STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Rehabilitation and Nursing	514 North Main Street Rural Retreat, VA 24368

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, staff interview, and resident interview the facility staff failed to treat resident with dignity and respect for 1 of 55 residents, Resident #1. The findings included: For Resident #1 the facility staff failed to treat the resident with dignity and respect during incontinence care. Resident #1's face sheet listed diagnoses which included but not limited to cerebral infarction, chronic kidney disease, chronic pain syndrome, and anxiety. Resident #1's most recent minimum data set with an assessment reference date of 01/10/25 assigned the resident a brief interview for mental status score of 8 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. On 04/07/25 at 9:55 am, surveyor went to speak with resident. Resident's door was observed open and lights in the room were off/dim. Surveyor knocked on the door and heard someone say come in. Surveyor entered the room and observed Resident #1's roommate lying on their bed, facing toward Resident #1. When surveyor entered the room, certified nurse's aide (CNA) #13 turned from Resident #1's bed, where she was providing incontinence care to Resident #1, and stated, I'm sorry, I thought the door was closed, sometimes they don't latch good. Surveyor observed that Resident #1 was on her side with her bare bottom exposed and the privacy curtain between Resident #1 and roommate was not fully closed. Surveyor exited the room and closed the door. Surveyor spoke with Resident #1 on 04/07/25 at 10:30 am regarding the door being open during incontinence care. Surveyor asked Resident #1 if it bothered her that the door was open while CNA #13 was providing care, and Resident #1 stated, Yes, it does, because those men walk up and down the hall, and sometimes come in here. They need to close the door. Surveyor spoke with the director of nursing on 04/07/25 at 2:50 pm regarding the door being left open during Resident #1's care, and DON stated that the door should have been closed, and the privacy curtain closed. The concern of not protecting Resident #1's dignity was discussed with the administrator, director of nursing, assistant director of nursing, regional director of clinical services, and regional vice-president of operations on 04/07/25 at 5:00 pm. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observations, resident interview, staff interview, and facility document review the facility staff failed to consider the views of the resident group and act promptly upon the grievances and recommendations of the group concerning issues of resident care and life in the facility and the facility staff failed to demonstrate a response to the concerns of the group. The findings include: For the Resident Council, the facility staff failed to follow-up on concerns and issues regarding not having knives with meals and/or having only plastic knives with meals. Surveyor reviewed Resident Council Minutes for October 16,2024 and the minutes read in part, .We are going to start asking our families to bring in knives so we can cut our meat & spread our butter and jelly-This concern has been beat to death with no results!!!!!! . Surveyor reviewed Resident Council Minutes for 11/20/24 and the minutes read in part, .Dietary .On weekends about every weekend we are receiving foam plates and plastic utensils Why is this?? . Surveyor reviewed Resident Council Minutes for 12/18/24 and the minutes read in part, .Dietary .Plastic dishes have been omitted but we are still receiving plastic silverware (forks & spoons) (Repeat concern) . Surveyor reviewed Resident Council Minutes for 1/15/25 and the minutes read in part, .Dietary .Several stated they are still receiving meals on paper plates .Receiving regular spoons and forks with plastic knives . we cannot cut meat with plastic . Surveyor reviewed Resident Council Minutes for 2/19/25 and the minutes read in part, .Dietary .Old concerns .We're still receiving plastic knives, we cannot cut our meat with plastic knives and staff isn't cutting it for us . Surveyor reviewed Resident Council Minutes for 3/19/25 and the minutes read in part, .Dietary .Receiving too much plastic plates and silverware (everyone agreed) . On 4/1/25 at 10:30 AM, surveyor met with Resident Council. Eight residents were in attendance, Resident #20, Resident #33, Resident #39, Resident #62, Resident #71, Resident #81, Resident #95, and Resident #253. All residents agreed they never get knives with their meals, and when they do get knives, they are plastic. The group stated pork chops were served for dinner last night (3/31/25) and they had no knives to cut the pork chops. They stated they either ate the pork chops with their fingers or used their forks to twist them. The group also agreed they get plastic plates on the weekends a lot instead of regular plates. On 4/4/25 at 9:02 AM, surveyor interviewed other staff #3 (OS#3) and she informed surveyor she started working at the facility in May 2024 and there were not many knives in the kitchen. She ordered knives and stated she told her staff today to make sure to give each resident a knife and do not give plastic knives. Surveyor informed her members of the survey team observed the breakfast meal on 4/1/25 and none of the multiple residents observed had knives with their meals. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested and received a purchase order dated 12/12/24 that revealed 5 cases of 12 silverware sets were ordered for the facility, which included 70 knives. On 4/4/25 at 12:56 PM, surveyor met with the administrator to discuss the ongoing concerns of the resident council and was informed about the ongoing concerns of residents not having knives on their trays and/or plastic knives. He was also informed of surveyor observations at the breakfast meal on 4/1/25 and the absence of knives with the meal. Administrator started Angel Rounds in December 2024, which included room rounds and staff education for some of the other repeated resident council issues/concerns that were identified in review of the Resident Council minutes. During the initial abbreviated survey conducted 3/11/25 through 3/17/25, administrator had provided surveyor with copies of staff education and room rounding sheets. This documentation did not address the concerns of not having knives and/or plastic knives with resident meals. No further information was provided to the survey team prior to the exit meeting on 4/8/25.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 4. For Resident #41, the facility staff failed to ensure the resident and/or the resident's representative had the opportunity to develop an advanced directive. Resident #41's diagnosis list indicated diagnoses that included, but were not limited to, Peripheral Vascular Disease, Acute and Chronic Respiratory Failure with Hypoxia, Congestive Heart Failure, Hypertension, Dependence on Supplemental Oxygen, Chronic Obstructive Pulmonary Disease, and Diabetes Mellitus-Type 2. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/18/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Review of Resident #41's clinical record failed to provide evidence of the facility staff addressing whether the resident and/or the resident's representative desired to formulate an advanced directive. On 4/8/25 this concern was discussed with the director of nursing and surveyor requested evidence of an advanced directive. On 4/8/25 at 10:24 AM, the director of nursing provided surveyor with an advanced directive dated 4/2/25. Surveyor requested and received a facility policy titled, Advance Directives with a revision date of 10/1/21 that read in part, .1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive . No further information was provided to the survey team prior to the exit conference on 4/8/25. 5. For Resident #77, the facility staff failed to ensure the resident and/or the resident's representative had the opportunity to develop an advanced directive. Resident #77's diagnosis list indicated diagnoses that included, but were not limited to, Atrial Fibrillation, Morbid Obesity, Obstructive Sleep Apnea, Hypertension, Hyperlipidemia, Peripheral Vascular Disease, Edema, Polyneuropathy, Dementia-Moderate with Mood Disturbance, Adjustment Disorder with Depressed Mood, and Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/21/25, assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Review of Resident #77's clinical record failed to provide evidence of the facility staff addressing whether the resident and/or the resident's representative desired to formulate an advanced directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This concern was discussed at the end of day meeting on 4/1/25 at 5:28 PM with the administrator, director of nursing, assistant director of nursing, director of clinical reimbursement, and regional director of clinical services. On 4/8/25 at 8:27 AM, administrator provided surveyor with a copy of an advance directive for Resident #77 dated 4/2/25. Surveyor requested and received a facility policy titled, Advance Directives with a revision date of 10/1/21 that read in part, .1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive . No further information was provided to the survey team prior to the exit conference on 4/8/25. 6. For Resident #93, the facility staff failed to accurately complete the resident's DDNR (Durable Do Not Resuscitate) Order form. All boxes on the DDNR Order form were left unchecked. Resident #93's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction, Metabolic Encephalopathy, Convulsions, Unspecified Psychosis, Major Depressive Disorder, and Generalized Anxiety Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/15/25 assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 indicating the resident was moderately cognitively impaired. A review of Resident #93's clinical record revealed a medical provider order dated 11/13/24 stating Do NOT Resuscitate. Resident #93's clinical record included a Virginia Department of Health Durable Do Not Resuscitate Order dated 11/13/24 and signed by the provider and resident. The DDNR Order form read in part under section 1, .I further certify (must check 1 or 2): 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment .2. The patient is INCAPABLE of making an informed decision . Neither of the boxes had been checked. Section 2 of the DDNR form read in part, .If you checked 2 above, check A, B, or C below . The three boxes were left unchecked. On 4/07/25 at 5:00 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, and Regional [NAME] President of Operations and discussed the concern of Resident #93's incomplete DDNR. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25. 3. For Resident #85 the facility staff failed to offer the resident the opportunity to request, refuse or formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #85's face sheet included diagnoses which included but not limited to cerebral infarction, type 2 diabetes mellitus, and hypertension. Resident #85's most recent minimum data set with an assessment reference date of 02/24/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resdient #85 comprehensive care plan was reviewed and contained a plan for Advanced Directives which read in part, Discuss Advanced Directives with resident and/or appointed health care representative as needed. Resident #85's clinical record was reviewed and contained a Virginia Advance Directive for Health Care with an illegible signature and date and signed by previous director of nursing. Surveyor spoke with Resident #85 on 04/03/25 2:35 pm regarding advance directive planning. Resident stated that no one has went over any advance directive information with them or discussed their preferences. Surveyor spoke with the facility social worker on 04/08/25 at 2:45 pm regarding advance directive information provided to residents. SW stated that she goes over the information between the time of admission and first comprehensive care plan. SW stated that if residents decline, she doesn't sign the form because residents have not provided any information. Surveyor requested and was provided with a facility policy entitled Advance Directives which read in part, It is the policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive. The concern of not providing Resident #85 with advance directive information was discussed with the administrator, director of nursing, regional director of clinical services on 04/04/25 at 10:35 am. No further information provided prior to exit. Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide the resident the right to formulate an advanced directive for 6 of 55 sampled residents, Residents #254, #255, #41, #85, #77, and #93. The findings include. 1. For Resident #254, the facility staff failed to review advance directive information with the resident upon their admit to the facility. Resident #254's diagnoses included chronic obstructive pulmonary disease, diabetes, and cerebrovascular disease. There was no completed minimum data set assessment on this resident. The resident was alert and orientated to self and place. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The profile section of Resident #254's clinical record listed this resident as being their own responsible party. Resident #254's clinical record included a provider order for a full code dated 03/27/25 and a progress note transcribed by the Social Worker (SW) on 03/28/25 that read in part, Spoke to daughter in law who was listed as the contact on the hospital records .suggested talking to the oldest son ____ who she says has the medical power of attorney over him and provided this writer a number for him. Message left. The surveyor was unable to find information in the clinical record regarding advance directives. On 04/02/25 at 5:14 p.m., the SW provided the surveyor with a form titled, VIRGINIA ADVANCE MEDICAL DIRECTIVE. The first and second page of the form had an X marked through it with decline written across the first page of this form. The second page of the form contained a signature that the SW identified as being Resident #254's. The area for the witness signature was blank. On at 04/02/25 at 6:15 p.m., the surveyor asked Resident #254 if the facility staff had gone over any advance directive information with him. Resident #254 shook their head no. On 04/03/25 at 8:35 a.m., the surveyor took a copy of the form provided by the SW to Resident #254's room and showed it to the Resident. The surveyor again asked this resident if anyone had gone over this form with him before he signed it. This resident again shook their head no. On 04/04/25 at 10:35 a.m., during a meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services the issue with the advance directive information not being shared with Resident #254 was reviewed. On 04/08/25 at 2:45 p.m., during an interview with the SW this staff stated they went over advance directive information with the residents from the time of admission until the first comprehensive care plan, if they decline, I don't sign the form as a witness as they have not provided any information. The facility staff provided the survey team with a copy of their policy titled, Advance Directives. This policy had a revision date of 10/01/21 and read in part, It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive .On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive .The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive . No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #255, the facility staff failed to review advance directive information with the resident upon their admit to the facility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #255's diagnoses included end stage renal disease, chronic atrial fibrillation, and congestive heart failure. There was no completed minimum data set assessment on this resident. This resident was alert and orientated to person and place. Resident #255's clinical record included a resident profile (face sheet) that listed Resident #255's nephew as being their guardian. Resident #255's clinical record included a do not resuscitate (DNR) order dated 03/28/25 and a Durable Do Not Resuscitate Order form that was dated 03/21/24 and signed by this resident. The surveyor was unable to locate any information referencing an advance directive. Per the request of the surveyor the Social Worker (SW) provided the surveyor with a copy of a form titled, VIRGINIA ADVANCE DIRECTIVE FOR HEALTH CARE. This form had a large X drawn through the first and second page of this document. The second page was dated 04/02/25 and contained a signature that the SW identified as belonging to Resident #255. The witness area of this form was blank (no signature). During an interview with this Resident the surveyor showed Resident #255 the advance directive form and asked him if anyone had reviewed this form with him. Resident #255 stated he had completed the DNR stuff a long time ago. When asked when he was admitted to the facility if anyone had gone over anything with him regarding advance directive information, he stated no. On 04/04/25 at 10:35 a.m., during a meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services the issue with the advance directive information not being shared with Resident #255 was reviewed. On 04/07/25 at 1:52 p.m., during an interview with the SW this staff stated they had saw on the paperwork after the resident had been admitted that they had a guardian listed. The SW stated they did not complete admission paperwork, and they had called requesting guardian paperwork from the nephew but had not heard back. On 04/08/25 at 9:34 a.m., the admissions director stated they had spoken with the nephew, and they do not have guardianship over this resident. On 04/08/25 at 2:45 p.m., during an interview with the SW this staff stated they went over advance directive information with the residents from the time of admission until the first comprehensive care plan, if they decline, I don't sign the form as a witness as they have not provided any information. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility staff provided the survey team with a copy of their policy titled, Advance Directives. This policy had a revision date of 10/01/21 and read in part, It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive .On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive .The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive . No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interview, clinical record review and facility document review, the facility staff failed to notify the physician of a significant change in condition for 1 of 55 residents in the survey sample, resident # 74 (R74). The findings included: R74 had diagnoses that included but were not limited to diabetes, atherosclerosis, peripheral vascular disease with a left below knee amputation of leg, gastroesophageal reflux disease, essential hypertension, and major depressive disorder. The minimum data set (MDS) assessment with an assessment reference date of 3/8/25 was reviewed. Resident was coded as having a significant weight gain of 5% or more in 30 days or 10% or more in the last 6 months. R74's weight record was reviewed. On 11/05/2024, the resident weighed 127.5 pounds (lbs.) On 12/16/2024, the resident weighed 146 pounds which is a 14.51 % gain from the previous month. On 09/05/2024, the resident weighed 126.8 lbs. On 03/04/2025, the resident weighed 153 pounds which is a 20.66 % gain in 6 months. The progress notes were reviewed. The Registered Dietician had reviewed each significant weight gain and updated the care plan. This surveyor was not able to find that the primary care provider had been notified of any significant weight gain. On 4/3/25 at 9:10 AM this surveyor interviewed the Director of Nursing (DON) and asked for evidence the provider has been notified of R74's weight gain and for a policy on weight management. The DON informed the surveyor at 4:20 PM that they did not locate any evidence the provider was made aware of the weight gain. The policy entitled, Weight Monitoring with a date reviewed/revised of 12/1/22 was reviewed. The policy read in part, 7. Documentation: a. The physician should be informed of a significant change in weight and may order nutritional interventions. On 4/7/25 at 5:00 PM the survey team met with the Administrator, DON, Assistant DON, Regional Director of Clinical Services and the Regional [NAME] President of Operations. This concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit conference.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, staff interview, resident interview, and clinical record review the facility staff failed to ensure personal privacy during activities of daily living care for 1 of 55 residents, Resident #1. The findings included: For Resident #1 the facility staff failed provide personal privacy during incontinence care. Resident #1's face sheet listed diagnoses which included but not limited to cerebral infarction, chronic kidney disease, and chronic pain syndrome. Resident #1's most recent minimum data set with an assessment reference date of 01/1025 assigned the resident a brief interview for mental status score of 8 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Section H, Bowel and Bladder, coded the resident as being frequently incontinent of urine, and occasionally incontinent of bowel. Surveyor went to speak with Resident #1 on 04/07/25 at 9:55 am. Resident #1's room door was open, and room was darkened. Surveyor knocked on resident's door, and someone said, come in. Surveyor started in room, and certified nurse's aide (CNA) #13 turned from Resident #1, who was lying on her side, with her buttocks exposed. CNA #13 stated, I thought that door was closed, it doesn't latch sometime. The privacy curtain between beds was partially pulled, and Resident #1's roommate was observed lying on their bed, facing toward Resident #1. Surveyor apologized and exited room, closing the door. Surveyor spoke with Resident #1 on 04/07/25 at 10:30 am regarding privacy while being provided care. Resident #1 stated that it bothered her that the door had been left open and stated, Those men walk up and down the hall, and sometimes try to come in here and They should be closing the door when they are changing me. Surveyor spoke with the director of nursing on 04/07/25 at 2:50 pm regarding the door being left open during Resident #1's care, and DON stated that the door should have been closed, and the privacy curtain closed. The concern of not protecting resident's personal privacy was discussed with the administrator, DON, assistant director of nursing, and regional director of clinical services on 04/07/25 at 5:00 pm. No further information was provided prior to exit.

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Mountain Laurel Rehabilitation and Nursing	514 North Main Street Rural Retreat, VA 24368

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. The facility staff failed to ensure a comfortable, homelike environment for the residents of the facility by failing to ensure residents have knives included with their meals. The findings include: On 4/1/25, some members of the survey team observed multiple resident's during the breakfast meal and none of the residents observed had knives with their meals. Surveyor reviewed Resident Council Minutes for October 16,2024 and the minutes read in part, .We are going to start asking our families to bring in knives so we can cut our meat & spread our butter and jelly-This concern has been beat to death with no results!!!!!! . Surveyor reviewed Resident Council Minutes for 11/20/24 and the minutes read in part, .Dietary .On weekends about every weekend we are receiving foam plates and plastic utensils Why is this?? . Surveyor reviewed Resident Council Minutes for 12/18/24 and the minutes read in part, .Dietary .Plastic dishes have been omitted but we are still receiving plastic silverware (forks & spoons) (Repeat concern) . Surveyor reviewed Resident Council Minutes for 1/15/25 and the minutes read in part, .Dietary .Several stated they are still receiving meals on paper plates .Receiving regular spoons and forks with plastic knives . we cannot cut meat with plastic . Surveyor reviewed Resident Council Minutes for 2/19/25 and the minutes read in part, .Dietary .Old concerns .We're still receiving plastic knives, we cannot cut our meat with plastic knives and staff isn't cutting it for us . Surveyor reviewed Resident Council Minutes for 3/19/25 and the minutes read in part, .Dietary .Receiving too much plastic plates and silverware (everyone agreed) . On 4/1/25 at 10:30 AM, surveyor met with Resident Council. Eight residents were in attendance, Resident #20, Resident #33, Resident #39, Resident #62, Resident #71, Resident #81, Resident #95, and Resident #253. All residents agreed they never get knives with their meals, and when they do get knives, they are plastic. The group stated pork chops were served for dinner last night (3/31/25) and they had no knives to cut the pork chops. They stated they either ate the pork chops with their fingers or used their forks to twist them. On 4/4/25 at 9:02 AM, surveyor interviewed other staff #3 (OS#3) and she informed surveyor she started working at the facility in May 2024 and there were not many knives in the kitchen. She ordered knives and stated she told her staff today to make sure to give each resident a knife and do not give plastic knives. Surveyor requested and received a purchase order dated 12/12/24 that revealed 5 cases of 12 silverware sets were ordered for the facility, which included 70 knives. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/25 at 12:56 PM, surveyor met with the administrator and discussed the ongoing concern of the residents not having knives on their trays and/or plastic knives. He was also informed of surveyor observations at the breakfast meal on 4/1/25 and the absence of knives with the meal. No further information was provided to the survey team prior to the exit meeting on 4/8/25. 5. The facility staff failed to ensure a safe, comfortable, homelike environment to residents that utilize 2 of 4 bathing areas in the facility, a shower room on East unit and a shower room on [NAME] unit. The findings include: On 4/1/25 at 10:30 AM, surveyor met with Resident Council. Eight residents were in attendance, Resident #20, Resident #33, Resident #39, Resident #62, Resident #71, Resident #81, Resident #95, and Resident #253. All residents' concurred tiles are falling out of shower room walls and the whirlpool has been inoperative for the past 6 months. On 4/8/25 at 8:45 AM, surveyor interviewed other staff #7 (OS#7) and observed three of the facility shower rooms. One of the shower rooms on the [NAME] Unit (shower room [ROOM NUMBER]) was observed to have 3 tiles missing on the bottom of the divider wall. OS#7 stated he put the corner edging around the divider wall to keep anymore tile from falling out and he's having a hard time finding the tiles. Surveyor and OS#7 attempted to observe the second shower room on the East unit (shower room [ROOM NUMBER]), but it was in-use at the time. On 4/8/25 at 9:13 AM, certified nursing assistant #2 (CNA#2) asked this surveyor to observe the second shower room on the East unit. CNA#2 informed surveyor the whirlpool tub was not working and then stated it is working, but the jets smell hot and they figured out the motors in the jets are causing the smell. She was giving residents baths in the whirlpool without using the jets, but then the seal on the door started leaking. Surveyor observed the divider wall had 2-3 tiles missing at the bottom of the wall and 2 tiles above that were of a different color. No edging was visible on this wall and 2 chipped tiles were also visible. The small tiles on the floor in the doorway of the shower room were observed and one tile was missing, and 2 tiles were chipped/cracked. On 04/08/25 at 9:38 AM, OS#7 asked surveyor to come to the second shower room on East unit and he stated the jets quit working in the whirlpool tub. He believed the jets had not worked for some time, even before he started working at the facility. He denied knowing the door on the tub was leaking and stated 2-3 weeks ago water was coming from the tub, but it was not an actual leak, the tub had been moved off the drain and the water was on the floor. The tub was moved back over the drain. OS#7 discussed the tiles on the divider wall and stated staff are hitting it with the shower chair and he demonstrated how the shower chair hits the divider wall at the area the tiles were missing. He stated he has the corner edging in his office to secure the tile on this wall and he has tile as well, that has been here since he started. He informed surveyor he has a quote for the jets and to replace the door of the tub. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested a copy of the quote to replace the whirlpool jets and door. On 4/4/25 at 11:13 AM, OS#7 informed surveyor the parts for the whirlpool tub are not replaceable by the company that manufactured it, and he is going to remove the whirlpool tub. On 4/4/25 at 12:56 PM, surveyor met with the administrator to discuss these concerns, and he stated when he came, he was told the whirlpool will not be replaced and he is not sure about having a bathtub for residents that prefer a bath. No other information was provided to the survey team prior to the exit conference on 4/8/25. 2. For resident # 39 the facility failed to ensure the residents toilet was clean. During a tour of the facility on 3/12/25 at 10:40 AM this surveyor entered R39's bathroom. There was a bedside commode over the toilet. The seat of the bedside commode as well as the frame that would hold the bucket had brown matter smeared on it. R39 stated housekeeping had not been in to clean yet. On 3/14/25 at 9:10 AM R39's toilet seat still had the brown substance on it as well as on the frame. On 3/14/25 at 12:15 PM, this surveyor met with the Administrator. When asked how often housekeeping cleaned resident bathrooms they stated that rooms including bathrooms are cleaned daily. This surveyor requested and received the policy entitled, Safe and Homelike Environment with a revised date of 12/1/22. The policy read in part, under the heading Definitions, Sanitary includes but is not limited to preventing the spread of disease-causing organisms by keeping resident equipment clean and properly stored. Resident equipment includes but is not limited to, equipment used in the completion of the activities of daily living. The survey team met with the Administrator, Interim Director of Nursing, Assistant Director of Nursing and Regional Nurse Support at 12:44 PM. This concern was reviewed with them at that time. On 3/17/25 at 11:09 AM the survey team met with the Regional Director of Clinical Services and the Regional [NAME] President of Operations and this concern was again discussed with no further information being provided to the team prior to the exit conference. Based on observation, staff interview, resident interview and facility document review the facility staff failed to provide a safe, clean, comfortable, homelike environment for 2 of 55 resident (Resident #13 and Resident #39), 2 of 2 nutrition rooms and 2 of 4 bathing areas. The findings included: 1. For Resident #13 the facility staff failed to ensure that resident's wheelchair was clean Resident #13's face sheet listed diagnoses which included but not limited to spastic quadriplegic cerebral palsy, gastrostomy status, and dysphagia. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13's most recent minimum data set with an assessment reference date of 02/07/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Surveyor observed Resident #13 on 04/01/25 at 8:30 am. Resident was seated in wheelchair in common room. Wheelchair seatbelt and frame were soiled with a dry, tan-colored substance. Surveyor observed Resident #13 on 04/03/25 at 8:45 am. Resident was seated in wheelchair in common room. Wheelchair seatbelt and frame were observed to be soiled with a dry, tan-colored substance. Surveyor, along with the assistant director of nursing (ADON), observed Resident #13 on 04/07/25 at 3:00 pm. Resident #13 was seated in wheelchair in common room. Wheelchair seatbelt and frame were soiled with a dry, tan-colored substance. Surveyor asked ADON if resident's chair should be soiled, and ADON stated, No it should not and I'll have someone clean it. Surveyor asked who is responsible for cleaning wheelchairs, and ADON stated that night shift is supposed to be doing it. Surveyor requested a cleaning schedule and was provided with a blank cleaning schedule. The concern of Resident #13's wheelchair being soiled was discussed with the administrator, director of nursing, assistant director of nursing, regional director of clinical services, and regional vice-president of operations on 04/07/25 at 5:00 pm. Surveyor observed Resident #13 on 04/08/25 at 8:55 am. Resident was seated in resident common area in wheelchair. Wheelchair frame was observed to be soiled with dried, tan-colored substance. No further information was provided prior to exit. 3. The facility staff failed to ensure the white trays placed beneath the ice-machines, in the nutrition rooms on resident units, were clean. On 4/1/25 at approximately 2:55 p.m., Licensed Practical Nurse (LPN) #4 and the surveyor observed the East Unit Nutrition area. A white tray was noted under the ice-machine in this area. The white tray was observed to contain: (a) a black/grey substance on its base, (b) five (5) paper straw covers, (c) one (1) plastic lid, and (d) a chicken bone. On 4/1/25 at 3:05 p.m., the surveyor shared the observation of the chicken bone in the white tray below the ice-machine in the East Unit Nutrition area with the Administrator. On 4/1/25 at 3:05 p.m., the Administrator and the surveyor observed the white plastic trays under the ice-machines in the Nutrition areas of both the facility's units. The white tray under the ice-machine on the [NAME] Unit was noted to contain: (a) a red/brown substance noted on its base, (b) half an alcohol prep cover, (c) at least four (4) hairs, (d) a silver balled up wrapper, (e) two (2) black rubber strips, and (f) two (2) scraps of paper. Water was not pooled in this white tray, but the aforementioned items found in this tray were noted to be moist. On 4/1/25 at 5:30 p.m., the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the aforementioned observations of the white trays beneath the ice-machines were discussed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/25 at 6:22 p.m., the Administrator confirmed the white trays below the ice-machines were not part of the ice-machines manufacturer's set-up instructions. The Administrator reported the white trays were an extra layer of protection for drainage. On 4/4/25 at 10:35 a.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Regional Director of Clinical Services (RDCS). The RDCS reported the areas under the ice-machines should be monitored daily with any cleanliness issues addressed when discovered.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on staff interviews, clinical record review, and facility document review, and in the course of a complaint investigation, the facility staff failed to protect a resident's right to be free from physical and mental abuse for one (1) of fifty-five (55) sampled residents (Resident #454). The scope and severity were originally cited at Immediate Jeopardy, Level IV isolated, beginning on 8/30/24, and was reduced to a Level III isolated after the facility was cleared of Immediate Jeopardy. The facility staff provided an abatement plan that was verified by the survey team through additional observations, interviews, and document reviews. The facility staff was notified that Immediate Jeopardy was removed on 4/3/25 at 5:30 PM. The findings include: For Resident #454, the facility staff failed to protect the resident's right to be free of physical and mental abuse by a licensed practical nurse (LPN) during an incident that occurred on 8/30/24 between the resident and the LPN. Resident #454's diagnosis list indicated diagnoses that included, but were not limited to, Atrial Fibrillation, Glaucoma, Seizures, Hypertension, Chronic Obstructive Pulmonary Disease, History of Falls, Dementia with Agitation, Depression, Anxiety Disorder, Heart Failure, Vascular Dementia-severe with Psychotic Disturbance, Traumatic Brain Injury, History of Suicidal Behavior, and Thyrotoxicosis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/28/24, assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of the clinical record revealed the following documentation: A behavior note dated 8/30/24, that read in part, .This nurse observed resident twisting the arm of CNA (certified nursing assistant) staff and pulling the sleeve of her hoodie not letting her go, resident was allegedly trying to attack another resident according to CNA. This nurse observed resident yelling and arguing with CNA staff. This nurse removed CNA from incident and was attempting to redirect this resident by taking him in his wheelchair to a quieter area. This nurse stated very calmly to resident .let's not do this. Please don't hit women, let's go back to your room. Resident initially was agreeing to go but resident then placed feet down firmly on the ground causing the wheelchair to stop, resident then leaned backwards reaching towards this nurse. This nurse was wearing hooded clothing at the time, resident grabbed this nurse by the hood of the hoodie while leaning back. This nurse tried to pull away from him causing my clothing to rip and the wheelchair to lean back. Resident then used his fingernails to scratch this nurse's neck and then placed his left thumb into this nurses' left eye causing this nurse to let go of the wheelchair which in turn caused resident to fall from the chair. Resident assessed for injuries. Resident does have contusion to the back of head, no other injuries present. Resident denying pain and discomfort at this time, vital signs were obtained by CNA and Hospice staff. All vital signs within normal limits . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An alert note dated 8/30/2024, that read in part, .This nurse contacted on call supervisor from [NAME] side of the building about resident's increase in behaviors per previous behavior notes. Hospice was contacted again to update on resident's increased behaviors and to get an ETA (estimated time of arrival) for resident's hospice nurse arrival to this facility. At this time, CNA on staff came to this nurse and reported that resident was at the nurse's station on East side yelling and grabbing at staff members and pulling on their clothing. CNA on staff reported to this nurse that resident was swinging his arms towards other staff and residents striking staff with his hands. CNA reported to this nurse that resident's wheelchair tipped backward, and resident fell to the floor striking his head on the floor. Notified on call supervisor of resident's behaviors and of his fall. Resident vital signs obtained, and resident assessed for injuries. Resident has an egg-shaped swollen area on the back of his head more towards the left of center, red/pink in color and raised approximately one inch. On call supervisor contacted [name omitted] NP (nurse practitioner) and obtained orders to send resident to the ER (emergency room at hospital) for his safety . An alert note dated 8/30/24 that read in part, .911 ambulance service transporting resident to [name omitted] (hospital) for evaluation. This nurse contacted resident's daughter [name omitted] to update her on resident's behaviors through the end of day shift. Resident's daughter notified of resident grabbing and hitting staff and attempting to harm other residents. Resident's daughter notified of resident being transported to .ER for further evaluation . A hospice visit note report dated 8/30/24, that read in part, .Facility called the on-call services and stated patient was having behaviors .The staff reported that he had hit staff members and made threats towards other residents. The patient had been in his wheelchair, one male staff member tried to get him to his room to have a place that was quiet. When he moved the chair forward the patient pushed it backwards and flipped the chair. He has a large hematoma on the back of his head. No open areas noted .Ice pack applied. Pain in that area rated a 3 out of 10 .Talked with this nurse with no behaviors noted. The facility had called 911 and the EMTs (emergency medical technicians) arrived at the facility approximately 2 (two) minutes prior to this nurse. Patient did not refuse questions from the EMT, nor was he combative during their assessment. His medication nurse [name omitted] was in patients' room during this visit. When asked by this nurse if he would take his medications, he agreed. The facility nurse was ask {sic} three different times to get patient his medications and she refused, stating, I'm not giving him his medications because he's going out .This nurse called (hospital) ER and spoke with the supervisor .to give report. She stated the patient had just arrived but seemed calm, no aggression noted. She asked the EMTs if he had any behavior during transport, they stated he had remained calm throughout their encounter .the patient's daughter was contacted, she was provided information about the event. She stated her father had never behaved in that manner, but she had noticed he had more confusion over the last few days during her phone calls . An alert note dated 8/31/24 that read in part, .Resident arrived back to this facility from (hospital) ER via ambulance stretcher transport. No paperwork was brought back with resident from that visit to the ER. EMS transport stated the hospital had called hours ago and that he had been discharged since like 12 (midnight). Resident assisted into bed and changed into clean clothing and bed sheets since the ones he had on and underneath them were drenched with urine. Resident requested to be up in wheelchair and this nurse and cna {sic} on staff assisted him up from bed into his wheelchair . A review of the hospital CT (computed tomography) report dated 8/30/24, read in part, .Findings .Small left posterior scalp hematoma . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor requested and reviewed the facility reported incident (FRI) dated 8/30/24, that read in part, .On 8/30/24, it was reported that resident was having a behavioral episode and grabbed [name omitted], CNA by the right wrist and would not let her go. It was reported that [name omitted], LPN (licensed practical nurse) intervened and aggressively spoke with resident regarding his behavior and grabbed the resident's arms. (LPN) then pushed the resident in his wheelchair down the hall towards the resident's room. It was reported that resident put his feet down to stop the wheelchair from rolling forward. (LPN) then tilted the wheelchair onto the back wheels and began to push the resident down the hall. (Resident #454) began leaning back and grabbing at (LPN), scratching his neck and poked (LPN) in the left eye. (LPN) let go of wheelchair causing the resident and chair to fall to the floor .resident evaluated for injury: resident has knot to the back of his head, sent to ER for evaluation . A review of the final report of the FRI dated 9/6/24, read in part, .(Resident #454) is a resident admitted .with a diagnosis of Dementia, Depression, Anxiety Disorder .Upon further investigation after admission, it was discovered that (Resident #454) has a previous neurological and psychological history, which includes Suicidal Ideations with suicide attempt, TBI (traumatic brain injury), Vascular Dementia with associated behaviors, Paranoia, and Fixed Delusions .Upon investigation it was discovered that (Resident #454) became physically and verbally aggressive with female staff, grabbing an employee by the wrist resulting in pain and discomfort, after which another employee, [name omitted], LPN (licensed practical nurse), intervened to assist, resulting in the wheelchair in which (Resident #454) was sitting tipping backwards and (Resident #454) hitting his head on the floor. The police found no evidence to charge (LPN) with any offense and in fact advised him that he had the right to press charges against (Resident #454) for scratching his {sic} and poking him in the eye .facility elected to DNR (do not return) the AGENCY staff member as a result of the investigation . A review of the employee statements within the FRI file revealed a statement from a witness of the incident that read in part, .(LPN) grabbed (Resident #454's) arms very aggressively and put his head against his and said, We aren't doing this. He (LPN) then leaned (Resident #454) back in his wheelchair and started down the hall. (Resident #454) became combative reaching for (LPN's) face when (LPN) dropped him (Resident #454) backwards hitting his head on the floor. (LPN) then helped lift him (Resident #454) back up and walked towards the nurse's station stating, If anyone wants to report me for abuse then so be it . The file from the FRI revealed another witness statement from the incident that read in part, .(LPN) stepped between (CNA) and (Resident #454) and grabbed him (Resident #454) by his arm and pushed him up against the nurse's station and told him to calm down and (Resident #454) still wouldn't calm down so (LPN) grabbed his wheelchair and started taking him down the hall but (Resident #454) wouldn't pick his feet up so he (LPN) stomped on the pedal on the back of the chair and got him (Resident #454) on 2 (two) wheels and started down the hall and (Resident #454) started hitting (LPN) in the face and he (LPN) dropped the chair resulting in (Resident #454) hitting his head on the floor . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/11/25 at 12:34 PM, surveyor interviewed local long-term care ombudsman (OS#1), and she recalled resident had behaviors and dementia. She informed surveyor an aide had been bringing resident down the hall and resident did not understand about taking medications. OS#1 stated his (Resident #454's) hospice nurse came up here (to facility) to attempt to give resident his medications. The resident went to swat at the aide and the agency nurse got a hold of the wheelchair and reared it back with the resident in it to keep resident from putting his feet down. When he reared it back, the wheelchair fell over. The facility did a FRI. The hospice nurse was here by then and tried to give the resident medication, but the facility would not let her try. The aide pressed charges against the resident, but it did not go to court. The resident was moved to another facility. On 3/12/25 at 10:38 AM, administrator (ADM) informed surveyor there was enough question after the incident to not bring the LPN back into the facility. He believes the LPN tried to help the CNA, the resident was combative, and the LPN had scratches and marks from the resident, but the ADM felt it best not to let him come back. On 3/13/25 at 3:49PM , surveyor interviewed certified nursing assistant #1 (CNA #1) about the incident that occurred on 8/30/24, and she stated Resident #454 was very upset and was hitting at the computer on the nurse's desk. He was trying to grab another resident and another CNA stepped on the other side to keep him from grabbing the resident and Resident #454 grabbed the CNA's wrist. The LPN slammed the resident up against the desk and then attempted to take the resident down the hall. The resident kept putting his feet down, so the LPN reared him back on two wheels. Then the resident was grabbing at the LPN and the nurse let go of the chair. The resident fell backwards and hit his head on the floor. This information was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, interim director of nursing, assistant director of nursing, and regional nurse support. The abbreviated survey was extended, and an abbreviated-extended-standard survey was conducted to include this complaint investigation from 3/11/25 through 4/8/25 and this information was discussed on 4/2/25 at 1:47 PM with the administrator and director of nursing when Immediate Jeopardy was identified by the survey team. Surveyor requested and received the facility background check that was conducted on the LPN named in the abuse allegation. The background check was completed on 5/21/24 and there were no entries/crimes disclosed on the document. Surveyor requested and received a facility policy titled, Abuse, Neglect and Exploitation that read in part, .It is the policy of [name omitted] to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .Definitions . Abuse means the willful infliction of injury .intimidation .with resulting in physical harm, pain, or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse .physical abuse, and mental abuse .IV .B. Possible indicators of abuse include but are not limited to .2. Physical marks such as bruises .on a resident's body .6. Physical abuse of a resident observed. 7. Psychological abuse of a resident observed . No further information regarding this concern was presented to the survey team prior to the exit on 4/8/25.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Rehabilitation and Nursing	514 North Main Street Rural Retreat, VA 24368

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview, employee record review, and facility document review, the facility staff failed to implement their policy regarding new hires for 13 of 25 new hires. New hires #1, #2, #3, #6, #11, #12, #13, #15, #18, #19, #22, #23, and #25. The findings include. The facility staff failed to follow their Abuse, Neglect, and Exploitation policy and procedure regarding screening of new hires. On 03/31/25 upon entrance to the facility the team leader requested the facility policy regarding abuse and neglect. This policy was provided to the survey team and was titled, Abuse, Neglect, and Exploitation. Date reviewed/revised 10/01/21. This policy read in part, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation .Screening .Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property .Background, reference, and credentials' checks shall be conducted on potential employees, contracted temporary staff .The facility will maintain documentation of proof that the screening occurred . The facility failed to provide the surveyor with the following documents to indicate these screenings had been completed. New hire #1 Licensed Practical Nurse, no reference checks. New hire #2 Certified Nursing Assistant, no reference checks. New hire #3 Certified Nursing Assistant, no reference checks. New hire #6 Occupational Therapist, no background check, no reference checks. New hire #11 Housekeeper, no reference checks. New hire #12 Physical Therapy Assistant, no reference checks. New hire #13 Registered Nurse, no reference checks. New hire #15 Housekeeper, no reference checks. New hire #18 Registered Nurse, no reference checks. New hire #19 Dietary Aide, no background check, no reference checks. New hire #22 Registered Nurse, no background check, no license verification, no reference checks. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	New hire #23 Certified Nursing Assistant, no background check, no license verification, no reference checks. New hire #25 Certified Nursing Assistant, no license verification. On 04/04/25 at 10:35 a.m., during a meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services the missing items regarding employee files were reviewed. The facility staff provided the surveyor with copies of background checks completed on new hire #6 and #19 obtained on 04/04/25 with no issues being identified by the Virginia State Police. The facility staff also provided the surveyor with a copy of a license verification obtained on 04/04/25 for new hire #25 indicating their license would expire 05/31/2025. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review and facility document review the facility staff failed to permit each resident to remain in the facility and not transfer or discharge the resident for one of 14 residents in the survey sample, resident # 454 (R454). R454's diagnoses according to the facility diagnoses sheet, included but were not limited to, other seizures, chronic obstructive pulmonary disease, hypertension, anxiety, heart failure, personal history of suicidal behavior, traumatic brain injury, major depressive disorder, and vascular dementia with psychotic disturbance. R454's minimum data set (MDS) assessment with an assessment reference date of 8/28/24 assigned the resident a brief interview for mental status score of 11 out of 15 indicating moderate cognitive impairment. There was no mood indicators captured on the assessment and the only behavior identified was wandering which occurred one to three days during the lookback period. Under the section for preferences for customary routine and activities, R454 had many activities coded as being very important. They included listening to music, being around animals or pets, keeping up with the news, doing things in groups, participating in religious activities, having snacks and using the phone in private. R454 was coded as requiring maximum assistance for toileting, bathing, dressing, bed mobility, transfers and standing and was not ambulatory in the lookback period. A hospice progress note dated 8/30/24 read in part, Facility called the on-call services and stated the patient was having behaviors and had refused his medications all day. The staff reported that he had hit staff members and made threats towards other residents. The patient had been in his wheelchair, one male staff member tried to get him to his room to have a place that was quiet. When he moved the chair forward the patient pushed it backwards and flipped the chair. He has a large hematoma on the back of his head, no open areas noted. Neuro checks WNL (within normal limits). Ice pack applied. Pain in that area rated a 3 out of 10. Patient is alert and oriented. Talked with this nurse with no behaviors noted. The facility had called 911 and the EMT's arrived at the facility approximately 2 minutes prior to this nurse. Patient did not refuse questions from the EMT nor was he combative during their assessment. His medication nurse (name omitted) was in the room during the visit. When ask by this nurse if he would take his medications he agreed. The facility nurse was asked three different times to get the patient's scheduled medications, and she refused stating, I'm not giving his medications because he's going out. The patient stated multiple times that he didn't want to go out to the hospital but remained calm the entire time. The facility administrator (name omitted) had arrived at the facility and stated it was facility policy that a patient be sent to the ER for evaluation if they exhibited aggressive behaviors. This nurse offered to stay with patient for a few hours to ensure he remained calm, but the facility staff refused, and the patient was transported out to (name of hospital omitted) ER. The hospice director was contacted and report provided. She spoke via phone with the facility administrator however the circumstances didn't change. This nurse called ER and spoke with the supervisor to give report. She stated that patient had just arrived but seemed calm, no aggression noted. She asked the EMT's if he had any behaviors during transport, they stated he had remained calm throughout their encounter including their assessment at the facility . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility progress note dated 8/31/24 at 9:10 AM read, Resident arrived back to this facility from (hospital name omitted) ER via ambulance stretcher transport. No paperwork was brought back with resident from that visit to the ER. EMS transport stated the hospital had called hours ago and that he had been discharged since like 12 (midnight). Resident assisted into bed and changed into clean clothing and bed sheets since the ones he had on and underneath them were drenched with urine. Resident requested to be up in wheelchair and this nurse and CNA on staff assisted him up from bed into his wheelchair. The hospital discharge summary was reviewed and stated that the resident had no behaviors while in the ER. On 3/11/25 at 2:09 PM this surveyor interviewed the above hospice nurse via telephone and asked about this visit. They stated, I had already been there once earlier in the day, not to see him but another patient and he was fine, but that evening they called me three or four times and I had told them the first time I was coming. The last time the nurse called she said. Well now he's fell. I went to the room and the rescue squad was there. They said he was going out. I told them no; we need to try to keep him here if he doesn't want to go. The nurse was outside the door and said nobody can handle him, and he's fell and hit the back of his head. But he was fine. His vital signs were fine, no problems, no behaviors or anything. I asked the EMT's why are we taking him out? They said because the staff said he was agitated, and maybe he was, but he wasn't with the EMT's or me and they hadn't given him his Seroquel. It was due several hours earlier from what I remember. I asked him if he would take it, and he said he would, but I had to ask that nurse three times to get it. She would not get it; said she wasn't going to give it because he was going out. She finally got the medicine, and I took it in there and he took it and thanked me. They said he was threatening others, but he was fine the whole time, and I offered to stay and sit with him for several hours, or as long as it took, but they would not listen and would not let him stay. He didn't want to go. When I asked him how he fell, he said, that boy did it. The administrator (name omitted) came in and I tried to talk to her too, but she put her hand up in my face, like talk to the hand, you know. Our (Hospice Director) called too and tried to talk to her, but she wouldn't listen. She said the facility policy was that he had to go out. Then they gave him a 30-day discharge notice and we had to find somewhere else for him to go. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 10:28 AM this surveyor met with the current Administrator who started September 1, 2024. When asked if there was a policy that stated residents had to go to the ER when they had behaviors they stated, It's not a policy but there is a section in the admission agreement that speaks to it. I wasn't here when it all started but came just a day or so later. We found out from hospice that he had a substantial psych history that we did not know about at first and we would not have taken him if we had known. We couldn't meet his needs; he was having altercations with staff and other residents. We tried to come up with a plan, hospice arranged for him to go GIP (general in-patient hospitalization) but they didn't keep him. When asked if he had told the family that if they didn't accept transfer to another facility that he would leave in a police car and become a ward of the state and be admitted to a facility for the criminally insane, as stated in a complaint received by the Office of Licensure and Certification, he stated, I was trying to get her help with the situation. Help for us to move him somewhere else because we couldn't meet his needs. I said those are some things that could happen, I wasn't saying that is what we were going to do. When asked what happened on 9/4/24 that caused the facility to issue a 30- day discharge notice they stated, We got the new information of his history from hospice. When asked if there were behaviors during or after the meeting that contributed to that decision they stated, No, when we learned the extent of his history, we knew we couldn't meet his needs. The admission agreement was reviewed and read in part, 3. Behaviors: (a) Aggressive or disruptive behaviors not diagnosis related, that threaten the safety and well-being of other residents, staff or guests are prohibited and will result in the staff notifying 911 for assistance. (b) For aggressive or disruptive behaviors that are diagnosis related, but impede the rights of other residents' safety and/or well-being, the facility retains the right to: (1) contact the residents physician for assessment and assistance in managing the behavior (2) obtain an order for consultation from other physician specialists i.e. psychiatrist, to assist in managing the behavior and/or seen an order from the magistrate for involuntary commitment for treatment. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 12:20 PM this surveyor interviewed the hospice Executive Director. When asked about R454, they stated, We had a call with the facility on a Monday morning after the GIP stay to come up with a plan. The hospital didn't keep him under GIP because he had no behaviors, he was there overnight. He did have a psych hospitalization history, for paranoia per his daughter. The facility said if we had the proper diagnosis, we could get the proper medications in there, so we got the psych notes from 2019 when he was in the psych ward in (hospital name omitted). He had stabbed himself in the abdomen. He had major depressive disorder, major neuro cognitive disorder with delusional disorder being ruled out. He was physically and sexually abused as a child and had a brother with schizophrenia. They (facility) said if we started Zyprexa and worked together to manage him it would be fine. We agreed to increase our visits to daily and work on getting some sort of psych services in to see him. We had a plan we thought everyone felt good about. We felt really good after the call and thought things would turn around, but less than 2 hours later, I called back to tell them something else maybe about the new medication orders, and (Administrator) said they were serving a 30-day notice of discharge, and they were giving it to the patient because he had not been deemed incapacitated. I couldn't believe it. They weren't even going to call his. I don't think they would have called us either. We notified the daughter about what was happening. He (Administrator) said the corporate office said to discharge him and that is what they are doing. I asked what happened, did he (patient) do something else after the first call with his behaviors, and he said no, it was due to what we told them about his history. We were able to get placement for him but that is where he wanted to be and where he had community ties and support to visit him. She stated that in her professional opinion R454's death was hastened by the move and that the rapid decline could have been delayed if the facility would have worked with them to manage his behaviors instead of against them. She stated that R454's daughter had appealed the discharge but when the other facility notified them that they would take him, they decided to go ahead with the move, Because at that point, we felt like we shouldn't trust that he would be allowed to live there comfortably and if they didn't win the appeal, this bed may have been gone and he wouldn't have had a place to go. He obviously couldn't go home alone and that was apparently the facility's plan. A facility progress note dated 9/4/24 at 6:44 PM and signed by the social worker read, Multiple IDT discussions and calls amongst multiple facility staff and hospice staff this date and discovery of additional clinical information review. IDT execution to resident this evening at 1830 of 30 day dc notice. Hospice aware and was conveying the same to daughter. Facility executing copy of notice via mail to daughter. Copy executed via fax to LTC Ombudsman. Facility will work with vested parties in facilitating transfer as needed. This surveyor attempted to interview the social worker regarding R454. They stated, I didn't have anything to do with any of that, you need to talk to (name of Administrator omitted). I made the note and filled out the 30-day paper but that's it. A hospice progress note written by their social worker on 9/4/24 read, SW came to (facility name omitted) to meet with staff regarding patient and his aggressive behavior. A meeting occurred with SW, (name omitted) Administrator for hospice, (name of facility Administrator omitted), (name of facility social worker omitted), (name of facility Admissions Director omitted), (name of unit manager omitted). Several options were discussed. Options were: A change in medication, a possible psychological evaluation and even a relocation to another facility. (Unit Manager) and SW spoke at length with patient's daughter. All options discussed were discussed with her, she is leery to relocate him as it's another move and it would pull him away from the support he has currently (other family and friends from the community). SW entered patient's room; he was sleeping soundly. SW exited the room and did not disturb him. Follow up meeting will be held Friday. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 12:57 PM this surveyor interviewed the hospice social worker. When asked about R454 and the meeting on 9/4/24 they stated, Yes I was in that meeting, I was there in person. We all agreed, and I felt really good about the plan we came up with and we had agreed to meet again in a week and see how things were going. When I left, I thought it was really productive and that everything would work out. It was a total shock and like a slap in the face, they didn't even give it a try. They undermined everything we talked about and discussed in that meeting. She stated that she thought R454's behaviors were mostly verbal stuff, he talked about what he would do or what he could do, but he never hurt anyone to my knowledge. He had a rapid and significant decline that started before he left and was probably exacerbated by the move. On 3/14/25 at 12:44 PM the survey team met with the Administrator, Interim Director of Nursing, Assistant Director of Nursing and the Regional Nurse support. This concern was discussed with them at that time. A progress note dated 9/17/24 and signed by the facility social worker read, Admissions coordinator and NP notified this writer separately that hospice has arranged for resident to transfer to [NAME] Health and Rehab and that they were looking to arrange transport and facilitate transfer ASAP possibly today. DC summary opened for clinical, and NP will put in order for transfer. On 3/17/25 at 11:09 the survey team met with the Regional Director of Clinical Services (RDCS) and the Regional [NAME] President of Operations, and this concern was discussed. The RDCS stated, Hospice pulled him out. We did issue a 30 day but if 30 days passed and he was still here we obviously wouldn't have put him out in the street. Surveyor asked if the 30-day discharge notice wasn't sincere, why was it issued and the RDCS stated, It was sincere, but we aren't going to put a resident out in the street, and, they did appeal it, so if hospice hadn't pulled him out, we couldn't have discharged him anyway while it was under appeal. Surveyor stated that the discharge notice had R454's home address as the place they were discharging him to and she stated, We had to put something on there, but we would not have discharged him without another facility to go to. She stated that they tried to get the daughter to accept placement at a sister facility that would have been closer to her, but she declined. RDCS stated they did not get notice of the appeal until after resident discharged . This surveyor reviewed the Facility Assessment which read in part, (facility name omitted) may accept residents with, or continue to provide care for residents that may develop the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management. Each resident is assessed and reviewed on an individual basis. Psychiatric/Mood Disorders: Psychosis (Hallucinations, Delusions, etc.), impaired cognition, mental disorder, depression, bipolar disorder (i.e., mania/depression), schizophrenia, post-traumatic stress disorder, anxiety disorder, behavior that needs interventions. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy entitled, Transfer and Discharge (Including AMA) with a revised date of 12/1/22 was reviewed and read in part, 2. The facility permits each resident to remain in the facility and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered. And 6. Non-emergency transfers or discharges initiated by the facility, return not anticipated. a. Document the reasons for the transfer or discharge in the resident's medical record, and in the case of necessity for the resident's welfare and the resident's needs that cannot be met in the facility, document the specific resident needs that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the needs. Document any danger to the health or safety of the resident or other individuals that failure to transfer or discharge would pose. This surveyor was unable to locate documentation of the specific needs that could not be met in the facility or the facility's attempts to meet the resident's needs or the services available at the receiving facility to meet the needs. The discharge notice in the record stated, 1. The facility is unable to meet your needs 2. Due to the health, safety, and well-being of self and others. According to the medical record, there were medications ordered in an attempt to help manage resident's behaviors. On 8/29/24 hospice gave an order for Seroquel 25 mg two be given twice daily. According to the record the medication was not started until 8/31/25 when hospice discovered it was not on R454's medication administration record (MAR). An order was given for Olanzapine (Zyprexa) 5 mg three times daily as needed for anxiety and agitation on 9/4/24 but not added to the MAR until 9/6/24. This medication was given only once on 9/12/24. An order for Ativan 0.5 mg every 4 hours as needed for anxiety and agitation was given on 9/4/24 and put on the MAR on 9/5/24, it was never given. On 3/17/25 at 11:20 AM this surveyor interviewed Licensed Practical Nurse (LPN) # 9. They stated they had never seen R454 attempt to hurt another resident, He would try to go in their rooms, take stuff off their walls or doors. I think there were times when he was maybe going after a staff member and came close to hitting a resident, but I don't know of him trying to hurt another resident. On 3/17/25 at 12:40 this surveyor interviewed the maintenance assistant. They stated they were working as a Certified Nursing Assistant (CNA) in September and was familiar with R454. I was in the dining room feeding one evening and he came up behind me and hit me with a broom handle. I was able to get the broom away from him and we got him calmed down. He didn't like men, most of his issues were with me, that one male nurse and the Administrator I think. When asked if he ever witnessed R454 try to hurt another resident he stated, No, I mean when he was swinging that broom handle, he could have hit the lady I was feeding but he wasn't trying to hit her. The facility provided a copy of the appeal letter they received after R454 discharged . No further information was provided prior to the exit conference.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide written notification of reasons for transfer and/or discharge to the resident and the resident's representative(s) for four (4) of fifty-five (55) sampled residents, (Resident #63, Resident #103, Resident #455, and Resident #21) and the facility staff failed to provide evidence the ombudsman was notified of transfer and/or discharge for one (1) of fifty-five (55) sampled residents (Resident #455). The findings include: 1.For Resident #63 the facility failed to provide written notification of reason for transfer and/or discharge to the resident and resident representative for a hospital discharge on [DATE]. Resident #63's diagnosis list indicated diagnoses that included but were not limited to Cerebral Infarction Affecting Right Dominant Side, Type 2 Diabetes Mellitus, Repeated Falls, Chronic Kidney Disease, Peripheral Vascular Disease, Dementia, Mood Affective Disorder, Depression, Anxiety, Restlessness and Agitation, and Acute Respiratory Failure with Hypoxia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/17/25, assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of the clinical record indicated Resident #63 was transferred to the hospital on 1/10/25. No evidence of written notice of the reason for transfer/discharge being provided to the resident and the resident's representative could be located. Surveyor requested evidence of written notification for reason of transfer/discharge for Resident #63 and resident's representative for the transfer/discharge that occurred on 1/10/25. This concern was discussed at the end of day meeting on 4/7/25 at 4:59 PM with administrator, director of nursing, assistant director of nursing, regional director of clinical services, and regional vice president of operations. On 4/8/25 at 8:38 AM, director of nursing informed surveyor a written notification for reason of transfer/discharge could not be located for resident and resident representative for the transfer/discharge on [DATE]. Surveyor requested and received a facility policy titled, Transfer and Discharge with a reviewed/revised date of 12/1/22 that read in part, .7 .j. Provide transfer notice as soon as practicable to resident and representative . No other information was provided to the survey team prior to exit on 4/8/25. 2.For Resident #103, the facility staff failed to provide the resident and the resident's representative(s) written notice of the reason(s) for transfer/discharge to the hospital on 2/24/25. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Rehabilitation and Nursing	514 North Main Street Rural Retreat, VA 24368

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #103's diagnosis list indicated diagnoses that included, but were not limited to, Hemiplegia, Hemiparesis, Type 2 (two) Diabetes Mellitus, Dysphagia, Hypertension, Weakness, Hypokalemia, Depression, and Rectal Fistula. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/20/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the clinical record indicated Resident #103 was transferred to the hospital on 2/24/25. No evidence of written notice of the reason for transfer/discharge being provided to the resident and the resident's representative could be located. Surveyor requested evidence of written notification for reason of transfer/discharge for Resident #103 and resident's representative for the transfer/discharge that occurred on 2/24/25. On 03/13/25 at 10:17 AM, assistant director of nursing informed surveyor no evidence of written notification of reasons for transfer/discharge being provided to Resident #12 and resident's representative for the transfer/discharge that occurred on 2/24/25 could be located. This concern was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, assistant director of nursing, interim director of nursing and regional nurse support. Surveyor requested and received a facility policy titled, Transfer and Discharge with a reviewed/revised date of 12/1/22 that read in part, .7 .j. Provide transfer notice as soon as practicable to resident and representative . No further information was provided to the survey team prior to exit on 4/8/25. (Note: An abbreviated portion of this abbreviated-extended-standard survey included the initial entrance on 3/11/25 to include the above findings.) 3.For Resident #455 the facility staff failed to provide the resident and the resident's representative(s) written notice of the reason(s) for transfer/discharge to the hospital on 3/16/25 and failed to notify the office of the local long-term care ombudsman of the transfer/discharge on [DATE]. Resident # 455's diagnoses included but were not limited to, Bipolar Disorder, Other Seizures, Insomnia, Chronic Kidney Disease, Borderline Personality Disorder, and Atrial Fibrillation. A facility document titled, MDS Data Collection with an effective date of 3/13/25 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. A review of the clinical record indicated Resident #455 was transferred to the hospital on 3/16/25. No evidence of written notice of the reason for transfer/discharge being provided to the resident and the resident's representative could be located. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested evidence of written notification for reason of transfer/discharge for Resident #455 and resident's representative for the transfer/discharge that occurred on 3/16/25 and evidence of notification of the transfer/discharge to the local long-term care ombudsman. On 4/7/25 at 4:18 PM surveyor interviewed other staff #23 and she informed surveyor she did not have any documentation the resident went out on 3/16/25 and said nothing was sent to the resident, family, or ombudsman due to not knowing the resident went out. This concern was discussed at the end of day meeting on 4/7/25 at 4:59 PM with administrator, director of nursing, assistant director of nursing, regional director of clinical services, and regional vice president of operations. Surveyor requested and received a facility policy titled, Transfer and Discharge with a reviewed/revised date of 12/1/22 that read in part, .7 .j. Provide transfer notice as soon as practicable to resident and representative . No further information was provided to the survey team prior to exit on 4/8/25. 4. For Resident #21, the facility staff failed to provide Resident #21 or the resident's representative written notice of transfer for the 01/16/25 transfer to the hospital. Resident #21's face sheet included the diagnoses acute and chronic respiratory failure, chronic kidney disease stage 4, history of malignant neoplasm of bladder, chronic pain syndrome, and diabetes. Section C (cognitive patterns) of Resident #21's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/29/25 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Per the MDS manual a score of 15=cognitively intact. Resident #21's clinical record included a progress note dated 01/16/25 documented by Licensed Practical Nurse (LPN) #9 indicating 911 emergency services contacted for resident transport to emergency room (ER). All relevant paperwork sent with resident to the ER. Resident's husband called unable to leave message. During the clinical record review, the surveyor was unable to locate any information to indicate the resident and/or resident representative was provided with a written notice of transfer. The facility policy titled, Transfer and Discharge with a revision date of 12/01/22 read in part, .Provide transfer notice as soon as practicable to resident and representative . On 04/02/25 at 4:45 p.m., during an interview with the facility Social Worker (SW) this staff stated they did not complete discharge notifications. On 04/02/25 at 5:00 p.m., the Assistant Director of Nursing provided the surveyor with a copy of the progress note dated 01/16/25 that had been documented by LPN #9 and stated that was all she had. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/04/25 at 10:35 a.m., during a meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services the issue with the lack of evidence to indicate written transfer notification had been provided to Resident #21 and/or the resident representative for 01/16/25 was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For Resident #63 the facility failed to provide the resident and/or the resident's representative with the facility bed-hold policy upon transfer on 1/10/25. Resident #63's diagnosis list indicated diagnoses that included but were not limited to Cerebral Infarction Affecting Right Dominant Side, Type 2 Diabetes Mellitus, Repeated Falls, Chronic Kidney Disease, Peripheral Vascular Disease, Dementia, Mood Affective Disorder, Depression, Anxiety, Restlessness and Agitation, and Acute Respiratory Failure with Hypoxia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/17/25, assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of the clinical record indicated Resident #63 was transferred to the hospital on 1/10/25. No evidence of the facility's bed-hold policy being provided to the resident and/or the resident's representative could be located. Surveyor requested evidence bed-hold policy was given to resident and/or resident representative. This concern was discussed at the end of day meeting on 4/7/25 at 4:59 PM with administrator, director of nursing, assistant director of nursing, regional director of clinical services, and regional vice president of operations. On 4/8/25 at 8:38 AM, director of nursing informed surveyor no evidence could be located that a bed hold was given at the time of discharge on [DATE]. Surveyor requested and received a facility policy titled, Bed Hold Notice Upon Transfer with a reviewed/revised date of 12/1/22 that read in part, .At the time of transfer for hospitalization .the facility will provide to the resident and/or resident representative written notice which specifies the duration of the bed-hold policy . No other information was provided to the survey team prior to exit on 4/8/25. 3. For Resident #103, the facility staff failed to provide the resident and/or the resident's representative with the facility bed-hold policy upon transfer on 2/24/25. Resident #103's diagnosis list indicated diagnoses that included, but were not limited to, Hemiplegia, Hemiparesis, Type 2 (two) Diabetes Mellitus, Dysphagia, Hypertension, Weakness, Hypokalemia, Depression, and Rectal Fistula. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/20/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record indicated Resident #103 was transferred to the hospital on 2/24/25. No evidence of the facility's bed-hold policy being provided to the resident and/or the resident's representative could be located. Surveyor requested evidence bed-hold policy was given to resident and/or resident representative. On 3/13/25 at 10:17 AM, assistant director of nursing informed surveyor no evidence of the bed-hold being given could be located. This concern was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, assistant director of nursing, interim director of nursing and regional nurse support. Surveyor requested and received a facility policy titled, Bed Hold Notice Upon Transfer with a reviewed/revised date of 12/1/22 that read in part, .At the time of transfer for hospitalization .the facility will provide to the resident and/or resident representative written notice which specifies the duration of the bed-hold policy . No further information was provided to the survey team prior to exit on 4/8/25. (Note: An abbreviated portion of this abbreviated-extended-standard survey included the initial entrance on 3/11/25 to include the above findings.) 4. For Resident #453, the facility staff failed to provide the resident and/or the resident's representative with the facility bed-hold policy upon transfer on 3/10/25. Resident #453's diagnosis list indicated diagnoses that included, but were not limited to, Hypertension, Atrial Fibrillation, Diverticulosis, Macular Degeneration, Unsteadiness on Feet, Depression, Difficulty Walking, Weakness, Polyosteoarthritis, Dementia, Alzheimer's, Chronic Kidney Disease-Stage 2, and Nightmare Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/19/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the clinical record indicated Resident #453 was transferred to the hospital on 3/10/25. No evidence of the facility's bed-hold policy being provided to the resident and/or the resident's representative could be located. Surveyor requested evidence bed-hold was given to resident and/or representative and on 3/12/25 at 3:26 PM, the assistant director of nursing informed surveyor no evidence of the bed-hold could be located. This concern was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, assistant director of nursing, interim director of nursing and regional nurse support. Surveyor requested and received a facility policy titled, Bed Hold Notice Upon Transfer with a reviewed/revised date of 12/1/22 that read in part, .At the time of transfer for hospitalization .the facility will provide to the resident and/or resident representative written notice which specifies the duration of the bed-hold policy . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided to the survey team prior to exit on 4/8/25. (Note: An abbreviated portion of this abbreviated-extended-standard survey included the initial entrance on 3/11/25 to include the above findings.) Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide a bed hold notice upon transfer for 4 of 55 sampled residents, Resident #21, #63, #103, and #453. The findings include. 1. The facility staff failed to offer Resident #21 a bed hold notice upon transfer to a local hospital that resulted in an inpatient stay. Resident #21's face sheet included the diagnoses acute and chronic respiratory failure, chronic kidney disease stage 4, history of malignant neoplasm of bladder, chronic pain syndrome, and diabetes. Section C (cognitive patterns) of Resident #21's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/29/25 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Per the MDS manual a score of 15=cognitively intact. Resident #21's clinical record included a nursing progress note dated 01/16/25 that read, 911 emergency services contacted for resident transport to _____ ER (emergency room) for further evaluation. 911 ambulance crew given report on resident and out of building at 15:00 (3:00 p.m.) _____ RN (registered nurse) at _____ ER given report by the nurse about resident's impending arrival to their facility. All relevant paperwork sent with resident to the ER. Resident's husband _____ was called on number listed in profile and the message This inbox is full was received. Unable to reach resident's husband. The surveyor was unable to locate any information to indicate this resident and/or the representative was ever offered a bed hold. On 04/02/25 at 4:45 p.m., the Social Worker was interviewed regarding a bed hold for this resident. The SW stated the nursing staff was responsible for the bed holds. On 04/02/25 at 5:00 p.m., the Assistant Director of Nursing (ADON) provided the surveyor with a copy of the progress note referenced above dated 01/16/25 and stated that was all they had. On 04/04/25 at 10:35 a.m., during a meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services the issue with the bed hold not being offered was reviewed. On 04/07/25, the ADON provided the survey team with a copy of a policy titled, Bed Hold Notice Upon Transfer. This policy read in part, At the time of transfer for hospitalization .the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed . (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. Based on staff interviews, clinical record review, and facility document review, the facility staff failed to ensure a resident's medication needs were addressed as part of admission orders for one (1) of 55 sampled residents (Resident #153). The findings include: The facility staff failed to ensure Resident #153's admission documentation/orders addressed the medications included as part of Resident #153's hospital discharge information. Resident #153's admission minimum data set (MDS) assessment was not due and had yet to be submitted prior to the surveyor's review of the resident's clinical record. A medical provider assessment indicated Resident #153 was alert and oriented times three (3). Resident #153 was documented as having adequate vision. Resident #153's hearing was documented as being grossly intact. Resident #153's clinical record included an Internal Medicine Discharge Summary from the local hospital; this document had a date of service of 3/26/25. This document included information about medications and/or supplements Resident #153 was to start taking and/or continue taking after discharge from the hospital. Resident #153 was documented as being admitted to the facility on the afternoon of 3/26/25. Resident #153's Internal Medicine Discharge Summary included instructions for the resident to continue enoxaparin 40mg every day via subcutaneous injection. (Enoxaparin is a medication used to prevent the development of blood clots; it was to be administered as an injection beneath the resident's skin.) The facility's medical provider did not order this medication to be started until 3/28/25. No information was found by, or provided to, the surveyor to address why Resident #153 was not ordered to receive enoxaparin on 3/27/25. On 4/8/25 at 11:45 a.m., the Director of Nursing (DON) confirmed Resident #153's enoxaparin was not ordered for 3/27/25. On 4/2/25 at 6:30 p.m., the surveyor asked the Director of Nursing (DON) about the absence of orders for Resident #153's Epipen and Baqsimi nasal spray. (Baqsimi is a nasal spray used to treat low blood sugar in diabetic residents. Epipen is a medical device used to inject epinephrine to treat severe allergic reactions.) Epipen and Baqsimi nasal spray were included in Resident #153's hospital discharge summary as part of the list of medications for the resident to continue taking. After the surveyor asked about Resident #153's Epipen and Baqsimi nasal spray, the facility staff obtained medical provider orders for the Epipen and Baqsimi. Resident #153's medical provider orders and/or documentation failed to address the following medications and/or supplements, documented as part of the resident hospital discharge summary, to be started and/or continued: ergocalciferol, olopatadine eye drops, elderberry, flaxseed, vitamin B complex, vitamin E, zinc, magnesium oxide, azo cranberry, ascorbic acid, Coenzyme Q10, and bisacodyl. On 4/8/25 at 11:45 a.m., the DON and the nursing consultant (who worked with the medical provider group used by the facility) acknowledged admission provider documentation did not address the aforementioned medications/supplements. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/25 at 12:05 p.m., the surveyor interviewed the DON and Staff Member (SM) #21 (a nurse practitioner) about the failure of the medical provider, who gave Resident #153's admission orders, to address all the medications and/or supplements listed as part of the resident's hospital discharge summary. It was reported, that although not all of the supplements were addressed, Resident #153 had been ordered a multivitamin. It was confirmed that the eye drops were not ordered when Resident #153 was admitted to the facility. It was reported that the admitting provider possibly did not give specific orders for the Epipen and Baqsimi nasal spray due to the facility's standing orders. The facility's standing orders did include orders to address low blood sugar levels; the standing orders did not include a nasal spray to address low blood sugar levels. The following information was found as part of a facility document titled admission Orders (with a reviewed/revised date of 12/1/22): - A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide orders for the residents' [sic] immediate care and needs. - The written orders should include at a minimum: . Medication orders if indicated . Routine care orders . - The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission. - The orders should provide information to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. On 4/8/25 at 3:02 p.m., the survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed: (a) the failure of a medical provider to address all the medications and/or supplements documented to be continued as part of Resident #153's hospital discharge summary and (b) the delay in the medical provider ordering Resident #153's enoxaparin.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure an accurate MDS assessment for (2) two of fifty-five (55) sampled residents (Resident #46 and Resident #93). The findings include: 1.For Resident #46, the facility staff failed to code the resident as having a right-hand splint and a right elbow extension brace on the minimum data set (MDS) assessment dated [DATE]. Resident #46's diagnosis list indicated diagnoses, which included, but not limited to, Mild Cognitive Impairment, Edema, Traumatic Hemorrhage of Cerebrum, Apraxia, Cerebral Infarction, Depression, Aphasia, Congestive Heart Failure, Acute Respiratory Failure, Anxiety Disorder, and Cognitive Social or Emotional Deficit,. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/21/25 assigned the resident a brief interview for mental status (BIMS) summary score of 6 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of Section O (Special Treatments, Procedures, and Programs) section O0500 Restorative Nursing Programs was coded as 0 indicating the resident did not have a restorative program in place for splint or brace assistance. On 4/3/25 at 4:40PM, surveyor observed resident lying in bed with a splint on his right-hand. A medical provider order with a start date of 6/14/24 read in part, .Pt (patient) may have right resting hand splint daily for contracture management for up to eight hours a day . A medical provider order with a start date of 6/14/24 read in part, .Pt to wear right elbow extension brace daily, for up to four hours for contracture management . A review of the February, March, and April 2025 TARs (treatment administration records) revealed resident was provided with the right-hand splint and right elbow brace as ordered by the provider. A review of the comprehensive person-centered care plan read in part, .Has right side Hemiparesis .Pt may have right resting hand splint daily for contracture management .Resident to wear elbow extension brace for contracture management . This concern was discussed on 4/4/25 at 10:35 AM at the end of day meeting with administrator, director of nursing, and regional director of clinical services. A review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1 with a revision date of 10/2024, read in part, [page O-51] .For the 7-day look-back period, enter the number of days on which the technique .was performed for a total of at least 15 minutes during the 24-hour period .[page O-52] .Code provision of .(2) a scheduled program of applying and removing a splint or brace . No further information regarding this concern was presented to the survey team prior to the exit conference on 4/8/25. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #93, the facility staff incorrectly coded the 2/15/25 minimum data set (MDS) assessment for the use of anticoagulant medication. Resident #93's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction, Metabolic Encephalopathy, Convulsions, Unspecified Psychosis, Major Depressive Disorder, and Generalized Anxiety Disorder. The most recent MDS with an assessment reference date (ARD) of 2/15/25 assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 indicating the resident was moderately cognitively impaired. The 2/15/25 MDS coded Resident #93 as taking an anticoagulant medication during the last seven (7) days. Surveyor reviewed Resident #93's clinical record and was unable to locate evidence of the resident receiving an anticoagulant medication during the seven-day period prior to the 2/15/25 MDS. On 4/07/25 at 9:08 AM, surveyor spoke with the MDS Coordinator regarding the anticoagulant coding on the 2/15/25 MDS. The MDS Coordinator returned to the surveyor at 9:35 AM and stated she had reviewed the MDS and Resident #93 was not taking an anticoagulant and she would do a correction. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 2. For Resident #93, the facility staff failed to ensure a Level I Preadmission Screening and Resident Review (PASARR) was completed. Resident #93's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction, Metabolic Encephalopathy, Convulsions, Unspecified Psychosis, Major Depressive Disorder, and Generalized Anxiety Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/15/25 assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 indicating the resident was moderately cognitively impaired. The MDS was coded for the presence of delusions and wandering behavior. Surveyor reviewed Resident #93's clinical record and was unable to locate a Level I PASARR. Resident #93 had resided at the facility for approximately five (5) months. Surveyor requested and received the facility policy titled Resident Assessment - Coordination with PASARR Program with a reviewed/revised date of 2/20/23 which read in part .1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the state's Medicaid rules for screening a. PASRR [sic] Level I -initial pre-screening that is completed prior to admission .5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process .6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status . On 4/07/25 at 4:35 PM, surveyor spoke with the facility social worker (SW) who stated Level I PASARRs should be done by the hospital but if not, admissions should do them. On 4/07/25 at 4:40 PM, surveyor spoke with the Admissions Coordinator who stated they had never been told they were to do Level I PASARRs, and they attempt to get them from the hospital. On 4/08/25 at approximately 3:00 PM, surveyor spoke with the Director of Nursing and requested assistance in locating a Level I PASARR for Resident #93. The DON returned at 5:42 PM and stated they did not have one for Resident #93. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25. Based on staff interview, clinical record review and facility document review the facility staff failed to complete a preadmission screening and resident review (PASARR) prior to admission for 2 of 55 residents, Resident #36 and Resident #93. The findings included: 1. For Resident #36 the facility staff failed to ensure a PASARR was completed prior to admission. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #36's face sheet listed diagnoses which included but not limited to suicidal ideations, major depressive disorder, and bipolar disorder, severe, with psychotic features. Resident #36's most recent minimum data set with an assessment reference of 02/04/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #36's clinical record was reviewed, and surveyor could not locate a level 1 PASARR. Surveyor spoke with the regional director of clinical services on 04/04/25 at 10:40 am regarding Resident #36's PASARR. Regional director of clinical services stated they were unable to locate a PASARR for Resident #36. Surveyor requested and was provided with a facility policy entitled Resident Assessment-Coordination with PASARR Program which read in part, 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASRR Level 1 -initial pre-screening that is completed prior to admission. 3. A record to the pre-screening shall be maintained in the resident's medical record. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. Surveyor spoke with the facility social worker (SW) on 04/07/25 at 4:35 pm. SW stated they don't do level 1 PASARR's and that they should be done prior to leaving the hospital. SW also stated that if they are not done at the hospital, admissions should be doing them. Surveyor pointed out to SW that facility policy stated that social services director is responsible for keeping track of residents PASARR's. SW stated they have never seen said policy. Surveyor spoke with admissions director on 04/07/25 at 4:40 pm. Admissions director stated they have never completed level 1 PASARR's and have never been told to do it. The concern of not completing a level 1 PASARR was discussed with the administrator, director of nursing, assistant director of nursing, and regional director of clinical services on 04/04/25 at 10:35 am. No further information provided prior to exit.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to develop and implement a baseline care plan and/or failed to provide the resident and their representative with a summary of the baseline care plan for seven (7) of fifty-five (55) sampled residents (Resident #455, Resident #255, Resident #254, Resident #85, Resident #61, Resident #17, and Resident #23). The findings include: 1.For Resident #455 the facility staff failed to provide the resident and their representative with a summary of the baseline care plan that was effective on 3/7/25. Resident # 455's diagnoses included but were not limited to, Bipolar Disorder, Other Seizures, Insomnia, Chronic Kidney Disease, Borderline Personality Disorder, and Atrial Fibrillation. A facility document titled, MDS Data Collection with an effective date of 3/13/25 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. On 4/2/25 at 9:08 AM, surveyor interviewed Resident #455 and she informed surveyor she did not recall being invited to care plan meetings. A review of the clinical record revealed a baseline care plan was created on 3/7/25. A review of Section 7. B. Resident and/or Resident Representative Signature Page was not marked or signed by the resident and/or resident representative to indicate the baseline care plan had been reviewed by the resident and/or resident representative or that the resident and/or resident representative had understood the plan of care or had the opportunity to add or modify the plan of care. This concern was discussed on 4/4/25 at 10:35 AM at the end of day meeting with administrator, director of nursing, and regional director of clinical services. On 4/7/24 the director of nursing informed surveyor no evidence could be located that Resident #455 attended or signed the baseline care plan. Surveyor requested and received a facility policy titled, Baseline Care Plan with a revision date of 12/1/22, that read in part, .4. A written summary of the baseline care plan shall be provided to the resident and representative .5. A supervising nurse or MDS (minimum data set) nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. This will be provided within 48 hours of admission .6. The person providing the written summary of the baseline care plan shall: a. Obtain a signature for the resident/representative to verify that the summary was provided. b. Make a copy of the summary for the medical record . No further information was provided to the survey team prior to exit on 4/8/25. 6. For resident # 17 (R17) the facility staff failed to develop a baseline care plan within 48 hours of admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/31/25 at 1:30 PM this surveyor interviewed R17 and a visiting family member. They stated that they had ongoing concerns with toileting. Resident prefers to sit on the toilet to have a bowel movement (bm) but the staff use a hoyer lift and have told them (resident and family) that resident has to be put to bed to have a bm. The family member stated, They put her to bed and tell her to use her diaper and they will clean her up. We told them we want her to be able to use the toilet and (unit manager name omitted) told me I would have to sign an AMA (Against Medical Advice form) in case she got hurt or the staff got hurt. This surveyor asked the resident if the staff ever offer the use of a bed pan, the family member stated, Well there's one in there but no I don't think so. R17 stated, They put me on it sometimes. This surveyor asked resident if she had received any physical or occupational therapy lately. The family member stated, They discharged her today. The clinical record was reviewed. This surveyor was unable to locate any evidence of a baseline care plan for R17's initial admission to the facility. On 4/7/25 this surveyor asked the Director of Nursing (DON) for a copy of R17's baseline care plan from their initial admission. They stated they were not able to locate one. The policy entitled, Baseline Care Plan with a date reviewed/revised of 12/1/22 was reviewed and read in part, 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission and, 3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. 4. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand . On 4/7/25 at 5:00 PM the survey team met with the Administrator, DON, Assistant DON, Regional Director of Clinical Services and the Regional Director of Operations. This concern was discussed at that time. No further information was provided to the survey team prior to the exit conference. 7. For Resident #23, the facility staff failed to provide the resident and/or resident representative with a summary of the baseline care plan. Resident 23's diagnosis list indicated diagnoses, which included, but not limited to Sepsis, Metabolic Encephalopathy, Urinary Tract Infection, Obstructive and Reflux Uropathy, and Parkinson's Disease. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/08/25 assigned the resident a brief interview for mental status (BIMS) summary score of 7 out of 15 indicating the resident was severely cognitively impaired. Resident #23's clinical record included a baseline care plan dated 3/03/25. A checkmark was placed by the statement I have a copy of the Baseline Care Plan, it has been reviewed with me, I understand my plan of care, and I have had the opportunity to add or modify my plan of care. The baseline care plan included lines for the resident's signature and date and/or the signature and date of the resident representative, both lines were left blank. Resident #23's baseline care plan did not include the resident or resident representative's signature. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/31/25 at 6:00 PM, surveyor spoke with Resident #23's representative who stated they had not been provided with a copy of the resident's care plan since admission. Surveyor requested and received a copy of the facility policy titled Baseline Care Plan with a reviewed/revised date of 12/01/22 which read in part .4. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand .5. A supervising nurse or MDS nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. This will be provided within 48 hours of admission .6. The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided. b. Make a copy of the summary for the medical record . On 4/02/25 at 6:20 PM, surveyor spoke with the MDS Coordinator who stated it was the responsibility of the nurse on the hall to give the resident a copy of the baseline care plan. On 4/07/25 at 3:05 PM, surveyor spoke with Registered Nurse (RN) #2 who stated when she completes an admission, she does the baseline care plan, gives a copy to the resident/resident representative and reviews it with them. RN #2 stated she was never instructed to have the resident/resident representative sign the baseline care plan. On 4/07/25 at 5:00 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, and Regional [NAME] President of Operations and discussed the concern of staff failing to provide evidence of Resident #23 receiving a copy of the baseline care plan. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25. 4. For Resident #85 the facility staff failed to review and provide a written copy of the baseline care plan to the resident and/or representative. Resident #85's face sheet listed diagnoses which included but not limited to cerebral infarction, type 2 diabetes mellitus, and hypertension. Resident #85's most recent minimum data set (minimum data set) with an assessment reference date of 02/24/25 assigned the resident brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. The assessments section of Resident #85's clinical record was reviewed and contained a Base Line Care Plan form dated 02/18/25 which read in part 1. I have a copy of the Baseline Care Plan, it has been reviewed with me, I understand my plan of care, and I have had the opportunity to add or modify my plan of care. 2. Signature of Resident and Date. This section has not been signed/dated. Surveyor spoke with registered nurse (RN) #1, who is the facility MDS coordinator, on 04/0/25 at 6:20 pm regarding who gives residents copies of their baseline care plan, and RN #1 stated that it is the responsibility of the nurse on the hall to give residents copies of their baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor spoke with licensed practical nurse (LPN) #7 on 04/03/25 at 8:40 am regarding who gives residents copies of their baseline care plan, and LPN #7 stated, I assume . (social worker) does. Surveyor spoke with Resident #85 on 04/03/25 at 2:35 pm regarding baseline care plan. Resident #83 stated that no one had went over a care plan with him, nor had they given him a copy of the care plan. Surveyor requested and was provided with a facility policy entitled Baseline Care Plan which read in part, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care . 4. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand 5. A supervising nurse or MDS (minimum data set) nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. This will be provided within 48 hours of admission 6. The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided. b. Make a copy of the summary for the medical record. The concern of not providing a reviewing/providing a written copy of the baseline care plan for Resident #85 was discussed with the administrator, director of nursing, assistant director of nursing, and regional director of clinical services on 04/04/25 at 10:35 am. On 04/07/25 at 11:00 am the assistant director of nursing provided surveyor with a copy of Resident #85's signed baseline care plan dated 04/04/25. No further information was provided prior to exit. 5. For Resident #61 the facility staff failed to review and provide a written copy of the baseline care plan to the resident and/or representative. Resident #61's face sheet listed diagnoses which included but not limited to atrial fibrillation, type 2 diabetes mellitus, and chronic obstructive pulmonary disease. Resident #61's most recent minimum data set with an assessment reference date of 03/04/25 assigned the resident a brief interview for mental status score of 10 out of 15 in section C, cognitive patterns. This indicated that the resident was moderately cognitively impaired. The assessments section of Resident #61's clinical record was reviewed and contained a Base Line Care Plan form dated 02/18/25 which read in part 1. I have a copy of the Baseline Care Plan, it has been reviewed with me, I understand my plan of care, and I have had the opportunity to add or modify my plan of care. 2. Signature of Resident and Date. This section has not been signed/dated. Surveyor spoke with the assistant director of nursing (ADON) on 04/08/25 at 11:30 am regarding Resident #61's baseline care plan. ADON stated the care plan in the electronic record is all they have. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested and was provided with a facility policy entitled Baseline Care Plan which read in part, The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care . 4. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand 5. A supervising nurse or MDS (minimum data set) nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative. This will be provided within 48 hours of admission 6. The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided. b. Make a copy of the summary for the medical record. The concern of not providing a reviewing/providing a written copy of the baseline care plan for Resident #61 was discussed with the administrator, director of nursing, assistant director of nursing, and regional director of clinical services on 04/08/25 at 3:00 pm. No further information was provided prior to exit. 2. For Resident #254, the facility staff failed to provide the resident with a summary or copy of their baseline care plan. Resident #254's diagnoses included chronic obstructive pulmonary disease, diabetes, and cerebrovascular disease. There was no completed minimum data set (MDS) assessment on this resident. The resident was alert and orientated to self and place. Resident #254's clinical record included a baseline care plan with a lock date of 03/28/25. Section 7 of the baseline care plan included the statement I have a copy of the Baseline Care Plan, it has been reviewed with me, I understand my plan of care, and I have had the opportunity to add or modify my plan of care. The box beside this statement was unchecked and the area for the resident and/or resident representative to date and sign were empty. On 04/02/25 at 6:15 p.m., Resident #254 was asked if he had received a copy of his baseline care plan. Resident #254 shook his head no. On 04/02/25 at 6:20 p.m., during an interview with the MDS coordinator this staff stated it was the responsibility of the nurse on the hall to give the residents a copy of their baseline care plan. On 04/02/25 at 6:45 p.m., the MDS coordinator documented a progress note that read, Care plan reviewed with resident by this nurse. Denies any concerns or questions. Copy provided to resident. On 04/03/25 at 8:40 a.m., during an interview with Licensed Practical Nurse (LPN) #7 this nurse was asked if she knew who would give the residents copies of their baseline care plan. LPN #7 stated I assume the social worker. On 04/04/25 10:35 a.m., the Administrator, Director of Nursing, and Regional Director of Clinical Services were made aware that Resident #254 had stated they had not received a summary or copy of their baseline care plan. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility staff provided the survey team with a copy of their policy titled, Baseline Care Plan. This policy read in part, .A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand . No further evidence was provided to the surveyor to indicate Resident #254 had received a copy or summary of their baseline care plan prior to the exit conference. 3. For Resident #255, the facility staff failed to provide the resident with a summary or copy of their baseline care plan. Resident #255's diagnoses included end stage renal disease, chronic atrial fibrillation, and congestive heart failure. There was no completed minimum data set assessment (MDS) on this resident. This resident was alert and orientated to person and place. Resident #255's clinical record included a baseline care plan with a lock date of 04/01/25. Section 7 of the baseline care plan included the statement I have a copy of the Baseline Care Plan, it has been reviewed with me, I understand my plan of care, and I have had the opportunity to add or modify my plan of care. The box beside this statement was checked and the area for the resident to sign had this resident's name typed in the box. On 04/02/25 at 6:20 p.m., during an interview with the MDS coordinator this staff stated it was the responsibility of the nurse on the hall to give the residents a copy of their baseline care plan. On 04/03/25 at 8:10 a.m., Resident #255 was asked by the surveyor if he had received a copy of his baseline care plan. Resident #255 stated he had not. On 04/03/25 at 8:40 a.m., during an interview with Licensed Practical Nurse (LPN) #7 this nurse was asked who would give the residents copies of their baseline care plan. LPN #7 stated I assume the social worker. On 04/04/25 at 10:35 a.m., the Administrator, Director of Nursing, and Regional Director of Clinical Services were made aware that Resident #255 had stated they had not received a copy of their baseline care plan. The facility staff provided the survey team with a copy of their policy titled, Baseline Care Plan. This policy read in part, .A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand . No evidence was ever provided to the surveyor to indicate this resident had received a copy or summary of their baseline care plan prior to the exit conference on 04/08/25.

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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. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to develop and/or revise the comprehensive person-centered care plan to meet the resident's needs for 5 of 55 sampled residents (Residents #454, 17, 65, 96 and Resident #40). 1. For resident #454 (R454), the facility staff failed to update the comprehensive care plan to reflect the resident's pertinent mental health history and diagnoses, failed to develop individualized person-centered interventions and failed to follow the care plan, specifically to administer medications that were ordered as a result of behaviors. R454's diagnoses according to the facility diagnoses sheet included but were not limited to other seizures, chronic obstructive pulmonary disease, hypertension, anxiety, heart failure, personal history of suicidal behavior, traumatic brain injury, major depressive disorder, and vascular dementia with psychotic disturbance. R454's minimum data set (MDS) assessment with an assessment reference date of 8/28/24 assigned the resident a brief interview for mental status score of 11 out of 15 indicating moderate cognitive impairment. There were no mood indicators captured on the assessment and the only behavior identified was wandering which occurred one to three days during the lookback period. The care plan was reviewed. R454's care plan included a problem statement that read, Resident is hospice and has had an atypical change in behavior/development of behavior - physically and verbally aggressive towards staff and other residents, increase anxiety, wandering into other resident's rooms and toward exit doors, etc . 9/4/24-Continues with physical and verbal aggression to staff and other residents. The interventions included, Administer medications as ordered. Monitor/document for side effects and effectiveness. There was no mention of a history of a suicide attempt, no mention of a history of abuse. A hospice note dated 8/31/24 read, Nurse (name omitted) states patient has been rolling to other residents rooms, attempting to pull items off residents walls. Upon arrival patient is sitting in wheelchair, alert and oriented to person and place. States he owns this facility and has been making updates. He whispered to this nurse that those blue lights over there, indicating the call light system, that's how they listen to us. Reoriented patient that is call bell system and yes they communicate to patient for safety reasons. Reoriented patient to stay in his area as he wouldn't want other residents in his room. Patient has Seroquel (an antipsychotic medication that balances the levels of hormones in the brain to help regulate mood, behaviors and thoughts) 25 mg BID (twice daily) ordered but not on facility MAR yet. Facility has medication, order resumed as lack of Seroquel could likely be the cause of increased paranoia . A facility nurse note dated 8/31/24 read, Hospice nurse in to see resident this shift. Hospice nurse (name omitted) talked with this nurse about increased behaviors resident has had and talked with this nurse about mentioning to the provider to change his Seroquel from two times a day to three times a day. This nurse looked for an order in this system for Seroquel and did not see one for resident to have. Hospice nurse stated that the order for resident to have Seroquel twice a day should have been put into our system on 8/29/24. Hospice wrote orders for resident to have Seroquel 25mg one tablet by mouth twice a day for paranoid behaviors. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Rehabilitation and Nursing	514 North Main Street Rural Retreat, VA 24368

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility progress note dated 9/4/24 by the facility social worker read, Multiple IDT discussions and calls amongst multiple facility staff and hospice staff this date and discovery of additional clinical information review. IDT execution to resident this evening at 1830 of 30 day dc notice. Hospice aware and was conveying the same to daughter. Facility executing copy of notice via mail to daughter. Copy executed via fax to LTC Ombudsman. Facility will work with vested parties in facilitating transfer as needed. A facility progress note dated 9/5/24 read, education was attempted to be given to resident and resident grabbed nurses arm with medicine and squeezed it tightly threatening that he owns this place and He will get her and show her how it is. Nurse then went to get unit Manager while leaving resident with another nurse and told her what happened. Unit Manager then came to talk to resident and he threatened to break her knee caps. He then told the administrator who accompanied the unit Manager that he will take him outside and show him how it is because he looks wimpy. Resident continues to go into other residents rooms and threaten them, attempting to physically assault them, and preaching the gospel because we are all sinners. On 9/6/24 a care plan note read, Multiple IDT meeting across the week regarding resident. Some involving hospice and various staff, some involving daughter and various staff, some consisting of facility staff only. Continues at this time under hospice complimenting care. Is a DNR. Behaviors off and on. Multiple med changes across the week. Staff continues with redirection attempts. A document entitled, Client Medication Report was noted under the heading of Hospice in the medical record. According to this document Seroquel 25 mg one tablet two times daily was ordered on 8/29/24. Lorazepam 0.5 mg tablet every 4 hours as needed for anxiety and agitation was ordered on 9/4/24. Olanzapine 5 mg tablet may give one three times daily as needed, wait 2 hours between doses for anxiety and agitation. The Medication Administration Record (MAR) for August 2024 was reviewed. An entry for Seroquel 25 mg give one tablet by mouth twice daily was noted to have started on August 31, 2024. The MAR for September 2024 was reviewed. The Lorazepam was never administered to resident and the Olanzapine (Zyprexa) was given only one time on 9/12/24. On 3/11/25 at 1:20 PM this surveyor interviewed the Executive Director of the hospice provider. They stated, The Seroquel was started per facility request on 8/29/24 25 mg BID. He did have a psychiatric hospitalization history for paranoia per daughter. The facility us if we had the proper dx we could get proper meds so we got the psych notes from 2019 when he was in the psych ward in (hospital name omitted) he had stabbed himself in the abdomen. he had major depressive disorder, major neurocognitive disorder with delusional disorder being ruled out. He was physically and sexually abused as a child and had a brother with schizophrenia. We had a call with them on Monday morning to come up with a plan. They said if we started Zyprexa and work together to manage his behaviors they would continue to work with him. We agreed to increase our visits to daily and work on getting some sort of psych services in to see him. On 3/12/25 at 10:28 AM this surveyor interviewed the Administrator. The administrator stated, We had a meeting with hospice and found out he had a substantial psych history that we did not know about at first and we would not have taken him if we had known. We found he had attempted suicide and had significant diagnoses like neuorcognitive disorder. We couldn't meet his needs with these diagnoses. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy entitled, Comprehensive Care Plans with a revised date of 12/1/22 was reviewed. The document read in part, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The policy entitled, Care Plan Revision Upon Status Change with a revised date of 12/1/22 was reviewed and read in part, 1. The comprehensive care plan will be reviewed and revised as necessary when a resident experiences a status change. Under section 2a. Upon identification of a change in status, the nurse or any member of the interdisciplinary team will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. On 3/14/25 at 12:44 PM the survey team met with the Administrator, the Interim Director of Nursing, the Assistant Director of Nursing and the Clinical Nurse Support. The concern of the suicidal and mental health history not being on the care plan and the medications no being given for the behaviors as stated on the care plan was discussed at that time. No further information was provided to the survey team prior to the exit conference. 2. For resident #17 (R17), the facility staff failed to ensure the care plan consistently and accurately reflected the level of care and assistance needed for safe toileting. On 3/31/25 at 1:30 PM this surveyor interviewed R17 and a visiting family member. They stated that resident prefers to sit on the toilet to have a bowel movement (bm) but the staff use a hoyer lift and have told them that resident has to be put to bed to have a bm. The family member stated, They put her to bed and tell her to use her diaper and they will clean her up. We told them we want her to be able to use the toilet and (unit manager name omitted) told me I would have to sign an AMA (Against Medical Advice form) in case she got hurt or the staff got hurt. This surveyor asked the resident if the staff ever offer the use of a bed pan, the family member stated, Well there's one in there but no I don't think so. R17 stated, They put me on it sometimes. This surveyor asked resident if she had received any physical or occupational therapy lately. The family member stated, They discharged her today. The clinical record was reviewed. R17's diagnoses included but were not limited to polyosteoarthritis, muscle weakness, constipation, difficulty walking, lack of coordination, unspecified abnormality of gait and mobility, and other chronic pain. The minimum data set (MDS) assessment with an assessment reference date of 2/14/25 assigned the resident a brief interview for mental status score (BIMS) of 15 out of 15 indicating intact cognition. R17 was coded as requiring moderate assistance for toileting hygiene and substantial assistance for bed mobility. For transfers R17 was coded as not attempted due to medical condition or safety concerns. The resident was coded as being always incontinent of urine and frequently incontinent of bowel. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan was reviewed. A focus for activities of daily living (ADLs) read, ADL self-care performance deficit r/t debility, impaired mobility and weakness uses w/c (wheel chair). Under interventions, Toilet use: The resident requires extensive assistance by 1-2 staff for toileting. Not safe to toilet per therapy, offer bed pan. This care plan focus contained another intervention that read, Transfer: the resident requires hoyer by 2 staff to move between surfaces as necessary. The care plan focus entitled, The resident is at risk for constipation r/t decreased mobility included an intervention that read, Encourage resident to sit on toilet to evacuate bowels if possible and Ensure the resident's feet are flat on the floor or flat on an elevated support during evacuation. Knees should be at 90 degrees or above hip height to promote east of evacuation where possible. On 4/3/25 at 4:11 PM this surveyor interviewed the Director of Rehabilitation Services (DOR). When asked about R17 and toileting they stated, She was just discharged from our services per her request. She is really weak and has bad arthritis with crepitus in her joints and is a Hoyer lift. I just don't think she can use the bathroom by two person transfer, she is dead weight and needs to be a lift for everyone's safety, especially hers. She is also not always cooperative. This surveyor asked the DOR if they had met with the resident and family to discuss this concern and they stated they had and it should be documented in the last care conference note. On 4/4/25 at 8:34 AM this surveyor interviewed the Unit Manager (UM) regarding R17 and was asked if staff make her soiled herself and then clean her up after. They stated, Absolutely not. We put her on the bed pan. The family has complained and want us to take her to the bathroom but she can't stand and pivot, it isn't safe and we've told them that. When asked if they told the family they would have to sign an AMA they stated, I did not, I did explain that manually transferring her to the toilet would be against medical advice because she is a lift. There is just no way to transfer her safely. Nobody told her she would have to use her brief. He stated the resident was not upset when they had this conversation but the family was. When asked when this was discussed with the family he stated, We talked about it in the last care plan meeting, just a couple weeks ago. It should be in the care plan note. On 4/4/25 at 9:19 AM this surveyor interviewed the Occupational Therapist familiar with R17 to speak with surveyor regarding toileting and transfers. They stated, Her arthritis is so severe, there is crepitus in practically every joint she has had at least one hip and one knee replacement. She really isn't physically able to stand and do the pivot motion in order to sit on the toilet. I would be really concerned for her safety, it would be a matter of when, not if she would be injured. Not to mention the risk to the staff, she is dead weight, really just is not able to help much at all. The Multidisciplinary Care Conference document with a date of 3/18/25 was reviewed. There was no documentation of the above being discussed during that meeting. The information provided was not specific to any topics discussed. The policy entitled, Comprehensive Care Plans with a revised date of 12/1/22 was reviewed. The document read in part, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy entitled, Care Plan Revision Upon Status Change with a revised date of 12/1/22 was reviewed and read in part, 1. The comprehensive care plan will be reviewed and revised as necessary when a resident experiences a status change. Under section 2a. Upon identification of a change in status, the nurse or any member of the interdisciplinary team will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. On 4/7/25 at 5:00 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services and Regional [NAME] President of Operations. The conflicting care plans for R17 and the family concern with toileting was discussed at that time. No further information was provided to the survey team prior to the exit conference. 4. For Resident #96, the facility staff failed to address the use of a peripherally inserted central line catheter (PICC). Resident #96's diagnosis list indicated diagnoses, which included, but not limited to Sepsis, Acute Respiratory Failure with Hypoxia, and Osteoarthritis. The minimum data set (MDS) with an assessment reference date (ARD) of 2/17/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. On 3/12/25 at 9:23 AM while speaking with Resident #96, surveyor observed a PICC line present in the resident's right arm. A review of Resident #96's clinical record revealed a PICC line was inserted on 2/18/25. A nursing progress note dated 2/18/25 at 6:10 PM read in part .picc line placed into Rt [right] upper arm by vascular health for IV [intravenous] ABT [antibiotic] . On 3/12/25, surveyor reviewed Resident #96's current comprehensive person-centered care plan and was unable to locate documentation of the PICC line. On 3/12/25 at 9:34 AM, surveyor spoke with the MDS Nurse regarding Resident #96's PICC line. The MDS Nurse stated she could not find documentation of the PICC line on the care plan but would add it. Surveyor requested and received the facility policy titled Comprehensive Care Plans with a reviewed/revised date of 12/01/22 which read in part .3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . On 3/13/25 at 3:13 PM, the survey team met with the Administrator, Interim Director of Nursing, and Assistant Director of Nursing and discussed the concern of Resident #96's comprehensive care plan. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. For Resident #40, the facility staff failed to implement the comprehensive care plan. The facility staff failed to use the residents bed bolsters to define the parameters of the bed. Resident #40's diagnoses included Parkinson's disease, diabetes, muscle weakness, hemiplegia affecting the right dominant side, and cerebrovascular disease. Section C (cognitive patterns) of Resident #40's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/11/25 included a brief interview for mental status (BIMS) score of 9 out of a possible 15 points. Per the MDS manual a score of 9=moderately impaired in cognitive skills for daily decision making. Section GG (functional abilities) was coded with a 1 for dependent on staff for roll left to right and chair/bed to chair transfers. Section J (fall history) was coded to indicate the resident had 1 fall with no injury. Resident #40's comprehensive care plan included the focus area actual falls related to generalized weakness, debility, cognitive loss. Interventions included bilateral bed bolsters to define parameters of bed, ensure bed bolsters are in proper position to define parameters of bed. Resident #40's clinical record included a provider order dated 04/22/24 for bilateral bed bolsters to define parameters of bed. The order type was documented as Other Orders (no documentation required). On 04/01/25 at 10:00 a.m., 04/02/25 at 12:35 p.m., and on 04/03/25 at 9:45 a.m., the surveyor completed observations of this resident. Each time the surveyor observed the bed bolsters across the room from the residents bed on top of a dresser. On 04/03/25 at 9:45 a.m., the surveyor asked Resident #40 if the staff ever put the bed bolsters in place Resident #40 stated the staff do not use them. On 04/04/25 at 10:35 a.m., during a meeting with the Administrator, Director of Nursing and Regional Director of Clinical Services the issue with the bed bolsters not being used per the providers orders and care plan was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. The facility staff failed to ensure Resident #65's comprehensive care plan correctly addressed the use of an anticonvulsant medication. Resident #65's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/25/25, was signed as completed on 3/6/25. Resident #65 was assessed as sometimes able to make self understood and as sometimes able to understand others. Resident #65's Brief Interview for Mental Status (BIMS) summary score was documented as a 00 out of 15; this indicated severe cognitive impairment. Resident #65's comprehensive care plan included a focus for the use of an anticonvulsant medication. This care plan focus did not identify the purpose of the anticonvulsant medication. One of the interventions for this focus was to Administer ANTI-PARKINSON'S medications as ordered by the physician. The following information was found in a facility document titled Comprehensive Care Plan (with a reviewed/revised date of 12/1/22): (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. - The comprehensive care plan will describe, at a minimum, the following: . The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. On 4/4/25 at 10:35 a.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the surveyor discussed Resident #65 being care planned for: (a) the use of an anticonvulsant medication without documentation of a history of seizures and (b) the use of an anti-Parkinson's medication without documentation of a history of Parkinson's disease. On 4/7/25 at 11:15 a.m., the Assistant Director of Nursing (ADON) provided the surveyor with a copy of Resident #65 revised care plan focusing on the use of an anticonvulsant medication. The anticonvulsant medication was care planned as being used to address a mood disorder. One of the interventions for this focus was corrected by replacing the wording of ANTI-PARKINSON'S medications with ANTI-convulsant medications.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 3. For Resident #96, the facility staff failed to ensure the PICC line was flushed and failed to change the PICC line dressing at least weekly. Resident #96's diagnosis list indicated diagnoses, which included, but not limited to Sepsis, Acute Respiratory Failure with Hypoxia, and Osteoarthritis. The minimum data set (MDS) with an assessment reference date (ARD) of 2/17/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. On 3/12/25 at 9:23 AM while speaking with Resident #96, surveyor observed a PICC line present in the resident's right arm. The PICC site dressing was heavily creased and rolled up around the edges and blood was visible in the line. When asked when the dressing was last changed, Resident #96 stated they were unsure but there was a date on the dressing. Due to the creasing and wear on the dressing, the complete date was illegible, however the partial date of 2/-6 was visible on the dressing. Surveyor asked how often staff were flushing the PICC line, Resident #96 stated the site had not been flushed since the antibiotic was completed. On 3/12/25 at 9:32 AM, the Unit Manager (UM) accompanied the surveyor to observe Resident #96's PICC line and dressing. UM observed the PICC line and stated it needed to come out and it was due to be pulled today because the medication was completed. UM stated he was unable to read the date on the dressing and stated PICC lines were flushed before and after medication and daily. A review of Resident #96's clinical record revealed a PICC line was inserted on 2/18/25. A nursing progress note dated 2/18/25 at 6:10 PM read in part .picc line placed into Rt [right] upper arm by vascular health for IV [intravenous] ABT [antibiotic] . According to Resident #96's March 2025 Medication Administration Record (MAR), the resident received the last dose of the IV antibiotic, Vancomycin, on 3/03/25. Surveyor reviewed Resident #96's clinical record and was unable to locate evidence of any PICC line dressing changes or PICC line flushes following the last dose of antibiotic on 3/03/25. There were no provider orders present for dressing changes or flushes. On 3/13/25 at approximately 10:50 AM, surveyor discussed these concerns with the Assistant Director of Nursing (ADON) who stated PICC line dressings were to be changed every seven (7) days and the best practice for PICC line flushes was every 12 hours. Surveyor requested and received the facility policy titled Dressing Change for Vascular Access Devices dated 10/24 which read in part .3. Central venous access device and peripheral midline dressings are changed every 7 days and immediately if the integrity of the dressing is compromised, if moisture, drainage or blood is present, or for further assessment if infection is suspected . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor also received the policy titled Maintaining Patency of Peripheral and Central Vascular Access Devices dated 10/24 which read in part Purpose To maintain the patency of all peripheral and central vascular access devices (VADs) .1. A prescriber's order is needed for all IV flushes. 2. All vascular access devices should be flushed routinely when not in use to maintain patency . On 3/13/25 at 3:13 PM, the survey team met with the Administrator, Interim Director of Nursing, and Assistant Director of Nursing and discussed the concern of Resident #96's PICC line dressing and flushes. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25. 4. For Resident #55, the facility staff failed to follow the medical provider order for the use of compression stockings (TED Hose). Facility staff documented the application and removal of compression stockings despite the resident not having them available. Resident #55's diagnosis list indicated diagnoses, which included, but not limited to Rectal Prolapse, Barrett's Esophagus, Gastro-Esophageal Reflux Disease, Essential Hypertension, and Dementia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 12/20/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #55's medical provider orders included orders to apply TED Hose/Compression Stockings every morning and remove at bedtime as the resident tolerates. On 4/01/25 at 8:30 AM, surveyor observed Resident #55 dressed in street clothes and wearing socks and shoes. When asked about the TED hose, Resident #55 stated she was not wearing them today and has not worn them for several weeks. She further stated she no longer had TED hose in her room. On 4/03/25 at 9:43 AM, surveyor spoke with Resident #55 regarding TED hose. She again stated she was not wearing them and had not had them for several weeks because they had holes in them and were probably thrown away. Surveyor reviewed Resident #55's March 2025 and April 2025 Medication Administration Records (MARs) which revealed the order to apply TED Hose/Compression Stockings in the morning was signed as completed during the past two weeks from 3/21/25 through 4/03/25 and the order to remove at bedtime was also signed as completed despite the resident not having TED Hose available. On 4/07/25 at 10:50 AM, surveyor informed the Director of Nursing (DON) of the concern with Resident #55's TED hose. The DON returned at 3:54 PM and stated Resident #55 received a new pair of TED hose today. Surveyor requested and received the facility policy titled Documentation in Medical Record with a reviewed/revised date of 12/01/22 which read in part Each resident's medical record shall contain an accurate representation of the actual experiences of the resident .3 .a. Documentation shall be factual .i. False information shall not be documented . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/07/25 at 5:00 PM, the survey team met with the Administrator, DON, Assistant DON, Regional Director of Clinical Services, and Regional [NAME] President of Operations and discussed the concern of staff documenting the application and removal of Resident #55's TED hose despite her not having them available for approximately two weeks. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25. Based on resident interview, staff interview, clinical record review, and facility document review the facility staff failed to provide care and services to meet professional standards of care of 5 of 55 residents, Resident #85, Resident #13, Resident #96, Resident #55 and Resident #153. The findings included: 1. For Resident #85 the facility staff failed to meet professional standards for obtaining and documenting laboratory tests. Resident #85's face sheet listed diagnoses which included but not limited to cerebral infarction, type 2 diabetes mellitus, and presence of prosthetic heart valve. Resident #85's most recent minimum data set with an assessment reference date of 02/24/25 assigned the resident brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #85's comprehensive care plan was reviewed and contained a plan for The resident has altered cardiovascular status r/t (related to) HTN (hypertension), HLD (hyperlipidemia) and Mechanical aortic valve and Resident is on Anticoagulant therapy 3/20/25 new order for weekly inr (international normalized ratio). Resident #85's clinical record was reviewed and contained a physician's order summary which read in part, INR daily x 5 days every night shift for lab for 5 days-order date 03/13/2025 and INR every Monday one time a day for INR-order date 03/22/2025. Resident's electronic medication administration record for the month of March 2025 was reviewed and contained entries as above. The entry for INR daily x 5 days was initialed as being obtained on 3 of the 5 days ordered. The entry for INR every Monday was initialed a being obtained daily, except for one day. Resident #85's nurse's progress notes were reviewed and contained notes which read in part, 03/13/2025 18:31 Vitamin K Oral Tablet. Give 2.5 mg by mouth one time only for increased INR for 1 day. Critical INR of 6.25, new order given for Vit K 2.5 mg per MD. INR to be repeated for next 5 days, 03/15/2025 03:02 INR daily x 5 days every night shift for lab for 5 days. Not obtained this shift, and 03/16/2025 06:56 INR daily x 5 days every night shift for lab for 5 days. Not obtained this shift. Resident #85's laboratory reports were reviewed and revealed that the order for INR x 5 days was obtained for 4 out of the 5 days ordered instead of the 3 out of 5 days documented. The order for INR every Monday was obtained at least three times a week instead of daily as documented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor spoke with Resident #85 on 04/03/25 at 2:35 pm regarding INR's. Resident #85 stated, The come in here at night about 3 times a week and take blood to check my INR. Surveyor spoke with the director of nursing (DON) on 04/07/25 at 10:40 am regarding Resident #85's INR's. DON stated that the order for daily INR's should have been obtained for all 5 days ordered. DON also stated that the order for INR every Monday should only be done on Mondays. Surveyor requested and was provided with a facility policy entitled Laboratory Services and Reporting which read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with the law. The concern of not following professional standards for obtaining and documenting laboratory tests was discussed with the administrator, DON, assistant director of nursing, regional director of clinical services, and regional vice-president of operations on 04/07/25 at 5:00 pm. No further information was provided prior to exit. 2. For Resident #13 the facility staff failed to follow professional standards for the documentation of medications. Resident #13's face sheet listed diagnoses which included spastic quadriplegic cerebral palsy, unspecified intellectual disabilities, and anxiety. Resident #13's most recent minimum data set with an assessment reference date of 02/07/25 assigned the resident a brief interview for mental status score of 15 out o15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #13's comprehensive care plan was reviewed and contained a plan for The resident requires tube feeding r/t (related to) DX (diagnosis) of Dysphagia. Resident #13's clinical record was reviewed and contained a physician's order summary which read in part, Tube Feed Diet NPO (nothing by mouth) texture, AHR-NPO (nothing by mouth) consistency, Milk of Magnesia Suspension 400 mg/5 ml (Magnesium Hydroxide). Give 30 milliliter by mouth at bedtime for no bowel movement in 3 days, for 1 day- order date 01/07/2025, Milk of Magnesia Suspension 1200 mg/15 ml (Magnesium Hydroxide). Give 1 dose by mouth one time only for constipation for 1 day-order date 02/24/2025, Milk of Magnesia Suspension 1200 mg/15 ml (Magnesium Hydroxide). Give 30 ml by mouth one time only for constipation for 1 day-order date 03/10/2025, and Milk of Magnesia Suspension 400 mg/5 ml (Magnesium Hydroxide). Give 30 milliliter by mouth at bedtime for no bowel movement in 3 days, for 1 day-order date 03/25/2025. Resident #13's electronic medication administration records for the months of January, February, and March of 2025 were reviewed and contained entries as above. Each of these entries had been initialed as completed per physician's order. Surveyor spoke with the director of nursing (DON) on 04/07/25 at 10:40 am regarding Resident #13's milk of magnesia orders. DON stated that resident is to have nothing by mouth, and that the orders should read as such. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested and was provided with a facility policy entitled Medication Administration which read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 11. Compare medication source (bubble pack, vial etc.) with MAR (medication administration record) to verify resident name, medication name, form, dose, route, and time. 20. Correct any discrepancies and report to nurse manager. Surveyor requested and was provided with a facility policy entitled Medication Orders which read in part,3. Elements of the Medication Order: f. Route of administraton. 4. Documentation of Medication Orders: b. Clarify the order. The concern of not following professional standards of practice for the documentation of medications was discussed with the administrator, DON, assistance director of nursing, regional director of clinical services, and regional vice-president of operations on 04/07/25 at 5:00 pm. No further information was provided prior to exit. 5. The facility staff failed to follow professional standards of practice related to Resident #153's duplicate allopurinol medication orders. (Allopurinol is a medication ordered orally for Resident #153 to address gout.) Resident #153's admission minimum data set (MDS) assessment was not due and had yet to be submitted prior to the surveyor's review of the resident's clinical record. A medical provider assessment indicated Resident #153 was alert and oriented times three (3). Resident #153 was documented as having adequate vision. Resident #153's hearing was documented as being grossly intact. Resident #153's clinical documentation included two (2) orders for allopurinol 100mg one (1) tablet by mouth once a day for gout. The first allopurinol order was ordered on 3/26/25 at 5:56 p.m.; the medical provider signed this order on 3/31/25 at 2:43 p.m. The second allopurinol order was ordered on 3/27/25 at 10:42 a.m.; the medical provider signed this order on 3/31/25 at 2:43 p.m. On 4/1/25, one (1) of the two (2) allopurinol orders was discontinued due to it being identified as a duplicate order. Resident #153's March 2025 Medication Administration Record (MAR) documentation indicated that two (2) doses of allopurinol 100mg tablets were administered on: 3/28/25, 3/29/25, 3/30/25, and 3/31/25. On 4/7/25 at 1:10 p.m., the Director of Nursing (DON), with the surveyor present, counted Resident #153's remaining allopurinol tablets. The DON reported the number of remaining allopurinol tablets indicated that only one (1) allopurinol 100 mg tablet had been administered on the four days when two (2) allopurinol tablets had been documented as being administered. On 4/7/25 at 1:10 p.m., the Director of Nursing (DON) reported that the duplicate allopurinol orders should have been clarified by nursing staff. On 4/7/25 at 5:00 p.m., the survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the failure of the facility staff to follow professional standards of practice by not clarifying Resident #153's duplicate orders for allopurinol with a medical provider.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. Based on interview, record review and facility document review, the facility staff failed to complete a discharge summary including a recapitulation of resident's stay and final summary of resident's status, to the continuing care provider and other authorized persons at the time of discharge for one of 14 residents reviewed, resident # 454 (R454). The findings included: R454's diagnoses included but were not limited to, R454's diagnoses according to the facility diagnoses sheet included but were not limited to other seizures, chronic obstructive pulmonary disease, hypertension, anxiety, heart failure, personal history of suicidal behavior, traumatic brain injury, major depressive disorder, and vascular dementia with psychotic disturbance. R454's minimum data set (MDS) assessment with an assessment reference date of 8/28/24 assigned the resident a brief interview for mental status score of 11 out of 15 indicating moderate cognitive impairment. According to the clinical record, R454 was issued a 30 day discharge notice on 9/4/24 that stated, 1. The facility is unable to meet your needs, 2. due to the health, safety and well-being of self and others. A progress note dated 9/4/24 at 6:44 PM and signed by the social worker read, Multiple IDT discussions and calls amongst multiple facility staff and hospice staff this date and discovery of additional clinical information review. IDT execution to resident this evening at 1830 of 30 day dc notice. Hospice aware and was conveying the same to daughter. Facility executing copy of notice via mail to daughter. Copy executed via fax to LTC Ombudsman. Facility will work with vested parties in facilitating transfer as needed. A progress note dated 9/17/24 at 1:03 PM and signed by the social worker read, Admissions coordinator and NP notified this writer separately that hospice has arranged for resident to transfer to (facility name omitted) and that they were looking to arrange transport and facilitate transfer ASAP possibly today. DC summary opened for clinical and NP will put in order for transfer. A progress note date 9/17/24 by the hospice social worker read in part, Social worker arrived with HHA (home health aide name omitted). Patient was in night gown. HHA cleaned patient up and dressed him in new clothes sent by his daughter. SW worked with facility staff to prepare the discharge. NP (name omitted) , signed d/c summary. SW verified number for paperwork to be sent to (name of facility omitted). The in home visit time for this note began at 12:03 PM and was completed at 2:14 PM. Under the assessment tab of the clinical record a discharge summary was located. Section 1., Summary of Stay, which included the section for the recapitulation of stay and summary of diagnoses, was blank except for the admission date of 8/21/24. Sections 2 and 3 were complete and signed by the social worker on 9/17/24. The nursing summary section was blank except for vital signs from 9/11/24 and allergies. The medication reconciliation section was blank. The dietary summary had a height and weight but no other information and was not signed. The activities and therapy sections, as well as the section labeled Final Disposition were blank. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 12:57 PM this surveyor interviewed hospice social worker. They stated, On the day he left there, the aide and I went to get him ready. I told the staff that he had been accepted at (name of facility omitted) and were wanting to go ahead and make the move happen that day if possible. I packed up his stuff and tried to do all I could to facilitate the move because they didn't know until I got there that we had found a place for him to go. When asked about the mention of the discharge summary they stated, I don't think I saw a discharge summary, I remember the NP saying she would sign it and I know I gave the facility the fax number they needed to send any paperwork to the other facility. Our office had already sent our paperwork to them. On 3/14/25 at 12:44 PM the survey team met with the Administrator, Interim Director of Nursing, Assistant Director of Nursing and the Regional Nurse Support. This concern was discussed at that time. On 3/17/25 at 11:09 AM the survey team met with the Regional Director of Clinical Services (RDCS) and the Regional [NAME] President of Operations. This concern was discussed and this surveyor asked for a copy of the discharge summary. The RDCS stated, It wouldn't have been complete because we didn't know he was leaving. They came that morning and took him out. The RDCS stated that the discharge summaries are opened and initiated by the social worker. This surveyor informed them that one was open and the social work section was complete. A copy was provided to surveyor. The policy entitled Transfer and Discharge (including AMA) with a revised date of 12/1/22 was reviewed. The document read in part, Policy Explanation and Compliance Guidelines 6. Non-Emergency Transfers or Discharges L. For a transfer to another provider, the following information must be provided to the receiving provider: vi. Other necessary information, including a copy of the resident's discharge summary, as applicable, to ensure a safe and effective transition of care. No further information was provided to the survey team prior to the exit conference.

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F 0675 Level of Harm - Actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. Based on observation, family interview, resident interview, staff interviews, clinical record review, and facility document review, the facility staff failed to provide the necessary care and services to attain and/or maintain the highest practicable physical, mental, and psychosocial well-being for two (2) of fifty-five (55) sampled residents, (Resident #454 and Resident #13). The findings include: 1.For Resident #454, the facility staff failed to provide the necessary care and services for the resident to attain or maintain the highest practicable physical, mental and psychosocial well-being during an incident that occurred on 8/30/24 between the resident and a nurse. The facility staff failed to recognize the resident as an individual, failed to provide an environment that was healthy and safe, failed to sustain the resident's sense of well-being, sense of self-worth, and failed to promote and sustain the resident's psychosocial well-being and quality of life. Resident #454's diagnosis list indicated diagnoses that included, but were not limited to, Atrial Fibrillation, Glaucoma, Seizures, Hypertension, Chronic Obstructive Pulmonary Disease, History of Falls, Dementia with Agitation, Depression, Anxiety Disorder, Heart Failure, Vascular Dementia-severe with Psychotic Disturbance, Traumatic Brain Injury, History of Suicidal Behavior, and Thyrotoxicosis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/28/24, assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of the clinical record revealed the following documentation: A behavior note dated 8/30/24, that read in part, .This nurse observed resident twisting the arm of CNA (certified nursing assistant) staff and pulling the sleeve of her hoodie not letting her go, resident was allegedly trying to attack another resident according to CNA. This nurse observed resident yelling and arguing with CNA staff. This nurse removed CNA from incident and was attempting to redirect this resident by taking him in his wheelchair to a quieter area. This nurse stated very calmly to resident .let's not do this. Please don't hit women, let's go back to your room. Resident initially was agreeing to go but resident then placed feet down firmly on the ground causing the wheelchair to stop, resident then leaned backwards reaching towards this nurse. This nurse was wearing hooded clothing at the time, resident grabbed this nurse by the hood of the hoodie while leaning back. This nurse tried to pull away from him causing my clothing to rip and the wheelchair to lean back. Resident then used his fingernails to scratch this nurse's neck and then placed his left thumb into this nurses' left eye causing this nurse to let go of the wheelchair which in turn caused resident to fall from the chair. Resident assessed for injuries. Resident does have contusion to the back of head, no other injuries present. Resident denying pain and discomfort at this time, vital signs were obtained by CNA and Hospice staff. All vital signs within normal limits . (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Few	An alert note dated 8/30/2024, that read in part, .This nurse contacted on call supervisor from [NAME] side of the building about resident's increase in behaviors per previous behavior notes. Hospice was contacted again to update on resident's increased behaviors and to get an ETA (estimated time of arrival) for resident's hospice nurse arrival to this facility. At this time, CNA on staff came to this nurse and reported that resident was at the nurse's station on East side yelling and grabbing at staff members and pulling on their clothing. CNA on staff reported to this nurse that resident was swinging his arms towards other staff and residents striking staff with his hands. CNA reported to this nurse that resident's wheelchair tipped backward, and resident fell to the floor striking his head on the floor. Notified on call supervisor of resident's behaviors and of his fall. Resident vital signs obtained, and resident assessed for injuries. Resident has an egg-shaped swollen area on the back of his head more towards the left of center, red/pink in color and raised approximately one inch. On call supervisor contacted [name omitted] NP (nurse practitioner) and obtained orders to send resident to the ER for his safety . An alert note dated 8/30/24 that read in part, .911 ambulance service transporting resident to [name omitted] (hospital) for evaluation. This nurse contacted resident's daughter [name omitted] to update her on resident's behaviors through the end of day shift. Resident's daughter notified of resident grabbing and hitting staff and attempting to harm other residents. Resident's daughter notified of resident being transported to .ER for further evaluation . A hospice visit note report dated 8/30/24, that read in part, .Facility called the on-call services and stated patient was having behaviors .The staff reported that he had hit staff members and made threats towards other residents. The patient had been in his wheelchair, one male staff member tried to get him to his room to have a place that was quiet. When he moved the chair forward the patient pushed it backwards and flipped the chair. He has a large hematoma on the back of his head. No open areas noted .Ice pack applied. Pain in that area rated a 3 out of 10 .Talked with this nurse with no behaviors noted. The facility had called 911 and the EMTs (emergency medical technicians) arrived at the facility approximately 2 (two) minutes prior to this nurse. Patient did not refuse questions from the EMT, nor was he combative during their assessment. His medication nurse [name omitted] was in patients' room during this visit. When asked by this nurse if he would take his medications, he agreed. The facility nurse was ask {sic} three different times to get patient his medications and she refused, stating, I'm not giving him his medications because he's going out .This nurse called (hospital) ER and spoke with the supervisor .to give report. She stated the patient had just arrived but seemed calm, no aggression noted. She asked the EMTs if he had any behavior during transport, they stated he had remained calm throughout their encounter .the patient's daughter was contacted, she was provided information about the event. She stated her father had never behaved in that manner, but she had noticed he had more confusion over the last few days during her phone calls . An alert note dated 8/31/24 that read in part, .Resident arrived back to this facility from (hospital) ER via ambulance stretcher transport. No paperwork was brought back with resident from that visit to the ER. EMS transport stated the hospital had called hours ago and that he had been discharged since like 12 (midnight). Resident assisted into bed and changed into clean clothing and bed sheets since the ones he had on and underneath them were drenched with urine. Resident requested to be up in wheelchair and this nurse and cna {sic} on staff assisted him up from bed into his wheelchair . A review of the hospital CT (computed tomography) report dated 8/30/24, read in part, .Findings .Small left posterior scalp hematoma . (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Few	Surveyor requested and reviewed the facility reported incident (FRI) dated 8/30/24, that read in part, .On 8/30/24, it was reported that resident was having a behavioral episode and grabbed [name omitted], CNA by the right wrist and would not let her go. It was reported that [name omitted], LPN (licensed practical nurse) intervened and aggressively spoke with resident regarding his behavior and grabbed the resident's arms. (LPN) then pushed the resident in his wheelchair down the hall towards the resident's room. It was reported that resident put his feet down to stop the wheelchair from rolling forward. (LPN) then tilted the wheelchair onto the back wheels and began to push the resident down the hall. (Resident #454) began leaning back and grabbing at (LPN), scratching his neck and poked (LPN) in the left eye. (LPN) let go of wheelchair causing the resident and chair to fall to the floor .resident evaluated for injury: resident has knot to the back of his head, sent to ER (emergency room at hospital) for evaluation . A review of the final report of the FRI dated 9/6/24, read in part, .(Resident #454) is a resident admitted .with a diagnosis of Dementia, Depression, Anxiety Disorder .Upon further investigation after admission, it was discovered that (Resident #454) has a previous neurological and psychological history, which includes Suicidal Ideations with suicide attempt, TBI (traumatic brain injury), Vascular Dementia with associated behaviors, Paranoia, and Fixed Delusions .Upon investigation it was discovered that (Resident #454) became physically and verbally aggressive with female staff, grabbing an employee by the wrist resulting in pain and discomfort, after which another employee, [name omitted], LPN (licensed practical nurse), intervened to assist, resulting in the wheelchair in which (Resident #454) was sitting tipping backwards and (Resident #454) hitting his head on the floor. The police found no evidence to charge (LPN) with any offense and in fact advised him that he had the right to press charges against (Resident #454) for scratching his {sic} and poking him in the eye .facility elected to DNR (do not return) the AGENCY staff member as a result of the investigation . A review of the employee statements within the FRI file revealed a statement from a witness of the incident that read in part, .(LPN) grabbed (Resident #454's) arms very aggressively and put his head against his and said, We aren't doing this. He (LPN) then leaned (Resident #454) back in his wheelchair and started down the hall. (Resident #454) became combative reaching for (LPN's) face when (LPN) dropped him (Resident #454) backwards hitting his head on the floor. (LPN) then helped lift him (Resident #454) back up and walked towards the nurse's station stating, If anyone wants to report me for abuse then so be it . The file from the FRI revealed another witness statement from the incident that read in part, .(LPN) stepped between (CNA) and (Resident #454) and grabbed him (Resident #454) by his arm and pushed him up against the nurse's station and told him to calm down and (Resident #454) still wouldn't calm down so (LPN) grabbed his wheelchair and started taking him down the hall but (Resident #454) wouldn't pick his feet up so he (LPN) stomped on the pedal on the back of the chair and got him (Resident #454) on 2 (two) wheels and started down the hall and (Resident #454) started hitting (LPN) in the face and he (LPN) dropped the chair resulting in (Resident #454) hitting his head on the floor . (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Few	On 3/11/25 at 12:34 PM, surveyor interviewed local long-term care ombudsman (OS#1), and she recalled resident had behaviors and dementia. She informed surveyor an aide had been bringing resident down the hall and resident did not understand about taking medications. OS#1 stated his (Resident #454's) hospice nurse came up here (to facility) to attempt to give resident his medications. The resident went to swat at the aide and the agency nurse got a hold of the wheelchair and reared it back with the resident in it to keep resident from putting his feet down. When he reared it back, the wheelchair fell over. The facility did a FRI. The hospice nurse was here by then and tried to give the resident medication, but the facility would not let her try. The aide pressed charges against the resident, but it did not go to court. The resident was moved to another facility. On 3/12/25 at 10:38 AM, administrator (ADM) informed surveyor there was enough question after the incident to not bring the LPN back into the facility. He believes the LPN tried to help the CNA, the resident was combative, and the LPN had scratches and marks from the resident, but the ADM felt it best not to let him come back. On 3/13/25 at 3:49PM , surveyor interviewed certified nursing assistant #1 (CNA #1) about the incident that occurred on 8/30/24, and she stated Resident #454 was very upset and was hitting at the computer on the nurse's desk. He was trying to grab another resident and another CNA stepped on the other side to keep him from grabbing the resident and Resident #454 grabbed the CNA's wrist. The LPN slammed the resident up against the desk and then attempted to take the resident down the hall. The resident kept putting his feet down, so the LPN reared him back on two wheels. Then the resident was grabbing at the LPN and the nurse let go of the chair. The resident fell backwards and hit his head on the floor. This information was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, interim director of nursing, assistant director of nursing, and regional nurse support. This abbreviated survey was extended, and an abbreviated-extended-standard survey was conducted to include this complaint investigation from 3/11/25 through 4/8/25. Surveyor requested and received the facility background check that was conducted on the LPN named in the abuse allegation. The background check was completed on 5/21/24 and there were no entries/crimes disclosed on the document. Surveyor requested and received a facility policy titled, Abuse, Neglect and Exploitation that read in part, .It is the policy of [name omitted] to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse .Definitions . Abuse means the willful infliction of injury .intimidation .with resulting in physical harm, pain, or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse .physical abuse, and mental abuse .IV .B. Possible indicators of abuse include but are not limited to .7. Psychological abuse of a resident observed . No further information regarding this concern was presented to the survey team prior to the exit on 4/8/25. 2. For Resident #13 the facility staff failed to sent resident to day support program. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Few	Resident #13's face sheet listed diagnoses which included spastic quadriplegic cerebral palsy, unspecified intellectual disabilities, and anxiety. Resident #13's most recent minimum data set with an assessment reference date of 02/07/25 assigned the resident a brief interview for mental status score of 15 out o15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #13's comprehensive care plan was reviewed and contained care plans for Resident perceives that daily routine is much different than that of community living, Self-Care Deficit-Total dependent on staff for completion of ADL's (activities of daily living) related to CP (cerebral palsy), functional quadriplegia and intellectual disability and Resident with Level II assessment: Specialized Services: Day Support/Transport (Resident is already attending day support wit . (name omitted) according to his . (name omitted) service plan they are providing transport). Interventions for these care plans include Encourage resident to participate in activities that will enhance daily life while in facility for long term care and Maintain consistent schedule with daily routine. Upon arrival at the facility on 03/31/25, surveyor observed Resident #13 seated in the resident common room of the facility at 12:30 pm. Surveyor spoke with Resident #13's family member/guardian on 04/01/25 at 9:30 am. Guardian stated that resident really enjoys going to his day support program, and is supposed to go three times a week, on Monday, Wednesday and Friday. Surveyor stated to guardian that resident was at the facility the previous day, and guardian stated, He was supposed to be at IDC (day support). Surveyor spoke with director of nursing (DON) on 04/01/25 at 10:50 am regarding Resident #13 not attending day support program. DON stated they did not know for sure and provided surveyor with phone number of day support supervisor. Surveyor spoke with day support supervisor on 04/01/25 at 11:25 am regarding Resident #13. Day support supervisor stated transportation arrived at the facility on 03/31/25 at 9:15 am, and was informed that resident was not ready, because they had not had morning medications and constant feed bag was not ready. Day support supervisor stated their staff contacted them and they informed them they could wait until 9:30 am for resident, but facility staff stated they could not have resident ready by 9:30 am. Surveyor asked day support supervisor if this happens often, and day support supervisor stated that it happens occasionally, but not often. Surveyor spoke with DON again on 04/01/25 at 5:30 pm regarding Resident #13. DON stated that the reason resident did not go to day support was because IDC staff wouldn't/couldn't wait. I don't know if he was being changed or what. Surveyor observed Resident #13 on 04/02/25 at 8:15 am, seated in common area in wheelchair. Surveyor asked resident if he was going to day support, and resident became very excited and stated, yeah, I like IDC (day support). The concern of not sending resident to day support program was discussed with the administrator, director of nursing, assistant director of nursing, and regional director of clinical services on 04/04/15 at 10:30 am. (continued on next page)

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F 0675 Level of Harm - Actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 4. For Resident #454 the facility staff failed to ensure the resident was offered a full bed bath/shower at least twice a week. Resident #454's diagnosis list indicated diagnoses that included, but were not limited to, Atrial Fibrillation, Glaucoma, Seizures, Hypertension, Chronic Obstructive Pulmonary Disease, History of Falls, Dementia with Agitation, Depression, Anxiety Disorder, Heart Failure, Vascular Dementia-severe with Psychotic Disturbance, Traumatic Brain Injury, History of Suicidal Behavior, and Thyrotoxicosis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/28/24, assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of Resident #454's comprehensive care plan contained a focus that read in part, ADL (activities of daily living) self-care performance deficit-Weakness, debility, impaired mobility, cognitive loss . with a created date of 8/22/24. Interventions for this focus read in part, .The resident requires Extensive assistance by 1-2 staff with bathing/showering on preferred shower days and as necessary . Surveyor requested and received the bathing records for Resident #454 for the months of August and September 2024. The records indicated that resident did not receive full bed baths and/or showers in the timeframe from 8/28/24 through 9/2/24, except for one partial bath on 8/31/24. No refusals of bed baths or showers were documented within this timeframe. Resident was transferred to the hospital on 9/2/24 and returned on 9/3/24. On 3/12/25 at 1:09 PM, surveyor interviewed other staff #9 (OS#9) and she stated at times if the resident had just finished eating, she had seen food on his shirt. At one time, she recalled the resident had vomited and it took a long time for someone to come to change his clothes. She was visiting him every day before he discharged from the facility. On 3/13/25 at 3:58 PM, surveyor interviewed certified nursing assistant #2 (CNA#2) and she recalled Resident #454 received his showers twice a week and believed his shower days to be Tuesdays and Fridays but then thought about it and thought the resident only received bed baths by his regular CNA. She stated she washed his hair once a week or if he was sweaty she would use a basin and soapy wash cloth and then rinse his hair with a cup. CNA#2 stated if the resident needed a shower at other times then his regular CNA would shower him in his room as it had a shower. This information was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, interim director of nursing, assistant director of nursing, and regional nurse support. This abbreviated survey was extended, and an abbreviated-extended-standard survey was conducted to include this complaint investigation from 3/11/25 through 4/8/25. Surveyor requested and received a facility policy titled, Bathing a Resident with a review/revised date of 12/1/2022 that read in part, .It is the practice of this facility to assist residents with their choice of bathing/hygiene options to maintain proper hygiene and help prevent skin issues . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information regarding this concern was presented to the survey team prior to the exit on 4/8/25. Based on observation, staff interview, resident interview, clinical record review and facility document review the facility staff failed to provide activities of daily living care for 4 of 55 residents, Resident #13, #37, #40, and #454. The finding included: 1. For Resident #13 the facility staff failed to provide incontinence care for a dependent resident. Resident #13's face sheet listed diagnoses which included but not limited to spastic quadriplegic cerebral palsy, gastrostomy status, and dysphagia. Resident #13's most recent minimum data set with an assessment reference date of 02/07/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section GG, functional abilities, coded the resident as dependent for toileting hygiene. Section H, bladder and bowel, coded the resident as always incontinent of both bowel and bladder. Resident #13's comprehensive care plan was reviewed and contains care plans for Self-Care Deficit-Total dependent on staff for completion of ADL's (activities of daily living) related to CP (cerebral palsy), functional quadriplegia and intellectual disability, Resident has actual impaired skin integrity related to impaired mobility, incontinence and DX (diagnosis) of eczema and excoriation and The resident has bowel and bladder incontinence. Interventions for these care plan include Check at Q (every) 2 hours and as required for incontinence, provide incontinence care after each incontinence episode and Provide assistance with ADL's/IADL's (activities of daily living/independent activities of daily living) as needed. Surveyor observed Resident #13 seated in his wheelchair in the common area on 04/01/25 at 8:15 am. Surveyor observed resident at various times throughout the day, and resident remained seated in the same place at each observation. Surveyor spoke with certified nurse's aide (CNA) #4 on 04/01/25 at 2:55 pm regarding Resident #13. CNA #4 stated that when she came into work today between 9-9:30 am, other staff informed her that resident had been changed twice. Surveyor asked CNA #4 if they had provided incontinence care to resident since they have been here, and CNA #4 stated they had just finished their first round of checking residents, and that no one has had a meal break yet. CNA #4 also stated, . (Resident #13) requires a lift, which takes two people, and there is no one available to help me. Surveyor observed CNA #4 and CNA #5 on 04/01/25 at 3:35 pm providing incontinence care for Resident #13. Surveyor observed that resident's incontinence brief was fully saturated, resident's shorts were wet, and pad in seat of wheelchair was wet. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor spoke with the regional director of clinical services, along with the director of nursing on 04/04/25 at 10:35 am regarding Resident #13. Surveyor asked how often resident should be changed/checked to see if they need to be changed, and regional director of clinical services stated the standard is every 2 hours. Surveyor requested and was provided with a facility policy entitled Activities of Daily Living (ADL's) which read in part, 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The concern of not providing ADL care for Resident #13 was discussed with the administrator, director of nursing, and regional director of clinical services on 04/04/25 at 10:35 am. No further information was provided prior to exit. 2. For Resident #37, the facility staff failed to provide nail care. Resident #37's toenails on their right foot were observed to be long. Resident 37's diagnoses included diabetes, chronic obstructive pulmonary disease, and Alzheimer's disease. Section C (cognitive patterns) of Resident #37's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/11/25 included a brief interview for mental status (BIMS) score of 14. Per the MDS manual a score of 14=cognitively intact. Section GG (functional abilities) was coded 1 for personal hygiene to indicate the resident was dependent on staff in this area. Resident #37's comprehensive care plan included the focus areas requires assistance of grooming, hygiene, toileting, bathing, dressing related to generalized weakness and at risk for impaired skin integrity. Interventions included provide assistance with activities of daily living as needed, ensure nails are clipped, nails should always be cut straight across, refer to podiatrist/foot care nurse to monitor/document foot care needs to cut long nails. On 03/31/25 at 12:15 p.m., Resident #37 was observed in their room. Resident #37's toenails on their right foot were observed by the surveyor to be long. When asked about her toenails Resident #37 stated they were unable to bend their right leg to cut them. The surveyor completed a second observation on 04/01/25 at 2:00 p.m., Resident #37's toenails on right foot remained long. On 04/01/25 at 5:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Director of Clinical Reimbursement the issue with Resident #37's toenails being long was reviewed. On 04/01/25 at 7:00 p.m., Registered Nurse (RN) #1 documented Nail care provided by this nurse. Fingernails and toenails trimmed and filed. Resident tolerated well. No areas of concerns noted. No further information regarding this issue was provided to the survey team prior to the exit conference. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. For Resident #40, the facility staff failed to provide nail care. Resident #40's fingernails were observed to be long and jagged with debris present and their toenails remained long and thick in appearance. Resident #40's diagnoses included diabetes and cerebrovascular disease. Section C (cognitive patterns) of Resident #40's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/11/25 included a brief interview for mental status (BIMS) score of 9 out of a possible 15 points. Per the MDS manual a score of 9=moderately impaired in cognitive skills for daily decision making. Section GG (functional status) was coded with a 1 for personal hygiene indicating this resident was dependent on staff for this task. Resident #40's comprehensive care plan included the focus area has an activities of daily living self-care performance deficit related to generalized weakness and debility. Interventions included check nail length and trim and clean on bath day and as necessary. On 03/31/25 at 12:05 p.m., Resident #40 was observed in their room. Their toenails were observed by the surveyor to be long and thick On 04/01/25 at 9:55 a.m., Resident #40's nails were observed to be thick and long on both feet. Certified Nursing Assistant (C.N.A.) #20 was observed in the resident room and stated they did not cut the resident's nails the podiatrist would do that. On 04/01/25 at 10:00 a.m., the surveyor and Director of Nursing (DON) completed an observation of this resident. Resident #40's fingernails were observed to be long and jagged with debris present and their toenails remained long and thick in appearance. On 04/01/25 at 5:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Director of Clinical Reimbursement the issue with Resident #40's nails was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on staff interview and clinical record review the facility staff failed to provide an on-going person-centered activity program to support resident choice, interests, and physical, mental and psychosocial well-being for 1 of 55 residents in the survey sample, resident #454 (R454) The findings included: R454's diagnoses according to the facility diagnoses sheet, included but were not limited to, other seizures, chronic obstructive pulmonary disease, hypertension, anxiety, heart failure, personal history of suicidal behavior, traumatic brain injury, major depressive disorder, and vascular dementia with psychotic disturbance. R454's minimum data set (MDS) assessment with an assessment reference date of 8/28/24 assigned the resident a brief interview for mental status score of 11 out of 15 indicating moderate cognitive impairment. There was no mood indicators captured on the assessment and the only behavior identified was wandering which occurred one to three days during the lookback period. Under the section for preferences for customary routine and activities, R454 had many activities coded as being very important. They included listening to music, being around animals or pets, keeping up with the news, doing things in groups, participating in religious activities, having snacks and using the phone in private and having family or a close friend involved in discussions about care. R454 was coded as requiring maximum assistance for toileting, bathing, dressing, bed mobility, transfers and standing and was not ambulatory in the lookback period. Under Section Q Participation in Assessment and Goal Setting only the resident was coded as a participant in the assessment. The Activities-Initial Review document with an effective date of 8/26/24 was reviewed. The document read in part, Resident has a nice personality, loves to talk likes to sit in day room tires easily hospice care needs encouragement to attend events of choice w/escorts assistance with games and crafts loves animals pet therapy when available. The document was marked with yes for all the following questions: C.1. Does the resident wish to participate in Activities while in the home? 2. Does the resident wish to participate in group Activities? 4. Does the resident wish 1:1 with staff? 5. Does the resident like independent Activities (reading, puzzles, etc.)? Question 3 regarding going on outings was marked no. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R454's Activities care plan was reviewed and included a focus that read, needs encouragement for events of choice tires easily loves to talk needs assistance w/ games & crafts provide pet therapy when available loves animals. The goal read, encourage reminders of events of choice likes to sit in day room socializing Hospice Care. Interventions included, needs encouragement for events of choice tires easily loves to TALK needs assistance w/ games & crafts provide pet therapy when available loves animals, encourage reminders of events of choice likes to sit in day room socializing Hospice Care, Explain to the resident the importance of social interaction, leisure activity time Encourage the resident's participation, Invite/encourage the resident's family members to attend activities with resident in order to support participation. Modify daily schedule, treatment plan PRN to accommodate activity participation, Remind the resident that The resident may leave activities at any time, and is not required to stay for entire activity, The resident needs assistance/escort to activity functions, The resident prefers the following TV channels: Old Westerns the Nightly news. There was no mention of music. Resident was a musician and had a guitar in his room per a social services note dated 8/26/24 at 1:01 PM that read in part, Resident has a wonderful outgoing and positive personality, likes conversation, smiles easily, loves music, plays guitar and has the same in his room, has recorded CD's of gospel music recorded with his wife who passed in 2015 . On 4/7/25 at 9:15 AM this surveyor interviewed the Activities Director regarding R454. She stated she doesn't really remember the resident well. Asked her to provide me with a copy of his Activity Logs for the duration of his stay. The log was blank except for 8/26/24, the same day her assessment was done. She stated she had nothing for September documented. She stated if he had refused, she thinks she would have remembered. Said she thinks his family was there a lot and he might have slept a lot but really is not sure, I just don't really remember him much. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress notes in the clinical record were reviewed. R454 had numerous entries regarding behaviors during their stay at the facility. The behaviors started a week or more after admission to the facility according to the progress notes. A note dated 8/30/24 at 5:03 PM read, Resident refused medications all shift after multiple attempts by staff. Resident unable to bear weight when aides in room assisting with changes. Resident using his restroom inside his room and told aides he owned this building and I'm getting everyone fired. Resident up in wheelchair at this time at the nurse's station. A note documented at 6:52 PM read, Resident up in wheelchair rolling around the hallway on East side. Resident stopped at this nurse's cart and would not let this nurse pass by to provide patient care to other residents. Resident held up a bible in the air and stretched his arm out to both sides and stated, no you're not gonna pass you are just standing there doing nothing, so you're fired. Everyone in here is gonna be fired. I own this place. Resident able to be redirected a short ways down the hallway where he stopped and talked with another resident. He grabbed a large hole punch off of the nurses' station and carried it into the dayroom and would not put it down. Resident then rolled down the hallway and grabbed the electrical cord from an oxygen concentrator. When CNA (certified nursing assistant) on staff attempted to redirect him from wrapping the cord around his hand several times, resident grabbed a fist full of CNA's hair and jerked her head downwards and was agitated at CNA's visible tattoos on her forearms. Resident stated multiple times, that ink is blood and you're taking good blood away from people that need it. Resident then picked up the o2 concentrator and hit same CNA on the ankle with it. Other staff was able to intervene and place the o2 concentrator in a locked room. Resident attempting multiple times to get out of the side door down 100 hall. Hospice called and on call supervisor called and alerted of resident's behaviors. A note documented at 7:06 PM read, Resident grabbed two CNA's arms at the wrist and twisted both their arms and shook. Resident able to be redirected from twisting staff's arms after a short time. A note documented at 8:20 PM read, This nurse observed resident twisting the arm of CNA staff and pulling the sleeve of her hoodie not letting her go, resident was allegedly trying to attack another resident according to CNA. This nurse observed resident yelling and arguing with CNA staff. This nurse removed CNA from incident and was attempting to redirect this resident by taking him in his wheelchair to a quieter area. This nurse stated very calmly to resident, (R454 name omitted), let's not do this. Please don't hit women, let's go back to your room. Resident initially was agreeing to go but resident then placed feet down firmly on the ground causing the wheelchair to stop, resident then leaned backwards reaching towards this nurse. This nurse was wearing hooded clothing at the time, resident grabbed this nurse by the hood of the hoodie while leaning back. This nurse tried to pull away from him causing my clothing to rip and the wheelchair to lean back. Resident then used his fingernails to scratch this nurse's neck and then placed his left thumb into this nurses' left eye causing this nurse to let go of the wheelchair which in turn caused resident to fall from the chair. Resident assessed for injuries. Resident does have contusion to the back of head, no other injuries present. Resident denying pain and discomfort at this time, vital signs were obtained by CNA and Hospice staff. All vital signs within normal limits. There were no notes in the record to indicate any staff attempted to use R454's activity preferences and interests to deter his behaviors. There were no notes located to indicate the R454's family or hospice workers were asked to participate or provide any activities that may deter his behaviors. On 4/8/25 at 3:00 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing and the Regional Director of Clinical Services. This concern was discussed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide treatment and care services in accordance with professional standards of practice for twenty-one (21) of fifty-five (55) sampled residents (Resident #103, Resident #453, Resident #41, Resident #17, Resident #454, Resident #71, Resident #153, Resident #32, Resident #40, Resident #50, Resident #78, Resident #254, Resident #255, Resident #13, Resident #85, Resident #93, Resident #23, Resident #96, Resident #353, Resident #100, and Resident #55). The scope and severity were originally cited at Immediate Jeopardy, Level IV isolated for Resident #103 and Resident #453, beginning on 2/24/25, and was reduced to a Level III isolated after the facility was cleared of Immediate Jeopardy. The facility staff provided an abatement plan that was verified by the survey team through additional observations, interviews, and document reviews. The facility staff was notified that Immediate Jeopardy was removed on 4/3/25 at 6:00 PM. The findings include: 1.For Resident #103, the facility staff failed to follow the medical director's standing orders for diabetic management and administer Glucagon 1 mg (milligram) IM (intra-muscularly) during a hypoglycemic episode on 2/24/25 resulting in the resident being transferred to a higher level of care. Resident #103's diagnosis list indicated diagnoses that included, but were not limited to, Hemiplegia, Hemiparesis, Type 2 (two) Diabetes Mellitus, Dysphagia, Hypertension, Weakness, Hypokalemia, Depression, and Rectal Fistula. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/20/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review the Facility Standing Orders Diabetic Management (Blood Glucose LESS than 70) read in part, .If the patient is unresponsive or unable to swallow and does not have a feeding tube .Administer Glucagon 1 mg IM(intramuscularly) .Repeat BG (blood glucose) after approximately 10 (ten) minutes; if <70 (less than seventy) and patient still unresponsive, repeat Glucagon .After giving a second Glucagon dose, if patient is still unresponsive, call 911 and notify provider immediately .If BG remains <70 but patient is conscious, initiate interventions for the conscious patient . A review of the February 2025 MAR (medication administration record) revealed Resident #103's Humalog (75/25 Subcutaneous Suspension 100 UNIT/ML (milliliters) injection) was held on the evening of 2/23/25 due to blood glucose reported at 106. This was within parameters to be held per a medical provider's order. A review of the clinical record revealed the following documentation: A Health Status note dated 2/24/25 at 6:15 AM read in part, .BS (blood sugar) @ (at) this time 30 (thirty). Will send to ER (emergency room at hospital) . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Health Status note dated 2/24/25 at 6:30 AM read in part, .Ambulance Service here for transportation . A Health Status note dated 2/24/25 at 6:35 AM read in part, .ER called & informed of need for transfer to ER . A review of the comprehensive person-centered care plan revealed a focus, goal, and intervention that read in part, .The resident has Diabetes Mellitus .The resident will have no complications related to diabetes through the review date Observe/document/report PRN (as needed) any s/sx (signs/symptoms) of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait . On 3/13/25, surveyor requested and received the cubex inventory sheet for 2/24/25 that revealed the following: Glutose Oral Gel-On Hand-2 Glucagon Syringe-On-Hand-4 Glocose Tablets-On-Hand-1 Surveyor also requested and received the Transactions by Patient (activity for accessing the cubex) dated 2/24/25 for Resident #103 and no activity was revealed for any access to the cubex by facility staff. Regional nurse support provided surveyor with a copy of the chat with licensed practical nurse #3 (LPN#3) and the on-call provider that read, 2/24/25 6:29 AM [name omitted] (Resident #103) BG 30, not sure if they have glucagon or glucose gel in house to raise her BG. Told the nurse she better find something. Glucagon, glucose gel, juice and peanut butter, something anything. On 3/12/25 at 12:37 PM, surveyor spoke with assistant director of nursing (ADON), and she stated the process for a resident with low blood sugar would typically be to give them something. The provider would be called, and the provider would typically give an order for something to be given. On 3/12/25 at 7:58 PM, surveyor interviewed LPN#3 via phone call to the facility. LPN#3 informed surveyor the process for a resident with low blood sugar is a standing order. For blood sugar below sixty (60) the nurse is to give glucagon gel or glycogen and stated she likes glycogen better because it's an injectable and works faster. LPN#3 stated she looked everywhere and could not find either one of those medications. Surveyor inquired if she looked in the cubex (an automated medication dispensing system that is a secure, electronically controlled cabinet that stores and dispenses medications to healthcare professionals) and LPN#3 stated she and another nurse looked in the cubex and could not find any. Surveyor asked LPN#3 for the name of the other nurse, and she stated, I can't remember. She stated she sent Resident #103 out because her blood sugar was low, and she could not find anything to give her to bring the blood sugar up. LPN#3 stated she called the medical provider but did not document it because she was in such a hurry to get the resident sent out. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Rehabilitation and Nursing	514 North Main Street Rural Retreat, VA 24368

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/13/25 at 8:11 PM, surveyor interviewed LPN#3 via phone call to the facility to inquire the status of Resident #103's consciousness level during the hypoglycemic incident on 2/24/25 and the nurse informed the surveyor the resident was not unconscious, but very lethargic. LPN#3 also informed this surveyor she remembered she had gone to the medication room and found glucagon gel and attempted to administer it to Resident #103 and the gel rolled-out of the resident's mouth. She stated she re-checked the resident's blood sugar, and it had gone up to 39 and then she called 911. LPN#3 then stated she called the provider first after the first blood sugar check when it was 30 and she called the resident's son. She stated she found the glucagon gel in the supply room, and it was the only one she could find. On 3/13/25 at 9:02 AM, another surveyor observed the cubex and it contained 1 container of glucose tablets, 4 IM glucagon injections and 1 tube of glucose gel. On 3/14/25 at 9:05 AM, surveyor interviewed nurse practitioner (OS#14-other staff #14), and she stated LPN#3 called her and she asked the nurse if they had any glucagon or something to give Resident #103 and she told the nurse they had to give her something. OS#14 stated she did not give an order to send the resident out. On 3/14/25 at 12:44 PM, ADON informed surveyor Resident #103's blood sugar did go up to 39 and the standing order states if the blood sugar is below 70 to send out to the ER. On 3/17/25 at 2:05 PM, surveyor interviewed licensed practical nurse #10 (LPN#10) via phone conversation and she informed surveyor LPN#3 had to send Resident #103 out that morning (2/24/25). She stated LPN#3 had given the resident glucose gel, orange juice with sugar, and peanut butter. She was unsure if LPN#3 had notified the provider but recalled hearing LPN#3 calling the family member and stated, she was in a panic. LPN#10 stated she did not witness LPN#3 administer anything to Resident #103 as she was busy with another resident at the time. This information was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, interim director of nursing, assistant director of nursing, and regional nurse support. This abbreviated survey was extended, and an abbreviated-extended-standard survey was conducted to include this complaint investigation from 3/11/25 through 4/8/25 and this information was discussed on 4/2/25 at 1:47 PM with the administrator and director of nursing when Immediate Jeopardy was identified by the survey team. No further information was provided to the survey team prior to exit on 4/8/25. 2. For Resident #453 the facility staff failed to provide and/or obtain timely radiology and/or diagnostic services after a medical provider ordered a left hip x-ray on 3/8/25 due to the resident having a fall on 3/7/25 with complaints of left hip pain and the facility staff failed to notify the medical provider the x-ray ordered for 3/8/25 was delayed until 3/10/25. Resident #453 was sent to a higher level of care and diagnosed with a left hip fracture requiring surgical repair. Resident #453's diagnosis list indicated diagnoses that included, but were not limited to, Hypertension, Atrial Fibrillation, Diverticulosis, Macular Degeneration, Unsteadiness on Feet, Depression, Difficulty Walking, Weakness, Polyosteoarthritis, Dementia, Alzheimer's, Chronic Kidney Disease-Stage 2, and Nightmare Disorder. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/19/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of a medical providers orders contained an order with a start date of 3/8/25 that read in part, .Left hip X-ray one time only for Pain for 1 (one) day . A review of the MAR (medication administration record) and TAR (treatment administration record) for March 9, 2025, revealed documentation of the left hip x-ray being administered. A review of Resident #453's clinical record revealed the following documentation. A Summary for Providers-Change In Condition dated 3/7/25 read in part, .The Change In Condition/s reported .are/were: Falls .Pain Status Evaluation: Does the resident/patient have pain? Yes .called to room by staff, observed resident in the floor on her bottom at bedside .upon entering the room, resident stated i {sic} was getting up from the potty chair and when i {sic} went to get in my wheelchair i {sic} forgot to lock it and it slid back .assessment completed .no visible injuries to note, assisted resident back to bed, no s/s (signs/symptoms) of distress, resident c/o (complaint of) some pain in left upper/inner thigh, described pain as tight, no changes to ROM (range of motion) to left leg .Primary Care Provider responded with the following feedback .monitor, if pain continues call for xray {sic} .repositioned patient in bed for c/o pain . A Medication Administration note dated 3/7/25 read in part, .Tylenol Oral Tablet 325 MG Give 2 tablet by mouth every 12 hours as needed for pain .given for c/o leg pain at this time . An Evaluation Note dated 3/8/25 read in part, .New orders post fall: x ray to left leg . A review of a Post Fall Assessment dated 3/8/25, read in part, .Resident reports pain .Resident states pain is 2/10 .left leg, thigh area .New orders post fall: x-ray to left leg . A Medication Administration note dated 3/9/25 read in part, .Left hip X-ray one time only for Pain for 1 Day . scheduled, will be here on Monday (3/10/25) to do x ray . An Evaluation Note dated 3/9/25 read in part, .Resident reports pain. Resident states pain is 4/10 .in left inner thigh .No notable findings .medication administered .order for x-ray, scheduled for Monday morning . An Evaluation Note dated 3/9/2025 read in part, .Late Entry .Resident reports pain. Resident states pain is 2/10 .Tylenol given by hall nurse .reports mild discomfort . A Health Status note dated 3/10/25 read in part, .LATE ENTRY .Upon returning to resident's room. Resident was lying in bed on her back with c/o pain with her left hip. Resident rated her pain at a level 4. PRN (as needed) medications was administered per MD (medical doctor) orders. Resident's pain level reassessed at 10:45am and resident rated her pain at a 3 at that time . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Summary for Providers Change in Condition dated 3/10/25 read in part, .The Change In Condition/s reported .are/were: New or Worsening Pain .Does the resident/patient have pain? Yes .Patient c/o pain upon ROM with left hip. PRN pain medication administered .Primary Care Provider responded with the following . Recommendations: Send to (hospital name omitted) Per family request . On 3/11/25 at 11:45 AM, surveyor met with local long-term care ombudsman (OMB) and she informed surveyor about Resident #453 having a fall at the facility. OMB recalled the resident's family member had called her on Friday (3/7/25) and informed her the resident had a fall at 3:00 PM and the facility was waiting for mobile x-ray. OMB stated this happened Friday evening and the x-ray was still not done yesterday (Monday 3/10/25). OMB stated the family called her after the resident got to the hospital and informed her Resident #453 had a left hip fracture and she was not sure if it would have to be pinned or replaced. On 3/12/25 at 1:19 PM, surveyor met with complainant at facility per her request. Complainant informed surveyor she called 911 on Monday (3/10/25) so the resident could have an x-ray of her hip because she was supposed to have the x-ray on Saturday (3/8/25), but the x-ray company did not show-up. Complainant stated Resident #453 was admitted to the hospital and had a left hip fracture and required surgery for a partial hip replacement. On 3/12/25 at 3:26 PM, surveyor met with assistant director of nursing (ADON), and she stated she spoke with Resident #453's family member on 3/10/25 in-person because she was called to the resident's room to speak with her about the fall. She informed surveyor resident fell at 4:00 PM on Friday (3/7/25). ADON stated they (nurses) called the provider, and he said if pain persists to get an x-ray. The unit manager called mobile x-ray and scheduled the x-ray. Mobile x-ray were supposed to come on the 8th (3/8/25) to do the x-ray. Surveyor asked ADON the process for complaints of pain after a fall and she stated the process is to medicate, contact the provider and depending on if an x-ray was ordered to get the x-ray. She informed surveyor the timeliness of mobile x-ray getting here is dependent on factors such as weekends and weather. She agreed mobile x-ray should come when they are scheduled. ADON informed surveyor she had started an Action Plan on 3/10/25 and provided surveyor with a copy of the action plan and staff education. Surveyor informed ADON the action plan was not completed prior to survey entrance on 3/11/25. ADON agreed the nurse should not have documented the x-ray was completed on 3/9/25. On 3/12/25 at 3:38 PM, surveyor interviewed licensed practical nurse #2 (LPN#2) and she informed surveyor she was working on 3/8/25 and did call mobile x-ray to see why they had not come to x-ray the resident and was informed by mobile x-ray they could not come until Monday (3/10/25) and they were delayed because it was the weekend. LPN#2 stated she informed the family at bedside. She stated she did not call the provider; another nurse called the provider. She stated the resident was complaining of hip pain, but the pain scale was not outrageous, and the resident was moving it (the leg/hip) good. 3/13/25 at 8:14 PM, surveyor interviewed licensed practical nurse #5 (LPN#5) via phone conversation and she informed surveyor she called the on-call provider on 3/8/25. She stated she did not work on that unit on Sunday (3/9/25) and LPN#2 was working that unit, and she (LPN#2) called mobile x-ray and she (LPN#2) would have called the provider about the x-ray being delayed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This information was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, interim director of nursing, assistant director of nursing, and regional nurse support. This abbreviated survey was extended, and an abbreviated-extended-standard survey was conducted to include this complaint investigation from 3/11/25 through 4/8/25 and this information was discussed on 4/2/25 at 1:47 PM with the administrator and director of nursing when Immediate Jeopardy was identified by the survey team. Surveyor requested and received the facility services agreement with the mobile x-ray company that read in part, .Mobile Imaging shall .2.3.1 make Radiology Services available for Facility patients seven days a week . Surveyor requested and received a facility policy titled, Notification of Changes with a reviewed/revised date of 12/1/22, that read in part, .The purpose of this policy is to ensure the facility promptly .consults the resident's physician .The facility must .consult with the resident's physician .when there is a change requiring such notification .Circumstances requiring notification include .1. Accidents .b. potential to require physician intervention . No further information was provided to the survey team prior to exit on 4/8/25. 3. For Resident #41 the facility staff failed to ensure a resident received treatment and care in accordance with professional standards of practice by failing to ensure the resident received a chest x-ray on 11/18/24. Resident #41's diagnosis list indicated diagnoses that included, but were not limited to, Peripheral Vascular Disease, Acute and Chronic Respiratory Failure with Hypoxia, Congestive Heart Failure, Hypertension, Dependence on Supplemental Oxygen, Chronic Obstructive Pulmonary Disease, and Diabetes Mellitus-Type 2. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/18/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A medical provider orders revealed an order dated 11/18/24 that read in part, .Chest x-ray, 2-view one time only for Congestion for 1 Day .Start Date 11/18/24 . A review of the November 2024 MAR showed no evidence the x-ray was completed as ordered by the provider. A review of radiology reports revealed no evidence the x-ray was completed as ordered by the provider. Surveyor requested evidence the chest x-ray was completed. This concern was discussed on 4/7/25 at 4:59 PM at the end of day meeting with administrator, director of nursing, assistant director of nursing, regional director of clinical services, and regional vice president of operations. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/8/25 at 8:38 AM, director of nursing informed surveyor no evidence could be located of the x-ray report or that the x-ray was completed. Surveyor requested and received a facility policy titled, Radiology and other Diagnostic Services and Reporting with a revision date of 12/1/22, that read in part, .The facility must provide or obtain radiology and other diagnostic services when ordered by a physician, physician assistant; nurse practitioner or clinical nurse specialist in accordance with state law . No further information was provided to the survey team prior to exit on 4/8/25. 4. For resident # 454 (R454), the facility staff failed to administer Seroquel per physician's order and failed to discontinue multiple medications per physician's order. R454's diagnoses included but were not limited to, anemia, atrial fibrillation, heart failure, hypertension, non-Alzheimer's dementia, seizure disorder, anxiety, depression and chronic obstructive pulmonary disease. R454's minimum data set (MDS) assessment with an assessment reference date of 8/28/24 assigned the resident a brief interview for mental status score of 11 out of 15 indicating moderate cognitive impairment. The medical record was reviewed. On 8/26/24 a hospice note read in part, . medication reconciliation completed, and adjustments made. Discontinue the following: Eliquis, folic acid, iron and atorvastatin. Decreased baclofen and gabapentin from TID (three times daily) to BID (twice daily) status, no changes in dosages. Patient agreeable to changes, previously discussed with daughter whom was also agreeable. VSS (vital signs stable) at the time of this visit. Patient reports he's not sure why he's here. Educated patient it was a safety issue for him to be home alone. Facility nurse (name omitted) updated with changes. The facility notes were reviewed. There was no nurse progress note for 8/26/24 noted in the facility documentation. The Medication Administration Record (MAR) was reviewed for August 2024. Orders were noted as active through 8/31/24 for Eliquis 5 mg twice daily, folic acid 1 mg daily, ferrous sulfate (iron) 325 mg daily and atorvastatin 10 mg at bedtime. Orders were noted as active for baclofen 10 mg three times daily and gabapentin 100 mg give 2 capsules three times daily. The MAR for September 2024 was reviewed. Orders were noted as active throughout September until R454's discharge on [DATE] for Eliquis, folic acid, ferrous sulfate, baclofen three times daily and gabapentin three times daily. On 8/29/24 a nurse progress note read, Resident exit seeking today, stating that he is going to heaven through that door. Aid informed to this nurse that resident was in the bathroom using the shower spray on himself. A hospice note for 8/29/24 read, Staff report that patient has made several attempts to get outdoors. Patient has difficulty completing conversation due to inattention. Patient seems mildly paranoid this visit. During visit patient acted aggressively toward male staff member. When this nurse asked him what he was doing patient stated, I'm going to kick his ass. Patient settled and resumed visit activities and patient made attempt to chase down male visitor for another resident. When questioned about this patient stated I know him, that man is evil. Unit manager (name omitted) states patient has exhibited this type of behavior all morning. Unit manager and patient nurse stated she may need a one on one for patient given behavior and flight risk. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A hospice note dated 8/31/24 read, Nurse (name omitted) states patient has been rolling to other residents rooms, attempting to pull items off residents walls. Upon arrival patient is sitting in wheelchair, alert and oriented to person and place. States he owns this facility and has been making updates. He whispered to this nurse that those blue lights over there, indicating the call light system, that's how they listen to us. Reoriented patient that is call bell system and yes they communicate to patient for safety reasons. Reoriented patient to stay in his area as he wouldn't want other residents in his room. Patient has Seroquel (an antipsychotic medication that balances the levels of hormones in the brain to help regulate mood, behaviors and thoughts) 25 mg BID (twice daily) ordered but not on facility MAR yet. Facility has medication, order resumed as lack of Seroquel could likely be the cause of increased paranoia . This surveyor could find no record of resident being on Seroquel prior to admission to the facility. A facility nurse note dated 8/31/24 read, Hospice nurse in to see resident this shift. Hospice nurse (name omitted) talked with this nurse about increased behaviors resident has had and talked with this nurse about mentioning to the provider to change his Seroquel from two times a day to three times a day. This nurse looked for an order in this system for Seroquel and did not see one for resident to have. Hospice nurse stated that the order for resident to have Seroquel twice a day should have been put into our system on 8/29/24. Hospice wrote orders for resident to have Seroquel 25mg one tablet by mouth twice a day for paranoid behaviors. The Medication Administration Record (MAR) for August 2024 was reviewed. An entry for Seroquel 25 mg give one tablet by mouth twice daily was noted to have started on August 31, 2024. A document entitled, Client Medication Report was noted under the heading of Hospice in the medical record. Seroquel 25 mg one tablet two times daily was ordered on 8/29/24. On 3/11/25 at 2:09 PM this surveyor interviewed other # 2, a hospice staff nurse who saw the resident on 8/30/24 when the facility had called due to R454's behavior. When asked about the visit they stated, They hadn't given him his Seroquel and it was due several hours prior. I asked him if he would take it and he said he would, but I had to ask that nurse 3 times to get it. She would not get it; said she wasn't going to give it because he was going out. She finally got the medicine, and I took it in there and he took it and thanked me. Surveyor asked if they could confirm that the Seroquel was one of the medications they administered as it was not on the MAR until 8/31/24. They stated, Well it's been a long time so I can't say that I remember every pill in the cup, but I know we talked specifically about Seroquel because it was for behaviors and that's why they called me, and I know we had an order to give it twice a day I think. This surveyor asked about the orders for Eliquis, atorvastatin, folic acid, iron, baclofen and gabapentin that were discontinued or changed according to hospice on 8/26/24. They stated, I'm not sure if that was me who did that, but I know that it was done due to falls or fear of him falling. Especially the Eliquis due to bleeding risk and then the baclofen and gabapentin were supposed to be decreased because they can have sedating side effects. On 3/17/25 at 11:20 AM this surveyor interviewed Licensed Practical Nurse (LPN) # 9. When asked about R454 they stated they remembered the resident well. When asked about 8/30/24, they stated they recalled R454's behaviors and the conversation with the hospice nurse. They stated, He had refused his medications for me, and I told the hospice nurse that. Our Administrator had come in because of his behaviors and said we had to send him out to the hospital. LPN # 9 stated that they did recall giving the hospice nurse some medications to administer but could not recall what it was and could not recall if Seroquel was discussed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/14/25 at 12:44 PM the survey team met with the Administrator, Interim Director of Nursing, Assistant Director of Nursing and the Regional Nurse Support. This concern was discussed with them at that time. On 3/17/25 at 11:09 AM the survey team met with the Regional Director of Clinical Services and the Regional [NAME] President of Operations. This concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference. 4/8/25 11:20 AM interviewed the current Medical Director who was not familiar with the R454. When asked if Seroquel 25 mg twice daily ordered on 8/29/24 for paranoia could have worked by 8/31/24 to control or improve behavior, he stated, It's hard to say not being familiar with the resident or the situation, but I have a hard time thinking it could have worked that quickly. I have to question if it was even an effective dose in a paranoid hospice patient. I am thinking I would have ordered a much larger dose but again, that is just thinking out loud with little information or knowledge of the resident or the situation. 5. For resident #17 (R17) the facility staff failed to follow provider orders for medications related to a change in condition. On 3/31/25 at 1:30 PM this surveyor interviewed R17 and a visiting family member. The family member stated that R17 fell ill on or around 2/5/25 with congestion and they did not feel that the staff had properly assessed or treated her. She ended up in third degree hear block and got sent out. She tested positive for flu and was so sick they were afraid to do surgery on her but really didn't have any choice she was going to die if they didn't. She was having these symptoms several days before they finally sent her out. R17's diagnoses include but are not limited to third degree heart block with cardiac pacemaker, essential hypertension, asthma and acute respiratory failure with hypoxia. The minimum data set (MDS) assessment with an assessment reference date of 2/14/25 assigned the resident a brief interview for mental status score (BIMS) of 15 out of 15 indicating intact cognition. R17 stated she did not recall a lot, I was so sick I guess, I don't remember a whole lot about it. The clinical record was reviewed. On 1/30/25 a provider progress note read in part, Staff requested patient be seen for bradycardia. Resident requested to be seen for upper respiratory infection and wheezing. The note went on to state, Plan: Suspect influenza Upper respiratory infection Possible asthma exacerbation Start DuoNebs (a combination of ipratropium and albuterol that is delivered through a nebulizer machine) every 8 hours for 5 days Start influenza protocol including guaifenesin Bradycardia Appears to be asymptomatic Not on any AV [NAME] blockers Continue to monitor and trend heart rate Consider heart rate evaluation while ambulating. A nurse progress note dated 2/1/25 at 2:46 PM read, Please note resident's (family member name omitted) came to nurse's desk and stated she wanted her mother checked for respiratory issues. Resident vitals taken and are all WNL at this time. She also stated her mother had refused breakfast and lunch and now requesting a grilled cheese sandwich from the kitchen. Kitchen prepared resident's request, and plate was taken to resident's room by this nurse and other nurse on duty. There was no other note and no nursing assessment of R17's condition documented that day. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A provider note dated 2/3/25 read in part, Staff requested patient be seen for bradycardia Resident requested to be seen for upper respiratory infection and wheezing. She believes that she has the flu. Under the heading Plan, Suspect influenza Upper respiratory infection Possible asthma exacerbation Increase DuoNebs to every 6 hours for 7 days Continue influenza protocol including guaifenesin Bradycardia Appears to be asymptomatic Not on any AV [NAME] blockers Continue to monitor and trend heart rate Plan to evaluate heart rate evaluation while ambulating Obtain EKG. The medication administration records (MAR) for January and February were reviewed. There was an order on the January MAR that read, Ipratropium-Albuterol solution 0.5-2.5 (3) mg/ml 3 ml inhale orally via nebulizer every four hours as needed for SOB (shortness of breath) and wheezing with a start date of 1/30/25 at 10:28 PM. The treatment was not administered to the resident in January or February. It was discontinued on 2/3/25 when another entry on the February MAR read, Ipratropium-Albuterol solution 0.5-2.5 (3) mg/ml 3 ml inhale orally via nebulizer four times a day for cough/wheezing for 7 days. The start date was 2/3/25 at 6:00 PM. The medication was never administered according to the record and was not supposed to be as needed according to the provider notes. There was no order for guaifenesin in the record for January or February. A nurse progress note dated 2/4/25 at 1:21 PM read, Received report from (name omitted) RN at (hospital name omitted) ER. Resident being transferred to (hospital name

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on staff interview, clinical record review, and facility document review, the facility nursing staff failed to complete a provider ordered treatment to a pressure ulcer for 1 of 55 sampled residents, Resident #34. The findings include. The facility nursing staff failed to complete a provider ordered treatment to Resident #34's left buttock. This treatment was for a pressure ulcer. Resident #34's diagnoses included paranoid schizophrenia, diabetes, and chronic pain syndrome. Section C (cognitive patterns) of Resident #34's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 01/07/25 included a brief interview for mental status (BIMS) score of 9 out of a possible 15 points. Per the MDS manual a 9=moderately impaired in cognitive skills for daily decision making. Section M (skin conditions) was coded to indicate the resident was at risk for developing pressure ulcers and had no unhealed pressure ulcers. This MDS was coded to indicate Resident #34 used a pressure reducing device for chair and bed and had application of dressings to feet. Resident #34's clinical record included a provider order dated 02/06/25 to cleanse open area to left buttock with wound cleanser, pat dry, apply barrier cream and cover with bordered gauze dressing daily on day shift and as needed. The clinical record included a provider skin and wound note with the date of service of 02/11/25. This progress note read in part, .The patient is being evaluated today for an arterial ulcer of the right second toe and a left buttock pressure injury .Left buttock pressure injury is healed today. Continue with turning and repositioning schedule per protocol for pressure prevention. Position patient side to side as tolerated. Assessed wound with DON [Director of Nursing]. A review of Resident #34's treatment administration record (TAR) revealed that for 02/19/25 Licensed Practical Nurse (LPN) #15 documented a 9 for the treatment to Resident #34's left buttock. Per the preprinted code on the TAR a 9=other/see nurse notes. On 02/19/25 at 7:42 p.m., LPN #15 transcribed a progress note that they were unable to complete this wound care due to increased patient load. This order was discontinued by the provider on 02/20/25 Wound care completed. On 04/07/25 at 5:00 p.m., during an end of the day meeting with the Administrator, Regional Director of Clinical Services, Regional [NAME] President of Operations, DON, and Assistant Director of Nursing the issue with the providers orders not being followed on 02/19/25 was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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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. Based on observation, staff interview, clinical record review, and facility document review the facility staff failed to ensure resident environment remains free of accident hazards and failed to provide adequate supervision to prevent accident for 1 of 55 residents, Resident #36. The findings of included: For Resident #36 the facility staff failed to provide an environment free of accident hazards and failed to provide adequate supervision to prevent accidents. Resident #36's face sheet listed diagnoses which included but not limited to suicidal ideations, major depressive disorder, and bipolar disorder, severe, with psychotic features. Resident #36's most recent minimum data set with an assessment reference of 02/04/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #36's comprehensive care plan was reviewed and contained plans for ADL (activities of daily living) self-care deficit r/t (related to) impaired mobility and weakness, The resident has a behavior problem patient threatens to sign out AMA (against medical advice) repeatedly, At risk for falls r/t Gait/balance problems, and The resident has had an actual fall with (SPECIFY: no injury, minor injury, serious injury) Poor Balance, Unsteady gait Resident #36's clinical record was reviewed and contained a Fall Risk Assessment dated 01/29/25 which indicated that the resident is a high risk for falling. Resident #36's clinical record also contained a Wandering Risk Assessment which indicated that the resident is at risk to wander. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #36's nurse's progress notes were reviewed and contained notes which read in part, 03/04/2025 18:25 Resident found outside smoking by the front door. Resident reeducated on no longer having smoking privileges at facility and that his smoking contract has been terminated. Resident put cigarette out. Resident states he got the cigarette from the ground. Lighter turned in and locked on cart. Resident aware that he can no longer smoke on facility premises, 03/17/2025 14:07 Resident has been noted twice in the last several hours to be in violation of the revocation of smoking that went into effect from violating the smoking policy. When educated resident stated that he's 60 d**n years old and he'll smoke a d**n cigarette whenever he wants, but when confronted by clinical on the second catch willingly gave up his lighter, 03/19/2025 10:20 Resident noted in lobby this a.m. noting he was leaving, reportedly threw things in the floor, told staff he's been to jail and he'll go back to jail again. Resident then took himself outside. Floor staff were able to convince resident to leave potential path of traffic in the driveway and return to the sidewalk, 03/19/2025 12:36 This nurse was notified by management that resident had fallen outside while attempting to walk with his walker. Resident reports he hit his head and abdomen while ambulating to find cigarettes and leave facility. Resident was back in his wheelchair when approached nurse ., and 03/23/2025 resident was seen several times outside of the building smoking cigarettes. Nurse reminded him that he was not allowed to smoke but he stated, 'I don't care I am leaving anyway.' When asked where he got them from, he stated, 'I found one on the ground', nurse expressed to resident the dangers of picking up stuff off the ground and putting something in his mouth that was previously in someone else's. on call was made aware of the situation. Surveyor observed Resident #36 on 03/31/25 at 6:30 pm seated in his wheelchair outside in front of building. No staff were observed in the area. Resident #36 asked surveyor if they knew where a motel was and stated he was leaving the facility. When surveyor told resident they did not know where a motel was, resident then asked where the nearest store was. Surveyor returned into the building and informed staff of resident being outside unsupervised, and the statements that were made. Assistant director of nursing stated, I'll go out and talk to him, he does that all the time. Resident #36's clinical record contained a Smoking Assessment form for Resident #36 dated 01/30/25. This form indicates that the resident does not use oxygen, can light/smoke while demonstrating safe technique and remains alert while smoking. Surveyor spoke with the regional director of clinical services on 04/04/25 at 10:40 am regarding Resident #36, and their revocation of smoking. Regional director of clinical services stated that Resident #36 had violated the smoking policy by picking up cigarettes off the ground and smoking them. Surveyor requested and was provided with a facility policy entitled Resident Smoking which read in part, 6. Residents who desire to continue smoking will be assessed to determine recommendations for safe smoking safety interventions. Residents will be educated on and must agree to the terms outlined in the facility residents smoking agreement. 11. For the safety of all residents, those residents who have agreed to the smoking terms must have their materials to include cigarettes, e-cigarettes, vaping pens and all incendiary devices secured in a locked system that is not accessible to other residents and in an area that is supervised by facility staff. The concern of not providing an environment free of accident hazards and not providing adequate supervision for Resident #36 was discussed with the administrator, regional director of clinical services, director of nursing, assistant director of nursing, and regional vice-president of operations on 04/07/25 at 5:00 pm. (continued on next page)

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F 0689 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 0690 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain the provider ordered laboratory test urinalysis for 1 of 55 sampled residents, Resident #21. This resulted in Resident #21 being transferred to a higher level of care and being treated in the emergency department with IV (intravenously) fluids and an antibiotic for a urinary tract infection (UTI), dehydration, and altered mental status. The findings include. For Resident #21 the facility staff failed to obtain the provider ordered laboratory test urinalysis. The provider ordered a urinalysis on 02/25/25. This urinalysis was not obtained, Resident #21 was transferred to a higher level of care on 03/08/25 and treated in the emergency department with IV fluids and an antibiotic for a UTI, dehydration, and altered mental status. Resident #21's face sheet included the diagnoses chronic kidney disease stage 4, history of malignant neoplasm of bladder, and diabetes. Resident #21 had a history of UTI's. Section C (cognitive patterns) of Resident #21's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/10/25 included a brief interview for mental status (BIMS) score of 5 out of a possible 15 points. Per the MDS manual a score of 5=severe impairment in cognitive skills for daily decision making. Section GG (functional abilities) was coded with a 1 for toileting hygiene indicating this resident was dependent on staff in this area. Section H (bladder and bowel) was coded to indicate this resident was always incontinent in both areas. Resident #21's previous MDS assessment with an ARD of 01/29/25 was a quarterly MDS assessment and included a BIMS score of 15 out of a possible 15 points. Indicating Resident #21 was cognitively intact. Section H was coded to indicate the resident was incontinent of bowel and bladder. Resident #21's comprehensive care plan included the focus areas renal insufficiency related to chronic kidney disease and has bowel incontinence related to impaired mobility. Interventions included provide pericare after each incontinent episode. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Resident #21's clinical record included a provider note with a date of service of 02/25/25. Chief complaint/nature of presenting problem: Family member husband called and requested patient to be seen . History of present illness .Patient recently completed 10 days of antibiotics on 2/21/2025 for urinary tract infection complicated by encephalopathy. Requested by husband to see patient as he felt she was not herself. Discussed with nursing staff who feel that patient sometimes seeks attention from husband by acting out. This is not clear. Patient is on multiple neuropathy and chronic pain medications for her contractures and diabetic neuropathy which are affecting her mental status which is known to wax and wane. Patient has history of diabetes and suspect patient has diabetic nephropathy and reduced creatinine clearance. Will order labs .Order CBC [complete blood count], CMP [comprehensive metabolic panel] and urinalysis . Discussed with husband at length that we would monitor patient closely. Discussed that we would order labs and urinalysis to make sure we are not missing any infections . The provider that documented this note no longer worked for this facility. Resident #21's clinical record included a provider order for a urinalysis dated 02/25/25. For (Indications for Use) UTI. A review of Resident #21's medication administration record (MAR) revealed that on 02/26/25 at 3:17 a.m. Licensed Practical Nurse (LPN) #16 documented a 9 on the MAR for this order. Per the MAR a 9=other/see nurse notes. On 02/26/25 at 3:17 a.m., LPN #16 documented urinalysis one time only for UTI not obtained this shift. This progress note included boxes beside of the documentation show on shift report and show on 24-hour report both boxes had been checked. The box that read show on MD/Nursing communications report was not checked. LPN #16 was no longer employed at the facility. On 02/27/25 LPN #7 documented resident is not eating well but obtain adequate fluids, mental status is off baseline. On 03/08/25 at 5:26 a.m., the nursing staff documented the following progress note, This shift resident has been very resistive to care, refused all medications as well as vital sign check. When CNA [certified nursing assistant] doing rounds resident screams out, attempts to hit staff. Redirection unsuccessful at this time, will monitor. On 03/08/25 at 4:49 p.m., LPN #7 documented, Residents husband, _____, called facility 4 times today inquiring about residents' condition, nurse conversed with husband about resident, Mr. _____ requested that another physician to assess resident, nurse informed him that we were doing everything to care for her and we would have the NP [nurse practitioner] check on resident again on Monday, her vitals were stable she is obtaining adequate fluids and assured him that she was okay and that we have an on call provider at all times if needed for emergencies, he was not pleased about the health status and stated, I have been getting the run around and not one single sure response about what is wrong with her. I dont want to call the state police for a well fare check but I will if you do not send her out. and requested her be sent to the ER [emergency room] asap [as soon as possible]. Nurse called on call supervisor .to alert them to situation. Husbands requested was honored and she was picked up by EMS [emergency medical services] via stretcher and taken to _____ County Hospital. (sic) (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Resident #21's clinical record included an emergency department report with a date of service of 03/08/25. Chief complaint was documented as altered mental status and dysuria. Vital signs were documented as pulse 66, respirations 9, blood pressure 89/54, oxygen concentration 97%. A urinalysis was obtained with the results reading abnormal. Resident #21 was administered sodium chloride 1000 milliliters (mls) beginning at 5:10 p.m. and the antibiotic Ceftriaxone (Rocephin) 2 gram in sodium chloride 50 mls beginning at 6:10 p.m. Final Diagnoses were documented as urinary tract infection with hematuria (blood), dehydration, and altered mental status. The Results of the urinalysis read as follows. Color yellow reference range yellow/straw. Appearance cloudy reference range clear. Blood large reference range negative. Protein 30 reference range negative. Nitrite positive reference range negative. Leukocyte esterase large reference range negative White blood count was documented as greater than or equal to 100 reference range 0-4. Red blood count 10-24 reference range 0-4. Bacteria 3+ reference range negative. CMP. Sodium 134 (low) reference range 136-145. BUN (blood urea nitrogen) 81 (high) reference range 8-23. Creatinine 2.52 (high) reference range 0.60-1.20. A CBC was obtained the only abnormal laboratory result documented was hemoglobin at 12.2 reference range 12.4-15.2. Resident #21 was released back to the facility with new orders for the antibiotic Cefuroxime (Ceftin) 250 mg tablet start date 03/08/25 end date 03/15/25 take 1 tablet by mouth 2 times a day for 7 days. LPN #18 documented this resident returned to the facility on [DATE] new orders received and noted. A review of the residents MAR indicated this medication was started at the facility on 03/09/25. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 04/07/25 at 3:30 p.m., the Assistant Director of Nursing (ADON) provided the survey team with a copy of a policy titled, Laboratory Services and Reporting. This policy read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law .The facility must provide or obtain laboratory services to meet the needs of its residents .The facility is responsible for the timeliness of the services . On 04/07/25 at 5:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), ADON, Regional Director of Clinical Services, and Regional [NAME] President of Operations the issue with the urinalysis not being obtained and the resident being transferred to a higher level of care and treated in the ER was reviewed. On 04/08/25 at 8:51 a.m., the DON stated they were checking with the hospital to see if they could locate the urinalysis. When asked how a nurse would know to collect the urine after someone had documented their initials in their computer software system the DON stated I want to say it would be communicated in report. On 04/08/25 at 9:20 a.m., during an interview with Licensed Practical Nurse (LPN) #19 was asked how they would know if a resident had an order for a urinalysis. This nurse stated if someone had an order for a urinalysis it would be on the MAR or in the lab book. On 04/08/25 at 9:27 a.m., the surveyor and DON reviewed the lab book and was unable to find a requisition for the urinalysis ordered in February. On 04/08/25 at 10:24 a.m., the DON stated they had called their lab company, and they did not have a urinalysis for this resident that corresponded with this date. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide a therapeutic diet to one (1) of fifty-five (55) sampled residents, (Resident #454). For Resident #454, the facility staff failed to provide evidence the resident received or refused a therapeutic diet as ordered by the medical provider during evening meals on 8/21/24, 9/9/24, and 9/10/24. Resident #454's diagnosis list indicated diagnoses that included, but were not limited to, Atrial Fibrillation, Glaucoma, Seizures, Hypertension, Chronic Obstructive Pulmonary Disease, History of Falls, Dementia with Agitation, Depression, Anxiety Disorder, Heart Failure, Vascular Dementia-severe with Psychotic Disturbance, Traumatic Brain Injury, History of Suicidal Behavior, and Thyrotoxicosis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 8/28/24, assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of Resident #454's medical provider orders included an order that read in part, .Regular diet Regular texture, thin consistency (liquids) . with a start date of 8/21/24. A review of the resident's person-centered comprehensive care plan revealed a focus that read in part, .The resident has nutritional problem or potential nutritional problem-High BMI (body mass index), hospice care, cognitive impairment . with a created date of 8/22/24. Review of the interventions associated with the focus revealed an intervention that read in part, .Provide, serve diet as ordered-Regular. Monitor intake and record q (every/each) meal . Surveyor requested and received meal intake records for Resident #454 for August and September 2024. The meal intake records revealed on 8/21/24, 9/9/24, 9/10/24, and 9/16/24 no evening meal percentages or refusals were documented for the resident. On 3/11/25 at 12:34PM, surveyor interviewed local long-term care ombudsman (OS#1), and she denied observing resident not getting served his meals. On 3/12/25 at 1:09 PM, surveyor interviewed other staff #9 and she did not recall resident not receiving meals during any of her visits and did not witness resident's meals sitting on the meal cart. On 3/13/25 at 3:49PM , surveyor interviewed certified nursing assistant #1 (CNA#1) and she informed surveyor the resident ate by himself after his tray was set-up and he did better with finger foods due to his dementia. This issue was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, interim director of nursing, assistant director of nursing, and regional nurse support. This abbreviated survey was extended, and an abbreviate-extended-standard survey was conducted to include this complaint investigation from 3/11/25 through 4/8/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested evidence of Resident #454 having been provided with meals or refusal of meals on 8/21/24, 9/9/24, 9/10/24, and 9/16/24. On 3/17/25, assistant director of nursing (ADON) provided surveyor with a facility document titled 1:1 (one on one) Feed Sign Off sheet that included Resident #454's name and documentation on 9/16/24 of the resident having consumed 50% of his dinner. The ADON agreed documentation could not be located for meal delivery or refusals of meals for 8/21/24, 9/9/24, or 9/10/24. Surveyor requested and received a facility policy titled, Meal Supervision and Assistance with a reviewed/revised date of 12/1/2022, that read in part, .Encourage the resident to participate with his or her meal as much as possible . No further information was provided to the survey team prior to exit on 4/8/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and clinical record review, the facility staff failed to provide ordered respiratory care and/or treatments for two (2) of 55 sampled residents (Resident #90 and Resident #100). The findings include: 1. The facility staff failed to ensure Resident #90's incentive spirometer was correctly ordered and/or provided. (An incentive spirometer is a handheld device used to improve lung function.) Resident #90's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], was signed as completed on [DATE]. Resident #90 was assessed as able to make self understood and as able to understand others. Resident #90's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #90's clinical record included orders for the use of an incentive spirometer. The incentive spirometer orders were dated as being created/revised on [DATE] but scheduled to be started on [DATE] at 7:00 a.m. The incentive spirometer orders were signed by the medical provider on [DATE]. The following incentive spirometer orders were part of Resident #90's medical provider orders: - Document total minutes of direct resident bedside care for incentive spirometer medication [sic] administration - 12-15 breathes [sic] total of 15-20 minutes span . every shift for 7 Days. - An order for vital signs and breath sounds before incentive spirometer treatments every shift for seven (7) days. - An order for vital signs and breath sounds after incentive spirometer treatments every shift for seven (7) days. On [DATE] at 5:30 p.m., the surveyor interviewed Registered Nurse (RN) #1 about Resident #90's incentive spirometer orders. RN #1 was the staff member who entered Resident #90's aforementioned incentive spirometer orders. The surveyor asked RN #1 about the ordered delay in starting Resident #90's incentive spirometer treatments. RN #1 reported she may have entered the incorrect start date. On [DATE] at 5:50 p.m., RN #1 reported she was unable to find documentation addressing Resident #90's incentive spirometer orders. RN #1 stated the incentive spirometer orders might have been entered for the incorrect resident. RN #1 stated Resident #90's incentive spirometer orders might need to be canceled. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Rehabilitation and Nursing	514 North Main Street Rural Retreat, VA 24368

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 6:15 p.m., the surveyor interviewed RN #1 and the facility's Medical Director. (RN #1 was interviewed in person but the Medical Director was involved in this interview via telephone.) RN #1 stated she reviewed Resident #90's clinical records and was unable to find documentation to support the incentive spirometer orders. RN #1 reported the incentive spirometer orders may have been entered for the incorrect resident. The Medical Director reported he was unable to remember for which resident he had given the incentive spirometer orders. The Medical Director denied remembering giving an order that would have delayed the initiation of a resident's incentive spirometer treatment. The surveyor asked if there was a way to identify the resident for whom the incentive spirometer orders were intended; the facility staff did not provide the surveyor with additional information addressing which resident the incentive spirometer orders in question were intended. On [DATE] at 10:35 a.m., the survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services. The surveyor discussed the issues with Resident #90's incentive spirometer orders. 2. The facility staff failed to provide Resident #100's scheduled nebulizer treatment included as part of the resident's hospice orders and hospice care plan. Resident #100 did not have an admission minimum data set (MDS) assessment completed due to the resident experiencing multiple discharges and readmissions to the facility. Resident #100's admission nursing assessment indicated the resident: (a) was oriented to person and place, (b) had adequate vision, and (c) had adequate hearing. Resident #100's HOSPICE CERTIFICATION AND PLAN OF CARE document, dated [DATE], included an order for albuterol and ipratropium nebulizer treatments to be administered every eight (8) hours. Resident #100 was documented as starting hospice care on [DATE]; Resident #100's [DATE] hospice visit was documented as starting at 10:36 a.m. (with 1.13 hours total in-home time). Resident #100's progress note, dated [DATE] at 10:00 a.m., documented the resident had expired. No evidence was found by, or provided to, the surveyor to indicate Resident #100 had been administered the aforementioned albuterol/ipratropium nebulizer treatments between the times of the hospice visit on [DATE] and the resident's death on the morning of [DATE]. On [DATE] at 1:10 p.m., the surveyor interviewed, via telephone, the Executive Director of the hospice that cared for Resident #100. The Executive Director confirmed that several of Resident #100's medications had been discontinued when the resident started receiving hospice care. The Executive Director directed the surveyor to the hospice plan of care to see which medications had been continued as part of Resident #100's hospice care. Resident #100's HOSPICE CERTIFICATION AND PLAN OF CARE document, dated [DATE], included information for albuterol and ipratropium nebulizer treatments to be administered every eight (8) hours. On [DATE] at 1:45 p.m., the surveyor asked the Director of Nursing (DON) about Resident #100's albuterol/ipratropium nebulizer treatments included in the resident's hospice plan of care. On [DATE] at 1:55 p.m., the DON reported she was unable to find evidence of the nebulizer treatments being administered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:02 p.m., the survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the absence of evidence of Resident #100 receiving her scheduled nebulizer treatments which had been documented as part of the resident's hospice plan of care.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on staff interview, clinical record review, and facility document review, the facility staff failed to coordinate care with the dialysis center for 1 of 1 dialysis residents in the survey sample. Resident #255. The findings include. The facility staff failed to coordinate care with the dialysis center. The facility staff failed to obtain pre and post dialysis weights. Resident #255's diagnosis included end stage renal disease. There was no completed minimum data set assessment on this resident. This resident was alert and orientated to person and place. Resident #255's care plan included the focus area of dialysis due to end stage renal disease. Interventions included coordinate plan of care with dialysis as needed The clinical record included provider orders for dialysis 3 times a week. On 04/04/25 at 10:15 a.m., Licensed Practical Nurse (LPN) #4 provided the surveyor with a copy of their policy titled, Care Planning Special Needs-Dialysis. This policy read in part, .Interventions will include Pre-and post-weights .If no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report . During the clinical record review the surveyor was unable to locate any pre and/or post dialysis weights. There was a dialysis book for this resident at the [NAME] side nurses station that included paperwork for dialysis these pages were blank. On 04/07/25 at 12:45 p.m., the Assistant Director of Nursing (ADON) was interviewed regarding this residents dialysis. The ADON stated a paper should be taken to dialysis daily and the staff should fill it out. On 04/07/25 at 5:00 p.m., the issue with the coordination of care with the dialysis center was reviewed with the Administrator, Regional Director of Clinical Services, ADON, and Director of Nursing. On 04/08/25 at 3:25 p.m., the Unit Manager stated they had called the dialysis center and obtained the missing weights. The Unit Manager stated the dialysis book should go with the resident to dialysis. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on staff interviews and clinical document review, the facility's medical providers failed to ensure resident's orders addressed the resident needs for two (2) of 55 residents (Resident #90 and Resident #153). The findings include: 1. A medical provider failed to identify concerns with the start date of Resident #90's incentive spirometer orders. (An incentive spirometer is a handheld device used to improve lung function.) Resident #90's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/18/25, was signed as completed on 1/30/25. Resident #90 was assessed as able to make self understood and as able to understand others. Resident #90's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #90's clinical record included orders for the use of an incentive spirometer. The incentive spirometer orders were dated as being created/revised on 3/25/25 but scheduled to be started on 4/13/25 at 7:00 a.m. The incentive spirometer orders were signed by a medical provider on 3/31/25 without the medical provider making adjustments or changes to the incentive spirometer orders. The following incentive spirometer orders were part of Resident #90's medical provider orders: - Document total minutes of direct resident bedside care for incentive spirometer medication [sic] administration - 12-15 breathes [sic] total of 15-20 minutes span . every shift for 7 Days. - An order for vital signs and breath sounds before incentive spirometer treatments every shift for seven (7) days. - An order for vital signs and breath sounds after incentive spirometer treatments every shift for seven (7) days. On 4/3/25 at 5:30 p.m., the surveyor interviewed Registered Nurse (RN) #1 about Resident #90's incentive spirometer orders. RN #1 was the staff member who entered Resident #90's aforementioned incentive spirometer orders. The surveyor asked RN #1 about the ordered delay in starting Resident #90's incentive spirometer treatments. RN #1 reported she may have entered the incorrect start date. On 4/3/25 at 5:50 p.m., RN #1 reported she was unable to find documentation addressing Resident #90's incentive spirometer orders. RN #1 stated the incentive spirometer orders might have been entered for the incorrect resident. RN #1 stated Resident #90's incentive spirometer orders might need to be canceled. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 6:15 p.m., the surveyor interviewed RN #1 and the facility's Medical Director. (RN #1 was interviewed in person but the Medical Director was involved in this interview via telephone.) RN #1 stated she reviewed Resident #90's clinical records and was unable to find documentation to support the incentive spirometer orders. RN #1 reported the incentive spirometer orders may have been entered for the incorrect resident. The Medical Director reported he was unable to remember for which resident he had given the incentive spirometer orders. The Medical Director denied remembering giving an order that would have delayed the initiation of a resident's incentive spirometer treatment. The surveyor asked if there was a way to identify the resident for whom the incentive spirometer orders were intended; the facility staff did not provide the surveyor with additional information addressing which resident the incentive spirometer orders in question were intended. 2. A medical provider failed to identify Resident #153's duplicate allopurinol orders when signing orders that had been entered, for the medical provider, by non-prescribing facility staff members. (Allopurinol is a medication ordered orally for Resident #153 to address gout.) Resident #153's admission minimum data set (MDS) assessment was not due and had yet to be submitted prior to the surveyor's review of the resident's clinical record. A medical provider assessment indicated Resident #153 was alert and oriented times three (3). Resident #153 was documented as having adequate vision. Resident #153's hearing was documented as being grossly intact. Resident #153's clinical documentation included two (2) orders for allopurinol 100mg one (1) tablet by mouth once a day for gout. The first allopurinol order was ordered on 3/26/25 at 5:56 p.m.; the medical provider signed this order on 3/31/25 at 2:43 p.m. The second allopurinol order was ordered on 3/27/25 at 10:42 a.m.; the medical provider signed this order on 3/31/25 at 2:43 p.m. On 4/1/25, one (1) of the two (2) allopurinol orders was discontinued due to it being identified as a duplicate by a different medical provider (this was not the medical provider that signed the allopurinol orders on 3/31/25). On 4/8/25 at 3:02 p.m., the survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services. During this meeting, the surveyor discussed the failure of the medical provider to identify the duplicate allopurinol orders when signing orders that had been entered by non-prescribing facility staff members.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to review the resident's total program of care, including medications and treatments for one (1) of fifty-five (55) sampled residents (Resident #77). The findings include: For Resident #77 the facility staff failed to ensure the attending physician reviewed the hospital discharge summary for a hospital stay ending on 1/12/24. This lack of review of the resident's total program of care, including medications and treatments resulted in the resident not receiving a review of orders for diabetic medications essential to the resident's medical treatment and care for a diagnosis of Type 2 Diabetes Mellitus. Resident #77's diagnosis list indicated diagnoses that included, but were not limited to, Atrial Fibrillation, Morbid Obesity, Obstructive Sleep Apnea, Hypertension, Hyperlipidemia, Peripheral Vascular Disease, Edema, Polyneuropathy, Dementia-Moderate with Mood Disturbance, Adjustment Disorder with Depressed Mood, and Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/21/25, assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the clinical record revealed resident was hospitalized from [DATE] through 1/12/24. A review of the hospital Discharge summary dated [DATE] read in part, .Your medications have changed . STOP taking .insulin .(HUMULIN) .insulin regular human .(NovoLIN) .metFORMIN 500 mg (milligrams) Tab (tablet) .Ozempic 1 mg/dose . Further review of the clinical record did not reveal a medical provider addressing the changes in the resident's diabetic medications after his readmission to the facility on 1/12/24. A Blood Sugar Summary revealed the last blood sugar check performed on Resident #77 was on 1/7/24 prior to resident being transferred to the hospital. A Labs Results Report dated 11/18/24 read in part, .Glucose .Result .255 .H (high) . A review of the current medical provider orders did not disclose any diabetic medications or diabetic monitoring for Resident #77. A review of the comprehensive person-centered care plan disclosed a focus that read in part, .The resident has DX (diagnosis) of Diabetes Mellitus . with an initiated date of 12/27/22 and a goal that read in part, .The resident will have no complications related to diabetes . (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 12:36 PM, surveyor interviewed administrative staff #6 (AS#6) and informed her of this concern. She stated she would check into this concern. At 1:01 PM, AS#6 returned to surveyor and informed surveyor she could not locate any provider orders or progress notes addressing why the diabetic medications were discontinued and she could not locate a provider order to check the resident's blood sugar. On 4/3/25 at 1:05 PM, surveyor interviewed Resident #77 and asked him if he was receiving any diabetic medications and he stated, I used to, they gave me a shot in the belly. The resident did not know if he was currently receiving diabetic medications and informed surveyor the nurses bring his medications to him in a cup, and he just takes what they bring him. On 4/3/25 at 2:32 PM, AS#6 informed surveyor she could not speak on behalf of the provider that was here in January 2024, as the current provider team took over in May 2024. She stated she spoke with the regional director of clinical services about this concern, and they were going to make the current medical provider aware of this issue. On 4/3/25 at 2:54 PM, AS#6 informed surveyor she had spoken with the current provider, and they ordered a CMP (complete metabolic panel) and an A1C (a blood test that measures the average blood sugar level over the past 2-3 months). Surveyor reviewed a medical provider's order dated 4/3/25 that read in part, .CMP (comprehensive metabolic panel) plus A1C at bedtime for 1 Day . A review of the Lab Results Report dated 4/4/25 read in part, .Hemoglobin A1c% .10.3 % (4.0-6.0) H-Final (high-final) . A review of the Lab Results Report dated 4/4/25 read in part, .Glucose .Result .354 .H (high) . A health status note dated 4/4/25 read in part, .Resident had lab results come back. Glucose on CMP was 354 and A1C 10.3 .NP (nurse practitioner) was notified of lab results. She advised of new orders. Metformin 500mg BID (twice daily) and accuchecks .Resident placed in rounding book for follow up on Monday (4/7/25) with in-house provider. RP (responsible party) and resident aware of new orders . This concern was discussed on 4/4/25 at 10:34 AM at the end of day meeting with the administrator, director of nursing, assistant director of nursing, and regional director of clinical services. A review of the Blood Sugar Summary for April 2025 revealed the following blood sugar values: 4/4/25 at 8:16 PM-306.0 4/5/25 at 8:13 AM-229.0 4/5/25 at 11:40 AM-180.0 4/5/25 at 4:08 PM-221.0 4/5/25 at 8:38 PM-194.0 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/6/25 at 5:50 AM-104.0 4/6/25 at 11:54 AM-202.0 4/6/25 at 4:44 PM-190.0 4/7/25 at 12:25 AM-271.0 4/7/25 at 5:31 AM-241.0 4/7/25 at 11:56 AM-194.0 On 4/8/25 at 10:40 AM, surveyor spoke with AS#6 and she informed surveyor the provider that ordered the labs on 11/18/24 no longer worked with her provider group and stated the expectation of provider services depends on the resident and their comorbidities but the expectation for a blood glucose at 255 would be some type of interventions. Surveyor requested and received a facility policy titled, Medication Orders with a revision date of 12/1/22 that read in part, .5. Specific Procedures for Medication Orders .c. Written Transfer Orders (sent with a resident by a hospital .) Implement a transfer order without further validation, if it is signed and dated by the resident's current attending physician .If the order is unsigned, or signed by another physician .the receiving nurse should verify the order with the current attending .The nurse should document verification on the admission order record, by entering the time, date, and signature. Example: Order verified by the phone with Dr. [NAME]/M. [NAME], R.N . No further information was provided to the survey team prior to exit on 4/8/25.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, staff interview, clinical record and facility document review the facility staff failed to ensure staffing to provide treatment and/or care for 6 of 55 residents, Resident #13, Resident #34, Resident #6, Resident #21, Resident #50, and Resident #32. The findings included: For Resident #13 the facility failed ensure staffing to provide activities of daily living care, specifically incontinence care. 1. Resident #13's face sheet listed diagnoses which included but not limited to Resident #13's face sheet listed diagnoses which included but not limited to spastic quadriplegic cerebral palsy, gastrostomy status, and dysphagia. Resident #13's most recent minimum data set with an assessment reference date of 02/07/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section GG, functional abilities, coded the resident as dependent for toileting hygiene. Section H, bladder and bowel, coded the resident as always incontinent of both bowel and bladder. Resident #13's comprehensive care plan was reviewed and contains care plans for Self-Care Deficit-Total dependent on staff for completion of ADL's (activities of daily living) related to CP (cerebral palsy), functional quadriplegia and intellectual disability, Resident has actual impaired skin integrity related to impaired mobility, incontinence and DX (diagnosis) of eczema and excoriation and The resident has bowel and bladder incontinence. Interventions for these care plan include Check at Q (every) 2 hours and as required for incontinence, provide incontinence care after each incontinence episode and Provide assistance with ADL's/IADL's (activities of daily living/independent activities of daily living) as needed. Surveyor observed Resident #13 seated in his wheelchair in the common area on 04/01/25 at 8:15 am. Surveyor observed resident at various times throughout the day, and resident remained seated in the same place at each observation. Surveyor spoke with certified nurse's aide (CNA) #4 on 04/01/25 at 2:55 pm regarding Resident #13. Surveyor asked CNA #4 if they had provided incontinence care to resident since they have been here, and CNA #4 stated that she came into work today between 9-9:30 am they had just finished their first round of checking residents, and that no one has had a meal break yet. CNA #4 also stated, . (Resident #13) requires a lift, which takes two people, and there is no one available to help me. Surveyor asked CNA #4 how many CNA's were assigned to the unit at this time, and CNA #4 stated, Four. Surveyor asked CNA #4 how many residents they were responsible for, and CNA #4 stated, I have 16, but that's the least I have had all week. Over the weekend, I had all of 500 hall (20 residents). Surveyor asked CNA #4 if they can get their work completed, and CNA #4 stated, If I don't stop. Surveyor observed CNA #4 and CNA #5 on 04/01/25 at 3:35 pm providing incontinence care for Resident #13. Surveyor observed that resident's incontinence brief was fully saturated, resident's shorts were wet, and pad in seat of wheelchair was wet. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor spoke with the facility staffing coordinator on 04/04/25 at 10:25 am. Staffing coordinator stated that are responsible for making all the schedules for nursing staff, scheduling appointments and transports. Surveyor asked staffing coordinator how many CNAs were usually assigned to [NAME] side (Resident #13 resides on [NAME] side), and staffing coordinator stated, I always run 3 CNAs on East side and try to run 5 on day shift and at least 3 at night on West. The concern of not ensuring staffing to provide ADL care for Resident #13 was discussed with the administrator, director of nursing, assistant director of nursing, regional director of clinical services, and regional vice president of operations on 04/07/25 at 5:00 pm. No further information was provided prior to exit. 2. For Residents #6, #21, #32, #34, and #50 Licensed Practical Nurse (LPN) #15 documented they were unable to complete provider orders due to increased patient load. A review of Resident #21's clinical record revealed that on 02/19/25 at 7:41 p.m. LPN #15 documented they were unable to complete due to increased patient load. This note did not reference what the nursing staff was not able to complete and during the clinical record review the surveyor was unable to find any medication and/or treatment that had been coded as being incomplete. This note type was identified in the clinical record as being a medication administration note. Resident #21 was not interviewable. On 04/07/25 at 9:34 a.m., the surveyor requested the facility census and work assignment for this nurse for 02/19/25. The Assistant Director of Nursing (ADON) and Regional Director of Clinical Services (RDCS) were made aware of the documentation by LPN #15. The RDCS stated they were aware and stated this nurse wanted a 1:10 ratio and was on a do not return list and was no longer allowed to work at the facility. A review of the facility census indicated that this nurse would have been responsible for 28 residents. The surveyor reviewed each of these residents clinical record for any nursing entry made by this nurse on 02/19/25. The surveyor identified a total of 5 residents with a similar progress note. Resident #6-the nurse did not define what they were unable to complete the only documentation read, unable to complete due to increased patient load. Resident #21-the nurse did not define what they were unable to complete the only documentation read, unable to complete due to increased patient load. Resident #32-cleanse right lateral ankle, apply skin prep, cover with protective dressing (red area). unable to complete due to increased patient load. Resident #34-cleanse open area left buttock, apply barrier cream, cover with bordered gauze. unable to complete due to increased patient load. Resident #50-cleanse abrasion to left dorsal foot with wound cleanser, paint with betadine, cover with bordered gauze. unable to complete due to increased patient load. (continued on next page)

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	495417	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Rehabilitation and Nursing	514 North Main Street Rural Retreat, VA 24368

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/07/25 at 10:50 a.m., the staffing coordinator provided the surveyor with a copy of the as worked schedule for 02/19/25. This nurse was identified as an agency nurse and had been assigned to the [NAME] unit on day shift 7:00 a.m.-7:00 p.m. A second nurse had been assigned to this same unit and 5 certified nursing assistants. There were also 2 staff assigned to the shower team. The staffing coordinator stated this was pretty normal staffing. The second nurse working this unit was also assigned to 28 residents. The census for the [NAME] side was documented as being 56. The surveyor requested contact information for this nurse. The surveyor attempted to contact this nurse twice on 04/08/25 once at 8:58 a.m. and again at 2:44 p.m. Both calls went to voicemail. The surveyor left a brief message after the first phone call, no return call was received as of the date of this report. On 04/08/25 at 3:00 p.m., during a meeting with the Administrator, RDCS, Director of Nursing (DON), and ADON the issue with LPN #15 not completing their work assignment and documenting unable to complete due to increased patient load for 5 residents of the facility on 02/19/25 was reviewed. The RDCS stated there was nothing out of the normal for the day/shift. The DON was new to the facility and had no information. The Unit Manager was also in a new position and was not the Unit Manager at the time of this occurrence. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, staff interview, and facility document review, the facility staff failed to post the nurse staffing information daily. The findings include. The facility staff failed to post the nurse staffing information. The nurse staffing information had not been posted since 03/17/25. On 04/01/25 at 8:15 a.m., the surveyor observed a nurse staffing summary posted at the [NAME] side nurses station. This document was dated 03/17/25 and had a documented census of 103. The surveyor did not observe any other postings throughout the facility to include the East side nurses station. The surveyor notified the Director of Nursing (DON) the DON and the surveyor went to the front desk with no postings being observed. On 04/01/25 at 5:30 p.m. during an end of the day meeting with the Administrator, DON, Assistant Director of Nursing, Regional Director of Clinical Services, and Regional Director of Clinical Reimbursement the issue with the nurse staffing posting not being updated since 03/17/25 was reviewed. On 04/04/25 at 10:45 a.m., during an interview with the Staffing Coordinator this staff acknowledged that they had not posted the nurse staffing data since 03/17/25. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, and facility document review the facility staff failed to provide the necessary health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care for 1 of 55 residents in the survey sample, resident # 454. The findings included: For resident # 454 (R454) the facility staff failed to involve the resident's family or hospice team in the comprehensive assessment, failed to develop a comprehensive care plan with individualized interventions, and failed to follow the care plan. R454's diagnoses according to the facility diagnoses sheet, included but were not limited to, other seizures, chronic obstructive pulmonary disease, hypertension, anxiety, heart failure, personal history of suicidal behavior, traumatic brain injury, major depressive disorder, and vascular dementia with psychotic disturbance. R454's minimum data set (MDS) assessment with an assessment reference date of [DATE] assigned the resident a brief interview for mental status score of 11 out of 15 indicating moderate cognitive impairment. There was no mood indicators captured on the assessment and the only behavior identified was wandering which occurred one to three days during the lookback period. Under the section for preferences for customary routine and activities, R454 had many activities coded as being very important. They included listening to music, being around animals or pets, keeping up with the news, doing things in groups, participating in religious activities, having snacks and using the phone in private and having family or a close friend involved in discussions about care. R454 was coded as requiring maximum assistance for toileting, bathing, dressing, bed mobility, transfers and standing and was not ambulatory in the lookback period. Under Section Q Participation in Assessment and Goal Setting only the resident was coded as a participant. The Activities-Initial Review document with an effective date of [DATE] was reviewed. The document read in part, Resident has a nice personality, loves to talk likes to sit in day room tires easily hospice care needs encouragement to attend events of choice w/escorts assistance with games and crafts loves animals pet therapy when available. The document was marked with yes for all the following questions: C.1. Does the resident wish to participate in Activities while in the home? 2. Does the resident wish to participate in group Activities? 4. Does the resident wish 1:1 with staff? 5. Does the resident like independent Activities (reading, puzzles, etc.)? Question 3 regarding going on outings was marked no. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan was reviewed. R454's care plan included a problem statement that read, Resident is hospice and has had an atypical change in behavior/development of behavior physically and verbally aggressive towards staff and other residents, increase anxiety, wandering into other resident's rooms and toward exit doors, etc . [DATE]-Continues with physical and verbal aggression to staff and other residents. The interventions included, Administer medications as ordered. Monitor/document for side effects and Effectiveness, Anticipate and meet the resident's needs. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. IDT medication review to include hospice provider, pharmacy, etc . PRN, intervene for the safety of resident and others PRN, attempt de-escalation techniques and redirection as available and appropriate, observe behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes, report behaviors PRN and provide referrals PRN. There was no mention of a history of suicide, no mention of a history of physical or sexual abuse or a family history of schizophrenia. None of the preferences from the MDS assessment were incorporated into the behavior care plan. The Activities care plan focus read, needs encouragement for events of choice tires easily loves to TALK needs assistance w/ games & crafts provide pet therapy when available loves animals. The goal read, encourage reminders of events of choice likes to sit in day room socializing Hospice Care. Interventions included, needs encouragement for events of choice tires easily loves to TALK needs assistance w/ games & crafts provide pet therapy when available loves animals, encourage reminders of events of choice likes to sit in day room socializing Hospice Care, Explain to the resident the importance of social interaction, leisure activity time Encourage the resident's participation, Invite/encourage the resident's family members to attend activities with resideorder to support participation. Modify daily schedule, treatment plan PRN to accommodate activity participation, Remind the resident that The resident may leave activities at any time, and is required to stay for entire activity, The resident needs assistance/escort to activity functions, The resident prefers the following TV channels: Old Westerns the Nightly news. There was no mention of music. Resident was a musician and had a guitar in his room per a social services note dated [DATE] at 1:01 PM that read in part, Resident has a wonderful outgoing and positive personality, likes conversation, smiles easily, loves music, plays guitar and has the same in his room, has recorded CD's of gospel music recorded with his wife who passed in 2015 . (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress notes in the clinical record were reviewed. R454 had numerous entries regarding behaviors during their stay at the facility. R454 was receiving hospice services prior to admission to the facility and was admitted there due to the inability to care for themselves at home. Behaviors started a week or more after admission to the facility according to the progress notes. A note dated [DATE] at 5:03 PM read, Resident refused medications all shift after multiple attempts by staff. Resident unable to bear weight when aides in room assisting with changes. Resident using his restroom inside his room and told aides he Owned this building and I'm getting everyone fired. Resident up in wheelchair at this time at the nurse's station. A note documented at 6:52 PM read, Resident up in wheelchair rolling around the hallway on East side. Resident stopped at this nurse's cart and would not let this nurse pass by to provide patient care to other residents. Resident held up a bible in the air and stretched his arm out to both sides and stated No you're not gonna pass you are just standing there doing nothing, so you're fired. Everyone in here is gonna be fired. I own this place. Resident able to be redirected a short ways down the hallway where he stopped and talked with another resident. He grabbed a large hole punch off of the nurses' station and carried it into the dayroom and would not put it down. Resident then rolled down the hallway and grabbed the electrical cord from an oxygen concentrator. When CNA (certified nursing assistant) on staff attempted to redirect him from wrapping the cord around his hand several times, resident grabbed a fist full of CNA's hair and jerked her head downwards and was agitated at CNA's visible tattoos on her forearms. Resident stated multiple times That ink is blood and you're taking good blood away from people that need it. Resident then picked up the o2 concentrator and hit same CNA on the ankle with it. Other staff was able to intervene and place the o2 concentrator in a locked room. Resident attempting multiple times to get out of the side door down 100 hall. Hospice called and on call supervisor called and alerted of resident's behaviors. A note documented at 7:06 PM read, Resident grabbed two CNA's arms at the wrist and twisted both their arms and shook. Resident able to be redirected from twisting staff's arms after a short time. A note documented at 8:20 PM read, This nurse observed resident twisting the arm of CNA staff and pulling the sleeve of her hoodie not letting her go, resident was allegedly trying to attack another resident according to CNA. This nurse observed resident yelling and arguing with CNA staff. This nurse removed CNA from incident and was attempting to redirect this resident by taking him in his wheelchair to a quieter area. This nurse stated very calmly to resident (R454 name omitted), let's not do this. Please don't hit women, let's go back to your room. Resident initially was agreeing to go but resident then placed feet down firmly on the ground causing the wheelchair to stop, resident then leaned backwards reaching towards this nurse. This nurse was wearing hooded clothing at the time, resident grabbed this nurse by the hood of the hoodie while leaning back. This nurse tried to pull away from him causing my clothing to rip and the wheelchair to lean back. Resident then used his fingernails to scratch this nurse's neck and then placed his left thumb into this nurses' left eye causing this nurse to let go of the wheelchair which in turn caused resident to fall from the chair. Resident assessed for injuries. Resident does have contusion to the back of head, no other injuries present. Resident denying pain and discomfort at this time, vital signs were obtained by CNA and Hospice staff. All vital signs within normal limits. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A hospice note dated [DATE] read in part, Facility called the on-call services and stated the patient was having behaviors and had refused his medications all day. The staff reported that he had hit staff members and made threats towards other residents. The patient had been in his wheelchair, one male staff member tried to get him to his room to have a place that was quiet. When he moved the chair forward the patient pushed it backwards and flipped the chair. He has a large hematoma on the back of his head, no open areas noted. Neuro checks WNL (within normal limits). Ice pack applied. Pain in that area rated a 3 out of 10. Patient is alert and oriented. Talked with this nurse with no behaviors noted. The facility had called 911 and the EMT's arrived at the facility approximately 2 minutes prior to this nurse. Patient did not refuse questions from the EMT nor was he combative during their assessment. His medication nurse (name omitted) was in the room during the visit. When ask by this nurse if he would take his medications he agreed. The facility nurse was asked three different times to get the patient's scheduled medications, and she refused stating, I'm not giving his medications because he's going out. The patient stated multiple times that he didn't want to go out to the hospital but remained calm the entire time. The facility administrator (name omitted) had arrived at the facility and stated it was facility policy that a patient be sent to the ER for evaluation if they exhibited aggressive behaviors. This nurse offered to stay with patient for a few hours to ensure he remained calm, but the facility staff refused, and the patient was transported out to (name of hospital omitted) ER. The hospice director was contacted and report provided. She spoke via phone with the facility administrator however the circumstances didn't change. This nurse called ER and spoke with the supervisor to give report. She stated that patient had just arrived but seemed calm, no aggression noted. She asked the EMT's if he had any behaviors during transport, they stated he had remained calm throughout their encounter including their assessment at the facility . On [DATE] at 2:09 PM this surveyor interviewed the above hospice nurse via telephone and asked about this visit. They stated, I had already been there once earlier in the day, not to see him but another patient and he was fine but that evening they called me three or four times and I had told them the first time I was coming. The last time the nurse called she said. Well now he's fell. I went to the room and the rescue squad was there. They said he was going out. I told them no; we need to try to keep him here if he doesn't want to go. The nurse was outside the door and said nobody can handle him, and he's fell and hit the back of his head. But he was fine. His vital signs were fine, no problems, no behaviors or anything. I asked the EMT's why are we taking him out? They said because the staff said he was agitated, and maybe he was, but he wasn't with the EMT's or me, and they hadn't given him his Seroquel. It was due several hours earlier from what I remember. I asked him if he would take it, and he said he would, but I had to ask that nurse three times to get it. She would not get it; said she wasn't going to give it because he was going out. She finally got the medicine, and I took it in there and he took it and thanked me. They said he was threatening others, but he was fine the whole time, and I offered to stay and sit with him for several hours, or as long as it took, but they would not listen and would not let him stay. He didn't want to go. When I asked him how he fell, he said, that boy did it. The administrator (name omitted) came in and I tried to talk to her too, but she put her hand up in my face, like talk to the hand you know. Our (Hospice Director) called too and tried to talk to her, but she wouldn't listen. She said the facility policy was that he had to go out. Then they gave him a 30-day discharge notice and we had to find somewhere else for him to go. They didn't try with him. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:28 AM this surveyor met with the current Administrator who started [DATE]. When asked if there was a policy that stated residents had to go to the ER when they had behaviors they stated, It's not a policy but there is a section in the admission agreement that speaks to it. I wasn't here when it all started but came just a day or so later. We found out from hospice that he had a substantial psych history that we did not know about at first and we would not have taken him if we had known. We couldn't meet his needs; he was having altercations with staff and other residents. We tried to come up with a plan, hospice arranged for him to go GIP (general in-patient hospitalization) but they didn't keep him. Surveyor asked what happened on [DATE] that caused the facility to issue R454 a 30-day discharge notice they stated, We got the new information of his history from hospice. He had attempted suicide and had some history of abuse and other serious diagnoses. When asked if there were behaviors during or after the meeting that contributed to that decision they stated, No, when we learned the extent of his history, we knew we couldn't meet his needs. This surveyor asked if the facility had any geriatric psych services available to come in and see residents and they stated that they did contract with a service. When asked if R454 had been referred for services they stated they didn't think so. There was no documentation located in the record that any such services had been sought. On [DATE] at 12:20 PM this surveyor interviewed the hospice Executive Director. When asked about R454, they stated, We had a call with the facility on a Monday morning after that the GIP stay to come up with a plan. They didn't keep him under GIP because he had no behaviors, he was there overnight. He did have a psych hospitalization history, for paranoia per his daughter. The facility said if we had the proper diagnosis, we could get the proper medications in there, so we got the psych notes from 2019 when he was in the psych ward in (hospital name omitted). He had stabbed himself in the abdomen. He had major depressive disorder, major neuro cognitive disorder with delusional disorder being ruled out. He was physically and sexually abused as a child and had a brother with schizophrenia. They (facility) said if we started Zyprexa and worked together to manage him it would be fine. We agreed to increase our visits to daily and work on getting some sort of psych services in to see him. We had a plan we thought everyone felt good about. We felt really good after the call, and thought things would turn around, but less than 2 hours later, I called back to tell them something else maybe about the new medication orders, and (Administrator) said they were serving a 30-day notice of discharge, and they were giving it to the patient because he had not been deemed incapacitated. I couldn't believe it. He didn't sign himself in but they were making him sign his 30 day discharge notice and were not even going to call his daughter. I don't think they would have called us either. We notified the daughter what was happening. He (Administrator) said the corporate office said to discharge him and that is what they are doing. I asked what happened did he do something else in the time between our calls, and he said it was due to what we told them about his history. We were able to get placement for him but that facility is where he wanted to be and where he had community ties and support to visit him. She stated that in her professional opinion R454's death was hastened by the move and that the rapid decline could have been delayed if the facility would have worked with them to manage his behaviors instead of against them. She stated that R454's daughter had appealed the discharge but when the other facility notified them that they would take him, they decided to go ahead with the move, Because at that point, we felt like we shouldn't trust that he would be allowed to live there comfortably, and if they didn't win the appeal, this bed may have been gone and he wouldn't have had a place to go. He obviously couldn't go home alone and that was apparently the facility's plan. She stated that R454 died four days after moving to the other facility. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to hospice notes Seroquel (an antipsychotic medication that balances the levels of hormones in the brain to help regulate mood, behaviors and thoughts) 25 mg twice daily was ordered on [DATE] for anxiety and agitation but was not entered onto the facility's medication administration record (MAR) until [DATE]. Zyprexa (another antipsychotic medication) 5 mg three times daily as needed for anxiety and agitation was ordered [DATE] but not put on the MAR until [DATE] and given only one time on [DATE], and Ativan 0.5 mg every 4 hours as needed for anxiety and agitation was ordered on [DATE], not added to the MAR until [DATE] and never administered despite ongoing behaviors. A note on [DATE] at 12:00 PM read, education was attempted to be given to resident and resident grabbed nurses arm with medicine and squeezed it tightly threatening that he owns this place and He will get her and show her how it is. Nurse then went to get unit Manager while leaving resident with another nurse and told her what happened. Unit Manager then came to talk to resident, and he threatened to break her knee caps. He then told the administrator who accompanied the unit Manager he will take him outside and show him how it is because he looks wimpy. Resident continues to go into other residents' rooms and threaten them, attempting to physically assault them, and preaching the gospel because we are all sinners. This surveyor reviewed the Facility Assessment which read in part, (facility name omitted) may accept residents with, or continue to provide care for residents that may develop the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management. Each resident is assessed and reviewed on an individual basis. Psychiatric/Mood Disorders: Psychosis (Hallucinations, Delusions, etc.), impaired cognition, mental disorder, depression, bipolar disorder (i.e., mania/depression), schizophrenia, post-traumatic stress disorder, anxiety disorder, behavior that needs interventions. R454 was served a 30-day notice of discharge on [DATE] that read the facility could not meet his needs. The policy entitled, Behavioral Health Services with a revised date of [DATE] was reviewed. The document read in part, Policy Explanation and Compliance Guidelines: 1. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorder. 2. The facility uses the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. 3. The resident and family are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as appropriate. The care plan shall: a. Be person-centered, b. Provide for meaningful activities which promote engagement and positive, meaningful relationships; c. Reflect the residents goals for care, d. Account for the resident's experiences and preferences, and e. Maximize the resident's dignity, autonomy, privacy, socialization, independence, and safety. On [DATE] at 9:15 AM this surveyor interviewed the Activities Director regarding R454. She stated she doesn't really remember the resident well. Asked her to provide me with a copy of his Activity Logs for the duration of his stay. The log was blank except for [DATE], the same day her assessment was done. Stated she had nothing for September documented. She stated if he had refused she thinks she would have remembered. Said she thinks his family was here a lot and he might have slept a lot but really is not sure, I just don't really remember him much. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For R454, the facility staff failed to appropriately assess and treat a hospice patient with a history of trauma, by involving the family in the comprehensive admission assessment and administering medications ordered by the provider for paranoia and agitation. R454's diagnoses according to the facility diagnoses sheet, included but were not limited to, other seizures, chronic obstructive pulmonary disease, hypertension, anxiety, heart failure, personal history of suicidal behavior, traumatic brain injury, major depressive disorder, and vascular dementia with psychotic disturbance. R454's minimum data set (MDS) assessment with an assessment reference date of [DATE] assigned the resident a brief interview for mental status score of 11 out of 15 indicating moderate cognitive impairment. There was no mood indicators captured on the assessment and the only behavior identified was wandering which occurred one to three days during the lookback period. Under the section for preferences for customary routine and activities, R454 had many activities coded as being very important. They included listening to music, being around animals or pets, keeping up with the news, doing things in groups, participating in religious activities, having snacks and using the phone in private. R454 was coded as requiring maximum assistance for toileting, bathing, dressing, bed mobility, transfers and standing and was not ambulatory in the lookback period. No family participated in the assessment. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The clinical record was reviewed. R454 had numerous entries regarding behaviors during their stay at the facility. R454 was receiving hospice services prior to admission to the facility and was admitted there due to the inability to care for themselves at home. Behaviors started a week or more after admission to the facility according to the progress notes. A note dated [DATE] at 5:03 PM read, Resident refused medications all shift after multiple attempts by staff. Resident unable to bear weight when aides in room assisting with changes. Resident using his restroom inside his room and told aides he Owned this building and I'm getting everyone fired. Resident up in wheelchair at this time at the nurse's station. A note documented at 6:52 PM read, Resident up in wheelchair rolling around the hallway on East side. Resident stopped at this nurse's cart and would not let this nurse pass by to provide patient care to other residents. Resident held up a bible in the air and stretched his arm out to both sides and stated No you're not gonna pass you are just standing there doing nothing, so you're fired. Everyone in here is gonna be fired. I own this place. Resident able to be redirected a short ways down the hallway where he stopped and talked with another resident. He grabbed a large hole punch off of the nurses' station and carried it into the dayroom and would not put it down. Resident then rolled down the hallway and grabbed the electrical cord from an oxygen concentrator. When CNA (certified nursing assistant) on staff attempted to redirect him from wrapping the cord around his hand several times, resident grabbed a fist full of CNA's hair and jerked her head downwards and was agitated at CNA's visible tattoos on her forearms. Resident stated multiple times That ink is blood and you're taking good blood away from people that need it. Resident then picked up the o2 concentrator and hit same CNA on the ankle with it. Other staff was able to intervene and place the o2 concentrator in a locked room. Resident attempting multiple times to get out of the side door down 100 hall. Hospice called and on call supervisor called and alerted of resident's behaviors. A note documented at 7:06 PM read, Resident grabbed two CNA's arms at the wrist and twisted both their arms and shook. Resident able to be redirected from twisting staff's arms after a short time. A note documented at 8:20 PM read, This nurse observed resident twisting the arm of CNA staff and pulling the sleeve of her hoodie not letting her go, resident was allegedly trying to attack another resident according to CNA. This nurse observed resident yelling and arguing with CNA staff. This nurse removed CNA from incident and was attempting to redirect this resident by taking him in his wheelchair to a quieter area. This nurse stated very calmly to resident (R454 name omitted), let's not do this. Please don't hit women, let's go back to your room. Resident initially was agreeing to go but resident then placed feet down firmly on the ground causing the wheelchair to stop, resident then leaned backwards reaching towards this nurse. This nurse was wearing hooded clothing at the time, resident grabbed this nurse by the hood of the hoodie while leaning back. This nurse tried to pull away from him causing my clothing to rip and the wheelchair to lean back. Resident then used his fingernails to scratch this nurse's neck and then placed his left thumb into this nurses' left eye causing this nurse to let go of the wheelchair which in turn caused resident to fall from the chair. Resident assessed for injuries. Resident does have contusion to the back of head, no other injuries present. Resident denying pain and discomfort at this time, vital signs were obtained by CNA and Hospice staff. All vital signs within normal limits. This surveyor reviewed the facility investigation into the [DATE] events. A statement by Certified Nursing Assistant (CNA) # 1 read in part, .that's when (nurses name omitted) stepped between (CNA) and (R454) and grabbed him (R454) by his arm and pushed him up against the nurses' station and told him to calm down. (R454) still wouldn't calm down so (nurse) grabbed his wheelchair and started taking him down the hall but (R454) wouldn't pick his feet up so he (nurse) stomped on the pedal on the back of the chair and got him (R454) on two wheels and went down the hall. (R454) started hitting (nurse) in the face and (nurse) dropped the chair resulting in (R454) hitting his head on the floor. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA # 1 was interviewed on [DATE] and there was no change in their statement. They stated to surveyors that the nurse got in (R454's) face, like really close while he was holding his arms. This surveyor asked if he was nose to nose with resident and CNA #1 stated, yeah, it was pretty close. The facility investigation led to the termination of the nurse involved in the [DATE], incident. A hospice note dated [DATE] read in part, Facility called the on-call services and stated the patient was having behaviors and had refused his medications all day. The staff reported that he had hit staff members and made threats towards other residents. The patient had been in his wheelchair, one male staff member tried to get him to his room to have a place that was quiet. When he moved the chair forward the patient pushed it backwards and flipped the chair. He has a large hematoma on the back of his head, no open areas noted. Neuro checks WNL (within normal limits). Ice pack applied. Pain in that area rated a 3 out of 10. Patient is alert and oriented. Talked with this nurse with no behaviors noted. The facility had called 911 and the EMT's arrived at the facility approximately 2 minutes prior to this nurse. Patient did not refuse questions from the EMT nor was he combative during their assessment. His medication nurse (name omitted) was in the room during the visit. When ask by this nurse if he would take his medications he agreed. The facility nurse was asked three different times to get the patient's scheduled medications, and she refused stating, I'm not giving his medications because he's going out. The patient stated multiple times that he didn't want to go out to the hospital but remained calm the entire time. The facility administrator (name omitted) had arrived at the facility and stated it was facility policy that a patient be sent to the ER for evaluation if they exhibited aggressive behaviors. This nurse offered to stay with patient for a few hours to ensure he remained calm, but the facility staff refused, and the patient was transported out to (name of hospital omitted) ER. The hospice director was contacted and report provided. She spoke via phone with the facility administrator however the circumstances didn't change. This nurse called ER and spoke with the supervisor to give report. She stated that patient had just arrived but seemed calm, no aggression noted. She asked the EMT's if he had any behaviors during transport, they stated he had remained calm throughout their encounter including their assessment at the facility . (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:09 PM this surveyor interviewed the above hospice nurse via telephone and asked about this visit. They stated, I had already been there once earlier in the day, not to see him but another patient and he was fine but that evening they called me three or four times and I had told them the first time I was coming. The last time the nurse called she said. Well now he's fell. I went to the room and the rescue squad was there. They said he was going out. I told them no; we need to try to keep him here if he doesn't want to go. The nurse was outside the door and said nobody can handle him, and he's fell and hit the back of his head. But he was fine. His vital signs were fine, no problems, no behaviors or anything. I asked the EMT's why are we taking him out? They said because the staff said he was agitated, and maybe he was but he wasn't with the EMT's or me and they hadn't given him his Seroquel. It was due several hours earlier from what I remember. I asked him if he would take it, and he said he would, but I had to ask that nurse three times to get it. She would not get it; said she wasn't going to give it because he was going out. She finally got the medicine, and I took it in there and he took it and thanked me. They said he was threatening others, but he was fine the whole time, and I offered to stay and sit with him for several hours, or as long as it took, but they would not listen and would not let him stay. He didn't want to go. When I asked him how he fell, he said, that boy did it. The administrator (name omitted) came in and I tried to talk to her too, but she put her hand up in my face, like talk to the hand you know. Our (Hospice Director) called too and tried to talk to her, but she wouldn't listen. She said the facility policy was that he had to go out. Then they gave him a 30-day discharge notice and we had to find somewhere else for him to go. On [DATE] at 10:28 AM this surveyor met with the current Administrator who started [DATE]. When asked if there was a policy that stated residents had to go to the ER when they had behaviors they stated, It's not a policy but there is a section in the admission agreement that speaks to it. I wasn't here when it all started but came just a day or so later. We found out from hospice that he had a substantial psych history that we did not know about at first and we would not have taken him if we had known. We couldn't meet his needs; he was having altercations with staff and other residents. We tried to come up with a plan, hospice arranged for him to go GIP (general in-patient hospitalization) but they didn't keep him. Surveyor asked what happened on [DATE] that caused the facility to issue R454 a 30-day discharge notice they stated, We got the new information of his history from hospice. He had attempted suicide and had some history of abuse and other serious diagnoses. When asked if there were behaviors during or after the meeting that contributed to that decision they stated, No, when we learned the extent of his history, we knew we couldn't meet his needs. This surveyor asked if the facility had any geriatric psych services available to come in and see residents and they stated that they did contract with a service. When asked if R454 had been referred for services they stated they didn't think so. There was no documentation in the record that any such services had been sought. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:20 PM this surveyor interviewed the hospice Executive Director. When asked about R454, they stated, We had a call with the facility on a Monday morning after that the GIP stay to come up with a plan. They didn't keep him under GIP because he had no behaviors, he was there overnight. He did have a psych hospitalization history, for paranoia per his daughter. The facility said if we had the proper diagnosis, we could get the proper medications in there, so we got the psych notes from 2019 when he was in the psych ward in (hospital name omitted). He had stabbed himself in the abdomen. He had major depressive disorder, major neuro cognitive disorder with delusional disorder being ruled out. He was physically and sexually abused as a child and had a brother with schizophrenia. They (facility) said if we started Zyprexa and worked together to manage him it would be fine. We agreed to increase our visits to daily and work on getting some sort of psych services in to see him. We had a plan we thought everyone felt good about. We felt really good after the call and thought things would turn around, but less than 2 hours later, I called back to tell them something else maybe about the new medication orders, and (Administrator) said they were serving a 30-day notice of discharge, and they were giving it to the patient because he had not been deemed incapacitated. I couldn't believe it. He didn't sign himself in but they were making him sign his 30 day discharge notice and were not even going to call his daughter. I don't think they would have called us either. We notified the daughter what was happening. He (Administrator) said the corporate office said to discharge him and that is what they are doing. I asked what happened did he do something else, and he said it was due to what we told them about his history. We were able to get placement for him but that is where he wanted to be and where he had community ties and support to visit him. She stated that in her professional opinion R454's death was hastened by the move and that the rapid decline could have been delayed if the facility would have worked with them to manage his behaviors instead of against them. She stated that R454's daughter had appealed the discharge but when the other facility notified them that they would take him, they decided to go ahead with the move, Because at that point, we felt like we shouldn't trust that he would be allowed to live there comfortably and if they didn't win the appeal, this bed may have been gone and he wouldn't have had a place to go. He obviously couldn't go home alone and that was apparently the facility's plan. She stated that R454 died four days after moving to the other facility. The care plan was reviewed. R454's care plan included a problem statement that read, Resident is hospice and has had an atypical change in behavior/development of behavior physically and verbally aggressive towards staff and other residents, increase anxiety, wandering into other resident's rooms and toward exit doors, etc . [DATE]-Continues with physical and verbal aggression to staff and other residents. The interventions included, Administer medications as ordered. Monitor/document for side effects and Effectiveness, Anticipate and meet the resident's needs. Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by. IDT medication review to include hospice provider, pharmacy, etc . PRN, intervene for the safety of resident and others PRN, attempt de-escalation techniques and redirection as available and appropriate, observe behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes, report behaviors PRN and provide referrals PRN. There was no mention of a history of suicide, no mention of a history of physical or sexual abuse or a family history of schizophrenia. None of the preferences from the MDS assessment were incorporated into the behavior care plan. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:57 PM this surveyor interviewed the hospice social worker. When asked about R454 and the meeting on [DATE] they stated, Yes I was in that meeting, I was there in person. We all agreed, and I felt really good about the plan we came up with and we had agreed to meet again in a week and see how things were going. When I left, I thought it was really productive and that everything would work out. It was a total shock and like a slap in the face, they didn't even give it a try. They undermined everything we talked about and discussed in that meeting. She stated the team had discussed increasing the hospice visits, getting psychiatric services in and medication changes. She stated that she thought R454's behaviors were mostly verbal stuff, he talked about what he would do or what he could do, but he never hurt anyone to my knowledge. He had a rapid and significant decline that started before he left and was probably exacerbated by the move. According to hospice notes Seroquel (an antipsychotic medication that balances the levels of hormones in the brain to help regulate mood, behaviors and thoughts) 25 mg twice daily was ordered on [DATE] for anxiety and agitation but was not entered onto the facility's medication administration record (MAR) until [DATE]. Zyprexa (another antipsychotic medication) 5 mg three times daily as needed for anxiety and agitation was ordered [DATE] but not put on the MAR until [DATE] and given only one time on [DATE], and Ativan 0.5 mg every 4 hours as needed for anxiety and agitation was ordered on [DATE], not added to the MAR until [DATE] and never administered despite ongoing behaviors. A note on [DATE] at 12:00 PM read, education was attempted to be given to resident and resident grabbed nurses arm with medicine and squeezed it tightly threatening that he owns this place and He will get her and show her how it is. Nurse then went to get unit Manager while leaving resident with another nurse and told her what happened. Unit Manager then came to talk to resident, and he threatened to break her knee caps. He then told the administrator who accompanied the unit Manager he will take him outside and show him how it is because he looks wimpy. Resident continues to go into other residents' rooms and threaten them, attempting to physically assault them, and preaching the gospel because we are all sinners. This surveyor reviewed the Facility Assessment which read in part, (facility name omitted) may accept residents with, or continue to provide care for residents that may develop the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management. Each resident is assessed and reviewed on an individual basis. Psychiatric/Mood Disorders: Psychosis (Hallucinations, Delusions, etc.), impaired cognition, mental disorder, depression, bipolar disorder (i.e., mania/depression), schizophrenia, post-traumatic stress disorder, anxiety disorder, behavior that needs interventions. R454 was served a 30-day notice of discharge on [DATE] that read the facility could not meet his needs. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The policy entitled, Behavioral Health Services with a revised date of [DATE] was reviewed. The document read in part, Policy Explanation and Compliance Guidelines: 1. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorder. 2. The facility uses the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. 3. The resident and family are included in the comprehensive assessment process along with the interdisciplinary team and outside sources, as appropriate. The care plan shall: a. Be person-centered, b. Provide for meaningful activities which promote engagement and positive, meaningful relationships; c. Reflect the residents goals for care, d. Account for the resident's experiences and preferences, and e. Maximize the resident's dignity, autonomy, privacy, socialization, independence, and safety. On [DATE] at 12:44 PM the survey team met with the Administrator, Interim Director of Nursing, Assistant Director of Nursing and the Regional Nurse support. This concern was discussed with them at that time. On [DATE] at 11:09 AM the survey team met with the Regional Director of Clinical Services (RDCS) and the Regional [NAME] President of Operations, and this concern was discussed. No further information was provided to the survey team prior to the exit conference. Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a resident who displays or is diagnosed with a mental disorder or psychosocial adjustment difficulty or has a history of trauma receives appropriate treatment and services to correct the assessed problem or attain the highest practicable mental and psychosocial well-being for 2 of 55 sampled residents (Resident #93 and Resident #454). The survey team informed the facility on [DATE] at 1:47 PM of the Immediate Jeopardy situation for Resident #93 and Resident #454. The scope and severity were originally cited at a Level IV, isolated. On [DATE] at 6:00 PM, the Immediate Jeopardy was abated and lowered to a Level III, isolated. The findings included: 1. For Resident #93, the facility staff failed to provide appropriate treatment and services following increased symptoms of a mental disorder including auditory/visual hallucinations, delusions, threatening another resident, suicidal ideation, and ongoing psychosis. The facility failed to appropriately address a [DATE] Pre-admission Screening and Resident Review (PASARR) determining Resident #93 did not meet psychiatric stability for nursing facility placement and recommended inpatient psychiatric hospitalization. As of [DATE], Resident #93 remained in the facility without a psychiatric evaluation for inpatient treatment. Resident #93's diagnosis list indicated diagnoses, which included, but not limited to Psychosis, Major Depressive Disorder, Generalized Anxiety Disorder, Convulsions, Metabolic Encephalopathy, Hypertensive Encephalopathy, and Cerebral Infarction. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The minimum data set (MDS) with an assessment reference date (ARD) of [DATE] assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 indicating the resident was moderately cognitively impaired. There were no mood indicators captured on the assessment and coded behaviors included delusions and wandering. Resident #93 was coded as requiring moderate assistance for bathing and supervision/touching assistance for toileting, dressing, personal hygiene, and walking. Resident #93 was coded as being independent with bed mobility and standing. A [DATE] Social Services Assessment and Data Collection described Resident #93 as being suspicious during interviews and expressing thoughts consistent with delusions. The assessment documented a reported history by friends of the resident having altered thoughts and behaviors. The friends stated they have tried to help him and are unaware of any family. A [DATE] 3:00 PM nursing progress note read in part Communication with resident's friend [name omitted] on this date. [Friend] states resident lived with her .prior to entering facility. [Friend] states resident has an extensive hx [history] of drug abuse .[Friend] stated she is scared of resident because he has threatened to kill her . A [DATE] 5:04 PM nursing progress note read in part Resident came into this nurses office at this time and began asking what my name is when this nurse stated her name resident begins talking irrationally and states that he knew someone by the same name but 'She's not here anymore because I killed her.' Resident began stating that the devil is in the room and that he is coming for us all. Resident continues speaking erratically until he exits room. Resident #93 was initially seen by the psychiatric nurse practitioner (NP) on [DATE]. The progress note read in part .Patient has a history of psychiatric hospitalizations, including a stay at a facility in [name omitted] and [name omitted] per his report but cannot verbalize the reasoning .Patient has a history of being in jail and penitentiaries, with four instances of being in prison. The reasons for these incarcerations are unclear, but one instance involved a threat to burn down a church .He denies any suicidal ideations stating, 'I would hurt someone else before I would hurt myself.' He states he 'would find the nearest airport and crash an airplane into this building and kill everyone.' Staff also reports that the patient asked when the next church service would be and that he would attend 'and burn the church down' .Patient is extremely delusional with paranoid thoughts and experiencing visual/auditory hallucinations. It is unclear of his history or accurate treatment . Appears Manic .Patient IS currently a danger to self/others .The patient's presentation suggests a possible psychotic disorder. He reported auditory hallucinations .He also mentioned a history of visual hallucinations . a psychiatric evaluation by an inpatient facility is warranted to further assess his mental status and confirm psychiatric history .Initiate Haldol 10 mg PO [by mouth] BID [twice a day] .Start Vistaril 25 mg PO BID PRN [as needed] x 14 days . Resident #93 was sent to the emergency room (ER) on [DATE] for evaluation/medical clearance and returned to the facility later the same day. The ER record dated [DATE] read in part .The patient appears in no acute distress .Patient has no thoughts/intents to harm self or others .Based on patient's history, exam, and evaluation, there is no indication for emergent intervention or admission .mental health symptoms appear to be from recent CVA .patient does not meet criteria for hospitalization, a TDO [temporary detention order] is not recommended, and patient is okay to be discharged back to nursing facility . (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], Resident #93 reported to a physical therapy staff member that he would wrap a therapy band around his roommate's neck. On [DATE] at 9:00 AM, surveyor spoke with the Occupational Therapist (OT) who stated Resident #93 asked what would happen if he took this (referring to a therapy band) and wrapped it around his roommate's neck. OT stated that she informed the resident that was inappropriate and then he stated he was just kidding. OT stated the roommate was not present at the time. Resident #93's clinical record failed to provide evidence of any immediate actions taken to ensure the roommate's safety. On [DATE], the medical provider requested Resident #93 be moved to a room by himself. Resident #93 was moved to a private room on [DATE], two days following the statement. On [DATE] at 4:11 PM, surveyor spoke with the Social Worker (SW) regarding the Resident #93's threat towards his roommate; SW stated she was unaware of this. SW returned to the surveyor at 5:16 PM and stated the OT note does not reference this behavior and the Director of Nursing (DON) spoke to the roommate on [DATE] about a room change. Surveyor reviewed the roommate's (Resident #101) clinical record which revealed a nursing progress note dated [DATE] at 1:20 PM which read in part Writer spoke with resident today with clinical team present regarding his voice concern of his safety while staying in the room with his room mate [sic]. Resident was asked if he would liked [sic] to be moved to another room. Resident replies 'Why do I need to move? I'm ok in this room.' I asked if he still felt as if he was not safe in the room with his room mate [sic]? Resident replied 'Yes I am ok I don't need to move rooms I'm ok with him in the room.' This note failed to include if the roommate was aware of the threat made towards him on [DATE]. Surveyor was unable to interview the roommate as they had been discharged and the writer of the note no longer worked at the facility. The psychiatric NP saw Resident #93 on [DATE] and documented the resident reported experiencing hallucinations, specifically mentioning [NAME]. NP ordered Remeron 7.5 mg at bedtime. On [DATE], Resident #93 expressed thoughts of self-harm. A [DATE] 7:41 AM nursing progress note read in part Reported to this nurse that resident had been screaming and yelling most of the night by off going nurse. CNA reported to this nurse that resident stated he was going to kill his self. Spoke to resident, he state that he didn't want to live. Resident put on one to one for his safety . Resident #93 was evaluated by the PA on [DATE] via telehealth and advised that one to one supervision could be discontinued. Surveyor was unable to speak with the PA as they no longer worked for the facility. Resident #93 was seen by the psychiatric NP on [DATE], the progress note read in part .the patient's behavior remains a concern. The caregiver reports that the patient refuses to use a wheelchair or walker and often ends up crawling on the floor. The patient also exhibits signs of distress, such as yelling and crying, and calls out for their mother. The patient's behavior was particularly challenging the day before the visit, with the caregiver describing it as 'horrible' .Initiate Lexapro 10 mg every morning .Continue Remeron (continued on next page)

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Mountain Laurel Rehabilitation and Nursing	514 North Main Street Rural Retreat, VA 24368

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #93 was seen by the PA on [DATE], the progress note read in part .seen today due to resident's increased behaviors and wandering. As per nursing staff, resident has wandering the hallways more frequently, and demonstrating increasing abnormal behavior. Resident mumbles incoherently often, and repeats the word mamaw or mama. When speaking to resident, he will break his incoherent speech and answer questions appropriately. He was originally admitted status-post CVA [cerebrovascular accident] with multiple areas of ischemic infarcts. When he was admitted , he did not demonstrate this type of behavior, and demonstrated more paranoia and delusional language, and even verbally aggressive speech, although resident never became physically aggressive towards any staff or residents. He was seen by the in house behavioral health provider, and stated that he was once on Haldol for his behaviors, and he was then restarted on Haldol 10mg PO BID for his behaviors. However, through close observation, Haldol appeared to make the resident withdrawn and somnolent, so this medication was slowly tapered and then discontinued. Since discontinuation, resident has become more alert, but is demonstrating more incoherent speech, repeating mamaw or mama more often, and is wondering around the hallways more often now. He continues to eat and drink, but uses his hands for eating now instead of utensils. He does not demonstrate any verbally aggressive language anymore, and has not had any seizures while in facility .His current behavioral health medications are as follows: Lexapro 10mg by mouth once daily, Mirtazapine 7.5mg by mouth at bedtime, and Divalproex Sodium oral tablet 250mg twice daily for seizure disorder/mood stabilization . At this time, plan is to refer resident to the [name omitted] Behavioral Health Facility for further behavioral health management . A Preadmission Screening and Resident Review (PASARR) Level II was completed for Resident #93 on [DATE]. The summary of findings documented in part . [Resident #93][TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure medical provider ordered medications were available for administration for 3 of 55 sampled residents (Resident #354, Resident #356, and Resident #9). The findings included: 1. For Resident #354, the facility staff failed to ensure the antibiotic Rocephin (Ceftriaxone Sodium) was available for administration. Resident #354's diagnosis list indicated diagnoses, which included, but not limited to Neuropathy, Type 2 Diabetes Mellitus, Alzheimer's Disease, and Atrial Fibrillation. The minimum data set (MDS) with an assessment reference date (ARD) of 1/13/25 assigned the resident a brief interview for mental status (BIMS) summary score of 13 out of 15 indicating the resident was cognitively intact. A review of the clinical record revealed Resident #354 was seen by the medical provider on 3/03/25, the progress note read in part .Staff concerned that patient is more lethargic today .Plan: Lethargic rule out urinary tract infection. Patient has history of urinary tract infections. Most recent in January sensitive to cephalosporins treated with Rocephin. Will start Rocephin IM 1 g every 24 hours x 5 days . An order for Rocephin (Ceftriaxone Sodium) 1 gram intramuscularly every 24 hours for urinary tract infection for 5 days was entered for Resident #354 on 3/03/25 at 1:42 PM. A review of Resident #354's March 2025 Medication Administration Record (MAR) revealed Rocephin (Ceftriaxone Sodium) was not administered as ordered on 3/04/25. On 3/12/25 at 10:48 AM, surveyor spoke with the Assistant Director of Nursing (ADON) who stated the Rocephin (Ceftriaxone Sodium) was placed on hold because it was not available in the Cubex (in-house medication supply). ADON stated staff used the last available dose on 3/03/25. The ADON provided a Cubex report indicating staff attempted to obtain Rocephin (Ceftriaxone Sodium) on 3/04/25 however none was available. According to the report a vial was removed for Resident #354 on 3/03/25. Prior to 3/03/25, a vial was removed on 2/21/25. On 3/12/25 at 1:55 PM, surveyor spoke with the ADON and asked why the Rocephin (Ceftriaxone Sodium) was not requested on a STAT run, she stated a STAT run often takes several hours and the medication was placed on hold until it arrived. On 3/12/25 at 4:24 PM, the Director of Nursing (DON) stated when the inventory of a medication in the Cubex reached a count of three, the pharmacy was alerted to restock the medication. The facility was unable to provide evidence of a restock of Rocephin (Ceftriaxone Sodium) when the inventory count last reached three. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/25 at 9:02 AM, surveyor accompanied the DON and Unit Manager to the Cubex where the system indicated an available supply of 7 vials of Rocephin (Ceftriaxone Sodium); however, upon inspection, there was none available in the Cubex. Surveyor requested and received the facility policy titled Unavailable Medications with a reviewed/revised date of 12/01/22 which read in part 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn [as needed], and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications . On 3/13/25 at 3:13 PM, the survey team met with the Administrator, Interim Director of Nursing, and Assistant Director of Nursing and discussed the concern of the unavailability of Rocephin (Ceftriaxone Sodium) for Resident #354. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25. 2. For Resident #356, the facility staff failed to ensure the antibiotic Ceftriaxone Sodium (Rocephin) was available for administration. Resident #356's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Obstructive and Reflux Uropathy, Essential Hypertension, and Atrial Fibrillation. The minimum data set (MDS) with an assessment reference date (ARD) of 1/17/25 assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 indicating the resident was moderately cognitively impaired. A review of Resident #356's clinical record revealed a provider order dated 1/13/25 at 6:19 PM for Ceftriaxone Sodium (Rocephin) 1 gram intramuscularly one time only for urinary tract infection. According to Resident #356's January 2025 Medication Administration Record (MAR), the one-time dose of Ceftriaxone Sodium (Rocephin) was not administered until 1/15/25 at 9:21 PM. A nursing progress note dated 1/14/25 at 2:14 AM read Please note that this nurse attempted to pull Ceftriaxone Sodium Injection Solution Reconstituted 1 GM (Ceftriaxone Sodium) from the cubex and there is none at this time. Surveyor requested and received the facility policy titled Unavailable Medications with a reviewed/revised date of 12/01/22 which read in part 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn [as needed], and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications . On 3/12/25 at 4:24 PM, the Director of Nursing (DON) stated when the inventory of a medication in the Cubex reached a count of three, the pharmacy was alerted to restock the medication. On 3/14/25 at 12:45 PM, the survey team met with the Administrator, Interim Director of Nursing, and Assistant Director of Nursing and discussed the concern of the unavailability of Ceftriaxone Sodium (Rocephin) for Resident #356. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25. 3. For Resident #9, the facility staff failed to ensure the medication Lyrica was available for administration. Lyrica is used to treat nerve pain. Resident #9's diagnosis list indicated diagnoses, which included, but not limited to Displaced Fracture of the Right Femur, Chronic Atrial Fibrillation, Restless Leg Syndrome, and Osteoarthritis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/04/25 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #9's current medical provider orders included an order dated 11/26/24 for Lyrica 50 mg by mouth two times a day for pain. A review of Resident #9's January 2025 Medication Administration Record (MAR) revealed Lyrica was not administered on 1/05/25 and the morning dose was not administered on 1/06/25. A 1/05/25 8:28 AM nursing progress note read this nurse called [pharmacy] at 8:22am in regards of residents Lyrica, [name omitted] stated they will need a new script, Nurse called on call provider [name omitted] and she said she will put a new order in and to hold the dose until arrival on pharmacy's first run. A 1/05/25 7:50 PM nursing progress note read in part Lyrica .On order. Awaiting arrival from pharmacy. A 1/06/25 8:38 AM nursing progress note read in part Lyrica .awaiting pharmacy delivery. Resident #9's comprehensive person-centered care plan included a focus area stating the resident was at risk for alteration in comfort related to right femur fracture, restless leg syndrome, and osteoarthritis with an intervention to medicate as ordered. On 4/07/25 at 5:00 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, and Regional [NAME] President of Operations and discussed the concern of Resident #9 not receiving Lyrica as ordered on 1/05/25 and 1/06/25. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25.

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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. 2.For Resident #86 the facility staff failed to provide evidence of the 2/24/25 medication regimen review being reported to and acted upon by the medical provider in a timely manner. Resident #86's diagnosis list indicated diagnoses that included but were not limited to Progressive Multifocal Leukoencephalopathy, Anorexia, Chronic Kidney Disease, Acute Kidney Failure, Anxiety Disorder, Repeated Falls, Ataxia, Acute Respiratory Failure with Hypoxia, and Wasting Disease Syndrome. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/23/25, did not assign the resident a brief interview for mental status (BIMS) summary score for cognitive abilities, but a review of the clinical record revealed resident was assigned 15 out of 15 on the BIMs, which indicated the resident was cognitively intact. Progress notes within R86's clinical record indicated medication regimen reviews (MRRs) were completed by a pharmacist on 2/24/25 and on 3/25/25 with recommendations. Surveyor was unable to locate the 2/24/25 recommendation report in the resident's clinical record. Surveyor requested and received the MRR recommendation report completed by the pharmacist from the director of nursing on 4/8/25. She agreed the MRR dated 2/24/25 had not been acknowledged or signed by a medical provider indicating review. The 2/24/25 Note to Attending Physician/Prescriber read in part .This resident has been taking the following 3 (three) antidepressants: DOXEPIN 10 mg (milligrams) every Evening, CITALOPRAM 40 mg Daily, and TRAZADONE 50 mg QHS (once a day at bedtime) depression since 8/2024 .Resident also takes Hydroxyzine 25 mg QHS Anxiety. Please evaluate the current dose and consider a trial reduction of DOXEPIN . Review of the clinical record revealed the 3/25/25 MRR with a Consultant Pharmacist Medication Regimen Review Recommendations Pending a Final Response report that read in part .This resident has been taking the following 3 (three) antidepressants: DOXEPIN 10 mg (milligrams) every Evening, CITALOPRAM 40 mg Daily, and TRAZADONE 50 mg QHS (once a day at bedtime) depression since 8/2024 .Resident also takes Hydroxyzine 25 mg QHS Anxiety. Please evaluate the current dose and consider a trial reduction of DOXEPIN . Review of the document indicated the medical provider did not check a response but did write the following on the bottom of the form, Discontinue hydroxyzine 25 mg PO (by mouth) Q (every) 24 hours PRN (as needed). This was signed and dated 3/27/25 by the medical provider. On 4/8/25 at 11:41 AM, DON brought surveyor a copy of the 2/24/25 Note to Attending Physician/Prescriber with acknowledgement by the medical provider with the following clinical rational, Hydroxyzine d/c'd (discontinued) 3/27/25. This concern was discussed at the pre-exit meeting on 4/8/25 at 3:00 PM with the administrator, director of nursing, assistant director of nursing, and regional director of clinical services. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received a facility policy titled Addressing Medication Regimen Review Irregularities with a revision date of 12/1/22, which read in part .4. The pharmacist must report any irregularities .the reports must be acted upon . No further information regarding this concern was presented to the survey team prior to the exit on 4/8/25. 3. For Resident #12 the facility staff failed to provide evidence of the 1/25/25 and 2/24/25 medication regimen reviews being reported to and acted upon by the medical provider in a timely manner and the facility staff failed to provide evidence the medication regimen reviews were completed monthly for March 2024, April 2024, and May 2024 by a licensed pharmacist. Resident #12's diagnosis list indicated diagnoses that included but were not limited to Overactive Bladder, Cerebral Infarction, Chronic Kidney Disease-Stage 4, Glaucoma, Depression, Anxiety, Dementia with Psychotic Disturbance, Alzheimer's, and Restlessness and Agitation. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/12/25, assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. Surveyor was unable to locate evidence of medication regimen reviews for the months of March 2024, April 2024, and May 2024. Progress notes within R12's clinical record indicated medication regimen reviews (MRRs) were completed by a pharmacist on 1/25/25, 2/24/25, and 3/25/25 with recommendations. Surveyor was unable to locate the recommendation reports within the resident's clinical record. Surveyor requested and received the MRR recommendation reports completed by the pharmacist from the director of nursing on 4/7/25. The 1/25/25 Note to Attending Physician/Prescriber read in part .This resident is receiving the thyroid drug, LEVOTHYROXINE 25 mcg Daily, without a recent thyroid assessment noted in the chart. Please consider a routine thyroid profile and TSH (thyroid-stimulating hormone) annually to monitor current therapy . A medical provider marked, Agree on the bottom of the document and signed and dated the document on 4/4/25. The 2/24/25 Note to Attending Physician/Prescriber read in part, .This resident has been taking the antipsychotic RISPERIDONE 0.75 mg Twice Daily for MDD (major depressive disorder) since 8/2024 . resident also takes ALPRAZOLAM 0.25 mg QHS Anxiety and REMERON 15 mg QHS and ESCITALOPRAM 20 mg every morning depression. Please evaluate the current dose and consider a trial dose reduction . A medical provider marked, Resident with good response, maintain the current dose on the bottom of the document and provided the rationale, Continue d/to (due to) dementia with psychotic features including SI (suicidal ideations), delusions, & hallucinations. The document was signed by the provider and dated 4/4/25. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another Note to Attending Physician/Prescriber dated 2/24/25 read in part, .The resident has an order for ERYTHROMYCIN Eye Ointment: Instill in Left Eye at Bedtime for INFECTION since 12/2024, which is subject to the stop order policy. Please clarify the order to include a stop date. If it is to be used routinely, an indication for a chronic condition should be documented to support usage . A medical provider marked, Agree on the bottom of the document and wrote, Stop date 4/4/25 and signed and dated the document on 4/4/25. The 3/25/25 Note to Attending Physician/Prescriber read in part .This resident is receiving the thyroid drug, LEVOTHYROXINE 25 mcg Daily, without a recent thyroid assessment noted in the chart. Please consider a routine thyroid profile and TSH annually to monitor current therapy . A medical provider marked, Agree on the bottom of the document and wrote, TSH ordered 4/4/25 and signed the document. On 4/7/25 at 3:19 PM, the director of nursing stated she could not locate MRR reviews for March, April, and May of 2024. This concern was discussed at the pre-exit meeting on 4/8/25 at 3:00 PM with the administrator, director of nursing, assistant director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled Addressing Medication Regimen Review Irregularities with a revision date of 12/1/22, which read in part .2. The medication regimen of each resident must be reviewed by a licensed pharmacist at least once a month .4. The pharmacist must report any irregularities . the reports must be acted upon . No further information regarding this concern was presented to the survey team prior to the exit on 4/8/25. Based on staff interviews, clinical record review, and facility document review, the facility staff failed to complete and/or act upon pharmacist medication regimen reviews (MRRs) for three (3) of 55 sampled residents (Resident #12, Resident #65, and Resident #86). The findings include: 1. The facility staff failed to ensure Resident #65's medical provider promptly responded to a pharmacist's request documented as part of a medication regimen review (MRR). Resident #65's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/25/25, was signed as completed on 3/6/25. Resident #65 was assessed as sometimes able to make self understood and as sometimes able to understand others. Resident #65's Brief Interview for Mental Status (BIMS) summary score was documented as a 00 out of 15; this indicated severe cognitive impairment. Resident #65's clinical record included a MRR dated 9/24/24. This MRR included the following statement: This resident has been taking DEPAKOTE 625 mg TWICE DAILY since 11/2023. Please evaluate the current dose and consider a dose reduction. This document had an area for a medical provider to document, sign, and date their response; this section was not completed. The following information was found in a facility document titled Addressing Medication Regimen Review Irregularities (with a reviewed/revised date of 12/1/22): (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- It is the policy of this facility to provide a Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner to prevent the occurrence of an adverse drug event. - The pharmacist must report any irregularities to the attending physician, the facility's medical director and director of nursing, and the reports must be acted upon. The following information was found in a Psychiatry Progress Note with a date of service of 1/2/25 (this document was electronically signed on 1/20/25: - Discontinue Depakote 625 mg (by mouth twice a day). - Start Depakote 500 mg (by mouth twice a day) for mood disturbance. Resident #65's medical provider orders indicated the resident's Depakote dose was decreased from 625 mg twice a day to 500 mg twice a day on 1/21/25. On 4/4/25 at 10:35 a.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Regional Director of Clinical Services (RDCS). During this meeting, the facility staff's delay in having a medical provider respond to Resident #65's MRR, dated 9/24/24, was discussed.

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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. Based on staff interview, clinical record review and facility document review the facility staff failed to ensure that 1 of 55 residents was free from unnecessary medications, Resident #85. The findings included: For Resident #85 the facility staff failed to ensure that resident was free of unnecessary medications. Resident #85's face sheet listed diagnoses which included but not limited to cerebral infarction, type 2 diabetes mellitus, and hypertension. Resident #85's most recent minimum data set (MDS) with an assessment reference date of 02/24/25 assigned the resident brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #85's comprehensive care plan was reviewed and contained a plan for The resident has Diabetes Mellitus. Interventions for this plan include Diabetes medication as ordered by doctor . Resident #85's clinical record was reviewed and contained a physician's order summary which read in part, Lantus Solution 100 unit/ml (Insulin Glargine). Inject 12 units subcutaneously every morning and at bedtime for DM (diabetes mellitus). Hold if BS (blood sugar) is less than 150. Resident #85's electronic medication administration records (eMAR) for the months of February and March 2025 were reviewed and contained an entry as above. The eMAR for February indicated that the resident received Lantus on 02/24/25 at 9 am with a BS of 147 and 02/27/25 at 9 pm with a BS of 129. The eMAR for March indicated that the resident received Lantus on 03/03/25 at 9 pm with a BS of 129, 03/04/25 at 9 am with a BS of 104, 03/05/25 at 9 am with a BS of 128, 03/06/25 at 9 am with a BS of 142, 03/10/25 at 9 am with a BS of 131, and 03/15/25 at 9 pm with a BS of 117. Surveyor spoke with the director of nursing (DON) on 04/07/25 at 10:40 am regarding Resident #85's Lantus insulin. DON stated the insulin should have been held per the parameters. Surveyor requested and was provided with a facility policy entitled Medication Administration which read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. The concern of not ensuring Resident #85 was free of unnecessary medications was discussed with the administrator, DON, assistant director of nursing, regional director of clinical services, and regional vice-president of operations on 04/07/25 at 5:00 pm. No further information was provided prior to exit.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure (2) two of fifty-five (55) sampled residents were free from unnecessary psychotropic medications (Resident #455 and Resident #86). The findings included: 1.For Resident #455 the facility staff failed to monitor the resident for behaviors or side effects related to psychotropic medications in March 2025. Resident #455's diagnoses included diagnosis but were not limited to, Bipolar Disorder, Other Seizures, Insomnia, Chronic Kidney Disease, Borderline Personality Disorder, and Atrial Fibrillation. The MDS (minimum data set) had not been completed related to the resident being a new admission to the facility. A facility document titled, MDS Data Collection with an effective date of 3/13/25 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. Review of the March 2025 medication administration record (MAR) revealed Resident #455 was prescribed Effexor 150 mg (milligrams) one time a day for Depression, Trazadone 50 mg daily (at bedtime) for Insomnia, Depakote 500 mg two times daily for Bipolar Disorder, and Ziprasidone 60 mg two times daily for Mood Disorder. There were no orders located for behavior monitoring or side effect monitoring related to any of these psychotropic medications in the clinical record for the month of March 2025. On 3/13/25 at 4:21 PM, surveyor met with assistant director of nursing and she informed surveyor no evidence of monitoring for psychotropic medication side effects could be located. This concern was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, assistant director of nursing, interim director of nursing, and regional nurse support manager. Assistant director of nursing provided surveyor with a copy of the updated medical provider orders on 3/17/25 that included monitoring for behaviors and side effects of Resident #455's psychotropic medications. Surveyor requested and received a facility policy titled, Use of Psychotropic Drugs with a reviewed/revised date of 12/1/22 that read in part, .9. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis .d. In accordance with . medication monitoring parameters consistent with clinical standards of practice, manufacturers specifications, and the residents comprehensive plan of care . No further information was provided to the survey team prior to the exit on 4/8/25. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Note: An abbreviated portion of this abbreviated-extended-standard survey included the initial entrance on 3/11/25 to include the above findings.) 2. For Resident #86 the facility staff failed to monitor the resident for behaviors or side effects related to psychotropic medications in April 2025. Resident #86's diagnosis list indicated diagnoses that included but were not limited to Progressive Multifocal Leukoencephalopathy, Anorexia, Chronic Kidney Disease, Acute Kidney Failure, Anxiety Disorder, Repeated Falls, Ataxia, Acute Respiratory Failure with Hypoxia, and Wasting Disease Syndrome. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/23/25, did not assign the resident a brief interview for mental status (BIMS) summary score for cognitive abilities. Further review of the clinical record provided documentation the resident was assigned a BIMS summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. Review of the April 2025 medication administration record (MAR) revealed Resident #86 was prescribed Citalopram Hydrobromide 40 mg-1 tablet in the morning for depression, Doxepin 10 mg at bedtime for depression, trazadone 50 mg at bedtime for major depressive disorder, Ativan 0.5 mg every 8 hours as needed for anxiety until 4/7/25, and Lorazepam 0.5 mg every 6 hours as needed for anxiety. Further review of the April MAR and TAR (treatment administration record) did not disclose any psychotropic drug monitoring for the resident. A review of the comprehensive person-centered care plan revealed a focus with a revision date of 3/31/25 that read in part, .The resident uses psychotropic medications-DX (diagnosis) depression and anxiety. Target behavior crying, sleeping, self-isolation, agitation, aggression, inappropriate behaviors, fear . with an intervention that read in part, .Observe/document/report PRN (as needed) any adverse reactions of psychotropic medications . On 4/8/25 at 11:51 AM, the director of nursing informed surveyor psychotropic drug monitoring for side effects was left off the April 2025 MAR for Resident #86 in error, she believed it was due to a recent hospitalization and was overlooked and stated the monitoring was on there (April 2025 MAR) now. Surveyor reviewed the April 2025 MAR, and it contained monitoring for psychotropic medications the resident was receiving with start dates of 4/8/25. This concern was discussed at the pre-exit meeting on 4/8/25 at 3:00 PM with the administrator, director of nursing, assistant director of nursing, and regional director of clinical services. Surveyor requested and received a facility policy titled, Use of Psychotropic Drugs with a reviewed/revised date of 12/1/22 that read in part, .9. The effects of the psychotropic medications on a resident's physical, mental, and psychosocial well-being will be evaluated on an ongoing basis .d. In accordance with . medication monitoring parameters consistent with clinical standards of practice, manufacturers specifications, and the residents comprehensive plan of care . No further information was provided to survey team prior to exit on 4/8/25.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, staff interview, clinical record review the facility staff failed to ensure a medication error rate of less than 5%. There were two (2) medication errors in 28 opportunities for a medication error rate of 7.14%. These medication errors affected Resident #253 (R253). The findings included: R253's diagnoses included but were not limited to atrial fibrillation, heart failure, bradycardia and gastroesophageal reflux disease (GERD). On 04/02/25 at 08:13 AM during a medication pass and pour observation, this surveyor observed Licensed Practical Nurse (LPN) #13 administer R253's morning medications. LPN #13 administered Eliquis 5 mg, Entresto 24-26 mg, famotidine 10 mg, and potassium ER 20 meq. LPN #13 took R253's pulse and stated to the resident, Your pulse is 60 so I am going to hold your metoprolol. R253's physician's orders were reviewed for morning medication regimen and included; Eliquis 5 mg give one tab by mouth twice daily, famotidine (used to treat GERD) 20 mg give one tablet by mouth, metoprolol succinate ER oral tablet extended release 50 mg give one tablet in the morning for hypertension (HTN) hold if manual heart rate is less than 60 or systolic blood pressure (SBP) is less than 100, potassium chloride ER tablet extended release give one tablet by mouth once daily. 04/02/25 at 04:32 PM this surveyor interviewed LPN #13 and asked her to show me the bottle of famotidine used for resident. She pulled out a bottle of 10 mg tabs. Surveyor asked the nurse to check the order and they confirmed the order was for 20 mg. They stated, Oh, I should have given her two. Surveyor asked nurse to review the metoprolol order for hold parameters. They stated, Her pulse was 60 so it looks like I should have given the medication, it says to hold if it's under 60. On 4/02/25 at 6:49 PM the survey team met with the Administrator, Director of Nursing, Regional Director of Clinical Services and the Regional Director of Clinical Reimbursement. This concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on clinical record review and facility document review, the facility staff failed to ensure that residents are free of any significant medication errors for (1) one of fifty-five (55) sampled residents (Resident #86). The findings included: For Resident #86, the facility staff failed to follow provider orders for the administration of the medication, Levofloxacin one time a day for infection for five days. (Levofloxacin is an antibiotic that is utilized to kill bacteria or prevent their growth in certain infections). Resident #86's diagnosis list indicated diagnoses that included but were not limited to Progressive Multifocal Leukoencephalopathy, Anorexia, Chronic Kidney Disease, Acute Kidney Failure, Anxiety Disorder, Repeated Falls, Ataxia, Acute Respiratory Failure with Hypoxia, and Wasting Disease Syndrome. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/23/25, did not assign the resident a brief interview for mental status (BIMS) summary score for cognitive abilities. Further review of the clinical record provided documentation the resident was assigned a BIMS summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A medical provider order dated 3/10/25 at 9:00 AM read in part, .Levofloxacin Oral Tablet 750 mg (milligrams) .Give 1 tablet by mouth one time a day for Infection for 5 days . with a start date of 3/11/25. A review of Resident #86's March 2025 MAR (medication administration record) revealed for Levofloxacin on 3/11/25 a code of 3 which indicated the resident was on leave of absence from the facility. The MAR also indicated the resident received a dose of the medication on 3/12/25, 3/13/25, 3/14/25, and 3/15/25. A review of Resident #86's census list revealed the resident had transferred out to the hospital on 3/11/25 and transferred back in from the hospital on 3/11/25. A progress note dated 3/12/25 at 12:34 AM read in part, .Resident came back from Hospital around 2240 (10:40 PM) . According to the provider orders and the March 2025 MAR, the medication, Levofloxacin, was not given as ordered for five days. The resident received four doses of Levofloxacin. This concern was discussed at the end of day meeting on 4/7/25 at 4:59 PM with the administrator, director of nursing, assistant director of nursing, regional director of clinical services, and regional vice president of operations. Surveyor requested and received a facility policy titled, Medication Administration with a revision date of 12/1/22 that read in part, .14. Administer medication as ordered . No further information was provided to the survey team prior to exit on 4/8/25.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interview, the facility staff failed to dispose of expired medications and/or biological's in 1 of 2 medication rooms, the [NAME] side medication room. The findings include. The facility staff failed to dispose of expired medication/biological's in the [NAME] side medication room. On 04/04/25 at 8:40 a.m., the surveyor and the Assistant Director of Nursing (ADON) completed an observation of the medication room on the [NAME] side. The surveyor identified 16 red top laboratory tubes with expiration dates of 12/31/24 and 11/30/24. A box of opened green top tubes with an expiration date of 03/31/25, 4 bottles of expired D3 medication with an expiration date of 03/2025, and 4 boxes of Influenza vaccine labeled 2023-2024 formula with an expiration date of 06/30/24 each box contained 10 syringes of the influenza vaccine. The ADON reviewed all these items, confirmed the items were expired, and disposed of the items. On 04/04/25 at 10:35 a.m., during a meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services the issues with the expired biological's/medications were reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. 3. For Resident #9, the facility staff failed to obtain PT/INR (prothrombin time with international normalized ratio) laboratory testing as ordered by the medical provider on three (3) separate occasions. A PT/INR test measures how long it takes for blood to form a clot and is used to monitor blood-thinner treatment (anticoagulant) medications. Resident #9's diagnosis list indicated diagnoses, which included, but not limited to Chronic Atrial Fibrillation, Displaced Fracture of the Right Femur, and Osteoarthritis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/04/25 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #9's current comprehensive person-centered care plan included a focus area stating the resident was on an anticoagulant related to atrial fibrillation with an intervention for labs as ordered. Resident #9's medical provider orders included orders for Coumadin 2.5 mg by mouth every evening and in addition, 0.5 mg by mouth every Tuesday, Thursday, and Saturday evenings for Atrial Fibrillation. Resident #9's orders also included an order to obtain a PT/INR every Monday. Surveyor reviewed Resident #9's clinical record and was unable to locate PT/INR results for 1/27/25, 3/03/25 and 3/17/25. On 4/07/25 at 3:53 PM, surveyor spoke with the Director of Nursing (DON) who stated they had called the lab and could not locate the three missing PT/INR results. Surveyor requested and received the facility policy titled Laboratory Services and Reporting with a reviewed/revised date of 12/01/22 which read in part The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law .1. The facility must provide or obtain laboratory services to meet the needs of its residents . On 4/07/25 at 5:00 PM, the survey team met with the Administrator, DON, Assistant DON, Regional Director of Clinical Services, and the Regional [NAME] President of Operations and discussed the concern of Resident #9's missing PT/INRs. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25. 4. For Resident #356, the facility staff failed to obtain a wound culture as ordered by the medical provider. Resident #356's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Obstructive and Reflux Uropathy, Essential Hypertension, and Atrial Fibrillation. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The minimum data set (MDS) with an assessment reference date (ARD) of 1/17/25 assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 indicating the resident was moderately cognitively impaired. Resident #356 was seen by the wound provider on 1/16/25, the progress note read in part, .The patient is being evaluated today for a left lower buttock abscess .New abscess x 2 assessed. Open and freely draining . Discussed this case with PCP [primary care physician] [name omitted]. A wound culture has been ordered to be obtained by nursing staff . A provider order dated 1/16/25 for aerobic and anaerobic wound culture - left buttock abscess was entered into Resident #356's electronic medical record on 1/16/25 at 2:37 PM. Surveyor was unable to locate wound culture results following the 1/16/25 order in the resident's clinical record. Resident #356 was seen again by the wound provider on 1/28/25, the progress note read in part, .The patient is being evaluated today for a left lower buttock abscess .Wound culture x2 were rejected by lab per facility staff report, reasoning unclear. Repeat wound culture was obtained by wound care nurse during today's visit .Left lower buttock abscess draining purulence but is stable from my prior assessment otherwise. No improvement noted .Recommend .begin antibiotic therapy until culture results are back and antibiotic therapy can be targeted . Wound cultures were obtained on 1/28/25 resulting in 4+ (heavy growth) Methicillin-Resistant Staphylococcus Aureus (MRSA), 1+ Escherichia Coli (E. coli), and 4+ (heavy growth) Enterococcus Avium. On 3/14/25 at 12:45 PM, the survey team met with the Administrator, Interim Director of Nursing, and Assistant Director of Nursing (ADON) and requested results of the 1/16/25 wound culture. The ADON stated they were reaching out to the hospital. Surveyor requested and received the facility policy titled Laboratory Services and Reporting with a reviewed/revised date of 12/01/22 which read in part .1. The facility must provide or obtain laboratory services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services . The facility failed to provide any information regarding the 1/16/25 wound culture prior to the end of the survey on 4/08/25. 2. For Resident #85 the facility staff failed to obtain physician ordered international normalized ratio (INR) laboratory tests. An INR is used to indicate how well the blood can clot. Resident #85's face sheet listed diagnoses which included but not limited to cerebral infarction, type 2 diabetes mellitus, and presence of prosthetic heart valve. Resident #85's most recent minimum data set with an assessment reference date of 02/24/25 assigned the resident brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #85's comprehensive care plan was reviewed and contained a plan for The resident has altered cardiovascular status r/t (related to) HTN (hypertension), HLD (hyperlipidemia) and Mechanical aortic valve and Resident is on Anticoagulant therapy 3/20/25 new order for weekly inr (international normal ratio). Resident #85's clinical record was reviewed and contained a physician's order summary which read in part, INR daily x 5 days every night shift for lab for 5 days-order date 03/13/2025. Resident's electronic medication administration record for the month of March 2025 was reviewed and contained an entry as above. The entry for INR daily x 5 days was initialed as being obtained on 3 of the 5 days ordered. Resident #85's nurse's progress notes were reviewed and contained notes which read in part, 03/13/2025 18:31 Vitamin K Oral Tablet. Give 2.5 mg by mouth one time only for increased INR for 1 day. Critical INR of 6.25, new order given for Vit K 2.5 mg per MD. INR to be repeated for next 5 days, 03/15/2025 03:02 INR daily x 5 days every night shift for lab for 5 days. Not obtained this shift, and 03/16/2025 06:56 INR daily x 5 days every night shift for lab for 5 days. Not obtained this shift. Surveyor spoke with Resident #85 on 04/03/25 at 2:35 pm regarding INR's. Resident #85 stated, The come in here at night about 3 times a week and take blood to check my INR. Surveyor spoke with the director of nursing (DON) on 04/07/25 at 10:40 am regarding Resident #85's INR's. DON stated that the order for daily INR's should have been obtained for all 5 days ordered. Surveyor requested and was provided with a facility policy entitled Laboratory Services and Reporting which read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with the law. The concern of not obtaining physician order laboratory tests was discussed with the administrator, DON, assistant director of nursing, regional director of clinical services, and regional vice-president of operations on 04/07/25 at 5:00 pm. No further information was provided prior to exit. Based on staff interview, clinical record review, and facility document review, the facility staff failed to obtain provider ordered laboratory tests for 4 of 55 residents, Residents #37, #85, #9, and #356. The findings include. 1. For Resident #37, the facility staff failed to obtain the provider ordered laboratory test basic metabolic panel (BMP). Resident #37's diagnoses included emphysema, chronic obstructive pulmonary disease, diabetes, chronic kidney disease, and chronic pain. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section C (cognitive patterns) of Resident #37's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 02/11/25 included a brief interview for mental status (BIMS) summary score of 14 out of a possible 15 points. Per the MDS manual a score of 14=cognitively intact. The clinical record included a provider order for the laboratory test basic metabolic panel (BMP) dated 03/05/25. During the clinical record review the surveyor was unable to find the results for this laboratory test. On 04/01/25 at 5:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Assistant Director of Nursing (ADON), and Regional Director of Clinical Reimbursement the issue with the missing BMP laboratory test results was reviewed. The clinical record included a progress note dated 04/04/25 that read, Spoke with _____ NP [nurse practitioner] in reference to order for BMP for 3/5. She advised to d/c [discontinue] due to having results from CMP [comprehensive metabolic panel] at this time. On 04/07/25 at 3:30 p.m., the ADON provided the survey team with a copy of a policy titled, Laboratory Services and Reporting. This policy read in part, The facility must provide or obtain laboratory services when ordered .The facility is responsible for the timeliness of the services . No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on staff interview, resident interview, clinical record review and facility document review the facility staff obtained laboratory test without a physician's order for 1 of 55 residents, Resident #85. The findings included: For Resident #85 the facility staff obtained physician ordered international normalized ratio (INR) laboratory tests more times than it was ordered. An INR is used to indicate how well the blood can clot. Resident #85's face sheet listed diagnoses which included but not limited to cerebral infarction, type 2 diabetes mellitus, and presence of prosthetic heart valve. Resident #85's most recent minimum data set with an assessment reference date of 02/24/25 assigned the resident brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #85's comprehensive care plan was reviewed and contained a plan for The resident has altered cardiovascular status r/t (related to) HTN (hypertension), HLD (hyperlipidemia) and Mechanical aortic valve and Resident is on Anticoagulant therapy 3/20/25 new order for weekly inr (international normal ratio). Resident #85's clinical record was reviewed and contained a physician's order summary which read in part, INR every Monday one time a day for INR-order date 03/22/2025. Resident's electronic medication administration record for the month of March 2025 was reviewed and contained an entry as above. The entry for INR every Monday was initialed a being obtained daily, except for one day. Resident #85's laboratory reports were reviewed and revealed that the order for INR every Monday was obtained on 03/24/25 (Monday), 03/26/26 (Wednesday), 03/27/25 (Thursday), 03/31/25 (Monday), 04/01/25 (Tuesday), 04/04/25 (Friday), and 04/07/25 (Monday). Surveyor spoke with Resident #85 on 04/03/25 at 2:35 pm regarding INR's. Resident #85 stated, The come in here at night about 3 times a week and take blood to check my INR. Surveyor spoke with the director of nursing (DON) on 04/07/25 at 10:40 am regarding Resident #85's INR's. DON stated that the order for INR every Monday should only be done on Mondays. Surveyor requested and was provided with a facility policy entitled Laboratory Services and Reporting which read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with the law. (continued on next page)

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	495417	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Laurel Rehabilitation and Nursing	514 North Main Street Rural Retreat, VA 24368

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern of not obtaining physician order laboratory tests without an order discussed with the administrator, DON, assistant director of nursing, regional director of clinical services, and regional vice-president of operations on 04/07/25 at 5:00 pm. No further information was provided prior to exit.

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F 0776 Level of Harm - Actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on family interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide and/or obtain timely radiology and/or other diagnostic services to meet the needs of the residents for (2) two of (55) fifty-five sampled residents (Resident #453 and Resident #93). The findings include: 1.For Resident #453 the facility staff failed to provide and/or obtain timely radiology and/or diagnostic services after a medical provider ordered a left hip x-ray on 3/8/25 due to the resident having a fall on 3/7/25 with complaints of left hip pain and the facility staff failed to notify the medical provider the x-ray ordered for 3/8/25 was delayed until 3/10/25. Resident #453 was sent to a higher level of care and diagnosed with a left hip fracture requiring surgical repair. Resident #453's diagnosis list indicated diagnoses that included, but were not limited to, Hypertension, Atrial Fibrillation, Diverticulosis, Macular Degeneration, Unsteadiness on Feet, Depression, Difficulty Walking, Weakness, Polyosteoarthritis, Dementia, Alzheimer's, Chronic Kidney Disease-Stage 2, and Nightmare Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/19/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of a medical provider orders contained an order with a start date of 3/8/25 that read in part, .Left hip X-ray one time only for Pain for 1 (one) day . A review of the MAR (medication administration record) and TAR (treatment administration record) for March 9, 2025, revealed documentation of the left hip x-ray being administered. A review of Resident #453's clinical record revealed the following documentation. A Summary for Providers-Change In Condition dated 3/07/25 read in part, .The Change In Condition/s reported .are/were: Falls .Pain Status Evaluation: Does the resident/patient have pain? Yes .called to room by staff, observed resident in the floor on her bottom at bedside .upon entering the room, resident stated i {sic} was getting up from the potty chair and when i {sic} went to get in my wheelchair i {sic} forgot to lock it and it slid back .assessment completed .no visible injuries to note, assisted resident back to bed, no s/s (signs/symptoms) of distress, resident c/o (complaint of) some pain in left upper/inner thigh, described pain as tight, no changes to ROM (range of motion) to left leg .Primary Care Provider responded with the following feedback .monitor, if pain continues call for xray {sic} .repositioned patient in bed for c/o pain . A Medication Administration note dated 3/07/25 read in part, .Tylenol Oral Tablet 325 MG Give 2 tablet by mouth every 12 hours as needed for pain .given for c/o leg pain at this time . An Evaluation Note dated 3/08/25 read in part, .Resident reports pain. Resident states pain is 2/10 .left leg, thigh area .Tylenol given .New orders post fall: x ray to left leg . (continued on next page)

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F 0776 Level of Harm - Actual harm Residents Affected - Few	A review of a Post Fall Assessment dated 3/8/25, read in part, .Resident reports pain .Resident states pain is 2/10 .left leg, thigh area .New orders post fall: x-ray to left leg . A Medication Administration note dated 3/09/25 read in part, .Left hip X-ray one time only for Pain for 1 Day . scheduled, will be here on Monday (3/10/25) to do x ray . A review of a Post Fall Assessment dated 3/9/25, read in part, .Resident reports pain .Resident states pain is 4/10 in left inner thigh .order for x-ray, scheduled for Monday morning . A Summary for Providers Change in Condition dated 3/10/25 read in part, .The Change In Condition/s reported .are/were: New or Worsening Pain .Does the resident/patient have pain? Yes .Patient c/o pain upon ROM (range of motion) with left hip. PRN (as needed) pain medication administered .Primary Care Provider responded with the following .Recommendations: Send to (hospital name omitted) Per family request . On 3/11/25 at 11:45 AM, surveyor met with local long-term care ombudsman (OMB) and she informed surveyor about Resident #453 having a fall at the facility. OMB recalled the resident's family member had called her on Friday (3/7/25) and informed her the resident had a fall at 3:00 PM and the facility was waiting for mobile x-ray. OMB stated this happened Friday evening and the x-ray was still not done yesterday (Monday 3/10/25). OMB stated the family called her after the resident got to the hospital and informed her Resident #453 had a left hip fracture and she was not sure if it would have to be pinned or replaced. On 3/12/25 at 1:19 PM, surveyor met with complainant at facility per her request. Complainant informed surveyor she called 911 on Monday (3/10/25) so the resident could have an x-ray of her hip because she was supposed to have the x-ray on Saturday (3/8/25), but the x-ray company did not show-up. Complainant stated Resident #453 was admitted to the hospital and had a left hip fracture and required surgery for a partial hip replacement. On 3/12/25 at 3:26 PM, surveyor met with assistant director of nursing (ADON), and she stated she spoke with Resident #453's family member on 3/10/25 in-person because she was called to the resident's room to speak with her about the fall. She informed surveyor resident fell at 4:00 PM on Friday (3/7/25). ADON stated they (nurses) called the provider, and he said if pain persists to get an x-ray. The unit manager called mobile x-ray and scheduled the x-ray. Mobile x-ray were supposed to come on the 8th (3/8/25) to do the x-ray. Surveyor asked ADON the process for complaints of pain after a fall and she stated the process is to medicate, contact the provider and depending on if an x-ray was ordered, to get the x-ray. She informed surveyor the timeliness of mobile x-ray getting here is dependent on factors such as weekends and weather. She agreed mobile x-ray should come when they are scheduled. ADON informed surveyor she had started an Action Plan on 3/10/25 and provided surveyor with a copy of the action plan and staff education. Surveyor informed ADON the action plan was not completed prior to survey entrance on 3/11/25. ADON agreed the nurse should not have documented the x-ray was completed on 3/9/25. (continued on next page)

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F 0776 Level of Harm - Actual harm Residents Affected - Few	On 3/12/25 at 3:38 PM, surveyor interviewed licensed practical nurse #2 (LPN#2) and she informed surveyor she was working on 3/8/25 and did call mobile x-ray to see why they had not come to x-ray the resident and was informed by mobile x-ray they could not come until Monday (3/10/25) and they were delayed because it was the weekend. LPN#2 stated she informed the family at bedside. She stated she did not call the provider; another nurse called the provider. She stated the resident was complaining of hip pain, but the pain scale was not outrageous, and the resident was moving it (the leg/hip) good. 3/13/25 at 8:14 PM, surveyor interviewed licensed practical nurse #5 (LPN#5) via phone conversation and she informed surveyor she called the on-call provider on 3/8/25. She stated she did not work on that unit on Sunday (3/9/25) and LPN#2 was working that unit, and she (LPN#2) called mobile x-ray and she (LPN#2) would have called the provider about the x-ray being delayed. This issue was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, interim director of nursing, assistant director of nursing, and regional nurse support. Surveyor requested and received the facility services agreement with the mobile x-ray company that read in part, .Mobile Imaging shall .2.3.1 make Radiology Services available for Facility patients seven days a week . Surveyor requested and received a facility policy titled, Notification of Changes with a reviewed/revised date of 12/1/22, that read in part, .The purpose of this policy is to ensure the facility promptly .consults the resident's physician .The facility must .consult with the resident's physician .when there is a change requiring such notification .Circumstances requiring notification include .1. Accidents .b. potential to require physician intervention . No further information was provided to the survey team prior to exit on 4/8/25. (Note: An abbreviated portion of this abbreviated-extended-standard survey included the initial entrance on 3/11/25 to include the above findings.) 2. For Resident #93, the facility staff failed to follow the medical provider order to obtain a chest x-ray (CXR) in a timely manner. Resident #93's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction, Metabolic Encephalopathy, Convulsions, Unspecified Psychosis, Major Depressive Disorder, and Generalized Anxiety Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/15/25 assigned the resident a brief interview for mental status (BIMS) summary score of 11 out of 15 indicating the resident was moderately cognitively impaired. Resident #93's clinical record included a nursing progress note dated 1/05/25 at 1:10 PM which read in part Nurse was notified by CNA [certified nursing assistant] and another nurse that resident appeared to be choking. Resident was observed having a large piece of sausage/hamburger patty in his hand. Resident began coughing and gagging. Resident expelled two large pieces of meat when he coughed .On call provider [name omitted] notified .request a speech consult, chest x-ray to rule out aspiration pneumonia . (continued on next page)

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F 0776 Level of Harm - Actual harm Residents Affected - Few	An order for a two-view CXR was entered into Resident #93's clinical record on 1/05/25 at 1:41 PM. According to the radiology report, the CXR was not obtained until 1/09/25 at 6:00 AM. Surveyor was unable to locate documentation explaining the delay. On 4/08/25 at 8:43 AM, surveyor spoke with the Director of Nursing (DON) who verified the CXR was not obtained until 1/09/25 and stated she had no answer for the reason for the delay. Surveyor requested and received the facility policy titled Radiology and other Diagnostic Services and Reporting with a reviewed/revised date of 12/01/22 which read in part .1, The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents . On 4/07/25 at 5:00 PM, the survey team met with the Administrator, DON, Assistant DON, Regional Director of Clinical Services, and Regional [NAME] President of Operations and discussed the concern of the delay in obtaining a CXR for Resident #93. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25.

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F 0777 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident, family and staff interviews, clinical record review and facility document review, the facility staff failed to promptly notify the provider of diagnostic results requiring urgent follow up for 1 of 55 residents in the survey sample, resident # 17 (R17). The findings included: R17's diagnoses included but were not limited to AV block complete, presence of cardiac pacemaker, essential hypertension, and asthma. The minimum data set (MDS) assessment with an assessment reference date of 2/14/25 assigned the resident a brief interview for mental status score (BIMS) of 15 out of 15 indicating intact cognition. On 3/31/25 at 1:30 PM this surveyor interviewed R 17 and a visiting family member. The family member asked if I had gotten their complaint. This surveyor asked what their concern was and they stated, In February, she was sick, she felt bad all weekend. My sister and her family were here visiting with her and she was just peaked. On Monday they called me, and said her heart rate was 32 and had been since Thursday. The flu was going around but that PA wasn't concerned about anything. She wouldn't test her for flu and wasn't worried about the heart rate. The nurse took it on herself to get an ekg ordered and she was in complete heart block. They sent her out and by the time I got to (name of hospital omitted) they had checked her for flu and covid and both were positive. She was so sick they couldn't put the pacemaker in. She was so sick, at 5 AM the next day they were calling me to confirm her code status because they didn't think she was going to make it. The had to do an external pacemaker at first then she got so bad they had no choice but to go ahead and try with the permanent one. We have to go for a follow up tomorrow. The clinical record was reviewed. On 1/30/25 a provider note was reviewed and read in part, Chief Complaint / Nature of Presenting Problem: Staff requested patient be seen for bradycardia Resident requested to be seen for upper respiratory infection and wheezing. Under Plan the document read, Bradycardia Appears to be asymptomatic Not on any AV [NAME] blockers Continue to monitor and trend heart rate Consider heart rate evaluation while ambulating. On 2/3/25 a provider note read in part, Pleasant [AGE] year-old female requesting to be seen for upper respiratory symptoms. Patient noted to have bradycardia at rest that is currently asymptomatic. Patient has been ordered the influenza protocol which includes nebulizers, guaifenesin. Patient reports that she may have had a slow heart rate her whole life she is not sure but denies any syncope or dizziness. Patient rolls around with wheelchair in her room and is generally sedentary. Under plan the note read, Bradycardia Appears to be asymptomatic Not on any AV [NAME] blockers Continue to monitor and trend heart rate (continued on next page)

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F 0777 Level of Harm - Actual harm Residents Affected - Few	Plan to evaluate heart rate evaluation while ambulating Obtain EKG. A nurse progress note dated 2/3/25 at 5:17 PM read, (name omitted) PA made aware that resident continues to be bradycardia, palpated pulse at wrist 32 beats per minute. No new orders noted. A nurse progress note dated 2/4/25 at 7:33 AM read, Resident EKG results obtained via fax, abnormal results that states resident needs urgent follow-up. Radial pulse 48 beats per minute and resident states, I feel so tired. OCP notified and order obtained to send resident to ER for further evaluation. On call supervisor, (name omitted) LPN, UM notified of residents transfer. RP, daughter (name omitted) notified and requested resident be sent to (name of hospital omitted). EMS called and transported resident at 0733 via stretcher x2 to hospital. Face sheet, order summary, admin record, careplan, and bed hold policy sent with EMS to hospital. Report called to (name omitted) RN at 0739. DNR faxed to ER as well. A nurse progress note dated 2/4/25 at 1:21 PM read, Received report from (name omitted) RN at (name omitted) ER. Resident being transferred to (hospital name omitted) to have pacemaker placed. Resident also tested positive for Flu A while at hospital. UM and ADON aware. Residents daughter at the bedside with resident. The EKG report was reviewed and read in part, Impression: URGENT Severe bradycardia, possible 3-degree heart block. Immediate f/u Signed by (physician name omitted) MD at 2/4/2025 the document was time stamped and indicated the results were faxed to facility at 12:47 AM. According to the above progress notes, the physician was not notified until 7:30 AM. The policy entitled, Radiology and other Diagnostic Services and Reporting with a reviewed/revised date of 12/1/22 read in part, 4. Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside the clinical reference range. The provider who ordered the EKG is no longer employed with the physician group and was not available for interview. On 4/3/25 at 3:15 PM this surveyor interviewed the Unit Manager (UM). When asked about R17 and the EKG results they stated, She was sent out right away as soon as those results came in. I believe it was around 7:30 in the morning. This surveyor showed the UM and the Regional Director of Clinical Services (RDCS) the document with the time stamp. The UM stated, I know we didn't get that until the next morning. This surveyor told the UM to bring in evidence to the contrary and the survey team would review it. On 4/7/25 at 5:00 PM the survey team met with the Administrator, Director of Nursing, RDCS, Assistant Director of Nursing and the Regional [NAME] President of Operations. This concern was reviewed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, staff interview, resident interview, clinical record review and facility document review the facility staff failed to provide food to accommodate the resident's preferences for 1 of 55 residents, Resident #1. The findings included: For Resident #1 the facility staff failed to honor resident's food preferences. Resident #1's face sheet listed diagnoses which included but not limited to cerebral infarction, chronic kidney disease, chronic pain syndrome, and anxiety. Resident #1's most recent minimum data set with an assessment reference date of 01/10/25 assigned the resident a brief interview for mental status score of 8 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Surveyor spoke with Resident #1 on 04/01/25 at 8:15 am. Resident was seated in bed, with breakfast tray on overbed table. Surveyor asked resident if they had a good breakfast and resident stated, I'm supposed to get boiled eggs for breakfast. I want boiled eggs every day. I have ate boiled eggs since I was a child. Surveyor observed that Resident #1's breakfast tray contained a cheese and egg omelet. Surveyor spoke with Resident #1 on 04/03/25 at 8:10 am. Resident stated they did not receive boiled eggs this morning, and stated, I reckon its too hard for them to boil water in the kitchen. Surveyor did not observe boiled eggs on resident's food tray. Surveyor observed Resident #1's tray ticket which read in part, Diet: Regular. Food Likes: Boiled Egg. Instructions: boiled eggs each day. Surveyor spoke with the dietary manager on 04/04/25 at 9:00 am. Surveyor asked dietary manager how they know resident's food preferences, and dietary manager stated they talk with residents, asked them their likes/dislikes, put it on their meal tickets. Surveyor asked dietary manager about Resident #1's preference for boiled eggs each day, and dietary manager stated, We give them when we can. I usually keep them, but have been running out lately, I guess I can just order more. The concern of not accommodating Resident #1's food preferences was discussed with the administrator, director of nursing, assistant director of nursing, regional director of clinical services, and regional vice president of operations on 04/07/25 at 5:00 pm. No further information was provided prior to exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and facility document review, the facility staff failed to: (a) store food in accordance with professional standards for food service safety and (b) failed to serve food according to menu serving size. The findings included: The facility staff failed to ensure residents refrigerated and/or frozen foods were correctly labeled and/or stored on two (2) of two (2) resident unit pantry/nutrition areas. On 4/1/25 at 2:40 p.m., the surveyor and Dietary Manager completed observations of the storage of resident food items in the [NAME] Unit pantry/nutrition area. The freezer housing resident foods contained: (a) an undated, unlabeled multi-serving vanilla ice cream container that had been opened, (b) an undated, unlabeled multi-serving cookie-dough ice cream container that had been opened, (c) a frozen individually packaged handheld filled pastry/pocket (ice crystals were noted inside the packaging; this item was removed from its box therefore it was not labeled with a use by date or an expiration date), (d) a frozen individually packaged handheld stuffed pita (this item was removed from its box therefore it was not labeled with a use by date or an expiration date), (e) a partially used, undated multi-serving Neapolitan ice cream container was labeled for west residents (ice crystals were noted on the ice cream). On 4/1/25 at 2:40 p.m., the surveyor and Dietary Manager completed observations of the storage of resident food items in the [NAME] Unit pantry/nutrition area. The refrigerator housing resident foods contained: (a) an unlabeled, half-empty bottle of water, (b) an unlabeled, partially used 2 liter bottle of soda, (c) a coffee drink dated 4/1/25 was not labeled with an individual's name, (d) a syrup container with a best by date of October 22, 2024, (e) a small, unopened container of milk dated March 25, and (f) a unlabeled, partially empty jar of strawberry jam with the lid ajar. On 4/1/25 at 2:55 p.m., the surveyor and Licensed Practical Nurse (LPN) #4 completed observations of the storage of resident food items in the [NAME] Unit pantry/nutrition area. The freezer housing resident foods contained two (2) unlabeled, undated multi-serving containers of ice-cream that had been opened. The refrigerator housing resident foods contained one (1) opened, multi-serving package of shredded cheese that was not labeled with a resident's name. The following information was found in a facility policy titled Food Safety Requirements (with a reviewed/revised date of 12/1/22): Refrigerated storage - foods that require refrigeration shall be refrigerated immediately upon receipt or placed in freezer, whichever is applicable. Practices to maintain safe refrigerated storage include: . iv. Labeling, dating, and monitoring refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded; and v. Keeping foods covered or in tight containers. The following information was found in a facility policy titled Date Marking for Food Safety (with a reviewed/revised date of 12/1/22): - The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. - The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. - The marking system shall consist of a label, the day/date of opening, and the day/date the item must be consumed or discarded. - The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. (For example, food prepared on Tuesday shall be discarded on or by Friday.) - The Head Cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. On 4/1/25 at 12:23 p.m., the surveyor observed residents' midday meal being plated from the food held on the steam table. The surveyor observed the dietary staff using green, three (3) ounce scoops to serve the green beans and collard greens. The facility's menu indicated the serving size, of the green beans and the collard greens, should have been four (4) ounces. On 4/1/25 at 12:25 p.m., the Dietary Manager confirmed the incorrect scoop was being used for the green beans and the collard greens; the Dietary Manager reported the four (4) ounce scoop should have been used. The Dietary Manager reported if the three (3) ounce scoop was full/rounded it would be close to or the correct serving size for the green beans and the collard greens. The Dietary Staff was noted to change the three (3) ounce serving scoops to the four (4) ounce serving scoops for the green beans and the collard greens; the dietary staff reported that two (2) of the six (6) carts, which transported resident trays, had been sent to the residents prior to changing the scoop size to allow for the correct serving size for the green beans and the collard greens. On 4/1/25 at 5:30 p.m., the survey team met with the Administrator, Director of Nursing, and Regional Director of Clinical Services. During this meeting, the aforementioned food storage and food serving observations were discussed.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observations and staff interviews, the facility staff failed to ensure proper disposal and/or containment of the facility's garbage/waste. The findings include: On 4/7/25 at 4:40 p.m., the surveyor and the Dietary Manager made observations of the garbage disposal area outside of the facility but located on the facility's campus. The following observations were noted: - The facility had two (2) dumpsters. One (1) dumpster had two (2) of its doors open; the other dumpster had one (1) of its doors open. - The following debris was noted on the ground around the dumpsters: (a) eight (8) blue medical gloves, (b) two (2) plastic drinking cups, (c) one (1) piece of foil, (d) one (1) disposable towel, (e) three (3) small medication cups, and (f) one (1) empty plastic cup which had held an individual serving of jello or pudding. On 4/7/25 at 5:00 p.m., the survey team met with the facility's Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Director of Clinical Services. During this meeting, the aforementioned observations of the facility's garbage disposal area was discussed.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on family interview, staff interview, clinical record review, and facility document review the facility staff failed to ensure the timeliness of radiology services furnished by an agency outside the facility under an arrangement for (1) one of fifty-five (55) sampled residents (Resident #453). The findings include: For Resident #453 the facility staff failed to ensure the timeliness of radiology services furnished by an outside mobile radiology agency under an arrangement for a left hip x-ray ordered for 3/8/25. Resident #453's diagnosis list indicated diagnoses that included, but were not limited to, Hypertension, Atrial Fibrillation, Diverticulosis, Macular Degeneration, Unsteadiness on Feet, Depression, Difficulty Walking, Weakness, Polyosteoarthritis, Dementia, Alzheimer's, Chronic Kidney Disease-Stage 2, and Nightmare Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/19/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of a medical provider orders contained an order with a start date of 3/8/25 that read in part, .Left hip X-ray one time only for Pain for 1 (one) day . A review of a Post Fall Assessment dated 3/8/25, read in part, .New orders post fall: x-ray to left leg . A Medication Administration note dated 3/09/25 read in part, .Left hip X-ray one time only for Pain for 1 Day . scheduled, will be here on Monday (3/10/25) to do x ray . On 3/11/25 at 11:45 AM, surveyor met with local long-term care ombudsman (OMB) and she informed surveyor about Resident #453 having a fall at the facility. OMB recalled the resident's family member had called her on Friday (3/7/25) and informed her the resident had a fall at 3:00 PM and the facility was waiting for mobile x-ray. OMB stated this happened Friday evening and the x-ray was still not done yesterday (Monday 3/10/25). On 3/12/25 at 1:19 PM, surveyor met with complainant at facility per her request. Complainant informed surveyor she called 911 on Monday (3/10/25) so the resident could have an x-ray of her hip because she was supposed to have the x-ray on Saturday (3/8/25), but the x-ray company did not show-up. On 3/12/25 at 3:26 PM, surveyor met with assistant director of nursing (ADON), and she stated they (nurses) called the provider, and he said if pain persists to get an x-ray. The unit manager called mobile x-ray and scheduled the x-ray. Mobile x-ray were supposed to come on the 8th (3/8/25) to do the x-ray. She informed surveyor the timeliness of mobile x-ray getting here is dependent on factors such as weekends and weather. She agreed mobile x-ray should come when they are scheduled. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/25 at 3:38 PM, surveyor interviewed licensed practical nurse #2 (LPN#2) and she informed surveyor she was working on 3/8/25 and did call mobile x-ray to see why they had not come to x-ray the resident and was informed by mobile x-ray they could not come until Monday (3/10/25) and they were delayed because it was the weekend. This issue was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, interim director of nursing, assistant director of nursing, and regional nurse support. Surveyor requested and received the facility services agreement with the mobile x-ray company that read in part, .Mobile Imaging shall .2.3.1 make Radiology Services available for Facility patients seven days a week . No further information was provided to the survey team prior to exit on 4/8/25. (Note: An abbreviated portion of this abbreviated-extended-standard survey included the initial entrance on 3/11/25 to include the above findings.)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on staff interviews and clinical record review, the facility staff failed to obtain the Medical Director's assistance when having trouble scheduling a surgical consult/appointment for one (1) of 55 sampled residents (Resident #55). The findings include: The facility staff failed to have the Medical Director assist with obtaining Resident #55's surgical consult to address a rectal prolapse. Resident #55's diagnoses included, but were not limited to: rectal prolapse, Barrett's Esophagus, Gastro-Esophageal Reflux Disease, and dementia. Resident #55's minimum data set (MDS), with an assessment reference date (ARD) of 12/20/24, had the resident's brief interview for mental status (BIMS) summary score documented as a 15 out of 15 (this indicated intact or borderline cognition). Resident #55 was seen by the physician assistant (PA) on 9/19/24, the progress note read in part .asked to be seen per nursing staff due to rectal bleeding and tissue protruding from rectum .Rectal exam: Rectal prolapse evident. Unable to reduce .Attempted reduction, not successful-No evidence of strangulation/rectal tissue damage-Refer to GI [gastrointestinal] . A provider order was entered on 9/20/24 for a referral to colorectal surgery for prolapsed rectum. Resident #55's clinical record included an appointment note, dated 9/23/24 at 1:03 PM, stating Per MD order a referral has been sent to [name omitted] Colorectal surgery. Resident #55's clinical record included documentation of the facility scheduler contacting the surgical clinic on 9/26/24, 10/14/24, 11/14/24, and 1/03/25. However, each time the scheduler was informed no appointment had been scheduled yet. A nursing progress note dated 2/21/25 at 8:00 AM read in part Nurse was notified by CNAs [certified nursing assistants] in shower room that resident needs to be assessed. CNAs advised that when resident came into shower, she request if she could use the bathroom .CNA assisted resident in wiping and noticed a mass. Resident was assessed and noted to have a rectal prolapse. [Name omitted], PA [physician assistant] in house advised. Order for surgical consult . A provider order was entered on 2/21/25 at 9:38 AM for surgery consult for rectal prolapse ASAP. Resident #55's clinical record included an appointment progress note dated 3/14/25 stating Call placed to [name omitted] Colorectal Surgery and was told by [name omitted] that referral has been received but no (appointment) has been made yet. Writer will continue to follow up on this. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/25 at 10:05 AM, a surveyor spoke with the Unit Manager regarding Resident #55's surgical appointment. The Unit Manager stated the facility scheduler has tried multiple places and cannot get the resident an appointment. The following day on 4/4/25 at 3:38 PM, the scheduler entered a progress note in Resident #55's clinical record stating Follow up call placed to [name omitted] and spoke with Centralized scheduler, who stated they had residents referral. Writer questioned why appt [appointment] hadn't been made yet. Centralized scheduler sent me to Colorectal Surgery scheduler. That representative also stated they had referral and asked if the resident was ready to get that (appointment) scheduled. Writer stated yes, and made appt for May 19 (at) 10:30 in the [name omitted] office with Dr. [name omitted]. Resident was made aware. On 4/7/25 at 12:48 PM, the surveyor spoke with the scheduler who stated she had sent the referral in September and checked on it at least monthly and each time was told they could see the referral, but an appointment had not been made. The scheduler stated she contacted one other clinic, but they did not do that type of surgery. On 4/7/25 at 5:00 PM, the survey team met with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Regional Director of Clinical Services (RDCS), and Regional [NAME] President of Operations. During this meeting, the surveyor discussed the delay in obtaining Resident #55's surgical consult. On 4/8/25 at 11:04 a.m., the Medical Director reported he had not been contacted to assist with obtaining a surgical consult for Resident #55. On 4/8/25 at 3:02 p.m., the survey team met with the facility's Administrator, DON, ADON, and RDCS. During this meeting, the surveyor discussed the failure of facility staff to involve the Medical Director when having difficulty scheduling Resident #55's surgical consult.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For Resident #453, the facility staff failed to maintain an accurately documented clinical record by inaccurately documenting a left hip x-ray was completed on 3/9/25. Resident #453's diagnosis list indicated diagnoses that included, but were not limited to, Hypertension, Atrial Fibrillation, Diverticulosis, Macular Degeneration, Unsteadiness on Feet, Depression, Difficulty Walking, Weakness, Polyosteoarthritis, Dementia, Alzheimer's, Chronic Kidney Disease-Stage 2, and Nightmare Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/19/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of a medical providers orders contained an order with a start date of 3/8/25 and an end date of 3/9/25 that read in part, .Left hip X-ray one time only for Pain for 1 (one) day . A review of the MAR (medication administration record) and TAR (treatment administration record) for March 9, 2025, revealed documentation of the left hip x-ray being administered. A review of Resident #453's clinical record revealed the following documentation. An Evaluation Note dated 3/08/25 read in part, .New orders post fall: x ray to left leg . A Medication Administration note dated 3/09/25 read in part, .Left hip X-ray one time only for Pain for 1 Day . scheduled, will be here on Monday (3/10/25) to do x ray . On 3/12/25 at 1:19 PM, surveyor met with complainant at facility per her request. Complainant informed surveyor she called 911 on Monday (3/10/25) so the resident could have an x-ray of her hip because she was supposed to have the x-ray on Saturday (3/8/25), but the x-ray company did not show-up. On 3/12/25 at 3:26 PM, surveyor met with assistant director of nursing (ADON), and she agreed the nurse should not have documented the x-ray was performed on 3/9/25. This issue was discussed at the end of day meeting on 3/14/25 at 12:44 PM with the administrator, interim director of nursing, assistant director of nursing, and regional nurse support. Surveyor requested and received a facility policy titled, Documentation in Medical Record with a reviewed/revised date of 12/1/22 that read in part, .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident .3 .a. Documentation should be factual . No further information was provided to the survey team prior to exit on 4/8/25. (Note: An abbreviated portion of this abbreviated-extended-standard survey included the initial entrance on 3/11/25 to include the above findings.) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure a complete and accurate medical record for 7 of 55 records reviewed, residents # 403, 453, 153, 9, 21, 255 and 13. The findings included: 1. For resident # 403 (R403), the facility staff failed to ensure the clinical record reflected an accurate and consistent date of death . R403's diagnoses included but were not limited to congestive heart failure (CHF), hypertension, chronic obstructive pulmonary disease, end stage renal disease, and adult failure to thrive. The progress notes for R403 were reviewed. On 6/23/24 at 11:25 PM a nurse note read, This nurse called to resident room due to absence of vital signs. Resident noted to have absence of vital signs, breath and heartsounds. No s/s of life at this time. DNR on file. Family notified and [NAME] Fields NP notified. Family wishes to visit with resident prior to notifying funeral home. Residents nurse notified. A note dated 6/25/24 and signed by the nurse practitioner (NP) read, History Of Present Illness: Nursing pronounced this patient at approximately 2325 on 06/25/2024. Unseen by this provider on this day. On 3/13/25 at 11:30 AM this surveyor interviewed the NP. When asked about the incorrect entry regarding the date of death they stated, It was probably just a typo. I believe the 23 rd was actually weekend day so I would not have been here then. I was just trying to document the death in my notes and put the wrong date. The NP did confirm that the date of death was 6/23/24. This surveyor asked for and received a copy of the policy entitled, Documentation in the Medical Record with a revised date of 12/1/22. The document read in part, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The document further stated, 3. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. On 3/13/25 the survey team met with the Administrator, Interim Director of Nursing, Assistant Director of Nursing and Regional [NAME] President of Operations. This concern was discussed with them at that time. On 3/17/25 during the exit conference the survey team was notified that the NP typo had been corrected to reflect the correct date and time of death. 4. For Resident #9, the facility staff failed to document the administration of Tylenol. Resident #9's diagnosis list indicated diagnoses, which included, but not limited to Displaced Fracture of the Right Femur, Chronic Atrial Fibrillation, Restless Leg Syndrome, and Osteoarthritis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 3/04/25 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9's comprehensive person-centered care plan included a focus area stating the resident was at risk for alteration in comfort related to right femur fracture, restless leg syndrome, and osteoarthritis with an intervention to medicate as ordered. A review of Resident #9's January 2025 Medication Administration Record (MAR) revealed a pain level of 5 on 1/05/25 dayshift. Surveyor reviewed the resident's clinical record and was unable to locate evidence of interventions to address Resident #9's pain. Resident #9 had an order for Tylenol 325 mg give two tablets by mouth every eight hours as needed for pain, however, there was no documentation of Tylenol being administered on 1/05/25. On 4/08/25 at 8:43 AM, surveyor spoke with the Director of Nursing (DON) who stated she could not locate documentation of Tylenol being given to Resident #9 on 1/05/25. On 4/08/25 at 11:38 AM, surveyor spoke with Licensed Practical Nurse (LPN) #20, Resident #9's nurse on 1/05/25 dayshift. LPN #20 stated she gave Resident #9 Tylenol on 1/05/25 but failed to document it on the MAR. On 4/08/25 at 3:05 PM, the survey team met with the Administrator, DON, Assistant Director of Nursing, and Regional Director of Clinical Services and discussed the concern of LPN #20 failing to document Tylenol administration on the MAR. No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25. 7. For Resident #13 the facility staff failed to ensure medication orders were correct. Resident #13's face sheet listed diagnoses which included spastic quadriplegic cerebral palsy, unspecified intellectual disabilities, and anxiety. Resident #13's most recent minimum data set with an assessment reference date of 02/07/25 assigned the resident a brief interview for mental status score of 15 out o15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #13's comprehensive care plan was reviewed and contained a plan for The resident requires tube feeding r/t (related to) DX (diagnosis) of Dysphagia. Resident #13's clinical record was reviewed and contained a physician's order summary which read in part, Tube Feed Diet NPO (nothing by mouth) texture, AHR-NPO (nothing by mouth) consistency, Milk of Magnesia Suspension 400 mg/5 ml (Magnesium Hydroxide). Give 30 milliliter by mouth at bedtime for no bowel movement in 3 days, for 1 day- order date 01/07/2025, Milk of Magnesia Suspension 1200 mg/15 ml (Magnesium Hydroxide). Give 1 dose by mouth one time only for constipation for 1 day-order date 02/24/2025, Milk of Magnesia Suspension 1200 mg/15 ml (Magnesium Hydroxide). Give 30 ml by mouth one time only for constipation for 1 day-order date 03/10/2025, and Milk of Magnesia Suspension 400 mg/5 ml (Magnesium Hydroxide). Give 30 milliliter by mouth at bedtime for no bowel movement in 3 days, for 1 day-order date 03/25/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13's electronic medication administration records for the months of January, February, and March of 2025 were reviewed and contained entries as above. Each of these entries had been initialed as completed per physician's order. Surveyor spoke with the director of nursing (DON) on 04/07/25 at 10:40 am regarding Resident #13's milk of magnesia orders. DON stated that resident is to have nothing by mouth, and that the orders should read as such. Surveyor requested and was provided with a facility policy entitled Documentation in Medical Record which read in part, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Surveyor requested and was provided with a facility policy entitled Medication Orders which read in part, 3. Elements of the Medication Order: f. Route of administration. 4. Documentation of Medication Orders: b. Clarify the order. The concern of not following professional standards of practice for the documentation of medications was discussed with the administrator, DON, assistance director of nursing, regional director of clinical services, and regional vice-president of operations on 04/07/25 at 5:00 pm. No further information was provided prior to exit. 5. For Resident #21, the facility staff documented in their provider notes that this resident was a full code when in fact they had a do not resuscitate (DNR) order in place and the facility nursing staff documented they had administered the antibiotic Ceftriaxone subcutaneously (SQ) when it should have been administered intramuscularly (IM). Resident #21's face sheet included the diagnoses acute and chronic respiratory failure, chronic kidney disease stage 4, history of malignant neoplasm of bladder, chronic pain syndrome, and diabetes. Section C (cognitive patterns) of Resident #21's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/10/25 included a brief interview for mental status (BIMS) score of 5 out of a possible 15 points. Per the MDS manual a score of 5=severe impairment in cognitive skills for daily decision making. Resident #21's clinical record included a provider order dated 01/10/25 for a DNR. The clinical record included progress notes from the provider with dates of service of 04/01/25, 03/23/25, 03/19/25, 03/12/25, 02/25/25, 02/20/25, 02/19/25, 02/12/25. 02/05/25, and 01/15/25 under the section titled Code Status the provider documented the patient is a full code. Resident #21's clinical record included a provider order dated 03/12/25 to administer the antibiotic Ceftriaxone SQ two times a day for 5 days. This order had been confirmed by Licensed Practical Nurse (LPN) #7. A review of the medication administration record (MAR) for 03/2025 revealed that for 03/12/25 LPN #12 documented on the MAR they administered this medication SQ. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/31/25 at 3:35 p.m., the Director of Nursing (DON) stated they had never known this medication to be given SQ. On 04/01/25 at 8:15 a.m., LPN #7 was asked about the order for the antibiotic being ordered SQ. LPN #7 stated this medication was always supposed to have been given IM. On 04/01/25 at 8:30 a.m., LPN #12 stated she had administered this medication IM and they most definitely did not give it SQ. On 04/01/25 at 9:01 a.m., during an interview with the Medical Director this staff was made aware of the issue of the residents antibiotic Ceftriaxone being ordered SQ on 03/12/25. The MD reviewed the clinical record and confirmed it was ordered SQ and stated it should either be given IM or intravenously (IV). On 04/04/25 at 10:35 a.m., during a meeting with the Administrator, DON, and Regional Director of Clinical Services the issue with the provider documenting the resident was a full code when they had a DNR order in place and the issue regarding the antibiotic Ceftriaxone being documented as being administered SQ was reviewed. The facility policy titled, Documentation in Medical Record with a reviewed/revised date of 12/01/22 read in part, Policy: Each resident's medical record shall contain an accurate representtion of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation . No further information regarding this issue was provided to the survey team prior to the exit conference. 6. For Resident #255, the facility staff failed to document dialysis pre and post weights in the clinical record. Resident #255's diagnosis included end stage renal disease. There was no completed minimum data set assessment on this resident. This resident was alert and orientated to person and place. Resident #255's care plan included the focus area of dialysis due to end stage renal disease. The clinical record included provider orders for dialysis 3 times a week. On 04/04/25 at 10:15 a.m., Licensed Practical Nurse (LPN) #4 provided the surveyor with a copy of their policy titled, Care Planning Special Needs-Dialysis. This policy read in part, .Interventions will include Pre-and post-weights .If no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report . During the clinical record review the surveyor was unable to locate any pre and/or post dialysis weights. There was a dialysis book for this resident at the [NAME] side nurses station that included paperwork for dialysis these pages were blank. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/07/25 at 12:45 p.m., the Assistant Director of Nursing was interviewed regarding this residents dialysis. The ADON stated a paper should be taken to dialysis daily and the staff should fill it out. On 04/07/25 at 5:00 p.m., the issue with the residents pre and post dialysis weights not being recorded in the clinical record were reviewed with the Administrator, Regional Director of Clinical Services, Assistant Director of Nursing, and DON. On 04/08/25 at 3:25 p.m., the Unit Manager stated they had called the dialysis center and obtained the residents weights. The Unit Manager stated the dialysis book should go with the resident to dialysis. The facility policy titled, Documentation in Medical Record with a reviewed/revised date of 12/01/22 read in part, Policy: Each resident's medical record shall contain an accurate representtion of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation . No further information regarding this issue was provided to the survey team prior to the exit conference. 3. The facility failed to accurately document Resident #153's allopurinol administration. (Allopurinol is a medication ordered orally for Resident #153 to address gout.) Resident #153's admission minimum data set (MDS) assessment was not due and had yet to be submitted prior to the surveyor's review of the resident's clinical record. A medical provider assessment indicated Resident #153 was alert and oriented times three (3). Resident #153 was documented as having adequate vision. Resident #153's hearing was documented as being grossly intact. Resident #153's clinical documentation included two (2) orders for allopurinol 100mg one (1) tablet by mouth once a day for gout. On 4/1/25, one (1) of the two (2) allopurinol orders was discontinued due to it being identified as a duplicate order. Resident #153's March 2025 Medication Administration Record (MAR) documentation indicated that two (2) doses of allopurinol 100mg tablets were administered on: 3/28/25, 3/29/25, 3/30/25, and 3/31/25. On 4/7/25 at 1:10 p.m., the Director of Nursing (DON), with the surveyor present, counted Resident #153's remaining allopurinol tablets. The DON reported the number of remaining allopurinol tablets indicated that only one (1) allopurinol 100 mg tablet had been administered on the four days when two (2) allopurinol tablets had been documented as administered. The following information was found in a facility policy titled Documentation in Medical Record (with a reviewed/revised date of 12/1/22): Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. On 4/7/25 at 5:00 p.m., the survey team met with the facility's Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Director of Clinical Services. During this meeting, the incorrect documentation of the allopurinol on Resident #153's MAR was discussed.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, the facility staff failed to meet the requirements set forth in the Nursing Facility Services Agreement to designate a member of the nursing home's interdisciplinary team to coordinate care with the hospice provider for 1 of 55 residents in the survey sample, resident 454 (R454). The findings included: R454's diagnoses according to the facility diagnoses sheet, included but were not limited to, other seizures, chronic obstructive pulmonary disease, hypertension, anxiety, heart failure, personal history of suicidal behavior, traumatic brain injury, major depressive disorder, and vascular dementia with psychotic disturbance. R454's minimum data set (MDS) assessment with an assessment reference date of 8/28/24 assigned the resident a brief interview for mental status score of 11 out of 15 indicating moderate cognitive impairment. There was no mood indicators captured on the assessment and the only behavior identified was wandering which occurred one to three days during the lookback period. Under the section for preferences for customary routine and activities, R454 had many activities coded as being very important. They included listening to music, being around animals or pets, keeping up with the news, doing things in groups, participating in religious activities, having snacks and using the phone in private. R454 was coded as requiring maximum assistance for toileting, bathing, dressing, bed mobility, transfers and standing and was not ambulatory in the lookback period. R 454 was coded as receiving hospice services. No family participated in the assessment. This surveyor requested a copy of the hospice contract for R454. The document entitled, Nursing Facilities Services Agreement was provided and reviewed. On page 3 under the paragraph Article 2 Responsibilities of Facility the document read in part, .Facility shall comply with Hospice Patient's Plan of Care and shall ensure that Hospice Patients are kept comfortable, clean, well groomed, and protected from negligent and intentional harm including but not limited to, accident, injury and infection . Also on page 3, 2.3 Professional Standards. Facility shall ensure that all facility services are provided competently and efficiently. Facility services shall meet or exceed the standards of care for providers of such services and shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements. On page 4 of the document under the heading, 2.6 Coordination of Care. Facility shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Facility services. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day. In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice Patient. Hospice retains primary responsibility for development of the Plan of Care. Facility will assist with periodic review and modification of the Plan of Care. Facility will not make any modifications to the Plan of Care without first consulting with Hospice. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical record was reviewed. On 8/26/24 a hospice note read in part, . medication reconciliation completed, and adjustments made. Discontinue the following: Eliquis, folic acid, iron and atorvastatin. Decreased baclofen and gabapentin from TID (three times daily) to BID (twice daily) status, no changes in dosages. Patient agreeable to changes, previously discussed with daughter whom was also agreeable. VSS (vital signs stable) at the time of this visit. Patient reports he's not sure why he's here. Educated patient it was a safety issue for him to be home alone. Facility nurse (name omitted) updated with changes. According to hospice notes Seroquel (an antipsychotic medication that balances the levels of hormones in the brain to help regulate mood, behaviors and thoughts) 25 mg twice daily was ordered on 8/29/24 for anxiety and agitation but was not entered onto the facility's medication administration record (MAR) until 8/31/24. Zyprexa (another antipsychotic medication) 5 mg three times daily as needed for anxiety and agitation was ordered 9/4/24 but not put on the MAR until 9/6/24 and given only one time on 9/12/24, and Ativan 0.5 mg every 4 hours as needed for anxiety and agitation was ordered on 9/4/24, not added to the MAR until 9/5/24 and never administered despite ongoing behaviors. A note on 9/5/24 at 12:00 PM read, education was attempted to be given to resident and resident grabbed nurses arm with medicine and squeezed it tightly threatening that he owns this place, and he will get her and show her how it is. Nurse then went to get unit Manager while leaving resident with another nurse and told her what happened. Unit Manager then came to talk to resident, and he threatened to break her kneecaps. He then told the administrator who accompanied the unit Manager he will take him outside and show him how it is because he looks [NAME]. Resident continues to go into other residents' rooms and threaten them, attempting to physically assault them, and preaching the gospel because we are all sinners. The Medication Administration Record (MAR) for August 2024 was reviewed. An entry for Seroquel 25 mg give one tablet by mouth twice daily was noted to have started on August 31, 2024. Orders were noted as active through 8/31/24 for Eliquis 5 mg twice daily, folic acid 1 mg daily, ferrous sulfate (iron) 325 mg daily and atorvastatin 10 mg at bedtime. Orders were noted as active for baclofen 10 mg three times daily and gabapentin 100 mg give 2 capsules three times daily. The MAR for September 2024 was reviewed. Orders were noted as active throughout September until R454's discharge on [DATE] for Eliquis, folic acid, ferrous sulfate, baclofen three times daily and gabapentin three times daily, they were never discontinued or changed. A document entitled, Client Medication Report was noted under the heading of Hospice in the medical record. Seroquel 25 mg one tablet two times daily was ordered on 8/29/24. A facility nurse note dated 8/31/24 read, Hospice nurse in to see resident this shift. Hospice nurse (name omitted) talked with this nurse about increased behaviors resident has had and talked with this nurse about mentioning to the provider to change his Seroquel from two times a day to three times a day. This nurse looked for an order in this system for Seroquel and did not see one for resident to have. Hospice nurse stated that the order for resident to have Seroquel twice a day should have been put into our system on 8/29/24. Hospice wrote orders for resident to have Seroquel 25mg one tablet by mouth twice a day for paranoid behaviors. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan was reviewed. R454's care plan included a problem statement that read, Resident is hospice and has had an atypical change in behavior/development of behavior physically and verbally aggressive towards staff and other residents, increase anxiety, wandering into other resident's rooms and toward exit doors, etc . 9/4/24-Continues with physical and verbal aggression to staff and other residents. The interventions included, Administer medications as ordered. Monitor/document for side effects and Effectiveness. None of the preferences from the MDS assessment were incorporated into the behavior care plan as interventions. This surveyor requested a policy regarding hospice services and was told there is no policy. On 4/7/25 at 5:00 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services (RDCS) and the Regional [NAME] President of Operations. This concern was discussed at that time. This surveyor asked who the was the coordinator for the hospice group. The RDCS stated, I'm not sure we have one person appointed. It could be the Director of Nursing, or it could be the Social Worker depending on what the concern or the issue would be. On 4/8/25 at 3:00 PM the team met with the Administrator, Director of Nursing, RDCS and Assistant Director of Nursing. This surveyor again asked if there was a hospice coordinator. The RDCS stated, Like we were talking yesterday, there isn't one specific person appointed for that. No further information was provided to the survey team prior to the exit conference.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure a Quality Assurance and Performance Improvement (QAPI) Program to meet the needs of the facility and failed to monitor and revise as needed the plan of corrections for the standard recertification and abbreviated surveys dated 7/01/21 through 1/23/25, in order to maintain compliance as evidenced by repeated deficiencies in the areas of Quality of Care, Pharmacy Services, Food and Nutrition Services, and Infection Control. The findings included: The area of Quality of Care was previously cited with the 7/01/21 and 8/09/23 standard surveys and the 1/23/25 abbreviated survey for failure to follow medical provider orders. This deficiency was cited again on the current standard survey dated 4/08/25 due to facility staff failing to follow medical provider orders for 20 of 55 sampled residents. The area of Pharmacy Services was previously cited with the 7/01/21 standard survey, and the 12/04/24 and 1/23/25 abbreviated surveys due to failure to ensure provider ordered medications were available and/or administered as ordered. This deficiency area was cited again on the current standard survey dated 4/08/25 due to facility staff failing to ensure ordered medications were available and/or administered as ordered for 4 of 55 sampled residents. The area of Food and Nutrition Services was previously cited with the 7/01/21 and 8/09/23 standard surveys for the presence of expired food items. This deficiency was cited again on the current standard survey dated 4/08/25 due to expired food items. The area of Infection Control was previously cited with the 7/01/21 standard survey and the 12/04/24 and 1/23/25 abbreviated surveys due to failure to follow established infection control guidelines. This deficiency was cited again with the current standard survey dated 4/08/25 due to failure to follow infection control guidelines. On 4/08/25 at 12:00 PM, surveyor met with the Administrator, Regional Director of Clinical Services, and Regional [NAME] President of Operations to discuss the facility QAPI Program. The Administrator stated the facility was aware of the concern regarding timeliness of X-ray services and had been exploring other vendor options. He also stated they were aware of the concern with unavailable medications and have been educating the nurses. Surveyor requested and received the facility policy titled QAPI Change Process with a reviewed/revised date of 12/01/22 which read in part The facility has established and utilizes a systemic approach to performance improvement activities to ensure changes are effective and improvements are sustained .5. Performance Tracking - a. Once actions are implemented, the facility continues to track performance to ensure that improvements are realized and sustained . No further information regarding this concern was presented to the survey team prior to the exit conference on 4/08/25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, clinical record review and facility document review the facility staff failed to follow established infection control guidelines for 1 of 55 residents, Resident #13. The findings included: For Resident #13 the facility staff failed to don proper personal protective equipment (PPE) and failed to follow infection control guidelines for the handling of trash and soiled clothing. Resident #13's face sheet listed diagnoses which included but not limited to spastic quadriplegic cerebral palsy, gastrostomy status, and dysphagia. Resident #13's most recent minimum data set with an assessment reference date of 02/07/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #13's most recent minimum data set with an assessment reference date of 02/07/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section GG, functional abilities, coded the resident as dependent for toileting hygiene. Section H, bladder and bowel, coded the resident as always incontinent of both bowel and bladder. Resident #13's comprehensive care plan was reviewed and contained a plan for The resident requires tube feeding r/t (related to) DX (diagnosis) of Dysphagia. Interventions for this care pan include EBP (enhanced barrier precautions) r/t Peg (percutaneous endoscopic gastrostomy) tube. Resident #13's clinical record was reviewed and contained a physician's order summary which read in part, Enhanced barrier precautions related to peg nutrition tube. Surveyor observed CNA #4 and CNA #5 on 04/01/25 at 3:35 pm providing incontinence care for Resident #13. Neither CNA was observed wearing proper PPE. After removing resident's soiled incontinence brief and wet shorts, surveyor observed CNA place these items in the floor beside the resident's bed. Surveyor spoke with CNA #4 on 04/02/25 at 11:15 am regarding Resident #13. Surveyor asked CNA #4 if they had worn PPE while providing care for Resident #13, and CNA #4 stated, I wore gloves, was I supposed to wear a gown? Surveyor informed CNA #4 that Resident #13 is on enhanced barrier precautions related to having a PEG tube. CNA #4 stated, I didn't know and asked surveyor if there was a sign on the door. Surveyor informed CNA #4 that there was. Surveyor spoke with the director of nursing (DON) on 04/04/25 at 10:35 am regarding not following infection control guidelines. DON stated that the CNA's should be wearing proper PPE when providing care for residents on enhanced barrier precautions and should not have placed Resident #13's soiled brief and wet shorts in the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and was provided with a copy of the enhanced barrier precautions sign from Resident #13's door which read in part, STOP ENHANCED BARRIER PRECAUTIONS. EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and gown for the following High-Contact Resident Care Activities: Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy . The concern of not following established infection control guidelines was discussed with the administrator, DON, assistant director of nursing, regional director of clinical services, and regional vice-president of operations on 04/07/25 at 5:00 pm. No further information was provided prior to exit.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on staff interview, clinical record review, and facility document review, the facility staff failed to offer a pneumococcal vaccine in accordance with nationally recognized standards for 2 of 5 residents reviewed for immunizations, Resident #47, and Resident #68. The findings included: 1. For Resident #47, the facility staff failed to offer the resident a pneumococcal conjugate vaccine 20 (PCV120) or a pneumococcal conjugate vaccine 21 (PCV20) following admission to the facility. Review of the Centers for Disease Control (CDC) guideline entitled Adult Immunization Schedule by Age-2025 read in part, Age 50 years or older who have: Previously received only PCV 13: 1 dose PCV 20 or 1 dose PCV 21 at least 1 year after the last PCV 13 dose. Resident #47's face sheet listed diagnoses which included but not limited to peripheral vascular disease, end stage renal disease, viral hepatitis, and Alzheimer's disease. Resident #47's most recent minimum data set with an assessment reference date of 02/27/25 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Section O, special treatments and programs, subsection 0300, Pneumococcal Vaccine, A. Is the resident's Pneumococcal vaccine up to date? indicated that the resident is not up to date with the pneumococcal vaccine. Section O, subsection 0300B If Pneumococcal vaccine not received, stated reason: Not offered. Review of Resident #47's clinical record revealed that resident had previously received the pneumococcal conjugate vaccine 13 (PCV13). Surveyor spoke with the assistant director of nursing (ADON), who is also the infection preventionist (IP), on 04/07/25 at 1:15 pm regarding Resident #47's pneumococcal vaccine. ADON stated they would look through the previous IP's records for any information pertaining to Resident #47's vaccine. Surveyor requested and was provided with a facility policy entitled Pneumococcal Vaccine (Series) which read in part, It is our policy to offer resident and staff immunizations against pneumococcal disease in accordance with current CDC guidelines and recommendations. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized. The concern of not ensuring Resident #47's pneumococcal vaccine is up to date was discussed with the administrator, director of nursing, ADON, regional director of clinical services, and regional vice president of operations of 04/07/25 at 5:00 pm. No further information was provided prior to exit. 2. For Resident #68 the facility staff failed to offer the resident a pneumococcal conjugate vaccine 20 (PCV120) or a pneumococcal conjugate vaccine 21 (PCV20) following admission to the facility. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #68's face sheet listed diagnoses which included but not limited to Alzheimer's disease, cerebrovascular accident (stroke), and seizure disorder. Resident #68's most recent minimum data set with an assessment reference date of 01/09/25 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Section O, special treatments and programs, subsection 0300, Pneumococcal Vaccine, A. Is the resident's Pneumococcal vaccine up to date? indicated that the resident is not up to date with the pneumococcal vaccine. Section O, subsection 0300B If Pneumococcal vaccine not received, stated reason: Not offered. Review of Resident #68's clinical record revealed that resident had previously received the pneumococcal conjugate vaccine 13 (PCV13). Surveyor spoke with the assistant director of nursing (ADON), who is also the infection preventionist (IP), on 04/07/25 at 1:15 pm regarding Resident #68's pneumococcal vaccine. ADON stated they would look through the previous IP's records for any information pertaining to Resident #68's vaccine. Surveyor requested and was provided with a facility policy entitled Pneumococcal Vaccine (Series) which read in part, It is our policy to offer resident and staff immunizations against pneumococcal disease in accordance with current CDC guidelines and recommendations. Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized. The concern of not ensuring Resident #68's pneumococcal vaccine is up to date was discussed with the administrator, director of nursing, ADON, regional director of clinical services, and regional vice president of operations of 04/07/25 at 5:00 pm. No further information was provided prior to exit.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on staff interview and facility document review, the facility staff failed to provide quality assurance and performance improvement (QAPI) training to the facility staff. The findings include. The facility staff failed to provide QAPI training to the facility staff. During the entrance conference the team leader requested the facility assessment. This document read in part, .Staff training/education and competencies. Each job description identifies the required education and credentials for the job .Additional knowledge competencies for all staff include .QAPI . On 04/07/25 at 5:00 p.m., during an end of the day meeting with the Administrator, Regional Director of Clinical Services, Regional [NAME] President of Operations. Assistant Director of Nursing, and Director of Nursing the surveyor requested any information regarding QAPI training for the facility staff. On 04/08/25 at 8:21 a.m., the Administrator stated they were unable to find any training/education regarding their QAPI program. On 04/08/25 at 1:35 p.m., during a review of nursing assistant files for education requirements the surveyor identified one staff that had completed QAPI for healthcare staff training on 07/20/24. This was Certified Nursing Assistant (C.N.A.) #14. No further information regarding this issue was provided to the survey team prior to the exit conference.