STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495368	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Newport Nursing and Rehabilitation Center	11141 Warwick Blvd Newport News, VA 23601

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 34306 Based on observations, staff interviews, and clinical record review, the facility staff failed to ensure that resident care information was not posted to be viewed in their room for 2 of 23 residents (Resident #27 and 36), in the survey sample. The findings included: Resident #27 was originally admitted to the facility 8/29/23 after an acute care hospital stay. The current diagnoses included stroke, dysphagia and adult failure to thrive. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/15/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 6 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were severely impaired. On 3/12/25 at approximately 4:10 PM a sign was observed above the head of the bed of Resident #27. The sign stated no straws. A review of the physician's orders failed to reveal an order for no straws and a review of the person-centered care plan dated 9/6/2023 - Present failed to identify and have interventions related to no use of straws. A care plan problem identified stated (name of the resident) is receiving mechanically altered diet/Mechanical soft diet. The goal stated (name of the resident) will maintain existing weight over the next 90 days. The intervention stated, Insert dentures/bridges prior to meals. Monitor and document weight. Record food intake at each meal; offer appropriate substitutes for uneaten food. Use of adaptive equipment while eating/drinking. A final interview was conducted with the Administrator, Director of Nursing, MDS Coordinator and three Corporate consultants on 3/18/25 at approximately 4:35 PM regarding the above information. The [NAME] President of Clinical Support stated the signage was not for the staff and she thought signage in a resident's room was appropriate for emergency support and to prevent family and friends from causing unnecessary problems for the resident. On 3/19/25 at approximately 1:15 PM another Clinical support staff #1 stated signage was appropriate as long as the resident and/or the resident representative directions. Clinical support staff #1's statement was acknowledged as correct but they failed to provide evidence that the signage was the resident and/or the resident representative directive. On 3/19/25 at approximately 1:10 PM the above information was provided to the above staff members. They provided no evidence and voiced no concerns. (continued on next page)

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

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #36 was originally admitted to the facility 1/9/25 after an acute care hospital stay. The current diagnoses included spinal stenosis. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/15/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #36's cognitive abilities for daily decision making were intact. On 3/12/25 at approximately 4:15 PM a sign was observed above the head of the bed of Resident #36. The sign stated no blood pressures in the left arm. An interview was conducted with the resident on 3/13/25 at approximately 2:05 PM regarding the signage above the head of the bed. Resident #36 stated she believes it was placed over the bed so others would know she experiences tingling and discomfort in the left arm. Resident #36 stated she did not request the signage. A review of the physician's orders revealed an order dated 1/15/2025 which stated, Please do blood pressures in the right arm only due to severe stenosis of the left subclavian artery which will give inaccurate blood pressures. Review of the resident's person centered care plan dated 1/9/2025 - Present failed to reveal an intervention which stated blood pressures in the right arm only. A final interview was conducted with the Administrator, Director of Nursing, MDS Coordinator and three Corporate consultants on 3/18/25 at approximately 4:35 PM regarding the above information. The [NAME] President of Clinical Support stated the signage was not for the staff and she thought signage in a resident's room was appropriate for emergency support and to prevent family and friends from causing unnecessary problems for the resident. On 3/19/25 at approximately 1:15 PM another Clinical support staff #1 stated signage was appropriate as long as the resident and/or the resident representative directions. Clinical support staff #1's statement was acknowledged as correct but they failed to provide evidence that the signage was the resident and/or the resident representative directive. On 3/19/25 at approximately 1:10 PM the above information was provided to the above staff members. They provided no evidence and voiced no concerns.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49917 Based on observation, resident interview, and staff interview the facility staff failed to maintain a clean, comfortable, homelike environment for 1 of 23 residents (Resident #244), in the survey sample. The findings included: Resident #244 was originally admitted to the facility 3/10/25 after an acute care hospital stay. The admission diagnoses included; spinal stenosis, paroxysmal atrial fibrillation, restless legs syndrome, and essential hypertension. The 5-day scheduled Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/13/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #244's cognitive abilities for daily decision making were intact. On 3/11/25 at 2:10 PM during an observation tour for room [ROOM NUMBER], it was observed that there was a large area on the drywall behind the resident bed headboard that was dirty with flacking paint and gauges in the wall. It was also observed that the floor under the bed was very dirty with black marks. On 3/11/25 at 2:12 PM an interview was conducted with Resident #244. Resident #244 stated, They have people paying private pay in this facility and there is no reason the walls and floors should look like this. Resident #244 also stated, You should look at some of the other rooms, they have the same issue as well. On 3/17/25 at 5:15 PM an interview was conducted with the Administrator. The Administrator stated that there are various rooms that have issues with the drywall behind the headboard of resident's beds. The Administrator also stated that the facility has a plan in place to fix this issue. On 3/19/25 at approximately 1:04 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Nursing, [NAME] President of Operations, Minimum Data Set Coordinator, Infection Preventionist, and Director of Clinical Support. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on observations, staff interviews, and clinical record reviews, the facility staff failed to develop a person-centered comprehensive care plan for 2 of 23 residents (Resident #27 and #34), in the survey sample. The findings included: 1. The facility staff failed to develop a person-centered comprehensive care plan to include to dysphagia for Resident #27. Resident #27 was originally admitted to the facility 8/29/23 after an acute care hospital stay. The current diagnoses included stroke, dysphagia and adult failure to thrive. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12/15/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 6 out of a possible 15. This indicated Resident #27's cognitive abilities for daily decision making were severely impaired. On 3/12/25 at approximately 4:10 PM a sign was observed above the head of the bed of Resident #27. The sign stated no straws. A review of the physician's orders failed to reveal an order for no straws and a review of the person-centered care plan dated 9/6/2023 - Present failed to identify and have interventions related to no use of straws and supervision with meals because of self-feeding impulsivity. A care plan problem identified stated (name of the resident) is receiving mechanically altered diet/Mechanical soft diet. The goal stated (name of the resident) will maintain existing weight over the next 90 days. The interventions stated, insert dentures/bridges prior to meals. Monitor and document weight. Record food intake at each meal, offer appropriate substitutes for uneaten food. Use of adaptive equipment while eating/drinking. A 12/05/23 Speech Therapist (ST) progress note stated the resident initially presented to the facility with an overall moderate oropharyngeal dysphagia, with the resident on a puree diet with thin liquids and no straws. The ST progress note further stated the resident was discharged from therapy with a mild-moderate oropharyngeal dysphagia, on a mechanical soft diet with thin liquids and no straws. The ST progress note also stated to continue to encourage supervision with meals due to self-feeding impulsivity. A final interview was conducted with the Administrator, Director of Nursing, MDS Coordinator and three Corporate consultants on 3/18/25 at approximately 4:35 PM regarding the above information. On 3/19/25 at approximately 1:10 PM the above information was provided to the above staff members. They provided no evidence and voiced no concerns. 40711 2. The facility's staff failed to ensure Resident #34 comprehensive care plan include the use of an abdominal binder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #34 was originally admitted to the facility 12/27/24 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Other disorders of plasma protein metabolism. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/22/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 00 out of a possible 15. This indicated Resident #34 cognitive abilities for daily decision making were severely impaired. In sectionGG(Functional Abilities Goals) the resident was coded as dependent with oral care, personal hygiene, toileting hygiene and shower/bathe self. The care plan read that the resident is receiving Tube Feeding (TF). The goal for the resident was that he will receive adequate nutrition without side effects associated with TFs. Interventions for the resident was to check tube placement by aspiration before giving feeding and elevate head of bed. The January 2025 Physicians Order Summary (POS) read: abdominal binder apply to prevent tugging of peg tube. May remove during care and replace check skin every shift. Order date: 1/18/25 at 8:31 AM. On 3/17/25 at approximately 1:15 PM., Resident #34 was assessed by the Director of Nursing (DON) to see if his Abdominal Binder (AB) had been placed on him. The resident's Abdominal Binder was not present on his abdomen. The resident was observed grabbing the bottom of his t-shirt. The DON was observed looking for the resident's (AB) but couldn't locate it. The DON left the resident's room. On 3/17/25 at approximately 1:35 PM., Licensed Practical Nurse (LPN) #2 was observed heading to the resident's room with another staff member. LPN #2 said that she would've noticed the binder wasn't on the resident's abdomen but she didn't administer his medications to him this morning. Shortly thereafter, LPN #2 with assistance from LPN #3 applied the abdominal binder around the resident's abdomen. LPN #2 said it's important to keep the binder on the resident to keep him from pulling his peg tube out. On 3/17/25 at approximately 2:30 PM., an interview was conducted with Certified Nursing Assistant (CNA) #2. CNA #2 said that when she came on shift this morning, there wasn't a binder on the resident. On 3/17/25 at approximately 5:20 PM., during the end of day meeting with the Administrator, DON and [NAME] President of Clinical Services (VPCS). The DON said that the Abdominal Binder was in the laundry due to it being soiled. A percutaneous endoscopic gastrostomy (PEG) is a surgery to place a feeding tube. Feeding tubes, or PEG tubes, allow you to receive nutrition through your stomach. You may need a PEG tube if you have difficulty swallowing or can't get all the nutrition you need by mouth.https://my.clevelandclinic.org/health/treatments/4911-percutaneous-endoscopic-gastrostomy-peg. After percutaneous endoscopic gastrostomy (PEG) tube placement, many surgeons will place an abdominal binder to protect the tube. https://pubmed.ncbi.nlm.nih.gov/22208829/ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at approximately 2:25 p.m., during the pre-exit the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant, The [NAME] President of Clinical Services (VPCS). The VPCS said, It was care planned. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to follow physician's order to ensure an abdominal binder was applied on a resident's abdomen to prevent pulling and or tugging of resident's peg tube for 1 of 23 residents (Resident #34), in the survey sample. The findings included: Resident #34 was originally admitted to the facility 12/27/24 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Other disorders of plasma protein metabolism. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/22/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 00 out of a possible 15. This indicated Resident #34 cognitive abilities for daily decision making were severely impaired. In sectionGG(Functional Abilities Goals) the resident was coded as dependent with oral care, personal hygiene, toileting hygiene and shower/bathe self. The care plan read that the resident is receiving Tube Feeding (TF). The goal for the resident was that he will receive adequate nutrition without side effects associated with TFs. Interventions for the resident was to check tube placement by aspiration before giving feeding and elevate head of bed. A review of the comprehensive care plan did not mention an andominal binder. The January 2025 Physicians Order Summary (POS) read: abdominal binder apply to prevent tugging of percutaneous endoscopic gastrostomy (peg) tube. May remove during care and replace check skin every shift. Order date: 1/18/25 at 8:31 AM. On 3/17/25 at approximately 1:15 PM., Resident #34 was assessed by the Director of Nursing (DON) to see if his Abdominal Binder (AB) had been placed on him. The resident's Abdominal Binder was not present on his abdomen. The resident was observed grabbing the bottom of his t-shirt. The DON was observed looking for the resident's (AB) but couldn't locate it. The DON left the resident's room. On 3/17/25 at approximately 1:35 PM., Licensed Practical Nurse (LPN) #2 was observed heading to the resident's room with another staff member. LPN #2 said that she would've noticed the binder wasn't on the resident's abdomen but she didn't administer his medications to him this morning. Shortly thereafter, LPN #2 with assistance from LPN #3 applied the abdominal binder around the resident's abdomen. LPN #2 said it's important to keep the binder on the resident to keep him from pulling his peg tube out. On 3/17/25 at approximately 2:30 PM., an interview was conducted with Certified Nursing Assistant (CNA) #2. CNA #2 said that when she came on shift this morning, there wasn't a binder on the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at approximately 5:20 PM., during the end of day meeting with the Administrator, DON and [NAME] President of Clinical Services (VPCS). The DON said that the Abdominal Binder was in the laundry due to it being soiled. A percutaneous endoscopic gastrostomy (PEG) is a surgery to place a feeding tube. Feeding tubes, or PEG tubes, allow you to receive nutrition through your stomach. You may need a PEG tube if you have difficulty swallowing or can't get all the nutrition you need by mouth.https://my.clevelandclinic.org/health/treatments/4911-percutaneous-endoscopic-gastrostomy-peg. After percutaneous endoscopic gastrostomy (PEG) tube placement, many surgeons will place an abdominal binder to protect the tube. https://pubmed.ncbi.nlm.nih.gov/22208829/ On 3/18/25 at approximately 2:25 p.m., during the pre-exit the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant, The [NAME] President of Clinical Services (VPCS). An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 34306 Based on resident interview, staff interview, and a clinical record review, the facility staff failed to supervise each resident to prevent avoidable falls for 2 of 23 residents (Resident #36 and 294), in the survey sample. The findings included: 1. Resident #36 was originally admitted to the facility 1/9/25 after an acute care hospital stay. The current diagnoses included spinal stenosis. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/15/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #36's cognitive abilities for daily decision making were intact. The MDS assessment was not coded for toileting transfers due to her medical condition or safety concerns. On 3/13/25 at approximately 2:05 PM an interview was conducted with Resident #36. The resident stated she had a fall in the bathroom after she had completed elimination and washing her hands. The resident stated she turned to get paper towels and lost her balance. She stated Certified Nursing Assistant CNA) #1 was nearby but she was unable to render assistance to prevent the fall. A review of the nurse's notes dated 2/27/25 at 6:43 PM, revealed Resident #36 had a fall at 4:30 PM. The nurse documented the resident was observed sitting on the floor. The resident stated she lost her balance and fell , striking her head on the tile. The resident also stated, her head hurt where she hit it. The nurse further documented upon assessment there were no bumps to the head palpated, therefore the resident was assisted into the wheelchair and then to bed. An interview was conducted with CNA #1 on 3/17/25 at 4:05 PM. CNA #1 stated she was with the resident when she experienced the fall on 2/27/25 but she was unable to intervene when the resident turned and lost her balance falling to the floor. CNA #1 stated because of the size of the bathroom and the position of the resident's walker, which was between her and the resident, she was unable to get to the resident. The person centered care plan dated 1/9/2025 - Present had a care plan problem which stated (name of the resident) is at risk for injury due to falls. The goal stated minimize the risk of injury due to falls. The interventions included, communicate with oncoming shift resident's risk status - make sure resident has someone with her when she's walking, doing ADL care to aid in preventing a fall if she loses her balance and assess the need for a personal /sensor mat alarm. The resident's person centered care plan also stated (name of the resident) has the potential for health and safety concerns related to ADL needs and her mobility status. The goal stated maintain (name of the resident) safety through appropriate assistance and safety measures. The interventions included assist with toileting as needed and provide assistive device for safest mobility based on the most current transfer assistance evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A final interview was conducted with the Administrator, Director of Nursing (DON), MDS Coordinator and three Corporate consultants on 3/18/25 at approximately 4:35 PM regarding the above information. The DON stated they would revisit the bathroom for appropriateness. On 3/19/25 at approximately 1:10 PM the above information was provided to the above staff members. They provided no additional information and voiced no concerns. 2. Resident #294 was originally admitted to the facility 3/3/25 after an acute care hospital stay. The current diagnoses included cellulitis of the right lower extremity and fluid retention of bilateral lower extremities. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/8/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #294's cognitive abilities for daily decision making were severely impaired. At section G00170 (Mobility) the resident was coded as requiring substantial/maximal assistance for toilet transfers. The active care plan dated 3/12/2025 - Present, had a problem which stated (name of the resident) is at risk for injury due to falls The goal stated minimize the risk of injury due to falls. The interventions included, 3/3/25 - Communicate with oncoming shift resident's risk status - resident needs constant reminders to use her call bell due to cognition, Staff to complete purposeful rounds on resident and 3/4/25 - Ensure resident is accompanied and not left alone when toileting, remind resident to please call for assistance with any ADL need. On 3/17/25 at approximately 3:30 PM an interview was conducted with Resident #294. Resident #294 stated she could speak five languages fluently. She was observed removing her shoes and attempting to put her severely edematous lower extremities onto the bed. The resident stated she had a fall but she was unable to state when or how, therefore a chart review was conducted. A nurse's note dated 3/3/25 at 6:30 PM revealed the resident was found on the floor beside her bed. The note also stated the resident was sitting on her bottom, facing her bed with her feet under her bed. The note further stated the resident said she slipped. Nonskid sock were provided to the resident, and she was encouraged to use the call bell for assistance. Another nurse's note dated 3/4/25 at 2:07 PM stated the Resident was placed on the toilet by CNA 10. and CNA #10 left the resident to get something and upon her return the resident was observed on the floor. A final interview was conducted with the Administrator, Director of Nursing (DON), MDS Coordinator and three Corporate consultants on 3/18/25 at approximately 4:35 PM regarding the above information. On 3/19/25 at approximately 1:10 PM the above information was provided to the above staff members. They provided no additional information and voiced no concerns.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure an abdominal binder was applied on a resident's abdomen to prevent pulling and or tugging of resident's peg tube for 1 of 23 residents (Resident #34), in the survey sample. The findings included: Resident #34 was originally admitted to the facility 12/27/24 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Other disorders of plasma protein metabolism. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/22/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 00 out of a possible 15. This indicated Resident #34 cognitive abilities for daily decision making were severely impaired. In sectionGG(Functional Abilities Goals) the resident was coded as dependent with oral care, personal hygiene, toileting hygiene and shower/bathe self. The care plan read that the resident is receiving Tube Feeding (TF). The goal for the resident was that he will receive adequate nutrition without side effects associated with TFs. Interventions for the resident was to check tube placement by aspiration before giving feeding and elevate head of bed. A review of the comprehensive care plan does not mention an andominal binder. The January 2025 Physicians Order Summary (POS) read: abdominal binder apply to prevent tugging of percutaneous endoscopic gastrostomy (peg) tube. May remove during care and replace check skin every shift. Order date: 1/18/25 at 8:31 AM. On 3/17/25 at approximately 1:15 PM., Resident #34 was assessed by the Director of Nursing (DON) to see if his Abdominal Binder (AB) had been placed on him. The resident's Abdominal Binder was not present on his abdomen. The resident was observed grabbing the bottom of his t-shirt. The DON was observed looking for the resident's (AB) but couldn't locate it. The DON left the resident's room. On 3/17/25 at approximately 1:35 PM., Licensed Practical Nurse (LPN) #2 was observed heading to the resident's room with another staff member. LPN #2 said that she would've noticed the binder wasn't on the resident's abdomen but she didn't administer his medications to him this morning. Shortly thereafter, LPN #2 with assistance from LPN #3 applied the abdominal binder around the resident's abdomen. LPN #2 said it's important to keep the binder on the resident to keep him from pulling his peg tube out. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at approximately 2:30 PM., an interview was conducted with Certified Nursing Assistant (CNA) #2. CNA #2 said that when she came on shift this morning, there wasn't a binder on the resident. On 3/17/25 at approximately 5:20 PM., during the end of day meeting with the Administrator, DON and [NAME] President of Clinical Services (VPCS). The DON said that the Abdominal Binder was in the laundry due to it being soiled. A percutaneous endoscopic gastrostomy (PEG) is a surgery to place a feeding tube. Feeding tubes, or PEG tubes, allow you to receive nutrition through your stomach. You may need a PEG tube if you have difficulty swallowing or can't get all the nutrition you need by mouth.https://my.clevelandclinic.org/health/treatments/4911-percutaneous-endoscopic-gastrostomy-peg. After percutaneous endoscopic gastrostomy (PEG) tube placement, many surgeons will place an abdominal binder to protect the tube. https://pubmed.ncbi.nlm.nih.gov/22208829/ On 3/18/25 at approximately 2:25 p.m., during the pre-exit the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant, The [NAME] President of Clinical Services (VPCS). An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49917 Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide the necessary behavioral health services for 1 of 23 residents (Resident #30), in the survey sample. The findings included: Resident #30 was originally admitted to the facility 8/19/24 after an acute care hospital stay. The admission diagnoses included; congestive heart failure, muscle weakness, pain in left shoulder, and essential hypertension. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/17/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #30's cognitive abilities for daily decision making were intact. On 3/11/25 at 1:50 PM an interview was conducted with Resident #30. Resident #30 stated, How do you think I'm doing? Would you be happy living like this? I lay here every day looking at this ceiling and they do nothing for me. I'm so fucking angry. On 3/12/25 at 2:10 PM an interview was conducted with the Administrator. The Administrator stated that Resident #30's wife and son passed away and he is having a hard time. On 3/18/25 at 2:24 PM an interview was conducted with the Administrator. The Administrator stated, No we do not have any referrals for Psych services. I spoke with the Psych Nurse Practitioner (NP), and she said that she will reach out to the NP. The Care Plan with an effective date of 8/28/24 through Present read that resident has a potential for impaired quality of life related to new environment and change in health status. The goal was resident's mood and behaviors will be monitored and managed. The interventions for Resident #30 was provide emotional support, provide non-pharmacological interventions as appropriate such as: offer fluids, offer snack, toileting, repositioning, assist as needed communication with family and friends, and monitor for safe environment and psychosocial well-being. Nursing Progress Notes included the following notations: 8/20/24 at 12:03 PM: Res reports feelings of social isolation often. 8/21/24 at 10:55 PM: Resident refusing tylenol and crestor. He stated that the tylenol gives him chest pain and the crestor gives him welts all over his body. NP made aware. She will discontinue the tylenol. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/19/24 at 5:43 PM: Attempts made for PT evaluation on Wednesday, September 18, 2024. Patient was clear and alert when he declined PT services. Patient was able to follow the explanation and the benefits of PT interventions and ultimately determined he would not be participating. No PT indicated at this time. 10/2/24 at 11:03 PM: Resident refused some of his medications tonight. He took one of the 4 COVID meds, refused Percocet. 10/3/24 at 3:00 PM: Resident refused all medications when asked. 10/4/24 at 2:21 PM: Resident refused all medications today. 10/9/24 at 10:05 PM: Resident stated he would take his pills and when I brought them in he refused. 10/16/24 at 9:54 PM: Resident refuses to take MOM. He said he will poop when he is ready. 10/21/24 at 2:21 PM: Refused all am medication. Became very verbal abusive with cursing and yelling. 10/22/24 at 10:22 PM: Resident refused all medications this shift. 10/23/24 at 9:08 AM: Resident refused all morning meds expect percocet and metoprolol. he states nope only two pills. 10/23/24 at 9:24 PM: Resident refused his Percocet at 10pm. Accidently signed it off. Resident refused all medications for me today. 10/24/24 at 8:24 AM: NP notified of resident refusing some medications. 10/30/24 at 7:35 AM: Resident refused morning medications. Stated he's not taking anymore medications for today. 11/21/24 at 6:46 PM: Res reports feelings of social isolation often. 12/2/24 at 11:19 AM: Resident yelling in the hallway god damit to PT i pay you to push me iam not pusing myself. 12/26/24 at 12:51 PM: CNA reported that the patient had cussed her out, and was yelling at her because he wanted his tray picked up because he was finished. The CNA reported that they do come around to pick the trays up, they just wait to give everyone a chance to eat their meal, and are assisting some residents with their meal. The patient stated to the CNA that he would just start calling to the front desk to tell them to come and get his tray. Patient continued to be verbally abusive to the staff, so the staff stated that she walked away. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/28/24 at 11:45 AM: Patient communicated during med pass I am not taking any cough syrup! Communicated to patient that I did not have cough syrup to administer at present. Assisted patient with sitting up in bed and patient became belligerent again stating that he was not taking cough syrup. This nurse communicated again that cough syrup was not being given to him at this time. Patient snatched water cup out of my hand. Patient had recurring outbursts during ADL care and when attempting to refuse care or medication. Patient was able to be redirected. No additional concerns communicated during this encounter. 1/18/25 at 12:01 PM: Resident is calling the front desk stating she's a [NAME] that she didnt page for help three cnas went to room to change him and he was not wet or dirty he than [NAME] they are liars, cna showed resident the brief. care is ongoing. 1/21/25 at 10:14 PM: Pt refused Senna this shift. 1/23/25 at 10:14 AM: Per lab refused to have labs drawn Spoke with NP [NAME]. Attempt x1 more. Placed back on schedule. 1/24/25 at 9:36 AM: Refused to have bmp,cbc and HgbA1c drawn per lab. NP [NAME] notified. 2/6/25 at 9:03 AM: Resident refused all morning medications states he not taking them today attempted two times. 2/11/25 at 10:08 PM: Pt refused Senna during evening med pass. 2/17/25 at 5:24 PM: Res reports feelings of social isolation often. 2/25/25 at 9:43 PM: Pt refused Senna this shift. 2/26/25 at 6:29 PM: SW supports IDT goals and will continue to follow resident's psychosocial needs as needed. 3/2/25 at 1:59 PM: Pt refused all medication this morning with the exception of Aspirin. No additional concerns this shift. On 3/18/25 at 5:12 PM an interview was conducted with the NP. The NP stated that residents are referred to behavioral health services when that individual is having issues such as suicidal ideations or behaviors. The NP also stated the Social Worker or Nursing screens the residents and will inform her when she should refer to Psych services. The NP further stated that she did not know that Resident #30 reported feelings of social isolation often and has been refusing medications recently. The NP lastly stated, hearing from what we have discussed, maybe we should have referred to Psych services. On 3/19/25 at approximately 1:04 PM, a final interview was conducted with the Administrator, Director of Nursing, [NAME] President of Nursing, [NAME] President of Operations, Minimum Data Set Coordinator, Infection Preventionist, and Director of Clinical Support. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on information obtained during the Antibiotic Stewardship task, staff interviews and clinical record review, the facility staff failed to have laboratory reports filed in the resident's clinical record for 1 of 23 residents (Resident #7), in the survey sample. The findings included: Resident #7 was originally admitted to the facility 12/18/23. The current diagnoses included a stroke and dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/11/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 1 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making were severely impaired. During the Antibiotic Stewardship task, on 3/17/25 at approximately 1:05 PM, it was identified that Resident #7 was diagnosed with a urinary tract infection on 3/10/25 at 11:35 PM, and started on an antibiotic. A further review revealed a nurse's note dated 3/07/25 at 7:58 PM which stated that Resident #7 was observed putting a cheeseburger with ketchup, mustard, and pickle into her vaginal area and complaining of pain in the area. Another nurse's note dated 3/10/2025 at 11:35 AM stated a urine specimen was obtained via catheter and the urine was very cloudy with a green milky tint and sediment. A new order was obtained on 3/10/25 at 12:13 PM to start Cipro (an antibiotic) 500 mg two times each day for seven days. On 3/17/25 a review of Resident #7's laboratory reports in the electronic record failed to reveal a urinalysis (a test conducted on urine) and urine culture and sensitivity (a test to identify microorganisms in urine) which were collected on 3/11/25. The Infection Preventionist had a copy of the urinalysis in a book that she brought to the interview on 3/17/25. The urinalysis had not been signed by a Physician or Practitioner to acknowledge the report had been reviewed. A review of the urinalysis final report was dated 3/11/25 at 11:24 PM and the culture and sensitivity final report was conveyed to the facility on [DATE] at 11:03 AM. A final interview was conducted with the Administrator, Director of Nursing (DON), MDS Coordinator and three Corporate consultants on 3/18/25 at approximately 4:35 PM regarding the above information. The [NAME] President of Clinical Operations (VPCO) stated the report was in the Nurse Practitioner's book waiting for a review and signature. The VPCO also stated that there is a delay in getting lab reports to the clinical record because they must be uploaded to the record because the lab's software does not interface with the facility's software. On 3/19/25 at approximately 1:10 PM the above information was provided to the above staff members. They provided no additional information and voiced no further concerns.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 34306 Based on information obtained during the Antibiotic Stewardship task, staff interviews and clinical record review, the facility staff failed to maintain a medical record which was complete and readily accessible for 1 of 23 residents (Resident #7), in the survey sample. The findings included: Resident #7 was originally admitted to the facility 12/18/23. The current diagnoses included a stroke and dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/11/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 1 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making were severely impaired. During the Antibiotic Stewardship task, on 3/17/25 at approximately 1:05 PM, it was identified that Resident #7 was diagnosed with a urinary tract infection on 3/10/25 at 11:35 PM, and started on an antibiotic. A further review revealed a nurse's note dated 3/07/25 at 7:58 PM which stated that Resident #7 was observed putting a cheeseburger with ketchup, mustard, and pickle into her vaginal area and complaining of pain in the area. Another nurse's note dated 3/10/2025 at 11:35 AM stated a urine specimen was obtained via catheter and the urine was very cloudy with a green milky tint and sediment. A new order was obtained on 3/10/25 at 12:13 PM to start Cipro (an antibiotic) 500 mg two times each day for seven days. On 3/17/25 a review of Resident #7's Nurse Practitioner/Physician's progress notes in the electronic record failed to reveal documentation concerning the resident's change in condition which resulted in a new orders on 3/10/25. On 3/17/25 a progress note was created but it still was not readily available on 3/19/25 at the time the survey ended. A final interview was conducted with the Administrator, Director of Nursing (DON), MDS Coordinator and three Corporate consultants on 3/18/25 at approximately 4:35 PM regarding the above information. The [NAME] President of Clinical Operations (VPCO) stated the report was in the Nurse Practitioner's book waiting for a review and signature. On 3/19/25 at approximately 1:10 PM the above information was provided to the facility's staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure enhanced barrier precautions were followed while providing wound care for 1 of 23 residents to prevent the spread of infection (Resident #10), in the survey sample. The findings included: Resident #10 was originally admitted to the facility on [DATE] and readmitted [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Pressure Injury of bilateral heels. The quarterly revision, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/28/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #10 cognitive abilities for daily decision making were intact. The care plan read that Resident #10 has a bilateral pressure injuries to his heels. Focus: The goal for the resident is that the size of the ulcer will decrease with evidence of healing over the next 90 days. Interventions for the resident include to provide wound care specialist evaluation and treat as ordered and administer dietary supplements as ordered. The Physician Order Summary (POS) Infection Control Precautions-Enhanced Barrier Notes : Instructions: Therapeutic Range: Ordering Prescriber: Nurse Pratictioner order date 1/18/25 at 8:31 AM. The Enhanced Barrier Precautions sign placed outside of the resident's door read the following: Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must also: Wear gloves and a gown for the following High - Contact Resident Care Activities such as: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, changing briefs or assisting with toileting Device care or use: Central line, urinary catheter, feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing. A wound care observation was conducted on 3/12/25 at approximately 2:35 PM., with Licensed Practical Nurse (LPN) #2. LPN #2 was observed performing wound care on Resident #10s bilateral heels without wearing a gown as indicated on the Enhanced Barrier Precaution sign that was located near the resident's room entry door. On 3/12/25 at approximately 2:55 PM., an interview was conducted with LPN #2 concerning the above issues. LPN #2 said that she was so busy providing wound care to the resident, that she forgot to put on a gown (PPE). On 3/17/25 at approximately 1:15 PM., a brief encounter was made with the Director of Nursing (DON) concerning Resident #10. The DON said that she was aware of what happened and has since educated the staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Enhanced barrier precautions (EBP), with the us of PPE is expanded for everyone's protection. Staff are required to use gown and during high-contact resident care activities that might result in the transfer of multidrug-resistant organisms (MDROs) to staff hands and clothing. MDROs then may be indirectly transferred from resident to resident during these high-contact activities, such as: Dressing, bathing and showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use: Central line indwelling urinary catheter (IUC), feeding tube, tracheostomy/ventilator, Wound care: any skin opening requiring a dressing2 https://www.medline.com/strategies/infection-prevention/enhanced-barrier-precautions-for-nursing-homes/ On 3/18/25 at approximately 2:25 p.m., during the pre-exit the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.