions. Update Care Plan as indicated. No further information was provided prior to exit. References: (1) Quetiapine tablets and extended-release (long- acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets .are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). This information is taken from the website https://medlineplus.gov/druginfo/meds/a698019.html 29125 8. For Resident #21 the facility staff failed to develop a comprehensive care plan for falls prior to 1/18/24. The resident had three falls prior to 1/18/24. 10/12/23: A review of the clinical record revealed a nurse's note dated 10/12/23 that documented, Staff observed resident slid off the bed in an upright position. Resident did not hit her head . 11/1/23: A nurse's note dated 11/1/23 documented, Resident reported to writer she had a fall last evening, bruise noted to right ischium. Resident reports mild discomfort. Resident noted ambulating on Wing 1 with rolling walker. NP (nurse practitioner, name) notified. Ordered STAT x-ray. (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A second nurse's note dated 11/1/23 documented, Upon entering residents' room, swelling to right hip noticeable through clothing. Patient reported more pain to right hip, resident still able to move right leg. RP (responsible party, name) notified and expressed concern, writer called MD (medical doctor, name) and gave orders to have resident sent out .

A review of the hospital record status post this fall, dated 11/1/23 documented, .history of A-fib (atrial fibrillation) on Eliquis CT abdomen pelvis .1. soft tissue hematoma lateral to the right hip 2. No acute fracture or dislocation .

12/28/23:

A review of the clinical record revealed a nurse's note dated 12/28/23 that documented, Writer heard yelling from down the hall, upon entry to room, writer noted resident on floor by her bed, no apparent injuries noted at this time .

A review of the comprehensive care plan failed to reveal any evidence that Resident #21 had a fall care plan in place prior to 1/18/24.

On 2/7/24 at 1:02 PM an interview was conducted with LPN #7 (licensed practical nurse). She stated that a care plan for falls should have been developed.

On 2/7/24 at 1:31 PM, an interview was conducted with LPN #4, the unit manager. She stated that falls should be investigated for root cause and the care plan reviewed and revised. She stated that Resident #21 was not on her unit at the time of the falls, and that she created the care plan on 1/18/24 after the resident had a fall on that date, when she went to review the care plan and realized there wasn't one.

On 2/7/24 at 2:10 PM an interview was conducted with LPN #12, the MDS nurse. She stated that the purpose of the care plan is to lay out a framework of personalized framework in caring for the resident and a holistic approach as a whole person. She stated that falls are discussed by the interdisciplinary team in the morning meetings and that they should be updating the care plans. She stated, I don't know that they are updated during the meeting but it is discussed what should be updated. She stated that Resident #21 should of had a fall care plan but did not. She stated that she did not know why Resident #21 did not have a fall care plan prior to 1/18/24.

On 2/8/24 at 11:50 AM, an interview was conducted with ASM #2. He stated that the MDS department does the care plans. He stated that usually when falls are discussed in morning meeting the MDS nurse brings a laptop to morning meeting and update the care plan at that time. He did not know why one had not been developed before 1/18/24, considering that Resident #21 had three falls prior to 1/18/24.

The facility policy, Plans of Care documented, .Develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment .Develop and Implement an Individualized Person-Centered comprehensive plan of care by the interdisciplinary team

On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided.

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

9. For Resident #54, the facility staff failed to implement the comprehensive care plan to obtain weekly weights as ordered; and failed to develop a comprehensive care plan for the use of side rails.

9. a. Weights:

A review of the clinical record revealed a physician's order dated 10/17/23 for weekly weights every Tuesday.

A review of the weight log revealed that the resident weighed 162.2 pounds on admission on 7/12/23. The most recent weight was on 1/9/24 and was 155.8 pounds. Between the two, the resident had weight fluctuations.

Further review of the clinical record revealed that weights were missing the weeks of 10/24/23, 11/7/23, 11/28/23, 12/19/23, 1/16/24, 1/23/24, and 1/30/24.

A review of the comprehensive care plan revealed one dated 7/21/23 for The resident has potential nutritional problem r/t (related to) COPD (chronic obstructive pulmonary disease) dementia, HTN (hypertension), alcohol abuse. An intervention dated 7/21/23 documented, Weights as ordered/indicated.

On 2/7/24 at 1:07 PM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that weights should be obtained as ordered. She stated that the resident may refuse it but that should be documented. She stated that if it is not documented we don't know that it was done. She stated that the care plan was not followed.

9. b. Siderails:

On 2/4/24 at 3:30 PM and 2/5/24 at 9:23 AM, Resident #54 was observed in bed with bilateral half side rails up.

A review of the clinical record revealed a Side Rail Evaluation dated 7/12/23 that documented, . Recommendations: 1. Side rails NOT indicated, 2. Side rails recommended, 3. Assist rail/grab bar . The box for Side rails NOT indicated was checked.

There were no further side rail evaluations completed to indicate that side rails were indicated. There was no informed consent signed for the use of side rails that documented risks vs benefits for the resident.

A review of the comprehensive care plan revealed that the resident was not care planned for the use of side rails.

On 2/7/24 at 1:12 PM an interview was conducted with LPN #7 (licensed practical nurse). She stated that he has upper side rails. When asked if the resident had an evaluation to indicate he needs side rails, she stated that she was not sure. She stated that normally before they activate side rails they have them sign a permission form (consent). When asked if the use of side rails should be care planned, she stated, Yes.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/7/24 at 2:10 PM an interview was conducted with LPN #12, the MDS nurse. She stated that the purpose of the care plan is to lay out a framework of personalized framework in caring for the resident and a holistic approach as a whole person. She stated that the use of siderails should be care planned. The facility policy, Plans of Care documented, .Develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment .Develop and Implement an Individualized Person-Centered comprehensive plan of care by the interdisciplinary team On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided. 10. For Resident #6, the facility staff failed to implement the comprehensive care plan for administering oxygen per order. On 2/4/24 at 2:53 PM, Resident #6 was observed in bed with the oxygen concentrator rate set at 3 liters per minute. When asked if he knew what his rate should be, he stated two to three liters. On 2/6/24 at 11:47 AM, Resident #6 was observed in bed with the oxygen concentrator rate at 3.5 liters per minute. Resident #6 stated that the staff changed it last night. A review of the clinical record revealed a physician's order dated 11/1/23 for Oxygen therapy 2LPM (liters per minute) via NC (nasal cannula) continuously every shift for COPD (chronic obstructive pulmonary disease). There were no orders to change the rate on or about 2/5/24, as the resident had indicated. A review of the comprehensive care plan revealed one dated 8/25/20 for (Resident #6) has COPD; need HOB (head of bed elevated) d/t (due to) SOB (shortness of br [TRUNCATED]

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42183

Based on staff interview, resident interview, clinical record review, and facility document review, it was determined the facility staff failed to review/revise the care plan for eight of 68 residents in the survey sample, Residents #111, #129, #41, #25, #21, #54, #72 and #162.

The findings include:

1. The facility failed to revise the comprehensive care plan to include a resident-to-resident altercation for Resident #111.

A review of a facility synopsis of events with incident date of 1/13/24 revealed, (Resident #111) slapped (Resident #129) on the left side of her face due to Resident #129 trying to open the back door. Residents separated. Resident to Resident incident substantiated. The final report dated 1/19/24 included, This letter serves as the final 5-day final internal investigation for the facility reported incident related to Resident #111 and Resident #129. Actions taken skin and pain assessments conducted on both residents. Psychosocial review with both residents conducted by the director of social services. Care plan was updated for (Resident #111 and Resident #129) .

A review of the comprehensive care plan dated 7/29/22 revealed, FOCUS: Resident has potential nutritional problem related to cerebral infarction, vascular dementia and PTSD. Resident has impaired cognitive communication function, related to dementia, behaviors and poor nutrition. INTERVENTIONS: RD (registered dietician to evaluate and make diet change recommendations as needed. Document/report as needed any changes in cognitive function, specifically changes in decision making ability, memory, recall/general awareness, difficulty expressing self or understanding others. There was no evidence of care plan being revised after abuse incident for Resident #111, the perpetrator.

An interview was conducted on 2/5/24 at 9:48 AM with Resident #111. When asked if he remembered any resident-to-resident interactions, Resident #111 stated, yes, I hit someone in the face.

An interview was conducted on 2/7/24 at 12:50 PM with LPN (licensed practical nurse) #8. When asked happens after a resident-to-resident altercation, LPN #8 stated, we immediately separate the residents. Assess the residents for any injuries and put the aggressor on every 15-minute checks. Inform the physician, RP, director of nursing and unit manager. When asked if the care plan is to be revised to reflect the incident, LPN #8 stated, yes, it should be revised.

An interview was conducted 2/7/24 at 2:10 PM with LPN #3. When asked if a care plan is to be reviewed and revised after a resident-to-resident altercation, LPN #3 stated, yes, it is to be revised. The manager revises the care plan.

On 2/8/24 at 4:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Plans of Care policy reveals, Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA MDS (Omnibus Budget Reconciliation Act Minimum Data Set) assessment, and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being. No further information was provided prior to exit. 2. The facility failed to revise the comprehensive care plan to include the resident-to-resident altercation/abuse for Resident #129. A review of a facility synopsis of events with incident date of 1/13/24 revealed, Resident #111 slapped Resident #129 on the left side of her face due to Resident #129 trying to open the back door. Residents separated. Resident to Resident incident substantiated. A review of the comprehensive care plan dated 4/21/23 revealed, FOCUS: Resident has behaviors of moving wheelchair up and down the hall almost running over residents with no awareness. INTERVENTIONS: Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Revised interventions as of 1/19/24: Ombudsman, APS, Physician and RP notified. Skin/pain assessment conducted. Psychosocial review conducted. There was no revision of the care plan after Resident #129 was the recipient of abuse. An attempt was made to interview Resident #129 on 2/6/24 at 8:40 AM, however Resident #129 was non-verbal and did not communicate at that time. An interview was conducted on 2/7/24 at 12:50 PM with LPN (licensed practical nurse) #8. When asked happens after a resident-to-resident altercation, LPN #8 stated, we immediately separate the residents. Assess the residents for any injuries and put the aggressor on every 15-minute checks. Inform the physician, RP, director of nursing and unit manager. When asked if the care plan is to be revised to reflect the incident, LPN #8 stated, yes, it should be revised. An interview was conducted 2/7/24 at 2:10 PM with LPN #3. When asked if a care plan is to be reviewed and revised after a resident-to-resident altercation, LPN #3 stated, yes, it is to be revised. The manager revises the care plan. On 2/8/24 at 4:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. No further information was provided prior to exit. 42106 3. For Resident #41 (R41), the facility staff failed to review and revise the comprehensive care plan to reflect the use of bed rails. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 12/21/2023, the resident scored 11 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. The assessment documented R41 having impairment to both upper extremities and requiring substantial/maximal assistance with bed mobility. On 2/4/2024 at 4:47 p.m., an observation was made of R41 in their room, in bed, with bilateral upper bed rails in place on the bed. At this time an interview was conducted with R41. When asked if they used the bed rails, R41 stated that they did not use them but they were on the bed because they had seizures and they liked having them there. Additional observations of R41 in bed with the bilateral upper bed rails in place were made on 2/5/2024 at 8:41 a.m. and 2/6/2024 at 9:56 a.m. The comprehensive care plan for R41 documented in part, [Name of R41] has an ADL (activities of daily living) self-care performance deficit r/t (related to) impaired balance, limited mobility, BLE (bilateral lower extremity) amputation, L (left) forearm/hand amputation, osteomyelitis, DM II (type two diabetes mellitus), quadriplegia. Date Initiated: 07/06/2023. Review of the care plan failed to evidence bed rail use. Review of the clinical record failed to evidence a bed rail assessment or consent for bed rail use. A quarterly data collection assessment dated [DATE] for R41 documented no bed rail use. Review of the most recent maintenance bed inspections documented R41's bed with the bed rails inspected on 12/20/2023. On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the purpose of the care plan was to give an initial baseline of the care that was to be provided to the resident. She stated that she was not sure if bed rails were included on the care plan or not. LPN #4 stated that when a resident wanted to use bed rails or needed them the nurse got an order for them and got a consent from the resident or the family. She stated that there was a bed rail evaluation that was done on the consent form initially and then done quarterly. On 2/7/2024 at 12:27 p.m., an interview was conducted with LPN #8. LPN #8 stated that they would expect bed rails to be on the residents care plan if they had them on their bed. The facility policy Side Rail/Bed Rail dated 4/19/2018 documented in part, . Obtain physician order for side rail/bed rail. Update the care plan and kardex. Re-evaluate the use of side rail/bed rail, quarterly, with a change in condition or as needed . On 2/7/2024 at 2:00 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the concern. No further information was obtained prior to exit. 4. For Resident #25 (R25), the facility staff failed to review and/or revise the comprehensive care plan after a fall on 1/3/2024 and 1/10/2024. (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 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 11/24/2023, the resident was assessed as having two falls with no injuries and two falls with non-major injuries since the previous assessment.

The comprehensive care plan for R25 documented in part, [Name of R25] is at risk for falls r/t (related to) factors that include Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, lack of coordination, and dementia. Date Initiated: 09/12/2023. Revision on: 09/12/2023. Review of the care plan failed to evidence a review and/or revision after the falls on 1/3/2024 and 1/10/2024.

The progress notes for R25 documented in part,

- 1/3/2024 13:51 (1:51 p.m.) Resident had a witness fall, resident attempting to carry chair to dining room, no injuries noted, no c/o (complaints of) pain/discomfort, resident assess all ROM (range of motion) WNL (within normal limits), V/S (vital signs) WNL .

- 1/10/2024 11:26 (11:26 a.m.) Nurse witness resident attempting to lift chair and carry into dining room, while resident slips and fall in hallway onto her buttocks, no c/o pain/discomfort, V/S all WNL .

On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the purpose of the care plan was to give an initial baseline of the care that was to be provided to the resident. She stated that the unit manager reviewed the care plan after falls to make sure the interventions in place were appropriate and add anything additional to prevent further falls. She stated that the review should be documented on the care plan dates.

The facility policy Fall Management revised 7/29/2019 documented in part, .Post Fall Strategies: .Update Care Plan and Nurse Aide Kardex with intervention(s) . Interdisciplinary team to review fall documentation and complete root cause analysis. Update plan of care with new interventions as appropriate .

On 2/7/2024 at 2:00 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the concern.

No further information was obtained prior to exit.

29125

5. For Resident #21, the facility staff failed to review and revise the comprehensive care plan after falls on 10/12/23, 11/1/23, and 12/28/23. Resident #21 had no fall care plan developed until 1/18/24.

10/12/23:

A review of the clinical record revealed a nurse's note dated 10/12/23 that documented, Staff observed resident slid off the bed in an upright position. Resident did not hit her head .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's progress note dated 10/12/23 documented, Resident is being assessed for change in condition per staff. The resident is currently sitting in the wheelchair. She is alert but nonverbal she is staring to the left side she is not following any commands at this time looks like she may be having a stroke Plan: Stroke send to ED (emergency department) for evaluation now. 11/1/23: A nurse's note dated 11/1/23 documented, Resident reported to writer she had a fall last evening, bruise noted to right ischium. Resident reports mild discomfort. Resident noted ambulating on Wing 1 with rolling walker. NP (nurse practitioner, name) notified. Ordered STAT x-ray. A review of the hospital record status post this fall, dated 11/1/23 documented, .history of A-fib (atrial fibrillation) on Eliquis CT abdomen pelvis .1. soft tissue hematoma lateral to the right hip 2. No acute fracture or dislocation . 12/28/23: A review of the clinical record revealed a nurse's note dated 12/28/23 that documented, Writer heard yelling from down the hall, upon entry to room, writer noted resident on floor by her bed, no apparent injuries noted at this time, ROM (range of motion) WNL (within normal limits), vitals obtained and are WNL. Fully clothes, socks on feet. Resident stated she went to grab her phone on her bedside table and rolled out of bed. [NAME] (sic) noted to be at floor level. Writer and another staff member assisted resident off the floor and back into bed RP (responsible party, name) / MD (medical doctor) notified. A review of the comprehensive care plan failed to reveal any evidence that Resident #21 had a fall care plan in place prior to 1/18/24. On 2/7/24 at 1:02 PM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that the fall should be reported as needing to be updated on the care plan. On 2/7/24 at 1:31 PM, an interview was conducted with LPN #4, the unit manager. She stated that falls should be investigated for root cause and the care plan reviewed and revised. She stated that Resident #21 was not on her unit at the time of the falls, and that she created the care plan on 1/18/24 after the resident had a fall on that date, when she went to review the care plan and realized there wasn't one. On 2/7/24 at 2:10 PM an interview was conducted with LPN #12, the MDS nurse. She stated that the purpose of the care plan is to lay out a framework of personalized framework in caring for the resident and a holistic approach as a whole person. She stated that falls are discussed by the interdisciplinary team in the morning meetings and that they should be updating the care plans. She stated, I don't know that they are updated during the meeting but it is discussed what should be updated. She stated that Resident #21 should of had a fall care plan but did not. She stated that she did not know why Resident #21 did not have a fall care plan prior to 1/18/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/8/24 at 11:50 AM, an interview was conducted with ASM #2. He stated that the MDS department does the care plans. He stated that usually when falls are discussed in morning meeting the MDS nurse brings a laptop to morning meeting and update the care plan at that time. He stated that it would be correct to say Resident #21's care plan was not reviewed as there was no care plan for falls, and that if it had been reviewed after a fall, it would have been identified that there was no fall care plan developed and then one would have been developed. The facility policy, Fall Management documented, C. Post Fall Strategies: 8. Update plan of care with new interventions as appropriate The facility policy, Plans of Care documented, .Develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions and as needed On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided. 6. For Resident #54, the facility staff failed to review and/or revise the comprehensive care plan after falls on 11/16/23 and 12/13/23. A review of the clinical record revealed a nurse's note dated 11/16/23 that documented, Resident had a fall today on 11/16/23. Resident was walking to his walker that was place beside his bed and fell without hitting his head. Resident fell on the floor matt that is placed on the floor. Resident has no injuries or bruising from the fall. Resident's vital signs are within normal limits, blood pressure a little high after the fall. Will continue to monitor residents' status post fall. Interventions that were put into place was to place the resident's walker closer to the bedside so that the resident has less increase of a fall happening. Further review revealed a nurse's note dated 12/13/23 that documented, Resident was walking in the hall without his walker writer asked him why he was walking without it he told writer to mind her business then he started taking things from the meds cart he was asked to please leave the med cart alone he stated (expletive) that meds cart he swung around trying to throw a cup of water at nurse and fell to the floor vss (vital signs) wnl (within normal limits) was witnessed via staff no injury noted no c/o (complaint of) pain or discomfort resident was assisted to his feet he refused to sit in w/c (wheelchair) provided he was assisted with walking down the hall to his room ROM (range of motion) wnl per base line resident stated he was not in pain sitting on the bed. A review of the comprehensive care plan revealed one dated 7/13/23 for (Resident #54) is at risk for falls r/t (related to) factors that include GLF (ground level fall) in bathtub prior to admission with resulting left wrist fracture, use of psychotropic medications, dementia, hx (history) ETOH (alcohol abuse). This review failed to reveal that this care plan was reviewed and revised after each of the above falls. The intervention documented in the above nurse's note of 11/16/23 was not included on the comprehensive care plan. (continued on next page)

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 2/7/24 at 9:00 AM, ASM #2 (Administrative Staff Member) the Director of Nursing, stated that there was no evidence the care plan was reviewed and revised.

On 2/7/24 at 1:02 PM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that the fall should be reported as needing to be updated on the care plan.

On 2/7/24 at 1:31 PM, an interview was conducted with LPN #4, the unit manager. She stated that she was not aware of Resident #54's falls. She stated that it was not reported to her so that the care plan could be reviewed and revised.

On 2/7/24 at 2:10 PM an interview was conducted with LPN #12, the MDS nurse. She stated that the purpose of the care plan is to lay out a framework of personalized framework in caring for the resident and a holistic approach as a whole person. She stated that falls are discussed by the interdisciplinary team in the morning meetings and that they should be updating the care plans. She stated, I don't know that they are updated during the meeting but it is discussed what should be updated.

On 2/8/24 at 11:50 AM, an interview was conducted with ASM #2. He stated that when a resident has a fall, the nurse assess the resident, fill out the change of condition form, start the fall investigation, notify the physician and the resident's responsible party and then the facility would update the care plan at that time or at least put an intervention in place and review it the next morning at the morning meeting. He stated that the purpose of the investigation was to find the root cause and put a proper intervention in place to prevent reoccurrence. He stated that he did not know what happened regarding why the investigations were not done. He stated that the MDS department does the care plans. He stated that usually when falls are discussed in morning meeting the MDS nurse brings a laptop to morning meeting and update the care plan at that time.

The facility policy, Fall Management documented, C. Post Fall Strategies: 8. Update plan of care with new interventions as appropriate

The facility policy, Plans of Care documented, .Develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions and as needed

On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided.

29843

7. For Resident #72 (R72), the facility staff failed revise the comprehensive care plan to include nebulizer (1) treatments according to the physician's order.

R72 was admitted to the facility with diagnoses that included but were not limited to asthma (2).

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F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/01/2023, R72 scored 6 (six) out of 15 on the BIMS (brief interview for mental status), indicating R72 was severely impaired of cognition for making daily decisions.

On 02/04/24 an approximately 3:35 p.m. and on 02/05/24 at approximately 8:28 a.m , an observation of R72's bed side table revealed a mouthpiece for a nebulizer hanging off the table.

The physician's order for R72 documented in part, Ipratropium-Albuterol (3) Inhalation Solution 3MG/3ML (three milligram/three milliliter). 3mg/ml inhale orally every 6 (six) hours as needed for SOB (shortness of breath).

The comprehensive care plan dated 07/10/2020 for R72 documented in part, Focus. (R72) has altered cardiovascular status r/t (related to) Hypertension and HDL (high-density lipoprotein). Date Initiated: 07/10/2020. Under Interventions it documented in part, Assess for shortness of breath and cyanosis as indicated. Date Initiated: 07/10/2020. Further review of the care plan failed to evidence documentation for the use of nebulizer treatments.

On 02/06/24 10:08 a.m. an interview was conducted with LPN (licensed practical nurse) #12, MDS coordinator regarding the use of nebulizer treatments on R72's care plan. After reviewing R72's comprehensive care plan LPN #12 stated that the care plan did not document nebulizer treatments. When asked why it was not part of the care plan she stated that it was an oversight. When asked to describe the procedure that is followed for completing the care plan LPN #12 stated that she follows the RAI (resident assessment instrument) manual.

On 04/06/2024 at approximately 4:30 p.m., ASM (administrative staff member) #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM 4, lead for marketing and ASM #5, vice president of risk management, were informed of the above findings.

No further information was provided prior to exit.

References:

(1) A small machine that turns liquid medicine into a mist. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm.

(2) A disease that causes the airways of the lungs to swell and narrow. It leads to wheezing, shortness of breath, chest tightness, and coughing. This information was obtained from the website: https://medlineplus.gov/ency/article/000141.htm.

8. For Resident #162 (R162), the facility staff failed revise the comprehensive care plan to include a fall on 08/30/2023.

R162 was admitted to the facility with diagnoses that included but were not limited to muscle weakness.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/20/2023, R162 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R162 was cognitively intact for making daily decisions.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Fall Risk Evaluation for R162 dated 04/13/2023 documented in part, History of falling (immediate of previous [within the last 6 months])? No. Category: No Risk. The comprehensive care plan dated 8/14/2023 documented in part, Focus. (R162) is at risk for falls r/t (related to) Confusion, Deconditioning, Incontinence, Poor communication/comprehension, Psychoactive drug use, indwelling foley catheter. Under Interventions it documented, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The facility's progress note for R162 dated 08/30/2023 at 7:41 a.m. documented in part, During rounds staff observed resident knealing [sic] at bedside. Resident stated, I did not fall, I was trying to empty my foley. Neuro (neurological) checks are within normal limits. ROM (range of motion) within normal limits to all extremities, no c/o (complaint of) pain or discomfort noted. Resident assistance [sic] back in w/c (wheelchair). Educated on using call bell for assistance when needed. Resident is own RP (responsible party. NP (nurse practitioner) made aware. The facility's Change in Condition SBAR (Situation Background Assessment Recommendation) form for R162 dated 08/30/2023 documented in part, A. Situation. 1. The change in condition, symptoms, or signs observed and evaluated are/is: Fall without injury. This started on: 8/30/2023. On 02/07/2024 at approximately 2:00 p.m. a request was made to ASM (administrative staff member) #2, director of nursing, for the facility's fall investigation regarding R162's fall on 08/30/2023. On 02/08/2024 at approximately 11:50 a.m., an interview was conducted with ASM #2. He stated that the facility did not have evidence of a fall investigation for R162. On 02/09/24 at approximately 9:50 a.m., an interview was conducted with LPN (licensed practical nurse) #12, MDS coordinator. When asked about R162's fall being documented on the care plan, LPN #12 reviewed the comprehensive care plan for R162 and stated that the fall was not documented on the care plan. When asked to describe the procedure that is followed for completing the care plan LPN #12 stated that she follows the RAI (resident assessment instrument) manual. On 04/08/2024 at approximately 4:45 p.m., ASM #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM 4, lead for marketing and ASM #5, vice president of risk management, were informed of the above findings. 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 49369 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of quality for five of 68 residents in the survey sample, Residents #46, #114, #148, #362, #3, and #54. The findings include: 1. For Resident #46 (R46), the facility staff failed to administer medications as ordered by the physician on 10/23/23. A review of R46's provider's orders revealed the following: 8/24/2023 Ferrous Sulfate (1) Oral Tablet 325 (65 Fe) MG (milligrams) (Ferrous Sulfate) Give 1 tablet by mouth two times a day for anemia. 8/18/2023 Gabapentin (2) Oral Capsule (Gabapentin) Give 300 mg by mouth every 8 hours for pain mgt (management). 8/18/2023 Hydralazine HCL (3) Oral Tablet 50 MG (Hydralazine HCL) Give 1 tablet by mouth every 8 hours for htn (hypertension). 8/23/2023 Saline Nasal Spray (4) Solution 0.65% (Saline) 2 spray in both nostrils every 8 hours for nasal dryness. A review of R46's October 2023 MAR (medication administration record), revealed she did not receive these medications as ordered on 10/8/23. On 2/7/24 at 11:40 p.m., LPN (licensed practical nurse) #8 was interviewed. She stated that medications should be given on time as ordered. She stated that it is important because the resident could need that medication at a certain time, or before or after a meal. If the medication is not given, the doctor and family should be notified, and it should be documented on a nurses note in the clinical record. On 2/7/24 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM#2, the director of nursing, ASM#3, the regional director of clinical services and ASM#5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Administering Medications, revealed, in part : Medications are administered in a safe and timely manner, and as prescribed .staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions .medications are administered in accordance with prescriber orders, including any required time frame .Medication administration times are determined by resident need and benefit, not staff convenience .medications are administered within one hour of their prescribed time, unless otherwise specified. No further information was provided prior to exit. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	References: (1) Iron (ferrous fumarate, ferrous gluconate, ferrous sulfate) is used to treat or prevent anemia (a lower than normal number of red blood cells) when the amount of iron taken in from the diet is not enough. Iron is a mineral that is available as a dietary supplement. It works by helping the body to produce red blood cells. This information is taken from the website https://medlineplus.gov/druginfo/meds/a682778.html#:~:text=Iron%20(ferrous%20fumarate%2C%20ferrous%20gluconate,available%20as%20a%20dietary%20supplement. (2) Hydralazine is used to treat high blood pressure It works by relaxing the blood vessels so that blood can flow more easily through the body. This information is taken from the website https://medlineplus.gov/druginfo/meds/a682246.html. (3) Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles. This information is taken from the website https://medlineplus.gov/druginfo/meds/a694007.html. (4) Saline Nasal wash helps flush pollen, dust, and other debris from your nasal passages. It also helps remove excess mucus (snot) and adds moisture. This information is taken from the website https://medlineplus.gov/ency/patientinstructions/000801.htm#:~:text=A%20saline%20nasal%20wash%20helps,passages%20before%20entering%20your%20lungs. 2. For Resident #114 (R114), the facility staff failed to administer medications as ordered by the physician on 10/8/23. A review of R114's provider's orders from October 2023 revealed the following: 8/7/2023 Melatonin (1) Tablet 3 MG (milligram) Give 1 tablet by mouth at bedtime for Insomnia. 8/26/2023 Mirtazapine (2) Oral Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for depression. 8/7/2023 Sertraline HCL (3) Oral Tablet 50 MG (Sertraline HCL) Give 1 tablet by mouth at bedtime for Depression. 8/7/2023 Trazadone HCL (4) Oral Tablet 150 MG (Trazadone HCL) Give 1 tablet by mouth at bedtime for Depression. A review of R114's October 2023 MAR (medication administration record), revealed she did not receive these medications as ordered on 10/8/23. On 2/7/24 at 11:40 p.m., LPN (licensed practical nurse) #8 was interviewed. She stated that medications should be given on time as ordered. She stated that it is important because the resident could need that medication at a certain time, or before or after a meal. If the medication is not given, the doctor and family should be notified, and it should be documented on a nurses note in the clinical record. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/7/24 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM#2, the director of nursing, ASM#3, the regional director of clinical services and ASM#5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Administering Medications, revealed, in part : Medications are administered in a safe and timely manner, and as prescribed .staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions .medications are administered in accordance with prescriber orders, including any required time frame .Medication administration times are determined by resident need and benefit, not staff convenience .medications are administered within one hour of their prescribed time, unless otherwise specified. No further information was provided prior to exit. References: (1) Melatonin is a hormone made in the body. It regulates night and day cycles or sleep-wake cycles .People most commonly use melatonin for insomnia and improving sleep in different conditions, such as jet lag. It is also used for depression, chronic pain, dementia, and many other conditions. This information is taken from the website https://medlineplus.gov/druginfo/natural/940.html. (2) Mirtazapine is used to treat depression. Mirtazapine is in a class of medications called antidepressants. It works by increasing certain types of activity in the brain to maintain mental balance. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697009.html. (3) Sertraline is used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). This information is taken from the website https://medlineplus.gov/druginfo/meds/a697048.html. (4) Trazadone is used to treat depression. Trazadone is in a class of medications called serotonin modulators. It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance. This information is taken from the website https://medlineplus.gov/druginfo/meds/a681038.html. 42183 3. For Resident #148, the facility staff failed to meet professional standards by not consistently monitoring for bleeding and bruising every shift while on an anticoagulant (blood thinner). A review of the physician orders dated 11/15/23, revealed Warfarin Sodium (1) 3 mg (milligram) tablet, give 1 tablet by mouth every evening. Anticoagulants-check for bleeding and bruising every shift. A review of the November 2023-February 2024 MAR (medication administration record) revealed the following missing anticoagulant monitoring documentation: (continued on next page)

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

November 2023: Day shift-11/27 and evening shift-11/24.

December 2023: Day shift-12/12; evening shift-12/15, 12/17 and 12/28; night shift-12/16, 12/17, 12/30 and 12/31.

January 2024: Day shift-1/12 and 1/13; evening shift 12/12 and night shift-1/2/24, 1/4/24 and 1/9.

February 2024: Day shift 2/1 and evening shift 2/3.

An interview was conducted on 2/7/24 at 12:50 PM with LPN (licensed practical nurse) #8. When asked how do you evidence monitoring of bruising / bleeding for a resident on anticoagulation, LPN #8 stated, it is documented on the MAR. When asked what it indicates if there is no documentation, LPN #8 stated, we did not follow physician orders.

An interview was conducted on 2/9/24 at 9:00 AM with LPN #5. When asked how do you evidence monitoring of bruising / bleeding for a resident on anticoagulation, LPN #5 stated, we document it on the MAR. When asked what it indicates if there is no documentation, LPN #5 stated, the physician orders were not followed.

On 2/9/24 at 12:50 PM, ASM #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns.

According to the facility's Administering Medication policy, which revealed, Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: enhancing optimal therapeutic effect of the medication; preventing potential medication or food interactions and honoring resident choices and preferences, consistent with his or her care plan.

No further information was provided prior to exit.

Reference:

(1) Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood. https://medlineplus.gov/druginfo/meds/a682277.html

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4. For Resident #362 (R362), the facility staff failed to administer medications in a timely manner, as ordered by the physician.

(continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/24 at 2:28 p.m., R362 was interviewed. She stated she was not receiving her medications at consistent times each day and evening. She added: I'm not sure, but I think I should take them pretty much at the same time every day. At least, that's what I do when I'm at home. A review of R362's physician's orders revealed the following: 1/27/24 Metoprolol tartrate (1) 25 mg (milligrams) Give 1 tablet by mouth two times a day for HTN (hypertension) (high blood pressure). 1/27/24 Furosemide Oral Tablet (2) 20 mg Give 1 tablet by mouth one time a day for edema (swelling). A review of R362's January 2024 MAR (medication administration record) revealed the resident received these medications at the following times: On 1/27/24, the Metoprolol, due at 9:00 a.m. was given at 11:59 a.m.; and the Metoprolol, due at 5:00 p.m., was given at 8:09 p.m. These medications were not given 12 hours apart. On 1/30/24, the Metoprolol, due at 9:00 a.m., was given at 4:00 p.m.; and the Metoprolol, due at 5:00 p.m., was given at 9:30 p.m. These medications were not given 12 hours apart. On 1/30/24, the Furosemide, due at 9:00 a.m., was given at 4:00 p.m. On 1/31/24, the Furosemide, due at 9:00 a.m., was given at 10:02 a.m. These medications were not given 24 hours apart. On 2/7/24 at 12:27 p.m., LPN (licensed practical nurse) #8 was interviewed. When asked how far apart medications should be given if they are scheduled for twice a day administration, she stated: Roughly 12 hours. When asked the same questions about medications scheduled for once a day administration, she stated: About 24 hours. When shown R362's January MARs and the administration times for Metoprolol and Lasix as described above, she stated: These were not given like they should have been. She stated nurses are required to give medications within an hour before or an hour after they are due on the MAR. She stated the errors in timing for Metoprolol could have negatively affected R362's blood pressure. On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit. References (1) Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure. This information is taken from the website https://medlineplus.gov/druginfo/meds/a682864.html. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2) Furosemide (Lasix) is used alone or in combination with other medications to treat high blood pressure. Furosemide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. Furosemide is in a class of medications called diuretics ('water pills'). It works by causing the kidneys to get rid of unneeded water and salt from the body into the urine. This information is taken from the website https://medlineplus.gov/druginfo/meds/a682858.html. 29843 6. For Resident #3 (R3), failed to clarify the physician's orders for the use of the PRN (as needed) pain medications of Oxycodone-Acetaminophen (1) 5-325mg (milligrams) and Oxycodone-Acetaminophen 5mg. R3 was admitted with diagnosis that included but not limited to chronic pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/07/2023, R3 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R3 was cognitively intact for making daily decisions. Section J Pain Management coded R3 as having occasional pain at a pain level of seven out of ten, with ten being the worse pain. The physician order for R3 documented in part, Oxycodone-Acetaminophen Oral Tablet 5-325 MG. Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain and Oxycodone Oral Tablet 5 MG. Give 1 tablet by mouth every 6 (six) hours as needed for pain. The eMAR (electronic medication administration record) for R3 dated December 2023 documented the physician's orders as stated above. The eMAR revealed that R3 received Oxycodone-Acetaminophen 5-325mg on 12/16/2023 at 5:27 a.m. with a pain level of six, 12/17/2023 at 5:40 a.m. with a pain level of seven, 12/20/2023 at 12:11 p.m. with a pain level of eight, 12/21/2023 at 5:01 a.m. with a pain level of five, 12/24/2023 at 8:32 a.m. with a pain level of eight, 12/27/2023 at 7:51 a.m. with a pain level of six and on 12/31/2023 at 5:35 a.m. with a pain level of eight. Further review of the eMAR revealed that R3 received Oxycodone 5mg on 12/11/2023 at 1:21 a.m. with a pain level of four; 12/13 at 8:17 p.m. with a pain level of seven; 12/15/2023 at 4:57 a.m. with a pain level of four; 12/22/2023 at 2:00 a.m. with a pain level of five and at 5:36 p.m. with a pain level of eight, 12/23/2023 at 5:19 p.m. with a pain level of seven and on 12/26/2023 at 4:32 p.m. with a pain level of seven. The eMAR (electronic medication administration record) for R3 dated January 2024 documented the physician's orders as stated above. The eMAR revealed that R3 received Oxycodone-Acetaminophen 5-325mg on 01/12/2024 at 8:26 p.m. with a pain level of nine, 01/15/2024 at 9:40 p.m. with a pain level of seven and on 01/16/2024 at 12:30 p.m. with a pain level of six. The eMAR revealed that R3 received Oxycodone 5mg on 01/09/2024 at 8:07 a.m. with a pain level of seven, 01/13/2024 at 1:11 a.m. with a pain level of seven; 01/14/2024 at 8:08 p.m. with a pain level of eight, 01/17/2024 at 10:19 a.m. with a pain level of seven, 01/19/2024 at 9:11 p.m. with a pain level of nine, 01/20/2024 at 7:30 p.m. with a pain level of six, 01/21/2024 at 4:08 p.m. with a pain level of seven and on 01/31/2024 at 9:30 a.m. with a pain level of seven. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's progress notes for R3 dated 12/01/2023 through 01/31/2024 failed to evidence documentation of the physician being notified for clarification of the administration of Oxycodone-Acetaminophen (1) 5-325mg and Oxycodone-Acetaminophen 5mg. The comprehensive care plan for R3 dated 12/21/2016 with a revision on 06/21/2023 documented in part, Focus. (R3) has alteration in pain/comfort AEB (as evidenced by) reports of pain/neuropathy hip pain. Revision on: 06/21/2023. Under Interventions it documented in part, Administer medications as ordered. Date Initiated: 01/15/2018. On 02/05/24 at approximately 11:38 a.m., an interview was conducted with R3. When asked if the staff attempt non-pharmacological interventions before administering the prn pain medication, R3 stated that the nurse gives the pain medication and do not try to alleviate the pain by other methods. On 02/07/24 at approximately 1:53 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding an order for two prn pain medications. When asked how a nurse determines which prn pain medication to administer when the physician has ordered two of them. LPN #5 stated the order should have parameter or indicator as to which medication to administer and the order would have to clarified with the physician. The facility's policy Administering Medications documented in part, 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns. 28. If a resident uses PRN medications frequently, the Attending Physician and Interdisciplinary Care Team, with support from the Consultant Pharmacist as needed, shall reevaluate the situation, examine individual needs, determine if there is a clinical reason for the frequent PRN use, and consider whether a standing dose of medication is clinically indicated. On 04/07/2024 at approximately 4:45 p.m., ASM (administrative staff member) #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #5, vice president of risk management, were informed of the above findings. No further information was provided prior to exit. References: (1) Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/ 29125 5. For Resident #54, the facility staff failed to obtain weekly weights as ordered. A review of the clinical record revealed a physician's order dated 10/17/23 for weekly weights every Tuesday. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the weight log revealed that the resident weighed 162.2 pounds on admission on 7/12/23. The most recent weight was on 1/9/24 and was 155.8 pounds. Between the two, the resident had weight fluctuations. Further review of the clinical record revealed that weights were missing the weeks of 10/24/23, 11/7/23, 11/28/23, 12/19/23, 1/16/24, 1/23/24, and 1/30/24. On 2/7/24 at 1:07 PM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that weights should be obtained as ordered. She stated that the resident may refuse it but that should be documented. She stated that if it is not documented we don't know that it was done. A review of the comprehensive care plan revealed one dated 7/21/23 for The resident has potential nutritional problem r/t (related to) COPD (chronic obstructive pulmonary disease) dementia, HTN (hypertension), alcohol abuse. An intervention dated 7/21/23 documented, Weights as ordered/indicated. On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided.

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on observation, staff interview, and clinical record review, the facility staff failed to implement communication techniques to maintain a resident's highest level of quality of life for one of 68 residents in the survey sample, Resident #145. The findings include: For Resident #145 (R145), the facility staff failed to utilize the resident's communication board to promote the most effective communication and highest quality of life. R145 was admitted to the facility on [DATE] with a diagnosis of [NAME] de [NAME] syndrome (1). Review of R145's clinical record revealed a psychosocial evaluation dated 12/4/23 that documented, Community Life Considerations: 4. Adaptations to communication needed to participate in activities? PICTURE BOARDS WILL BE HELPFUL. R145's comprehensive care plan dated 12/4/23 failed to document information regarding communication. A speech therapy evaluation dated for the certification period of 1/1/24 through 1/30/24 documented, Pt (Patient) is nonverbal at baseline and with hx (history) of [NAME] De Language [sic] syndrome . Communication: Ability to Understand Others= Sometimes understands; Follows 1-Step Directions= Usually, with prompts/cues; Makes self understood=Rarely/Never understood. Speech Clarity=Unclear Speech . Reason for Therapy Severe cognitive communication deficits characterized by minimal verbalization, some vocalizations; able to point to pictures in books . A speech therapy discharge summary dated 1/29/24 documented, SLP (Speech Language Pathologist) educated on AAC (augmentative and alternate communication) board, expressive communication abilities/preferences, strategies to increase functional communication between pt and staff . On 2/5/24 at 9:27 a.m., R145 was observed lying in bed. The resident verbalized sounds such as, ca, ca, ca and ugh, ugh. On 2/5/24 at 11:14 a.m., 2/5/24 at 12:25 p.m., and 2/5/24 at 4:54 p.m., R145 was observed in bed. Staff were observed interacting with R145 however a communication board was not used. On 2/6/24 at 2:11 p.m., an interview was conducted with CNA (certified nursing assistant) #21 (a CNA who routinely cared for R145). CNA #21 stated she didn't think R145 could communicate but he says, mama when his mother is present. CNA #21 stated R145 is nonverbal, moves around a lot, and performs gestures but she can't understand the gestures. CNA #21 stated there isn't a way to communicate with R145, but she checks on the resident a lot, feeds him, changes his brief, and gives him a toy that he sometimes throws. (continued on next page)

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F 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/24 at 10:30 a.m., an interview was conducted with OSM (other staff member) #18 (a speech language pathologist who treated R145). OSM #18 stated when R145 was admitted , he was marked as non-verbal with aphasia (a comprehension and communication disorder) but after communicating with him, she realized he knows some sign language and will attempt to say words that are approximately correct (such as trying to say spoon, but it sounds like boo). OSM #18 stated that through further discussion with R145's mother, she created a communication board that contained a highlighted list of R145's preferred items, and basic wants and needs such as if R145 is hungry, thirsty, wants to get out of bed, and if he is in pain. OSM #18 stated she has educated staff on the use of the communication board, but she does not see staff using the board. In regard to the importance of communication and how it impacts residents' quality of life, OSM #18 stated every single human is given the right, naturally and federally, to have access to communication and to express their wants, needs, ideas, medical information and pain. OSM #18 stated communication is important because it increases opportunities to facilitate socialization and because residents are being taken care of by staff and need to be able to expressively communicate any needs to them. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, Communication Strategies documented specific strategies for residents with dementia. R145 did not have a diagnosis of dementia. Reference: (1) [NAME] de [NAME] syndrome (CdLS) is a developmental disorder that affects many parts of the body. The severity of the condition and the associated signs and symptoms can vary widely, but may include distinctive facial characteristics, growth delays, intellectual disability and limb defects. This information was obtained from the website: https://rarediseases.info.nih.gov/diseases/10109/[NAME]-de-[NAME]-syndrome

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 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 assistance to maintain ADL (activities of daily living) abilities for two of 68 residents in the survey sample, Residents #45 and #55. The findings include: 1. For Resident #45 (R45), the facility staff failed to provide assistance with toileting/incontinence care as needed during the night shift on 1/2/24, 1/4/24, 1/6/24-1/9/24, 1/11/24-1/16/24, and 1/18/24-1/31/24, 2/1/24 and 2/1/24-2/5/24. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/14/2023, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating that the resident was cognitively intact for making daily decisions. The assessment documented R45 requiring supervision with toileting and toilet transfers. Section H documented R45 being frequently incontinent of bowel and bladder. On 2/4/2024 at 3:14 p.m., an interview was conducted with R45. R45 stated that they had problems making it to the bathroom in time during the night and frequently had incontinent episodes. R45 stated that they had to wait long times for staff to assist them to get changed after having an incontinent episode and had certain staff that they knew they could count on to help them and others not as much. She stated that the call bell was not answered timely and she normally had to wait at least an hour after asking to get cleaned up. Review of the ADL documentation for R45 dated 1/1/2024-1/31/2024 for B&B- Bladder function failed to evidence care provided on the following 26 dates during night shift: - 1/2/24, 1/4/24, 1/6/24-1/9/24, 1/11/24-1/16/24, and 1/18/24-1/31/24. Review of the ADL documentation for R45 dated 2/1/2024-2/29/2024 for B&B- Bladder function failed to evidence care provided on the following 5 dates during night shift: - 2/1/24-2/5/24. The comprehensive care plan for R45 documented in part, [Name of R45] has episodes of bowel and bladder incontinence r/t (related to) confusion, impaired mobility. Date Initiated: 06/12/2023. Under Interventions it documented in part, . Clean peri-area with each incontinence episode . The care plan further documented, [Name of R45] has an ADL self-care performance deficit r/t factors which include COPD (chronic obstructive pulmonary disease), OA (osteoarthritis), CKD (chronic kidney disease), DM (diabetes mellitus) with diabetic retinopathy, and neuropathy. Date Initiated: 06/01/2023. Under Interventions it documented in part, .Toilet Use: The resident is able to perform independently. May require staff assist x 1 during episodes of incontinence. Date Initiated: 06/12/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. Building B. Wing	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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 0676

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 2/5/2024 at 6:37 a.m., an interview was conducted with CNA (certified nursing assistant) #9. CNA #9 stated that they were often the only CNA assigned on the night shift and had recently switched shift because of this. She stated that when this happened she started on one end and worked room to room prioritizing changing residents and giving showers. She stated that she found it hard to get things done and residents did complain about having to wait for her but she did the best that she could.

On 2/6/2024 at 1:10 p.m., an interview was conducted with CNA #10. CNA #10 stated that residents were checked every two hours for incontinence care and if they were short staffed she checked them when she came on her shift, again after lunch or before she left for the day. She stated that they evidenced the care they provided by documenting it in the ADL's.

The facility policy Activities of Daily Living dated 2/1/2022 documented in part, Policy: To encourage resident choice and participation in activities of daily living (ADL) and provide oversight, cuing and assistance as necessary. ADLs includes bathing, dressing, grooming, hygiene, toileting and eating . CNA (certified nursing assistant) will provide needed oversight, cuing or assistance to resident. CNA will report any changes in ability or refusals to the nurse .

On 2/7/2024 at 2:00 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the concern.

No further information was provided prior to exit.

2. For Resident #55 (R55), the facility staff failed to assist with dressing. R55 was observed wearing the same t-shirt from 2/4/2024 through 2/6/2024.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/27/2023, the resident scored 4 out of 15 on the BIMS (brief interview for mental status) assessment, indicating that the resident was severely impaired for making daily decisions.

On 2/4/2024 at 2:35 p.m., an observation was made of R55 in the facility hallway in their wheelchair. R55 was observed wearing a red t-shirt with black lettering on it.

Additional observations of R55 were conducted on 2/4/2024 at 3:39 p.m., 2/5/2024 at 9:08 a.m., 11:59 a.m. and 3:38 p.m. and 2/6/2024 at 10:34 a.m. revealed R55 wearing the same red t-shirt with black lettering on it.

Review of the clinical record failed to evidence documentation of R55 refusing to change clothing on the dates documented above.

The comprehensive care plan for R55 documented in part, [Name of R55] has ADL deficits r/t (related to) CVA (cerebrovascular accident), T8 (thoracic) vertebral fracture, R rib fracture, CAD (coronary artery disease), disc degeneration, meningioma of brain. Date Initiated: 05/02/2023. Under Interventions it documented in part, . Dressing: [Name of R55] requires assistance by 1 staff to dress. Date Initiated: 05/02/2023 .

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER: Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 906 Thompson Street Ashland, VA 23005	

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/2024 at 1:10 p.m., an interview was conducted with CNA (certified nursing assistant) #10. CNA #10 stated that residents were encouraged to change their clothing every day. She stated that even if the resident was independent in dressing, if they were cognitively impaired she would encourage the resident to change clothes because of the confusion. She stated if the resident refused she would report it to the nurse because it was a behavior that needed to be reported. On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that residents should be encouraged to change their clothing every day. She stated that a couple of the dementia residents did try to put the same clothing on every day and the staff would remind them to change clothing. She stated that refusals to change clothing would be a behavior that would be documented and monitored. On 2/7/2024 at 2:00 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
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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. 32642 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for six of 68 residents in the survey sample, Residents #119, #39, #148, #75, #145, and #165. The findings include: 1. For Resident #119 (R119), the facility staff failed to provide incontinence care during the entire day shift on 2/4/24. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/27/23, R119 was coded as being cognitively intact for making daily decisions, and as being always incontinent of bowel and bladder. On 2/4/24 at 2:35 p.m., an interview was conducted with R119 who stated the facility staff does not take care of the patients. He stated: There is not enough staff, people go 16 or 17 hours without being changed. He stated he had not had his incontinence brief changed since 10:30 p.m. the night before (2/3/24). R119 agreed to allow the surveyor to observe his brief change. R119 traveled back to his room. CNA (certified nursing assistant) #14 was nearby, and stated she was assigned to R119 during that day shift. She stated: It is a little hectic when I am the only aide for 22 residents. No. I have not changed [R119] all day. I am still making my rounds. At 3:00 p.m., CNA #14 assisted R119 to position himself on the bed for incontinence care. CNA #14 removed the incontinence brief. The brief was full of both stool (smeared and dried) and urine. A review of R119's care plan dated 1/23/23 and updated 8/15/23 revealed, in part: [R119] has an ADL self-care performance deficit .Toilet use .the resident requires supervision to extensive assistance by one staff .[R119] has bowel and bladder incontinence. On 2/4/24 at 3:15 p.m., CNA #14 was interviewed. She stated she ordinarily does a walk through first thing when she arrives on the floor. She states she looks in each room to make sure all residents are safe. She stated she next tries to provide morning care to residents who like to get up and move around. She stated morning care includes washing the resident up, assisting them to get dressed, and to assist them to a bedside chair or wheelchair, all depending on the resident's preference. She stated after she serves and assists with feeding residents breakfast, she finishes morning care before lunchtime normally. After lunch, she provides incontinence care a second time for residents who need assistance. She stated on this day (2/4/24), she was assigned to 22 residents. She stated she had tried to get to all her residents at least once a shift, but had not yet gotten to R119. She stated she understood the risks of not providing incontinence care included skin breakdown or the development of urinary tract infections. She stated she was sorry she had not yet gotten to change R119. On 2/6/24 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the Market Lead, and ASM #5, the vice president of risk management, were informed of these concerns. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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	A review of the facility policy, Activities of Daily Living, revealed, in part: To encourage resident choice and participation in activities of daily living (ADL) and provide oversight, cueing, and assistance as necessary. ADLs include bathing, dressing, grooming, hygiene, toileting, and eating .CNA will provide needed oversight, cueing, or assistance to the resident .CNA will report any changes in ability or refusals to the nurse .CNA will document care provided in the medical record. No further information was provided prior to exit. 2. For Resident #39 (R39), the facility staff failed to provide evidence of bathing the resident on multiple days in January and February 2024. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/12/24, R39 was coded as being cognitively intact for making daily decisions. She was coded as requiring substantial/maximal assistance of staff for showering and bathing. On 2/8/24 at 2:10 p.m., R39 was observed sitting up in bed. When asked if the staff was providing her with consistent ADL (activities of daily living) care, she stated, No. They don't give me baths or showers. Not even in bed. She stated she hates to sit for hours in wet briefs, and would like to have a shower at least twice a week. She added: I don't think they have enough help to take care of us. A review of R39's clinical record, including ADL records and progress notes, revealed no documentation of a bath or shower of any kind, and no evidence that the resident refused a bath or shower, on all dates in January and February 2024 except the following dates: 1/2, 1/3, 1/4, 1/8, 1/9, 1/10, 1/11, 2/6. A review of R39's care plan dated 11/6/23 and updated 1/23/24 revealed, in part: [R39] has an ADL self-care deficit .Bathing/Showering: The resident requires substantial assistance by one staff with showering/bathing needs. On 2/7/24 at 12:58 p.m., CNA (certified nursing assistant) #8 was interviewed. She stated residents should get a bed bath every day, and a shower or tub bath twice a week. She stated all baths, whether bed, tub, or shower, are documented by the CNA in the electronic medical record. She stated if it is not documented, she cannot say it has been done. She stated if a resident refuses a bath or shower, she tells the nurse. On 2/7/24 at 1:40 p.m., LPN (licensed practical nurse) # 10 was interviewed. She stated the CNAs are responsible for making sure residents receive a bath. She stated if a resident refuses a bath, the CNA tells the nurse, and the nurse documents it in the electronic medical record. She stated if a resident refuses, she usually goes to the resident to try to determine the reason for the refusal, and to encourage the resident to receive a bath or shower. She stated if the CNAs do not document the bathing in the medical record, there is no way to say for certain the care occurred. On 2/8/24 at 4:22 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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	42183 3. For Resident #148, the facility staff failed to provide evidence of incontinence care. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 11/15/23, 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 bed mobility/transferring/toileting and set up for eating. A review of the comprehensive care plan dated 11/21/23 revealed, FOCUS: Resident has an ADL self-care performance deficit related to shortness of breath (SOB) and morbid obesity. INTERVENTIONS: The resident is totally dependent on 1 staff for toileting/incontinent care. The resident is totally dependent on 1 staff for repositioning and turning in bed. A review of the ADL (activities of daily living) documents from December 2023-February 2024 revealed the missing documentation for bladder incontinence care: December 2023- day shift: 12/8, 12/11, 12/15, 12/16, 12/25, 12/28, 12/30 and 12/31; evening shift: 12/7, 12/8 12/9, 12/10, 12/16, 12/17, 12/21, 12/22, 12/23, 12/25, 12/26, 12/30 and 12/31; night shift 12/8, 12/9, 12/10, 12/11, 12/18, 12/20, 12/22, 12/23, 12/24, 12/25, 12/26, 12/27, 12/30 and 12/31. January 2024-day shift: 1/1, 1/5, 1/8, 1/11, 1/12, 1/14, 1/19, 1/22, 1/23, 1/26, 1/27, 1/28; evening shift: 1/1, 1/4, 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/16, 1/18, 1/19, 1/20, 1/24, 1/25, 1/26, 1/27, 1/28 and 1/30; and night shift: 1/2, 1/3, 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/16, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30 and 1/31. February 2024-evening shift: 2/1, 2/2, 2/3, 2/4 and 2/5; night shift 2/1, 2/2, 2/3, 2/4 and 2/5. On 2/4/24 at approximately 2:00 PM, an interview was conducted with Resident #148. When asked about incontinence care, Resident #148 stated, Well, for instance last evening [2/3/24], I rang the call bell at 9:30 PM and the nurse came in at 10:00 PM. I told her I needed to be cleaned up and she said she would get help and be back. At 11:30 PM, I called again and she came back in and said they never came back, I said no and she was going to get someone. I did not get cleaned up till day shift. It was uncomfortable being wet that whole time. I did not feel good about it. Resident #148 stated, They are very short staffed here, they do not have enough aids to clean us up. On 2/5/24 at approximately 6:05 AM, an interview was conducted with CNA #4. When asked about providing incontinence care, CNA #4 stated, It is very short staffed here. I try to do my best but it is impossible to provide care to this many residents. I make rounds, but in addition to trying to provide incontinence care, am managing wanders, call lights and getting water/snacks for the residents. When asked if she had been able to provide incontinence care to Resident #148 on 2/3/24 night shift, CNA #4 stated, Not sure that I was able to. She usually lets us know. When asked where bladder incontinence care is documented, CNA #4 stated, on the ADL form. When asked how incontinence care can be evidenced if there is no documentation, CNA #4 stated, It cannot be. It probably was not done. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/24 at 7:00 AM, an interview was conducted with CNA #1. When asked about providing incontinence care, CNA #1 stated, we try to do rounds every two hours. When asked where bladder incontinence care is documented, CNA #1 stated, it is on the ADL form. When asked how incontinence care can be evidenced if there is no documentation, CNA #1 stated, It would just be documented on the form, if it was not documented, I guess it was not done. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. No further information was provided prior to exit. 4. For Resident #75, the facility failed to provide evidence of incontinence care. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/6/23, 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 requiring supervision for toileting/eating and independent for mobility/transfers. A review of the comprehensive care plan dated 10/24/19 revealed, FOCUS: Resident has bowel and bladder incontinence. INTERVENTIONS: Clean peri-area with each incontinence episode. A review of the ADL (activities of daily living) documents from December 2023-February 2024 reveals the missing documentation for bladder incontinence care: December 2023- day shift: 12/2, 12/3, 12/4, 12/5, 12/6, 12/7, 12/8, 12/9, 12/10, 12/11, 12/15, 12/16, 12/25, 12/28, 12/29, 12/30 and 12/31; evening shift: 1/2, 12/2, 12/3, 12/4, 12/5, 12/6, 12/7, 12/8 12/9, 12/10, 12/16, 12/17, 12/21, 12/22, 12/23, 12/25, 12/26, 12/27, 12/30 and 12/31; night shift 12/1, 12/3, 12/4, 12/5, 12/6, 12/8, 12/20, 12/22, 12/23, 12/24, 12/25, 12/26, 12/27, 12/30 and 12/31. January 2024-day shift: 1/1, 1/5, 1/8, 1/11, 1/12, 1/13, 1/14, 1/19, 1/22, 1/23, 1/24, 1/26, 1/27, 1/28; evening shift: 1/1, 1/9, 1/11, 1/12, 1/13, 1/14, 1/16, 1/18, 1/19, 1/20, 1/24, 1/25, 1/26, 1/27, 1/28, 1/30; and night shift: 1/1, 1/2, 1/4, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, 1/12, 1/13, 1/14, 1/15, 1/16, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23, 1/24, 1/25, 1/26, 1/27, 1/28, 1/29, 1/30 and 1/31. February 2024-evening shift: 2/1, 2/2, 2/3, 2/4 and 2/5; night shift 2/1, 2/2, 2/3, 2/4 and 2/5. Resident #75 did not verbalize any answers in multiple attempts to interview her on 2/5, 2/6 and 2/7/24. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/24 at approximately 6:05 AM, an interview was conducted with CNA #4 on Wing 2. When asked about providing incontinence care, CNA #4 stated, it is very short staffed here. I try to do my best but it is impossible to provide care to this many residents. I make rounds, but in addition to trying to provide incontinence care, am managing wanders, call lights and getting water/snacks for the residents. When asked where bladder incontinence care is documented, CNA #4 stated, on the ADL form. When asked how incontinence care can be evidenced if there is no documentation, CNA #4 stated, it cannot be. It probably was not done. On 2/5/24 at 7:00 AM, an interview was conducted with CNA #1 on Wing 2. When asked about providing incontinence care, CNA #1 stated, we try to do rounds every two hours. When asked where bladder incontinence care is documented, CNA #1 stated, it is on the ADL form. When asked how incontinence care can be evidenced if there is no documentation, CNA #1 stated, it would just be documented on the form, if it was not documented, I guess it was not done. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. No further information was provided prior to exit. 31753 5. For Resident #145 (R145), the facility staff failed to assist the resident out of bed. R145's comprehensive care plan dated 12/4/23 failed to document information regarding ADLs (activities of daily living). An occupational discharge summary dated 1/31/24 documented, Discharge Recommendations: Assist with ADLs, assist with transfers to WC (wheelchair) to allow for time OOB (out of bed). A physical therapy discharge summary dated 2/1/24 documented, Patient is tolerating his wheelchair and a [sic] propelling with supervision. CNA (Certified Nursing Assistant) ADL records for January 2024 and February 2024 failed to reveal documentation the CNAs assisted R145 with transfers. The ADLs documented the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity. On 2/4/24 at 2:55 p.m., 2/5/24 at 9:27 a.m., 2/5/24 at 11:14 a.m., 2/5/24 at 2:09 p.m., 2/5/24 at 4:54 p.m., 2/6/24 at 9:27 a.m., 2/6/24 at 11:18 a.m., and 2/6/24 at 2:01 p.m., R145 was observed lying in bed. On 2/6/24 at 2:11 p.m., an interview was conducted with CNA #21 (a CNA who routinely cared for R145). CNA #21 stated she has seen R145 in the wheelchair a few times and she has assisted R145 to the wheelchair a few times, once because staff had to change the resident's mattress. CNA #21 stated that since she has begun employment at the facility two months ago, no one has really gotten R145 up out of bed and she wasn't sure why. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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	On 2/7/24 at 12:47 p.m., an interview was conducted with OSM (other staff member) #14 (a physical therapist who treated R145). OSM #14 stated the CNAs should assist R145 out of bed with two-person assistance and the therapy staff made sure the CNAs were able to do that. OSM #14 stated he recently has not seen R145 out of bed except for one day during the previous week. OSM #14 stated there is no reason for R145 to stay in bed all day every day and the resident enjoys getting out of bed and propelling in the wheelchair. OSM #14 stated R145 does have some days when he doesn't want to cooperate but a majority of the time, R145 is willing to get out of bed. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. 42106 6. For Resident #165 (R165), the facility staff failed to provide consistent incontinence care in June 2023. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/15/2023, the assessment documented R165 requiring extensive assistance of one person with toileting and being frequently incontinent of bowel and bladder. Review of the ADL documentation for R165 dated 6/1/2023-6/30/2023 for B&B- Bladder function failed to evidence care provided on the following dates: - On day shift on 6/14/23, 6/20/23 and 6/25/23. - On evening shift on 6/10/23, 6/19/23 and 6/24/23. - On night shift on 6/10/23, 6/14/23, 6/17/23, 6/22/23, 6/23/23 and 6/25/23. R165 was discharged from the facility prior to the comprehensive care plan being completed. There was no baseline care plan regarding ADL care available for review. On 2/6/2024 at 1:10 p.m., an interview was conducted with CNA #10. CNA #10 stated that residents were checked every two hours for incontinence care and if they were short staffed she checked them when she came on her shift, again after lunch or before she left for the day. She stated that they evidenced the care they provided by documenting it in the ADL's. On 2/7/2024 at 2:00 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER: Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 906 Thompson Street Ashland, VA 23005	

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F 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide activities to meet all resident's needs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31753

Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide activities to meet residents' interests and needs for five of 68 residents in the survey sample, Residents #63, #93, #141, #145, and #167.

The findings include:

1. For Resident #63 (R63), the facility staff failed to provide the resident's preferred activities.

R63's comprehensive care plan dated 8/5/21 documented, (R63) is alert and verbal with confusion but is able to voice her wants and needs. She enjoys going outside for walks, snacks, listening to country music and being around other people at times. She also enjoys keeping to herself at times. She will be reminded and encouraged to engage with 1-3 OOR (out of room) activities of choice per week. Section F of R63's annual minimum data set assessment with an assessment reference date of 10/23/23 documented it was very important for the resident to listen to music and participate in religious services.

On 2/4/24 at 2:50 p.m., 2/5/24 at 9:20 a.m., 2/5/24 at 11:22 a.m., 2/5/24 at 2:04 p.m., 2/5/24 at 5:00 p.m., 2/6/24 at 9:30 a.m., 2/6/24 at 11:20 a.m., and 2/6/24 at 1:51 p.m., R63 was observed lying in bed. During these observations, the resident was not observed participating in any individual activities (including music).

On 2/6/24 at 3:00 p.m., an interview was conducted with OSM (other staff member) #15, the activities director. OSM #15 stated she completes a psychosocial assessment upon admission and completes section F of the minimum data set assessments to assess residents' desired activities. OSM #15 stated she tries to interview the residents but if she can't, she calls the families or talks to the nursing staff. OSM #15 stated residents' participation in activities should be documented as a group activity or a one-on-one activity in the residents' ADL (activities of daily living) records. OSM #15 stated it was hard for the activities staff to provide activities on the memory care unit because there are only two staff, including her, and she is busy keeping up with assessments and completing activities with other residents. OSM #15 stated R63 does not come out of the memory care unit, and she did not know what the resident's preferred activities were.

A review of R63's ADL records for January 2024 through February 2024 failed to reveal the resident participated in any group or individual activities.

On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern.

The facility policy titled, Community Life Overview documented, Community Life programming can enhance quality of life for residents by integrating meaningful and enjoyable activities into daily experiences. Center staff plans, coordinates, encourages, and supports a variety of recreational and Community Life for all residents based on individually identified needs, interests, culture, and background.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For Resident #93 (R93), the facility staff failed to provide the resident's preferred activities. R93's comprehensive care plan dated 4/28/22 documented, (R93) is alert and verbal and able to voice his wants and needs. He ambulates but may need to be reminded, encouraged, and assisted with direction to and from activities of choice. He prefers to walk constantly but needs to be reminded to rest. Introduce the resident to residents with similar background, interests and encourage/facilitate interaction. Invite the resident to scheduled activities. Section F of R93's annual minimum data set assessment with an assessment reference date of 4/30/23 documented it was somewhat important for the resident to have books, newspapers, and magazines to read, listen to music, do things with groups of people, and participate in religious services or practices. On 2/5/24 at 2:03 p.m., R93 was observed wandering in the hall. On 2/5/24 at 5:01 p.m., 2/6/24 at 9:31 a.m., and 2/6/24 at 11:20 a.m., R93 was sitting in a chair in the day/dining room. On 2/6/24 at 1:52 p.m., R93 was lying in bed. During these observations, the resident was not observed participating in any group or individual activities. On 2/6/24 at 3:00 p.m., an interview was conducted with OSM (other staff member) #15, the activities director. OSM #15 stated she completes a psychosocial assessment upon admission and completes section F of the minimum data set assessments to assess residents' desired activities. OSM #15 stated she tries to interview the residents but if she can't, she calls the families or talks to the nursing staff. OSM #15 stated residents' participation in activities should be documented as a group activity or a one-on-one activity in the residents' ADL (activities of daily living) records. OSM #15 stated it was hard for the activities staff to provide activities on the memory care unit because there are only two staff, including her, and she is busy keeping up with assessments and completing activities with other residents. OSM #15 stated she has not completed activities with R93, but she knew the resident doesn't sit long enough to engage in activities. OSM #15 stated in the past, staff has walked with R93. A review of R93's ADL records for January 2024 through February 2024 failed to reveal the resident participated in any group or individual activities. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. 3. For Resident #141 (R141), the facility staff failed to provide the resident's preferred activities. R141's comprehensive care plan dated 8/14/23 failed to reveal any documentation regarding activities. Section F of R141's admission minimum data set assessment with an assessment reference date of 8/20/23, documented it was very important for the resident to listen to music and go outside when the weather is good. On 2/5/24 at 9:24 a.m., and 2/5/24 at 11:22 a.m., R141 was sitting in a chair in the hall. On 2/5/24 at 2:06 p.m., and 2/5/24 at 5:02 p.m., R141 was sitting in the day/dining room. On 2/6/24 at 9:31 a.m., and 2/6/24 at 1:54 p.m., R141 was lying in bed. During these observations, the resident was not observed participating in any group or individual activities (including music). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/24 at 3:00 p.m., an interview was conducted with OSM (other staff member) #15, the activities director. OSM #15 stated she completes a psychosocial assessment upon admission and completes section F of the minimum data set assessments to assess residents' desired activities. OSM #15 stated she tries to interview the residents but if she can't, she calls the families or talks to the nursing staff. OSM #15 stated residents' participation in activities should be documented as a group activity or a one-on-one activity in the residents' ADL (activities of daily living) records. OSM #15 stated it was hard for the activities staff to provide activities on the memory care unit because there are only two staff, including her, and she is busy keeping up with assessments and completing activities with other residents. OSM #15 stated R141 enjoys watching television and meals/snacks. OSM #15 stated the resident does not do well with overstimulation. A review of R141's ADL records for January 2024 through February 2024 failed to reveal the resident participated in any group or individual activities. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. 4. For Resident #145 (R145), the facility staff failed to provide preferred activities. A psychosocial evaluation dated 12/4/23 documented R145 would like to regularly participate in hobbies or center activities, would prefer to do hobbies or activities in the activity room and outside, and preferred one on one, and group activities. R145's comprehensive care plan dated 12/3/23 failed to document information regarding activities. Section F of R145's annual minimum data set assessment with an assessment reference date of 12/19/23 documented it was somewhat important for the resident to listen to music, go outside when the weather is good, and participate in religious services or practices. On 2/4/24 at 2:55 p.m., 2/5/24 at 9:27 a.m., 2/5/24 at 11:14 a.m., 2/5/24 at 2:09 p.m., 2/6/24 at 9:27 a.m., 2/6/24 at 11:18 a.m., and 2/6/24 at 2:01 p.m. R145 was lying in bed. During these observations, the resident was not participating in any group or individual preferred activities; only the television was on. On 2/6/24 at 3:00 p.m., an interview was conducted with OSM (other staff member) #15, the activities director. OSM #15 stated she completes a psychosocial assessment upon admission and completes section F of the minimum data set assessments to assess residents' desired activities. OSM #15 stated she tries to interview the residents but if she can't, she calls the families or talks to the nursing staff. OSM #15 stated residents' participation in activities should be documented as a group activity or a one-on-one activity in the residents' ADL (activities of daily living) records. OSM #15 stated it was hard for the activities staff to provide activities on the memory care unit because there are only two staff, including her, and she is busy keeping up with assessments and completing activities with other residents. OSM #15 stated R145 has musical items such as a piano and guitar in his room, but he does not participate in group activities. A review of R145's ADL records for January 2024 through February 2024 failed to reveal the resident participated in any group or individual activities. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. For Resident #167 (R167), the facility staff failed to provide the resident's preferred activities. R167 was admitted to the facility on [DATE] and discharged on [DATE]. Section F of R167's admission minimum data set assessment with an assessment reference date of 7/28/23 documented it was very important for the resident to listen to music, keep up with the news, go outside when the weather is good, and participate in religious services or practices. R167's comprehensive care plan dated 8/15/23 documented, The resident is dependent on staff meeting emotional, intellectual, physical, and social needs. Cognitive deficits .Introduce the resident to residents with similar background, interests and encourage/facilitate interaction. Invite the resident to scheduled activities . On 2/6/24 at 3:00 p.m., an interview was conducted with OSM (other staff member) #15, the activities director. OSM #15 stated she completes a psychosocial assessment upon admission and completes section F of the minimum data set assessments to assess residents' desired activities. OSM #15 stated she tries to interview the residents but if she can't, she calls the families or talks to the nursing staff. OSM #15 stated residents' participation in activities should be documented as a group activity or a one-on-one activity in the residents' ADL (activities of daily living) records. OSM #15 stated it was hard for the activities staff to provide activities on the memory care unit because there are only two staff, including her, and she is busy keeping up with assessments and completing activities with other residents. OSM #15 was not employed in the activities department when R167 resided at the facility. A review of R167's ADL records for July 2023 through September 2023 failed to reveal the resident participated in any group or individual activities. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 31753 Based on staff interview and facility document review, the facility staff failed to ensure the activities program was directed by a qualified professional potentially affecting all residents in the facility. The findings include: The facility staff failed to ensure OSM (other staff member) #15, the director of activities, was qualified upon hire. A review of OSM #15's employee record revealed OSM #15 was hired as the director of activities on 10/12/23. On 2/6/24 at 3:00 p.m., an interview was conducted with OSM #15. OSM #15 stated she was previously employed as a CNA (certified nursing assistant) and supply/transportation coordinator, but on 10/12/23, she became the director of activities. OSM #15 stated she recently completed an activity management certification class from 1/15/24 through 1/19/24 and was not certified prior to then. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. On 2/8/24 at approximately 8:30 a.m., ASM #1 presented OSM #15's certificate that documented OSM #15 completed an activity management class 1/15/24 through 1/19/24. ASM #1 could not provide evidence that OSM #15 was qualified from 10/12/23 through 1/14/24. The job description for the director of activities documented, Education: Must possess, as a minimum, a Bachelor's Degree in therapeutic recreation or equivalent training/experience. National Certification Council for Activity Professionals (NCCAP) certification required; Applicants/employees that currently do not have the NCCAP certification will be provided a provisional 6 month period to complete that certification while they work. Experience: Must possess a minimum of two (2) years experience in therapeutic recreation. Supervision, training and/or experience in a setting serving the same age/type of resident served by this facility. The facility policy titled, Community Life Director documented, The role of the Community Life Director includes, but is not limited to: -Identification, implementation, supervision, management, and ongoing monitoring of recreational opportunities and Community Life to meet individualized resident interests and needs. -Management of space, equipment, and supplies for various activities. -Coordination and management of center Volunteer Services; identifying and working with community resources. -Coordination of Resident Council activities as approved by Resident Council. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Coordination of individual and group activities, encourages residents to form independent clubs for small group activities. -Development and display of a calendar for scheduled recreation and activity choices. This calendar should be placed at wheelchair height and may be hard copy or electronic. The calendar should include structured activities as well as the clubs available to the residents. -Documentation of resident participation in scheduled and non-scheduled activities. -Review of resident response to activities and revises approaches as indicated. -Coordination and/or direction of training for staff on integrating Community Life into daily care. -Building a sense of community within the center. -Champion of Culture Change and person directed care. A Community Life Director, in addition to the above requirements, has completed additional training and/or credentialing by an accredited body in therapeutic recreation services or a training course approved by the state and is licensed or registered by the state in which practicing if applicable.

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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.

32642

Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide care to promote the highest level of well-being for two of 68 residents in the survey sample, Residents #22 and #312.

The findings include:

1. For Resident #22 (R22), the facility staff failed to position a resident's fractured arm to promote comfort and safety.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/6/23, R22 was coded as being severely cognitively impaired for making daily decisions.

On the following dates and times, R22 was observed in her room, with her right harm hanging by her side. There was no sling or other positioning device visible on the resident's right arm at any of these observations: 2/4/24 at 2:33 p.m. and 5:23 p.m.; 2/5/23 at 8:53 a.m.

A review of R22's clinical record revealed the following nurses' notes:

12/14/23 at 9:29 p.m. Resident return (sic) from ortho (orthopedic) app (appointment at 6:15 p.m .'Resident has comminuted displaced periprosthetic fracture of right proximal humerus, decreased ROM (range of motion) and strength, fingers well perfused, radial pulse palpable, recommended she go back to see the surgeon who did her right shoulder replacement .for a revision or right total shoulder replacement. Resident can come out of sling for elbow and wrist ROM, can do pendulum exercises for right shoulder, no lifting/pulling, pushing with RUE (right upper extremity).

12/14/23 at 10:21 p.m. Resident has fracture of R shoulder, c/o (complained of) moderate pain throughout shift, pain level controlled via Tylenol or Ibuprofen .radial pulse palpable. Will continue to monitor resident for any changes in condition. (The nurse who wrote these progress notes was unavailable for interview at the time of the survey.)

A review of R22's physicians' orders revealed the following order dated 12/14/23: Resident can come out of sling for elbow and wrist ROM, can do pendulum exercises for right shoulder, no lifting/pulling, pushing with RUE (right upper extremity).

Further review of R22's clinical record revealed no escalation in the resident's pain medication needs or usage from 12/14/23. However, the record, including other physicians' orders, the care plan, the MARs, and TARs (medication administration records and treatment administration records) also failed to reveal any evidence of a sling or other positioning device to be used for R22's comfort or to prevent further damage to the fractured right arm. The review failed to reveal evidence of ROM exercises or pendulum exercises with R22.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/24 at 11:37 a.m., OSM #6, the occupational therapist, was interviewed. She stated she evaluated R22 after the shoulder fracture. She stated prior to the 12/14/23 X-ray revealing the shoulder fracture, the resident had decreased ROM in her right arm, and complained of pain after a couple of ROM exercise sessions. She stated she provided the resident a sling when the resident began to experience pain in her arm, and the resident was wearing a sling when the resident left for the 12/14/23 appointment with the orthopedist. She stated: I put her in the sling before she left. She stated she was hoping the orthopedist would provide the resident with a different sling to promote comfort and more optimal positioning of the left arm. She stated she was not aware that the resident was not currently wearing the sling, and was not aware of the orthopedist's recommendations for ROM and pendulum exercises. On 2/7/24 at 10:20 a.m., ASM (administrative staff member) #6, a nurse practitioner, was interviewed. She stated she was aware of R22's X-ray which was positive for a right shoulder fracture, and she sent her immediately to get an orthopedic consult. She stated the family declined a surgical consult due to the resident's age and condition. She stated she did not remember reviewing the resident's consultation report, and if she had, she would have ordered the sling, the ROM, and the pendulum exercises. She stated the resident has a black sling which she usually wears. She stated according to the orthopedic consultation report, the resident needed to continue to wear the sling, except for exercises, in order to prevent further damage and to promote better pain management. On 2/7/24 at 12:27 p.m., LPN (licensed practical nurse) #8 was interviewed. She stated she was assigned to R22 that day. She stated: I don't know very much about her. I was told something happened to her shoulder, but the family didn't want any follow up. Nobody has said anything to me about a sling. On 2/7/24 at 12:58 a.m., CNA (certified nursing assistant) #8, who was currently assigned to care for R22, was interviewed. She stated: I don't know anything about a sling for her. I haven't ever seen one in her room. On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. When asked to provide a policy on the use of slings, the facility staff provided the policy, Physician Orders. A review of this policy did not contain any information regarding specifically the use of a sling. No further information was provided prior to exit. 31753 2. For Resident #312 (R312), the facility staff failed to provide treatment per physician's order for the resident's right heel wound on 1/31/24 and 2/2/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R312's clinical record revealed a nurse's note dated 1/26/24 that documented the resident presented with a surgical wound on the right heel. A physician's order dated 1/29/24 documented to take down the wound vac, cleanse the right heel with wound cleanser, replace the wound vac with the settings at 125 continuous every Monday, Wednesday and Friday and as needed. R312's care plan dated 1/31/24 documented, The resident has diabetic ulcer of the right heel r/t (related to) diabetes. R312's January 2024 and February 2024 TARs (treatment administration records) documented the same physician's order. Further review of R312's TARs failed to reveal this treatment was completed on Wednesday 1/31/24 and Friday 2/2/24 (as evidenced by blank spaces on the TARs). Nurse's notes also failed to reveal documentation that the treatment was completed on those dates. On 2/7/24 at 12:30 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated physician's orders for wound treatments are communicated to nurses via the TARs and nurses sign the treatments off on the TARs to evidence the treatments were completed. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern.

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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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 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 for pressure injuries for five of 68 residents in the survey sample, Residents #41, #54, #312, #145, and #47. The findings include: 1. For Resident #41 (R41), the facility staff failed to provide pressure injury (1) treatment as ordered on 1/3/2024, 1/14/2024, 1/18/2024, 1/20/2024, 1/25/2024, 1/31/2024 and 2/2/2024, failed to set up an evaluation for the outpatient wound clinic as requested by the resident and in-house wound physician, and failed to evidence pressure injury assessments completed between 10/27/23-11/22/23, 11/22/23-12/20/23, 1/2/24-1/15/24 and 1/22/24-2/6/24. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/21/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment, indicating that the resident was moderately impaired for making daily decisions. The assessment documented R41 having one stage 3 pressure injury and two stage 4 pressure injuries. The assessment documented all of the pressure injuries were present upon admission. On 2/5/2024 at 8:41 a.m., an interview was conducted with R41 in their room. R41 stated that they had wounds on their backside that the nurses put dressings on. R41 stated that they thought they were supposed to change the dressings every day and most of the time they did but there were some nurses that did not do it. R41 stated that they used to see the wound doctor in the facility but they did not get along with them so they were waiting to go to someone outside for the wounds and the wound nurse did the treatments. On 2/6/2024 at 9:56 a.m., an observation was made of RN (registered nurse) #3, the wound nurse, providing treatment as ordered to R41's pressure injuries. RN #3 stated that they assessed R41's pressure injuries and measured them every Monday and documented the assessment in the medical record. The physician order's for R41 documented in part, - Left Ischium: cleanse with wound cleanser, apply barrier cream to the peri wound, apply honey fiber to the wound .assuring to pack the undermining at 9-10 o'clock areas with a cotton tipped applicator (honey side facing down), cover with a border foam every day shift every Mon, Tue, Wed, Thu, Fri for wound care. Order Date: 11/21/2023. - Left Ischium: cleanse with wound cleanser, apply barrier cream to the peri wound, apply honey fiber to the wound .assuring to pack the undermining at 9-10 o'clock areas with a cotton tipped applicator (honey side facing down), cover with a border foam every night shift every Sat, Sun for wound care. Order Date: 11/21/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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	- Right Ischium: cleanse with wound cleanser, pat dry, apply barrier cream to the peri wound, apply honey fiber to the wound .assuring to pack the undermining at 12 o'clock area with a cotton tipped applicator (honey side facing down), cover with a border foam every day shift every Mon, Tue, Wed, Thu, Fri for wound care. Order Date: 11/21/2023. - Right Ischium: cleanse with wound cleanser, pat dry, apply barrier cream to the peri wound, apply honey fiber to the wound .assuring to pack the undermining at 12 o'clock area with a cotton tipped applicator (honey side facing down), cover with a border foam every night shift every Sat, Sun for wound care. Order Date: 11/21/2023. - Sacrum: Apply barrier cream TID (three times a day) every shift for wound care. Order Date: 11/28/2023. Review of the eTAR (electronic treatment administration record) dated 1/1/2024-1/31/2024 failed to evidence treatment to the right and left Ischium completed on 1/14/2024, 1/20/2024, 1/25/2024 and 1/31/2024. The eTAR failed to evidence treatment to the sacrum on day shift 1/25/2024 and 1/31/2024, and on evening shift on 1/3/2024, 1/14/2024, 1/18/2024. Review of the eTAR dated 2/1/2024-2/29/2024 failed to evidence treatment to the right and left Ischium completed on 2/2/2024. The eTAR failed to evidence treatment to the sacrum on day shift 2/2/2024. Review of the wound physician provider notes from 10/1/23 to the present, documented pressure injury assessment and treatment completed on 10/4/23, 10/11/23, 10/18/23, and 11/22/23. A note dated 11/29/23 documented the resident not seen, 12/6/23 documented visit rescheduled due to COVID-19 outbreak in the facility and 12/13/23 documented visit rescheduled due to dressings changed earlier by wound nurse. A note dated 12/20/2023 documented Signing off on patient who remains in facility. Pt would like to go to a wound clinic. Sign off without visit- In house . Review of the facility Pressure Wound Ulcer Rounds from 10/1/23 to the present, documented pressure injury assessments completed on 10/27/23, 12/20/23, 12/29/23, 1/2/24, 1/15/24, 1/16/24, 1/22/24, and 2/6/24. The clinical record failed to evidence documentation of attempts to set up the referral to the wound clinic or assessments of the pressure injury between 10/27/23-11/22/23, 11/22/23-12/20/23, 1/2/24-1/15/24 and 1/22/24-2/6/24. The comprehensive care plan for R41 documented in part, [Name of R41] has pressure injuries: Stage 4 on the Right Ischium, Stage 4 on the Left Ischium; Stage 3 Sacrum; Date Initiated: 07/06/2023. Revision on: 09/12/2023. The care plan further documented, [Name of R41] has behaviors r/t (related to) PTSD (post traumatic stress disorder), Bipolar. Refuses medication/care . Date Initiated: 07/06/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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

On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the purpose of the care plan was to provide a baseline of the care that the resident received at the facility. She stated that the care plan should be implemented to provide the care. LPN #4 stated that wound care was evidenced by dating and initialing the dressings placed on the resident and by documenting the treatment as completed on the eTAR. She stated that there was a place on the eTAR that they documented if the resident refused the treatment.

On 2/7/2024 at 9:42 a.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated that wound care was evidenced by documenting that it was completed on the eTAR. She stated that if the resident refused the wound care it was documented on the eTAR in a progress note area. She stated that she measured R41's pressure injuries weekly on Mondays when she was working. She stated that R41 had stopped seeing the in-house wound physician back in December by their choice and requested to go to an outside wound clinic for evaluation. She stated that the staff member that was responsible for setting up appointments no longer worked at the facility and did not set up the appointment before they left. She stated that R41 had agreed to be seen by the new wound physician who was scheduled to begin that week rather than go to the outside wound clinic. She stated that she had worked at the facility for about 3 months and was trained that weekly pressure injury assessments were to be completed for all wounds and documented in the medical record. When asked about the dates without pressure injury measurements or assessments, she stated that there were dates when she was not working and there was no one in her place when she was not in the building but any RN could measure, stage and assess the pressure injury.

On 2/7/2024 at 2:00 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the concern.

The facility policy, Skin and Wound revised 1/24/2022 documented in part, Policy: To provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention and healing of pressure injuries . Document presence of skin impairment(s)/new skin impairment(s) when observed and weekly until resolved .

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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	2. For Resident #54, the facility staff failed to complete physician ordered weekly skin checks. A review of the clinical record revealed a physician's order dated 7/12/23 for weekly skin checks. Further review of the clinical record revealed that skin checks were not completed the weeks of 7/23/23 to 7/29/23, 8/27/23 to 9/2/23, 9/3/23 to 9/9/23, 10/29/23 to 11/4/23, 1/14/24 to 1/20/24. On 2/7/24 at 1:00 PM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that the checks should be done weekly. She stated that if it is not being done weekly, there is risk of potentially missing some skin issues. She stated that if the resident refuses, it should be documented. A review of the comprehensive care plan revealed one dated 8/25/23 for (Resident #54) has potential for pressure injury development r/t (related to) factors that include unspecified dementia, muscle weakness, and episodes of incontinence. An intervention dated 8/25/23 documented, Observe/document/report PRN (as needed) any changes in skin status. The facility policy, Skin Evaluation documented, A Licensed Nurse will complete a total body evaluation on each resident weekly, and prior to a hospital or other facility transfer/discharge, paying particular attention to any skin tears, bruises, stasis ulcers, rashes, pressure injury, lesions, abrasions, reddened areas and skin problems 1. A Licensed Nurse will complete a total body evaluation on each resident weekly and document the observation on the Skin Evaluation form On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided. 31753 3. For Resident #312 (R312), the facility staff failed to provide treatment for the resident's pressure injuries on multiple dates in January 2024 and February 2024. A review of R312's clinical record revealed a nurse's note dated 1/26/24 that documented the resident presented with an unstageable pressure injury (1) on the right lateral lower leg and a stage three pressure injury (1) on the left buttock. Physician's orders dated 1/26/24 documented to cleanse the right lateral lower leg with wound cleanser, apple nickel thick Santyl (used to treat wounds), and cover with a border gauze every day shift and as needed, and to cleanse the left buttock, pat dry, apply Greer's goo (used to treat wounds) to the periwound, apply medihoney, and cover with a border gauze every day shift and as needed. R312's baseline care plan initiated on 1/31/24 failed to document any information regarding pressure injuries. R312's January 2024 and February 2024 TARs (treatment administration records) documented the same physician's orders. Further review of R312's TARs failed to reveal the right lateral lower leg treatment was completed on 1/29/24, 1/31/24, 2/2/24, 2/3/24, and 2/4/24, and failed to reveal the left buttock treatment was completed on 1/29/24, 1/31/24, 2/2/24, 2/3/24, and 2/4/24 (as evidenced by blank spaces on the TARs). Nurse's notes also failed to reveal documentation that the treatment was completed on those dates. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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	On 2/7/24 at 12:30 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated physician's orders for pressure injury treatments are communicated to nurses via the TARs and nurses sign the treatments off on the TARs to evidence the treatments were completed. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. Reference: (1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (dead tissue). This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf 4. For Resident #145 (R145), the facility staff failed to provide treatment for the resident's pressure injury on multiple dates in January 2024 and February 2024. A nurse's note dated 12/3/23 documented R145 was admitted to the facility with a primary diagnosis of infection of a sacral decubitus (pressure injury). Treatment was initiated upon admission. R145's comprehensive care plan dated 12/3/23 documented, (R145) has stage IV pressure injury (1) and remains at risk for additional skin breakdown. Administer treatments as ordered . A physician's order dated 1/17/24 documented to cleanse the wound with wound cleanser, pack with Dakin's (antiseptic) soaked roll gauze, apply barrier cream to the periwound, and cover with a border foam every day shift and every evening shift. R145's January 2024 and February 2024 TARs documented the same physician's order. Further review of R145's TARs failed to reveal the sacrum treatment was completed during the day shift on 1/26/24, 1/29/24, and 2/1/24 through 2/4/24, and during the evening shift on 1/24/24 and 1/30/24 (as evidenced by blank spaces on the TARs). Nurse's notes also failed to reveal documentation that the treatment was completed on those dates. On 2/7/24 at 12:30 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated physician's orders for pressure injury treatments are communicated to nurses via the TARs and nurses sign the treatments off on the TARs to evidence the treatments were completed. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. Reference: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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	(1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf 32642 5. For Resident #47 (R47), the facility staff failed to clarify orders for pressure injury care. A review of R47's clinical record revealed the following orders: Cleanse L (left) lateral knee with wound cleanser. Apply Medi honey wound gel and dry dressing two times a day for wound care. Start Date 12/30/23 .D/C (discontinue) Date 1/14/24. Left lateral knee Cleanse with wound cleanser, pat dry, skin prep the periwound, apply nickel thick Santyl, cover with a border foam every day shift. Start Date 1/10/24. A review of R47's January 2024 MAR (medication administration record) and TAR (treatment administration record) revealed signatures indicating both of the wound care orders were followed on 1/10/24 through 1/14/24. A review of R47's care plan dated 12/30/23 and updated 2/5/24 revealed, in part: [R47] has pressure injury . Treatments as ordered. On 2/7/24 at 9:42 a.m., RN (registered nurse) #3, the wound care nurse, was interviewed. RN #3's initials indicated that the Santyl order had been followed on 1/10/24 through 1/14/24. After reviewing the two conflicting pressure injury orders and the MAR and TAR for January 2024, she stated: It looks like the Medihoney was not discontinued, and it should have been. The order should have been clarified. She stated the MAR and TAR looked like both treatments had been administered from 1/10/24 through 1/14/24, but she did not think that was possible. She stated it looked like a nurse signed of the treatment as given when she had actually not performed the treatment. On 2/7/24 at 12:27 p.m., LPN (licensed practical nurse) #8, the floor nurse taking care of R47, and who signed the January 2024 MAR as having administered the day shift Medihoney treatments from 1/10/24 through 1/14/24, was interviewed. She stated: I initiated the treatment of Medihoney [for the pressure injury]. The wound nurse went in behind me and wrote new wound orders. She did not dc my wound orders. She stated the MAR and TAR looked like a nurse signed of the treatment as given when she had actually not performed the treatment. On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. (continued on next page)

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Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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	No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024

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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 0687

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate foot care.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42183

Based on observations, resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide foot care for two of 68 residents in the sample Resident #166 and Resident #47.

The findings include:

1. For Resident #166, the facility failed to provide and/or arrange timely foot care.

Resident #166 was admitted to the facility on [DATE] with diagnosis that included but were not limited to Alzheimer's disease, dementia, and diabetes mellitus (DM).

A review of the progress note dated 3/15/23 at 6:10 PM revealed, Family would like resident to have toenails clipped.

A review of the progress note dated 3/29/23 at 3:25 PM, revealed Daughter spoke with writer this afternoon. She requested her mom's toenails be clipped and her heels cleaned. This writer reported request to nurse.

A review of the progress note dated 4/11/23 at 12:53 PM, revealed, Daughter requested her mom's toenails be clipped and her heels smoothed down. This writer had her placed on list for podiatrist appointment.

A review of the physician orders dated 5/11/23 revealed, Consult Podiatrist one time only. A review of the physician orders dated 6/6/23 revealed, Podiatry consult for thick nails.

A review of the progress note dated 6/20/23 at 4:38 PM, revealed, Resident back from podiatrist. No new orders, follow up appoint after 9 weeks.

A review of the consultation report for Resident #166 dated 6/20/23 revealed, Consulted for thick toenails. Onychomycosis nails, hammer toe and bunion. Debrided all toenails. Follow up in 9 weeks.

On 2/5/24 at 6:10 AM, an interview was conducted with LPN (licensed practical nurse) #1. When asked who provides nail care, LPN #1 stated, the CNAs provide nail care unless the resident is a diabetic then they are sent to a podiatrist.

On 2/5/24 at 7:00 AM, an interview was conducted with CNA (certified nursing assistant) #1. When asked who provides nail care, CNA #1 stated, it depends on if they are diabetic or have thick nails. If they do, then they go to a podiatrist, otherwise we cut their nails.

An interview was conducted on 2/7/24 at 12:50 PM with LPN #8. When asked who provides nail care, LPN #8 stated, if the resident is a diabetic, they are referred to a podiatrist. If not, nail care is provided by the CNAs when they get their shower.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No one at the facility including ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing or any unit manager was present at the time of this resident's request for podiatry care and could explain why it was not provided earlier. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. A review of the facility's Activities of Daily Living policy revealed, To encourage resident choice and participation in activities of daily living (ADL) and provide oversight, cuing and assistance as necessary. ADLs includes bathing, dressing, grooming, hygiene, toileting and eating. CNA will review the resident Kardex for information on individual care needs and preferences. CNA will provide needed oversight, cuing or assistance to resident. CNA will report any changes in ability or refusals to the nurse. CNA will document care provided in the medical record. No further information was provided prior to exit. 32642 2. For Resident #47 (R47), the facility failed to provide foot care in a manner to maintain clean feet. On 2/5/24 at 1:18 p.m., R47 was observed lying on her right side in bed. LPN (licensed practical nurse) #8 was at the bedside to provide wound care. The bottom of both R47's feet were dry and had large flakes of skin. When LPN #8 gently brushed the feet, the flakes of skin were easily removed. The areas between R47's toes were dry and scaly. LPN #8 stated: I think she could do with foot care. Her feet need to be washed with soap and water and lotioned. She added it looked like R47's feet had not been touched in several days. A review of R47's bathing records failed to reveal evidence that the resident received a scheduled bath or shower (or refused it) on 1/6/24, 1/17/24, 1/20/24, 1/24/24, 1/27/24, 1/31/24, and 2/3/24. On 2/7/24 at 12:58 p.m., CNA (certified nursing assistant) #8 was interviewed. She stated she makes certain to wash a resident's feet during the scheduled twice a week bath or shower. She stated if a resident refuses the bath or shower, she washes the feet during the bed bath. She stated she records all the bathing she provides a resident in the electronic medical record. She stated a resident's feet should be washed for infection control purposes, and to monitor the resident for any skin breakdown or other problems with the resident's feet. On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, 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 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

32642

Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement interventions to prevent a decrease in ROM (range of motion) for a resident's contractures for one of 68 residents in the survey sample, Resident #47.

The findings include:

For Resident #47 (R47), the facility staff failed to assess and implement interventions to prevent a decrease in ROM for the resident's bilateral leg contractures.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/10/23, R47 was coded as being severely cognitively impaired for making daily decisions. She was coded as being completely dependent on staff for moving in the bed, and as being impaired on both sides for lower extremity range of motion.

On the following dates and times, R47 was observed lying on her side in bed, with both legs severely contracted at the knees: 2/4/24 at 2:36 p.m. and 5:55 p.m.; 2/5/24 at 8:41 a.m., 11:58 a.m., and 1:18 p.m. There were no positioning pillows visible at any of these observations.

A review of R47's clinical record, including orders, progress notes, therapy notes, and care plan (dated 8/4/20 and updated 11/18/22) failed to reveal a current assessment of R47's leg contractures or interventions to prevent the contractures from worsening.

On 2/6/24 at 10:30 a.m., OSM (other staff member) #19, (the director of rehab and a physical therapy assistant), was interviewed. She stated the rehab staff works closely with the MDS nurses to determine which residents need to be assessed for services. She stated if there is a referral from nursing or a decline in the resident's functioning, therapists will screen the residents. She stated: If there is nothing triggering or nothing mentioned in our quality of life meetings, we don't screen. She stated the therapy staff does not perform routine screenings on all residents. She stated R47 had been referred to occupational therapy on 1/31/24 to work on upper body ROM (range of motion) to mitigate contracture worsening. She stated she was not aware of any services provided for R47's leg contractures. When asked if she had observed R47's legs, she stated she had not, and added: We would hope that IDT (the interdisciplinary team) would have identified this.

On 2/6/24 at 11:26 a.m., OSM #14, the physical therapist, was interviewed. He stated he evaluates a resident based on an MDS screening or a nursing referral. He stated if he assesses a resident, he compares the resident with baselines and documents any declines/worsening in the resident's condition. When asked about R47's leg contractures, he stated the resident has had the contractures for a while, and that her baseline was some knee contractures for sure. He stated he was aware that the resident's comfortable position is 90 degree flexing in her knees. He added: She needs a few pillows to be positioned comfortably. He stated he could not provide any evidence that any current assessments had been completed or interventions had been put in place to prevent the contractures from worsening or to provide comfort for the resident.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Contractures, Prevention, revealed, in part: Each resident must be evaluated for need of contracture prevention procedures on admission, readmission, and as needed .Resident with inactive extremities should have range of motion exercises done to those extremities as part of their daily care .Residents who are unable to move themselves should be repositioned frequently .May use pillows, rolled towels, folded sheets or positioning devices to aid in positioning. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024

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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 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 29843

Based on observations, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide service to prevent accidents and hazards for six of 68 residents in the survey sample, Resident #162, #54, #21, #75, #111, #62.

The findings include:

1. For Resident #162 (R162), facility staff failed to complete a fall investigation following a fall on 08/30/2023.

R162 was admitted to the facility with diagnoses that included but were not limited to muscle weakness.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/20/2023, R162 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R162 was cognitively intact for making daily decisions.

The facility's Fall Risk Evaluation for R162 dated 04/13/2023 documented in part, History of falling (immediate of previous [within the last 6 months])? No. Category: No Risk.

The comprehensive care plan for R162 documented in part, Focus. (R162) is at risk for falls r/t (related to) Confusion, Deconditioning, Incontinence, Poor communication/comprehension, Psychoactive drug use, indwelling foley catheter. Under Interventions it documented, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.

The facility's progress note for R162 dated 08/30/2023 at 7:41 a.m. documented in part, During rounds staff observed resident knealing [sic] at bedside. Resident stated, I did not fall, I was trying to empty my foley. Neuro (neurological) checks are within normal limits. ROM (range of motion) within normal limits to all extremities, no c/o (complaint of) pain or discomfort noted. Resident assistance [sic] back in w/c (wheelchair). Educated on using call bell for assistance when needed. Resident is own RP (responsible party. NP (nurse practitioner) made aware.

The facility's Change in Condition SBAR (Situation Background Assessment Recommendation) form for R162 dated 08/30/2023 documented in part, A. Situation. 1. The change in condition, symptoms, or signs observed and evaluated are/is: Fall without injury. This started on: 8/30/2023.

On 02/07/2024 at approximately 2:00 p.m. a request was made to ASM (administrative staff member) #2, director of nursing, for the facility's fall investigation regarding R162's fall on 08/30/2023.

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NAME OF PROVIDER OR SUPPLIER: Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 906 Thompson Street Ashland, VA 23005	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/08/2024 at approximately 11:50 a.m., an interview was conducted with ASM #2. He stated that the facility did not have evidence of a fall investigation for R162. When asked to describe the procedure that is followed after a resident falls he stated that the nurse assess the resident, fills out the COC (change of condition), start the fall investigation, notify the MD (medical doctor), RP (responsible party) and then update the care plan at that time or at least put an intervention in place and review it the next morning at the morning meeting. When asked to describe the purpose of completing a fall investigation he stated that it was to find the root cause and put a proper intervention in place to prevent reoccurrence. When asked why the fall investigation was not completed for R162 ASM #2 stated he did not know what happened regarding why the investigation were not done. The facility's policy Fall Management documented in part, Overview: A fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. C. Post fall Strategies: 5. Update Care plan and Nurse Kardex with interventions. 7. Interdisciplinary Team to review fall documentation and complete root cause analysis. On 04/07/2024 at approximately 4:45 p.m., ASM #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #5, vice president of risk management, were informed of the above findings. No further information was provided prior to exit. 29125 2. For Resident #54, the facility staff failed to investigate falls to evaluate root causes and prevention for falls on 11/16/23 and 12/13/23. A review of the clinical record revealed a nurse's note dated 11/16/23 that documented, Resident had a fall today on 11/16/23. Resident was walking to his walker that was place beside his bed and fell without hitting his head. Resident fell on the floor matt that is placed on the floor. Resident has no injuries or bruising from the fall. Resident's vital signs are within normal limits, blood pressure a little high after the fall. Will continue to monitor residents' status post fall. Interventions that were put into place was to place the resident's walker closer to the bedside so that the resident has less increase of a fall happening. Further review revealed a nurse's note dated 12/13/23 that documented, Resident was walking in the hall without his walker writer asked him why he was walking without it he told writer to mind her business then he started taking things from the meds cart he was asked to please leave the med cart alone he stated (expletive) that meds cart he swung around trying to throw a cup of water at nurse and fell to the floor vss (vital signs) wnl (within normal limits) was witnessed via staff no injury noted no c/o (complaint of) pain or discomfort resident was assisted to his feet he refused to sit in w/c (wheelchair) provided he was assisted with walking down the hall to his room ROM (range of motion) wnl per base line resident stated he was not in pain sitting on the bed. (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 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 2/6/24 at 4:35 PM at the end-of-day meeting with ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing, a request was made for the fall investigations related to these falls.

On 2/7/24 at 9:00 AM, ASM #2 (Administrative Staff Member) the Director of Nursing, stated he was unable to find fall the investigations. He stated that there was no evidence the care plan was reviewed and revised.

On 2/7/24 at 1:02 PM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that after a fall the facility does a risk management and fall documentation. She stated that as the nurse she would investigate it and see what could have contributed to the fall, if there was a witness, if it was an unwitnessed fall and if the resident was not able to say if they hit their head, she activate neuro checks. She stated that if there was a witness, staff should talk to them and get their statement on what they saw. She stated that the fall should be reported as needing to be updated on the care plan.

On 2/7/24 at 1:31 PM, an interview was conducted with LPN #4, the unit manager. She stated that falls should be investigated for root cause and the care plan reviewed and revised. She stated that she was not aware of Resident #54's falls. She stated that it was not reported to her so that the care plan could be reviewed and revised.

On 2/8/24 at 11:50 AM, an interview was conducted with ASM #2. He stated that when a resident has a fall, the nurse assess the resident, fill out the change of condition form, start the fall investigation, notify the physician and the resident's responsible party and then the facility would update the care plan at that time or at least put an intervention in place and review it the next morning at the morning meeting. He stated that the purpose of the investigation was to find the root cause and put a proper intervention in place to prevent reoccurrence. He stated that he did not know what happened regarding why the investigations were not done. He stated that the MDS department does the care plans. He stated that usually when falls are discussed in morning meeting the MDS nurse brings a laptop to morning meeting and update the care plan at that time.

The facility policy, Fall Management documented, C. Post Fall Strategies: 1. Resident will be evaluated and post fall care provided. 2. Initiate Neurological checks as per policy or directed by physician order. 3. Notify the Physician and resident representative. 4. Re-evaluate fall risk utilizing the Post Fall Evaluation. 5. Update Care plan and Nurse Aide Kardex with intervention(s). 6. Initiate post fall documentation every shift for 72 hours. 7. Interdisciplinary Team to review fall documentation and complete root cause analysis. 8. Update plan of care with new interventions as appropriate. 9. Review resident weekly x 4.

On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided.

3. For Resident #21, the facility staff failed to investigate falls to evaluate root causes and prevention for falls on 10/12/23 and 10/31/23.

10/12/23:

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F 0689

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 10/12/23 that documented, Staff observed resident slid off the bed in an upright position. Resident did not hit her head. Neuro checks are within normal range .

A physician's progress note dated 10/12/23 documented, Resident is being assessed for change in condition per staff. The resident is currently sitting in the wheelchair. She is alert but nonverbal she is staring to the left side she is not following any commands at this time looks like she may be having a stroke Plan: Stroke send to ED (emergency department) for evaluation now.

11/1/23:

A nurse's note dated 11/1/23 documented, Resident reported to writer she had a fall last evening, bruise noted to right ischium. Resident reports mild discomfort. Resident noted ambulating on Wing 1 with rolling walker. NP (nurse practitioner, name) notified. Ordered STAT x-ray.

A second nurse's note dated 11/1/23 documented, Upon entering residents' room, swelling to right hip noticeable through clothing. Patient reported more pain to right hip, resident still able to move right leg .

A review of the hospital record status post this fall, dated 11/1/23 documented, .history of A-fib (atrial fibrillation) on Eliquis CT abdomen pelvis .1. soft tissue hematoma lateral to the right hip 2. No acute fracture or dislocation .

A review of the comprehensive care plan failed to reveal any evidence that Resident #21 had a fall care plan in place prior to 1/18/24.

On 2/6/24 at 4:35 PM at the end-of-day meeting with ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing, a request was made for the fall investigations related to these falls.

On 2/7/24 at 9:00 AM, ASM #2 (Administrative Staff Member) the Director of Nursing, stated he was unable to find fall the investigations. He stated that there was no evidence the care plan was reviewed and revised.

On 2/7/24 at 1:02 PM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that after a fall the facility does a risk management and fall documentation. She stated that as the nurse she would investigate it and see what could have contributed to the fall, if there was a witness, if it was an unwitnessed fall and if the resident was not able to say if they hit their head, she activate neuro checks. She stated that if there was a witness, staff should talk to them and get their statement on what they saw. She stated that the fall should be reported as needing to be updated on the care plan.

On 2/7/24 at 1:31 PM, an interview was conducted with LPN #4, the unit manager. She stated that falls should be investigated for root cause and the care plan reviewed and revised. She stated that Resident #21 was not on her unit at the time of the falls, and that she created the care plan on 1/18/24 after the resident had a fall on that date, when she went to review the care plan and realized there wasn't one.

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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 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 2/8/24 at 11:50 AM, an interview was conducted with ASM #2. He stated that when a resident has a fall, the nurse assess the resident, fill out the change of condition form, start the fall investigation, notify the physician and the resident's responsible party and then the facility would update the care plan at that time or at least put an intervention in place and review it the next morning at the morning meeting. He stated that the purpose of the investigation was to find the root cause and put a proper intervention in place to prevent reoccurrence. He stated that he did not know what happened regarding why the investigations were not done. He stated that the MDS department does the care plans. He stated that usually when falls are discussed in morning meeting the MDS nurse brings a laptop to morning meeting and update the care plan at that time. He stated that it would be correct to say Resident #21's care plan was not reviewed as there was no care plan for falls, that if it had been reviewed after a fall, it would have been identified that there was no fall care plan developed.

The facility policy, Fall Management documented, C. Post Fall Strategies: 1. Resident will be evaluated and post fall care provided. 2. Initiate Neurological checks as per policy or directed by physician order. 3. Notify the Physician and resident representative. 4. Re-evaluate fall risk utilizing the Post Fall Evaluation. 5. Update Care plan and Nurse Aide Kardex with intervention(s). 6. Initiate post fall documentation every shift for 72 hours. 7. Interdisciplinary Team to review fall documentation and complete root cause analysis. 8. Update plan of care with new interventions as appropriate. 9. Review resident weekly x 4.

On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided.

42183

4. Resident #75 did not have consistent interventions implemented to monitor her wander guard.

Resident #75 was admitted to the facility on [DATE] with diagnosis that included but were not limited to dementia, bipolar, and neurocognitive disorder with Lewy Bodies.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/6/23, 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 requiring supervision for toileting/eating and independent for mobility/transfers. Section P: Restraints/Alarms Wander/elopement: daily use.

A review of the comprehensive care plan dated 5/6/18 revealed, FOCUS: Resident is an elopement risk/wanderer. INTERVENTIONS: Electronic monitoring device, check for placement and function as ordered.

On 2/5/24 at 6:30 AM, Resident #75 was observed with wander guard to right ankle.

A review of the physician orders dated 3/13/22 revealed, Wander guard check every shift for placement.

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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 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A review of the physician orders dated 10/17/23 revealed, Wander guard check function daily, night shift.

A review of the Elopement Risk Evaluation dated 5/7/23 and 10/16/23, Resident is determined to be AT RISK for elopement.

A review of the TAR (treatment administration record) from October 2023-February 2024 revealed missing Wander guard check function daily, night shift and Wander guard check every shift for placement documentation:

October 2023: Wander guard check every shift for placement: Day shift: 10/8, 10/17 and 10/31.

November 2023: Wander guard check function daily, night shift: 11/12. Wander guard check every shift for placement: Day shift: 11/1, 11/3, 11/9; Evening shift: 11/3, 11/10 and 11/24 and night shift 11/12.

December 2023: Wander guard check function daily, night shift: 12/16, 12/17, 12/30 and 12/31. Wander guard check every shift for placement: Day shift: 12/10, 12/12 and 12/26; evening shift: 12/15, 12/17 and 12/28; night shift 12/16, 12/17, 12/30 and 12/31.

January 2024: Wander guard check function daily, night shift: 1/2/24, 1/4/24 and 1/9. Wander guard check every shift for placement: Day shift: 1/12 and 1/13; evening shift 1/12 and night shift 1/2/24 and 1/4/24.

February 2024: Wander guard check every shift for placement: Day shift: 2/1 and evening shift 2/3.

On 2/5/24 at 6:10 AM, an interview was conducted with LPN (licensed practical nurse) #1, when asked how do you evidence that you are monitoring a wander guard placement, LPN #1 stated, they document that we are checking the placement of it every shift on the TAR. When asked if there is no documentation on the TAR, what does that indicate, LPN #1 stated, it means that it was not checked.

An interview was conducted on 2/7/24 at 12:50 PM with LPN #8, when asked how do you evidence that you are monitoring a wander guard placement, LPN #8 stated, it is documented on the TAR. When asked if there is no documentation on the TAR, what does that indicate, LPN #8 stated, it means that it was not done.

On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns.

A review of the facility's Elopement/Wandering Risk Guidelines policy reveals, To evaluate and identify patient/residents that are at risk for elopement and develop individualized interventions. If a patient/resident is identified as being at risk complete an Elopement Risk Alert and obtain a photograph. Initiate individualized interventions based on Patient/Residents' risk. Document individualized interventions in the patient/resident Care Plan and Kardex. If utilizing a wander monitoring system device check placement of the device every shift and functionality every day. Maintain the Elopement Risk Alerts in an easily accessible location.

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NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. 5. Resident #111 did not have consistent interventions implemented to monitor his wander guard. Resident #111 was admitted to the facility on [DATE] with diagnoses that included but were not limited to vascular dementia, PTSD (post-traumatic stress disorder). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/26/23, coded the resident as scoring a 12 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 GG-functional abilities and goals coded the resident as being independent for mobility/transfers and eating. Section P: Restraints/Alarms Wander/elopement: daily use. A review of the comprehensive care plan dated 7/3/22 revealed, FOCUS: Resident has behaviors related to wandering and exit seeking. INTERVENTIONS: Assess elopement risk. Wander guard as ordered. Check placement and function as ordered and as needed. On 2/4/24 at 4:00 PM and 2/5/24 at 9:00 AM, Resident #111 was observed with wander guard to RLE (right lower extremity) ankle. A review of the physician orders dated 7/31/22 revealed, Wander guard to RLE, check function daily, night shift. A review of the Elopement Risk Evaluation dated 2/5/23 and 5/6/23, Resident is determined to be AT RISK for elopement. A review of the TAR (treatment administration record) from October 2023-January 2024 revealed missing Wander guard to RLE, check function daily, night shift documentation: October 2023: 10/19, 10/23, 10/24, 10/25, 10/28, 10/29 and 10/30. November 2023: 11/3, 11/6, 11/11, 11/22 and 11/29. December 2023: 12/25. January 2024: 1/25. On 2/5/24 at 6:10 AM, an interview was conducted with LPN (licensed practical nurse) #1, when asked how do you evidence that you are monitoring a wander guard placement, LPN #1 stated, we document that we are checking the placement of it every shift on the TAR. When asked if there is no documentation on the TAR, what does that indicate, LPN #1 stated, it means that it was not checked. An interview was conducted on 2/5/24 at 9:48 AM with Resident #111. When asked if his wander guard on his ankle is checked, Resident #111 stated, sometimes they check it. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 2/7/24 at 12:50 PM with LPN #8, when asked how do you evidence that you are monitoring a wander guard placement, LPN #8 stated, it is documented on the TAR. When asked if there is no documentation on the TAR, what does that indicate, LPN #8 stated, it means that it was not done. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. No further information was provided prior to exit. 6. Resident #62 did not have consistent interventions implemented to monitor her wander guard. Resident #62 was admitted to the facility on [DATE] with diagnoses that included but were not limited to dementia. A review of the comprehensive care plan dated 5/6/18 revealed, FOCUS: Resident has impaired behaviors related to wandering. INTERVENTIONS: Check wander guard for function/placement/expiration as ordered and PRN (as needed). On 2/5/24 at 8:00 AM, Resident #62 was observed with wander guard to left ankle. A review of the physician orders dated 8/16/23 revealed, Wander guard to LLE (left lower extremity), check function daily, night shift. Wander guard check every shift for placement. A review of the Elopement Risk Evaluation dated 8/16/23, Resident is determined to be AT RISK for elopement. A review of the TAR (treatment administration record) from October 2023-February 2024 revealed missing Wander guard check function daily, night shift and Wander guard check every shift for placement documentation: October 2023: Wander guard check every shift for placement: Day shift: 10/24. November 2023: Wander guard check function daily, night shift: 11/23. Wander guard check every shift for placement: Evening shift: 11/15, 11/21 and 11/23 and night shift 11/15 and 11/23. December 2023: Wander guard check function daily, night shift: 12/16, 12/17, 12/30 and 12/31. Wander guard check every shift for placement: Day shift: 12/12 and 12/26; evening shift: 12/15, 12/17 and 12/28; night shift 12/16, 12/17, 12/30 and 12/31. January 2024: Wander guard check function daily, night shift: 1/2/24, 1/4/24 and 1/9. Wander guard check every shift for placement: Day shift: 1/12 and 1/13; evening shift 1/12 and night shift 1/2/24, 1/4/24 and 1/9/24. February 2024: Wander guard check every shift for placement: Day shift: 2/1 and evening shift 2/3. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/24 at 6:10 AM, an interview was conducted with LPN (licensed practical nurse) #1, when asked how do you evidence that you are monitoring a wander guard placement, LPN #1 stated, we document that we are checking the placement of it every shift on the TAR. When asked if there is no documentation on the TAR, what does that indicate, LPN #1 stated, it means that it was not checked. On 2/5/24 at 8:00 AM, an interview was conducted with Resident #62. When asked if his wander guard on her ankle is checked, Resident #62 stated, do they check it? I do not know. An interview was conducted on 2/7/24 at 12:50 PM with LPN #8, when asked how do you evidence that you are monitoring a wander guard placement, LPN #8 stated, it is documented on the TAR. When asked if there is no documentation on the TAR, what does that indicate, LPN #8 stated, it means that it was not done. On 2/9/24 at 12:50 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. 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. 32642 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement interventions to promote continence and/or provide indwelling catheter care for three of 68 residents in the survey sample, Residents #39, #93, and #61. The findings include: 1. For Resident #39 (R39), the facility staff failed to offer the resident the opportunity to transfer to the toilet for urination, to help her to become more continent of urine. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/12/24, R39 was coded as being cognitively intact for making daily decisions. She was coded as being always incontinent of urine. On the preceding MDS, an admission assessment with an ARD of 10/12/23, R39 was also coded as being incontinent of urine. On both assessments, she was coded as being completely dependent on staff for transferring from surface to surface, and as not having attempted to move from the bed to the toilet. A review of the clinical record, including all ADL (activities of daily living) records for January and February 2024, revealed R39 was incontinent of urine and not toileted on any occasion. This review failed to reveal evidence that a bladder retraining evaluation had been performed for R39. A review of R39's care plan dated 1/23/24 revealed, in part: [R39] has bowel and bladder incontinence .[R39] has an ADL self-care deficit .The resident is totally dependent on 1 staff for toileting/incontinence care .The resident requires Mechanical Lift with 2 staff assistance for transfers. On 2/8/24 at 10:52 a.m., CNA (certified nurse aide) #7 was interviewed. She stated she takes care of R39 on most days. She stated: [R39] is incontinent. She is [mechanical] lift right now. I can't transfer her safely to the toilet. She doesn't like the bedpan. She could use the toilet if I could get her there, but she needs the lift, so that's why we don't put her on the toilet. She added the lift sling available on the unit was not structured to allow for a resident to use the toilet while in the sling. On 2/8/24 at 2:10 p.m., R39 was interviewed. When asked about her urinary continence status, she stated she is usually aware when she needs to urinate, but the staff has not offered to help her get to the toilet. She stated she hates to sit in wet briefs while waiting to be changed. On 2/8/24 at 2:15 p.m., LPN (licensed practical nurse) #11 was interviewed. She stated if a resident is able to be toileted, then the staff should make sure the resident has that opportunity. She stated she did not know about the availability of a mechanical lift sling to accommodate a resident's toileting while utilizing the lift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/8/24 at 12:18 p.m., OSM (other staff member) OSM #15, the activities director, showed the survey team a mechanical lift sling that would accommodate a resident's toileting while being in the lift. She stated the lift was located on a different unit than R39, but was available to all staff all over the building. On 2/8/24 at 4:22 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Bowel and Bladder Re-Training, revealed, in part: A nurse will evaluate resident's bowel and bladder retraining potential upon admission, readmission and change of bowel or bladder function. Review the Bowel and Bladder Evaluation for risk factors to be considered during re-training. Review Bowel and Bladder Elimination Pattern Evaluation to identify patterns and trends that are specific to the resident .Educate resident on personalized bowel and/or bladder program .Review progress on a routine basis and adjust the toileting schedule as indicated. No further information was provided prior to exit. 31753 2. For Resident #93 (R93), the facility staff failed to address the resident's increase in urinary incontinence that was coded on the resident's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/31/23. R93's comprehensive care plan dated 6/1/22 documented, (R93) has bladder and bowel incontinence r/t (related to) confusion, encephalopathy, liver cirrhosis. Clean peri-area with each incontinent episode. Ensure the resident has has [sic] unobstructed path to the bathroom. Section H of R93's quarterly MDS assessment with an ARD of 7/31/23 coded the resident as occasionally incontinent of urine (less than seven episodes of incontinence during the seven-day look back period). Section H of R93's quarterly MDS with an ARD of 10/31/23 coded the resident as frequently incontinent of urine (seven or more episodes of urinary incontinence, but at least one episode of continent voiding during the seven-day look back period). A review of the look back period for the 7/31/23 MDS revealed R93 presented with six episodes of urinary incontinence from 7/25/23 through 7/31/23. A review of the look back period for the 10/31/23 MDS revealed R93 presented with 11 episodes of urinary incontinence from 10/25/23 through 10/31/23. Further review of R93's clinical record failed to reveal the increase in incontinence was addressed, or R93's care plan was reviewed and revised. On 2/6/24 at 10:00 a.m., an interview was conducted with RN (registered nurse) #4. RN #4 stated R93's BIMS (brief interview for mental status) changes almost daily because of the resident's alcoholic encephalopathy. RN #4 presented R93's following BIMS assessments: -A BIMS dated 9/23/23 that documented a score of 9 (indicating the resident's cognition was moderately impaired). -A BIMS dated 11/1/23 that documented a score of 11 (indicating the resident's cognition was moderately impaired). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A BIMS dated 1/29/24 that documented a score of 10 (indicating the resident's cognition was moderately impaired). RN #4 stated R93 has a bowel and bladder care plan and R93's level of needed assistance and level of incontinence varies. RN #4 stated R93 resides on the memory care unit for a reason, and it would be difficult to obtain a referral for therapy because the resident would not retain the information. RN #4 stated R93 could have been placed on a restorative program for toileting, but the facility does not have a toileting program per the Centers for Medicare and Medicaid Services Resident Assessment Instrument. On 2/6/24 at 10:24 a.m., another interview was conducted with RN #4 regarding the facility process for when a resident has a decline in urinary continence. RN #4 stated that if the resident has a stable BIMS, then the MDS coordinators notify the interdisciplinary team, discuss the matter, then place a referral for therapy or a restorative program. RN #4 stated due to R93's dementia, she would say the best the staff could do is to attempt a routine toileting time, but she did not know if that would work because of R93's cognition and behaviors. When asked if a routine toileting time had been attempted, RN #4 stated she did not have that information. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, Bowel and Bladder Re-Training documented, A Nurse will evaluate resident's bowel and bladder retraining potential upon admission, readmission and change of bowel or bladder function. -Review the Bowel and Bladder Evaluation for risk factors to be considered during re-training. -Review Bowel and Bladder Elimination Pattern Evaluation to identify patterns and trends that are specific to the resident. -Establish initial re-training schedule using identified patterns and times from the patterning evaluation, resident routines and mobility factors. -Use the Personalized Toileting Schedule to identify times to take resident to bathroom for toileting needs by checking the Re-Training box and checking the identified times to assist resident to the bathroom. -Educate resident on personalized bowel and/or bladder program. -Identify on the resident's care plan the bowel and/or bladder re-training program. -Review progress on a routine basis and adjust the toileting schedule as indicated. 29125 3. For Resident #61, the facility staff failed to obtain physician orders for care and services of a urostomy (1). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/05/24 at 1:36 PM, Resident #61 was observed in the bed. A urostomy tube was observed draining urine from the site on his abdomen down to a urinary collection bag. There was a dressing / bandage around the urostomy site. A review of the clinical record failed to reveal any orders for the care of a urostomy. On 2/7/24 at 1:07 PM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that she was not familiar with the resident but that residents with a urostomy should have orders for care of a urostomy. She stated that if there are not any orders, to call the physician. She stated that she would check for standing orders for the care and if not call the physician and get the orders activated as soon as possible. She stated they may say call the urologist if there is a specialist involved as well. On 2/7 at 1:54 PM an interview was conducted with LPN #8, who was familiar with the resident. She stated that there should have been an order for urostomy care. She checked the computer and stated, I don't see any. She stated, I know the nurses have changed the bag when it leaks and the site is observed during wound care. A review of the comprehensive care plan revealed one dated 8/2/23 for (Resident #61) has a Urostomy related to factors that include other artificial openings of urinary tract status. There were only two interventions, both dated 8/2/23, and were Observe/Document prn (as needed) for s/sx (signs and symptoms) of discomfort on urination and frequency. and Observe/record/report to MD (medical doctor) PRN for s/sx UTI (urinary tract infection). The facility policy, Suprapubic Catheter Care documented, Procedure: Obtain physicians orders Assess stoma site for drainage and inflammation Leave site open to air unless otherwise ordered by physician then apply clean gauze around insertion site and secure with tape On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided. Reference: (1) A urostomy surgery creates a stoma in your abdomen. The stoma is attached to a place in your urinary tract to let urine leave your body. You use a pouch, also called an ostomy bag, to collect the urine for disposal. https://my.clevelandclinic.org/health/treatments/22476-urostomy

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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.

29843

Based on observation, resident interview, staff interview, and clinical record review, it was determined that facility staff failed to provide respiratory care and services for six of 68 residents in the survey sample, Residents #72, #73, #46, #6, #41, and #148.

The findings include:

1. For Resident #72 (R72), the facility staff failed to store a mouthpiece for the nebulizer (1) in a sanitary manner.

R72 was admitted to the facility with diagnoses that included but were not limited to asthma (2).

On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/01/2023, R72 scored 6 out of 15 on the BIMS (brief interview for mental status), indicating R72 was severely impaired of cognition for making daily decisions.

On 02/04/24 an approximately 3:35 p.m., an observation of R72's bed side table revealed a mouthpiece for the nebulizer hanging off the table uncovered.

On 02/05/24 at approximately 8:28 a.m , an observation of R72's bed side table revealed a mouthpiece for the nebulizer hanging off the table uncovered.

The physician's order for R72 documented in part, Ipratropium-Albuterol (3) Inhalation Solution 3MG/3ML (three milligram/three milliliter). 3mg/ml inhale orally every 6 (six) hours as needed for SOB (shortness of breath).

On 02/05/2024 at approximately 4:20 p.m. an interview was conducted with LPN (licensed practical nurse) #8. When asked how the mouthpiece for a nebulizer should be stored when not being used, she stated it should be placed in a plastic bag for infection control. After observing R72's mouthpiece for the nebulizer hanging off the bed side table uncovered, LPN #8 stated that the mouthpiece should have been placed in a bag.

On 04/06/2024 at approximately 4:30 p.m., ASM (administrative staff member) #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM 4, lead for marketing and ASM #5, vice president of risk management, were informed of the above findings.

No further information was provided prior to exit.

References:

(1) A small machine that turns liquid medicine into a mist. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2) A disease that causes the airways of the lungs to swell and narrow. It leads to wheezing, shortness of breath, chest tightness, and coughing. This information was obtained from the website: https://medlineplus.gov/ency/article/000141.htm. (3) The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease and emphysema. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html. 2. For Resident #73 (R73), the facility staff failed to administer oxygen according to the physician's order, and store a BiPAP (Bi-level Positive Airway Pressure) (1) mask in a sanitary manner. R73 was admitted to the facility with diagnoses that included but were not limited to respiratory failure and sleep apnea. On the most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 12/07/2023, R73 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R73 was cognitively intact for making daily decisions. Section O Special Treatments, Procedures and Programs coded R73 for Oxygen therapy and BiPAP. On 02/04/24 at approximately 3:00 p.m., an observation of R73 revealed he was laying bed receiving oxygen (O2) by nasal cannula (2). Observation of the flow meter on the O2 concentrator (3) revealed a flow rate between four and 4.5 (four-and a-half) liters per minute. Observation of R73's over-the-bed table revealed a BiPAP mask on the table uncovered. On 02/05/24 at approximately 8:25 a.m., an observation of R73 revealed he was laying bed receiving O2 by nasal cannula. Observation of the flow meter on the O2 concentrator revealed a flow rate between four and 4.5 liters per minute. Observation of R73's over-the-bed table revealed a BiPAP mask on the table uncovered. Physician's order for R73 documented in part, Respiratory: Oxygen - continuous @ (at) 4L every shift. Order Date: 11/30/2023. Start date:12/01/2023 and BiPAP: Check placement and functioning every evening and night shift. Order Date: 12/03/2023. Start date:12/03/2023. The comprehensive care plan for R73 documented in part, Focus. (R73) has altered respiratory status/difficulty breathing r/t (related to) sleep apnea, chronic respiratory failure with hypoxia, hx (history) of pneumonia and bronchitis. Date Initiated: 12/08/2023. Under Interventions it documented in part, Oxygen settings via (by) NC (nasal cannula) as ordered. Date Initiated: 12/08/2023. On 02/06/2024 at approximately 4:15 p.m. an interview was conducted with LPN (licensed practical nurse) #8 regarding respiratory care and services. When asked how the flow meter on an oxygen concentrator is read to determine the amount of O2 a resident is receiving she stated that the liter line on the flow meter should pass through the middle of the float ball. When asked to describe the procedure for checking a resident's O2 she stated the O2 should be checked every shift and as needed. When asked how a resident's BiPAP mask should be stored when not in use LPN #8 stated they should be placed in a bag for infection control. After observing R73's flow meter on the oxygen concentrator LPN #8 stated R73 was receiving 4.5 liter of O2. After checking the physician's orders for R73 O2, she stated R73 should be receiving 4L/M. After informed of the above observations regarding the R73's BiPAP mask, LPN #8 stated they should have been placed in a bag. (continued on next page)

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 04/06/2024 at approximately 4:30 p.m., ASM (administrative staff member) #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM 4, lead for marketing and ASM #5, vice president of risk management, were informed of the above findings.

No further information was provided prior to exit.

References:

(1) A non-invasive form of therapy for patients suffering from sleep apnea. The air pressure keeps the throat muscles from collapsing and reducing obstructions by acting as a splint. BiPAP machines allow patients to breathe easily and regularly throughout the night. This information was obtained from the website: https://www.alaskasleep.com/blog/what-is-bipap-therapy-machine-bilevel-positive-airway-pressure.

(2) Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/nasal+cannula.

(3) Is a medical device that concentrates oxygen from environmental air and delivers it to a patient in need of supplemental oxygen. This information was obtained from the website: https://www.oxygenconcentratorstore.com/help-center/what-is-the-medical-definition-of-an-oxygen-concentrator/

3. For Resident #46 (R46), the facility staff failed to administer O2 (oxygen) according to the physician's order.

R46 was admitted to the facility with diagnoses that included but were not limited to respiratory failure.

On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/15/2024, R46 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R46 was cognitively intact for making daily decisions. Section O Special Treatments, Procedures and Programs coded R46 for Oxygen therapy.

On 02/05/24 at approximately 10:12 a.m., an observation of R46 revealed she was lying in bed receiving O2 (oxygen) by nasal cannula (1). Observation of the flow meter on the O2 concentrator (2) revealed a flow rate of four liters per minute.

Physician's order R46 documented in part, Oxygen at 4.5 LPM (four-and a-half liters) per minute) via (by) nasal cannula continuous every shift. Order Date: 01/24/2024. Start Date: 01/24/2024.

The comprehensive care plan for R46 documented in part, Focus. (R46) has oxygen therapy r/t (related to) CHF (congestive heart failure), respiratory failure. Date Initiated: 04/17/2023. Under Interventions it documented in part, Oxygen: O@ as ordered. Date Initiated: : 04/17/2023.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/06/2024 at approximately 4:20 p.m. an interview was conducted with LPN (licensed practical nurse) #8 regarding respiratory care and services. When asked how the flow meter on an oxygen concentrator is read to determine the amount of O2 a resident is receiving she stated that the liter line on the flow meter should pass through the middle of the float ball. When asked to describe the procedure for checking a resident's O2 she stated the O2 should be checked every shift and as needed. After observing R46's flow meter on the oxygen concentrator LPN #8 stated (R46) was receiving 4 liters of O2. After checking the physician's orders for R46's O2, she stated (R46) should be receiving 4.5L/M. On 04/06/2024 at approximately 4:30 p.m., ASM (administrative staff member) #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM 4, lead for marketing and ASM #5, vice president of risk management, were informed of the above findings. No further information was provided prior to exit. References: (1) Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/nasal+cannula. (2) Is a medical device that concentrates oxygen from environmental air and delivers it to a patient in need of supplemental oxygen. This information was obtained from the website: https://www.oxygenconcentratorstore.com/help-center/what-is-the-medical-definition-of-an-oxygen-concentrator/ 29125 4. For Resident #6, the facility staff failed to administer oxygen per the physician's order. On 2/4/24 at 2:53 PM, Resident #6 was observed in bed with the oxygen concentrator rate set at 3 liters per minute. When asked if he knew what his rate should be, he stated two to three liters. On 2/6/24 at 11:47 AM, Resident #6 was observed in bed with the oxygen concentrator rate at 3.5 liters per minute. Resident #6 stated that the staff changed it last night. A review of the clinical record revealed a physician's order dated 11/1/23 for Oxygen therapy 2LPM (liters per minute) via NC (nasal cannula) continuously every shift for COPD (chronic obstructive pulmonary disease). There were no orders to change the rate on or about 2/5/24, as the resident had indicated. On 2/7/24 at 1:08 PM an interview was conducted with LPN #7 (licensed practical nurse). She stated that Resident #6's oxygen rate was supposed to be two liters per minute. She stated that sometimes the resident will remove his oxygen or turn it off or unplug it but that she was not aware of him ever adjusting the rate himself. There were no nurse's notes identified that indicated the resident had ever self-adjusted the rate of his oxygen. (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 comprehensive care plan revealed one dated 8/25/20 for (Resident #6) has COPD; need HOB (head of bed elevated) d/t (due to) SOB (shortness of breath). An intervention dated 8/25/20 documented, Oxygen settings O2 (oxygen) via NC as ordered. A policy for administering oxygen per orders was requested. The policy provided, Physician Orders did not address oxygen or implementing the physician's orders. It only addressed accepting, transcribing, and documenting physician's orders. On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided. 42106 5. For Resident #41 (R41), the facility staff failed to store a nebulizer mask (1) in a sanitary manner when not in use. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/21/2023, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment, indicating that the resident was moderately impaired for making daily decisions. On 2/4/2024 at 2:24 p.m., an observation was made of R41's room. R41 was not in the room at the time. A nebulizer machine was observed on the nightstand to the right of R41's bed beside the window. The nebulizer tubing and a mask were observed to be attached to the nebulizer machine with the mask hanging from the side of the nightstand. The mask was observed to be open to air and uncovered. On 2/4/2024 at 4:47 p.m., an observation was made of R41 in their room. The nebulizer machine and uncovered nebulizer mask were observed sitting on the nightstand to the right of R41's bed beside the window. At this time an interview was conducted with R41 who stated that the nurses gave them medication in the nebulizer with the mask a couple of times a day. R41 stated that they were not sure how the nurses cared for the nebulizer mask or stored it and it was normally on top of the nightstand. Additional observations on 2/5/2024 at 8:28 a.m. and 12:00 p.m. revealed the nebulizer mask uncovered and open to air on the nightstand in R41's room. The physician order's for R41 documented in part, - Duoneb inhalation Inhaler 0.083%/0.017% (Albuterol/Atrovent) 1 inhalation inhale orally every 6 hours for Hypoxia Inhale 3ml (milliliter) via nebulizer as directed. Order Date: 1/31/2024. Review of the eMAR (electronic medication administration record) dated 2/1/2024-2/29/2024 documented the Duoneb nebulizer administered four times daily from 2/1/2024 through 2/5/2024. On 2/6/2024 at 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that nebulizers were rinsed out after each use, dried and stored in a plastic bag when not in use. She stated that this was done to keep them clean and not open to the air. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/2024 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the administrator market lead, and ASM #5, the vice president of risk management were made aware of the concern. The facility policy Nebulizer (small volume nebulizer) revised 3/20/2018 documented in part, . Procedure: . Disassemble device and rinse the mouthpiece and nebulizer cup with water and air dry. Place entire unit in a bag to be maintained in the resident's room . No further information was provided prior to exit. Reference: (1) A nebulizer is a small machine that turns liquid medicine into a mist. You sit with the machine and breathe in through a connected mouthpiece. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm 42183 6. For Resident #148, the facility staff failed to provide respiratory therapy per standard of care. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 11/15/23, 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 comprehensive care plan dated 11/21/23 revealed, FOCUS: Resident has an ADL self-care performance deficit related to shortness of breath (SOB) and morbid obesity . There was no mention of oxygen on the care plan. A review of the physician orders dated 11/8/23 revealed, Oxygen continuous at 2L (liters) via nasal cannula. A review of the November 2023-February 2024 MAR-TAR (medication administration record-treatment administration record) did not evidence any monitoring of oxygen flow rate. A review of the vital sign oxygen saturation sheet did not evidence monitoring of oxygen flow rate. An interview was conducted on 2/4/24 at approximately 2:00 PM, with Resident #148. When asked her oxygen rate, Resident #148 stated, It is at 2 liters. I get them to turn it down a little bit at a time to see if I can wean myself off. An interview was conducted on 2/7/24 at 12:50 PM with LPN (licensed practical nurse) #8. When asked how they evidence the oxygen rate for a resident, LPN #8 stated, it is documented on the MAR. An interview was conducted on 2/9/24 at 9:00 AM with LPN #5. When asked how they evidence the rate that oxygen therapy is being administered as ordered, LPN #5 stated, it is on the MAR. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/9/24 at 12:50 PM, ASM #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above 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 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. 29843 Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program for one of 68 residents in the survey sample, Resident #3. The findings include: For Resident #3 (R3), the facility staff failed to attempt non-pharmacological interventions prior to the administration of a prn (as needed) pain medications of Oxycodone-Acetaminophen 5-325mg (milligrams) and Oxycodone-Acetaminophen 5mg. R3 was admitted with diagnoses that included, but not limited to, chronic pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/07/2023, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R3 was cognitively intact for making daily decisions. Section J Pain Management coded R3 as having occasional pain at a pain level of seven out of ten, with ten being the worse pain. The physician order for R3 documented in part, Oxycodone-Acetaminophen Oral Tablet 5-325 MG. Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain and Oxycodone Oral Tablet 5 MG. Give 1 tablet by mouth every 6 (six) hours as needed for pain. The comprehensive care plan for R3 dated 12/21/2016 with a revision on 06/21/2023 documented in part, Focus. (R3) has alteration in pain/comfort AEB (as evidenced by) reports of pain/neuropathy hip pain. Revision on: 06/21/2023. Under Interventions it documented in part, Attempt non-pharmacological interventions PRN (as needed) - See Pain Flow Record. Date Initiated: 10/08/2018. The eMAR (electronic medication administration record) for R3 dated December 2023 documented the physician's orders as stated above. The eMAR revealed that R3 received Oxycodone-Acetaminophen 5-325mg with no evidence of non-pharmacological interventions being attempted on 12/20/2023 at 12:11 p.m. with a pain level of eight. Further review of the eMAR revealed that R3 received Oxycodone 5mg with no evidence of non-pharmacological interventions being attempted on 12/11/2023 at 1:21 a.m. with a pain level of four; 12/13 at 8:17 p.m. with a pain level of seven; 12/15/2023 at 4:57 a.m. with a pain level of four; and on 12/22/2023 at 5:36 p.m. with a pain level of eight. Further review of the December eMAR failed to document evidence of non-pharmacological interventions for the dates and times listed above. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The eMAR (electronic medication administration record) for R3 dated January 2024 documented the physician's orders as stated above. The eMAR revealed that R3 received Oxycodone-Acetaminophen 5-325mg with no evidence of non-pharmacological interventions being attempted on 01/12/2024 at 8:26 p.m. with a pain level of nine and on 01/15/2024 at 9:40 p.m. with a pain level of seven. The eMAR revealed that R3 received Oxycodone 5mg with no evidence of non-pharmacological interventions being attempted on 01/13/2024 at 1:11 a.m. with a pain level of seven; 01/14/2024 at 8:08 p.m. with a pain level of eight; 01/19/2024 at 9:11 p.m. with a pain level of nine and on 01/21/2024 at 4:08 p.m. with a pain level of seven. Further review of the January eMAR failed to document evidence of non-pharmacological interventions for the dates and times listed above. Review of the facility's Pain Flow Record for R3 dated December 2023 and January 2024 failed to evidence documentation of non-pharmacological interventions for the dates and times listed above on the eMARs. The facility's progress notes for R3 for the dates and times listed above on the eMARs dated December 2023 and January 2024 failed to evidence documentation of non-pharmacological interventions. On 02/05/24 at approximately 11:38 a.m., an interview was conducted with R3. When asked if the staff attempt non-pharmacological interventions before administering the prn pain medication, R3 stated that the nurse gives the pain medication and do not try to alleviate the pain by other methods. On 02/07/24 at approximately 1:53 p.m., an interview was conducted with LPN (licensed practical nurse) #5 regarding the administration of prn (as needed) pain medication. When asked to describe the procedure for administering prn pain medication to a resident LPN #5 stated she would attempt non-pharmacological intervention first, if it doesn't work she would ask the resident where pain is located, the severity of pain on a scale of zero to ten with ten being the worse pain, check the eMAR for the prn pain medication and document in the progress note stating what the medication was for an the non-pharmacological interventions that were attempted or that alleviated the resident's pain. The facility's policy Pain Management Guideline documented in part, Treatment: Develop patient centered interventions (pharmacological and non-pharmacological) to manage pain. Monitoring: Monitor and document the patient/resident's response to the interventions. On 04/07/2024 at approximately 4:45 p.m., ASM (administrative staff member) #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #5, vice president of risk management, were informed of the above findings. No further information was provided prior to exit. References: (1) Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 32642 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services for one of one residents receiving dialysis care, Resident #119. The findings include: For Resident #119 (R119), the facility staff failed to assess the resident's dialysis access site for bruit and thrill (1). On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/27/23, R119 was coded as being cognitively intact for making daily decisions. He was coded as receiving dialysis services. A review of R119's clinical record revealed the following order dated 8/21/23: [Name of dialysis center] Dialysis, transport at 10:00 a.m., chair time at 11:00 a.m., return pick up at 3:00 p.m. MWF (Monday, Wednesday, Friday). The review failed to reveal additional orders for or evidence of assessments of the resident's dialysis access site. A review of R119's care plan dated 1/23/23 and updated 6/19/23 revealed, in part: [R119] needs dialysis. The interventions did not include assessing the access site for bruit and thrill. On 2/5/24 at 8:30 a.m., R119 was interviewed. When asked if the nurses are assessing his dialysis access site consistently, he stated: No. Nobody even looks at it. I don't even know if they know what they are supposed to do. On 2/7/24 at 1:40 p.m., LPN (licensed practical nurse) #10 was interviewed. When asked what services she provides for a resident who receives dialysis, she stated she checks the dialysis communication book, provides ADL (activities of daily living) care if the resident needs it, and gives the resident any medications related to dialysis. When asked specifically about the resident's dialysis access site, she stated she would check for bleeding, bruit, and thrill. When asked how often these assessments needed to be performed, she stated they should be done each shift, just in case. She stated the resident has orders for these assessments and the nurse signs them off on the MAR or TAR (medication administration record or treatment administration record). She stated the only way to know if assessments are done is if the nurse signs them off. On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Care of Resident Hemodialysis, revealed, in part: Report signs of infection - observe for evidence of erythema, swelling, drainage, excessive tenderness. Report signs of thrombosis formation - in a healthy fistula a bruit can be heard over the venous side and a thrill can be palpated as arterialized blood flows through the vein. Absence of these signs may indicate clot development. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided before exit. References (1) Your access is your lifeline. You will need to protect your access. Wash the area around your access with soap and warm water every day. Check the area for signs of infection, such as warmth or redness. When blood is flowing through your access and your access is working well, you can feel a vibration over the area. Let your dialysis center know if you can't feel the vibration. This information is taken from the website https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/hemodialysis.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 42183

Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide trauma informed care for one of 68 residents in the sample Resident #111.

The findings include:

The facility failed to evidence provision of trauma informed care for Resident #111.

Resident #111 was admitted to the facility on [DATE] with diagnosis that included but were not limited to vascular dementia, PTSD (post-traumatic stress disorder), DM (diabetes mellitus) and COPD (chronic obstructive pulmonary disease).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/26/23, coded the resident as scoring a 12 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 GG-functional abilities and goals coded the resident as being independent for mobility/transfers and eating. Section P: Restraints/Alarms Wander/elopement: daily use.

A review of the comprehensive care plan dated 7/29/22 revealed, FOCUS: Resident has potential nutritional problem related to cerebral infarction, vascular dementia and PTSD. Resident has impaired cognitive communication function, related to dementia, behaviors and poor nutrition. INTERVENTIONS: RD (registered dietician to evaluate and make diet change recommendations as needed. Document/report as needed any changes in cognitive function, specifically changes in decision making ability, memory, recall/general awareness, difficulty expressing self or understanding others. There was no evidence of a trauma informed care plan for Resident #111.

A review of the facility's Psychosocial Evaluation dated 1/4/24 and 1/24/23 revealed, Have you ever been through anything life threatening or traumatic? Answer-when went to Vietnam. Are you aware of any particular 'triggers' that may make this worse for you? Answer-Messy roommates.

A review of the physician orders did not indicate any psychiatry consult or orders to monitor behavior.

A review of the MAR-TAR (medication administration record-treatment administration record) for October 2023-February 4, 2024, did not reveal any monitoring of behaviors.

A review of the medical record did not reveal any social services follow up regarding trauma informed care from 10/1/23-1/26/24.

A review of a facility synopsis of event with an incident date of 1/13/24 revealed, Resident #111 slapped Resident #129 on the left side of her face due to Resident #129 trying to open the back door. Residents separated .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the progress note dated 1/13/24 at 10:17 PM revealed, Writer heard alarm at the back door when headed down the hall resident was observed standing at the door when as well another resident headed up the hall leaving the door holding her face. Writer asked resident that was standing at the door why was she holding her face, he stated I smacked her because she keeps trying to open the door. Residents were separated and the aggressor was put on every 15-minute safety checks . A review of the progress note dated 1/14/24 at 8:57 PM revealed, The resident continues on every 15-minute safety checks related to hitting another resident. No behavioral issues noted today. A review of the physician's progress note dated 1/19/24 revealed, Past medical history-PTSD. Patient with past psychiatric history of MDD (major depressive disorder). Recommendations: Patient benefits from psychotropic medications as ordered. Approach the patient in a way that does not escalate distress or result in behavioral dysregulation. Maintain a quiet stress-free environment. A review of the social services progress note dated 1/24/24 at 11:47 AM revealed, Social Worker spoke to resident about him punching his roommate in the face on 1/23/24. The resident says he does not like a messy room. He says his roommate is nasty and leaves things all around all the time. He said it has been building up for some time now, and he finally got tired of it and punched him in the face. He says he will refrain from putting his hands on anyone else, what he did was wrong and has since been moved to another room. A review of the social services progress note dated 1/26/24 revealed, BIMS=12, Mood/Behavior/Emotional Status-no items checked, Current Behavior Status since last review (check all that are present) no items checked including hitting, biting, kicking. Referrals OT/PT/ST as needed. Psychology, Psychiatry, Podiatry and Dental as needed. An interview was conducted on 2/5/24 at 9:48 AM with Resident #111. When asked if he is provided with counseling for PTSD, Resident #111 stated, there is someone I talk with but I do not know if it is a counselor. An interview was conducted on 2/7/24 at 12:50 PM with LPN (licensed practical nurse) #8. When asked about trauma informed care for Resident #111, LPN #8 stated, not sure of any special care. When asked if she had received any education regarding trauma informed care, LPN #8 stated, no, I have not had any education. An interview was conducted on 2/7/24 at 1:15 PM with CNA (certified nursing assistant) #8. When asked about trauma informed care for Resident #111, CNA #8 stated, trauma informed care, it should be in the chart and on the care plan and the nurses would let us know. There has been no education on trauma informed care. An interview was conducted on 2/7/24 at approximately 1:50 PM with OSM (other staff member) #10, the director of social services. When asked what services are provided to a resident with a diagnosis of PTSD, OSM #10 stated, they would interview him, have a psych consult if needed and put it on the care plan. When asked how triggers would be identified and communicated with the nursing staff, OSM #10 stated, that is covered in the interview, I believe but will have to get back with you on that. No further information was provided from OSM #10, regarding Resident #111's PTSD triggers and plan of care. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 2/8/24 at 12:10 PM with ASM #2, the director of nursing. When asked who was responsible for implementing trauma informed care, ASM #2 stated, the social worker and staff development. On 2/8/24 at 4:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. A review of the facility's Trauma Informed Care policy, reveals, Residents will be evaluated to identify a history of trauma, triggers and cultural preferences. Resident-centered interventions are initiated based on the resident triggers and preferences to decrease the risk of re-traumatization. Residents are evaluated for trauma, triggers and cultural preferences on admission/re-admission, quarterly and annually. Develop resident-center interventions based on trauma triggers and resident cultural preferences. Develop a care plan and add interventions to the nurse aide Kardex. No further information was provided prior to exit.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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 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. **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 evidence bed rail requirements were completed prior to use for two of 68 residents in the survey sample, Residents #41 and #54. The findings include: 1. For Resident #41 (R41), the facility staff failed to obtain consent for the use of bed rails, and failed to assess the resident for bed rail use or evaluate for alternatives prior to use. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 12/21/2023, the resident scored 11 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. The assessment documented R41 having impairment to both upper extremities and requiring substantial/maximal assistance with bed mobility. On 2/4/2024 at 4:47 p.m., an observation was made of R41 in their room. R41 was observed in bed with bilateral upper bed rails in place on the bed. At this time an interview was conducted with R41. When asked if they used the bed rails, R41 stated that they did not use them but they were on the bed because they had seizures and they liked having them there. Additional observations of R41 in bed with the bilateral upper bed rails in place were made on 2/5/2024 at 8:41 a.m. and 2/6/2024 at 9:56 a.m. Review of the clinical record failed to evidence a bed rail assessment, order for bed rails, or consent for bed rail use. The most recent quarterly data collection assessment dated [DATE] for R41 documented no bed rail use. Review of the most recent maintenance bed inspections documented R41's bed with the bed rails inspected on 12/20/2023. The comprehensive care plan for R41 documented in part, [Name of R41] has an ADL (activities of daily living) self-care performance deficit r/t (related to) impaired balance, limited mobility . Date Initiated: 07/06/2023. Under Interventions it documented in part, . Bed Mobility: The resident is totally dependent on staff for repositioning and turning in bed. Date Initiated: 07/06/2023 . Review of the care plan failed to evidence bed rail use. On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that when a resident wanted to use bed rails or needed them the nurse got an order for them and got a consent from the resident or the family. She stated that there was a bed rail evaluation that was done on the consent form initially and then done quarterly. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/2024 at 8:44 a.m., ASM (administrative staff member) #2, the director of nursing, stated that they were unable to locate a bed rail assessment or consent for R41. The facility policy Side Rail/Bed Rail dated 4/19/2018 documented in part, Policy: The Center, will attempt alternative intervention, and document in the medical record, prior to the use of side rail/bed rail . Prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment. Review the risk and benefits with the resident and/or resident representative. Obtain consent from the resident and/or resident representative. Obtain physician order for side rail/bed rail. Update the care plan and kardex. Re-evaluate the use of side rail/bed rail, quarterly, with a change in condition or as needed . On 2/7/2024 at 2:00 p.m., ASM #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the concern. No further information was obtained prior to exit. 29125 2. For Resident #54, the facility staff failed to ensure a side rail assessment was in place that indicated the use of side rails was necessary, and failed to obtain an informed consent, prior to the use of side rails. On 2/4/24 at 3:30 PM and 2/5/24 at 9:23 AM, Resident #54 was observed in bed with bilateral half side rails up. A review of the clinical record revealed a Side Rail Evaluation dated 7/12/23 that documented, . Recommendations: 1. Side rails NOT indicated, 2. Side rails recommended, 3. Assist rail/grab bar . The box for Side rails NOT indicated was checked. There were no further side rail evaluations completed to indicate that side rails were indicated. There was no informed consent signed for the use of side rails that documented risks vs benefits for the resident. A review of the comprehensive care plan revealed that the resident was not care planned for the use of side rails. On 2/7/24 at 1:12 PM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that he has upper side rails. When asked if the resident had an evaluation to indicate he needs side rails, she stated that she was not sure. She stated that normally before they activate side rails they have them sign a permission form (consent). When asked if the use of side rails should be care planned, she stated, Yes. On 2/7/24 at approximately 5:00 PM at an end-of-day meeting, the Administrator (ASM #1 - Administrative Staff Member) and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure required physician visits for two of 68 residents in the survey sample, Residents #14, and #124. The findings include: 1. For Resident #14 (R14), the facility staff failed to ensure the resident was seen by the physician after 6/8/23. A review of R14's clinical record revealed the resident was seen by the physician on 6/8/23. Further review of R14's clinical record revealed the resident was seen by a nurse practitioner on 6/30/23, 7/27/23, 8/22/23, 8/30/23, 9/21/23, 9/22/23, 9/26/23, and 12/21/23. R14 was not seen by the physician since 6/8/23. On 2/9/24 at 9:20 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated the facility staff follows the facility policies in regard to physician visits. On 2/9/24 at 12:39 p.m., ASM #1, the executive director, and ASM #2 were made aware of the above concern. The facility policy titled, Medical Care/Standards of Practice documented, Physician visits are required according to resident needs and/or State and Federal guidelines. For long-term care, a physician must see the resident at least once every 30 days for the first 90 days after admission. After 90 days, an alternative schedule of visits, not to exceed 60 days, may be set if the physician justifies in the resident record that the resident's condition does not necessitate visits at 30 day intervals. A physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist that is under the supervision [sic] the physician, as permitted by state law. A physician may not delegate tasks when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under state law or by the Center's own policies. 2. For Resident #124 (R124), the facility staff failed to ensure the resident was seen by the physician after 9/12/23. A review of R124's clinical record revealed the resident was seen by the physician on 9/12/23. Further review of R124's clinical record revealed the resident was seen by a nurse practitioner on 9/27/23, 11/21/23, 11/27/23, 12/6/23, and 1/2/24. R124 was not seen by the physician since 9/12/23. On 2/9/24 at 9:20 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated the facility staff follows the facility policies in regard to physician visits. On 2/9/24 at 12:39 p.m., ASM #1, the executive director, and ASM #2 were made aware of the above concern. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Medical Care/Standards of Practice documented, Physician visits are required according to resident needs and/or State and Federal guidelines. For long-term care, a physician must see the resident at least once every 30 days for the first 90 days after admission. After 90 days, an alternative schedule of visits, not to exceed 60 days, may be set if the physician justifies in the resident record that the resident's condition does not necessitate visits at 30 day intervals. A physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist that is under the supervision [sic] the physician, as permitted by state law. A physician may not delegate tasks when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under state law or by the Center's own policies.

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

42183

Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide sufficient staffing to meet resident needs for five of 68 residents in the survey sample, Resident #148, #119, #32, #46 and #114.

The findings include:

1. For Resident #148, the facility staff failed to provide sufficient nursing staffing to meet resident's incontinence needs.

During the course of the survey, a request was made on 2/5/24 for the as worked staffing schedule for 2/2/24, 2/3/24 and 2/4/24. When asked during the entrance conference if there were any staffing waivers, ASM (administrative staff member) #2, the director of nursing, stated, No, there are no waivers.

Wing 1 had 66 residents; Wing 2 had 66 residents; and Wing 3 had 55 residents.

A review of the as worked staffing sheets for 2/2/24 night shift revealed:

Wing 1: 1 nurse and 1 CNA (certified nursing assistant) and 1 CNA 3:00 PM-7:00 AM,

Wing 2: 1 nurse and 1 CNA,

Wing 3: 1 nurse and 1 CNA and in addition, 1 house aide.

A review of the as worked staffing sheets for 2/3/24 night shift revealed:

Wing 1: 2 nurses and 1 CNA,

Wing 2: 1 nurse and 1 CNA,

Wing 3: 2 nurses and 1 CNA.

A review of the as worked staffing sheets for 2/4/24 night shift revealed:

Wing 1: 1 nurse and 1 CNA,

Wing 2: 1 nurse and 1 CNA,

Wing 3: 1 nurse and 1 CNA.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For Resident #148, the most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 11/15/23, 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 bed mobility/transferring/toileting and set up for eating. A review of the comprehensive care plan dated 11/21/23 revealed, FOCUS: Resident has an ADL self-care performance deficit related to shortness of breath (SOB) and morbid obesity. INTERVENTIONS: The resident is totally dependent on 1 staff for toileting/incontinent care. The resident is totally dependent on 1 staff for repositioning and turning in bed. On 2/4/24 at approximately 2:00 PM, an interview was conducted with Resident #148 who resided on Wing 2. When asked about incontinence care, Resident #148 stated, Well, for instance last evening [2/3/24], I rang the call bell at 9:30 PM and the nurse came in at 10:00 PM. I told her I needed to be cleaned up and she said she would get help and be back. At 11:30 PM, I called again and she came back in and said they never came back? I said no and she was going to get someone. I did not get cleaned up till day shift. It was uncomfortable being wet that whole time. I did not feel good about it. Resident #148 stated, they are very short staffed here, they do not have enough aids to clean us up. On 2/5/24 at approximately 6:05 AM, an interview was conducted with CNA #4 on Wing 2. When asked about staffing, CNA #4 stated, It is very short staffed here. I try to do my best but it is impossible to provide care to this many residents. I make rounds, but in addition to trying to provide incontinence care, am managing wanders, call lights and getting water/snacks for the residents. When asked is she had been able to provide incontinence care to Resident #148 on 2/3/24 night shift, CNA #4 stated, Not sure that I was able to. She usually lets us know. On 2/5/24 at 6:10 AM, an interview was conducted with LPN (licensed practical nurse) #1, when asked if there was sufficient staff to meet resident needs, LPN #1 stated, No, there is not. I have come on duty and I am the only one scheduled, with no aide. It is impossible to give care to all these residents and meet their needs. There are anywhere from zero to three aides scheduled on this unit on nights. An interview was conducted on 2/8/24 at 10:20 AM with OSM #17, the Human Resources Director. When asked about staffing, OSM #17 stated, I just started about 3 weeks ago. My primary focus was to hire staff as they were critically staffed. An interview was conducted on 2/8/24 at 12:10 PM with ASM #2, the director of nursing. When asked who is responsible for staffing to meet the resident needs, ASM #2 stated, the administrator and they were. When asked to describe the staffing/scheduling process, ASM #2 stated, they do the scheduling and everyone is to call off to them either by phone or by text 24/7. ASM #2 explained that on days and evenings, it is common for 2 aides, but prefer 3-4 aides, and are budgeted for 5. ASM #2 stated they fill in shifts on weekends and evenings; if they are not a nurse, then they are an aide. ASM #2 stated, I hold staff accountable. A lot of staff quit after I write them up, based on policies. Average call outs are 7 per day. ASM #2 stated they don't use agency staff. ASM #2 stated the memory care unit does not get extra staff, there is one nurse for both sides, but aides are divided up. Staff might get shifted based on acuity of residents. If a nurse calls off, they send out a mass text to all nurses, then ask inside staff if they can work extra. (continued on next page)

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

On 2/8/24 at 4:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns.

According to the facility's Staffing Requirements policy, which revealed, The facility retains knowledgeable, competent employees to provide for the needs of the residents and to provide for the safety of the residents as well as the staff. To provide the residents with staff who are knowledgeable of Alzheimer's disease and related disorders/dementias. To provide a sufficient number of employees who are able to maximize each resident's potential and to minimize each resident's deficits by becoming partners in care. To provide a structured therapeutic activity-intensive program that provides opportunities for success, minimizes behaviors, associated with the disease, and nourishes the human spirit. To provide for the safety and security of the residents and staff.

No further information was provided prior to exit.

32642

2. For Resident #119 (R119), the facility staff failed to provide sufficient nursing staffing to meet the resident's incontinence needs.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/27/23, R119 was coded as being cognitively intact for making daily decisions, and as being always incontinent of bowel and bladder.

On 2/4/24 at 2:35 p.m., R119 was interviewed and stated the facility staff does not take care of the patients. He stated: There is not enough staff, people go 16 or 17 hours without being changed. He stated he had not had his incontinence brief changed since 10:30 p.m. the night before (2/3/24). R119 agreed to allow the surveyor to observe his brief change. CNA (certified nursing assistant) #14 stated she was assigned to R119 during that day shift. She stated: It is a little hectic when I am the only aide for 22 residents. No. I have not changed [R119] all day. I am still making my rounds. At 3:00 p.m., CNA #14 assisted R119 to position himself on the bed for incontinence care. CNA #14 removed the incontinence brief. The brief was full of both stool (smeared and dried) and urine. After the resident's brief was changed, he began to cry. He stated: I feel like I am trapped here. There is not enough people to take care of me. I go all day in dirty underpants. I stink. I am not crying because I am weak. I am crying because I am sad and so mad.

A review of R119's care plan dated 1/23/23 and updated 8/15/23 revealed, in part: [R119] has an ADL self-care performance deficit .Toilet use .the resident requires supervision to extensive assistance by one staff .[R119] has bowel and bladder incontinence.

On 2/4/24 at 3:15 p.m., CNA #14 was interviewed. She stated on this day (2/4/24), she was assigned to 22 residents. She stated she had tried to get to all her residents at least once a shift, but had not yet gotten to R119. She stated: There just isn't enough staff to take care of everyone, especially on the weekends. She stated she was sorry she had not yet gotten to change R119.

On 2/6/24 at 4:40 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the Market Lead, and ASM #5, the vice president of risk management, were informed of these concerns.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/8/24 at 11:51 a.m., ASM (administrative staff member) #2 was interviewed. After reviewing scheduling documents for 2/4/24, he stated on day shift on 2/4/24, two CNAs were working on R119's unit. He stated CNA #14 was personally assigned to take care of 22 residents. He stated there were not enough staff members to meet the residents' needs on R119's unit on 2/4/24 day shift. He stated that he prefers to have three or more scheduled on this unit, and that the facility is budgeted to have five CNAs on this unit. He stated: On Sunday, that is all the staff I have. When asked what efforts the facility is taking to increase staffing, he stated the new human resources director is actively recruiting nursing staff. He stated the facility is not allowed to use outside contract nursing staffing. No further information was provided prior to exit. 49369 3. For Resident #32 (R32), the facility staff failed to administer Carvedilol (1) as ordered by a physician. A review of R32's provider's orders from October 2023 revealed the following: 8/9/2023 Carvedilol Oral Tablet 12.5 MG (milligrams) (Carvedilol) Give 1 tablet by mouth every 12 hours for HTN (hypertension). A review of R32's October 2023 MARs (medication administration records) revealed he did not receive this medication as ordered on 10/8/23 on the evening shift. A review of the as worked schedule for 11/8/23 revealed that on unit 1 there was one nurse on duty during the hours of 3:30 p.m. to p.m. and from 7:00 p.m. until 11:00 p.m. On 2/7/24 at 11:40 p.m., LPN (licensed practical nurse) #8 was interviewed. She stated that medications should be given on time as ordered. She stated that it is important because the resident could need that medication at a certain time, or before or after a meal. If the medication is not given, the doctor and family should be notified and it should be documented on a nurses note in the clinical record. On 2/8/24 at 11:50 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. He stated that 2 nurses are needed to staff unit 1 during the evening shift. He said that having only one nurse on 10/8/23 was not enough staffing to take care of the whole unit. He stated that the residents not receiving their medications could be attributed to the insufficient staffing. On 2/8/24 at 4:16 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit. References: (continued on next page)

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

(1) Carvedilol is used alone or in combination with other medications to treat heart failure (condition in which the heart cannot pump enough blood to all the parts of the body) and high blood pressure. It is also used to improve survival after a heart attack. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697042.html.

4. For Resident #46 (R46), the facility staff failed to administer medication as ordered by the physician.

A review of R46's provider's orders from October 2023 revealed the following:

8/24/2023 Ferrous Sulfate Oral Tablet 325 (65 Fe) MG (Ferrous Sulfate) Give 1 tablet by mouth two times a day for anemia.

8/18/2023 Gabapentin Oral Capsule (Gabapentin) Give 300 mg by mouth every 8 hours for pain mgt (management).

8/18/2023 Hydralazine HCL Oral Tablet 50 MG (Hydralazine HCL) Give 1 tablet by mouth every 8 hours for htn (hypertension).

8/23/2023 Saline Nasal Spray Solution 0.65% (Saline) 2 spray in both nostrils every 8 hours for nasal dryness.

A review of R46's October 2023 MARs (medication administration records), revealed she did not receive the above medications as ordered by the physician on 10/8/23 on the afternoon and evening shift.

A review of the as worked schedule for 11/8/23 revealed that on unit 1 there was one nurse on duty during the hours of 3:30 p.m. to 5 p.m.

On 2/7/24 at 11:40 p.m., LPN (licensed practical nurse) #8 was interviewed. She stated that medications should be given on time as ordered. She stated that it is important because the resident could need that medication at a certain time, or before or after a meal. If the medication is not given, the doctor and family should be notified and it should be documented on a nurses note in the clinical record.

On 2/8/24 at 11:50 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. He stated that 2 nurses are needed to staff unit 1 during the evening shift. He said that having only one nurse on 10/8/23 was not enough staffing to take care of the whole unit. He stated that the residents not receiving their medications could be attributed to the insufficient staffing.

On 2/8/24 at 4:16 p.m., ASM #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns.

No further concerns were identified prior to exit.

5. For Resident #114 (R114), the facility staff failed to administer medications as ordered by the physician.

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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	A review of R114's provider's orders from October 2023 revealed the following: 8/7/2023 Melatonin Tablet 3 MG Give 1 tablet by mouth at bedtime for Insomnia. 8/26/2023 Mirtazapine Oral Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for depression. 8/8/2023 Sertraline HCL Oral Tablet 50 MG (Sertraline HCL) Give 1 tablet by mouth at bedtime for Depression. 8/7/2023 Trazadone HCL Oral Tablet 150 MG (Trazadone HCL) Give 1 tablet by mouth at bedtime for Depression. A review of R114's October 2023 MARs (medication administration records), revealed she did not receive the above medications as ordered on the evening shift. A review of the as worked schedule for 11/8/23 revealed that on unit 1 there was one nurse on duty during the hours of 3:30 p.m. to p.m. On 2/7/24 at 11:40 p.m., LPN (licensed practical nurse) #8 was interviewed. She stated that medications should be given on time as ordered. She stated that it is important because the resident could need that medication at a certain time, or before or after a meal. If the medication is not given, the doctor and family should be notified and it should be documented on a nurses note in the clinical record. On 2/8/24 at 11:50 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. He stated that 2 nurses are needed to staff unit 1 during the evening shift. He said that having only one nurse on 10/8/23 was not enough staffing to take care of the whole unit. He stated that the residents not receiving their medications could be attributed to the insufficient staffing. On 2/8/24 at 4:16 p.m., ASM #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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 0726

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.

32642

Based on staff interview, facility document review, and clinical record review, the facility staff failed to determine competencies for nurses for one of 68 residents in the survey sample, Resident #164.

The findings include:

For Resident #164 (R164), who received TPN (total parental nutrition) (1), the facility staff failed to determine that nurses were competent to administer it.

A review of R164's clinical record revealed he was no longer a current facility resident. While R164 was a resident at the facility, he had physician's orders for, and received, TPN. A review of R164's MARs (medication administration records) from May, June, July, and August of 2023 revealed that both RNs (registered nurses) and LPNs (licensed practical nurses) administered TPN to R164.

On 2/6/24 at 2:26 p.m., ASM (administrative staff member) #2, the director of nursing, and ASM #3, the regional director of clinical services, were requested to provide evidence that nurses were evaluated for competencies to administer TPN.

On 2/7/24 at 11:35 a.m., ASM #3 stated: We don't have the competencies.

On 2/7/24 at 11:38 a.m., ASM #2 was interviewed. He stated TPN is not something ordinarily administered in a SNF or long term care facility. He stated usually RNs only are allowed to administer TPN, and not LPNs. He stated TPN comes from the pharmacy in huge bags, and sometimes requires other things (electrolytes, vitamins, for example) to be added to it. He stated TPN administration requires skills that are beyond the everyday things nurses do. He stated for a nurse to be competent to administer TPN, the nurse would need training if they had not ever given it before. He stated competencies should have been determined for all nurses who administered TPN at the facility. He stated the pharmacy should have sent someone out to review the specialized skills needed for TPN administration. He stated the company's policy regarding LPN administration of TPN has changed recently, and that LPNs are now allowed to administer it if they have received specialized training. He added: I don't know if we have trained anyone since [name of organization] has allowed it in the last two months.

On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns.

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NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked to provide a policy on TPN administration, ASM #2 provided a Skills Checklist for the Preparation and Administration of Parenteral Nutrition. This checklist included the following information: Assess vascular access site .inspect medication/solution container for leaks, clarity, color, precipitants and expiration date .close clamp on administration set and attach appropriate filter, if not integrated .using ANTT (aseptic non touch technique), insert spike into solution container access port .Hang new medication/solution container on IV pole .Attach primed needleless connector to catheter lumen .Maintaining ANTT, attach flush syringe to needleless connector. Aspirate the catheter to obtain positive blood return to verify vascular access patency .Flush with prescribed flushing agent .Attache administration set to needleless connector . Open clamp and begin infusion .Access vascular access device site .Observe for any signs or symptoms of complications per procedure and report if appropriate. No further information was provided prior to exit. Reference (1) Total parenteral nutrition is a medication used to manage and treat malnourishment. It is in the nutrition class of drugs. Total parenteral nutrition is indicated when there is impaired gastrointestinal function and contraindications to enteral nutrition. Total parenteral nutrition (TPN) is when the IV administered nutrition is the only source of nutrition the patient is receiving .Due to safety concerns and the complexity of administration, parenteral nutrition is considered high risk by the ISMP(Institute for Safe Medication Practice). This information is taken from the website https://www.ncbi.nlm.nih.gov/books/NBK559036/.

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 31753 Based on staff interview, and facility document review, the facility staff failed to meet the RN (registered nurse) requirements for two of 30 days of RN coverage review. The findings include: The facility staff failed to ensure the Director of Nursing did not serve as a charge nurse on 1/20/24 and 1/21/24. A review of the facility nursing staff schedules revealed the facility census was 158 on 1/20/24 and 157 on 1/21/24. Further review of the facility nursing staff schedules revealed the Director of Nursing served as the RN charge nurse, working the day shift on Saturday 1/20/24 and Sunday 1/21/24. On 2/8/24 at 12:10 p.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Nursing. ASM #2 stated the facility does not have enough staff so sometimes he works on the floor as a charge nurse on the weekends or evenings. ASM #2 stated that he does this in addition to working his full-time role as the Director of Nursing. On 2/8/24 at 2:45 p.m., ASM #1, the executive director, and ASM #2 were made aware of the above concern. The facility policy titled, Staffing Requirements failed to document information regarding this concern.

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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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 31753 Based on staff interview and facility document review, the facility staff failed to complete an annual performance review for five of five CNA (certified nursing assistant) record reviews. The findings include: For CNA #11, CNA #12, CNA #13, CNA #14, and CNA #15, the facility staff failed to complete an annual performance review. CNA #11 was hired on 3/11/76; CNA #12 was hired on 1/5/89; CNA #13 was hired on 3/22/22; CNA #14 was hired on 5/31/22; and CNA #15 was hired on 8/16/22. The facility staff could not provide an annual performance review for all five CNAs. On 2/7/24 at 9:04 a.m., an interview was conducted with OSM (other staff member) #17, the director of human resources. OSM #17 stated she was only employed at the facility since 1/15/24 but it is her responsibility to keep up with performance reviews and make sure they are done. OSM #17 stated at the beginning of each month, she prints out performance reviews that are due and passes them out to supervisors who need to complete them, then follows up throughout the month. OSM #17 stated she was going to conduct an audit to track whose performance reviews were due. OSM #17 stated she could not provide annual performance reviews for CNA #11, CNA #12, CNA #13, CNA #14, and CNA #15. On 2/8/24 at 4:25 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, Employee j=Job Performance Evaluations documented, It is the policy of The Company to evaluate each employee's job performance on a continual and on-going basis. Employees will receive an evaluation of their performance prior to the completion of their Introductory Period and annually thereafter.

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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 0740

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident must receive and the facility must provide necessary behavioral health care and services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31753

Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide mental and behavioral health services for two of 68 residents in the survey sample, Residents #63 and #95.

The findings include:

1. For Resident #63 (R63), the facility staff failed to obtain a psychiatry follow up appointment.

R63 was admitted to the facility on [DATE] with diagnoses of schizophrenia, major depressive disorder, and anxiety disorder. R63's comprehensive care plan dated 4/12/21 documented, (R63) has behaviors of trying to bribe people to leave the facility with her, pretending that she is using the bathroom, but will try to avoid staff using the other room, talking in her sleep, biting, kicking and punching staff, and trying to elope the facility. Refuses medication and Showers and refuses meals and Fluid.

A review of R63's clinical record revealed the resident was last seen by psychiatry on 3/31/22. The note documented, Patient seen today to evaluate for inadequate response to medication changes . Assessment/Plan: 1. Schizophrenia, unspecified is not being treated with medications. improved hallucination, on hospice .3. Major depressive disorder, recurrent, unspecified is not being treated with medications. ongoing, on hospice, refusing medication .Future Visits: Revisit in 4 weeks.

A social services progress review dated 1/23/24 documented, Current Mood Status: (a check mark beside) Feeling or appearing down, depressed or hopeless (and a check mark beside) Moving or speaking so slowly that others have noticed, or so restless that s/he has been moving around more than usual .I. Social Service Intervention Status: 1. Describe resident's current status, including related psychiatric diagnosis and efficacy of current psychoactive medication, if applicable. Specifically address 'problem' areas or interventions that social services is currently reviewing: CNA (Certified Nursing Assistant) helps with ADL's (activities of daily living). Her dx (diagnoses): Vascular Dementia, Unspecified Severity with other Behavioral Disturbance, Major Depressive Disorder, Anxiety, and Schizophrenia. Psychoactive medication is Seroquel (1) 25mg (milligrams) and Lorazepam (2) 2mg. No, intervention being reviewed by Social Services .

On 2/4/24 at 2:50 p.m., 2/5/24 at 9:20 a.m., 2/5/24 at 11:22 a.m., 2/5/24 at 2:04 p.m., 2/5/24 at 5:00 p.m., 2/6/24 at 9:30 a.m., 2/6/24 at 11:20 a.m., and 2/6/24 at 1:51 p.m., R63 was observed lying in bed.

On 2/7/24 at 1:53 p.m., an interview was conducted with OSM (other staff member) #10, the director of social services, regarding how the social services staff ensure residents maintain their highest level of psychosocial well-being and receive the services needed for mental disorders. OSM #10 stated that if a resident has a mental disorder, then she asks them if they want to be referred to psychological and psychiatry services, or if they want, they can talk to the social services staff about whatever they want.

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Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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 0740

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 2/7/24 at 2:30 p.m., an interview was conducted with LPN (licensed practical nurse) #8, regarding how nurses ensure residents maintain their highest level of psychosocial well-being and receive the services needed for mental disorders. LPN #8 stated, I know psych is here, so we have psych. I'm not really sure but I guess it all depends. It might be something simple. It depends on the resident, and it depends on their need at the time.

On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern.

The facility policy titled, Mental Health Referrals documented, Mental Health referrals will be utilized by the facility when a resident's behavior and affect appears disturbed or indicates distress.

References:

(1) Seroquel is used to treat schizophrenia, bipolar disorder and depression. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html.

(2) Lorazepam is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html

2. For Resident #95 (R95), the facility staff failed to provide behavioral health services in a timely manner. R95 presented with behaviors beginning on 10/5/23 and the resident was not evaluated by psychological services until 11/30/23.

R95 was admitted to the facility on [DATE] with a diagnosis of schizophrenia.

A nurse's note dated 10/5/23 documented, Resident yelling out, into resident room, resident states she was cold, turned heat on and turned air off. Writer back to nurses station. Resident again yelling into resident room asked resident not to yell to use call bell due to resident waking up otherresidents [sic] on hall. Gave resident call bell. This writer back to nurses station, resident again yelling with call bell on, into resident room again, resident requesting meds and snacks, advised resident meds not here yet, gave resident snacks. Left room, resident quiet at this time. This writer received call from 911 stating resident had call to request transport to hospital. Resident sent to hospital per her request .

A nurse's note dated 10/6/23 documented, Res (Resident) called the police and in presence of this writer requested police to call ambulance because she wanted to go to the hospital because she 'couldn't breath [sic].' .

A nurse's note dated 10/7/23 documented, Resident called 911 herself at 10am, EMS (Emergency Medical Services) arrived with 5 attendants as well as their supervisor. Resident stated to EMS 'I don't want to call you. I just want them to pay attention to me.' EMS asked Resident 'are you having an emergency? Because you look just fine laying in that bed.' Resident stated she felt okay, EMS told Resident she cannot continue to call 911 when there is not an emergency. Resident stated understanding. Resident stated she didn't want to go to hospital when EMS asked her .

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Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 10/8/23 documented, Mood status is anxious negative statements flat affect Resident displays manipulative behavior and often tells lies to staff. Resident called 911 and stated that we are not feeding her or giving her medication. I later went in the room and reminded her of giving morning medication and she agreed that she did get them. Provided resident with snacks between meals to console resident. Resident has made accusations that I am hacking her phone . A psychosocial evaluation completed by the facility social services staff dated 10/9/23 documented, Relationships: 2. Resident/family feelings about admission, diagnosis, changes in health status prompting admission. She responded, 'It was hard to accept' .08. What have been the most difficult time(s) of your life? She said, 'when she was married.' 9. Have you ever been through anything life threatening or traumatic? Yes, married to a guy that was not nice . A nurse's note dated 10/10/23 documented, writer was approached by 911 in the hall while passing meds they stated the resident called them stating she needed medical attention her complaint to the [sic] was SOB (shortness of breath) on assessment they found nothing wrong with resident they asked her if he [sic] wanted to go to the hospital she refused they called the dispatcher he made her aware that calling 911 was for emergency use only and that if she continues to misuse there [sic] service she [sic] be held accountable and if they had to return they would be coming back with the (name of town) POLICE she was advised to call the staff for help she stated that she would not call them any more she would use her call bell for help. A nurse's note dated 10/12/23 documented, Resident back out to hospital via ambulance. A nurse's note dated 10/13/23 documented, Resident requested to be taken out to the hospital, resident left the building at 1:07 am. A nurse's note dated 10/13/23 documented, Resident and rescue squad came right back to the building, rescuers reported that she requested to be taken back to the facility when they reached the parking lot. A nurse's note dated 10/14/23 documented, 'Resident called 911 complaining of shortness of breath. O2 (Oxygen) reading is 98, no respiratory distress noted. 911 crew arrived at the facility and where [sic] about to take her back to the hospital and resident change [sic] her mind and told them she is not actually having any heath [sic] emergency, but she keeps calling 911 because she cannot get in contact with her family. 911 crew spent with her for about 30 minutes taking [sic] with her and left the building without the patient. A nurse's note dated 10/15/23 documented, Resident called 911 again. Police Chief came, and he said if she wants to go to the hospital she has to be taken to the hospital. 911 crew took her out at 6:08 am. A nurse's note dated 10/16/23 documented, Resident is screaming obscenities and refusing care. A nurse's note dated 10/17/23 documented, Resident called 911 to be sent to (name of hospital) for SOB and facial pain. Resident refused nurse assessment and vital signs. Refused adl (activities of daily living) care prior to departure. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 906 Thompson Street Ashland, VA 23005	

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated 10/18/23 documented, resident called 911, EMT, police, unit manager, social services and EMT chief in and had a meeting with resident about her excessive calling. Resident decided that she still wanted to go to the hospital. Resident taken back to hospital. A nurse's note dated 10/21/23 documented, Resident continues to yell out throughout shift even after being medicated with as needed pain medication upon request. Resident is also being verbally abusive to staff . A nurse's note dated 10/23/23 documented, Resident quiet but continuing to use call bell several times during shift stating something crawling on face, resident also stating felt like something [sic] falling from bottom . A nurse's note dated 11/2/23 documented, Resident continuing to yell out and ring call bell O2 in place, resident continuing to complain of not being able to breath, O2 sats (oxygen saturation level) 95 to 98%. Medicated resident with pain and anxiety meds. Asked resident to not yell as waking up other residents. Resident continues to state staff is abusubg [sic] her. Resident quiet at this time. A nurse's note dated 11/7/23 documented, EMS was observed coming down hallway and attendant stated they were here to transport resident to the hospital. Resident left facility . A nurse's note dated 11/7/23 documented, Resident returned from hospital with no new orders noted . A nurse's note dated 11/23/23 documented, Resident called 911 x 2, did not go to hosp (hospital) when EMS called, however resident transported 2nd time resident called. R95 was not evaluated by the facility psychological or psychiatric services until 11/30/23. A note signed by a licensed clinical social worker with the contracted psychological services documented, (R95) was referred due to concerns with Isolation, Anxiety, Adjustment Disorder, Physical Aggression, Attention Seeking Behavior. Estimated frequency and duration of treatment: 4 times per month for 4 months . On 2/7/24 at 1:53 p.m., an interview was conducted with OSM (other staff member) #10, the director of social services, regarding how the social services staff ensure residents maintain their highest level of psychosocial well-being and receive the services needed for mental disorders. OSM #10 stated that if a resident has a mental disorder, then she asks them if they want to be referred to psychological and psychiatry services, or if they want, they can talk to the social services staff about whatever they want. On 2/7/24 at 2:30 p.m., an interview was conducted with LPN (licensed practical nurse) #8, regarding how nurses ensure residents maintain their highest level of psychosocial well-being, and receive the services needed for mental disorders. LPN #8 stated, I know psych is here, so we have psych. I'm not really sure but I guess it all depends. It might be something simple. It depends on the resident, and it depends on their need at the time. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern.

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F 0745

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide medically-related social services to help each resident achieve the highest possible quality of life.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 31753

Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide medically related social services for three of 68 residents in the survey sample, Residents #63, #95, and #111.

The findings include:

1. For Resident #63 (R63), the facility staff failed to provide medically related social services regarding the resident's psychiatric needs.

R63 was admitted to the facility on [DATE] with diagnoses of schizophrenia, major depressive disorder, and anxiety disorder. R63's comprehensive care plan dated 4/12/21 documented, (R63) has behaviors of trying to bribe people to leave the facility with her, pretending that she is using the bathroom, but will try to avoid staff using the other room, talking in her sleep, biting, kicking and punching staff, and trying to elope the facility. Refuses medication and Showers and refuses meals and Fluid.

A review of R63's clinical record revealed the resident was last seen by psychiatry on 3/31/22. The note documented, Patient seen today to evaluate for inadequate response to medication changes . Assessment/Plan: 1. Schizophrenia, unspecified is not being treated with medications. improved hallucination, on hospice .3. Major depressive disorder, recurrent, unspecified is not being treated with medications. ongoing, on hospice, refusing medication .Future Visits: Revisit in 4 weeks.

A social services progress review dated 1/23/24 documented, Current Mood Status: (a check mark beside) Feeling or appearing down, depressed or hopeless (and a check mark beside) Moving or speaking so slowly that others have noticed, or so restless that s/he has been moving around more than usual .I. Social Service Intervention Status: 1. Describe resident's current status, including related psychiatric diagnosis and efficacy of current psychoactive medication, if applicable. Specifically address 'problem' areas or interventions that social services is currently reviewing: CNA (Certified Nursing Assistant) helps with ADL's (activities of daily living). Her dx (diagnoses): Vascular Dementia, Unspecified Severity with other Behavioral Disturbance, Major Depressive Disorder, Anxiety, and Schizophrenia. Psychoactive medication is Seroquel (1) 25mg (milligrams) and Lorazepam (2) 2mg. No, intervention being reviewed by Social Services .

On 2/7/24 at 1:53 p.m., an interview was conducted with OSM (other staff member) #10, the director of social services, in regard to how she ensures residents receive medically related social services related to residents with mental illness. OSM #10 stated if her assessments trigger then she requests an order for psychiatry and if the nurses see a difference in residents' mood, then they place an order for psychiatry and make her aware.

On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Mental Health Referrals documented, Mental Health referrals will be utilized by the facility when a resident's behavior and affect appears disturbed or indicates distress. The manager of social services job description documented, 5. Conduct and document a social services evaluation, including identification of resident problems/needs. 6. Provide/arrange for social work services as indicated by resident/family needs. References: (1) Seroquel is used to treat schizophrenia, bipolar disorder and depression. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html. (2) Lorazepam is used to treat anxiety. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682053.html 2. For Resident #95 (R95), the facility staff failed to provide medically related social services regarding the resident's psychiatric needs. (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024
NAME OF PROVIDER OR SUPPLIER Ashland Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 906 Thompson Street Ashland, VA 23005	

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R95 was admitted to the facility on [DATE] with a diagnosis of schizophrenia. A nurse's note dated 10/5/23 documented, Resident yelling out, into resident room, resident states she was cold, turned heat on and turned air off. Writer back to nurses station. Resident again yelling into resident room asked resident not to yell to use call bell due to resident waking up otherresidents [sic] on hall. Gave resident call bell. This writer back to nurses station, resident again yelling with call bell on, into resident room again, resident requesting meds and snacks, advised resident meds not here yet, gave resident snacks. Left room, resident quiet at this time. This writer received call from 911 stating resident had call to request transport to hospital. Resident sent to hospital per her request . A nurse's note dated 10/6/23 documented, Res (Resident) called the police and in presence of this writer requested police to call ambulance because she wanted to go to the hospital because she 'couldn't breath [sic].' . A nurse's note dated 10/7/23 documented, Resident called 911 herself at 10am, EMS (Emergency Medical Services) arrived with 5 attendants as well as their supervisor. Resident stated to EMS 'I don't want to call you. I just want them to pay attention to me.' EMS asked Resident 'are you having an emergency? Because you look just fine laying in that bed.' Resident stated she felt okay, EMS told Resident she cannot continue to call 911 when there is not an emergency. Resident stated understanding. Resident stated she didn't want to go to hospital when EMS asked her . A nurse's note dated 10/8/23 documented, Mood status is anxious negative statements flat affect Resident displays manipulative behavior and often tells lies to staff. Resident called 911 and stated that we are not feeding her or giving her medication. I later went in the room and reminded her of giving morning medication and she agreed that she did get them. Provided resident with snacks between meals to console resident. Resident has made accusations that I am hacking her phone . A psychosocial evaluation completed by the facility social services staff dated 10/9/23 documented, Relationships: 2. Resident/family feelings about admission, diagnosis, changes in health status prompting admission. She responded, 'It was hard to accept' .08. What have been the most difficult time(s) of your life? She said, 'when she was married.' 9. Have you ever been through anything life threatening or traumatic? Yes, married to a guy that was not nice . A nurse's note dated 10/10/23 documented, writer was approached by 911 in the hall while passing meds they stated the resident called them stating she needed medical attention her complaint to the [sic] was SOB (shortness of breath) on assessment they found nothing wrong with resident they asked her if he [sic] wanted to go to the hospital she refused they called the dispatcher he made her aware that calling 911 was for emergency use only and that if she continues to misuse there [sic] service she [sic] be held accountable and if they had to return they would be coming back with the (name of town) POLICE she was advised to call the staff for help she stated that she would not call them any more she would use her call bell for help. A nurse's note dated 10/12/23 documented, Resident back out to hospital via ambulance. A nurse's note dated 10/13/23 documented, Resident requested to be taken out to the hospital, resident left the building at 1:07 am. A nurse's note dated 10/13/23 documented, Resident and rescue squad came right back to the building, rescuers reported that she requested to be taken back to the facility when they reached the parking lot. A nurse's note dated 10/14/23 documented, 'Resident called 911 complaining of shortness of breath. O2 (Oxygen) reading is 98, no respiratory distress noted. 911 crew arrived at the facility and where [sic] about to take her back to the hospital and resident change [sic] her mind and told them she is not actually having any heath [sic] emergency, but she keeps calling 911 because she cannot get in contact with her family. 911 crew spent with her for about 30 minutes taking [sic] with her and left the building without the patient. A nurse's note dated 10/15/23 documented, Resident called 911 again. Police Chief came, and he said if she wants to go to the hospital she has to be taken to the hospital. 911 crew took her out at 6:08 am. A nurse's note dated 10/16/23 documented, Resident is screaming obscenities and refusing care. A nurse's note dated 10/17/23 documented, Resident called 911 to be sent to (name of hospital) for SOB and facial pain. Resident refused nurse assessment and vital signs. Refused adl (activities of daily living) care prior to departure. A nurse's note dated 10/18/23 documented, resident called 911, EMT, police, unit manager, social services and EMT chief in and had a meeting with resident about her excessive calling. Resident decided that she still wanted to go to the hospital. Resident taken back to hospital. A nurse's note dated 10/21/23 documented, Resident continues to yell out throughout shift even after being medicated with as needed pain medication upon request. Resident is also being verbally abusive to staff . A nurse's note dated 10/23/23 documented, Resident quiet but continuing to use call bell several times during shift stating something crawling on face

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R95 was not evaluated by the facility psychological or psychiatric services until 11/30/23. A note signed by a licensed clinical social worker with the contracted psychological services documented, (R95) was referred due to concerns with Isolation, Anxiety, Adjustment Disorder, Physical Aggression, Attention Seeking Behavior. Estimated frequency and duration of treatment: 4 times per month for 4 months . On 2/7/24 at 1:53 p.m., an interview was conducted with OSM (other staff member) #10, the director of social services, in regard to how she ensures residents receive medically related social services related to residents with mental illness. OSM #10 stated if her assessments trigger then she requests an order for psychiatry and if the nurses see a difference in residents' mood, then they place an order for psychiatry and make her aware. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. 42183 3. For Resident #111, the facility staff failed to provide psychosocial follow up regarding the diagnosis of PTSD (post-traumatic stress disorder) and development of a trauma informed plan of care. Resident #111 was admitted to the facility on [DATE] with diagnoses that included but were not limited to vascular dementia and PTSD (post-traumatic stress disorder). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/26/23, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. There was no evidence of a trauma informed care plan for Resident #111. A review of the facility's Psychosocial Evaluation dated 1/4/24 and 1/24/23 revealed, Have you ever been through anything life threatening or traumatic? Answer-when went to Vietnam. Are you aware of any particular 'triggers' that may make this worse for you? Answer-Messy roommates. A review of the medical record did not reveal any social services follow up regarding trauma informed care from 10/1/23-1/26/24. A review of a facility event synopsis with incident date of 1/13/24 revealed, Resident #111 slapped Resident #129 on the left side of her face due to Resident #129 trying to open the back door. Residents separated. Resident to Resident incident substantiated. A review of the physician's progress note dated 1/19/24 revealed, Past medical history-PTSD. Patient with past psychiatric history of MDD (major depressive disorder). Recommendations: Patient benefits from psychotropic medications as ordered. Approach the patient in a way that does not escalate distress or result in behavioral dysregulation. Maintain a quiet stress-free environment. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the social services progress note dated 1/24/24 at 11:47 AM revealed, Social Worker spoke to resident about him punching his roommate in the face on 1/23/24. The resident says he does not like a messy room. He says his roommate is nasty and leaves things all around all the time. He said it has been building up for some time now, and he finally got tired of it and punched him in the face. He says he will refrain from putting his hands on anyone else, what he did was wrong and has since been moved to another room. A review of the social services progress note dated 1/26/24 revealed, BIMS=12, Mood/Behavior/Emotional Status-no items checked, Current Behavior Status since last review (check all that are present) no items checked including hitting, biting, kicking. Referrals OT/PT/ST as needed. Psychology, Psychiatry, Podiatry and Dental as needed. An interview was conducted on 2/5/24 at 9:48 AM with Resident #111. When asked if he is provided with counseling for PTSD, Resident #111 stated, there is someone I talk with but I do not know if it is a counselor. An interview was conducted on 2/7/24 at approximately 1:50 PM with OSM (other staff member) #10, the director of social services. When asked what services are provided to a resident with a diagnosis of PTSD, OSM #10 stated, we would interview him, have a psych consult if needed and put it on the care plan. When asked how triggers would be identified and communicated with the nursing staff, OSM #10 stated, that is covered in the interview, I believe but will have to get back with you on that. No further information from OSM #10, regarding Resident #111's PTSD triggers and plan of care. An interview was conducted on 2/8/24 at 12:10 PM with ASM #2, the director of nursing. When asked who was responsible for implementing trauma informed care, ASM #2 stated, the social worker and staff development. On 2/8/24 at 4:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, director of nursing and ASM #3, the regional director of clinical services was made aware of the above concerns. A review of the facility's social work job description reveals, Essential Job Functions: Provides exposure to, and an understanding of those services/programs that can enhance the patient's quality of life and independence. 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 - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49369 Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement interventions to prevent administration of unnecessary psychotropic medications for two of 68 residents in the survey sample, Resident #78 and #63. The findings include: 1. For Resident #78 (R78), the facility staff failed to monitor for behaviors and side effects while on the antipsychotic medication, Quetiapine Fumarate (1). R78 was admitted to the facility on [DATE] with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety. A review of R78's clinical record revealed the following order dated 2/2/24: Quetiapine Fumarate Oral Tablet 50 MG (milligram) (Quetiapine Fumarate) Give 1 tablet by mouth two times a day for mood disorder related to neurocognitive disorder with Lewy bodies (G31.83); unspecified dementia; unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (F03.90). A review of R78's MARs (medication administration records) for January 2024 and February 2024 revealed the resident had received the Quetiapine as ordered. A review of R78's clinical record failed to reveal evidence of monitoring behaviors and side effects while on the antipsychotic medication. On 2/7/24 at 2:10 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated that if someone is taking this type of medication, she would look for behaviors and side effects. She stated if it is documented, then it would be found in the progress notes. On 2/7/24 at 5:38 p.m., LPN#12, the MDS (Minimum Data Set) coordinator, was interviewed. She stated that if a resident is on this type of medication, the resident should be monitored for behaviors. On 2/7/24 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Medication Management- Psychotropic Medications, revealed, in part: Psychotropic Medications is any medications that affects brain activities associated with mental process and behavior .Monitor behavior and side effects every shift utilizing the Behavior Monitoring Flow Record (BMFR) or electronic equivalent .Monitor resident's response to medication, including the effectiveness of the medication and potential adverse consequences .Monitoring should also include evaluation of the effectiveness of non-pharmacological approaches. (continued on next page)

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

No further information was provided prior to exit.

References:

(1) Quetiapine tablets and extended-release (long- acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets .are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). This information is taken from the website https://medlineplus.gov/druginfo/meds/a698019.html

31753

2. For Resident #63 (R63), the facility staff failed to monitor the resident for behaviors and side effects while on the antipsychotic medication, Seroquel (1).

R63 was admitted to the facility on [DATE] with a diagnosis of schizophrenia. R63's comprehensive care plan dated 11/23/22 documented, The resident is on antipsychotic therapy. The care plan failed to document information regarding behavior monitoring or side effect monitoring.

A review of R63's clinical record revealed a physician's order dated 9/22/23 for Seroquel 25 milligrams every 12 hours. A review of R63's MARs (medication administration records) for September 2023 through February 2024 revealed the resident was administered Seroquel every 12 hours. Further review of R63's clinical record (including the MARs and nurses' notes for September 2023 through February 2024) failed to reveal the resident was monitored for behaviors or monitored for side effects from the medication (except for a nurse's note dated 9/29/23 that documented R63 was yelling and redirected from the exit door).

On 2/7/24 at 12:30 p.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated residents who receive antipsychotic medication should be monitored for behaviors and side effects. LPN #8 stated behavior and side effect monitoring isn't really evidenced unless the nurses attach a note when they check off the MAR. LPN #8 stated for residents who especially have behaviors, there is a little drop box on the MAR to check off behaviors and the interventions used for the behaviors.

On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern.

The facility policy titled, Medication Management- Psychotropic Medications documented, 4. Monitor behavior and side effects every shift utilizing the Behavior Monitoring Flow Record (BMFR) or electronic equivalent.

Reference:

(1) Seroquel is used to treat schizophrenia, bipolar disorder and depression. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49369 Based on staff interview, facility document review, and clinical record review, the facility staff failed to prevent significant medication errors for one of 68 sampled residents, Resident #32. The findings include: For Resident #32 (R32), the facility staff failed to administer Carvedilol (1) as ordered. A review of R32's physician orders revealed the following order dated October 31, 2023: Carvedilol Oral Tablet 12.5 Mg [milligrams] (Carvedilol) Give 1 tablet by mouth every 12 hours for HTN (hypertension). A review of R32's January and February 2024 MARs (medication administration records) revealed that he did not receive his Carvedilol on October 8, 2023 (due at 9:00 p.m.). On 2/7/24 at 11:40 p.m., LPN (licensed practical nurse) #8 was interviewed. She stated that medications should be given on time as ordered. She stated that it is important because they could really need that medication at a certain time or before or after a meal. If the medication is not given, the doctor and family should be notified and it should be documented on a nurses note in the clinical record. On 2/7/24 at 5:17 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Administering Medications, revealed, in part : Medications are administered in a safe and timely manner, and as prescribed .staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions .medications are administered in accordance with prescriber orders, including any required time frame .Medication administration times are determined by resident need and benefit, not staff convenience .medications are administered within one hour of their prescribed time, unless otherwise specified. No further information was provided prior to exit. Reference: (1) Carvedilol is used alone or in combination with other medication to treat heart failure (condition in which the hearth cannot pump enough blood to all parts of the body) and high blood pressure. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697042.html.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 42106 Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to obtain timely radiology services for one of 68 residents in the survey sample, Resident #42. The findings include: For Resident #42 (R42), the facility staff failed to obtain an ordered x-ray in a timely manner. R42 had an order for an x-ray to the right hip for severe pain on 12/13/2023 which was not completed until 12/15/2023. The progress notes for R42 documented in part, - 12/13/2023 11:15 (11:15 a.m.) Resident unable to sit on side of bed this morning to eat breakfast, which is abnormal for resident as she eats every meal. Assessment completed- resident c/o (complains of) severe Right hip pain, prn (as needed) tylenol given with semi effective results. NP (nurse practitioner) notified- new order for x-ray to Right hip and one time dose of ibuprofen- again, semi-helpful. X-ray called in at this time. [Claim #]. RP (responsible party) aware. - 12/13/2023 Nurse Practitioner Progress note .The resident's been assessed today status post a fall with complaint of hip pain per staff. The resident is resting in the bed she is alert but disoriented no acute distress is noted at this time .Plan: Right hip pain, x-ray of the right hip to rule out a fracture . - 12/14/2023 15:22 (3:22 p.m.) Xray technician arrived to facility at this time to complete xray for resident, however, when attempting to take x-ray- her machine showed error messages on her machine per xray technician. Technician stated she would have to go get another machine and return back to facility. This writer explained Resident has been waiting since yesterday for xray to be completed and that xray needed to be completed this evening. Technician stated understanding, stated I will try my best. NP/Resident aware. - 12/15/2023 10:18 (10:18 a.m.) Resident go [sic] xray of right hip this am. The physician order's for R42 documented in part, - Order Date: 12/13/2023 12:17 X-ray to R Hip one time only for unresolved pain. Review of the Radiology Results Report for R42 documented an x-ray of the Right hip with an examination date of 12/15/2023 at 10:30 a.m. showing no acute findings. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/6/2024 at 2:03 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that x-rays were obtained by calling in to a third party provider who came in to perform them. She stated that when they received the order they called the x-ray company and received a confirmation number. She stated that they did not always come as quickly as they used to and if they did not come by the end of their shift they passed it to the next nurse for follow up. She stated that a hip x-ray for a resident having pain after a fall was unacceptable to be done three days later. She stated that if the machine malfunctioned the resident should have been sent out for the x-ray to confirm whether or not there was an injury. The facility policy Laboratory, Diagnostic and X-ray revised 6/21/2021 documented in part, . Policy: To provide guidance on ordering, obtaining, documenting and reporting laboratory, diagnostic and x-ray results. Procedure: Obtain a physician's order for laboratory work, diagnostic testing, and x-ray. Complete the required requisition form(s). Schedule laboratory work, diagnostic test and or x-ray as indicated. If the laboratory work, diagnostic test of x-ray requires the resident to obtain the test outside of the Center, the Center to schedule the appointment and transportation as indicated . On 2/7/2024 at 2:00 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the concern. No further information was provided prior to exit.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **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 dental services for one of 68 residents in the survey sample, Resident #41. The findings include: For Resident #41 (R41), the facility staff failed to obtain dental services as requested by the resident for mouth pain. R41 was admitted to the facility on [DATE] with a readmission on 8/17/2023 with the primary payer being Medicaid. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 12/21/2023, the resident scored 11 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. On 2/4/2024 at 4:47 p.m., an interview was conducted with R41 who stated they had several teeth that hurt them off and on and had requested to see a dentist for at least three months but had not heard anything about an appointment being set up. R41 stated that they had been at the facility for about a year and had not seen a dentist since being there. R41 stated that at times their mouth hurt so much that they had to only eat soft foods. Review of the clinical record failed to evidence documentation of dental consults or pending dental appointments. The physician orders for R41 documented in part, Dental as needed. Order Date: 08/18/2023. On 2/5/2024 at approximately 4:00 p.m., a request was made to ASM (administrative staff member) #1, the executive director for R41's most recent dental consult/examination. On 2/7/2024 at 8:44 a.m., ASM #2, the director of nursing, stated that they were unable to locate any dental consults for R41 however they had confirmed that R41 was on the list to see the visiting in-house dentist in May of 2024. On 2/7/2024 at 10:57 a.m., an interview was conducted with OSM #8, assistant social worker. OSM #8 stated that they had a staff member who used to set up dental appointments for residents but they no longer worked at the facility and she thought that the unit managers made appointments for residents currently. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/7/2024 at 11:29 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that they had a third party dentist who came to the facility to see residents. She stated that she thought the dentist came in monthly but was not exactly sure. She stated that they created a list of residents prior to the day the dentist comes in and they saw the residents on the list. She stated that if the resident had something acute going on they sent them outside of the facility to be seen faster. She stated that R41 had been coming to her and asking to see the dentist for a while and she had explained that she had to find a dentist that would accept the insurance. She stated that she was responsible for making all the appointments for the residents on her wing and had been working on the floor passing medications as well and had to triage the appointments to make the most important ones first. She stated that yesterday she had verified that R41 was on the list to be seen in May. The facility policy Dentist Services revised 9/16/2022 documented in part, Policy: A dentist must be available for each resident. The center will assist a resident in obtaining routine and emergency dental care . If a referral does not occur within 3 days the nurse will evaluate and document changes in ability to eat and drink. Review ability with physician and obtain orders as indicated . On 2/7/2024 at 2:00 p.m., ASM #1, the executive director, ASM #2, the director of nursing, and ASM #3, the regional director of clinical services were made aware of the concern. No further information was obtained prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashland Nursing and Rehabilitation	906 Thompson Street Ashland, VA 23005

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 29843 Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to follow the posted menu for two of 68 residents in the survey sample, Residents #48, and #362. The findings include: 1. For Resident #48 (R48), the facility staff failed to provide a complete meal. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/14/2023, R48 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the R48 was cognitively intact for making daily decisions. The facility's meal ticket for R48 documented, Sunday Dinner. 2/4/2024. Grilled two cheese sandwich, 1/2 (half) cup French fries, 1/2 cup cucumber and onion salad, 6 (six) oz (ounce) of tomato soup, 1 (one) PKT (packet) saltine crackers, 1/2 cup chilled pears, 1 cup iced tea, 4 (four) oz juice of choice, 4 (four) oz juice of choice. (Name of R48). On 02/04/24 at approximately 5:14 p.m., an observation of R48's evening meal revealed that the meal tray did not contain tomato soup, saltine crackers, or any juice. On 02/05/24 at approximately 8:30 a.m., an interview was conducted with R48. When asked about his evening meal the day before R48 stated that he did not receive the tomato soup, saltine crackers, or any juice. On 02/05/24 at approximately 3:15 p.m., an interview was conducted with OSM (other staff member) #1, dining services manager, regarding R48 evening meal on 02/04/2024. When asked how she makes sure residents receive everything on the meal ticket, OSM #1 stated that a kitchen staff member checks the items on the meal tray with the meal ticket before it is put on the cart. When informed of the above observation, OSM # 1 stated that kitchen staff was probably not paying attention and did not put the tomato soup on the tray and did not know the resident should have had two types of juice. She further stated that R48 should have received everything that was on the meal ticket. The facility's policy Menus documented in part, Policy Statement. Menus will be planned to meet the nutritional needs of the residents/patients in accordance with established national guidelines .Procedures: 6. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. On 02/06/2024 at approximately 4:30 p.m., ASM (administrative staff member) #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM 4, lead for marketing and ASM #5, vice president of risk management, were informed of the above findings. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit. 32642 2. For Resident #362 (R362), the facility staff failed to serve the food as posted on the menu on 2/4/24 at dinner. On 2/4/24 at 2:28 p.m., R362 was interviewed. She stated she did not always get enough food, and did not always receive what was listed on her meal ticket. On 2/4/24 at 5:50 p.m., R362's dinner tray was observed as soon as it was delivered. The tray ticket, listing all the items on the menu the resident was to receive, contained the following items: Tomato soup, 6 oz (ounces), Juice (4 oz), and Juice (4 oz). R362 stated she would have liked to have had soup and the two juices to supplement her dinner. She stated she would probably not ask a staff member for the items because they are always so busy. On 2/5/24 at 3:13 p.m., OSM (other staff member) #1, the dining services manager, was interviewed. She stated: What is listed on the ticket should be what the resident gets. She added the staff probably wasn't paying close attention when they placed R362's tray on the cart at dinner on the previous evening. She stated ordinarily, three people are involved in preparing and checking the meal tray. She stated on 2/4/24 at dinner, only two staff members were on the tray service line. On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, 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 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. 29125 Based on observation, staff interview and facility document review, it was determined that the facility staff failed to serve food at an appetizing temperature and form from one of one facility kitchens. The findings include: On 2/4/24 starting at 4:31 PM, the tray line services was observed. The temperature of food items were as follows: Chicken breast was 190 degrees (an alternative item), burger patties were 175 degrees (an alternative item), grilled cheese sandwiches were 165 degrees, tomato soup was 203 degrees, french fries were 192 degrees, chopped chicken was 195 degrees, puree chicken was 180 degrees, puree soup was 169 degrees, mashed potatoes was 160 degrees, cucumber salad was 39 degrees. At 6:02 PM the last cart was being prepared. At that time a test tray was requested to go on the cart as the last tray prepared. At 6:29 PM, the last cart was sent out but not all trays were on it. Several resident trays were placed on an open push cart rather than an enclosed dietary cart. This cart left the kitchen at 6:33 PM. At that time, OSM #1 carried the test tray in her hand to the last unit that received the last cart and sat it on the open push cart. Temperatures were obtained of the test tray at 6:38 PM by OSM #1 as follows: Grilled cheese sandwich was 49 degrees, cucumber salad was 70 degrees, chopped chicken was 121 degrees, tomato soup was 147 degrees, green beans was 169 degrees, mashed potatoes was 121, cut potato fries was 49 degrees and chilled pears was 58 degrees. Note, that the cut potato fries was not the same as the french fries the kitchen originally had on the tray line. The kitchen ran out of the original french fries and attempted to substitute with cutting potatoes and frying them on the grill where the grilled cheese sandwiches had been cooked. At 6:45 PM, the food items were taste tested by OSM #1 and two surveyors. All agreed that the substitute potato fries were undercooked on the inside and mushy on the outside and lacked any crispness expected of french fries; the grilled cheese sandwich was not warm; the green beans needed seasoning; the chopped chicken was not warm; the mashed potatoes were not warm; and the cucumber salad was not cold. The facility policy, Food: Quality and Palatability documented, Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature. Food and liquids are prepared and served in a manner, form, and texture to meet the resident's needs 1. The Dining Services Director and Cook(s) are responsible for food preparation. Menu items are prepared according to the menu, production guidelines, and standardized recipes 4. The Cook(s) prepare food in accordance with the recipes, and season for region and/or ethnic preferences, as appropriate. Cook(s) use proper cooking techniques to ensure color and flavor retention On 2/6/24 at 4:35 PM, ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the 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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 32642 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to serve food in the form ordered by the physician for one of 68 residents in the survey sample, Resident #47. The findings include: For Resident #46 (R47), the facility failed to serve pureed eggs at breakfast on 2/5/24. On 2/5/24 at 8:41 a.m., CNA (certified nursing assistant) #9 stood next to the resident's bed and was feeding the resident breakfast. The resident's plate contained pureed bread and scrambled eggs that were a regular consistency. The resident did not cough or sputter at any time she was eating the scrambled eggs. A review of R47's physician's orders revealed the following order, in effect on 2/5/24: Regular diet, dysphagia puree texture. On 2/6/24 at 11:47 a.m., OSM (other staff member) #18, the speech pathologist, was interviewed. When asked if a resident who has orders for pureed food should receive regular consistency scrambled eggs, she stated: No. If a resident has an order for pureed food, they should have a pureed scrambled egg on the plate. She stated regular scrambled eggs requires more of a chewing effort than the pureed form. She stated if a resident receives the wrong consistency of food, there is a risk of choking or aspirating. On 2/7/24 at 12:30 p.m., OSM (other staff member) #1, the dining services manager, was interviewed. She stated: The cook is responsible for food consistency. The scrambled eggs [for R47] should have been pureed. On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. A review of the facility policy, Therapeutic Diets, revealed, in part: All residents have a diet order .including texture modifications .that is prescribed by the attending physician .diets are prepared in accordance with the guidelines in the .individualized plan of care. No further information was provided prior to exit.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 29125 Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to provide meals at the scheduled time from one of one facility kitchens. The findings include: A review of the facility dining schedule revealed the following: Breakfast is served between 7:30 AM and 8:30 AM. Lunch is served between 11:30 AM and 12:30 PM. Dinner is served between 4:30 PM and 5:30 PM. On 2/4/24 starting at 4:31 PM, the tray line services was observed. At 6:02 PM the last cart was being prepared. At 6:29 PM, the last cart was sent out but not all trays were on it. Several resident trays were placed on an open push cart rather than an enclosed dietary cart. The open cart left the kitchen at 6:33 PM. On 2/05/24 at 3:17 PM, an interview was conducted with OSM #1 and OSM #16, the District Manager of dietary services. OSM #16 stated that they will in-service staff to make sure tray line is done properly. OSM #1 stated that they don't understand the importance of having the tray line done in a certain time frame. The facility policy, Frequency of Meals documented, At least three daily meals will be provided, at regular times comparable to normal mealtimes in the community Procedures: 1. The Dining Service Director coordinates with the residents, administrator and/or Director of Nursing Services to establish the meal and snack times that are comparable with the normal times in the community. 2. A schedule of meal service times will be provided to the nursing staff and available in resident/patient care areas. 3. The Dining Services Director will ensure that each meal is served within the designated time frame unless there is an emergency situation or a resident request On 2/6/24 at 4:35 PM, ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the 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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 31753 Based on observation, staff interview, and clinical record review, the facility staff failed to provide an assistive device for a meal for one of 68 residents in the survey sample, Resident #145. The findings include: For Resident #145 (R145), the facility staff failed to provide an adaptive cup during lunch on 2/5/24. A review of R145's clinical record revealed a physician's order dated 1/31/24 that documented, Regular diet Regular texture, Regular/Thin Liquids consistency, drinks via PROVALE cup or feeder-controlled volume 10cc (cubic centimeters). On 2/5/24 at 9:27 a.m., R145 was observed lying in bed. A Styrofoam cup that contained ice water was observed on the nightstand beside the bed. An adaptive cup with a handle and a controlled volume lid was empty and on the nightstand. On 2/5/24 at 12:25 p.m., a CNA (certified nursing assistant) was observed feeding R145 and giving the resident spoonfuls of tea, instead of using the adaptive cup. On 2/6/24 at 2:11 p.m., an interview was conducted with CNA #21. CNA #21 stated R145 had a special sippy cup that the CNAs are supposed to use. On 2/6/24 at 4:36 p.m., ASM (administrative staff member) #1 (the executive director), and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Activities of Daily Living documented, 1. CNA will review the resident Kardex for information on individual care needs and preferences. R145's kardex did not document information regarding an adaptive cup. Reference: Designed for people with dysphagia, The Provale Cup delivers small sips of thin liquids with every normal drinking motion. https://www.provamed.com/provale-cup

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 29125 Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to store, prepare, and serve food in a sanitary manner in one of one facility kitchens and for three of 68 residents in the survey sample, Residents #46, #163 and #22. The findings include: 1. On 2/4/24 at 2:16 PM, an observation was made of the facility kitchen. The following were identified: in the walk-in freezer was a box of frozen green beans which had been opened, with the bag also open and the green beans exposed to the environment. In the walk-in refrigerator were loaves of prepackaged bread on which was water that had dripped from the condensation from a pipe above the bread. In the dishroom area there was a thick layer of white/yellowish substance spilled and dried all over floor by the paper products that were stored on shelves in the dishroom. Next to the substance was an open hole in dishroom floor approximately 10 inches by 10 inches filled with white unidentified liquid. Note: On follow up at 4:00 PM, OSM #1 (Other Staff Member) the Dietary Manager, stated that this substance was paint. She stated that on the other side of the wall was a sink where the maintenance department had been dumping paint after recent painting projects around the facility. She stated that the paint has caused blockages in the drain and was causing the drain to overflow and backup into the kitchen floor. On follow up observations in the kitchen on 2/4/24 starting at 4:31 PM and going to approximately 6:30 PM, the tray line services was observed. The following were noted: Trays were wet nesting at the tray line. OSM #1 used a cloth rag to wipe each tray down as she removed them from the stack to place on the steam table for service. Some of the plate bases bases were wet nested. Four male dietary aides (OSM #21, #22, #23, and #24) with varying amount of facial hair had no beard/moustache guards. Two female staff (OSM #20 the cook and OSM #25 a dietary aide) were observed with hair hanging from under the hair net at times. OSM #25 was observed to slinging chicken breasts (an alternative meal item) across other trays of food that she was plating, dripping cooked chicken juice on other residents food who did not have chicken. OSM #1, who was setting up each tray for tray line, propped trays on top of each other, in a roof shingle pattern. The trays all had been prepared with silverware and condiments on them, which were in contact with the bottom of other trays that were propped on top. On 2/05/24 at 3:17 PM, an interview was conducted with OSM #1 and OSM #16, the District Manager of dietary services. OSM #16 stated that he will in-service staff to make sure tray line is done properly. No other statements were made regarding specific identified concerns. The facility policy, Warewashing documented, All dishware will be air dried and properly stored. The facility policy, Preventing Foodborne Illnesses - Food Handling did not address the remaining concerns other than to document, 3. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. The issues regarding hair and beard/moustache restraints, the opened box of food in the freezer, and the dripping of condensation on food in the refrigerator were not addressed in polices provided. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/24 at 4:35 PM, ASM #1 (Administrative Staff Member) the Administrator and ASM #2 the Director of Nursing, were made aware of the findings. No further information was provided by the end of the survey. 29843 2. For Resident #46 (R46), facility staff touched the resident's drink cup with contaminated gloved hands. On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/15/2024, R46 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R46 was cognitively intact for making daily decisions. On 02/05/24 at approximately 9:04 a.m., an observation of R46's room revealed CNA (certified nursing assistant) #8 entered the room with two towels, put on a pair of gloves and began wiping up a yellow substance on the floor next to R46's bed covering an area approximately three feet long and twelve inches wide. After wiping up the substance on the floor, CNA #8 stood holding the soiled towels in her hands and backed into R46's over-the-bed table. When she backed into the table a drink cup tipped over on the table without falling off. While holding the soiled towels in her gloved hands, CNA #8 reached behind herself with one of the gloved hands, grabbed the cup and placed it in an upright position on the table, disposed of the soiled towels in a plastic bag, removed her gloves and washed her hands. On 02/08/2024 at approximately 8:05 a.m., an interview was conducted with CNA #8. When informed her of the observation described above, CNA #8 stated that she recalled the incident and realized what she failed to do. CNA #8 stated that she should have discarded the towels, removed the gloves, washed her hands then pick up R46's cup. When asked what the substance was that she cleaned up on the floor in R46's room CNA #8 stated that she did not know. When asked why she should have removed the gloves and wash her hands before picking up R46's cup CNA #8 stated that she could spread bacteria. On 02/07/2024 at approximately 4:45 p.m., ASM (administrative staff member) #1, executive director, ASM #2, director of nursing, ASM #3, regional director of clinical services, and ASM #5, vice president of risk management, were informed of the above findings. No further information was provided prior to exit. 31753 3. For Resident #163 (R163), the facility staff failed to handle the resident's soda bottle cap in a sanitary manner. On 2/6/24 at 11:14 a.m., R163 was observed sitting in the hall drinking a bottled soda. R163 dropped the soda bottle cap on the floor and OSM (other staff member) #16, the regional dietary manager, picked the cap up off the floor and handed it to the resident. R163 placed the cap back on the soda bottle. On 2/6/24 at 11:23 a.m., R163 removed the cap from the soda bottle and drank from the bottle. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/6/24 at approximately 11:45 a.m., an interview was conducted with OSM #16 who stated that if a resident drops anything, including a soda bottle cap on the floor, it should be disposed of or cleaned properly. OSM #16 stated that it was just an automatic reaction when he picked R163's bottle cap up off the floor and handed it back to the resident. On 2/7/24 at 4:49 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. 32642 4. For Resident #22 (R22), the facility staff failed to follow infection control procedures during service of the dinner meal on 2/4/24. On 2/4/24 at 5:25 p.m., CNA (certified nursing assistant) #8 was observed serving dinner trays. Before she entered R22's room, they had served another resident's tray. She did not wear gloves or sanitize her hands before getting R22's dinner tray out of the cart. She placed R22's dinner tray on their overbed table. She removed the covers off the plate and the individual serving pieces. She tore open salt and pepper packets and sprinkled them on the food. She put a sweetener in the tea, picked up R22's spoon, and stirred the tea. Without assisting R22 to sanitize her hands, CNA #8 left the room and R22 began eating. On 2/7/24 at 12:58 p.m., CNA #8 was interviewed. She stated when she serves meal trays, she should wash or sanitize her hands between serving each resident. When asked if she habitually assisted residents to wash their own hands before eating, she stated: I can't honestly say that I do. I probably should, though. She stated these are important parts of preventing the spread of germs and infection. On 2/7/24 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. 31753 Based on staff interview, and facility document review, the facility staff failed to maintain a written transfer agreement with a hospital potentially affecting all residents in the facility. The findings include: The facility staff failed to provide a written transfer agreement with one or more hospitals. On 2/9/24 at 11:51 a.m., an interview was conducted with ASM (administrative staff member) #1, the executive director. ASM #1 stated he was not able to produce a hospital transfer agreement. ASM #1 was made aware this was a concern and stated he will make sure it is corrected. The facility policy titled, Contract Management documented, All contracts entered into by Facilities should be routed through the contract management software to ensure they receive appropriate approval prior to execution and are properly stored.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49369 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide a complete pneumonia immunization program for two of five residents reviewed for immunizations, Residents #46 and #61. The findings include: 1. For Resident #46 (R46), who was admitted on [DATE], the facility staff failed to screen, educate, or offer to administer the pneumonia immunization. A review of R46's clinical record failed to reveal evidence that the resident was assessed for or offered the pneumonia vaccine. On 2/8/24 at 11:50 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. He stated that pneumonia vaccinations should be given during admission and the resident should be educated on the risks and benefits of the vaccine. On 2/8/24 at 4:16 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit. 2. For Resident #61 (R61), who was admitted on [DATE] the facility staff failed to screen, educate, or offer to administer the pneumonia immunization. A review of R61's clinical record failed to reveal evidence that the resident was assessed for or offered the pneumonia vaccine. On 2/8/24 at 11:50 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. He stated that pneumonia vaccinations should be given during admission and the resident should be educated on the risks and benefits of the vaccine. On 2/8/24 at 4:16 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. No further information was provided prior to exit.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49369 Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide a complete COVID-19 immunization program for one of five residents reviewed for immunizations, Resident #61. The findings include: For Resident #61 (R61), who was admitted on [DATE], the facility staff failed to provide evidence of education to the resident of the risks and benefits of the COVID-19 vaccine and failed to offer or administer the vaccine to the resident. A review of R61's clinical record revealed no evidence of the resident being educated about or offered the COVID-19 vaccine. On 2/8/24 at 11:50 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. He stated that COVID-19 vaccines should be given during admission and the resident should be educated on the risks and benefits of vaccine. On 2/8/24 at 4:16 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. A review of the facility policy, COVID-19 Vaccine-Resident, revealed, in part: Residents/representatives will be educated on the COVID-19 vaccine they are offered, in a manner they can understand, including information on the benefits and risks consistent with CDC and/or FDA information. This education will at a minimum include the FDA EUA Fact Sheet for the vaccine(s) being offered until such time that the CDC creates a vaccine information sheet (VIS): . Resident/representatives will be provided the opportunity to refuse the vaccine and/or change their decision about the vaccination at any time .Vaccine will be administered per manufacturer's recommendation .Review the COVID-19 consent with the resident/ resident representatives .file consent form in resident electronic health record .documentation includes but is not limited to: Residents (in the electronic health record) a) Whether the resident/ representative consented or declined the vaccine. No further information was provided prior to exit.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 42183 Based on observations, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to evidence bed inspections for one of 68 residents in the survey sample, Residents #148. The findings include: The facility staff failed to perform bed rail inspections for the use of positioning / assist bars for Resident #148. Resident #148 was observed in bed with bilateral quarter bed rails in use on 2/04/24 at 12:00 PM, on 2/05/24 at 9:45 AM and on 2/6/24 at 11:10 AM. A review of the physician orders dated 12/15/23, revealed, One fourth top rails to bed for turning and repositioning. A review of the facility's Seven Zones of Entrapment Worksheet revealed no bed inspections for the bed in the last twelve months. An interview was conducted on 2/4/24 at 12:00 PM with Resident #148. When asked if she used the bed rails, Resident #148 stated, Yes, they help me move. I like them for safety so I do not fall out of bed. An interview was conducted on 2/5/24 at 3:45 PM with OSM (other staff member) #2, the maintenance director. When asked to review the bed inspection documents provided, OSM #2 stated, Everything we have is in the book. We do not have many siderails, most of them are on the bariatric bed. An interview was conducted on 2/6/24 at 11:00 AM with OSM #2, the maintenance director. When told that there was no bed inspection for the bed in (room number), OSM #2 stated, That bed must not have been in place when we did the bed inspections. We go room to room and they move these beds around. On 2/6/24 at 4:40 PM, ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services was made aware of the findings. A review of the facility's Bed Rail / Side Rail policy, revealed, The Center, will attempt alternative interventions, and document in the medical record, prior to the use of side rail/bed rail. Side rail/bed rail may include but not limited to side rails, bed rails, safety rails, grab bars and assist bars. Prior to installation of a side rail/bed rail complete the side rail/bed rail evaluation to evaluate the resident for risk of entrapment. No further information was provided prior to exit.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49369 Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to maintain an effective pest control program for one of three facility units, Unit 3. The findings include: On 2/06/24 at 1:45 p.m., a tour of resident rooms was conducted. Large flies were observed flying in room [ROOM NUMBER] and outside room [ROOM NUMBER]. On 2/06/24 at 1:52 p.m. an interview was conducted with Resident #8 (R8). She stated that there were and still are cockroaches, flies and spiders that she will see in her room. A review of the pest control inspection reports revealed the following: 1. 9/5/23: Ecolab large fly program serviced .Performed exterior fly treatment. Performed interior spot treatment for large flies. No cockroach activity was noted during the inspection and/or service. 2. 9/20/23: Cockroach/Rodent program- Pest Activity Found. 3. 9/29/23: Cockroach/ Rodent program. Large fly problem . Cockroach activity was noted during services . Inspected and treated selected areas. 4. 10/9/23: Large fly program serviced . Target Pest: Cockroaches . Target Pest: Flies-Large Inspected and treated selected areas. 5. 10/24/23: Finding: Cockroaches noted during services. Two crs (cockroaches) found in WAR 1 2 storage closet .Target Pest: Cockroaches .Target Pest: Flies-Large . Inspected and treated selected areas. On 2/07/24 at 1:29 p.m., an interview was conducted with OSM (other staff member) #2, the director of maintenance. When asked if he is aware of reports of roaches in October, he stated that he does not know the exact dates, but he is aware they had issues with pests from before. He stated that pest control comes to the facility every week. He stated that when a resident reports pests he adds it to his personal maintenance log and will match it to his pest service reports. The facility policy, Pest Control, revealed, in part: The facility will maintain a pest control program, which includes inspection, reporting and prevention. This policy did not address the need to keep all areas of the facility, including resident rooms, free of food, dirt, debris, excess moisture, etc., that might attract pests. On 2/7/24 at 5:17 p.m., ASM #1, the executive director, ASM #2, the director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of risk management, were informed of these concerns. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 31753 Based on staff interview, and facility document review, the facility staff failed to maintain an effective training program for six of ten employee record reviews and failed to develop and implement a training program based on the facility assessment. The findings include: The facility staff failed to ensure training for multiple training topics, including communication, resident rights, abuse/neglect/exploitation, QAPI, compliance/ethics, and behavioral health, was completed by all required staff. Refer to F941, F952, F943, F944, F946, F947, and F949 for specific staff and topics that were not in compliance. A review of the facility assessment was conducted during the survey. On 2/9/24 at 10:48 a.m., ASM (administrative staff member) #1, the administrator stated he did not have evidence of a training program based on the facility assessment. The facility policy titled, In-Service Training- General documented, Employees will be provided training on required topics on an annual basis. Additional training may be provided based on the center Facility Assessment, areas of deficiency identified and to improve the overall knowledge of the staff.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 31753 Based on staff interview, and facility document review, the facility staff failed to ensure effective communication training was completed for one of five direct care staff employee reviews. The findings include: For RN (registered nurse) #2, the facility staff failed to ensure effective communication training was completed. RN #2 was hired on 1/18/22. The facility staff failed to provide evidence that RN #2 had completed effective communication training. On 2/9/24 at 12:28 p.m., an interview was conducted with OSM (other staff member) #17, the director of human resources. OSM #17 stated training for effective communication is in the facility online training system for staff to complete. OSM #17 stated the facility does not currently have a staff development coordinator, so she is going to monitor to make sure staff completes all required trainings. On 2/9/24 at 12:39 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, In-Service Training-General documented, 1. The Executive Director and/or the Director of Nursing /designee will be responsible for assigning, coordinating, and monitoring education and in-service training. 2. Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 31753 Based on staff interview, and facility document review, the facility staff failed to ensure resident rights training was completed for one of five employee reviews. The findings include: For RN (registered nurse) #2, the facility staff failed to ensure resident rights training was completed. RN #2 was hired on 1/18/22. The facility staff failed to provide evidence that RN #2 had completed resident rights training. On 2/9/24 at 12:28 p.m., an interview was conducted with OSM (other staff member) #17, the director of human resources. OSM #17 stated training for resident rights is in the facility online training system for staff to complete. OSM #17 stated the facility does not currently have a staff development coordinator, so she is going to monitor to make sure staff completes all required trainings. On 2/9/24 at 12:39 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, In-Service Training-General documented, 1. The Executive Director and/or the Director of Nursing /designee will be responsible for assigning, coordinating, and monitoring education and in-service training. 2. Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 31753 Based on staff interview and facility document review, the facility staff failed to ensure required dementia management and abuse training was completed for four of five CNA (certified nursing assistant) reviews. The findings include: For CNA #12, CNA #13, CNA #14, and CNA #15, the facility staff failed to ensure the CNAs completed dementia management training. For CNA #12 and CNA #13, the facility staff failed to ensure the CNAs completed abuse training. A review of employee records revealed CNA #12 was hired on 1/5/89, CNA #13 was hired on 3/22/22, CNA #14 was hired on 5/31/22, and CNA #15 was hired on 8/16/22. The facility staff failed to provide evidence that CNA #12, CNA #13, CNA #14, and CNA #15 had completed dementia management training, and failed to provide evidence that CNA #12 and CNA #13 had completed abuse training. On 2/9/24 at 12:28 p.m., an interview was conducted with OSM (other staff member) #17, the director of human resources. OSM #17 stated training for dementia management and abuse is in the facility online training system for staff to complete. OSM #17 stated the facility does not currently have a staff development coordinator, so she is going to monitor to make sure staff completes all required training. On 2/8/24 at 4:25 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, In-Service Training-General documented, 1. The Executive Director and/or the Director of Nursing /designee will be responsible for assigning, coordinating, and monitoring education and in-service training. 2. Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 31753 Based on staff interview, and facility document review, the facility staff failed to ensure QAPI (quality assurance and performance improvement) program training was completed for two of five employee reviews. The findings include: For RN (registered nurse) #2, and OSM (other staff member) #12, a laundry tech, the facility staff failed to ensure training regarding the facility QAPI program was completed. RN #2 was hired on 1/18/22 and OSM #12 was hired on 11/3/21. The facility staff failed to provide evidence that RN #2 or OSM #12 had completed training regarding the facility QAPI program. On 2/9/24 at 12:28 p.m., an interview was conducted with OSM (other staff member) #17, the director of human resources. OSM #17 stated training for QAPI is in the facility online training system for staff to complete. OSM #17 stated the facility does not currently have a staff development coordinator, so she is going to monitor to make sure staff completes all required training. OSM #17 stated the laundry staff did not have access to the facility on line training system but had their own training system. The laundry department was employed by a contracted company. On 2/9/24 at 12:18 p.m., an interview was conducted with OSM #13, the director of housekeeping and laundry. OSM #13 stated QAPI training is only provided to account managers and OSM #12 had not completed training regarding the facility QAPI program. On 2/9/24 at 12:39 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, In-Service Training-General documented, 1. The Executive Director and/or the Director of Nursing /designee will be responsible for assigning, coordinating, and monitoring education and in-service training. 2. Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. 31753 Based on staff interview, and facility document review, the facility staff failed to ensure annual compliance and ethics training was completed for two of five employee reviews. The findings include: For RN (registered nurse) #2, and OSM (other staff member) #12, a laundry tech, the facility staff failed to ensure annual compliance and ethics training was completed. RN #2 was hired on 1/18/22 and OSM #12 was hired on 11/3/21. The facility staff failed to provide evidence that RN #2 or OSM #12 completed annual compliance and ethics training. On 2/9/24 at 12:28 p.m., an interview was conducted with OSM (other staff member) #17, the director of human resources. OSM #17 stated training for compliance and ethics is in the facility online training system for staff to complete. OSM #17 stated the facility does not currently have a staff development coordinator, so she is going to monitor to make sure staff completes all required training. OSM #17 stated the laundry staff did not have access to the facility on line training system but had their own training system. The laundry department was employed by a contracted company. On 2/9/24 at 12:18 p.m., an interview was conducted with OSM #13, the director of housekeeping and laundry. OSM #13 stated compliance and ethics training is only provided to account managers and OSM #12 had not completed compliance and ethics. On 2/9/24 at 12:39 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, In-Service Training-General documented, 1. The Executive Director and/or the Director of Nursing /designee will be responsible for assigning, coordinating, and monitoring education and in-service training. 2. Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.

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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 annual in-service training for four of five CNA reviews. The findings include: For CNA #12, CNA #13, CNA #14, and CNA #15, the facility staff failed to ensure the CNAs completed annual abuse prevention and dementia management training. A review of employee records revealed CNA #12 was hired on 1/5/89, CNA #13 was hired on 3/22/22, CNA #14 was hired on 5/31/22, and CNA #15 was hired on 8/16/22. The facility staff failed to provide evidence that CNA #12, CNA #13, CNA #14, and CNA #15 had completed annual abuse prevention and dementia training. On 2/9/24 at 12:28 p.m., an interview was conducted with OSM (other staff member) #17, the director of human resources. OSM #17 stated training for abuse and dementia management is in the facility online training system for staff to complete. OSM #17 stated the facility does not currently have a staff development coordinator, so she is going to monitor to make sure staff completes all required training. On 2/8/24 at 4:25 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, In-Service Training-General documented, 1. The Executive Director and/or the Director of Nursing /designee will be responsible for assigning, coordinating, and monitoring education and in-service training. 2. Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 31753 Based on staff interview, and facility document review, the facility staff failed to ensure behavioral health training was completed for one of five employee reviews. The findings include: For RN (registered nurse) #2, the facility staff failed to ensure behavioral health training was completed. RN #2 was hired on 1/18/22. The facility staff failed to provide evidence that RN #2 had completed behavioral health training. On 2/9/24 at 12:28 p.m., an interview was conducted with OSM (other staff member) #17, the director of human resources. OSM #17 stated training for behavioral health is in the facility online training system for staff to complete. OSM #17 stated the facility does not currently have a staff development coordinator, so she is going to monitor to make sure staff completes all required training. On 2/9/24 at 12:39 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, In-Service Training-General documented, 1. The Executive Director and/or the Director of Nursing /designee will be responsible for assigning, coordinating, and monitoring education and in-service training. 2. Required education and in-services may include a combination of requirements based on Federal, State, and/or local regulations, company required in-service education topics and the center Facility Assessment. Each center is responsible to ensure that required Federal, State, and/or Local regulations are followed accordingly.