STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515007	A. Building B. Wing	03/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Health and Rehabilitation Center	1720 17th Street Huntington, WV 25701

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51553 Based on Observation and Record Review, the facility failed to provide a home-like dining environment and to serve residents in the Third Floor Assisted Dining Room at the same time in order. This was a random opportunity for discovery. This failed practice had the potenital to affect more than a limited number of residents. Resident Identifer: #7. Facility Census: 184. Findings included: a) The facility's Dining Experience policy and procedure stated, Design the meal serving tray delivery to ensure residents seated at the same table are served at the same time, similar to a restaurant with table service. b) On 03/19/25 at 12:52 PM, the surveyor observed the Third Floor Assisted Dining Room. Residents were not served at the same table at the same time or in order. Resident #7 waited twelve (12) minutes after all the other residents in the dining room were served to receive the lunch tray.

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 49467 Based on observation and resident and staff interview, the facility failed to ensure call lights were within reach and accessible to Residents #166, 487, 184, 38. This was a random opportunity for discovery. Resident identifiers: 166, 487, 184, 38. Facility census: 184. Findings include: A) Resident #166 At approximately 2:25 PM on 3/17/2025, during an interview with Resident #166, she stated she was unable to ring her call light for help because she did not know where it was. Upon further inspection, Resident #166 ' s call light was found to be lying on the floor to the left side of her bed. At approximately 2:37 PM on 3/17/2025, the call light was confirmed to be in the floor and out of reach of Resident #166 by Licensed Practical Nurse (LPN) #75. B)Resident #487 At approximately 2:55 PM on 3/20/2025, during observation of the lunch meal pass, Resident #487 stated to the surveyor, I need to go to the bathroom but I can ' t find my button (call light). Upon further inspection, Resident #487 ' s call light was found to be on the floor, to the left side of her bed. At approximately 2:58 PM on 3/20/2025, the call light was confirmed to be lying on the floor by LPN #108. C) Resident #184 At approximately 2:55 PM on 3/20/2025, following the discovery of Resident #487 ' s call light on the floor next to her bed, the status of Resident #184 ' s call light was checked, in the same room. Resident #184 ' s call light was found to be wrapped around the arm of a chair, to the left side of the resident ' s bed, with the button itself lying on the floor, out of reach of the resident. At approximately 2:58 PM, on 3/20/2025, the call light was confirmed to be out of reach of the resident by LPN #108. 51553 d) On 03/17/25 at 12:30 PM, during the initial resident interview process, Resident #38 reported she was wet and needed changed. The resident stated, Can you please get my bottom dry? The resident's call light was lying in the floor out of reach. Registered Nurse #30 confirmed the Resident #38's call light was in the floor on the left side of the bed and the resident's water pitcher had been knocked over and into the floor on the right side of the bed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 51553 Based upon Record Review and Staff Interview, the facility failed to ensure a resident with capacity was given the right to participate in the development and sign advance directives and a signature was not obtained in a timely manner by the Resident's Health Care Surrogate. This was true for two (2) of fifty (50) advanced directives reviewed. Resident identifiers: #487 and #75. Facility Census: 184. Findings included: a) Resident #487 The resident's Portable Orders for Scope of Treatment (POST) form was reviewed. The capacitated resident's POST form was signed by the Power of Attorney and not the capacitated resident. This was confirmed by Corporate Registered Nurse #223 on 03/18/25 at 5:00 PM. b) Resident #75 On 03/20/25 at 10:06 AM , the State Surveyor interviewed Social Worker #1 concerning Resident #75's Advanced Directive/POST form being signed in a timely manner. Social Worker #1 confirmed there were no documented attempts to obtain the Power of Attorney's signature. Resident #75's Power of Attorney had given verbal consent on 09/18/23.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 51553 Based on Record Review and Staff Interview, the facility failed to ensure the Resident and/or Power of Attorney (POA) was notified of a change in condition/order. This was a random opportunity for discovery that had the potential to affect more than a limited number of residents. Resident Identifiers: #7, #151, #169, #48, #8, #80, #97, #59, #34, #58, #111, #152, #124, #116, and #33. Facility Census: 184 Findings included: -The Facility's Policy and Procedure for Change in a Residents Condition stated, The facility will promptly notify the resident, his or her physician/practitioner, and representative of changes in the resident's medical/mental condition and/or status. a) Resident #7's Resident #7's order was revised on 03/19/25. Aspiration Precautions were removed from the resident's dietary order. b) Resident #151 Resident #151's order was revised on 03/19/25. Double portions of protein with lunch and dinner, Full upright position with PO, Alternate bites and drinks were removed from the resident's dietary order. c) Resident #169 Resident #169's order was revised on 03/19/25. Resident prefers plastic water bottle provided by family, filled 1/4 full or approximately 4 oz. to assist with rate and bolus control were removed from the resident's diet order. A two-handled mug was added. d) Resident #48 Resident #48's order was revised on 03/19/25. Resident straw with all liquids was removed from the dietary order. e) Resident #80 Resident #80 order was revised on 03/19/25. Three (3) second hold with ALL drinks, small bites. sips, alternate bites/sips and aspiration precautions were removed from the resident's diet order. g) Resident #97 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #97's order was revised on 03/19/25. Set up assistance, Alternate solids and liquids, small bites/drinks, make sure the resident is upright during all PO intake and for 30 minutes following PO intake were removed from the resident's dietary order. h) Resident #59's order was revised on 03/19/25. Aspiration precautions were removed from the resident's dietary order. i) Resident #34's order was revised on 03/19/25. Strict aspiration precautions were removed from the resident's diet order. j) Resident #58's order was revised on 03/20/25. No straws was removed from the resident's diet order. K) Resident #111 Resident #111's order was revised on 03/19/25. Fill upright position for all PO intake, no talking while food is in mouth, Chew food thoroughly before swallowing, alternate bites/drinks (every 1-3 bites) were removed from the resident's diet order. l) Resident #152 Resident #152's order was revised on 03/20/25. No straws and set-up with meals were removed from the resident's dietary order. m) Resident #124 Resident #124's order was revised on 03/19/25. Ground meat was removed from her diet order. n) Resident #116 Resident #116's diet order was revised on 03/19/25. Aspiration precautions were removed from the resident's diet order. o) Resident #33 Resident #33's diet order was revised on 03/19/25. NO STRAWS was removed from the resident's diet order. Additional documentation was requested by the State Surveyor for documentation of the notifications regarding the change in condition/order. No additional information was provided. On 03/24/25, Corporate Life Enrichment Staff #224 confirmed there was no additional documentation.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 39043 Based on record review and staff interview, the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for two (2) of 50 residents reviewed in the long-term care survey sample and one (1) of three (3) closed record reviews. Resident identifiers: #9, #21, and #183. Facility census: 184. Findings included: a) Resident #9 Review of Resident #9's medical records showed a weekly wound evaluation completed on 01/08/25. A suspected deep tissue injury to the left heel was noted. This was a new skin issue that had been present when the resident returned to the facility from the hospital that day. An order was entered to apply sureprep to the wound and monitor the skin surrounding the wound. Resident #9's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 01/10/25 documented that the resident had no unhealed pressure ulcers or injuries. On 03/20/25 at 4:13 PM, the Regional MDS Coordinator confirmed Resident #9's MDS with ARD 01/10/25 should have documented the resident had a pressure ulcer/injury. He stated the MDS had been corrected. b) Resident #21 Review of Resident #21's medical records showed the resident was discharged from the hospital on 01/23/25. The admission and discharge diagnoses were urinary tract infection with chronic suprapubic catheter, vomiting, mild hypokalemia, constipation, atrial fibrillation, type 2 insulin dependent diabetes mellitus, and history of cerebrovascular accident. The resident's urinalysis showed extremely turbid urine with a large amount of occult blood, large leukocyte esterase, white blood cell count, and mucus. The resident received intravenous antibiotics before transitioning to oral antibiotics. Oral antibiotics continued upon the resident's return to the nursing facility. Resident #21's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 01/27/25 documented the resident had not had a urinary tract infection in the last 30 days. On 03/18/25 at 4:34 PM, the Regional MDS Coordinator confirmed Resident #21's MDS with ARD 01/07/25 should have documented the resident had a urinary tract infection in the last 30 days. He stated the MDS will be corrected. 52482

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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 39043 Based on record review and staff interview, the facility failed to ensure a complete and accurate Preadmission Screening and Resident Review (PASRR) had been completed for one (1) of four (4) residents reviewed for the care area of PASRR. Resident identifier: #179. Facility census: 184. Findings included: a) Resident #179 Review of the facility's policy titled, Antipsychotic Medication Use, with no approval or implementation date given, stated that Preadmission Screening and Resident Review (PASRR) would be reviewed for residents transferred from a hospital who were already receiving antipsychotic medications. Review of Resident #179's medical record showed a PASRR completed on 02/11/25, before the resident's admission to the facility. The PASRR documented the resident had no major mental illness or suspected mental illness. Review of Resident #179's medical records showed she had a diagnosis of schizophrenia. She had been admitted to the facility from the hospital. The hospital recommended the facility continued the antipsychotic medication Loxapine, which the resident had been taking in the hospital. On 03/24/25 at 9:24 AM, Business Manager #6 confirmed Resident #179's admission PASSR dated 02/11/25 was incorrect in that it did not identify the resident had a diagnosis of schizophrenia. The business manager stated PASSRs are usually reviewed for residents newly admitted to the facility to ensure accuracy. She stated Resident #179 would have a new PASSR completed soon. No further information was provided through the completion of the survey.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45173 Based on record review and staff interview, the facility failed to develop and implement care plans This was true for two (2) of five (5) residents reviewed. Resident identifiers: #144 and #24. Facility Census: 184. Findings Include: a) Resident #144 On 03/18/25 at 1:00 PM, a record review was completed for Resident #144. The review found the care plan focus area of (Name of Resident) may decline to attend dialysis, at times. She may refuse hygiene care, including showers and bed baths. May report contradictory information at time (Typed as written.) These areas had no interventions or goals noted. In addition, the focus area of risk for falls had an intervention stating, no description provided. (Typed as written.) Lastly, a focus area of risk for pain, listed an intervention of administer medication as ordered. (Typed as written.) The resident did not currently have a physician's order for any type of pain medication. On 03/19/25 at 10:04 AM, Registered Nurse (RN) #44 confirmed the errors on the care plan. RN #44 stated, We have some errors .we will get these fixed. b) Resident #24 On 03/18/25 at 1:00 PM, a record review was completed for Resident #144. The review found a physician's order dated 11/24/24 for Enhanced Barrier Precautions every shift for a history of Extended Spectrum Beta Lactamase (ESBL) resistance. The care plan was reviewed; and there was no indication the resident was on EBP. On 03/18/25 at 3:00 PM, Registered Nurse (RN) 44 was interviewed regarding Resident #44. RN #44 confirmed the resident was on enhanced-barrier precautions due to having the MDRO, ESBL.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45173 Based on record review and staff interview, the facility failed to revise care plans for three (3) of 50 reisdents. Resident #31's care plan was not revised regarding safety checks. Resident #109 did not have a care plan revised with the discontinuation of dialysis and comfort care in place. Resident #67 did not have a care plane revision for the discontinuation of opiate. Resident #24 did not have a care plan for Enhanced-Barrier Precautions (EBP) and a multidrug resistant organism (MDRO). Resident identifiers: #31, #109, #67. Facility Census: 184. Findings include: a) Resident #31 On 03/24/24 at 1:00 PM, a record review was completed for Resident #31. The review found the resident had a physician's order dated 09/05/24 for safety checks every 30 minutes document on paper. The safety checks were added for a history of multiple falls and family request. The care plan listed a focus area of (Name of Resident) has experienced an actual fall, continues to be at risk for falls related to weakness, impaired mobility and left femur fracture, muscle wasting, Atrial Fibrillation, lymphedema, fibromyalgia, coronary artery disease and anemia. The interventions were reviewed, the safety checks every 30 minutes were not added to the care plan. On 03/24/25 at 2:48 PM, the Director of Nursing (DON) confirmed the intervention had not been added to the care plan. b) Resident #109 On 03/17/25 at 2:15 PM, a record review was completed for Resident #109. The review found the resident had made the decision to discontinue dialysis and begin comfort care only. The decision was discussed with the resident's Medical Power of Attorney (MPOA). The MPOA agreed with the resident's wishes to be on comfort care only. The Physician Orders for Scope of Treatment (POST) was changed to Do Not Resuscitate (DNR) comfort care, no weights, no dialysis, no emergency room visits and no tube feeding. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was held with Registered Nurse (RN) #44 on 03/17/25 at 3:30 PM. RN #44 stated, For the longest time (Name of Resident) would refuse to go to dialysis and then go to the hospital, get dialysis and change his mind again .but he finally decided to stop dialysis and be comfort care. RN #44 confirmed the care plan was not revised to indicate the resident had stopped dialysis and was currently under comfort care. Also, RN #44 was asked about the focus area of diuretics on the care plan. The focus area included the resident is at risk for complications secondary to diuretic use due to a diagnosis of _____ (blank). RN #44 confirmed the care plan was incorrect under this focus area. On 03/21/25 at approximately 9:30 a.m., an attempt was made to interview Resident #109. However, the resident was sleeping. Licensed Practical Nurse (LPN) #77 approached the resident's door. An interview was held with LPN #77 at this time. LPN #77 stated, He is not doing good this morning. LPN #77 continued to state, About a week or two ago, he was made a DNR with comfort measures by his Medical Power of Attorney (MPOA) . He didn't want to do dialysis treatments anymore. In the past, he just wanted to go to the hospital and let them fix him up each time. LPN #77 was asked, How involved is the resident in decisions regarding his care? LPN #77 stated, His MPOA always included him in the decisions. She really cares about him. c) Resident #67 On 03/17/25 at 9:30 AM, a record review was completed for Resident #67. The review found the care plan listed a focus area of opioids with an intervention of administer medications as ordered. The review, also, found no current physician's order for opioids. On 03/19/25 at 10:50 AM, the DON confirmed the resident was not taking any opioid for pain.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 d) Resident #179 On 03/17/25 at 3:28 PM, Resident #179 was interviewed in her room. She was tearful. She stated she was supposed to have a shower today, but she hadn't had one yet. She stated she wanted her hair washed today. Her hair looked greasy. Review of the facility's shower schedule showed the resident was scheduled to receive showers on Mondays and Thursdays. Resident #179's bathing/showering task report for the last 30 days was reviewed on 03/18/25. The only shower documented in the last 30 days was on 03/17/25. The resident was documented as receiving bed or towel baths on 02/19/25, 02/20/25, 02/21/25, 02/22/25, and 02/24/25. The resident was out of the facility from 02/24/25 through 03/07/25. The resident was documented as receiving bed or towel baths on 03/07/25, 03/08/25, 03/09/25, 03/10/25, 03/13/25, 03/15/25, and 03/16/25. Resident #179's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 03/06/25 gave the resident's Brief Interview for Mental Status (BIMS) score as 9, indicating moderately impaired cognition. The resident was determined not to have the capacity to make her own medical decisions. The resident's comprehensive care plan for preferences stated as follows: At times, resident prefers not to take showers. Prefers to follow facility shower schedule for twice weekly, has no individual preference for days, times or etc. Resident will decline both shower and bedbath at times. [Typed as written.] On 03/19/25 at 5:06 PM, the Director of Nursing confirmed Resident #179's bathing/showering task report only showed a shower on 03/17/25. She stated Resident #179 may prefer bed baths to showers. She stated she would look for documentation regarding the resident's preferences for bed baths and documentation of any showers the resident refused. No new documentation was provided through the completion of the survey. 51553 Based on Record Review, Observation and Staff and Resident Interview, the facility failed to provide care for residents requiring assistance with Activities of Daily Living (ADLs) for shaving and showers for 4 of 10 residents. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #123, #174, #484 and #179. Census: 184. Findings included: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) On 03/17/25, Resident #123 stated, I usually keep it shaved. When the resident was asked about a shower, Resident #123 stated, I need one or at least a bed bath. Record review, documented the resident had been receiving regular bed baths, but no showers. On 03/20/25 at 01:00 PM, the resident was observed to still have facial hair. When the resident was asked if he had been shaved, the resident stated, No, it needs it. Nursing Assistant (NA) #114, confirmed the patient had facial hair and wanted to be shaved. b) On 03/17/25, during the initial interview in the resident's room, Resident #174 reported he had been a resident of the facility for about 4 months. The resident reported he had not been able to get a shower, only bed baths. He stated he would like to have showers. He reported he didn't mind using a special device to have a shower due to his physical limitations. On 03/19/25 at 05:06 PM, no showers were confirmed by Director of Nursing (DON). The DON reported she was going to look for additional refusal documentation. No additional documentation was provided. The residents care plan stated, At times, [NAME] prefers not to take showers. Prefers to follow facility shower schedule for twice weekly showers, has no individual preference for days, times, or etc. Offer bed baths per facility schedule twice weekly if resident declines shower. Resident will decline both a shower and a bath at times. c) 03/17/25 01:50 PM, Resident #484 and her daughter reported she had not had a shower since admission. Review of the ADL Task Log for Bathing/Showering, confirmed Resident #484 had not had a shower or bed bath from 03/10/25-03/15/25. The patient received a bed bath on 03/16/25 per documentation. The resident's shower days were scheduled for Thursdays and Sundays. On 03/19/25 at 05:06 PM, no showers were confirmed by Director of Nursing (DON). The DON reported she was going to look for additional refusal documentation. No additional documentation was provided. The resident's Care Plan initiated on 03/20/2025 stated, refuses showers and baths at times.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 45173 Based on record review and staff interview, the facility failed to follow physician's orders for Resident #144's arm restrictions, the amount of assistance needed for transfers for Resident #31, Resident #31's safety checks, and Resident #7's aspiration precautions. This was true for three (3) of 50 residents reviewed during the survey process. Resident Identifiers: #144, #31 and #7. Facility Census: 184. Findings Include: a) Resident #144 On 03/19/25 at 9:00 AM, a record review was completed for Resident #144. The review found a physician's order dated 11/19/24 stating, Dialysis: No BP (blood pressure) or lab draw in right arm due to permacath every shift for ESRD (end stage renal disease). The review, for 03/2025, found multiple dates and times the blood pressure was taken in the right arm. The following are the dates and times: --03/18/25 at 9:19 AM --03/17/25 at 8:51 PM --03/17/25 at 5:18 AM --03/16/25 at 8:51 PM --03/14/25 at 5:25 AM --03/12/25 at 8:04 PM --03/08/25 at 8:45 PM --03/07/25 at 8:27 PM --03/05/25 at 8:24 PM --03/04/25 at 8:32 PM --03/04/25 at 8:41 AM --03/03/25 at 10:03 PM --03/03/25 at 1:26 PM --03/03/25 at 8:17 AM --03/03/25 at 6:53 AM (continued on next page)

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Huntington Health and Rehabilitation Center	1720 17th Street Huntington, WV 25701

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--03/02/25 at 9:02 PM --03/01/25 at 10:15 PM An additional review of 02/2024 found the following dates and times: --02/28/25 at 5:25 AM --02/27/25 at 10:11 PM --02/26/25 at 5:16 AM --02/25/25 at 8:40 AM --02/24/25 at 6:03 PM --02/24/25 at 1:31 PM --02/23/25 at 8:44 PM --02/23/25 at 8:31 AM --02/22/25 at 9:20 PM --02/21/25 at 8:51 PM --02/19/25 at 9:57 AM --02/18/25 at 8:49 AM --02/18/25 at 8:37 AM --02/14/25 at 10:43 PM --02/14/25 at 12:00 PM --02/12/25 at 8:53 AM --02/11/25 at 9:09 AM --02/10/25 at 8:18 PM --02/09/25 at 9:08 PM --02/06/25 at 7:39 AM --02/05/25 at 12:32 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--02/05/25 at 5:18 AM --02/03/25 at 11:29 PM --02/03/25 at 7:16 AM --02/01/25 at 7:19 AM Upon further review of 01/2025, found the following dates and times: --01/31/25 at 1:45 PM --01/31/25 at 8:40 AM --01/30/25 at 10:29 PM --01/30/25 at 8:34 AM --01/26/25 at 7:32 AM --01/25/25 at 8:51 PM --01/25/25 at 9:39 AM --01/24/25 at 8:03 PM --01/23/25 at 12:32 PM --01/23/25 at 8:18 AM --01/22/25 at 9:22 PM --01/22/25 at 1:30 PM --01/17/25 at 12:07 PM --01/16/25 at 9:12 AM --01/13/25 at 3:29 PM --01/12/25 at 12:26 PM --01/10/25 at 3:33 PM --01/06/25 at 9:28 AM --01/03/25 at 12:05 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--01/03/25 at 11:37 AM --01/03/25 at 7:02 AM --01/02/25 at 3:49 PM On 03/19/25 at approximately 1:45 PM, the Director of Nursing (DON) confirmed the blood pressures were obtained from the restricted right arm. b) Resident #31 On 03/24/25 at 12:34 PM, a record review was completed for Resident #31. The review found the resident was having multiple falls due to the resident trying to transfer herself to go to the bathroom. A progress note dated 09/10/24 at 4:33 PM, stated, Spoke to (Name of the facility nurse practitioner) about resident's transfer order and family request. She said to put her 2-person extensive assist non-wight bearing to LLE (left lower extremity) during the morning until bedtime and at bedtime to have her order for 3-person extensive assist with non-weight bearing to LLE (left lower extremity). (Typed as written.) Upon further review, the documentation under the tasks tab for transferring dated 09/2024 was reviewed. The following dates and times in 09/24 did not follow the approved assistance needed for transfers: --09/14/24 at 9:44 PM limited assistance, one person physical assist --09/15/24 at 6:25 PM extensive assistance, one person physical assist --09/19/24 at 6:59 AM limited assistance, one person physical assist --09/23/24 at 6:59 AM supervision, set up help only --09/25/24 at 3:47 AM supervision, set up help only --09/26/24 at 5:02 PM extensive assistance, one person physical assist --09/29/24 at 6:51 AM supervision, set up help only Lastly, the documentation under the tasks tab for transferring dated 10/2024 was reviewed. The following dates and times in 10/2024 did not follow the approved assistance needed for transfers: --10/03/24 at 1:00 AM extensive assistance, one person physical assist --10/08/24 at 3:07 AM supervision, set up help only --10/09/24 at 4:50 AM supervision, set up help only --10/16/24 at 4:17 AM limited assistance, one person physical assist (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--10/17/24 at 5:36 AM supervision, set up help only --10/18/24 at 6:59 AM limited assistance, one person physical assist --10/26/24 at 6:59 AM limited assistance, one person physical assist On 03/24/25 at 2:48 PM, the Director of Nursing (DON) confirmed the documentation did not reflect the approved assistance needed for transfers. c) Resident #31 On 03/24/25 at 1:00 PM, a record review was completed for Resident #31. The review found the resident had a physician's order dated 09/05/24 for safety checks every 30 minutes document on paper. The safety checks were added for a history of multiple falls and family request. The following dates and times were incomplete and did not have documentation: --02/20/25 6:00 AM --02/20/25 6:30 AM --02/23/25 6:00 AM --02/23/25 6:30 AM On 03/24/25 at 2:48 PM, the Director of Nursing (DON) confirmed the documentation was incomplete for the safety checks. c) Resident #7 On 03/19/25 at 1:12 PM, Nursing Assistant (NA) #156 was observed feeding Resident #7 in the third-floor dining room. The resident required full assistance. Resident #7's meal tray card gave the diet order as NAS (no added salt) chopped meat aspiration precautions. The tray card also gave the following instructions: upright @ 90 degrees, sm. Bites, alt. liquids/solids, add sauce tableside as needed, liquids by straw only. The resident had chopped lasagna, green beans, garlic bread, and chocolate pudding. The resident was placed in a gerichair positioned at a 45-degree angle. NA #156 did not alternate solids and liquids. Five (5) bites were consumed by the resident with no liquids presented. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor intervened at 1:22 PM and reviewed the meal tray card instructions with NA #156. NA #156 stated Resident #7 usually ate in bed, and not in the gerichair. Resident #7's orders were reviewed. The resident had a diet order written on 03/14/25, CCD[consistent carbohydrate diet] chopped texture, regular/thin consistency, liquids by straw only, serve liquids in a Kennedy cup, Full assist, use pillow behind head for chin down position while eating drinking, cue [resident] to take small sips, aspiration precautions, upright @ 90 degrees. On 03/19/25 at 1:36 PM, Resident #7 was observed again. NA #156 continued to feed the resident. The resident's neck was slightly extended back with no chin tuck. The resident did not have a pillow behind her head. When asked about the resident's positioning, NA #156 stated, I didn't know. The NA stated she usually worked on a different hallway. Further review of Resident #156's records showed until this diet change on 03/14/25, the resident was receiving a mechanical soft mechanical diet with honey thickened liquids. A Speech Therapy evaluation dated 03/04/25 gave the following swallow strategies/positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: general swallow techniques/precautions. Resident #7 had a Fiberoptic Endoscopic Evaluation of Swallowing (FEES) performed on 03/14/25. The FEES report concluded, Pharyngeal phase: Penetration of thin liquids via spoon on 2 nd presentation secondary to loss of bolus control. Patient was able to clean material with consecutive swallows. Once head positioning was adjusted due to chin-down posture, penetration diminished. No aspiration observed. Patient with complete but mistimed laryngeal squeeze. Trace residue due to slightly reduced pharyngeal squeeze. Overall: Patient with mild oral dysphagia characterized by inconsistent loss of bolus control. Based on observation, current medical status, and mobility, patient is a mild risk for aspiration and potential development of nosocomial pneumonia. With implementation of compensatory strategies of small sips via straw and optimal positioning at 90 degrees with chin tuck as tolerated, risk reduces to minimal .Compensatory Strategies: 1. Small sips via (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	straw 2. Upright at 90 degrees as tolerated. 3. [NAME] tuck to improve oral control. The resident had been discharged from the hospital on 03/03/25 after being admitted on 02/18/25 for coronavirus. The discharge documentation stated, hospitalization was complicated by worsening hypoxia despite appropriate treatment. It was associated with worsening dysphagia .Currently her diet is a mechanical soft diet with honey thickened liquids. The patient has to have a no straws and be fully upright for all p.o. [oral] intake during and for 30 minutes after eating . Review of resident diets for the entire resident population showed 44 residents had diet orders recommending safe swallowing strategies/precautions. 51553 c) Resident #7 On 03/19/25 at 1:12 PM, Nursing Assistant (NA) #156 was observed feeding Resident #7 in the third-floor dining room. The resident required full assistance. Resident #7's meal tray card gave the diet order as NAS (no added salt) chopped meat aspiration precautions. The tray card also gave the following instructions: upright @ 90 degrees, sm. Bites, alt. liquids/solids, add sauce tableside as needed, liquids by straw only. The resident had chopped lasagna, green beans, garlic bread, and chocolate pudding. The resident was placed in a gerichair positioned at a 45-degree angle. NA #156 did not alternate solids and liquids. Five (5) bites were consumed by the resident with no liquids presented. The surveyor intervened at 1:22 PM and reviewed the meal tray card instructions with NA #156. NA #156 stated Resident #7 usually ate in bed, and not in the gerichair. Resident #7's orders were reviewed. The resident had a diet order written on 03/14/25, CCD[consistent carbohydrate diet] chopped texture, regular/thin consistency, liquids by straw only, serve liquids in a Kennedy cup, Full assist, use pillow behind head for chin down position while eating drinking, cue [resident] to take small sips, aspiration precautions, upright @ 90 degrees. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/25 at 1:36 PM, Resident #7 was observed again. NA #156 continued to feed the resident. The resident's neck was slightly extended back with no chin tuck. The resident did not have a pillow behind her head. When asked about the resident's positioning, NA #156 stated, I didn't know. The NA stated she usually worked on a different hallway. Further review of Resident #156's records showed until this diet change on 03/14/25, the resident was receiving a mechanical soft mechanical diet with honey thickened liquids. A Speech Therapy evaluation dated 03/04/25 gave the following swallow strategies/positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake: general swallow techniques/precautions. Resident #7 had a Fiberoptic Endoscopic Evaluation of Swallowing (FEES) performed on 03/14/25. The FEES report concluded, Pharyngeal phase: Penetration of thin liquids via spoon on 2 nd presentation secondary to loss of bolus control. Patient was able to clean material with consecutive swallows. Once head positioning was adjusted due to chin-down posture, penetration diminished. No aspiration observed. Patient with complete but mistimed laryngeal squeeze. Trace residue due to slightly reduced pharyngeal squeeze. Overall: Patient with mild oral dysphagia characterized by inconsistent loss of bolus control. Based on observation, current medical status, and mobility, patient is a mild risk for aspiration and potential development of nosocomial pneumonia. With implementation of compensatory strategies of small sips via straw and optimal positioning at 90 degrees with chin tuck as tolerated, risk reduces to minimal .Compensatory Strategies: 1. Small sips via straw 2. Upright at 90 degrees as tolerated. 3. [NAME] tuck to improve oral control. The resident had been discharged from the hospital on 03/03/25 after being admitted on 02/18/25 for coronavirus. The discharge documentation stated, hospitalization was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complicated by worsening hypoxia despite appropriate treatment. It was associated with worsening dysphagia .Currently her diet is a mechanical soft diet with honey thickened liquids. The patient has to have a no straws and be fully upright for all p.o. [oral] intake during and for 30 minutes after eating . Review of resident diets for the entire resident population showed 44 residents had diet orders recommending safe swallowing strategies/precautions.

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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. 39043 Based on record review and staff interview, the facility failed to document the amount of nutritional supplement consumed for one (1) of 10 residents reviewed for the care area of nutrition. Resident Identifier: #14. Facility census: 184. Findings included: a) Resident #14 Review of Resident #14's physician's orders showed an order written on 02/22/24 for Fortified pudding three times a day for weight loss. The resident's Medication Administration Record (MAR) showed the resident received fortified pudding three (3) times a day. However, the amount eaten by the resident was not recorded. On 03/20/25 at 10:38 AM, the Director of Nursing confirmed Resident #14's consumption of fortified pudding was not recorded. No further information was provided through the completion of the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 39043 Based on observation, record review, and staff interview, the facility failed to ensure the medication error rate during the facility task of Medication Administration was less than 5%. The medication error rate was 7%. Resident identifier: #17. Facility Census: 184. Findings included: a) Resident #17 On 03/19/25 at 7:10 AM, Licensed Practical Nurse (LPN) #76 was observed administering morning medications to Resident #17. The medications were in blister packaging, where tablets were individually pushed through the sealed foil into the medication administration cup by LPN #76. LPN #76 dispensed a buspirone 10 mg tablet from the blister package into the medication administration cup. She placed the buspirone blister package back into the medication cart drawer. She pulled the buspirone blister package back out of the medication cart and pushed another buspirone 10 mg from the blister packaging into the medication administration cup. The other medications LPN #76 dispensed from blister packets into the medication administration cup for Resident #17 were amlodipine, baclofen, fluoxetine, and lisinopril. LPN #76 also dispensed a multivitamin and an aspirin tablet from multi-use floor stock bottles. LPN #76 picked up the medication administration cup to take the cup into Resident #17's room to dispense the medication. She was stopped by the surveyor and asked to retrieve the buspirone blister packet from the medication cart. The buspirone 10 mg tablets were found to be white, round tablets with HP/24 printed on them. The medication cup was found to have two white, round tablets with HP/24 printed on them. LPN #76 confirmed Resident #17 was prescribed buspirone 10 mg. She removed one of the buspirone 10 mg tablets from the medication cup and then administered the medications to Resident #17. Review of Resident #17's medication orders showed on 03/07/25 the resident was ordered buspirone 10 mg, two (2) times a day for restlessness related to unspecified anxiety disorder. Review of Resident #17's medication orders also showed on 02/27/25 the resident was ordered famotidine 20 mg, two (2) times a day related to gastro-esophageal reflux disease without esophagitis. The resident did not receive famotidine during the medication administration on 03/19/25 at 7:10 AM. According to the buspirone package insert, available on-line on the Food and Drug Administration Website, buspirone side effects included dizziness, drowsiness, nervousness, and lightheadedness. On 03/19/25 at 10:57 AM, the Administrator and Director of Nursing were informed that LPN #76 had been stopped by the surveyor from giving two (2) buspirone 10 mg tablets to Resident #17. They were also informed that Resident #17 did not receive famotidine that morning. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Two (2) errors were found out of 28 medications observed during the Medication Administration facility task observation. No further information was provided through the completion of the survey process.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49467 Based on observation and resident and staff interview, the facility failed to ensure proper portions were served to residents during mealtimes. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents. Facility census: 184. Findings include: a) Resident #101 During an interview on 03/17/25 at 12:01 PM, Resident #101 stated the food portions at the facility were too small. At approximately 12:45 PM on 03/19/25, an observation was conducted during lunch service in the facility kitchen. The diet spreadsheet for the meal called for the following portion sizes to be served, six (6) ounces of homestyle lasagna; one (1) dinner roll; four (4) ounces of Italian green beans; four (4) ounces of chocolate pudding; four (4) ounces of milk; eight (8) ounces of coffee or hot tea. During service, Dietary Aide (DA) #176 was observed serving regular lasagna with a number ten scoop, ground lasagna with a number ten scoop, ground chicken (main dish for the alternate meal) with a number ten scoop. Size ten scoops will serve approximately three (3) ounce portions. DA #176 was asked how he knew if correct scoop sizes were being used and if correct portions were being served, to which he replied, Usually they just put the scoops in here and I use them, that's all I know, they usually set things up for me and I just serve it. When asked if he knew if a size ten scoop would serve six (6) ounces of lasagna, he stated, We couldn't find a six (6) for the lasagna, so we used a ten. Furthermore, there was no scoop size guide posted in the kitchen and no dietary employee was able to point out where they received guidance on correct portion sizes. The facility provided a scoop size chart, and it revealed the number ten scoop serves 3.2 ounces, roughly half the size of the six (6) ounce portion size the menu stated was to be served.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49467 Based on observation and resident and staff interview, the facility failed to provide appetizing and palatable meals to residents of the facility. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents residing in the facility. Resident identifiers: #116, #166. Facility census: 184 Findings include: a) At approximately 1:05 PM on 03/17/25, during an interview with Resident #116, the resident stated the food at the facility was awful. At approximately 2:31 PM on 3/17/2025, during an interview with Resident #166, the resident stated The food is horrible. It tastes awful and it's cold. At approximately 12:00 PM on 3/19/2025, the dietary department presented surveyors with test trays. The meal was tested by five (5) of five (5) surveyors in the facility at the time. The meal consisted of chicken strips, broccoli, and parsley noodles. Upon examination of the meal, the broccoli appeared gray in color as opposed to green. Upon tasting the broccoli, it was non-cohesive and formed a mush-type substance when picked up with a fork or fingers and had little to no taste. The noodles were plain with no taste. The chicken strips were cold. Five (5) out of five (5) surveyors testing the meal agreed that the meal was not palatable or appetizing. At approximately 2:25 PM on 3/19/2025, after service concluded on the parkway hallway, the temperature of the last tray remaining on the cart was taken to test food temperatures. Temperatures were taken by Dietary Aide (DA) #177. The food temperatures were: Chicken: 101.8 Green Beans: 113 Bread was served at room temperature

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on observations, record review, and staff interview, the facility failed to ensure meals were delivered in a timely manner and failed to ensure snacks were delivered to residents, as ordered. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents residing in the facility. Resident identifiers: #65, #135, #76, #134, #1, #155, #149, #87, #54, #30, #19. Findings include: a) Mealtimes Upon entrance to the facility on [DATE], the survey team was provided with a document titled Meal Service and Tray Cart Delivery Times. According to the schedule, lunch service was as follows: Third Floor- 11:30 AM to 11:50 AM Third Floor Assists- 11:50 AM to 11:55 AM Fourth Floor- 11:55 AM to 12:10 PM West 12:10 PM to 12:25 PM South 12:25 PM to 12:40 PM Fourth Floor Assists 12:40 PM to 12:55 PM Parkway 12:55 PM to 1:10 PM During an interview conducted with Dietary Aide (DA) #147 at approximately 11:00 AM on 3/17/2025, he was asked when the kitchen started meal service, he stated, We try to start between 12:15 PM and 12:30 PM if we can. Sometimes we can, sometimes we can't. Service started at approximately 12:35 PM. Prior to service beginning, dietary staff were observed to continue to wash dishes up until the point of service beginning. Staff would remove dishware from the dishwasher and immediately place it on the tray line to get started with service. It was noted during observation that most plates, silverware, cups, etc. being placed on the line for service were still wet and were not allowed to dry prior to use due to the department seemingly running behind schedule. On 3/19/2025, trays were delivered to the third floor at approximately 1:00 PM. The last trays were delivered to the parkway hall at approximately 2:10 PM, and a temperature was received from a test tray on that cart immediately following service. DA #177 acknowledged the tray cart was recently delivered. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/20/2025, trays were delivered to the third floor at approximately 1:20 PM. Trays arrived at the parkway hall, and service began at approximately 2:35 PM. Licensed Practical Nurse Unit Manager (LPNUM) #49 acknowledged the time of the trays being delivered and confirmed the trays were late. Multiple residents during the survey process were observed stating they were hungry, with several staff stating Lunch will be ready soon after the scheduled arrival time for the trays. At approximately 10:45 AM on 3/20/2025 during observation of the fourth-floor nourishment room, bedtime snacks from 3/19/2025 for Residents #65, 135, 76, 1, 155, 149, 87, 54, 30, and 19 were discovered on a tray in the refrigerator, unopened, with the labels still attached to them. This was confirmed by Registered Nurse Unit Manager (RNUM) #83. Tasks lists were reviewed for all 10 residents from 03/19/25. All task list stated the residents accepted their snacks despite them being in the refrigerator of the nourishment room, unopened. This was confirmed by the Administrator and Director of Nursing (DON) in an interview at approximately 1:45 PM on 03/24/25. 51553 c) Resident #134 Resident #134's snack was found dated and labeled for 03/19/25 in the refrigerator on 03/20/25 at 10:20 AM. However, the evening/bedtime snack was documented on the Nutrition Task Log as A snack was offered and accepted on 03/19/25 at 20:00 PM.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 51553 Based on Observation, Policy and Procedure and Staff Interview, the facility failed to provide a resident with adaptive equipment per order. This was a random opportunity for discovery. Resident identifier: #146. Facility Census: 184. Findings included: a) Resident #146 Resident #146 was ordered a divided plate on 11/28/23. On 03/19/2025 at 01:02 PM, Resident #146 was served the lunch meal on a regular plate. Tray card for a divided plate was reviewed and confirmed with Licensed Practical Nurse (LPN) #76 on 03/19/25 at 01:02 PM. Resident #146's care plan stated, Diet as ordered-built up utensils, divided plate. Policy and Procedure reviewed stated, Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them.

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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. 49467 Based on observation, record review, and staff interview, the facility failed to ensure complete temperature logs for food, the chemical test log for the three (3) compartment sink, and to reheat resident food to appropriate temperatures before consumption. This was a random opportunity for discovery. This had the potential to affect more than a limited number of residents. Findings include: a) Temperature log On 3/20/2025, temperature logs from the dietary department were reviewed. During the review, it was determined a number of logs in the range of 03/01/25 through 03/19/25 had not been completed. 3/4/2025- None completed 3/5/2025- Dinner not completed 3/6/2025- Dinner not completed 3/7/2025- Breakfast and lunch not completed 3/8/2025- Breakfast and lunch not completed 3/9/2025- None completed 3/10/2025- None completed 3/11/2025- None completed 3/12/2025-Dinner not completed 3/13/2025- Dinner not completed 3/16/2025- Dinner not completed 3/17/2025- Dinner not completed 3/19/2025- Lunch and dinner not completed These were confirmed as incomplete in an interview with the Administrator and Director of Nursing (DON) on 3/24/2025 at approximately 1:45 PM. b) Three (3) Compartment Sink (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/24/2025, a review of the Three (3) compartment sink chemical test log revealed it to be incomplete. The log is to be completed three (3) times a day at breakfast, lunch, and dinner. The following were times it was not complete: 3/3/2025- Dinner 3/4/2025- None completed 3/5/2025- Dinner 3/6/2025- Dinner 3/7/2025- Breakfast and lunch 3/8/2025- Breakfast and lunch 3/9/2025- None completed 3/10/2025- None completed 3/11/2025- None completed 3/12/2025- Lunch and dinner 3/13/2025- None completed 3/14/2025- None completed 3/15/2025- None completed 3/16/2025- None completed 3/17/2025- None completed 3/18/2025- None completed 3/19/2025- None completed 3/20/2025- None completed 3/21/2025- None completed 3/22/2025- None completed 3/23/2025- None completed 3/24/2025- Breakfast and lunch incomplete at this time (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These were confirmed as incomplete in an interview with the Administrator and Director of Nursing (DON) on 3/24/2025 at approximately 1:45 PM. C) Reheated food During an observation of the south nourishment room at approximately 10:30 AM on 3/20/2025, it was noted the facility was not reheating food to appropriate temperatures before the food was being consumed by residents, as evidenced by a document titled Reheated Food/Beverage Log. Furthermore, review of the facility's policy on food service stated food was to be reheated to 165 degrees for 15 seconds before being consumed and ready to eat food will be heated to 135 degrees. Dated 02/28/25, a biscuit was reheated for a resident and the temperature recorded was 95 degrees. Dated 03/12/25, macaroni and cheese and dumplings were reheated for a resident with a recorded temperature of 112 degrees. Dated 03/17/25, a roasted turkey meal was reheated for a resident with a record temperature of 104 degrees. These were confirmed as incomplete in an interview with the Administrator and Director of Nursing (DON) on 3/24/25 at approximately 1:45 PM. The temperatures were confirmed as being too low for consumption.

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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** 45173 Based on record review and staff interview, the facility failed to ensure an accurate and complete record for five (5) of 50 residents. For Resident #144 the diagnosis for a medication was incorrect. The date of transfer and diagnosis of a medication for Resident #24 was incourrect. Resident #14's choice for medically assisted nutrition was incorrect and Resident #487's code status and documentation of a fracture for Resident #69 were incorrect. Resident Identifiers: #144, #24, #14 #487 and #69. Facility Census: 184. FindingsiInclude: a) Resident #144 On [DATE] at 12:15 PM, a record review was completed for Resident #144. The review found a physician's order for Eliquis 5mg (milligram) by mouth two times daily for essential (primary) hypertension. However, the primary use for Eliquis, a blood thinner, is prevention and/or treatment of blood clots. The resident had a diagnosis of thrombosis and embolism. On [DATE] at 2:00 PM, Registered Nurse (RN) #44 confirmed the diagnosis for the Eliquis was incorrect. b) Resident #24 On [DATE] at 12:40 PM, a record review was completed for Resident #24. The review found an incorrect date on a transfer form to an acute care facility. The date found on the transfer form was [DATE]; however, the correct date was [DATE]. On [DATE] at 3:00 PM, Corporate Life Enrichment #224 was notified and confirmed the date on the transfer form was incorrect. On [DATE] at 12:40 PM, a record review was completed for Resident #24. The review found a physician's order for Melatonin 1mg by mouth one time daily for insomnia. The diagnosis of insomnia was incorrect. The diagnosis for Melatonin should have been listed as a supplement. On [DATE] at 2:00 PM, Registered Nurse (RN) #44 confirmed the diagnosis for Melatonin was incorrect. 51553 e) Resident #487 On [DATE], Resident #487's Advanced Directive was reviewed. The resident's order stated, Full Code. The Resident's Advanced Directive was marked, No CPR: Do Not Attempt Resuscitation. and Full Treatments. This was confirmed by Corporate Registered Nurse #223 on [DATE] at 5:00 PM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	52482 f) Resident #69 A review of Resident #69's medical record at 12:29 PM on [DATE] found a progress note stating, Patient has a fx (fracture) to right great toe. All other documentation stated patient had a fracture to the left great toe. During an interview with the Corporate Life Enrichment, Employee #224, at approximately 1:37 PM on [DATE], it was agreed upon the error in documentation for Resident #69. 39043 d) Resident #14 Review of Resident #14's diagnoses list showed the resident had diagnoses of multiple sclerosis and dysphagia. The resident did not have the capacity to make medical decisions. Review of the resident's medical records showed a [NAME] Virginia Physician's Orders for Scope of Treatment (POST) form dated [DATE], signed by the resident's Medical Power of Attorney (MPOA). A POST form indicates end-of-life instructions. The section titled, Medically Assisted Nutrition, was not completed to convey the resident's or resident's representative's wishes. This section contained the following options: - Provide feeding through new or existing surgically-placed tubes -Time-limited trial of ____ days but no surgically placed tubes - No artificial means of nutrition desired - Discussed but no decision made None of these options had been checked. On [DATE] at 4:32 PM, the Director of Nursing confirmed the medically assisted nutrition section of Resident #14's POST form dated [DATE] was not completed. No further information was provided through the completion of the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49467 Based on observation and resident and staff interview, the facility failed to maintain proper infection control standards by failing to complete hand hygiene with residents before meals. This was a random opportunity for discovery. This had the potential to affect more than a limited number of residents residing in the facility. Resident identifiers: #97, #106. Facility census: 184. Findings include: a) At approximately 12:45 PM on 3/20/2025, the survey team was present in the 300 hallway to observe lunch. At approximately 1:20 PM, lunch service started on the hallway. From approximately 12:45 PM through the time service began, no hand hygiene was seen being performed for the residents who wished to receive it before their meals were delivered. Facility staff had a bottle of hand sanitizer sitting on top of the delivery carts; however, it was being used for staff hand hygiene. Lunch service was completed and no residents on the hallway were observed by the survey team receiving hand hygiene. At approximately 1:29 PM on 3/20/2025, an interview was conducted with Resident #106 regarding hand hygiene. The resident was asked if any staff member came through to offer hand hygiene before his meal was served. The resident stated, no. At approximately 1:40 PM on 3/20/2025, an interview was conducted with Resident #97 regarding hand hygiene. The resident was asked if any staff member came through to offer hand hygiene before his meal was served. The resident stated no. The survey team relocated to the South/Parkway side of the facility to wait for the lunch service to begin at approximately 1:50 PM. Service started on the hallway at approximately 2:40 PM. No hand hygiene was observed taking place during that time or during tray pass. At this point, an interview was conducted with Licensed Practical Nurse Unit Manager (LPNUM) #49 regarding hand hygiene taking place. LPNUM #49 stated, We went around with hand sanitizer at 12:30 PM. Some residents accepted it and some didn't. LPNUM #49 acknowledged hand sanitizer was offered over two (2) hours prior to meal service beginning and not when meal service was happening. Upon reviewing the facility's policy titled Assistance with Meals, the policy states Facility staff will assist the resident as needed with appropriate positioning and hygiene before serving the meal.