STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Bon Air	9101 Bon Air Crossings Drive Bon Air, VA 23235

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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 - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42106 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to evidence notification of the responsible party of a fall for 1 of 43 residents in the survey sample, Resident #323. The findings include: For Resident #323 (R323), the facility staff failed to evidence notification of the responsible party of a fall on 4/2/2024. The admission record for R323 documented a designated responsible party/power of attorney/emergency contact person for the resident with phone number listed. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/3/2024, the resident scored 4 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. Section J documented R323 having one fall with fracture prior to admission and one fall since admission to the facility with injury but not major injury. The comprehensive care plan for R323 documented in part, [Name of R323] is at risk for fall related injury and falls R/T (related to) fall hx (history), generalized weakness, decreased functional mobility. Date Initiated: 03/28/2024. Review of R323's progress notes revealed the following: - 4/2/2024 23:27 (11:27 p.m.) Note Text: Resident found lying on her right side near the toilet she seemed to be trying to transfer herself to the bathroom. Resident vitals and neurological status taken, resident redirected and taken into bed. She was re educated on using her call bell before trying to transfer. She was noted to have a skin tear to left shin as well as well as a small skin tear and bruising to right rib. The progress notes failed to evidence notification of the responsible party for the fall on 4/2/2024. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the fall investigation for R323 documented the physician notified of the fall on 4/2/2024 at 23:23 (11:23 p.m.). On 6/26/2024 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that when a resident had a fall they assessed the resident for injury, assisted them back to bed or the chair and notified the responsible party, the director of nursing and the physician. She stated that the responsible party was notified at the same time the physician was notified unless it was in the middle of the night and not emergent and then they notified the responsible party the next morning. On 6/26/2024 at 1:45 p.m., an interview was conducted with LPN #3. LPN #3 stated that he remembered R323 vaguely but did not recall the fall on 4/2/2024 or the progress note written. He stated that if a resident was found on the floor they assessed range of motion, take vital signs, do a skin assessment, check the residents head and assess for any injury. LPN #3 stated that they notified the responsible party and the physician any time a resident fell and documented in the progress notes. On 6/26/2024 at 2:00 p.m., an interview was conducted with LPN #4. LPN #4 stated that when a resident had a fall they assessed them for injury, checked their vital signs, and contacted the physician for further orders. LPN #4 stated that they also notified the responsible party of the fall and documented it in the progress notes. The facility policy Fall Management dated 9/22/2023 documented in part, . The licensed nurse will notify the attending physician and the responsible party of the fall, and document the notification in the medical record . On 6/27/2024 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional clinical coordinator were made aware of the findings. No further information was provided prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 31753 Based on staff interview and clinical record review, the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 43 residents in the survey sample, Resident #121. The findings include: For Resident #121 (R121), the facility staff failed to code the resident's discharge as, planned on the discharge MDS assessment with an ARD (assessment reference date) of 4/5/24. Section A0310 of R121's discharge MDS assessment with an ARD of 4/5/24 documented, F. Entry/discharge reporting: 10. Discharge-return not anticipated. G. Type of Discharge: 2. Unplanned. A review of R121's clinical record revealed a nurse's note dated 4/6/24 that documented the resident discharged home. On 6/26/24 at 11:11 a.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator). RN #1 stated she had documented in her book that R121's discharge was planned but she accidentally coded the discharge as unplanned on the MDS assessment. RN #1 stated this was a coding error and she follows the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments. On 6/26/24 at 2:47 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The CMS RAI manual documented, Coding Instructions for A0310G. Code 1: if type of discharge is a planned discharge. Code 2: if type of discharge is unplanned. No further information was presented prior to exit.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to implement the baseline care plan for one of 43 residents in the survey sample, Resident #76. The findings include: For Resident #76 (R76), the facility staff failed to implement the resident's baseline care plan for oxygen administration. A review of R76's clinical record revealed a baseline care plan dated 6/11/24 that documented, (Name of R76) has a potential for difficulty breathing and risk for respiratory complications R/T (Related To): COPD (Chronic Obstructive Pulmonary Disease) exacerbation, chronic hypoxic respiratory failure, use of O2 (oxygen). Apply O2 per physician's orders. A Brief Interview for Mental Status assessment dated [DATE] documented R76 was cognitively intact, scoring a 15 out of 15. Further review of R76's clinical record revealed a physician's order dated 6/24/24 for continuous oxygen at two liters per minute. On 6/24/24 at 3:13 p.m., R76 was observed receiving oxygen via nasal cannula at a rate between three and half and four liters per minute, as evidenced by the middle of the ball in the oxygen concentrator flowmeter positioned between the three and half and four-liter lines. On 6/25/24 at 10:46 a.m., R76 was observed receiving oxygen via nasal cannula at a rate between one and half and two liters per minute, as evidenced by the middle of the ball in the oxygen concentrator flowmeter positioned between the one and half and two-liter lines. R76 stated he doesn't know how to adjust his oxygen and he does not adjust his oxygen concentrator flowmeter. On 6/26/24 at 10:03 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the purpose of the care plan is so staff can figure out how to best care for the patient. LPN #1 stated nurses can look at the care plan any time to ensure they are implementing it. LPN #1 stated nurses administer oxygen per the physician's orders and should check the rate of oxygen any time they are in the resident's room. LPN #1 stated the middle of the ball in the oxygen concentrator flowmeter should be on the two-liter line if the physician's order is for two liters. On 6/26/24 at 2:47 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Care Planning documented, Every resident in the facility will have a person-centered Plan of Care developed and implemented . No further information was presented 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. 29125 Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for four of 43 residents; Residents #97, #22, #19, and #86. The findings include: 1. For Resident #97, the facility staff failed to implement the comprehensive care plan related to the Foley catheter. A review of the comprehensive care plan revealed one dated 2/12/24 for (Resident #97) is at risk for urinary tract infection and catheter-related trauma: has Indwelling Catheter 16F r/t (related to) chronic obstructive uropathy. This care plan included the intervention, dated 2/13/24 for Ensure the drainage bag is secured properly with a dignity cover in place. On 6/25/24 at 10:21 AM, Resident #97 was observed in her room up in the wheelchair. The Foley catheter bag was hanging under the wheelchair, with the bag mostly laying on the floor. On 6/25/24 at 10:32 AM Resident #97 was observed sitting in the doorway just outside of her room asking a staff member for water. The Foley bag was still noted to be dragging the floor. The staff member did not address the Foley bag on the floor. On 6/25/24 at 10:37 AM, Resident #97 was back in her room. Upon passing by the resident's room, it was noted that the resident was sitting in her wheelchair approximately three quarters of the way to the opposite side of the room from the door, with the Foley catheter bag laying on the floor several feet behind her wheelchair, with the tubing fully stretched from the bag to the resident. On 6/27/24 at 9:28 AM, an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated that the Foley bag should not be on the floor. She stated that risks would include urinary tract infections and urethral trauma. When asked if the care plan intervention to ensure the drainage bag was secured properly was being followed, she stated that it was not. On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She stated that the resident likes to have the tubing in her pant leg and that makes it difficult to keep the Foley off the floor. She stated that it should be hung higher up on the wheelchair to keep it off the floor. When asked if the care plan intervention to ensure the drainage bag was secured properly was being followed, she stated that it was not. The facility policy, Care Planning documented, Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nuring, and mental and psychosocial needs . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #22, the facility staff failed to implement the comprehensive care plan to monitor for the use of an anticoagulant medication; and failed to implement the comprehensive care plan to have a fall matt by the bed; and failed to develop a comprehensive care plan for the safety intervention of having the bed by the wall. A. Anticoagulant medication: A review of the clinical record revealed a physician's order dated 2/25/24 for Eliquis (1) Oral Tablet 2.5 MG (milligrams) (Apixaban) Give 1 tablet by mouth two times a day for a fib (atrial fibrillation). There were no orders for consistent (daily or every shift) monitoring of the use of this medication. A review of the MAR (Medication Administration Record) and TAR (Treatment Administration Record) for February through June, 2024, failed to reveal any evidence of this ongoing monitoring. On 6/27/24 at 11:18 AM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that monitoring should be done daily and that it should be documented in the progress notes or on the MAR. She stated that risks of anticoagulant medication includes bleeding. When asked what signs of bleeding would she look for, she was not able to identify any. A review of the comprehensive care plan revealed one dated 11/23/22 for Administer medication as ordered. Observe for ineffectiveness and side effects. A second intervention dated 11/23/22 documented, (Resident #22) is at risk for abnormal bleeding/bruising r/t (related to) Medication use: -Anticoagulant. Dx (diagnosis) A Fib. An intervention dated 11/23/22 documented, Observe and report to physician PRN (as needed) s/sx (signs and symptoms) of complications: blood tinged/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, , diarrhea, muscle joint pain, lethargy, bruising , blurred vision, SOB (shortness of breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs), bleeding gums, petechiae, back or abdominal pain and nosebleeds. The facility policy, Care Planning documented, Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nuring, and mental and psychosocial needs . On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. References: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) Eliquis is used to help prevent strokes or blood clots in people who have atrial fibrillation and to prevent deep vein thrombosis and pulmonary embolism. Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html B. Fall matt: A review of the physician's orders revealed one dated 4/29/23 for Fall mat to the right side of bed while guest is in bed. A review of the comprehensive care plan revealed one dated 11/22/22 for (Resident #22) is at risk for fall related injury and falls . An intervention dated 5/1/23 documented, Fall matt to right side of bed. On 6/24/24 at 12:42 PM and at 2:54 PM, 6/25/24 at 10:17 AM and on 6/27/24 at 9:13 AM, Resident #22 was observed in bed. There was no fall mat next to the right side of the bed per physician's order. On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She stated that the physician order and care plan for the fall mat was not being followed as required. The facility policy, Care Planning documented, Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nuring, and mental and psychosocial needs . On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. C. Bed by the wall: A review of the clinical record revealed a Physical Device Evaluation dated 12/18/22. This evaluation documented that the type of safety device to be used was Bed against the wall and the reason was for Safety awareness. A review of the Siderail Informed Consent dated 12222 (incorrect date format which made it difficult to determine what was the intended date) documented, Bed against (the wall) Left side of the bed. No rails. On 6/24/24 at 12:42 PM and at 2:54 PM, 6/25/24 at 10:17 AM and on 6/27/24 at 9:13 AM, Resident #22 was observed in bed. The bed was noted to be approximately 12 to 18 inches away from the wall on the left side. The bed was not against the wall, per the facility's individualized assessment to implement this safety measure for Resident #22. A review of the comprehensive care plan, including cancelled and resolved items, failed to reveal any evidence of the assessed need of the bed against the wall being care planned. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She stated that having the bed against the wall helps prevent the resident from rolling out of the bed and that it should be care planned. She stated that this facility-assessed safety measure was not being implemented. She stated that staff were told not to put any beds against the walls. Further review of the clinical record failed to reveal any evidence of an updated Physical Device Evaluation and informed consent, or any nurse's notes, indicating that Resident #22 was individually evaluated to determine that the safety measure of having the bed against the wall was no longer required. On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. On 6/27/24 at approximately 12:45 ASM #2 stated that the facility removed the intervention from all residents for the bed against the wall, and that the care plans were updated to remove this. She stated that she didn't think about updating the siderail assessments and consents to reflect this change or to document in nurse's notes to reflect that the beds were to no longer be against the wall. As there was no updated individualized reassessment of Resident #22 to determine if she no longer required having the bed against the wall, this remained a concern that facility assessed intervention was not being implemented and care planned. 3. For Resident #19, facility staff failed to implement the comprehensive care plan to maintain the bed against the wall. On 6/24/24 at 12:48 PM, 6/25/24 at 10:30 AM and 6/27/24 at 9:22 AM, Resident #19 was noted in bed asleep with quarter length sized siderails on both sides of the bed in the upright position. The bed was noted approximately one foot from the wall one side. A review of the Physical Device Evaluation dated 7/19/22 documented, Bed Against the wall. A review of the Siderail Informed Consent dated 7/19/22 documented, Bed by the wall. A review of the comprehensive care plan revealed one dated 1/22/20 for (Resident #19) is at risk for fall related injury and falls . This care plan incldued an intervention dated 4/13/21 for May have one side of bed against wall. The facility policy, Care Planning documented, Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nuring, and mental and psychosocial needs . On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at approximately 12:45 ASM #2 stated that the facility removed the intervention from all residents for the bed against the wall, and that the care plans were updated to remove this. She stated that she didn't think about updating the siderail assessments and consents to reflect this change or to document in nurse's notes to reflect that the beds were to no longer be against the wall. As there was no updated individualized reassessment of Resident #19 to determine if she no longer required having the bed against the wall, and this intervention remained on the care plan, this remained a concern that facility assessed intervention was not being implemented as care planned. 4. For Resident #86, the facility staff failed to implement the comprehensive care plan to Discuss and record with resident and family, the risks and benefits of bilateral enabler bar use. On 6/25/24 at 10:16 AM, 6/27/24 at 9:08 AM and on 6/27/24 at 9:13 AM, Resident #86 was observed in bed with bilateral quarter length side rails up. A review of the comprehensive care plan revealed one dated 5/4/23 for (Resident #86) is at risk for complications due to they require the use of bilateral enabler bars, does not restrict movement, guest has impaired mobility. This care plan include an intervention dated 5/4/23 for Discuss and record with resident and family, the risks and benefits of bilateral enabler bar use. A review of the clinical record revealed a Siderail Informed Consent dated 12/15/22 that documented, Has no rails at this time. Further review failed to reveal an assessment for the use of the siderails that were observed, and an updated informed consent for the use of the siderails. In addition, there was no evidence that the care planned intervention to Discuss and record with resident and family, the risks and benefits of bilateral enabler bar (side rail) use. was followed, as there was no updated reassessment and consent for the use of the side rails. The facility policy, Care Planning documented, Every resident in the facility will have a person-centered Plan of Care developed and implemented that is consistent with the resident rights, based on the comprehensive assessment that includes measurable objectives and time frames to meet a residents medical, nuring, and mental and psychosocial needs . On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 29125 Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to review and revise the comprehensive care plan for two of 43 residents in the survey sample; Residents #22 and #19. The findings include: 1. For Resident #22, the facility staff failed to review and revise the comprehensive care plan to include the use of side rails once the facility implemented the use of side rails. A review of the clinical record revealed a Physical Device Evaluation dated 12/18/22. This document documented that the type of safety device to be used was Bed against the wall and the reason was for Safety awareness. The options for any type of side rails were not checked. On 6/24/24 at 12:42 PM and at 2:54 PM, 6/25/24 at 10:17 AM and on 6/27/24 at 9:13 AM, Resident #22 was observed in bed. Quarter length sized side rails were observed on both sides of the bed in the upright position. A review of the comprehensive care plan failed to reveal any evidence that the current use of the side rails was care planned. On 6/27/24 at 9:28 AM, an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated the care plan should have been revised to reflect the current use of side rails. On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She also stated that the care plan should have been revised to reflect the current use of side rails. The facility policy, Care Planning documented, 1. Resident's will be assessed as they are admitted and readmitted to the nursing facility to determine their physical, psychological, emotional, medical and psychosocial needs. The results of interdisciplinary assessments will be used to develop, review and revise the resident's comprehensive care plans On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #19, the facility staff failed to review and revise the comprehensive care plan to include the use of side rails once the facility implemented the use of side rails. A review of the Physical Device Evaluation dated 7/19/22 documented, Bed Against the wall. None of the options for side rails were checked. On 6/24/24 at 12:48 PM, 6/25/24 at 10:30 AM and 6/27/24 at 9:22 AM, Resident #19 was noted in bed asleep with quarter length sized side rails on both sides of the bed in the upright position. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the comprehensive care plan failed to reveal any evidence that the current use of the side rails was care planned. On 6/27/24 at 9:28 AM, an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated the care plan should have been revised to reflect the current use of side rails. On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She also stated that the care plan should have been revised to reflect the current use of side rails. The facility policy, Care Planning documented, 1. Resident's will be assessed as they are admitted and readmitted to the nursing facility to determine their physical, psychological, emotional, medical and psychosocial needs. The results of interdisciplinary assessments will be used to develop, review and revise the resident's comprehensive care plans On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey.

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The Laurels of Bon Air	9101 Bon Air Crossings Drive Bon Air, VA 23235

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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 - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42106 Based on resident interview, clinical record review, staff interview and facility document review, it was determined the facility staff failed to follow professional standards of practice for two of 43 residents in the survey sample, Resident #26 and Resident #323. The findings include: 1. For Resident #26 (R26), the facility staff failed to clarify the physician orders for Tramadol (1) and acetaminophen (2) with numerical pain parameters for administration that were not being followed. On the most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 6/2/2024, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. The assessment documented R26 having almost constant pain and receiving scheduled and as needed pain medications. On 6/24/2024 at approximately 2:15 p.m., an interview was conducted with R26. R26 stated that they managed their pain with medication they took as needed. R26 stated that sometimes they took Tylenol and when they had muscle spasms they took Tramadol. The physician orders documented in part, - Acetaminophen Oral Tablet 325 MG (milligram) (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for pain 1-4. Order Date: 11/27/2023. - Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 2 tablet by mouth every 6 hours as needed for pain level 5-10. Order Date: 12/07/2023. The eMAR (electronic medication administration record) dated 6/1/2024-6/30/2024 documented the Acetaminophen given on the following dates and times with the pain levels documented. - On 6/1/2024 at 5:55 a.m. for a pain level of 8 and 1:27 p.m. for a pain level of 7. - On 6/2/2024 at 6:21 a.m. for a pain level of 6 and at 6:48 p.m. for a pain level of 8. - On 6/3/2024 at 1:04 p.m. for a pain level of 6 and 10:15 p.m. for a pain level of 8. - On 6/4/2024 at 1:08 p.m. for a pain level of 8. - On 6/7/2024 at 1:19 p.m. for a pain level of 6 and at 10:08 p.m. for a pain level of 7. - On 6/8/2024 at 1:30 p.m. for a pain level of 6 and at 6:55 p.m. for a pain level of 8. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 6/9/2024 at 3:32 p.m. for a pain level of 9. - On 6/10/2024 at 1:56 p.m. for a pain level of 6 and 10:12 p.m. for a pain level of 7. - On 6/11/2024 at 10:05 p.m. for a pain level of 7. - On 6/12/2024 at 1:29 p.m. for a pain level of 6. - On 6/14/2024 at 9:21 p.m. for a pain level of 6. - On 6/15/2024 at 9:51 p.m. for a pain level of 8. - On 6/16/2024 at 11:40 a.m. for a pain level of 9. - On 6/18/2024 at 1:40 p.m. for a pain level of 5. - On 6/19/2024 at 1:37 p.m. for a pain level of 8. - On 6/20/2024 at 1:44 p.m. for a pain level of 6 and 9:59 p.m. for a pain level of 7. - On 6/21/2024 at 2:01 p.m. for a pain level of 7. - On 6/23/2024 at 8:43 p.m. for a pain level of 7. - On 6/24/2024 at 1:53 p.m. for a pain level of 7. - On 6/25/2024 at 1:57 p.m. for a pain level of 6. The eMAR (electronic medication administration record) dated 6/1/2024-6/30/2024 documented the Tramadol given on the following dates and times with the pain levels documented. - On 6/5/2024 at 5:30 a.m. for a pain level of 1. - On 6/6/2024 at 5:30 a.m. for a pain level of 1. - On 6/8/2024 at 5:30 a.m. for a pain level of 1. - On 6/9/2024 at 5:30 a.m. for a pain level of 1. - On 6/11/2024 at 6:00 a.m. for a pain level of 1. - On 6/13/2024 at 5:30 a.m. for a pain level of 1. - On 6/14/2024 at 5:30 a.m. for a pain level of 1. - On 6/15/2024 at 5:30 a.m. for a pain level of 1. - On 6/17/2024 at 5:30 a.m. for a pain level of 1. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 6/18/2024 at 5:30 a.m. for a pain level of 1. - On 6/19/2024 at 5:30 a.m. for a pain level of 1. - On 6/20/2024 at 5:30 a.m. for a pain level of 1. - On 6/21/2024 at 5:30 a.m. for a pain level of 1. - On 6/22/2024 at 5:30 a.m. for a pain level of 1. - On 6/23/2024 at 5:30 a.m. for a pain level of 1. - On 6/24/2024 at 5:30 a.m. for a pain level of 1. - On 6/25/2024 at 5:30 a.m. for a pain level of 1. - On 6/26/2024 at 5:30 a.m. for a pain level of 1. On 6/26/2024 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated pain medications were given as ordered. She stated that if a resident requested pain medication for a pain level that was outside of the ordered pain parameters for the medication she would have to call the physician to clarify the order. She stated that she would call the physician to clarify because it was an order and they would need to decide if it was ok to give. The facility policy, Physician's Order dated 10/20/2023 documented in part, .Physician orders are obtained to provide a clear direction in the care of the resident . In Fundamentals of Nursing 6th edition, 2005; [NAME] A. [NAME] and [NAME] Perry; Mosby, Inc; Page 419. The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary On 6/26/2024 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional clinical coordinator were made aware of the findings. No further information was provided prior to exit. Reference: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Tramadol immediate-release tablets and oral solution are used as a short-term treatment to relieve severe pain (pain that begins suddenly, has a specific cause, and is expected to go away when the cause of the pain is healed) in people who are expected to need an opioid pain medication and who cannot be controlled by the use of alternative pain medications. Tramadol extended-release tablets and capsules are used to relieve severe and persistent pain in people who are expected to need an opioid pain medication to relieve pain around-the-clock for a long time and who cannot be treated with other pain medications. Tramadol extended-release tablets and capsules should not be used to treat mild or moderate pain, short-term pain, or pain that can be controlled by medication that is taken as needed. Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.html (2) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.html 2. For Resident #323 (R323), the facility staff failed to properly transcribe and monitor blood glucose levels. R323 was admitted to the facility with diagnoses that included but were not limited to Type 2 Diabetes Mellitus (1) and dementia. On the most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 4/3/2024, the resident scored a 4 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions. The assessment documented R323 having a diagnosis of diabetes mellitus, not taking insulin and taking a hypoglycemic medication. Review of the physician orders documented in part, - Blood sugars BID (twice a day). Order Date: 03/27/2024. End Date: 04/16/2024 . - Glipizide tablet 5mg (milligram) Give 1 tablet by mouth one time a day for diabetes. Order Date: 03/27/2024. Start Date: 03/28/2024. End Date: 04/16/2024 . The progress notes documented a physician progress note dated 4/3/2024 which documented in part, .Chief Complaint/Reason for this Visit: follow-up post fall . Diabetes Type 2: blood glucose levels not available in record, continue glipizide 5mg po daily. Check fasting blood glucose daily. CMP (comprehensive metabolic panel), Hgb (hemoglobin) A1c 4/4 . Review of the clinical record for R323 documented a blood glucose (sugar) reading of 149 on 4/4/2024 at 5:42 a.m. The clinical record failed to evidence documentation of a blood glucose reading prior to 4/4/2024. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the eMAR (electronic medication record) dated 3/1/2024-3/31/2024 and 4/1/2024-4/30/2024 documented in Unscheduled other orders: Blood sugars BID however the eMAR's failed to evidence documentation of any blood glucose results. On 6/26/2024 at 2:00 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that when a resident had an order for a blood glucose check it populated on the eMAR and then popped up when it was due during the medication pass. She stated that the nurse obtained the blood glucose and documented it in the eMAR which recorded it in the medical record. She stated that the blood glucose should not be an unscheduled order and may not have been entered correctly and should be clarified. She stated that she did not remember R323 but if there were glucose levels recorded they would populate on the eMAR. On 6/26/2024 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional clinical coordinator were made aware of the findings. No further information was provided prior to exit. Reference: (1) diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 31753 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services to maintain residents' highest level of well-being for two of 43 residents in the survey sample, Residents #104 and #133. The findings include: 1. For Resident #104 (R104), the facility staff failed to initiate and implement treatment for toe wounds that were identified on 6/12/24. A review of R104's clinical record revealed a note signed by the wound care physician on 6/12/24 that documented the resident presented with a wound on the right first toe that measured 1.5 x 0.6 x 0.3 cm (centimeters) and a wound on the left first toe that measured 1.5 x 0.5 x 0.2 cm. The note further document dressing treatment plans to apply a primary dressing of Xeroform gauze three times per week. Further review of R104's clinical record (including physician's orders, the June 2024 treatment administration record, and nurses' notes) failed to reveal any physician's orders for treatments to the R104's toes and failed to reveal evidence that any treatments were implemented for the resident's toes. On 6/26/24 at 2:17 p.m., an interview was conducted with LPN (licensed practical nurse) #2 (the wound care nurse). LPN #2 stated that when the wound care physician writes treatment plans, she or another nurse enters the orders into the computer system then the orders are generated onto the treatment administration record so they can be signed off by a nurse when the treatments are done. LPN #2 reviewed R104's clinical record and stated that she did not see any physician's orders for treatment to the resident's toes but there was supposed to be orders for Xeroform once a week. On 6/26/24 at 2:47 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Skin Management documented, Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. No further information was presented prior to exit. 32642 2. For Resident #133 (R133), the facility staff failed to provide assessment of and care for two incisions on the resident's leg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/24 at 2:19 p.m., R133 was observed sitting up in a wheelchair in his room. The resident stated he was concerned about two incisions on his right leg, both of which were currently closed with staples. He stated these incisions were the result of a surgical procedure he received while he was in the hospital prior to his admission in the facility. R133 showed the surveyor his right leg. An incision along the inner aspect of the resident's right shin measured approximately four inches long, and was closed with staples. A second incision along the inner aspect of his right thigh measured approximately two inches long, and was also closed with staples. The resident stated he was not aware of any staff member assessing the incisions at any time, or of any appointment to have the staples removed. A review of R133's admission nursing assessment dated [DATE] revealed, in part: Location of skin conditions/wounds .right inner thigh has 7 staples intact .right lower shin has 13 staples intact. Further review of R133's clinical record revealed no evidence of regular nursing assessment of these wounds, and no evidence of a plan for the staples to be removed. On 6/26/24 at 11:44 a.m., LPN (licensed practical nurse) #4 was interviewed. She stated she has been taking care of R133 since his admission on 6/20/24. She stated she had seen the two incisions once when she performed his weekly skin assessment. She stated: I'm not sure where the staples or from, or what we are doing for them. She stated she believed there should be some kind of orders for regular assessment, and that facility nursing staff should be assessing the incisions regularly to make sure they are intact, and that there are no signs or symptoms of infection. On 6/26/24 at 2:44 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator, were informed of these concerns. No further information was provided prior to exit.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 32642 Based on observation, family interview, facility document review, and clinical record review, the facility staff failed to provide foot care for one of 43 residents in the survey sample, Resident #27. The findings include: For Resident #27 (R27), the facility staff failed to trim the resident's toenails. On 6/24/24 at 1:07 p.m., R27 was observed sitting in a chair in his room. R27was unable to carry on a coherent conversation. R27's daughter was sitting in the room, and expressed concerns about the length of the resident's toenails. R27's daughter removed the shoe and sock from the resident's left foot. The resident's great toe, second toe, and third toenails all extended greater than one inch past the tip of the resident's toes. A review of R27's clinical record revealed no documentation of diagnoses of diabetes or other conditions that would indicate a lack of blood flow to the feet. This review also revealed no orders for foot care, and no documentation of offering for the resident to be sent out for a podiatry consultation. On 6/26/24 at 9:10 a.m., LPN (licensed practical nurse) #3 was interviewed. She stated CNAs are responsible for clipping toenails for residents who are not diabetic, and who do not have a condition contributing to vascular insufficiency in a resident's feet. She stated R27 is on the list to see the podiatrist, but is not sure how long it will be until the podiatrist comes to the facility to see resident. She stated: If his toenails are too long, he shouldn't have to wait. She stated she has not looked at R27's toenails. On 6/26/24 at 9:47 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated she is not allowed to cut a resident's toenails. She stated she has not looked at R27's toenails recently. On 6/26/24 at 2:44 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator, were informed of these concerns. On 6/26/24 at 3:10 p.m., ASM (administrative staff member) #2, the director of nursing was interviewed. She stated facility CNAs are not allowed to trim toenails. She further stated that nurses are allowed to trim toenails of nondiabetic residents if they feel comfortable doing so. She stated it is always an option for a resident to be sent out to a podiatrist if the need is urgent or requested. On 6/26/24 at 3:34 p.m., LPN #5 was interviewed. She stated she took care of R27 when he was initially admitted to the facility, but had not seen him in the past week or two. She stated she put the resident on the list to be seen by the podiatrist. She stated she was not sure how long it would be until the podiatrist comes to the facility. A review of the facility policy, Personal Hygiene, revealed, in part: Nail care .Nails should be kept neatly trimmed. (continued on next page)

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F 0687 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 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. 32642 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide a safe environment for three of 43 residents in the survey sample, Residents #56, #22, and #19. The findings include: 1. For Residents #56 (R56) and #123 (R123), the facility staff failed to store portable oxygen tanks safely in the residents' room. On 6/24/24 at 12:07 p.m. and 6/25/24 at 8:17 a.m., observations were made in the room shared by R56 and R123. Two freestanding portable oxygen tanks were observed along the wall. Neither tank was secured in a rolling cart or any other device. One tank measured 1000 psi (pounds per square inch) of oxygen; the second tank measured just under 1000 psi. On 6/26/24 at 9:10 a.m., LPN (licensed practical nurse) #3 was interviewed. She stated portable oxygen tanks should always be secured in a secure storage rack in the supply room, or on rolling carts if they are any other place in the facility. She stated portable tanks should never be unsecured at all. She stated: Anything could happen. It could fall over, or turn on, or possibly catch on fire. She stated this is a safety concern for residents. On 6/26/24 at 9:47 a.m., CNA (certified nursing assistant) #1 was interviewed. She stated a portable oxygen tank should be stored out of the way. She stated if a tank is empty, it should never be in a resident's room. She stated if the tank has any oxygen remaining in it, the tank should be secured either in a storage bag on the back of a resident's wheelchair, or in a rolling cart. On 6/26/24 at 2:44 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator, were informed of these concerns. A review of the facility policy, Oxygen Storage and Assembly, revealed, in part: Oxygen Tank Safety .Secure each tank individually, by a chain, on a cart, or on a stand. No further information was provided prior to exit. 29125 2. For Resident #22, facility staff failed to implement the physician-ordered fall prevention of a fall mat; and failed to implement the facility assessed intervention of having the bed against the wall. A review of the physician's orders revealed one dated 4/29/23 for Fall mat to the right side of bed while guest is in bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the clinical record revealed a Physical Device Evaluation dated 12/18/22. This evaluation documented that the type of safety device to be used was Bed against the wall and the reason was for Safety awareness. A review of the Siderail Informed Consent dated 12222 (incorrect date format which made it difficult to determine what was the intended date) documented, Bed against (the wall) Left side of the bed. No rails. On 6/24/24 at 12:42 PM and at 2:54 PM, 6/25/24 at 10:17 AM and on 6/27/24 at 9:13 AM, Resident #22 was observed in bed. There was no fall mat next to the right side of the bed per physician's order. In addition, the bed was noted to be approximately 12 to 18 inches away from the wall on the left side. The bed was not against the wall, per the facility's individualized assessment to implement this safety measure for Resident #22. On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She stated that the physician order and care plan for the fall mat was not being followed as required. Regarding the bed against the wall, she stated that having the bed against the wall helps prevent the resident from rolling out of the bed. She stated that this facility-assessed safety measure was not being implemented. She stated that staff were told not to put any beds against the walls. Further review of the clinical record failed to reveal any evidence of an updated Physical Device Evaluation and informed consent, or any nurse's notes, indicating that Resident #22 was individually evaluated to determine that the safety measure of having the bed against the wall was no longer required. A review of the comprehensive care plan revealed one dated 11/22/22 for (Resident #22) is at risk for fall related injury and falls . An intervention dated 5/1/23 documented, Fall matt to right side of bed. Further review of the comprehensive care plan, including cancelled and resolved items, failed to reveal any evidence of the assessed need of the bed against the wall being care planned. On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. On 6/27/24 at approximately 12:45 ASM #2 stated that the facility removed the intervention from all residents for the bed against the wall, and that the care plans were updated to remove this. She stated that she didn't think about updating the siderail assessments and consents to reflect this change or to document in nurse's notes to reflect that the beds were to no longer be against the wall. As there was no updated individualized reassessment of Resident #22 to determine if she no longer required having the bed against the wall, this remained a concern that facility assessed intervention was not being implemented. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Bon Air	9101 Bon Air Crossings Drive Bon Air, VA 23235

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Fall Management documented, Each resident is assisted in attaining/maintaining his or her highest practical level of function by providing the resident adequate supervision, assistive devices, and/or functional programs as appropriate to minimize the risk for falls. Residents will be evaluated by the interdisciplinary team for their risk for falls. A plan of care is developed and implemented based on this evaluation with ongoing review 1. The licensed nurse will evaluate residents for fall risk upon admission, re-admission, quarterly, annually and with a significant change in condition. 2. Residents identified at risk for falls will have an initial plan of care developed to meet each resident's needs. Interventions should be related to the risk factors as well as incorporating resident choice to help minimize the risk of a fall 3. For Resident #19, facility staff failed to maintain the bed against the wall per the comprehensive care plan and side rail evaluation and consent. A review of the Physical Device Evaluation dated 7/19/22 documented, Bed Against the wall. A review of the Siderail Informed Consent dated 7/19/22 documented, Bed by the wall. A review of the comprehensive care plan revealed one dated 1/22/20 for (Resident #19) is at risk for fall related injury and falls . This care plan included an intervention dated 4/13/21 for May have one side of bed against wall. On 6/24/24 at 12:48 PM, 6/25/24 at 10:30 AM and 6/27/24 at 9:22 AM, Resident #19 was noted in bed asleep. The bed was noted to be approximately 12 to 18 inches from the wall one side. The bed was not against the wall, per the facility's individualized assessment to implement this safety measure for Resident #19. On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She stated that having the bed against the wall helps prevent the resident from rolling out of the bed. She stated that the facility-assessed safety measure was not being implemented. She stated that staff were told not to put any beds against the walls. Further review of the clinical record failed to reveal any evidence of an updated Physical Device Evaluation and informed consent, or any nurse's notes, indicating that Resident #19 was individually evaluated to determine that the safety measure of having the bed against the wall was no longer required. On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. On 6/27/24 at approximately 12:45 ASM #2 stated that the facility removed the intervention from all residents for the bed against the wall, and that the care plans were updated to remove this. She stated that she didn't think about updating the siderail assessments and consents to reflect this change or to document in nurse's notes to reflect that the beds were to no longer be against the wall. As there was no updated individualized reassessment of Resident #19 to determine if she no longer required having the bed against the wall, this remained a concern that facility assessed intervention was not being implemented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Fall Management documented, Each resident is assisted in attaining/maintaining his or her highest practical level of function by providing the resident adequate supervision, assistive devices, and/or functional programs as appropriate to minimize the risk for falls. Residents will be evaluated by the interdisciplinary team for their risk for falls. A plan of care is developed and implemented based on this evaluation with ongoing review 1. The licensed nurse will evaluate residents for fall risk upon admission, re-admission, quarterly, annually and with a significant change in condition. 2. Residents identified at risk for falls will have an initial plan of care developed to meet each resident's needs. Interventions should be related to the risk factors as well as incorporating resident choice to help minimize the risk of a fall

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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. 29125 Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to maintain a Foley catheter in a sanitary manner for one of 43 residents in the survey sample; Resident #97. The findings include: On 6/25/24 at 10:21 AM, Resident #97 was observed in her room up in the wheelchair. The Foley catheter bag was hanging under the wheelchair, with the bag mostly laying on the floor. On 6/25/24 at 10:32 AM Resident #97 was observed sitting in the doorway just outside of her room asking a staff member for water. The Foley bag was still noted to be dragging the floor. The staff member did not address the Foley bag on the floor. On 6/25/24 at 10:37 AM, Resident #97 was back in her room. Upon passing by the resident's room, it was noted that the resident was sitting in her wheelchair approximately three quarters of the way to the opposite side of the room from the door, with the Foley catheter bag laying on the floor several feet behind her wheelchair, with the tubing fully stretched from the bag to the resident. On 6/27/24 at 9:28 AM, an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated that the Foley bag should not be on the floor. She stated that risks would include urinary tract infections and urethral trauma. On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She stated that the resident likes to have the tubing in her pant leg and that makes it difficult to keep the Foley off the floor. She stated that it should be hung higher up on the wheelchair to keep it off the floor. A review of the comprehensive care plan revealed one dated 2/12/24 for (Resident #97) is at risk for urinary tract infection and catheter-related trauma: has Indwelling Catheter 16F r/t (related to) chronic obstructive uropathy. This care plan included the intervention, dated 2/13/24 for Ensure the drainage bag is secured properly with a dignity cover in place. The facility policy, Catheter Associated Urinary Tract Infection Prevention documented, .9. Keep the collection bag and tubing off the floor . On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide colostomy care and services for one of 43 residents in the survey sample, Resident #127. The findings include: For Resident #127 (R127), the facility staff failed to obtain physician's orders and provide care for the resident's colostomy (1). A review of R127's clinical record revealed a nurse's note dated 6/11/24 that documented the resident was admitted with a colostomy. A review of R127's June 2024 physician's orders failed to reveal any orders regarding the resident's colostomy. Further review of R127's clinical record (including the June 2024 treatment administration record and June 2024 nurses' notes) failed to reveal colostomy care was provided (except for a nurse's note dated 6/14/24 that documented the colostomy bag was intact and changed on 6/13/24, and a nurse's note dated 6/17/24 that documented the colostomy bag was intact and emptied once during that shift). On 6/26/24 at 10:03 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated there should be physician's orders for colostomy care so nurses know the care is done. LPN #1 stated the orders should consist of checking the colostomy stoma site daily, completing colostomy care every shift, and as needed, and when to change the colostomy wafer and bag. On 6/26/24 at 2:47 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. A facility policy regarding colostomy care was not provided. The American Cancer Society documented, The skin around your stoma should always look the same as skin anywhere else on your abdomen. But ostomy output can make this skin tender or sore. Here are some ways to help keep your skin healthy: Use the right size pouch and skin barrier opening. An opening that's too small can cut or injure the stoma and may cause it to swell. If the opening is too large, output could get to and irritate the skin. In both cases, change the pouch or skin barrier and replace it with one that fits well. Change the pouching system regularly to avoid leaks and skin irritation. It's important to have a regular schedule for changing your pouch. Don't wait for leaks or other signs of problems, such as itching and burning. This information was obtained from the website: https://www.cancer.org/cancer/managing-cancer/treatment-types/surgery/ostomies/colostomy/management.html No further information was presented prior to exit. Reference: (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) A colostomy is an opening in the belly (abdominal wall) that's made during surgery. It's usually needed because a problem is causing the colon to not work properly, or a disease is affecting a part of the colon and it needs to be removed. The end of the colon (large intestine) is brought through this opening in the skin to form a stoma. This information was obtained from the website: https://www.cancer.org/cancer/managing-cancer/treatment-types/surgery/ostomies/colostomy/what-is-colostomy.html

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide respiratory care and services for one of 43 residents in the survey sample, Resident #76. The findings include: For Resident #76 (R76), the facility staff failed to administer oxygen at the physician prescribed rate of two liters per minute. A review of R76's clinical record revealed a Brief Interview for Mental Status assessment dated [DATE] that documented the resident was cognitively intact, scoring a 15 out of 15. Further review of R76's clinical record revealed a physician's order dated 6/24/24 for continuous oxygen at two liters per minute. On 6/24/24 at 3:13 p.m., R76 was observed receiving oxygen via nasal cannula at a rate between three and half and four liters per minute, as evidenced by the middle of the ball in the oxygen concentrator flowmeter positioned between the three and half and four-liter lines. On 6/25/24 at 10:46 a.m., R76 was observed receiving oxygen via nasal cannula at a rate between one and half and two liters per minute, as evidenced by the middle of the ball in the oxygen concentrator flowmeter positioned between the one and half and two-liter lines. R76 stated he doesn't know how to adjust his oxygen and he does not adjust his oxygen concentrator flowmeter. On 6/26/24 at 10:03 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated nurses administer oxygen per the physician's orders and should check the rate of oxygen any time they are in the resident's room. LPN #1 stated the middle of the ball in the oxygen concentrator flowmeter should be on the two-liter line if the physician's order is for two liters. On 6/26/24 at 2:47 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. A facility policy regarding oxygen administration was not provided. The oxygen concentrator manufacturer's instructions documented, Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed. No further information was presented prior to exit.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 29125 Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure that a current evaluation and consent, including risks and benefits, were in place prior to implementing side rails, for three of 43 residents in the survey sample; Residents #22, #19 and #86. The findings include: 1. For Resident #22, the facility staff failed to ensure that a side rail evaluation and consent, to include risks and benefits, that determined side rails were needed, was completed prior to implementing side rails. On 6/24/24 at 12:42 PM and at 2:54 PM, 6/25/24 at 10:17 AM and on 6/27/24 at 9:13 AM, Resident #22 was observed in bed. Quarter length sized side rails were observed on both sides of the bed in the upright position. A review of the clinical record revealed a Physical Device Evaluation dated 12/18/22. This document documented that the type of safety device to be used was Bed against the wall and the reason was for Safety awareness. The options for any type of side rails were not checked. A review of the Siderail Informed Consent dated 12222 (incorrect date format documented, which made it difficult to determine what was the intended date) documented, Bed against (the wall) Left side of the bed. No rails. None of the options for side rails were checked. Further review failed to reveal any updated evaluation and consent, including risks and benefits, to reflect the use of side rails was determined to be needed. A review of the comprehensive care plan failed to reveal any evidence that the use of the side rails was care planned. On 6/27/24 at 9:28 AM, an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated that there should be a current evaluation and consent for the use of side rails. She stated that if an initial assessment determined side rails were not needed, and then later side rails were implemented, there should have been a reassessment and updated consent before implementing side rails. She stated that the use of side rails should be on the care plan. On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She also stated that there should be a current evaluation and consent for the use of side rails and that if an initial assessment determined side rails were not needed, and then later side rails were implemented, there should have been a reassessment and updated consent before implementing side rails. She stated that the use of side rails should be on the care plan. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Restraint Management documented, 3. A Physical Device Evaluation will be completed prior to initiating a device by a licensed nurse or the interdisciplinary team 5. Any guest/resident using a physical restraint or side rails must have a current, signed restraint consent in the medical record. The facility will explain how the use of the restraint would treat the guest's/resident's medical symptoms and assist the guest/resident in attaining or maintaining his/her highest practicable level of physical and psychosocial well-being. In addition, the facility will explain the potential risks and benefits of that specific restraint in use by the guest/resident, and the least restrictive alternatives that have been attempted. If the responsible party/legal representative is not able to provide signed authorization for use of the restraint, telephone authorization will be documented until written consent is obtained 10. Any guest/resident using side rails will have a current order with the following components: Type of side rails (1/2, 3/4, full, assist bars); Number of side rails to be raised; Reason for use / medical symptom; Guest/resident request for use of side rails (if applicable) . On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. 2. For Resident #19, the facility staff failed to ensure that a side rail evaluation and consent, to include risks and benefits, that determined side rails were needed, was completed prior to implementing side rails. On 6/24/24 at 12:48 PM, 6/25/24 at 10:30 AM and 6/27/24 at 9:22 AM, Resident #19 was noted in bed asleep with quarter length sized side rails on both sides of the bed in the upright position. A review of the Physical Device Evaluation dated 7/19/22 documented, Bed Against the wall. None of the options for side rails were checked. A review of the Siderail Informed Consent dated 7/19/22 documented, Bed by the wall. None of the options for side rails were checked. Further review failed to reveal any updated evaluation and consent, including risks and benefits, to reflect the use of side rails was determined to be needed. A review of the comprehensive care plan failed to reveal any evidence that the use of the side rails was care planned. On 6/27/24 at 9:28 AM, an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated that there should be a current evaluation and consent for the use of side rails. She stated that if an initial assessment determined side rails were not needed, and then later side rails were implemented, there should have been a reassessment and updated consent before implementing side rails. She stated that the use of side rails should be on the care plan. On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She also stated that there should be a current evaluation and consent for the use of side rails and that if an initial assessment determined side rails were not needed, and then later side rails were implemented, there should have been a reassessment and updated consent before implementing side rails. She stated that the use of side rails should be on the care plan. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Restraint Management documented, 3. A Physical Device Evaluation will be completed prior to initiating a device by a licensed nurse or the interdisciplinary team 5. Any guest/resident using a physical restraint or side rails must have a current, signed restraint consent in the medical record. The facility will explain how the use of the restraint would treat the guest's/resident's medical symptoms and assist the guest/resident in attaining or maintaining his/her highest practicable level of physical and psychosocial well-being. In addition, the facility will explain the potential risks and benefits of that specific restraint in use by the guest/resident, and the least restrictive alternatives that have been attempted. If the responsible party/legal representative is not able to provide signed authorization for use of the restraint, telephone authorization will be documented until written consent is obtained 10. Any guest/resident using side rails will have a current order with the following components: Type of side rails (1/2, 3/4, full, assist bars); Number of side rails to be raised; Reason for use / medical symptom; Guest/resident request for use of side rails (if applicable) . On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. 3. For Resident #86, the facility staff failed to ensure that a side rail evaluation and consent, to include risks and benefits, that determined side rails were needed, was completed prior to implementing side rails. On 6/25/24 at 10:16 AM and on 6/27/24 at 9:08 AM, Resident #86 was observed in bed with bilateral quarter length side rails up. A review of the clinical record revealed a Siderail Informed Consent dated 12/15/22 that documented, Has no rails at this time. Further review failed to reveal an assessment for the use of the side rails that were observed, and an updated informed consent for the use of the side rails. A review of the comprehensive care plan revealed one dated 5/4/23 for (Resident #86) is at risk for complications due to they require the use of bilateral enabler bars, does not restrict movement, guest has impaired mobility. This care plan include an intervention dated 5/4/23 for Discuss and record with resident and family, the risks and benefits of bilateral enabler bar use. On 6/27/24 at 9:28 AM, an interview was conducted with LPN #5 (Licensed Practical Nurse). She stated that there should be a current evaluation and consent for the use of side rails. She stated that if an initial assessment determined side rails were not needed, and then later side rails were implemented, there should have been a reassessment and updated consent before implementing side rails. She stated that the care plan was not followed. On 6/27/24 at 10:18 AM an interview was conducted with LPN #7. She also stated that there should be a current evaluation and consent for the use of side rails and that if an initial assessment determined side rails were not needed, and then later side rails were implemented, there should have been a reassessment and updated consent before implementing side rails. She stated that the care plan was not followed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Restraint Management documented, 3. A Physical Device Evaluation will be completed prior to initiating a device by a licensed nurse or the interdisciplinary team 5. Any guest/resident using a physical restraint or side rails must have a current, signed restraint consent in the medical record. The facility will explain how the use of the restraint would treat the guest's/resident's medical symptoms and assist the guest/resident in attaining or maintaining his/her highest practicable level of physical and psychosocial well-being. In addition, the facility will explain the potential risks and benefits of that specific restraint in use by the guest/resident, and the least restrictive alternatives that have been attempted. If the responsible party/legal representative is not able to provide signed authorization for use of the restraint, telephone authorization will be documented until written consent is obtained 10. Any guest/resident using side rails will have a current order with the following components: Type of side rails (1/2, 3/4, full, assist bars); Number of side rails to be raised; Reason for use / medical symptom; Guest/resident request for use of side rails (if applicable) . On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 42106 Based on clinical record review, staff interview and facility document review it was determined that the facility staff failed to ensure that pharmacy recommendations were reviewed and implemented in a timely manner for three of 43 residents in the survey sample, Resident #26, Resident #75 and Resident #29. The findings include: 1. For Resident #26 (R26), the facility staff failed to ensure pharmacy recommendations were reviewed and implemented as needed for the 9/2/2023, 11/3/2023 and 12/5/2023 monthly medication regimen reviews. A review of the monthly pharmacy medication regimen reviews for R26 documented monthly consultations documented in progress notes. The progress notes dated 9/2/2023, 11/3/2023 and 12/5/2023 all documented .See report for any noted irregularities and/or recommendations . On 6/26/2024 at approximately 10:27 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of the pharmacy recommendations with physician and/or facility response for the dates listed above. On 6/26/2024 at approximately 2:25 p.m., ASM #2, the director of nursing provided documentation for additional dates requested and stated that was what she had to provide. The documents provided failed to evidence the recommendations on the dates listed above. On 6/27/2024 at 9:27 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that the pharmacist completed the reviews monthly and emailed them to her and the unit manager. She stated that after they printed them out, she and the unit manager worked together to get them completed and then after completion they should be scanned into the medical record. She stated that there were ones that were missing and she could not say with certainty whether or not they had been reviewed. She stated that the purpose of monthly reviews was for the pharmacy to monitor the medications for their appropriateness for the guest and to make sure that monitoring was in place. The facility policy Timeliness of Medication Regimen Review (MRR) Reports dated 9/7/2023, documented in part, .3. The consultant will provide monthly MRR reports addressed to the Medical Director, Director of Nursing and Attending Physician within 3-5 days of completion via secure e-mail or hard copy. 4. The attending physician is expected to review the resident's individual MRR and document and sign the he/she has reviewed the pharmacist's identified recommendations within 14 days of receipt. 5. If the attending Physician does not respond to the resident's MRR report within 14 days, the Director of Nursing will notify the physician of pending MRR reports. 6. If by the 21st day, the attending physician has not yet responded to the resident's individual MRR report, the Director of Nursing will notify the Medical Director to review and respond to the pending MRR reports. 7. If the Medical Director is also the attending physician, the Director of Nursing will escalate the issue to the facility Administrator . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/2024 at approximately 12:01 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional clinical coordinator were made aware of the findings. No further information was provided prior to exit. 2. For Resident #75 (R75), the facility staff failed to ensure pharmacy recommendations were reviewed and implemented as needed for the 9/3/2023, 11/3/2023 and 12/6/2023 monthly medication regimen reviews. A review of the monthly pharmacy medication regimen reviews for R75 documented monthly consultations documented in progress notes. The progress notes dated 9/3/2023, 11/3/2023 and 12/6/2023 all documented .See report for any noted irregularities and/or recommendations . On 6/26/2024 at approximately 10:27 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of the pharmacy recommendations with physician and/or facility response for the dates listed above. On 6/26/2024 at approximately 2:25 p.m., ASM #2, the director of nursing provided documentation for additional dates requested and stated that was what she had to provide. The documents provided failed to evidence the recommendations on the dates listed above. On 6/27/2024 at 9:27 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that the pharmacist completed the reviews monthly and emailed them to her and the unit manager. She stated that after they printed them out, she and the unit manager worked together to get them completed and then after completion they should be scanned into the medical record. She stated that there were ones that were missing and she could not say with certainty whether or not they had been reviewed. She stated that the purpose of monthly reviews was for the pharmacy to monitor the medications for their appropriateness for the guest and to make sure that monitoring was in place. On 6/27/2024 at approximately 12:01 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional clinical coordinator were made aware of the findings. No further information was provided prior to exit. 3. For Resident #29 (R29), the facility staff failed to ensure pharmacy recommendations were reviewed and implemented as needed for the 7/7/2023, 8/4/2023, 9/4/2023, 11/4/2023, 1/8/2024, 2/5/2024, 3/7/2024 and 5/6/2024 monthly medication regimen reviews. A review of the monthly pharmacy medication regimen reviews for R29 documented monthly consultations documented in progress notes. The progress notes dated 7/7/2023, 8/4/2023, 9/4/2023, 11/4/2023, 1/8/2024, 2/5/2024, 3/7/2024 and 5/6/2024 all documented .See report for any noted irregularities and/or recommendations . On 6/26/2024 at approximately 11:29 a.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of the pharmacy recommendations with physician and/or facility response for the dates listed above. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/2024 at approximately 8:20 a.m., ASM #2, the director of nursing provided documentation for additional dates requested and stated that was what she had to provide. The documents provided failed to evidence the recommendations on the dates listed above. On 6/27/2024 at 9:27 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that the pharmacist completed the reviews monthly and emailed them to her and the unit manager. She stated that after they printed them out, she and the unit manager worked together to get them completed and then after completion they should be scanned into the medical record. She stated that there were ones that were missing and she was not sure if the ones for R29 had been reviewed. She stated that the purpose of monthly reviews was for the pharmacy to monitor the medications for their appropriateness for the guest and to make sure that monitoring was in place. On 6/27/2024 at approximately 12:01 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional clinical coordinator were made aware of the findings. No further information was provided prior to exit.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 29125 Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure that one of 43 residents was free of unnecessary medication; Resident #22. The findings include: For Resident #22, the facility staff failed to evidence that consistent ongoing monitoring for the use of an anticoagulant medication was conducted. A review of the clinical record revealed a physician's order dated 2/25/24 for Eliquis (1) Oral Tablet 2.5 MG (milligrams) (Apixaban) Give 1 tablet by mouth two times a day for a fib (atrial fibrillation). There were no orders for consistent (daily or every shift) monitoring of the use of this medication. A review of the comprehensive care plan revealed one dated 11/23/22 for Administer medication as ordered. Observe for ineffectiveness and side effects. A second intervention dated 11/23/22 documented, (Resident #22) is at risk for abnormal bleeding/bruising r/t (related to) Medication use: -Anticoagulant. Dx (diagnosis) A Fib. An intervention dated 11/23/22 documented, Observe and report to physician PRN (as needed) s/sx (signs and symptoms) of complications: blood tinged/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, , diarrhea, muscle joint pain, lethargy, bruising , blurred vision, SOB (shortness of breath), Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs), bleeding gums, petechiae, back or abdominal pain and nosebleeds. A review of the MAR (Medication Administration Record) and TAR (Treatment Administration Record) for February through June, 2024, failed to reveal any evidence of this ongoing monitoring, from the date of the order (2/25/24) through the date of the survey (6/27/24). On 6/27/24 at 11:18 AM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that monitoring should be done daily and that it should be documented in the progress notes or on the MAR. She stated that risks of anticoagulant medication includes bleeding. When asked what signs of bleeding would she look for, she was not able to identify any. The facility policy, Anticoagulant Therapy documented, .5. Throughout anticoagulant therapy monitor the resident for signs and symptoms of bleeding. If signs and symptoms of bleeding are noted, hold anticoagulant medication and notify physician immediately On 6/27/24 at 12:10 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, and ASM #3, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. References: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Eliquis is used to help prevent strokes or blood clots in people who have atrial fibrillation and to prevent deep vein thrombosis and pulmonary embolism. Information obtained from https://medlineplus.gov/druginfo/meds/a613032.html

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42106 Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to maintain a complete and accurate medical record for 1 of 43 residents in the survey sample, Resident #323. The findings include: For Resident #323 (R323), the facility staff failed to maintain a complete and accurate medical record documenting the reason for transfer to the emergency roiagnom on [DATE]. Review of R323's progress notes revealed the following: - 4/4/2024 08:37 (8:37 a.m.) Nurses Notes. Note Text: Res. (resident) left via ambulance with emergency services, res. was alert at time of departure, res. POA (power of attorney) called and notified of res. transfer to hospital, res. POA to meet res. at hospital. - 4/4/2024 14:15 (2:15 p.m.) Nurses Notes. Note Text: Writer called [Name of hospital] and was notified that res. was admitted to ICU (intensive care unit). Review of clinical record failed to evidence documentation regarding a change in condition or the reason why R323 was transferred to the hospital on 4/4/2024. On 6/25/2024 at approximately 4:10 p.m., a request was made to ASM (administrative staff member) #1, the administrator for evidence of documentation for the reason why R323 was sent out to the emergency roiagnom on [DATE]. On 6/26/2024 at 9:39 a.m., ASM #2, the director of nursing stated that they did not have anything to provide to evidence why R323 was sent to the hospital. ASM #2 stated that the nurse who sent R323 out to the hospital no longer worked at the facility and could not be interviewed. On 6/26/2024 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that when a resident was sent to the emergency room the nurse did an SBAR (situation, background, assessment, recommendation) assessment, a transfer to the hospital nurses note and a change in condition assessment which documented what was going on with the resident. She stated that if the nurses note did not detail what was going on with the resident there should be an assessment documenting what was happening to show why they sent them to the hospital. She stated that this was done for continuity of care for the other staff to know what happened to the resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy Medical Records Management dated 3/1/2022 documented in part, . The facility must maintain medical records on each guest/resident, in accordance with accepted professional standards and practice and state and federal law. Medical records must be complete, accurately documented, readily accessible, systematically organized, and maintained in a safe and secure environment. This includes medical records that are kept in an Electronic Medical Record (EMR) format . A complete medical record contains an accurate and functional representation of the guest's/resident's actual experience in the facility . [NAME]-[NAME], Fundamentals of Nursing, 6th edition, [NAME] and [NAME]; page 480, was used as a reference regarding assessments and documentation. The record needs to describe exactly what happened to a client. Nurses need to indicate all assessments, interventions, client responses, instructions, and referrals in the medical record. On 6/27/2024 at approximately 4:30 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional clinical coordinator were made aware of the findings. No further information was provided prior to exit.

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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. 32642 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control procedures for one of 43 residents in the survey sample, Resident #93. The findings include: For Resident #93 (R93), the facility staff failed to use proper hand hygiene to prevent the spread of infection. On 6/24/24 at 2:33 p.m., CNA (certified nursing assistant) #2 was observed entering R93's room. R93's door had a sign indicating anyone entering the room should observe contact precautions (1). Prior to entering R93's room, CNA #2 donned gloves; she did not put on an isolation gown. CNA #2 assisted the resident to transfer to the wheelchair, and pushed the resident into the bathroom. CNA #2 closed the resident's bathroom door, removed her gloves, and left R93's room without washing her hands. She then entered the room of another resident and closed the door. On 6/24/24 at 2:44 p.m., CNA #2 was interviewed. She stated she did not wear an isolation gown because she merely assisted the resident into the wheelchair, and pushed her into the bathroom. She stated she did not provide any direct care to the resident. She stated she could not remember whether or not she washed her hands after removing her gloves in R93's room and before entering the next resident's room. She stated: It's my first day here. On 6/26/24 at 9:10 a.m., LPN (licensed practical nurse) #3 was interviewed. She stated anyone entering a room with contact isolation precautions should wear gown and gloves. She stated once the staff member is finished in that room, gloves should be removed, and the staff member should wash her hands before going into another resident's room. On 6/26 24 at 9:47 a.m., CNA #1 was interviewed. She stated that any staff member leaving a resident's room should wash hands after removing gloves and before entering another resident's room. On 6/26/24 at 2:44 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional clinical coordinator, were informed of these concerns. A review of the facility policy, Hand Hygiene, revealed, in part: Policy: To decrease the risk of transmission of infection by appropriate hand hygiene. Hand washing/hand hygiene is generally considered the most important single procedure for preventing healthcare-associated infections .Hand hygiene should be performed .after removing personal protective equipment. No further information was provided prior to exit. Reference (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment .Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. This information is taken from the website https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html.