STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515035	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Valley of Journey	6500 MacCorkle Avenue SW Saint Albans, WV 25177

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** e) Resident #139 A review of Resident #139's medical record on 07/02/25 found the resident was sent to the hospital on [DATE] after facility staff discovered he was smoking an illegal drug in his room at his facility. The resident reported to staff that he had swallowed the drug therefore they sent him to the emergency room via ambulance. The initial review of the reportable incident found the only issue identified was the residents illegal drug use in the facility. An interview with Nursing Home Administrator (NHA) on the morning of 0702/25 confirmed the resident was sent to the hospital on [DATE] and he was not permitted to return to the facility. When asked if they issued the resident a 30 day discharge notice the facility initially was uncertain if they did or not. During this interview the NHA stated, the main reason Resident #139 was not permitted to return was because as he was on his way out the door he made a statement that he would get a gun an shoot everyone when he came back. The NHA stated, He is already proven he can get illegal substances and we felt he could probably get a gun if he wanted to. When asked why none of the statements contained in the reportable incident indicated this he stated, We probably have some more statements. When asked why the medical record was void of any nursing notes related to this incident he stated, That's when we switched companies and they are probably on paper in medical records. The surveyor requested any documentation related to this incident. At the time of exit this information from the medical record was not provided. Later in the afternoon on 07/02/25 the NHA provided two (2) staff statements which were not in the original reportable incident provided to the surveyor earlier in the day. The NHA stated he was not sure why they were not in the file with the other statements. Both statements detailed the residents threat to bring a gun and shoot everyone. The NHA was then asked to provide the 30 day notice which was issued to Resident #139. He later provided a notice dated 09/03/24. This notice indicated the resident was being discharged to the local hospital due to the safety of individuals in the facility was endangered due to clinical or behavioral status of the resident. The facility wrote in the area provided threats to life of staff and residents. (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In the area where the resident signature should have been the facility wrote 'Dropped off to hospital upon discharge did not receive signed copy back. The NHA was asked if this was delivered to the resident or just left at the hospital. The NHA replied, We just left it at the hospital. The NHA was then asked to provide evidence this notice was sent to the Ombudsman as required at the time it was issued. On the morning of 07/07/25 the NHA provided an email dated 10/21/24 which was sent by the regional ombudsman's to the NHA. In this email the ombudsman requested a copy of the discharge notice. The NHA stated, I'm sure we sent it in response to this email but I can't find it because that social worker no longer works here and it was in the old email system. A telephone interview with the regional long term care ombudsman on 07/07/25 at 05:31 PM confirmed they never received a copy of the Transfer/Discharge notice. She indicated she first became aware of the issue in October of 2024 when the social worker from the hospital contacted her to request assistance. She indicated she requested the notice of transfer/discharge on [DATE] and 10/21/24. She stated, they never received the notice until this morning when the NHA emailed it. The ombudsman indicated that she spoke with the resident and he confirmed he never received the notice. 07/02/25 09:38 AM Stated that this was a repeat occurrence it was probably mid 2023. I would say that it had three or four times. Since we had changed the sheets it was on the floor next to his be and in his sheets. He was leaving the facility that day he threatening to come back and shoot everybody. Not ideal. He denied consistently until the last incident on 09/01/24. He indicated to the staff that he had swallowed. The NHA confirmed they did not issue a discharge notice because he was threatening to shoot everybody. We could not let him come back because he stated he was going to bring a gun back and kill everybody. And have illegal items in the building. Based upon record review, staff interviews, and an interview with the State Long Term Care Ombudsman, the facility failed to provide documentation verifying the Ombudsman received notification of the transfer or discharge of residents. This was found to be true in five (5) out of five (5) residents reviewed for discharge and hospitalization during the long term care survey process. Resident identifiers: #79, #2, #54, #37, #139. Facility Census: 84. Findings included: a) Resident #79 Resident #79 was transferred to an acute care facility on 05/11/25, due to abnormal vital signs. The Resident returned to the long term care facility on 05/17/25 The resident does not have capacity to make own medical decisions. On 07/02/25 at 9:18 AM, the surveyor requested to see verification of an acute transfer notice being provided to the Resident's representative, and verification of a copy being sent to the State Long Term Care Ombudsman. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/02/25 mid afternoon, the Nursing Home Administrator (NHA) brought a fax confirmation of the notice being provided to the Ombudsman on 07/02/25 at 12:12 PM. Thus, the ombudsman was not notified until after the surveyor requested to see verification. When asked about why the notice was just now being sent, the NHA stated they could not find verification that it had been sent at the time of transfer. On 07/08/25 at approximately 1:00 PM, discussion with Staff # 110, verified the notice was not sent to the Ombudsman until 07/02/25. b) Resident #2 Resident #2 was transferred to an acute care facility on 02/11/25 for shortness of breath, and abnormal pulse. Resident was admitted to the acute care facility and returned to the long term care facility on 02/14/25. Resident has capacity to make his own medical decisions. On 07/03/25 at 10:18 AM, the surveyor requested to see verification of an acute transfer/discharge notice being provided to the Resident, as well as verification the notice was sent to the Office of the State Long Term Care Ombudsman. The Notice of Transfer form was given to resident at time of transfer to hospital. On 07/07/25 at 12:10 pm, the Nursing Home Administration provided a copy of the transfer notice, and stated there is no documentation to support that ombudsman was sent a copy of the notice of transfer. Per interview with the Regional [NAME] President of Clinical Services on 07/07/25 at 1:45 PM, there was no additional information she could provide. c) Resident # 54 Resident #54 was transferred to an acute care facility on 03/31/25 due to abnormal vital signs. The Resident was transported by EMS. Due to a diagnosis of severe sepsis, the Resident was admitted . The resident returned to the long term care facility on 04/07/25. Resident does not have capacity to make her own medical decisions. On 07/02/25 mid-morning, the surveyor requested to review the Notice of Acute Transfer or Discharge form for 04/07/25 for the Resident, as well as verification the Notice was sent to the Office of the State Long Term Care Ombudsman. On 07/03/25 mid-afternoon, the NHA provided a copy of a fax coversheet sent to the Ombudsman at 07/02/25 at 3:01 PM. Thus, the Ombudsman was not notified in a timely manner about the transfer. Notification was not provided until the surveyor asked for it. Per interview with the Regional [NAME] President of Clinical Services on 07/07/25 at 1:45 PM, there was no additional information she could provide. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/25 at approximately 12:45 PM, Staff #110, provided a copy of a Bed Reservation Approval form, which had been sent to with the Resident to the hospital, with a copy sent to the Resident's Representative, and verified the notice was not sent to the Ombudsman until 07/02/25. d) Resident #37 On 4/27/25, the family requested Resident #37 be sent to an acute care facility. Resident was admitted , returning to the long term care facility on 05/01/25. On 07/07/25 at 1:07 PM, the surveyor requested from the facility the acute transfer/discharge letter, as well as verification of the notice being sent to the Office of the State Long Term Care Ombudsman. On 07/07/25 at 4:00 PM, the DON provided a copy of a form, Bed Reservation Approval. This form had been sent with the Resident to the acute care facility, with a copy mailed to the Resident's representative. During this conversation, the DON stated the other information was not available. On 07/08/25 at approximately 1:00 PM, discussion with Staff # 110, verified she could not locate where a copy had been sent to the Ombudsman.

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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. Based on record review and staff interview, the facility failed to ensure a complete and accurate care plan in the area of psychotropic medications. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of unnecessary medications. Resident identifier: #51. Facility census: 84. Findings included: a) Resident #51 Review of Resident #51's physician orders showed an order written on 05/02/25 for Remeron oral tablet (Mirtazapine), give 7.5 mg [milligrams] by mouth one (1) time a day for appetite stimulant. Review of Resident #51's comprehensive care plan showed the following focus, The resident uses antidepressant medication (Remeron) r/t [related to] Depression. The focus was initiated on 05/02/25. Interventions were as follows: - Administer antidepressant medications as ordered by physician. Observe for side effects and effectiveness. - Educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of anti-depressant drugs. - Encourage to express feelings during interactions and observe for non verbal signs of depression, report and document if noted, notify MD [physician] if concerned, refer to psych as needed. - Monitor/document/report PRN [as needed] adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL [activities of daily living] ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs [problems], movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt [weight] loss, n/v [nausea and vomiting], dry mouth, dry eyes Review of Resident #51's diagnoses did not show a diagnosis of depression. A Dietician Comprehensive Nutritional Evaluation performed on 06/12/25 documented the resident had 11. 3% weight loss within the last 180 days and Remeron had been initiated the previous month to support increased appetite. On 07/07/25 at approximately 11:00 AM, the Director of Nursing confirmed Resident #51's comprehensive care plan was incorrect and should have indicated the resident was receiving the medication Remeron for appetite stimulation and not depression. No further information was provided through the completion of the survey process.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and staff interview, the facility failed to ensure Activities of Daily Living (ADL) care was provided to dependent residents. One (1) of two (2) residents reviewed for the care area of Activities of Daily Living had not received twice weekly showers. Resident Identifier: #74. Facility Census: 84. a) Resident #74 Review of the facility's shower schedule showed Resident #74 was to receive showers on Mondays and Thursdays. Review of Resident #74's bathing task reports for May 2025 showed the resident had received a shower on 05/19/25, a full body bed bath on 05/19/25, and partial baths on the remaining Mondays and Thursdays of the month. Review of Resident #74's bathing task reports for June 2025 showed the resident had received showers on 06/19/25, 06/23/25, 06/26/25, and 06/30/25, a full body bed bath on 06/16/25, and partial baths on the remaining Mondays and Thursdays of the month. The resident was non-interviewable and dependent on staff for activities of daily living care. On 07/07/25 at approximately 11:00 AM, the Director of Nursing (DON) stated the task report documentation may have been incorrect. The DON stated Nurse Aides also complete handwritten shower sheets for bathing activities. The handwritten shower sheets were provided and showed the resident had received showers on 05/07/25, 05/14/25, 05/19/25, 05/26/25, and 06/29/25. The shower sheets also showed the resident had received a bed bath on 05/01/25. The shower sheet confirmed the resident had received bed baths on 05/08/25, 05/12/25, and 05/15/25. However, the handwritten shower sheets showed the resident received a bed bath on 05/22/25 instead of the shower indicated on the task report. The handwritten shower sheets also showed the resident had received showers on 06/05/25 and 06/14/25. The handwritten shower sheets confirmed the other showers and bed baths for June 2025 documented on the task report. The combination of task report and shower sheet documentation showed Resident #74 had not received showers from 05/08/25 through 05/13/25, which was a six (6) day period. The combination of task report and shower sheet documentation showed Resident #74 had not received showers from 06/06/25 through 06/13/25, which was an eight (8) day period. The above findings were discussed with the Director of Nursing on 07/07/25 at approximately 3:00 PM. No further information or documentation was provided through the completion of the survey process.

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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. b) Resident #55 A review of Resident #55's medical record found she suffered an unwitnessed fall on 12/11/24 and 12/18/24. According to the incident reports neurological assessments were initiated on both occasions. In the afternoon of 07/7/25 the Director of Nursing (DON) was asked to provide the surveyor with a copy of the neurological assessments for Resident #55 on 12/11/24 and 12/18/24. Later in the afternoon the DON confirmed there were no neurological assessments found for the fall on 12/11/24. She did provide the neurological assessments for 12/18/24. A review of the neurological assessments for 12/18/24 found they were incomplete. The assessment consists of 25 occasions were a neurological assessment should be completed beginning with the initial assessment and proceeding as follows: 1. Initial 2. 15 minute evaluation #1 3. !5 minute evaluation #2 4. 15 minute evaluation #3 5. 15 minute evaluation #4 6. 30 minute evaluation #1 7. 30 minute evaluation #2 8. 30 minute evaluation #3 9. 30 minute evaluation #4 10. 1 hour evaluation #1 11. 1 hour evaluation #2 12. 1 hour evaluation #3 13. 1 hour evaluation #4 14. 4 hour evaluation #1 15. 4 hour evaluation #2 16. 4 hour evaluation #3 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	17. 4 hour evaluation #4 18. 8 hour evaluation #1 19. 8 hour evaluation #2 20. 8 hour evaluation #3 21. 8 hour evaluation #4 22. 8 hour evaluation #5 23. 8 hour evaluation #6 24. 8 hour evaluation #7 25. 8 hour evaluation #8 Further review of the neurological assessments for Resident #55 which began on 12/18/24 found the following evaluations were not completed as required: 14. 4 hour evaluation #1 15. 4 hour evaluation #2 16. 4 hour evaluation #3 18. 8 hour evaluation #1 19. 8 hour evaluation #2 20. 8 hour evaluation #3 21. 8 hour evaluation #4 22. 8 hour evaluation #5 23. 8 hour evaluation #6 24. 8 hour evaluation #7 25. 8 hour evaluation #8. An interview with the DON confirmed this in the late afternoon of 07/07/25. C) Resident #140 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:29 PM on 07/07/25 while passing through the dining room Resident #140 was sitting on the calf rests of his wheelchair. His entire buttocks was off the wheelchair seat an was resting on the wheelchair calf support pads. A lift pad was noted in the wheelchair. He stated the wheelchair was hurting his buttocks and that is why he was trying to get out of the chair. Nurse Aide # 77 and Activities Director #72 took position on either side of the Resident. Nurse Aide #77 grabbed the resident under the arm and by his shorts and AD #72 had the resident under the arm. The surveyor was not in a position to tell what AD #72 did with her other hand. They then lifted the resident from the calf support pads to the seat of his wheelchair. At no time was a licensed nurse present to assess the resident or to give guidance to the nurse aides to ensure Resident #140 was transferred back to his seat safely. A review of the residents care plan found the following intervention related to assistance with activities of daily living: -- · Transfer Assist: Total Dependence x2 staff and a mechanical lift An interview with the Nursing Home Administrator (NHA) confirmed a license nurse did not come into the dining room to assess the resident or to assist the NA's in deciding the best way to get Resident #140 back into the wheelchair. d) Resident #51 Review of Resident #51's physician's orders showed an order written on 05/16/25 for Novolog injection solution 100 unit/ml [milliliter] (Insulin Aspart), inject 5 units subcutaneously three times a day for DM [diabetes mellitus]. Hold for blood sugar less than 140. Resident #51's Medication Administration Records (MARs) were reviewed for June and July 2025. The MARs showed numerous occasions when Resident #51's insulin was given despite the resident's blood glucose being less than 140. These occasions were as follows: - On 06/02/25, insulin was administered at 12:00 PM. The resident's blood glucose was 117 at 11:30 AM. - On 06/04/25, insulin was administered at 8:00 AM. The resident's blood glucose was 115 at 6:00 AM. - On 06/09/25, insulin was administered at 8:00 AM. The resident's blood glucose was 128 at 6:30 AM. - On 06/12/25, insulin was administered at 12:00 PM. The resident's blood glucose was 118 at 11:30 AM. - On 06/13/25, insulin was administered at 5:00 PM. The resident's blood glucose was 126 at 4:30 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 06/14/25, insulin was administered at 8:00 AM. The resident's blood glucose was 131 at 6:30 AM. - On 06/15/25, insulin was administered at 8:00 AM. The resident's blood glucose was 124 at 6:30 AM. - On 06/18/25, insulin was administered at 12:00 PM. The resident's blood glucose was 122 at 11:30 AM. - On 06/20/25, insulin was administered at 8:00 AM. The resident's blood glucose was 128 at 6:30 AM. - On 06/26/25, insulin was administered at 8:00 AM. The resident's blood glucose was 133 at 6:30 AM. - On 06/26/25, insulin was administered at 12:00 PM. The resident's blood glucose was 101 at 11:30 AM. - On 06/27/25, insulin was administered at 8:00 AM. The resident's blood glucose was 129 at 6:30 AM. - On 06/30/25, insulin was administered at 8:00 AM. The resident's blood glucose was 126 at 6:30 AM. - On 07/01/25, insulin was administered at 8:00 AM. The resident's blood glucose was 114 at 6:30 AM. - On 07/01/25, insulin was administered at 12:00 PM. The resident's blood glucose was 129 at 11:30 AM. - On 07/01/25, insulin was administered at 5:00 PM. The resident's blood glucose was 104 at 4:30 PM. - On 07/04/25, insulin was administered at 12:00 PM. The resident's blood glucose was 138 at 11:30 AM. - On 07/04/25, insulin was administered at 5:00 PM. The resident's blood glucose was 122 at 4:30 PM. - On 07/05/25, insulin was administered at 8:00 AM. The resident's blood glucose was 76 at 6:30 AM. - On 07/05/25, insulin was administered at 12:00 PM. The resident's blood glucose was 134 at 11:30 AM. - On 07/05/25, insulin was administered at 5:00 PM. The resident's blood glucose was 111 at 4:30 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 07/06/25, insulin was administered at 5:00 PM. The resident's blood glucose was 123 at 4:30 PM. On 07/07/25 at approximately 11:00 AM, the Director of Nursing confirmed the physician's order had not been followed to hold Resident #51's Novalog insulin when the blood glucose was less than 140. No further information was provided through the completion of the survey. Based on record review and staff interview, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice. This was true for four (4) out of 31 residents reviewed throughout the Long-Term Care Survey Process. The facility failed to follow physician orders regarding use of wheelchair and an order for staff to encourage Resident #26 to be up and out of bed for the lunch and dinner meals. The facility failed to follow physician orders for insulin administration for Resident #51. The facility failed to complete neurological checks for Resident #33. The facility failed to have a nurse assess Resident #140 following a fall prior to staff intervention. Resident identifiers: #26, #33, and #140 and #51. Facility census: 84 Findings included: a) Resident #26 A record review, completed on 07/07/25 at 11:50 AM, revealed the following physician orders: -Encourage resident to be in high traffic area when up in chair. Make sure leg rests are on and chair is slightly reclines. -Staff to encourage and assist resident to be up in chair and in dining room for lunch and dinner. During an observation of Resident #26 in the dining room on 07/07/25 at 12:10 PM, the Administrator confirmed there were no leg rests on resident's wheelchair and the wheelchair was not slightly reclined. The Administrator stated he believed therapy had recently evaluated the resident but it appeared that the physician order had not been updated to reflect resident's new plan of care. Review of the January 2025 - June 2025 treatment administration records (TARs) revealed the following dates and times the TAR was left blank: 01/18/25 for dinner 01/28/25 for dinner 01/30/25 for dinner 02/03/25 for dinner 03/29/25 for dinner 04/13/25 for dinner (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/24/25 for dinner 05/03/25 for dinner 06/22/25 for dinner During an interview on 07/07/25 at approximately 12:55 PM, the Director of Nursing (DON) acknowledged the dates and times the TAR had been left blank and agreed that according to professional standards of practice the lack of documentation should be interpreted as the task not being done.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. b) Resident #12 The facility's policy titled Resident Self-Administration of Medication, with implementation date 02/01/24 and revision date 02/14/24 stated as follows: - A resident may only self-administer medications after the facility's interdisciplinary team (IDT) has determined which medications may be self-administered safely. The results of the assessment by the IDT would be recorded on the Medication Self-Administration Assessment Form. - Medications for self-administration must be stored in a manner that prevents access by other residents. - Nurses and Aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. On 07/02/25 at 7:52 AM, medication administration to Resident #12 by Registered Nurse (RN) #9 was observed. The resident was noted to have a bottle of calcium carbonate stored in a clear plastic set of drawers by her bedside. The resident stated she had been having nausea and her daughter brought the bottle of calcium carbonate for her. RN #9 asked the resident for permission to take the medication away from her bedside and the resident consented. RN #9 reported the incident to RN #40, who stated she would give the bottle of medication to the resident's daughter and ask the physician to order medication for Resident #12's nausea. No Medication Self-Administration Assessment Form was found in Resident #12's medical records. On 07/07/25 at approximately 2:00 PM, the Administrator stated he did not think Resident #12 had been assessed for medication self-administration. He stated he would provide the medication self-administration form for Resident #12 if an assessment had been performed. No further information was provided through the completion of the survey process. Based on observation an staff interview the faiclity failed to ensure the resident enviroment over which it had control was as free from accident hazards as possible. This was a random opputunity for discovery and had the potential to effect more than a limited numbr of residents. Resident Identifiers: #2 and #12. Facility Census: 84. Findings included: A) Resident #2 On 07/01/25 at 9:51 AM, during a visit to this Resident's room, surveyor observed two disposable razors sitting on top of the air conditioner, and one disposable razor on the sink laying behind the water faucet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident was in a private room, with the door open. According to the Resident's MDS assessment, dated 05/23/25, the Resident is dependent on staff to provide personal hygiene, and showers. The Resident has a diagnosis of major depressive disorder and is on an anti-depressant medication. On 07/01/25, at 10:25 AM, during an interview with DON, surveyor requested the DON to accompany her to the Resident's room. Surveyor pointed out the razors, and asked what the facility policy was on having sharps in residents' rooms. The DON stated they are not to be left in the Residents' room, and then picked the disposable razors up and removed them.

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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 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 record review and staff interview, the facility failed to ensure residents did not receive foods they were allergic to. This was true for one (1) of three (3) residents reviewed for food allergies. This was found to be an issue of past non-compliance that began on 12/13/24 and ended on 12/19/24. Resident Identifier: #189. Facility census: 84. Findings included: a) Resident #189 On 12/20/24, Resident #189 reported to the Office of Health Facility Licensure and Certification (OHFLAC) that she had been served cranberry juice despite being allergic to cranberries. Review of Resident #189's electronic health records showed she had allergies to cranberry fruit extract and cranberry juice. A progress note written on 12/13/24 stated, Resident was given cranapple juice on accident by CNA [Certified Nursing Assistant]. Resident drank the entire cup and then realized it was indeed cranberry juice. Resident given rescue inhaler and benadryl per nurse pract [practitioner]. Will continue to monitor resident. Resident #189 was monitored and experienced no adverse reactions. Two (2) current residents with food allergies, Residents #34 and #32, were interviewed on 07/02/24 at approximately 10:00 AM. These residents denied receiving foods to which they were allergic. On 07/02/25 at approximately 12:00 PM, Nursing Assistant (NA) #91 was interviewed as she was passing drinks to the residents. She stated there was a list of residents with allergies located in the pantry. She also stated when the kitchen prepared the drink cart, if there were residents with allergies to anything that could be on the drink cart, the kitchen would put that information on a Post-It note on the cart. NA #91 stated there were no such residents in this hallway at this time. On 07/02/25 at approximately 12:10 PM, Nursing Assistant (NA) #29 was interviewed as she was passing drinks to the residents in another hallway. She also stated there was a list of residents with allergies located in the pantry. She also stated when the kitchen prepared the drink cart, if there were residents with allergies to anything that could be on the drink cart, the kitchen would put that information on a Post-It note on the cart. She demonstrated that there were two (2) such notes on the cart. One note indicated Resident #12 was allergic to milk and one note indicated Resident #36 was allergic to apple juice. The residents were identified by their room and bed numbers. On 07/02/25 at 2:17 PM, the Director of Nursing (DON) was interviewed about Resident #189 receiving cranberry juice. The DON stated after this event, staff education was immediately started on 12/13/24. The DON also stated the incident was discussed by the Quality Assurance and Performance Improvement committee. The education was as follows: (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- When serving drinks, always ask the residents what they want. This will not only give them satisfaction of being able to choose but will also held avoid allergies. - The dietary department will place a Drink Allergy List (as they occur) on the drink cart for staff to refer to. - If a resident requests a drink that the list says they are allergic to, remind them it is on the allergy list and notify the nurse of their request. Do not give them a drink that is on their allergy list. - Always check allergies before providing care, this includes medications, foods/fluids, and products used for care. - If a resident consumes or uses a substance, they are allergic to the nurse needs to perform an immediate assessment and notify the provider. An accompanying in-service sign-in sheet confirmed all staff had been educated. On 07/08/25 at 2:00 PM, the Staff Development Coordinator confirmed education for staff had been completed on 12/19/25. No further information was provided through the completion of the survey process.

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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. Based on observation, record review, and staff interview, the facility failed to provide physician-ordered adaptive eating equipment to Resident #24. This was a random opportunity for discovery. Resident Identifier: #24. Facility census: 84. Findings included: a) Resident #24 Review of Resident #24's physician's orders showed an order written on 06/26/25 for the resident to have a two (2) handled cup with all meals. On 07/02/25 at 1:05 PM, Resident #24 was observed eating lunch in her room. She did not have a two (2) handled cup. Her beverage was in a cup with no handles. The resident's tray ticket stated she was to have a two (2) handled cup. Registered Nurse (RN) #9 confirmed Resident #24 did not have a two (2) handled cup with her tray. She stated she would obtain one for the resident. No further information was provided through the completion of the survey process.

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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 observation and staff interview the facility failed to ensure food was stored and prepared in a safe and sanitary manner. This failed practice has the potential to effect more than an isolated number of residents. Facility Census: 84. Findings Include: a) Initial tour of the Kitchen An initial tour of the kitchen upon entrance of the facility on 07/01/25 at 9:00 AM found the walk-in refrigerator had one gallon of milk with best by date June 26, 2025. Certified Dietary Manager CDM #16 reported that the milk deliverer will take it back when he comes to deliver fresh milk if it was date and placed seperately from the food good for consumption. I expressed that it was not currently separate from the milk in date to be used and she marked it and separated it for pick up and set it aside. b)Tour of the nourishment rooms on the floors on 07/02/25. At 10:57 AM observed the East Nourishment room. Twelve (12) packages of individually wrapped saltine crackers with no dates inside of a plastic bag with no dates and not labeled were located in the drawer. There were 34 individual packages of saltines inside of a drawer with no expiration dates. There were also twenty two (22) packages of individually wrapped graham crackers in a plastic container that was not labeled. Licensed Practical Nurse #57 acknowledged. At 11:00 AM it was observed in the [NAME] Nourishment room that nine (9) individually wrapped, undated, graham crackers in a plastic container with no labels or dates were in the nourishment drawer along with twenty three (23) individually wrapped packs of saltines in a plastic bag with no dates and not labeled. Interviewed CDM #16 0n 07/02/25 at 11:13 AM who acknowledged that the graham crackers and saltines were not dated/labeled in the nourishment rooms or in the boxed they arrived in. They will contact the distributer and label them. c)Observation of serving line in kitchen on 07/02/25. Observed Dietary Aide #49 wrapping silverware and prepping food with no beard net 12:00 PM to 12:10 PM on 07/02/25. CDM #16 acknowledged that he was not wearing it and reported that he just got here. d) Facility Policy titled Healtcare Services Group, Inc. and its subsidiaries HCGS POLICY 018, Food Storage: Dry Goods, Procedure number 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. e) Facility Policy titled Healthcare Service Group, Inc. and its subsidiaries HCSG Policy 024, Staff Attire, Procedure 1. All staff members will have their hair off the shoulders, confined in a hair net or cap and facial hair properly restrained.

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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. d) Resident #24 On 07/01/25 at 1:16 PM, Nursing Assistant (NA) #91 was observed removing Resident #24's tray from her room. It did not appear that the resident had eaten much of the food. The silverware on the tray had not been unwrapped from the napkin. When questioned, NA #91 stated the resident was able to feed herself. On 07/02/25, review of Resident #24's electronic health records, specifically the task report for amount eaten/fluids consumed at meals, showed documentation the resident had eaten 76 to 100 percent (%) of lunch on 07/01/25. The medical records also confirmed the resident could feed herself after set up. The resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was mentally intact. On 07/02/25 at 3:14 PM, the Director of Nursing (DON) was informed of the surveyor's observation that Resident #24 had not eaten 76 to 100% of her lunch meal on 07/01/25. The DON stated she would check to see if the resident had later eaten a different meal at lunchtime.No further information was provided through the completion of the survey process. (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 observation, record review and staff interview the facility failed to ensure the medical record was complete and accurate four (4) of 31 sampled residents reviewed during the long term care survey process. Resident Identifiers: #55, #140, #72, and #24. Facility Census: 84. The facility failed to have complete and accurate records. Findings Include: a) Resident #55 A review of Resident #55's medical record found she required neurological assessments to be completed on 01/03/25, 04/21/25, 06/24/25 and 06/28/25. The facility was asked to provide the surveyor with a copy of the neurological assessments for the aforementioned dates. A review of the neurological assessments provided found, the assessment consists of 25 occasions were a neurological assessment should be completed beginning with the initial assessment and proceeding as follows: 1. Initial 2. 15 minute evaluation #1 3. !5 minute evaluation #2 4. 15 minute evaluation #3 5. 15 minute evaluation #4 6. 30 minute evaluation #1 7. 30 minute evaluation #2 8. 30 minute evaluation #3 9. 30 minute evaluation #4 10. 1 hour evaluation #1 11. 1 hour evaluation #2 12. 1 hour evaluation #3 13. 1 hour evaluation #4 14. 4 hour evaluation #1 15. 4 hour evaluation #2 16. 4 hour evaluation #3 17. 4 hour evaluation #4 18. 8 hour evaluation #1 19. 8 hour evaluation #220. 8 hour evaluation #321. 8 hour evaluation #422. 8 hour evaluation #523. 8 hour evaluation #624. 8 hour evaluation #7 25. 8 hour evaluation #8. A review of the provided assessments found the following when a nurse other than the nurse completing the assessment entered it into the electronic medical record giving that nurse entered the assessment completed the assessment:-- Assessments began on 01/03/25 and the following sections were entered by the former Assistant Director of Nursing 03/11/25:10. 1 hour evaluation #1 11. 1 hour evaluation #2 12. 1 hour evaluation #3 13. 1 hour evaluation #4 14. 4 hour evaluation #1 15. 4 hour evaluation #2 16. 4 hour evaluation #3 17. 4 hour evaluation #4 18. 8 hour evaluation #1 19. 8 hour evaluation #220. 8 hour evaluation #321. 8 hour evaluation #422. 8 hour evaluation #523. 8 hour evaluation #624. 8 hour evaluation #7 25. 8 hour evaluation #8. -- Assessments which began on 04/21/25 found the former Assistant Director of Nursing (ADON) documented the following assessments on 04/28/25:1. Initial 2. 15 minute evaluation #1 3. !5 minute evaluation #2 4. 15 minute evaluation #3 5. 15 minute evaluation #4 6. 30 minute evaluation #1 7. 30 minute evaluation #2 8. 30 minute evaluation #3 9. 30 minute evaluation #4 10. 1 hour evaluation #1 11. 1 hour evaluation #2 12. 1 hour evaluation #3 13. 1 hour evaluation #4 14. 4 hour evaluation #1 15. 4 hour evaluation #2 16. 4 hour evaluation #3 17. 4 hour evaluation #4 18. 8 hour evaluation #1 19. 8 hour evaluation #220. 8 hour evaluation #321. 8 hour evaluation #422. 8 hour evaluation #523. 8 hour evaluation #624. 8 hour evaluation #7 25. 8 hour evaluation #8. -- Assessments which began on 06/24/25 found the current Staff Development Coordinator entered the following section on 06/27/25:19. 8 hour evaluation #220. 8 hour evaluation #321. 8 hour evaluation #422. 8 hour evaluation #523. 8 hour evaluation #624. 8 hour evaluation #7 25. 8 hour evaluation #8. -- Assessments which began on 06/28/25 found the current Staff Development Coordinator entered the following sections on 07/02/25:1. Initial 2. 15 minute evaluation #1 3. !5 minute evaluation #2 4. 15 minute evaluation #3 5. 15 minute evaluation #4 6. 30 minute evaluation #1 7. 30 minute evaluation #2 8. 30 minute evaluation #3 9. 30 minute evaluation #4 10. 1 hour evaluation #1 11. 1 hour evaluation #2 12. 1 hour evaluation #3 13. 1 hour evaluation #4 14. 4 hour evaluation #1 15. 4 hour evaluation #2 16. 4 hour evaluation #3 17. 4 hour evaluation #4 18. 8 hour evaluation #1 19. 8 hour evaluation #220. 8 hour evaluation #321. 8 hour evaluation #422. 8 hour evaluation #523. 8 hour evaluation #624. 8 hour evaluation #7 25. 8 hour evaluation #8. An interview with the Director of Nursing found, some nurses will complete the assessments on paper instead of putting them into the electronic medical record then one of the nurses in administration will enter them into the electronic medical record. She was asked if they maintained the paper copies to show which nurse actually completed the assessments and she confirmed they did not. She stated once they enter them they shred them. b) Resident #72An observation at approximately 3:00 PM of 07/02/25 found Resident #72's mighty shake unopened sitting on a tray in the dining room. This was labeled to indicate it was the residents 2:00 pm mighty shake. A review of Resident #72's medical record on 07/02/25 at approximately 4:30 PM it was discovered the nurse had documented Resident #72 consumed 50 percent of her 2:00 pm mighty shake. An observation with the Director of Nursing (DON) immediately following this discovery confirmed the might shake was still sitting on the tray in the dining room unopened. The DON took the mighty shake and asked Registered Nurse #9 why she had documented 50 percent when it was unopened. She stated, the nurse aide told me she had drank 50 percent. c) Resident #140An observation at 11:14 AM on 07/01/25 found his 10:00 AM Mighty Shake was

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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, record review and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Contact precautions were not followed for a resident with shingles. This was a random opportunity for discovery. Resident Identifier: #46. Facility census: 84. Findings included: a) Resident #46 The facility's policy titled Transmission-based (Isolation) Precautions, with no implementation date or revision date given, stated for Herpes zoster (shingles), airborne precautions would be followed for disseminated disease, contact precautions would be followed for immunocompromised residents, and standard precautions would be followed for localized disease. The policy further stated for contact isolation the following personal protective equipment (PPE) would be utilized: - Gloves would be worn whenever touching the resident's intact skin or surfaces and articles near the resident. Gloves were to be donned upon entry into the room. - Gowns would be worn whenever anticipating that clothing would have direct contact with the resident or potentially contaminated surfaces or equipment near the resident. Gowns were to be donned upon entry into the room. On 07/01/25 at 12:48 PM, Nurse Aide (NA) #90 was observed taking a lunch tray into Resident #46's room. NA #90 had on gloves but no gown. Resident #46's room door had a Contact Precautions sign on room to his door. The sign stated as follows: Contact Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gowns before room entry. Discard gown before room exit. An Enhanced Barrier Precautions sign was also on the wall next to his room. The sign stated as follows: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. Dressing Bathing/showering Transferring Changing linens Providing hygiene Changing briefs or assisting with toileting Device care or use: Central line, urinary catheter, feeding tube, tracheostomy Wound care: any skin opening requiring a dressing After she left Resident #46's room, NA #90 was asked what type of isolation precautions the resident required. NA #90 stated, I saw that up there (indicating the contact precautions sign) but I didn't see any (PPE) so I thought maybe I only had to wear gloves. PPE was in a caddy on the wall between Resident #46's room and the room next door. On 07/01/25 at 12:51 PM, NA #90 was observed sitting in a chair beside Resident #46, who was in his bed. NA #90 did not have on a gown. The surveyor brought this to the attention to the Director of Nursing, who also observed NA #90 sitting in the chair beside the resident's bed. Review of Resident #46's physician's orders showed the resident had been receiving the medication Valtrex for shingles since 06/30/25. The resident did not have an order for Contact Precautions. The resident did have an order written on 11/11/24 for Enhanced Barrier Precautions due to methicillin-resistant staphylococcus aureus. There was no evidence the resident was immunocompromised. Resident #46's comprehensive care plan showed the following focus written on 06/30/25, Contact Precautions related to shingles. An intervention was to wear gloves and gown when entering the room and remove before exit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/01/25 at 2:11 PM, the Director of Nursing confirmed Resident #46 was on contact precautions due to shingles. The DON stated the resident's shingles lesions have dried and contact precautions would probably be discontinued soon. The DON agreed staff should follow contact precautions for residents with contact precaution signage at their room entrance. A physician's order for the resident to have contact precautions was written on 07/01/25. On 07/02/25 at 10:00 AM, Resident #46's lesions were assessed with Registered Nurse (RN) #40. The resident's lesions were localized to the resident's right side and trunk. The lesions appeared dry with no drainage or open areas present. On 07/03/25, the resident's order for contact precautions was discontinued. No further information was provided through the completion of the survey process.