STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515049	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgantown Health and Rehabilitation, LLC	1379 Van Voorhis Rd Morgantown, WV 26505

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on medical record review and staff interviews, the facility failed to inform and provide written information to the resident on their right to formulate an advance directive. This was true for one (1) of four (4) residents reviewed for the care area of advance directives during the annual survey. Resident identifier: #179. Census: 82. Findings included: a) Resident #179 On 03/04/24 at approximately 11:00 AM during a record review of Resident #179's medical record it was identified the resident admitted to the facility on [DATE] for short term rehab care. It was noted in the Minimum Data Set (MDS) with the Assessment Reference Date (ARD)/Target of 02/28/24 that Resident #179 had a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intact. Upon review of the resident's physician orders, there was not an order for end-of-life care. During a review of the miscellaneous uploaded medical records, no end-of-life documents were found on file. No nursing notes were found regarding advance directives being offered. During an interview with the Director of Nursing (DON) on 03/04/24 at 2:43 PM, the DON agreed the facility did not have an advance directive completed and on file for Resident #179. A copy of the facilities Advanced Directives policy effective date of 04/15/20 was then provided by DON. During a review of the facilities Advanced Directives policy on 03/05/24 at approximately 1:15 PM the following information was identified under the Policy Interpretation and Implementation on Page 2: 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. .8. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decision. 8b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. On 3/05/24 at 1:26 PM during an interview with the Assistant Director of Nursing (ADON) #42, he confirmed the advance directive was not noted to have been offered to Resident #179 upon admission and is now being completed as of 3/04/24 after surveyor intervention.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 40595 Based on observation, record review and staff interview the facility failed to ensure privacy during administration of nasal spray for Resident #330. This was a random opportunity for discovery. Resident identifier: #330. Facility census: 82. Findings included: a) Resident #330 On 02/27/24 at 11:13 PM Resident #330 stated, I need my nasal spray, I want to go to bed. I can't breathe my nose is plugged up. On 02/28/24 at 12:08 AM Resident #330 came out into the hallway in his wheelchair outside of his room door. Resident #330 asked Registered Nurse (RN) #55 if he could have his nasal spray so he could go to bed. RN #55 replied, Yes roll up here (in wheelchair) and I will give it to you. RN #55 then administered nasal spray to Resident #55 while he was sitting in his wheelchair in the hallway. Record review revealed an order for Saline Nasal Solution 0.9 % (Saline). 1 spray resident in each nostril every 6 hours as needed for Dry Nose. During an interview, on 02/28/24 at 10:00 AM, the Assistant Director of Nursing stated RN #55 should not have administered any medications in the hallway, especially nasal spray.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45174 Based on observation and staff interviews, the facility failed to provide residents with a safe, clean, comfortable, and homelike environment. A glove that appeared soiled was observed on the handrail; clean linens were not available; and dining room chairs were observed to be unclean. These failed practices were a random opportunity for discovery and had the potential to affect more than a limited number of residents. Facility Census: 82 Findings include: a) glove On 03/03/24 at 11:33 PM during a tour of facility, a glove which appeared tog be soiled was observed balled up and stuck in the top back edge of the hallway handrail at the entrance of room [ROOM NUMBER]. During an interview with Certified Nursing Assistant (CNA) #9 and CNA #56, both agreed the glove was stuck in the top back of the handrail and appeared soiled. CNA #9 then took the glove from the handrail and threw it away. b) clean linens On 03/05/24 at 10:34 AM during a tour of the building, the North Unit clean linen closet had no towels or washcloths. During an interview with Certified Nursing Assistant (CNA) # 51 on 03/05/24 at approximately 10:36 AM, she stated if she needed towels or wash clothes with this closet being empty, she would go to the laundry room. CNA #51 further stated, she sometimes had issues with having enough clean linens readily available when needed. Upon observation in the laundry room the staff was folding sheets and bed coverings. It was then observed on 03/05/24 at 10:40 AM the South Unit clean linen closet only had 10 towels and 20 wash clothes available. During an interview with the Housekeeping Manager (HM) #92 on 03/05/24 at 10:42 AM, she stated there were not enough clean linens available for the facility at this time. c) Unclean Main Dining Room Chairs During an observation, on 02/27/24 at 12:15 PM, the main dining room chairs were found with several food stains and food particles on the chair seat and chair back. During an interview, on 02/27/24 at 12:20 PM, Housekeeping Manager (HM) #92 stated the chairs were cleaned every two (2) weeks with a green machine (a portable machine which cleans carpets and upholstery). HM #92 said, We do not have a cleaning schedule or a record of the cleaning of the chairs. The last time the chairs were clean was the week of New Years Eve. I will get to it today; I have been short staffed and have not had the time. 49650

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40595 Based on observation, record review, staff interview, and resident interview the facility failed to ensure residents were free from abuse and neglect. The survey team witnessed the failure of staff to provide timely incontinence care to Resident's #6 and #237. When the observations of the surveyors were presented to the facility, the facility reported the incident to the state agency as required. Immediate jeopardy (IJ) occurred when the facility failed to provide education and servicing to one of the witnessed perpetrators before allowing this staff person to return to work. This failure placed all residents currently residing in the facility at an immediate risk for serious harm and/or death. After the immediacy was removed a deficient practice remained for Resident #331 who was improperly lifted off the floor after 2 falls. This was a random opportunity for discovery and had the potential to affect all residents at the facility. Therefore, the scope and severity was decreased from a L to a D. The facility was first notified of the IJ at 4:24 PM, on 03/06/24. The state agency (SA) received the Plan of Correction (POC) at 8:45 PM on 03/06/24. The SA accepted the POC on 03/06/24 at 9:00 PM. The SA observed for the implementation of the POC and the IJ was abated on 03/11/24 at 2:30 PM. Resident identifiers #6, #237, and #331. Facility census 82. Findings included: a) Resident #6 Upon an unannounced entrance to the facility on [DATE] at 11:08 PM, staff member Licensed Practical Nurse (LPN) #62 and Nursing Assistant (NA) #63 were observed sitting in the room labeled Conference room with their feet propped up in a chair looking at their cell phones. These staff members were unable to see resident call lights. An observation, on 02/27/24 at 11:10 PM, of the North Nurse's station revealed six (6) call lights were going off, according to the call light board on the wall. An observation, on 02/27/24 at 11:15 PM, of North 2 (two) hall revealed the following: - At 11:15 PM Resident #6's call light came on. - At 11:30 PM NA #63 went into Resident #6's room, and his light went off. NA #63 came out of the room at 11:31 PM. -At 11:33 PM Resident #6's light came back on. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview, on 02/27/24 at 11:34 PM, Resident # 6 stated, I just want changed. They came in and turned my light off and told me they would be back. I just want to get dry and go to sleep. I am sick of this. Observation on 02/27/24 at 11:40 PM, of North Nurses station found NA# 63, NA#65, LPN #63, and LPN #43 at the nursing station. During an observation, on 02/27/24 at 11:44 PM, of the North Nurses station, the surveyor heard LPN # 40 announce, I am going on my 15-minute break, because I am supposed to get it. I will set my watch. Resident #6's call light continued to go off. Further observation at 11:47 PM, showed LPN #62 going into Resident #6's room and immediately walked back out. The call light was turned off. She then stated, He is a 2 person assist, I got to wait on help. An observation on 02/27/24 at 11:50 PM, showed LPN #62 and NA #63 going into Resident #6's room to change him. Resident #6's room was under constant observation by a surveyor from 02/27/24 at 11:15 PM to 02/27/24 at 11:50 PM. Assistance and incontinence care was not provided to Resident #6 until 02/27/24 at 11:50 PM. On 02/28/24 at 12:35 AM the Director of Nursing (DON) confirmed residents should not wait that long to be changed and staff should not be turning call lights off and saying I will be back. She further stated, yes, this is neglectful. A record review, on 02/28/24 at 12:15 PM, of Resident #6's care plan found the following: -Focus: I have the Potential for Skin Issues related to incontinence of bowel and bladder, decreased mobility/ability to reposition myself. -Goal: My skin will remain intact without signs of breakdown by next review. -Interventions: Turn and reposition frequently to decrease pressure. Further review of the care plan reads as follows: Focus: I have an ADL self-care performance deficit due to limited mobility. Goal: I will maintain current level of function in all ADL's through the review date. Interventions: Assist resident to bathroom for toileting every 2 hours. Toilet use: I require extensive assistance by staff for toileting. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facilities Abuse and Neglect policy on 02/28/24 at 11:30 AM described Neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional stress. The facility reported these allegations to the proper State authorities on 02/28/24. Employees #62 and NA #63 were suspended from 02/28/24 through 03/05/24. The facility stated they were going to in-service all staff on Resident Rights, Abuse/Neglect, using the care plans, call lights, safe lifting, teamwork, customer service, meals/snacks. At 2:45 PM on 03/06/24 the assistant director of nursing (ADON) confirmed NA #63 had not been in-serviced and NA #63 had worked from 7:00 PM to 7:00 AM on 03/05/24. Further review of the sign in sheets found NA #63 did not sign the acknowledgement of training before returning to work. B) Resident #237 02/27/24 Incident During an unannounced visit to the facility on [DATE] at 11:05 PM, the following observations were made: At 11:08 PM, Resident # 237 was lying in bed with his feet hanging over the right side of the bed touching the floor. His bottom was in the middle of the bed, his head and his upper torso leaning towards the left side of the bed off the pillows. A strong smell of urine appeared to come from the room. Another observation on 02/27/24 at 11:35 PM, showed Resident # 237 continued to be laying in the same position with the sheet now on the floor yelling, [NAME], [NAME] get the car let's go. Another observation on 02/27/24 at 11:53 PM, showed Resident # 237' s feet continued to be on the right side touching the floor. Now his head was hanging over the bed on the left side. Another observation on 02/28/24 at 12:05 AM, showed Resident # 237 was in the same position as before. The smell of bowel movement was present. This was observed by another surveyor as well. At that time, Resident # 237 was pulling the privacy curtain and yelling out. Another observation, on 02/28/24 at 12:08 AM, Resident # 237 was yelling [NAME], [NAME]. Nursing Assistant (NA) #31 walked to another resident's room to tell NA #6 in the room she needed assistance when she was done. An observation on 02/28/24 at 12:09 AM, revealed NA #31 told NA #6, I guess I will see what [Resident # 237] wants but he is not my resident. Another observation on 02/28/24 at 12:10 AM, showed NA #31 entered and exited Resident # 237's room without providing assistance. An observation, on 02/28/24 at 12:11 AM, showed NA #31 went to another resident's room where NA #6 was assisting the resident in that room. NA #31 stated, He needs changed. You can do it when you are done. He is not mine so I am not cleaning him up. An observation on 02/28/24 at 12:15 AM, showed NA #6 was in Resident #237's room assisting him. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #237's room was in constant observation by a surveyor from 02/27/24 at 11:08 PM to 02/28/24 at 12:15 AM. Assistance and incontinence care was not provided to the resident until 12:15 AM on 02/28/24, despite the resident yelling for help beginning at 11:08 PM on 02/27/24. During an interview on 02/28/24 at 1:30 AM, the DON stated, Are you kidding me. The nursing staff tells me all of this is being taken care of. They never mention call lights are not being answered. I thought everything was ok. They should not turn off a call light without the need being addressed, if they can't get to it they should leave it on until the resident is changed or whatever they need. And everyone can answer a call light not just the aides. That's not my job or my resident doesn't fly. Sounds to me like a bunch [staff] need to be in the unemployment line. That should have never happened, they should work as a team. He should have never laid there that long without assistance. On 02/28/24 at 1:34 PM, the Corp RN #97 stated, The DON told me there were small issues last night, call lights not answered and late medications. RN #97 was unsure if the incidents with the call lights not answered, and residents being left soiled were reported. She said she would have to look around and see what she could find. DON was unavailable for any further comment at that time and not in the facility. The OHFLAC (Office of Health Facilities Licensure and Certification) 225 Allegation reporting form dated 02/28/24 completed by Social Worker #36. Alleged Victim Name: Resident #237's Name Alleged Perpetrator Name: name of Nurse Aide (NA) #31 Position/title: Certified Nsg (nursing) Assistant Date of Incident: 02/27/24 Time of Incident: Night Shift Location of Incident: room [ROOM NUMBER]-1 Brief Description of the Incident: Allegation was received that (Resident #237's) name was waiting for an extended period of time for his call light to be answered for incontinence care. The 5 five day follow up determination on Resident #237 was completed and faxed to the state agencies on 03/05/24. c) Resident #237 03/03/24 incident On 03/03/24 at 11:00 PM, an unannounced visit was made to the facility. During an observation on 03/03/24 at 11:05 PM, Resident # 237 was resting in bed with a pillow under his legs. During an observation on 03/03/24 at 11:35 PM, Resident # 237 ' s legs were hanging over the right side of the bed. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 03/03/24 at 11:38 PM, Resident # 237 was yelling Hello. His head was now almost to the middle of the bed, and his feet continued to be on the floor. The following further observations were made: 03/03/04 at 11:41 PM, LPN #28 walked by Resident # 237 room. 03/03/24 at 11:44 PM, Resident #237 was yelling Help in here. 03/03/24 at 11:45 PM, Corporate nurse #97 was going from room to room. 03/03/34 at 11:47 PM, LPN #28 walked by resident's room again. 03/03/24 at 11:53 PM, NA #57 walked by Resident # 237's looking into his room. 03/03/24 at 11:56 PM, Resident # 237 yelling Help in here Hello, Help. 03/03/24 at 11:59 PM, Resident # 237 yelling Hello Corporate's Nurse #97 stated to Resident # 237 Hang on, let me get someone. 03/04/24 at 12:04 AM, Corporate RN #97 stating Did that fix it? [Resident # 237] pulled the call light halfway out of the wall, that is where the emergency light was coming from. During an interview on 03/04/24 at 1:34 PM, the DON and SW were informed of the incidents occurring on 03/03/24. During an interview on 03/05/24 at 11:30 AM, the Corporate Nurse #97 stated I will watch the cameras to see if I feel a report needs to be filed. During an interview on 03/05/24 at 2:35 PM, the ADON stated they do not feel a report needs to be done. On 03/06/24 at 5:47 PM, social worker #237 gave this report to the surveyor. The OHFLAC (Office of Health Facilities Licensure and Certification) 225 Allegation reporting form dated 03/05/24 completed by Social Worker # 36. Alleged Victim Name: Resident #237 ' s Name Alleged Perpetrator Name: Unknown Date of Incident: 03/04/24 Night Shift Time of Incident: Night Shift Location of Incident: Name of the Nursing Home Facilities (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Brief Description of the Incident: Surveyor alleged on 03/04/24 that Resident #237 ' s name was neglected with delayed response time in addressing his needs during night shift 03/03/24 into 03/04/24. The 5 five day follow up determination on Resident #237 was not completed upon exiting the facility on 03/11/24. Two (2) surveyors on 03/05/24 at 7:39 PM, Resident # 237 stated This is the best day since I have been here. I have not slept in four (4) days and I slept well last night, sleeping like a baby. I ate everything today, my dinner was good. I think I was admitted on Friday but I was so out of it, I am not really sure. Resident # 237 was asked, do you need assistance with the bathroom? Resident # 237 stated they make me use the call light when i need to use the bathroom, but they take so long to get here I pee myself. The other night I laid in pee all night. The DON was made aware of the above interview with Resident #237. d) Resident #331 On 02/27/24 at 11:54 PM Resident #331 was witnessed by a Surveyor falling out of his wheelchair in the hallway near the nurse's station on the south side. Resident scooted to the edge of his wheelchair, and leaned forward and fell out onto the floor. The Resident landed on his right side with his head against the wall. The Resident's right leg and arm were pinned under him. Resident was laying across the leg of the floor stand blood pressure monitor. Resident was yelling Oh, Oh, Oh damn. RN #55 came up the hallway and asked the resident if he was ok? RN #55 pulled up the sweatshirt sleeve of his right arm and said. I don't see anything; you did hit hard I bet that hurt. RN #55 was then joined by CNA #31 and they proceeded to try to lift the resident back into the wheelchair by grabbing his pants and reaching under his arms. RN #55 lifted under the right arm and CNA # 31 lifted under the left arm and they both grabbed the back of the resident's pants. After the third try with the wheelchair sliding backwards, RN #55 and CNA #31 tossed the resident back into the wheelchair. Resident #331 continued to yell, Oh. Oh, Oh damn it the entire time. RN #55 said, Yea he's heavy! RN #55 then reported to the Surveyor, Don't worry, he is care planned for falls, he slides out of his chair all the time. Once resident was back in chair at 12:00 AM, RN #55 attempted to take residents blood pressure and stated, This don't seem to be working right, but I think he's ok. Resident #331 was wearing an AAA (hinged) knee brace in place on his left lower extremity and was non weight bearing to left lower extremity at the time of the fall. The Resident was wearing regular socks at the time of the incident. Record review of care plan found an intervention of mechanical lift with two person assist for all transfers, resident was unable to bear weight with the right foot was not initiated until 02/28/2024. Record review showed no progress note to indicate the Power of Attorney (POA) was notified of the fall. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/28/24 at 10:50 AM, the Incident report for the fall (which occurred 02/27/24 at 11;54 PM) was requested from Corp RN #97. The report was given for a fall that happened on 02/27/24 during the day shift. Corporate RN #97 stated, Oh sorry about that I am sure they done one if not I will have them to do a late entry. Record review showed a radiology report dated 02/24/28 indicated Resident #331 had fractured right clavicle and slightly displaced fracture at the distal clavicle age indeterminate. Results for bilateral hips and pelvis showed a postoperative change at the right hip with a pin and side plate in place. Mild arthritic changes in both hip joints. Review of incident report dated 02/27/24 at 11:30 PM for a fall that occurred on 02/27/24 at 11:54 PM, completed by the Director of Nursing (DON). The DON was asked how she completed the incident when she wasn't there to witness the fall. The DON stated, The other nurse started it and never finished it. I thought I was already here at that time. If the time is wrong its because I redone it. You are right I never witnessed the fall. -The incident description stated (typed as written), resident fell out of wheelchair outside of his room near the Rosies that were plugged into the wall. This RN witnessed the fall from down the hallway. -The incident reports' immediate action taken stated, (typed as written), Before putting him [resident #331] back into the wheelchair this RN [#55] did a full body assessment checking for injuries. Resident stated that he banged his elbow, assessment of elbow was done including visual assessment and full ROM [range of motion] to right hand and right shoulder. After confirming there were no injuries, the resident was assisted by myself and CNA to his wheelchair. During a phone interview on 03/05/24 at 1:50 PM Resident #331's Power of Attorney (POA) stated, I don't think they are calling me every time he is falling. He falls so much. I can tell you they did not call me Tuesday night (02/27/24) when he fell around midnight. They called me Tuesday on the 27th (02/27/24) during the evening sometime to tell me he fell that day. The POA further stated that when he was admitted they promised her he would be close to the nurses station and when she got there he could not have been further away. She made them move him closer and would not leave until they put some fall mats down for him. The POA stated, I am physical therapist myself; they are not transferring him right either. He is not supposed to be bearing weight on that one leg and they just drag him around everywhere. I don't know why they don't use a lift. On 03/04/24 at 3:04 PM the Assistant Director of Nursing (ADON) verified a mechanical lift should have been used to pick the resident up off the floor when he fell from the wheelchair on 02/27/24. The ADON stated, Especially since [resident #331 name] is unable to put any weight on his leg and wearing that brace. e) Resident 331 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a tour of the facility, on 03/11/24 at 01:27 PM, Resident #331 was observed to be lying on the floor on his left side and his wheelchair was laying over on its side directly behind him. Three staff members were observed to be standing around him and they all three lifted him by his upper body and simultaneously picked the wheelchair upright and sat him in it. During an interview with the Licensed Practical Nurse Unit Manager (LPN-UM) #30, she stated that the facility was not a no lift facility, and they can pick him up if he is safe. Staff identified to assist LPN-UM #30 physically picking up the resident and the chair are LPN # 64 and Certified Nursing Assistant (CNA) #99. 03/11/24 02:17 PM During an interview with Assistant Director of Nursing (ADON) #42, he stated that he had completed the resident's assessment himself and Resident #331 was a total lift. He further stated that LPN-UM #30 had been educated on this previously and a lift should have been used with this fall. The residents ELC Lift Transfer Reposition Evaluation dated 03/06/24, physicians order dated 03/06/24 and care plan with the total lift intervention revision dated 03/07/24 that identified the resident being a total lift was provided by the ADON at this time. f) Plan of Correction (POC) HOW WILLL CORRECTIVE ACTIONS BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? The allegation of neglect was reported by state surveyor to VPCO and ADON on 2/28/24. The allegation was reported to the state survey office, APS and Ombudsman, by Social Worker on 2/28/24. A thorough investigation was initiated. Resident # 237 A skin assessment was completed on 2/28/24 by a nurse. A trauma assessment was completed 3/1/24 by Social worker. Resident # 6 A skin assessment was completed on 2/28/24 by ADON. A trauma assessment was completed on 3/1/24 by the Social Worker. Resident # 237 was assessed on 2/28/24 by social worker, with no concerns noted. A thorough investigation was initiated on 2/28/24 and completed on 3/4/24 by social worker. Resident # 6 was assessed on 2/28/24 by social worker, with no concerns noted. A thorough investigation was initiated on 2/28/24 and completed on 3/4/24 by social worker. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN TO PREVENT REOCCURENCE? (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Current residents have been assessed for any signs and symptoms of abuse/neglect. Those residents with BIMs >8 were interviewed by the management team for any abuse/neglect concerns 2/28/24 through 3/1/24. Those residents with BIMs < 8 were physically assessed by the nursing supervisors for any signs and symptoms of abuse/neglect on 2/29/24. Abuse/neglect assessments, interviews and questionnaires were reviewed by the Administrator on 3/1/24 for any indications of abuse/neglect concerns. There were 5 concerns voiced during the interviews and were addressed at time of concern. Grievances/concerns were reviewed for the last 60 days with no trends noted by social worker and Administrator on 3/6/24. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT REOCCUR? All staff will be re-educated on abuse/neglect starting on 3/6/24 and completed by 3/7/24 by the ADON or designee. This training was performed to facilitate discussion and question and include examples. Staff who were unable to attend will be provided with the education prior to working their next scheduled shift. Any new staff will be educated upon hire prior to providing patient care. Agency staff will be educated prior to working their next scheduled shift. 5 Call light audits will be conducted per shift by DON or designee daily x 30 days. 5 residents will be interviewed per day by DON or designee daily x 30 days for care concerns/allegations of neglect. Observations for resident needs will be conducted of 5 residents on day shift and 5 residents on night shift daily x 30 days. The results of these audits will be reviewed through the QAPI committee weekly. A nurse from the regional team or corporate office has been onsite or available by phone since 2/26/24 and will follow up with facility daily for 2 weeks, then daily M-F for 2 weeks. The nurses from the regional team or home office assist with investigations, observing staff treatment of residents, performing chart audits and providing oversight and consultation. 49650 c2) Resident 331 During a tour of the facility on 03/11/24 at 01:27 PM, Resident #331 was observed to be lying on the floor on his left side and his wheelchair was laying over on its side directly behind him. Three staff members were observed to be standing around him and they all three lifted him by his upper body and simultaneously picked the wheelchair upright and sat him in it. During an interview with the Licensed Practical Nurse Unit Manager (LPN-UM) #30, she stated that the facility was not a no lift facility, and they can pick him up if he is safe. Staff identified to assist LPN-UM #30 physically picking up the resident and the chair are LPN # 64 and Certified Nursing Assistant (CNA) #99. 03/11/24 02:17 PM During an interview with Assistant Director of Nursing (ADON) #42, he stated that he had completed the resident's assessment himself and Resident #331 was a total lift. He further stated that LPN-UM #30 had been educated on this previously and a lift should have been used with this fall. The residents ELC Lift Transfer Reposition Evaluation dated 03/06/24, physicians order dated 03/06/24 and care plan with the total lift intervention revision dated 03/07/24 that identified the resident being a total lift was provided by the ADON at this time.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 40595 Based on record review, staff interview, and resident interview the facility failed to report alleged violations related to misappropriation of property and failed to report the results of all investigations to the proper authorities within required time frames. This failed practice was a random opportunity for discovery. Resident identifiers: #64, #65. Facility census: 82. Findings include: a) Resident #64 On 02/26/24 at 3:35 PM Resident #64, stated he is not getting the right meds. Resident said about a week ago on a Sunday (02/18/24) he got the wrong blue pill for pain. Resident produced pictures from his iPhone of the pill he was given and the right medication lying beside it. Resident stated he looked it up and the medicine he was given was Finasteride, that he wasn't even prescribed to take. (Finasteride is used to shrink an enlarged prostate in adult men by decreasing the amount of a natural body hormone). The incorrect blue tablet had F5 stamped on the pill and the Resident knew it wasn't right. The Resident should have gotten morphine sulphate. The resident said the staff brings his medicine and leaves it set for him to take when he is ready overnight. Resident stated he has gotten the wrong medication for pain twice. On 02/28/24 at 10:00 AM, Resident #64 stated it was the Sunday before Presidents' Day that he got the wrong medication. He was going to tell the Director of Nursing (DON) on Monday, but she was off for the holiday. Resident stated he showed the picture on his phone of the medications (blue pills) to the DON the Tuesday (02/20/24) of the week and told her what happened. Resident #64 stated, I feel like I need to be an advocate for these people. I am not your typical nursing home resident. I know my mediations and pay attention to what I get, some of these people can't speak for themselves. If it is happening to me, it is happening to others here. Record review showed Resident #64 to have capacity to make medical decisions. Record review showed an order for MS (Morphine Sulphate) Contin Oral Tablet Extended Release 15mg. Give 15 mg by mouth two times a day for Pain. Start Date 09/09/2023. On 03/04/24 at 4:00 PM the DON stated, Yea he told me about getting the wrong med and I thought the nurse that gave it told me it was Nifedipine (Nifedipine extended release tablet 60 MG) that he gets. I never went and looked. On 03/04/24, Licensed Practical Nurse (LPN) #101 reviewed mediations in cart and found no blue pills to match the description of the pill he got. Nifedipine that was prescribed to the resident just pulled out of drawer and reviewed. The Nifedipine tablet was brown/tan in color. The DON stated, Well it couldn't have been that then. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/24 at 9:52 AM the DON stated, You are right, I was off president's day just like he [Resident #64] said I was. He gave me the pill, but I didn't look it up, he said he already researched it. The DON further stated, It may have been a reportable, I will have to let you. Record review shows a reportable completed on 03/05/24 for Resident #64 for the alleged incident on 02/18/24. The reportable stated, State surveyor reported misappropriation of medication. Date of incident 02/18/24. During an interview on 03/06/24 at 4:07 PM Corporate Registered Nurse (CRN) #97 stated, He [Resident #64] didn't take the wrong pill so it technically wasn't a medication error and so it didn't hurt him because he didn't take it. When we talked to her [RN # 55] she said they were correct. He said he got his morphine so there was no cause for concern. No misappropriation of funds to begin with. b) Resident #65 On 02/27/24 9:45 AM, LPN #64 stated We got a problem here with controlled substances coming up missing. The DON knows about it . This is my license. See here, this hydromorphone for [Resident #65's name] was signed out and he wasn't even taking it. LPN #64 showed surveyor the controlled substance sign-out book for Resident #65 where Registered Nurse (RN) #55 signed out the pain medication on 02/08/24. LPN #64 then stated, I clean out the med cart at the end of my shift and only leave enough pain meds for the night. That's what I was told to do. Record review shows and order for Hydromorphone HCl Oral Tablet 2 MG (Hydromorphone HCl). Give1 tablet by mouth every 24 hours as needed for pain control. Order was discontinued on 10/17/23. Review of the controlled substance sign-out log showed RN #55 signed out one (1) Hydromorphone 2mg tablet on 02/08/24 at 11:00 PM. No documentation of where the hydromorphone was administered to the Resident was found. On 03/04/24 at 4:15 PM the DON stated Now that does spark my interest. CRN #97 stated, How did she sign it out and administer it if there was no order? DON stated, I done a med error on it, she said he needed something for pain and that was the first thing she saw and pulled it out and gave it. Record review shows no pain medication was documented as given on 02/08/24 at 11:00 PM. On 03/05/24 at 9:31 AM no reportable or investigation was found to have been done. The DON said this wasn't a reportable issue. On 03/05/24 at 9:52 AM, the DON stated they are still investigating what the Surveyor has brought to their attention and it may end up being reportable. DON stated, I told you I didn't know about this, but I guess I did. When they gave me the mediations to destroy last week the nurse told me I may want to take a look at that this one, a pill was missing. Record review of the Controlled substance destruction log showed Hydromorphone 2 tabs were destroyed on 02/29/24 by the DON and pharmacist. At that time the DON was made aware of the missing hydromorphone tablet by nursing staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/24 at 11:30 AM the DON presented a form titled Employee Warning form and stated she had filled this report out for RN #63 due to Resident #65's mediation error. Reason for written warning was Mediation was given without an order. No follow up completed. All medications given must have an order and all PRN meds must have a follow up to verify effectiveness. Always follow the 5 rights of medications Administration. The DON clarified the form was originally completed for resident #65 but could be used for both Resident #64 and #65 since they both involved pain pills. The form was signed by the DON on 02/22/24, by the Administrator on 03/04/24, by RN #63 on 02/22/24. Record review shows a reportable completed on 03/05/24 for Resident #64 for the alleged incident on 02/08/24. The reportable stated, State surveyor reported misappropriation of medication. Date of incident 02/08/24. During an interview on 03/06/24 at 4:07 PM, Corporate Registered Nurse (CRN) #97 stated, We went ahead and reported [Resident #65 name] missing hydromorphone pill as misappropriation of property since we done [Resident #64's] since we don't know what was done with the hydromorphone that was signed out.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40595 45174 .Based on observation, resident interview, record review, and staff interview the facility failed to ensure potential allegations of neglect were thoroughly investigated and failed to provide a corrective action for an allegation that did happen prior to letting the Nursing Assistant (NA) #63 return to work. This placed resident #6 and #237 in an immediate jeopardy situation by not thoroughly investigating allegations of neglect, and letting the alleged perpetrator return to work without the required Abuse and Neglect training. This deficient practice had the potential to affect all residents currently residing in the facility and was a random opportunity for discovery. In addition, the facility failed to maintain accurate records and investigate medication distribution for controlled substances for Resident #64, and #65. This deficient practice had the potential to affect all residents currently residing in the facility and was a random opportunity for discovery. The state agency determined these failures caused Resident #6 and #237 to suffer psychosocial harm because of the allegation of neglect not being thoroughly investigated. The facility allowed NA #63 to return to work without having The Abuse and Neglect training, and by not interviewing the day shift, which was the next following shift. Not only did these failures harm Residents #6 and #237, but they also placed them and the remaining 80 residents at risk for serious harm because the alleged perpetrator was not given the proper training prior to her return to work, and the allegation was not thoroughly investigated. This placed all 82 residents in an immediate jeopardy (IJ) situation. The facility was first notified of the IJ at 4:24 PM, on 03/06/24. The state agency (SA) received the Plan of Correction (POC) at 8:45 PM on 03/06/24. The SA accepted the POC on 03/06/24 at 9:00 PM. The SA observed for the implementation of the POC and the IJ was abated on 03/11/24 at 2:30 PM. Once the Immediate Jeopardy was abated a deficient practice did remain for Resident #64 and #65. Therefore, the scope and severity were decreased from a L to a F. Resident identifiers #6, #237 #64 and #65. Facility census 82. a) Resident #6 Upon an unannounced entrance to the facility on [DATE] at 11:08 PM, staff member Licensed Practical Nurse (LPN) #62 and Nursing Assistant (NA) #63 were observed sitting in the room labeled Conference room with their feet propped up in a chair looking at their cell phones. An observation on 02/27/24 at 11:10 PM, of the North Nurse's station revealed that 6 call lights were going off, according to the call light board on the wall. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An observation on 02/27/24 at 11:15 PM, of North 2 (two) hall revealed the following: - At 11:15 PM Resident #6's call light came on. - At 11:30 PM NA #63 went into Resident #6's room, and his light went off. NA #63 came out of room at 11:31. -At 11:33 PM Resident #6 ' s light came back on. During an interview on 02/27/24 at 11:34 PM, Resident # 6 stated, I just want changed. They came in and turned my light off and told me they would be back. I just want to get dry and go to sleep. I am sick of this. Observation on 02/27/24 at 11:40 PM, of North Nurses station showed NA# 63, NA#65, LPN #63, and LPN #43 at the nursing station. Nobody appeared to be paying any attention to the light going off in resident # 6's room. Observation on 02/27/24 at 11:44 PM, of North Nurses station surveyor heard LPN # 40 announce, I am going on my 15-minute break, because I am supposed to get it. I will set my watch. Resident #6's call light continued to go off. Further observation at 11:47 PM, showed LPN #62 going in Resident #6's room and immediately walked back out. The call light was turned off. She then stated, He is a 2 person assist, I got to wait on help. An observation on 02/27/24 at 11:50 PM, showed LPN #62 and NA #63 going into Resident #6's room to change him. Resident #6's room was under constant observation by a surveyor from 02/27/24 at 11:10 PM to 02/27/24 at 11:50 PM. Assistance and incontinence care was not provided to Resident #6 until 02/27/24 at 11:50 PM. An interview with the Director of Nursing (DON) on 02/28/24 at 12:35 AM she confirmed the residents should not wait that long to be changed and staff should not be turning call lights off and saying I will be back. She further confirmed that yes this is neglectful. A review of the facilities Abuse and Neglect policy on 02/28/24 at 11:30 AM describes Neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional stress. A record review on 02/28/24 at 12:15 PM, of Resident #6 ' s care plan reads as follows: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Focus: I have the Potential for Skin Issues related to incontinence of bowel and bladder, decreased mobility/ability to reposition myself. -Goal: My skin will remain intact without signs of breakdown by next review. -Interventions: Turn and reposition frequently to decrease pressure. Further review of the care plan reads as follows: Focus: I have an ADL self-care performance deficit due to limited mobility. Goal: I will maintain current level of function in all ADL ' s through the review date. Interventions: Assist resident to bathroom for toileting every 2 hours. Toilet use: I require extensive assistance by staff for toileting. b) Resident #237 02/27/24 Incident During an unannounced visit to the facility on [DATE] at 11:05 PM, the following observations were made: At 11:08 PM, Resident # 237 was lying in bed with his feet hanging over the right side of the bed touching the floor. His bottom was in the middle of the bed, his head and his upper torso leaning towards the left side of the bed off the pillows. A strong smell of urine appeared to come from the room. Another observation on 02/27/24 at 11:35 PM, showed Resident # 237 continued to be laying in the same position with the sheet now on the floor yelling, [NAME], [NAME] get the car let's go. Another observation on 02/27/24 at 11:53 PM, showed Resident # 237' s feet continued to be on the right side touching the floor. Now his head was hanging over the bed on the left side. Another observation on 02/28/24 at 12:05 AM, showed Resident # 237 was in the same position as before. The smell of bowel movement was present. This was observed by another surveyor as well. At that time, Resident # 237 was pulling the privacy curtain and yelling out. Another observation on 02/28/24 at 12:08 AM, Resident # 237 was yelling [NAME], [NAME]. Nursing Assistant (NA) #31 walked to another resident's room to tell the NA #6 in the room she needed assistance when she was done. An observation on 02/28/24 at 12:09 AM, revealed NA #31 told NA #6, I guess I will see what [Resident # 237] wants but he is not my resident. Another observation on 02/28/24 at 12:10 AM, showed NA #31 entered and exited Resident # 237's room without providing assistance. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An observation on 02/28/24 at 12:11 AM, showed NA #31 went to another resident's room where NA #6 was assisting the resident in that room. NA #31 stated, He needs changed. You can do it when you are done. He is not mine, so I am not cleaning him up. An observation on 02/28/24 at 12:15 AM, showed NA #6 was in Resident #237's room assisting him. Resident #237's room was in constant observation by a surveyor from 02/27/24 at 11:08 PM to 02/28/24 at 12:15 AM. Assistance and incontinence care was not provided to the resident until 12:15 on 02/28/24, despite the resident beginning to yell for help at 11:08 PM on 02/27/24. During an interview on 02/28/24 at 1:30 AM, the DON stated, Are you kidding me. The nursing staff tells me all of this is being taken care of. They never mention call lights are not being answered. I thought everything was ok. They should not turn off a call light without the need being addressed, if they can't get to it they should leave it on until the resident is changed or whatever they need. And everyone can answer a call light not just the aides. That's not my job or my resident doesn't fly. Sounds to me like a bunch [staff] need to be on the unemployment line. That should have never happened, they should work as a team. He should have never laid there that long without assistance. On 02/28/24 at 1:34 PM, the Corp RN #97 stated, The DON told me there were small issues last night, call lights not answered and late medications. RN #97 was unsure if the incidents with the call lights not answered, and residents being left soiled were reported. She said she would have to look around and see what she could find. DON was unavailable for any further comment at that time and not in the facility. The OHFLAC (Office of Health Facilities Licensure and Certification) 225 Allegation reporting form dated 02/28/24 completed by Social Worker # 36. Alleged Victim Name: Resident #237 ' s Name Alleged Perpetrator Name: Nurse Aide (NA) #31 Position/title: Certified Nursing Assistant Date of Incident: 02/27/24 Time of Incident: Night Shift Location of Incident: room [ROOM NUMBER]-1 Brief Description of the Incident: Allegation was received that Resident #237's name was waiting for an extended period for his call light to be answered for incontinence care. The 5 five day follow up determination on Resident #237 was completed and faxed to the state agencies on 03/05/24. c) Resident #237 03/03/24 incident (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 03/03/24 at 11:00 PM, an unannounced visit was made to the facility. During an observation on 03/03/24 at 11:05 PM, Resident # 237 was resting in bed with a pillow under his legs. During an observation on 03/03/24 at 11:35 PM, Resident # 237's legs were hanging over the right side of the bed. Observation on 03/03/24 at 11:38 PM, Resident # 237 was yelling Hello. His head was now almost to the middle of the bed, and his feet continued to be on the floor. The following further observations were made: 03/03/04 at 11:41 PM, LPN #28 walked by Resident # 237 room. 03/03/24 at 11:44 PM, Resident #237 was yelling Help in here. 03/03/24 at 11:45 PM, Corporate nurse #97 was going from room to room. 03/03/34 at 11:47 PM, LPN #28 walked by resident's room again. 03/03/24 at 11:53 PM, NA #57 walked by Resident # 237's looking into his room. 03/03/24 at 11:56 PM, Resident # 237 yelling Help in here Hello, Help. 03/03/24 at 11:59 PM, Resident # 237 yelling Hello Corporate's Nurse #97 stated to Resident # 237 Hang on, let me get someone. 03/04/24 at 12:04 AM, Corporate RN #97 stating Did that fix it? [Resident # 237] pulled the call light halfway out of the wall, that is where the emergency light was coming from. During an interview on 03/04/24 at 1:34 PM, DON and SW were informed of the incidents occurring on 03/03/24. During an interview on 03/05/24 at 11:30 AM, the Corporate Nurse #97 stated I will watch the cameras to see if I feel a report needs to be filed. During an interview on 03/05/24 at 2:35 PM, the ADON stated they do not feel a report needs to be done. On 03/06/24 at 5:47 PM, social worker #237 gave this report to the surveyor. The OHFLAC (Office of Health Facilities Licensure and Certification) 225 Allegation reporting form dated 03/05/24 completed by Social Worker # 36. Alleged Victim Name: Resident #237 ' s Name Alleged Perpetrator Name: Unknown (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Date of Incident: 03/04/24 Night Shift Time of Incident: Night Shift Location of Incident: Name of the Nursing Home Facilities Brief Description of the Incident: Surveyor alleged on 03/04/24 that Resident #237 ' s name was neglected with delayed response time in addressing his needs during night shift 03/03/24 into 03/04/24. The 5 five day follow up determination on Resident #237 was not completed upon exiting the facility on 03/11/24. Two (2) surveyors on 03/05/24 at 7:39 PM, Resident # 237 stated This is the best day since I have been here. I have not slept in four (4) days and I slept well last night, sleeping like a baby. I ate everything today, my dinner was good. I think I was admitted on Friday but I was so out of it, I am not really sure. Resident # 237 was asked, do you need assistance with the bathroom? Resident # 237 stated they make me use the call light when I need to use the bathroom, but they take so long to get here I pee myself. The other night I laid in pee all night. The DON was made aware of the above interview with Resident #237. d) Interview wit Nurse Aide (NA) #49 On 02/28/24 at 12:07 PM, NA #49 asked to speak to surveyors in private. NA #49 stated, I guess the best way I can put it is this place is awful and residents are being neglected. NA #49 stated this morning Resident #237 and Resident #6 were brown ringed, meaning the residents ' urine had seeped out of the adult briefs, leaving brown stains on the sheets. NA #49 stated, It happens all the time. Resident #237 brief was so saturated with urine it started to disintegrate. We have taken this issue to Human Resources (HR), and we are not on good terms and nothing is being done. Administration is stressing on us now to get showers done because the state is here, but any other time they do not care. CNA #49 informed surveyor that she relieved NA #63 and CNA #57 this morning and was not sure which one or if both were assigned to the residents left wet. CNA #57 stated she told the ADON this morning what shape she found Resident #237 and Resident #6 very saturated with urine. e) Facility investigation for Resident #6 and #237 (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/26/24 at 3:35 PM Resident #64 stated he is not getting the right meds. Resident said about a week ago on a Sunday (02/18/24) he got the wrong blue pill for pain. Resident produced pictures from his iPhone of the pill he was given and the right medication lying beside it. Resident stated he looked it up and the medicine he was given was Finasteride, that he wasn't even prescribed to take. (Finasteride is used to shrink an enlarged prostate in adult men by decreasing the amount of a natural body hormone). The incorrect blue tablet had F5 stamped on the pill and the Resident knew it wasn't right. The Resident should have gotten morphine sulphate. The resident said the staff brings his medicine and leaves it set for him to take when he is ready overnight. Resident stated he has gotten the wrong medication for pain twice. On 02/28/24 at 10:00 AM Resident stated it was the Sunday before Presidents' Day that he got the wrong medication. He was going to tell the Director of Nursing (DON) on Monday, but she was off for the holiday. Resident stated he showed the picture on his phone of the medications (blue pills) to the DON the Tuesday (02/20/24) of the week and told her what happened. Resident #64 stated, I feel like I need to be an advocate for these people. I am not your typical nursing home resident. I know my mediations and pay attention to what I get, some of these people can't speak for themselves. If it is happening to me, it is happening to others here. Record review showed Resident #64 has the capacity to make medical decisions. Record review showed an order for MS (Morphine Sulphate) Contin Oral Tablet Extended Release 15 mg. Give 15 mg by mouth two times a day for Pain. Start Date 09/09/2023. On 03/04/24 at 4:00 PM the DON stated, Yea he told me about getting the wrong med and I thought the nurse that gave it told me it was Nifedipine (Nifedipine extended-release tablet 60 MG) that he gets. I never went and looked. On 03/04/24 Licensed Practical Nurse (LPN) #101 reviewed mediations in cart and found no blue pills to match the description of the pill he got. Nifedipine that was prescribed to the resident just pulled out of drawer and reviewed. The Nifedipine tablet was brown/tan in color. The DON stated, Well it couldn't have been that then. On 03/05/24 at 9:52 AM the DON stated, You are right, I was off president's day just like he [Resident #64] said I was. He gave me the pill, but I didn't look it up, he said he already researched it. The DON further stated, It may have been a reportable, I will have to let you. Record review shows a reportable completed on 03/05/24 for Resident #64 for the alleged incident on 02/18/22. The reportable stated, State surveyor reported misappropriation of medication. Date of incident 02/18/24. During an interview on 03/06/24 at 4:07 PM Corporate Registered Nurse (CRN) #97 stated, He [Resident #64] didn't take the wrong pill so it technically wasn't a medication error and so it didn't hurt because he didn't take it. When we talked to her [RN # 55] she said they were correct. He said he got his morphine so there was no cause for concern. No misappropriation of funds to begin with. h) Resident #65 (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/27/24 9:45 AM, LPN #64 stated We got a problem here with controlled substances coming up missing. The DON knows about it . This is my license. See here, this hydromorphone for [Resident #65's name] was signed out and he wasn't even taking it. LPN #64 showed surveyor the controlled substance sign-out book for Resident #65 where Registered Nurse (RN) #55 signed out the pain medication on 02/08/24. LPN #64 then stated, I clean out the med cart at the end of my shift and only leave enough pain meds for the night. That's what I was told to do. Record review shows and order for Hydromorphone HCl Oral Tablet 2 MG (Hydromorphone HCl). Give1 tablet by mouth every 24 hours as needed for pain control. Order was discontinued on 10/17/23. Review of the controlled substance sign-out long showed RN #55 signed out one (1) Hydromorphone 2mg tablet on 02/08/24 at 11:00 PM. No documentation of where the hydromorphone was administered to the Resident. On 03/04/24 at 4:15 PM the DON stated, Now that does spark my interest. CRN #97 stated, How did she sign it out and administer it if the was no order was discontinued? DON stated, I done a med error on it, she said he needed something for pain and that was the first thing she saw and pulled it out and gave it. Record review shows no pain medication to documented as given on 02/08/24 at 11:00 PM. On 03/05/24 at 9:31 AM no reportable or investigation was found to have been done. The DON said this wasn't a reportable issue. On 03/05/24 at 9:52 AM DON stated they are still investigating what the Surveyor has brought to their attention and it may end up being reportable. DON stated, I told you I didn't know about this, but I guess I did. When they gave me the mediations to destroy last week the nurse told me I may want to take a look at that this one, a pill was missing. Record review of the Controlled substance destruction log showed Hydromorphone 2 tabs were destroyed on 02/29/24 by the DON and pharmacist. At that time DON was made aware of the missing hydromorphone tablet by nursing staff. On 03/05/24 at 11:30 AM the DON presented a form titled Employee Warning form and stated she had filled this report out for RN #63 due to Resident #65's mediation error. The reason for the written warning was Mediation was given without an order. No follow up completed. All medications given must have an order and all PRN meds must have a follow up to verify effectiveness. Always follow the 5 rights of medications Administration. The DON clarified the form was originally completed for resident #65 but could be used for both Resident #64 and #65 since they both involved pain pills. The form was signed by the DON on 02/22/24, by the Administrator on 03/04/24, by RN #63 on 02/22/24. Record review shows a reportable completed on 03/05/24 for Resident #64 for the alleged incident on 02/18/22. The reportable stated, State surveyor reported misappropriation of medication. Date of incident 02/08/24. During an interview on 03/06/24 at 4:07 PM Corporate Registered Nurse (CRN) #97 stated, We went ahead and reported [Resident #65 name] missing hydromorphone pill as misappropriation of property since we done [Resident #64's] since we don't know what was done with the hydromorphone that was signed out. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	49465

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 39043 Based on record review and staff interview, the facility failed to ensure a complete and accurate discharge Minimum Data Set (MDS) Assessment for one (1) of one (1) residents reviewed for the care area of discharge. Resident Identifier: #77. Facility census: 82. Findings include: a) Resident #77 Review of Resident #77's medical records showed the resident was admitted for short-term rehabilitation on 11/29/23. He was discharged to home on 12/01/23. A Social Service Progress Note written on 12/03/23 stated, Resident had a brief stay here from 11/29/2023 to 12/1/2023 when he opted to discharge to home. He stated he no longer needed to be in SNF [skilled nursing facility] for rehab [rehabilitation]. Review of Resident #77's combined five (5) day and discharge Minimum Data Set (MDS) Assessment with Assessment Reference Date (ARD) 12/01/23 coded the resident's discharge as Discharge assessment - return anticipated. On 03/05/24 at 05:13 PM, the Assistant Director of Nursing (ADON) confirmed Resident #77's medical records contained no evidence the resident was expected to return to the facility. The ADON confirmed Resident #77's MDS with ARD 12/02/23 was incorrect. No further information was provided through the completion of the survey.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45174 Based on medical record review, family interview, resident interview and staff interviews, the facility failed to complete an accurate Minimum Data Set (MDS) assessment for one (1) of 24 residents reviewed during the Long-Term Care Survey (LTCSP). The MDS's for Resident #233 did not accurately reflect the residents' status for communication deficit. Resident Identifiers: #233. Facility Census: 82 Findings Include: a) Resident #233 During the initial interview on 02/26/24 at 3:36 PM, Resident #233 and her daughter were present during the interview. Resident shook her hand to respond yes and no to some answer and looked at her daughter for other responses. The daughter stated she has some communication issues due speaking Spanish and having a stroke. She mostly understands others but has some issues communicating needs to others. She mostly responds by shaking her head. During an interview on 02/27/24 at 4:56 PM, the Director of Nursing (DON) stated they have books and other things to help communicate with (Resident # 233's name). During a record review on 03/04/24 at 2:02 PM, Resident #233's medical record revealed a Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/19/24. Section B, titled Hearing, Speech and Vision Section B0600 Speech Clarity Select best description of speech pattern was coded 0(zero) for clear speech-distinct intelligible words Section B0700 Makes Self Understood was coded 0 (zero)Understood Section B0800 Ability to Understand Others was coded 0 (zero) Understands-clear comprehension. During an interview on 03/04/24 at 2:42 PM, DON acknowledged the MDS with an ARD of 02/19/24 were coded inaccurate for unclear speech, makes self understood and ability to understand. During an interview on 03/05/24 at 11:18 AM, Nurse Aide (NA) #45 stated Resident #233 has some communication struggles, she will point to stuff, sometimes the struggle is more from her stroke than language. She speaks mostly Spanish and some English. During an interview on 03/05/24 at 11:21 AM, Licensed Practical Nurse (LPN) #64 stated Resident #233 has a language barrier but we do very well, she answers yes or no questions with yes or no or shaking her head. She has a tablet with her family pictures on it. You pick up the tablet, press the family member and someone is always available for facetime. They are always there to help with what she is trying to say to us. It is so easy.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 45174 Based on medical record review, family interview, resident interview and staff interviews, the facility failed to complete a baseline care plan for Resident #233's communication deficit. This was true for one (1) of 24 residents reviewed during the Long-Term Care Survey (LTCSP). Resident Identifier: #233. Facility Census: 82. Findings Include: a) Resident #233 During the initial interview on 02/26/24 at 3:36 PM, Resident #233 and her daughter were present during the interview. Resident shook her hand to respond yes and no to some answer and looked at her daughter for other responses. The daughter stated she has some communication issues due to speaking Spanish and having a stroke. She mostly understands others but has some issues communicating needs to others. She mostly responds by shaking her head. During an interview on 02/27/24 at 4:56 PM, the Director of Nursing (DON) stated they have books and other things to help communicate with (Resident # 233's name). During a record review on 03/04/24 at 2:06 PM, Resident #233 medical records revealed a care plan with an initiated date of 02/13/24. This care plan showed no focus, goal or interventions for Resident #233's language deficit. During an interview on 03/04/24 at 2:42 PM, the DON acknowledged the care plan with an initiated date of 02/13/24 did not address the communication deficit. During an interview on 03/05/24 at 11:18 AM, Nurse Aide (NA) #45 stated Resident #233 has some communication struggles, she will point to stuff, sometimes the struggle is more from her stroke than language. She speaks mostly Spanish and some English. During an interview on 03/05/24 at 11:21 AM, Licensed Practical Nurse (LPN) #64 stated Resident #233 has a language barrier but we do very well, she answers yes or no questions with yes or no or shaking her head. She has a tablet with her family pictures on it. You pick up the tablet, press the family member and someone is always available for facetime. They are always there to help with what she is trying to say to us. It is so easy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review, staff interview, and resident interview the facility failed to develop and/or implement care plans related to dementia, pain, dialysis and Diabetes. This failed practice was found true for (4) four of 24 residents reviewed for care plans during the Long Term Care Survey Process. Resident identifiers #23, #181, #40, and #7. Facility Census 82. Findings include: a) Resident #23 During an interview on 02/27/24 at 4:45 PM, with Resident #23, she stated, The pain medicine does not always help me. A record review on 03/05/24 at 10:03 AM, revealed Resident #23 is prescribed Percocet Tablet 10-325 MG (oxycodone-Acetaminophen) for pain, and she has a diagnosis of Dementia. Further record review showed Resident #23 does not have a care plan developed for pain or Dementia. An interview on 03/05/24 at 11:22 AM, with Assistant Director of Nursing (ADON) #42 , He confirmed a care plan for pain or Dementia was not developed for Resident #23. b) Resident #181 During an interview on 2/27/24 at 1:00 PM, with Resident #181 she stated, I hurt all the time, I feel like I need a different pain medicine. A record review on 03/05/24 at 10:15 AM, revealed that Resident #181 has a diagnosis of pain. Further record review showed Resident #181 does not have a care plan developed for pain. During an interview on 03/05/24 at 11:22 AM with Assistant Director of Nursing (ADON) #42 , he confirmed a care plan for pain was not developed for Resident #181. c) Resident #4 Review of Resident #40's comprehensive care plan showed the following focus, The resident needs dialysis hemodialysis r/t [related to] ESRD [end stage renal disease]. An intervention dated 02/18/24 was to Check vital signs post dialysis q [every] shift x 24 hours. The resident's medical records contained documentation the resident's vital signs were checked immediately upon return from the dialysis unit. However, there was no documentation Resident #40's vital signs had continued to be checked every shift for 24 hours. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/05/24 at 1:41 PM, the Assistant Director of Nursing (ADON) confirmed Resident #40's medical records contained no documentation to show the resident's vital signs were checked post dialysis every shift x 24 hours as specified in the resident's care plan. No further information was provided through the completion of the survey process. d) Resident #7 On 03/05/24 at 12:01 PM during a medical record review for Resident #7 who admitted on [DATE] had a Care Plan that was initiated on 01/30/23 to include a focus, goal and interventions for diabetes mellitus. Upon reviewing the physician diagnosis for Resident #7, the diagnosis of diabetes mellitus was not identified. During an interview with the Assistant Director of Nursing (ADON) on 03/05/24 at approximately 12:07 PM, he stated the resident did not have diabetes mellitus and that the care plan was in error. 49465 49650

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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, resident interview and staff interview, the facility failed to revise the care plan regarding bathing preferences and refusals of showers for Resident #58, diagnosis for antibiotic therapy and end-of-life wishes for Resident #76, multiple diagnoses including the use of a foley catheter, Gastromy (G-tube) tube and supplemental oxygen for Resident #179, pain for Resident #19, a splint for Resident #68, actual pain for Resident #10, and a diagnosis of dementia and pain for Resident #23. This was true for seven (7) of 24 residents reviewed during the survey process. Resident Identifier: #58, #76, #179, #19, #68, #10 and #23. Facility Census: 82. Findings Included: a) Resident #58 On 03/05/24 at 9:25 AM, a record review was completed for Resident #58. Upon completion of the review, the resident does not have a bathing preference or refusals of showers noted. The resident prefers bed baths to showers. On 03/05/24 at 11:00 AM, the Director of Nursing (DON) stated, she refuses a lot (showers) she would rather have a bed bath. The DON also confirmed the care plan was not revised in regards to a bathing preference and refusals of shower. No further information was obtained during the survey process. b) Resident #76 On 03/04/24 at 12:38 PM, a record review was completed for Resident #76. The review found the care plan was not revised to include a diagnosis for antibiotic therapy and the terminal diagnosis for hospice services. The care plan also did not indicate the resident's code status had been changed to Do Not Resuscitate from a full code. On 03/05/24 at 11:23 AM, the DON was notified and confirmed the care plan had not been revised to include the diagnosis for antibiotic therapy, a terminal diagnosis for hospice services and the change in code status. No further information was obtained during the survey process. c) Resident #179 On 03/04/24 at 10:30 AM, a record review was completed for Resident #179. The review found the care plan had not been revised to include the diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Asthma, Gastroesphoageal Disease (GERD), gastroparesis, the diagnoses and the reasons for a urinary foley catheter, G-tube and supplemental oxygen. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/24 at 11:30 AM, the DON confirmed the diagnoses and reasons for the urinary foley catheter, G-tube and supplemental oxygen were not listed within the care plan. No further information was obtained during the survey process. d) Resident #19 On 03/06/24 at 12:15 PM, a record review was completed for Resident #19. The review found the care plan was not revised to indicate actual pain. The care plan stated potential for pain r/t (related to) decreased mobility, DMII (diabetes mellitus 2) and GERD. The resident is ordered Voltaren External Gel 1% (one percent) apply to lower extremities topically four (4) times a day for pain. The resident also has hydrocodone-acetaminophen 5-325mg give one (1) tablet by mouth every 4 (four) hours as needed for pain. The resident rated the pain she experienced as two (2) through seven (7) out of 10 on the pain scale. On 03/06/24 at 2:02 PM, the DON confirmed the resident was having actual pain and the care plan would be updated. No further information was obtained during the survey process. e) Resident #68 On 03/04/24 at 11:00 AM, a record review was completed for Resident #68. The review found the care plan was not revised to include a right lower extremity drop splint. On 03/04/24 at 12:03 PM, the Assistant Director of Nursing (ADON) #42 was notified and confirmed the right lower extremity drop splint was not included on the care plan. No further information was obtained during the survey process. f) Resident #10 On 03/06/24 at 12:15 PM, a record review was completed for Resident #19. The review found the care plan was not revised to indicate actual pain. The care plan stated Actual/Potential for Pain r/t (related to) Arthritis and decreased mobility. The resident was ordered Tylenol 325mg (milligrams) give two (2) tablets by mouth every 4 (four) hours as needed for pain. The resident has documented pain ranging from 2 (two)-5 (five) out of 10 on a pain scale. The care plan also included a focus area of I have a history of Insomnia. I may have difficulty sleeping some nights. One of the interventions stated Medicate with Melatonin for Insomnia per MD (medical doctor) orders. The Melatonin was discontinued on 02/24/24. On 03/06/24 at 2:02 PM, the DON confirmed the resident was having actual pain and the Melatonin was discontinued. The DON stated, the care plan would be updated. No further information was obtained during the survey process. g) Resident #23 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/24 at 4:45 PM, with Resident #23, she stated, The pain medicine does not always help me. A record review on 03/05/24 at 10:03 AM, revealed Resident #23 is prescribed Percocet Tablet 10-325 MG (oxycodone-Acetaminophen) for pain, and she has a diagnosis of Dementia. Further record review showed Resident #23 does not have a care plan developed for pain or Dementia. During an interview on 03/05/24 at 11:22 AM, with Assistant Director of Nursing (ADON) #42 , he confirmed a care plan for pain or Dementia was not developed for Resident #23. 49465

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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** 45173 Based on record review, staff interview, and resident interview the facility failed to ensure residents were receiving the necessary services to maintain good personal hygiene. Resident #44, #58 and #234 were not receiving showers. This failed practice was found true for (3) three of (9) nine residents reviewed for Activities of Daily Living (ADL's) during the Long Term Care Survey Process. Resident identifiers #44, #58, and #234. Facility census 82. Findings include: a) Resident #44 During an interview on 02/26/24 at 3:58 PM, Resident #44 stated, I don't always get my showers. A record review on 03/04/24 at 12:31 PM, of Resident #44's care plan found following: -Focus: Requires assistance with ADL's due to self care deficit, weakness, decreased mobility, debility, pain. -Goal: Will continue to have needs met on a daily basis through review date: remaining clean, dry, dressed, groomed and free of odors. -Intervention: Showering Assit: (Independent, Supervision/Oversight, Set-Up, Verbal Cues/Encouragement, Non-Weight-Bearing Assistance, Weight-Bearing Assistance, Total Dependence) Further review of the facilities shower schedule shows Resident #44 was to get showers on Tuesday's and Friday's on day shift. During the month of January 2024 she received one tub bath, (3) three bed baths, and (2) two showers, only (1) one of which was given on her scheduled day. During the month of February 2024 she received (1) one bed bath and (2) two showers on her scheduled days. She had not received a shower for the month of March 2024 by the end of the survey. An interview with Assistant Director of Nursing (ADON) on 03/04/24 at 2:00PM , he confirmed Resident # 44 had not been given her showers as scheduled. b) Resident #58 On 03/04/24 at 10:02 AM, during the initial interview, the resident stated I've only had one (1) shower recently. On 03/04/24 at 2:40 PM, a record found the resident was scheduled for showers two (2) x (times) weekly on Tuesday and Friday on nightshift. The resident is listed as requires extensive assistance of one (1) staff for personal hygiene. The bathing documentation was reviewed from 02/02/24 through 03/02/24. There were nine (9) scheduled opportunities for showers on the following dates: --02/02/24 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--02/05/24 --02/09/24 --02/12/24 --02/16/24 --02/19/24 --02/23/24 --02/26/24 --03/01/24 The review found one (1) shower was given on 02/17/24 which was not a scheduled shower day which was documented in the progress notes. There also was one refusal documented on 02/20/24 which was not a scheduled shower day. On 03/04/24 at 2:40 PM, the Director of Nursing (DON) was notified regarding the showers not being documented. The DON stated, they need to chart if there were refusals. No further information was obtained during the survey process. c) Resident #234 During an interview on 02/27/24 at 9:05 AM, Resident #234 stated I have been here for a week and I got my first bath last night at 3 AM this morning. During a record review on 03/04/24 02:37 PM, Resident # 234's medical records revealed the resident was admitted on [DATE]. Further review of medical records revealed the bathing/shower task was coded for the following: -02/21/24 NA (Not Applicable) -02/22/24 NA -02/23/24 BB(Bed Bath) 4(Total Dependence) 2(one person assist) -03/01/24 Shower 4(Total Dependence) 2(one person assist) The Shower schedule received on 03/04/24 revealed the following shower days for Resident #234 the AM shift on Tuesday and Friday. Further record review revealed a care plan with an initiated date of 02/22/24 read as follows: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: Requires assistance with ADL's due to weakness, decreased mobility. Interventions: .Assist as needed with showers twice weekly or per resident preference. During an interview on 03/04/24 at 3:47 PM, the DON acknowledged Resident #234 did not receive the scheduled amount of showers they should have. 45174 49465

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45174 Based on observation, record review, resident interview, and staff interview the facility failed to provide an ongoing program of activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. This failed practice was found true for (3) three of (4) four residents reviewed for the care of activities during the Long Term Care Survey Process. Resident identifiers #35, #6, and #233. Facility census 82. Findings include: a) Resident #35 During an interview on 02/26/24 at 3:36 PM, Resident #35 stated, I don't like much that they do here. An observation on 02/27/24 at 10:00 AM, of Resident # 35, showed the resident was sitting on his bed, touching and rubbing his catheter tubing and bag that he had taken off of his wheelchair. An observation on 03/04/24 at 11:00 AM, of Resident # 35, revealed the resident was lying in his bed, rubbing his sheets. A record review on 03/04/24 at 2:20 PM, of Resident # 35's Activity Participation Records (APR) revealed during the month of January and February 2024 he participated in 11 out of room activities. Further record review of Resident # 35's Minimum Data Set (MDS), section F, question F, with an Assessment Refrence Date (ARD) date of 02/02/24 revealed it is somewhat important for him to do his favorite activities. A review of Resident # 35's care plan on 03/04/24 at 2:25 PM, read as follows: -Focus: I prefer independent and one on one activities. -Goal: Resident will participate in one on one activities that promote socialization. -Intervention: Redirect/divert resident if he becomes irritated/overwhelmed during conversation. Resident converses one on one with staff and spends time in the Activity room. Further review of Resident #35's APR for the months of January and February 2024 shows he has no (1) one to (1) one visits documented. During an interview on 3/04/24 at 3:35 PM, with the facilities Activity director (AD), she stated, ' I am new and still learning this role, no there is not much documentation for him. b) Resident #6 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 02/26/24 at 3:45 PM, Resident # 6 showed him lying in the bed, in the dark with no stimulation. During an interview on 02/26/24 at 3:45 PM, with Resident # 6, he stated, I just lay here all day, and wait for the time to pass. During an observation on 03/04/24 at 11:15AM, showed Resident # 6 lying in the bed, in the dark with no stimulation. A record review on 03/04/24 at 3:00 PM of Resident # 6's APR, revealed during the month of January and February 2024 he participated in (6) six out of room activities. No (1) one to (1) one visits are documented on the participation records. Further record review of Resident # 6's MDS, section F, question E, revealed it is very important for him to do things with groups of people. Question F is answered it is very important for him to participate in his favorite activities. A review of Resident # 6's care plan on 03/04/24 at 2:05 PM, read as follows: -Focus: Resident enjoys one on one activities with fell ow residents and independent activities. -Goal: Resident will participate in activities to promote socialization. -Intervention: Enjoys relaxing: Listening to music and watching TV I enjoy spending time outside when it's nice. There is no mention in the careplan of Resident # 6's interest according to his Activity Assessment completed on 10/27/23. His interest include trivia, discussion, reading and word puzzles. During and interview on 3/04/24 at 3:35 PM, with the facilities Activity director (AD), she stated, ' I am new and still learning this role, no there is not much documentation for him. c) Resident # 233 During a record review on 03/04/24 at 2:19 PM, Resident #233's medical records revealed a Activities assessment dated [DATE] which read as follows: A3. Attendance: 1. Small Group Attendance: daily 2. Large Group Attendance: daily 3. 1:1 Attendance: daily A9. Activity Review the following categories were checked: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Cognitive c. Creative d. Entertainment e. Outings f. Games h. Spiritual i. Sensory j. Social Further record review revealed a monthly participation sheet was void any documentation for the following dates: -02/18/24 -02/13/24 -02/12/24 The Monthly participation sheet was documented GS (General Socialization) but no other group activities were documented for the following days: -03/04/24 -03/02/24 -03/01/24 -02/29/24 -02/28/24 -02/27/24 -02/24/24 -02/19/24 -02/15/24 Further record review revealed the care plan with a initiated date of 02/13/24 read as follows: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Focus: Activities come join and socialize with others. Goal: Get up and come to the activities that I like to come to. Interventions: Go ask her to come to bingo and crafts. Ask about coming to spay day as well. During an interview on 03/05/24 at 11:29 AM, the AD acknowledged Resident #233 did not receive the invitation to the group activities of interest. The AD stated we documented she attends the lunch and dinner meals in the dining room for group socialization, but she has attended some other group activities, but we have not invited or documented the attendance or refusal of all the activity participation. 49465

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the activities program is directed by a qualified professional. 45174 Based on observation and staff interviews the facility failed to ensure the activities program is directed by a qualified professional. This had a potential to affect all residents residing in the facility. Facility Census: 82. Findings Include: a) Qualified Activity Professional During an observation on 02/26/24 at 12:35 PM, the activity office was void of any documentation of a certification of an activity professional. During an interview on 02/26/24 at 12:35 PM, the Activity Director(AD) was asked to see her activity certification. The AD stated I do not have a certificate, I will start the class in March. The Occupational Therapist reviews my stuff. I was thrown into this position when the other person was let go. During an interview on 02/27/24 at 2:44 PM, the Director of Nursing (DON) stated the Occupational Therapist stated she has not been working with the activity department for a few months. The DON acknowledged there is no certified Activity Professional.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on resident interview, record review, and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice. This deficient practice had the potential to affect five (5) of 24 residents reviewed in the long-term care survey sample. For residents #44, #40, and #7, physicians' orders were not followed. Additionally, Resident #19 was receiving a medication without an order. Resident #7's diagnoses were not complete in the electronic health records. Resident #179 did not have a physician's assessment for capacity to make medical decisions. Also, a random opportunity for discovery found Residents #331, #64, #330, #65, and #47 were given their evening medications late. Resident identifiers: #44, #40, #19, #7, #179, #331, and #64. Facility census: 82. Findings included: a) Resident #44 During an interview on 02/26/24 at 4:19 PM, Resident #44 stated the physician had ordered a urinalysis test for her, but it took five (5) days for the facility to collect it. Review of Resident #44's progress note showed a physician's progress note written on 1/16/24 at 6:39 PM stated, The pt [patient] has ongoing urine complaints and says has to pee all the time. Resident #44's physician's orders showed urinalysis and culture and sensitivity testing was ordered on 01/17/24, 01/19/24, and 02/01/24. Resident #44's medical records showed urinalysis and culture and sensitivity testing results for 02/01/24 only. On 03/05/24 at 11:12 AM, the Assistant Director of Nursing stated urinalysis and culture and sensitivity testing was not done for Resident #44 as ordered on 01/17/24 and 01/19/24 because the physician's orders were incorrectly entered into the computer. No further information was provided through the completion of the survey. b) Resident #40 Review of Resident #40's physician's orders showed an order written on 02/02/24 for wound care to an abdominal surgical incision every day shift. The order was to clean with wound cleanser, pack with Dakins solution and gauze, and cover with a pad. Review of Resident #40's Treatment Administration Record (TAR) for February 2024 showed the dressing change was not signed by the nurse to indicate the treatment had been performed on the following dates: 02/02/24, 02/05/24, 02/07/24, 02/16/24, 02/19/24 and 02/22/24. On 03/04/24 at 2:12 PM, the Director of Nursing verified there was no documentation Resident #40's abdominal incision dressing change had been performed on 02/02/24, 02/05/24, 02/07/24, 02/16/24, 02/19/24 and 02/22/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided through the completion of the survey process. c) Resident #19 On 02/26/24 at 2:30 PM, an initial interview was held with Resident #19 and the Resident Representative (RR). The RR stated, the resident was showered today and still waiting on the pad to be put back on her knee for pain control. The resident stated, my shower was around 9:00-10:00 AM this morning. The resident was told she had to wait until after the shower and they would put the pad on. At the time of the interview, no staff had returned with the pad. On 03/06/24 at 11:00 AM, a review of the physician's order found no order for any type of pain patch. On 03/06/24 at 11:45 AM, Licensed Practical Nurse (LPN) #64 confirmed the resident's nephew brings the over-the-counter pain patches from home and applies the patches to the resident's knee. LPN #64 also confirmed the nephew visits every Monday, Wednesday and Friday of every week. LPN #64 verified the resident does not have an order for the pain patches from home. On 03/06/24 at 12:05 PM, the Director of Nursing (DON) stated, we have to have an order for those even if the nephew brings them in from home. No further information was obtained during the survey process. d) Resident #7 On 03/04/24 at approximately 11:15 AM during a review of Resident #7 medical administration record, the following medications were identified to have not been administered per the physicians orders on each date listed. There were no nursing notes to identify the reason the medications were not administered. * Artificial Tears Ophthalmic Solution- 02/20/24 * Artificial Tears Ophtalmic Solution- 02/21/24 (4 doses- 0900, 1300, 1700, 2100) * Artificial Tears Ophtalmic Solution- 02/22/24 (3 doses- 0900, 1300, 1700, 2100) * Enhanced Barrier Precaution r/t: wounds- 02/27/24 * Observe resident for side affection of psychotropic medications- 02/27/24 * Artificial Tears Ophthalmic Solution- 02/28/24 * Levothyroxine Sodium Oral Tablet 150 MCG- 02/28/24 * Percocet Oral Tablet 1-325- 02/28/24 During an interview on 03/04/24 at approximately 3:37 PM the Director of Nursing (DON) agreed the medication administration was not completed per the physician orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e) Resident #179 On 03/04/24 at approximately 11:00 AM during a medical record review of Resident # 179, it was identified the resident admitted on [DATE] for short term rehab care. A Brief Interview of Mental Status (BIMS) of 15 is identified in the Minimum Data Set (MDS) with Assessment Reference Date (ARD)/Target Date of 02/28/24. Upon review of the residents miscellaneous uploaded medical records, a physician determination of capacity form was not identified to be on file. During an interview with the DON on 03/04/24 at 2:43 PM, she agreed the facility does not have a capacity form completed and on file for Resident #179. f) Late Medications 1) Resident #331 On 02/27/24 at 11:10 PM Registered Nurse (RN) #55 asked if she was still working on her evening mediation pass? She stated, Yes I am behind I have the entire South Hallway to myself and residents have been crawling out of bed and everything. I have to help with that. RN # 55 stated, There is usually two (2) nurses on south hallway, but it's just me tonight. On 02/27/24 at 11:14 PM Resident #331 stated, I need my nasal spray, I want to go to bed. I can't breathe, my nose is plugged up. On 02/28/24 at 12:08 AM Resident #330 came to the hallway outside his room door and asked RN #55 if he could have his nasal spray so he could go to bed. The RN then said yes roll up here (in wheelchair) and administered nasal spray. Record review shows the following medications were administered late by Registered Nurse (RN) #55: Oxymetazoline HCl Nasal Solution 0.05 % (Oxymetazoline HCl) 1 spray in both nostrils in the evening for Rhinitis. Time ordered to be given: 7:00 PM. Time administered: 12:19 AM Tamsulosin HCl Oral Capsule 0.4 MG (Tamsulosin HCl). Give 1 capsule by mouth at bedtime for urinary retention. Time ordered to be given: 9:00 PM. Time administered: 12:19 AM Senna Oral Tablet 8.6 MG (Sennosides) Give 1 tablet by mouth at bedtime for constipation. Time ordered to be given: 9:00 PM. Time administered: 12:19 AM Isosorbide Dinitrate Oral Tablet 10 MG (Isosorbide Dinitrate). Give 1 tablet by mouth three times a day for hypertension. Time ordered to be given: 9:00 PM. Time administered: 12:19 AM Methocarbamol Oral Tablet 500 MG (Methocarbamol). Give 0.5 tablet by mouth three times a day for muscle spasms. Time ordered to be given: 9:00 PM. Time administered: 12:19 AM Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate). Give 1 tablet by mouth two times a day for HTN. Time ordered to be given: 9:00 PM. Time administered: 12:19 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Melatonin Oral Tablet 3 MG (Melatonin). Give 3 tablet by mouth at bedtime for insomnia. Time ordered to be given: 9:00 PM. Time administered: 12:19 AM Atorvastatin Calcium Oral Tablet 40 MG (Atorvastatin Calcium). Give 1 tablet by mouth at bedtime for HLD. Time ordered to be given: 9:00 PM. Time administered: 12:19 AM 2) Resident #64 On 02/27/24 at 11:13 PM Resident #64, stated he had not had his nighttime meds, no pain medication since 1:00 PM that day. He had not seen a nurse for night shift. Resident further stated he would like to have his meds so he could go to bed. Record review shows the following medications were administered late by Registered Nurse (RN) #55: MagOx 400 Oral Tablet (Magnesium Oxide Supplement). Give 1 tablet by mouth two times a day for supplement administer with 8 oz of water. Time ordered to be given: 9:00 PM. Time administered: 12:22 AM. Methocarbamol Oral Tablet 500 MG (Methocarbamol). Give 1 tablet by mouth three times a day for muscle relaxer. Time ordered to be given: 9:00 PM. Time administered: 12:22 AM. Aspirin Oral Tablet (Aspirin). Give 81 mg by mouth two times a day for supplement. Time ordered to be given: 9:00 PM. Time administered: 12:22 AM. Atorvastatin Calcium Oral Tablet 80 MG (Atorvastatin Calcium). Give 1 tablet by mouth at bedtime for high cholesterol. Time ordered to be given: 9:00 PM. Time administered: 12:22 AM. Melatonin Oral Tablet (Melatonin). Give 6 mg by mouth at bedtime for supplement. Time ordered to be given: 9:00 PM. Time administered: 12:22 AM. Mirtazapine Oral Tablet 7.5 MG (Mirtazapine). Give 1 tablet by mouth at bedtime for depression. Time ordered to be given: 9:00 PM. Time administered: 12:22 AM. Gabapentin Oral Capsule 400 MG (Gabapentin). Give 1 capsule by mouth two times a day for pain. Time ordered to be given: 9:00 PM. Time administered: 12:22 AM. Oxycodone HCl Oral Tablet 10 MG (Oxycodone HCl). Give 1 tablet by mouth every 8 hours for pain. Time ordered to be given: 10:00 PM. Time administered: 12:22 AM. 40595 45173 49650

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40595 Based on observation, record review, staff and resident interview, the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. Medications were left in Resident #64's room unsupervised. Resident #236 and #72 were unknowingly smoking without supervision in an outside non-smoking recreation area. These failed practices were a random opportunity for discovery. Resident identifiers: #64, #236, and #72. Facility census: 82. Findings include: a) Resident #64 On 02/28/24 at 12:25 AM, Registered Nurse (RN) #55 was observed taking Resident #64's medications into his room. Surveyor entered the room at after RN #55 exited and found the Resident going through the pills which were left in the room. The Resident stated that they do it all the time, leave the pills for him to take when he wants. At 12:30 PM RN #55 was called back into the room and asked if the Resident had an order to self administer the mediations and she stated no I thought he took them. RN #55 then said to the Resident, Well can you take them now so I don't get into more trouble. During an interview on 02/28/24 at 10:01 AM the Assistant Director Nursing (ADON) stated, Yea I heard about the meds being left in [Resident #64's name] room, they know better than that. I guess I'll educate some more. b) Resident #236 and Resident #7 During an observation on 02/26/24 at 6:24 PM, three state surveyors were exiting the facility, two residents; Resident #236 and Resident #72 were observed sitting outside on the porch area. One surveyor thought she observed the residents passing a cigarette. The three surveyors continued to observe the residents from the parking lot. On 02/26/24 at 6:25 PM, The Director of Nursing (DON) and the Maintenance Director (MD) #32 appeared on the porch to approach Residents #236 and Resident #72. The three (3) surveyors approached the porch. The MD #32 stated he was informed by another staff member the residents were smoking, I went and got the DON. The MD #32 stated I got the pack of cigarettes from them. It had two cigarettes left in it. The DON asked the resident if they knew the facility was a smoke free facility. Resident #7 stated someone told us we could smoke outside on the patio. Resident #236 stated I will not tell you who it is so I don't get her in trouble. I went home today and got some stuff and I brought the pack of cigarettes and the lighter back . When the DON questioned Resident #236, pulled the lighter out of his sweat pants pocket and gave it to the DON. The DON was asked Were either Residents offered a Nicotine Patch? The DON stated We did not know they smoked, or they would have been offered? (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/27/24 at 2:00 PM, Resident #236 stated, I went out yesterday and got some shoes and shirts. We went to the bank. I got all my money out and paid my rent. During an interview on 02/27/24 at 2:35 PM, the DON stated we completed smoking evaluation for the residents. They both knew we were a non smoking facility. 45174

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40595 Based on observation and staff interview, the facility failed to ensure residents with indwelling urinary catheters receive treatment and care in accordance with professional standards of practice. These were random opportunities for discovery. Resident Identifiers: #179 and #29. Facility Census: 82. Findings Include: a) Resident #179 On 03/03/24 at 11:08 PM, the resident was observed to have a urinary foley catheter. The urinary foley catheter drainage bag was touching the floor. On 03/03/24 at 11:12 PM, Licensed Practical Nurse (LPN) #126 was notified and confirmed the urinary foley catheter drainage bag should not be touching the floor. No further information was obtained during the survey process. b) Resident #29 On 02/26/24 at 3:30 PM observation was made of Bedside Urinary Drainage bag under the middle of Resident #29's bed. Urine was backed up in the tubing up to the Resident's leg. Licensed Practice Nurse Unit Manager (LPN) #38 was called into room to verify finding. LPN #38 stated, Oh, well hospice just bathed her a bit ago and must have left it [catheter bag] like that. LPN #38 picked the catheter bag up out of the floor and hooked the catheter bag to the bedside. LPN #38 stated, I guess we need to start checking residents after hospice leaves them to make sure they are tucked in ok. 45173

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49465 Based on observation and staff interview the facility failed to ensure residents receive necessary respiratory care and services in accordance with professional standards of practice, by not safely storing oxygen tanks. This was a random opportunity for discovery. Facility census 82. Findings include: a) Oxygen storage An observation on 03/03/24 at 11:20 PM, revealed an oxygen tank stored in the corner of the bathroom in the floor of Room # 130. No resident was in the room. During an interview on 03/03/24 at 11:22 PM, with Licensed Practical Nurse (LPN) #61, she stated, No, that oxygen tank should not be in there. It should be locked up. I will have someone get it out. A review of the facilities policy titled Oxygen Tank Storage on 03/04/24 at 10:00 AM, read: -Policy: The facility must ensure that the resident environment remains as free of accident hazards as possible. -Procedure: All pressurized oxygen canisters will be secured in a rack or fastened to a wheeled carrier. This includes full, partially full, and empty canisters, and canisters that are located in the oxygen storage location or in use in the resident's room. An interview on 03/03/24 at 12:00 PM, with Assistant Director of Nursing (ADON), confirmed oxygen was not stored in a safe manner.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 40595 Based on record review, resident and staff interview, and observation the facility failed to ensure pain management was provided in accordance with professional standards of practice for two (2) of seven (7) residents reviewed for pain. Resident #331 was not provided pain medication after continued presentation of pain. Resident #181 was not provided with adequate pain medication for pain control or prior to physical therapy to allow adequate participation. This failed practice resulted in Resident #331 and Resident #181 suffering actual harm becuase thier pain was not assessed and/or treated timely resulting in the pain lasting longer than needed. This failed practice had the potential to affect only a limited number of residents. Resident identifiers: #331, #181. Facility census: 82. Findings include: a) Resident #331 Upon entrance at 11:05 PM on 02/27/24, Resident #331 was in wheelchair following Registered Nurse (RN) #55 around in the hallway while she passed medications. Resident #331 was grimacing, extending his right leg and writhing in his wheelchair. RN #55 was asked if Resident had anything ordered for pain and she stated, He has a muscle relaxer due that should help. Record review showed Methocarbamol Oral Tablet 500 MG tablet to be used for muscle spasms was given 2/27/24 at 11:40 PM. No pain medication was ordered or administered. On 02/27/24 at 11:54 PM, Resident #331 was witnessed by Surveyor falling out of his wheelchair in the hallway near the nurse's station on south side. Resident scooted to edge of his wheelchair, and leaned forward and fell out onto the floor. Resident landed on his right side with his head against the wall. The Resident's right leg and arm were pinned under him. Resident was laying across the leg of the floor stand blood pressure monitor. Resident was yelling Oh, Oh, Oh damn. RN #55 came up the hallway and asked the resident if he was ok? RN #55 pulled up the sweatshirt sleeve of his right arm and said. I don't see anything; you did hit hard I bet that hurt. RN #55 was then joined by CNA #31 and they proceeded to try to lift the resident back into the wheelchair by grabbing his pants and reaching under his arms. RN #55 lifted under the right arm and CNA # 31 lifted under the left arm and they both grabbed the back of the resident's pants. After the third try with the wheelchair sliding backwards, RN #55 and CNA #31 tossed the resident back into the wheelchair. Resident #331 continued to yell, Oh. Oh, Oh damn it the entire time. RN #55 said, Yea he's heavy! RN #55 then reported to the Surveyor, Don't worry, he is care planned for falls, he slides out of his chair all the time. Once resident was back in chair at 12:00 AM, RN #331 attempted to take residents BP and stated, This don't seem to be working right, but I think he's ok. Resident #331 was wearing a AAA (hinged) knee brace in place on his left lower extremity and was non weight bearing to left lower extremity at the time of the fall. The Resident was wearing regular socks at the time of the incident. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 03/03/24 at 11:07 PM Resident #331 was heard yelling from his room. Oh, oh, help. Resident was observed laying cross ways in the bed writhing and flinging his legs. The resident was grabbing at his right leg hip area and legs were twitching. Certified Nursing Assistant (CNA) #9 went into the Resident's room and came back out and told LPN #40, He's in pain. LPN #40 stated to surveyor, He's been repositioned for pain. At 11:30 PM, LPN #40 stated I guess I'll get him an order for pain. An order was added for Tylenol Oral Tablet 325 MG, give 650mg for pain every 6 hours PRN . At 11:37 PM Tylenol was given for pain. On 03/05/24 at 4:30 PM Resident was observed setting at nurses station grimmacing and rubbing his leg. Resident was asked if he was hurting? The Resident stated, I hurt all the damn time. LPN #64 stated, Yea I just called the doctor and got him some Tramadol (pain medication), I was tired of watching him thrash around. Record review showed physicains orders for: Tylenol Oral Tablet 325 MG (Acetaminophen) Give 650 mg by mouth every 6 hours as needed for pain. Start Date 03/03/2024 at 11:30 PM. Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 6 hours for Pain Management. Start Date 03/05/2024 at 6:00 PM. b) Resident #181 During an interview on 02/27/24 at 1:00 PM, Resident # 181 stated, I hurt all the time, I feel like I need a different pain medicine or something. An observation on 03/05/24 at 3:32 PM, showed Resident #181 in the hallway rocking in her wheelchair back and forth saying, I want a pain pill. Further observation at 3:32 PM, showed the Assistant Director of Nursing (ADON) walking by and telling her the nurse would be there in a minute to give her a pain pill. An observation at 03/05/24 at 4:00 PM, showed that Resident #181 was taken to therapy. During an interview on 03/05/24 at 4:14 PM, with the Registered Nurse Unit Manager (RNUM), she stated, I am doing her finger stick. A record review on 03/05/24 at 4:16 PM, of Resident #181's Medication Administration Record (MAR) revealed that residents documented pain was 10 and was given a PRN order of oxycodone 15 milligrams. An interview on 03/05/24 at 4:33 PM, with Physical Therapy Assistant (PTA) # 100, she stated, (Resident #181 name) did not say she was in pain, but she was moaning. So it's really hard to tell. An interview and observation on 03/05/24 at 5:05 PM, with Resident #181, showed resident sitting on the edge of her bed doubled over. She stated, I don't even feel like I have had pain medicine. An observation on 03/05/24 at 5:24 PM, of Resident #181, she continues to sit on the edge of her bed with her head in her lap. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A record review on 03/05/24 at 5:28 PM, of Resident #181's MAR, shows that she has not been assessed to see if the pain medicine was effective. Further record review of Resident #181's Minimum Data Set (MDS), Section F, Question JO520 is marked that the resident occasionally has pain that interferes with therapy activities. A review on 03/06/24 at 10:00 AM, of the facilities policy titled Administering Pain Medications under general guidelines number (5) five reads: Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after onset and reassessed as indicated until relief is obtained. An interview on 03/06/24 at 10:05 AM, with ADON, he stated, I will have them reasses her pain, and see what's going on. She does have a history of drug seeking but, pain should be assessed 30 minutes to an hour after pain medication is given. 49465

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 39043 Based on resident interview, record review and staff interview, the facility failed to provide dialysis care and services in accordance with professional standards of practice. Resident #40 was erroneously monitored for a thrill and bruit. This deficient practice had the potential to affect one (1) of one (1) resident reviewed for dialysis. Resident identifier: #40. Facility census: 82. Findings include: a) Resident #40 During an interview on 03/05/24 at 12:21 PM, Resident #40 stated she received dialysis through a Permacath access in her right chest. The resident stated she did not have a fistula dialysis access. Review of Resident #40's physician's orders showed an order written on 02/01/24 to Auscultate bruit and palpate thrill every shift. A dialysis fistula is an access made by joining an artery and vein in the arm. To make sure the fistula is working, a bruit, or whooshing sound, is auscultated with a stethoscope and a thrill, or buzzing, is palpated with the fingers. Review of Resident #40's Medication Administration Records (MARs) for February 2024 and March 2024 showed the nurses had signed off as auscultating for bruit and palpating for a thrill every shift. On 03/05/24 at 1:40 PM, the Assistant Director of Nursing (ADON) confirmed Resident #40 did not have a fistula access for dialysis. The ADON confirmed that, therefore, a bruit could not be auscultated and a thrill could not be palpated. No further information was provided through the completion of the survey process.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 39043 Based on observation, record review, resident interview, and staff interview, the facility failed to ensure nursing staff possessed the competencies and skill sets necessary to provide nursing and related services. This deficient practice had the potential to affect all residents residing in the facility. Facility census: 82. Findings included: #600 #610 all findings for #697 #684 late med pass

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40595 Based on record review and staff interview the facility failed to account for controlled substances within professional standards of practice for Resident #65. This failed practice was a random opportunity for discovery. Resident identifier: #65. Facility census: 82. Findings include: On 02/27/24 at 9:45 AM, LPN #64 stated We got a problem here with controlled substances coming up missing. The DON knows about it . This is my license. See here, this hydromorphone for [Resident #65's name] was signed out and he wasn't even taking it. LPN #64 showed surveyor the controlled substance sign-out book for Resident #65 where Registered Nurse (RN) #55 signed out the pain medication on 02/08/24. LPN #64 then stated, I clean out the med cart at the end of my shift and only leave enough pain meds for the night. That's what I was told to do. Record review shows and order for Hydromorphone HCl Oral Tablet 2 MG (Hydromorphone HCl). Give1 tablet by mouth every 24 hours as needed for pain control. Order was discontinued on 10/17/23. Review of the controlled substance sign-out long showed RN #55 signed out one (1) Hydromorphone 2mg tablet on 02/08/24 at 11:00 PM. No documentation of where the hydromorphone was administered to the Resident. On 03/04/24 at 4:15 PM the DON stated Now that does spark my interest. CRN #97 stated, How did she sign it out and administer it if the order was discontinued? DON stated, I done a med error on it, she said he needed something for pain and that was the first thing she saw and pulled it out and gave it. Record review shows no pain medication documented as given on 02/08/24 at 11:00 PM. On 03/05/24 at 9:31 AM no reportable or investigation was found to have been done. The DON said this wasn't a reportable issue. On 03/05/24 at 9:52 AM, the DON stated they are still investigating what the Surveyor has brought to their attention and it may end up being reportable. DON stated, I told you I didn't know about this, but I guess I did. When they gave me the mediations to destroy last week the nurse told me I may want to take a look at that this one, a pill was missing. Record review of the Controlled substance destruction log showed Hydromorphone 2 tabs were destroyed on 02/29/24 by the DON and pharmacist. At that time the DON was made aware of the missing hydromorphone tablet by nursing staff. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/05/24 at 11:30 AM the DON presented a form titled Employee Warning form and stated she had filled this report out for RN #63 due to Resident #65's mediation error. Reason for written warning was Mediation was given without an order. No follow up completed. All medications given must have an order and all PRN meds must have a follow up to verify effectiveness. Always follow the 5 rights of medications Administration. The DON clarified the form was originally completed for resident #65 but could be used for both Resident #64 and #65 since they both involved pain pills. The form was signed by the DON on 02/22/24, by the Administrator on 03/04/24, by RN #63 on 02/22/24. Record review shows a reportable completed on 03/05/24 for Resident #64 for the alleged incident on 02/18/22. The reportable stated, State surveyor reported misappropriation of medication. Date of incident 02/08/24. During an interview on 03/06/24 at 4:07 PM Corporate Registered Nurse (CRN) #97 stated, We went ahead and reported [Resident #65 name] missing hydromorphone pill as misappropriation of property since we done [Resident #64's] since we don't know what was done with the hydromorphone that was signed out.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49465 Based on record review and staff interview the facility failed to ensure the drug regimen of each resident was reviewed at least once a month by a licensed Pharmacist. This failed practice was found true for (1) one of (5) five residents reviewed for unnecessary medications during the Long Term Care Survey Process. Resident identifier #61. Facility census 82. Findings include: a) Resident #61 A record review on 03/05/24 at 1:50 PM, of Resident #61's Pharmacy notes revealed the following Pharmacy reviews: (Typed as written, leaving out the Pharmacist name) -03/3/2024 18:34 Note Text: I reviewed this resident's medication regimen and have noted any irregularities and/or observations on a separate report to the Director of Nursing and prescriber. Pharmacy -02/7/2024 19:00 Note Text: I have completed the Pharmacy MMR for this patient for the month of FEBRUARY 2024, please see the report for specific comments. Thank you. Pharmacy -01/7/2024 13:54 Note Text: I have completed the Pharmacy MMR for this patient for the month of JANUARY 2024, please see report for specific comments. Thank you. Pharmacy -11/1/2023 18:34 Note Text: I have completed the Pharmacy MMR for this patient for the month of NOVEMBER 2023, please see report for specific comments. Thank you. Pharmacy -10/2/2023 19:34 Pharmacy Note Note Text: I have completed the Pharmacy MMR for this patient for the month of OCTOBER 2023, please see report for specific comments. Thank you. Pharmacy - 09/3/2023 14:42 Pharmacy Note Note Text: I, have completed the Pharmacy MMR for this patient for the month of SEPTEMBER 2023, please see report for specific comments. Thank you. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further record review revealed that there was no Pharmacy review completed for the month of December 2023. During an interview on 03/05/24 at 2:10 PM, with Assistant Director of Nursing (ADON), he stated, No, I did not see one in her chart for the month of December.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 39043 Based on record review and staff interview, the facility failed to monitor efficacy 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: #47. Facility census: 82. Findings include: a) Resident #47 Review of Resident #47's medical records showed the resident had been ordered the medication mirtazapine for anxiety since 10/27/23 and the medication trazodone for anxiety since 11/16/23. The resident's comprehensive care plan had a focus related to anxiety disorder. The goal initiated 06/17/23 was I will remain free from signs and symptoms of increased restlessness daily through the next review. Resident #47's medical records contained no documentation the resident was monitored for signs and symptoms of anxiety. During an interview on 03/05/24 at 1:45 PM, the Director of Nursing (DON) confirmed Resident #47's medical records contained no documentation the resident was monitored for signs and symptoms of anxiety. No further information was provided through the completion of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on observation, record review, and staff interview, the facility failed to ensure medications were stored and labeled in accordance with currently accepted professional principles. A syringe of injectable medication had been in use for longer than manufacturer's recommendations. This was a random opportunity for discovery. Resident identifier: #61. Facility census: 82. Findings include: a) Medication Cart - North 2 On [DATE] at 9:11 AM, the North 2 medication cart was inspected with Licensed Practical Nurse (LPN) #44 in attendance. A pen-injector for Resident #61 containing Tymlos (Abaloparatide) was in the cart. This medication is given subcutaneously for osteoporosis. A date written on the pen-injector indicated the medication had been opened on [DATE]. LPN #44 stated she did not know how long Tymlos could be used after the syringe had been opened. There was no product insert with the pen-injector. The Tymlos medication guide available on-line at www.tymlos.com stated, Throw away the Tymlos pen after 30 days even if some medicine is left in the pen. On [DATE] at 9:45 AM, LPN #44 was told the Tymlos pen-injector had expired 30 days after being opened. She stated she would throw it away. No further information was provided through the completion of the survey.

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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. 45174 Based on observation, resident interview and staff interview the facility failed to ensure food was served at a safe and palatable temperature. The failed practice had the potential to affect all residents currently receiving nutrition from the facility's kitchen. Resident Identifiers: #61. Facility Census: 82. Findings Include: a) Resident #61 During an interview on 02/26/24 at 3:33 PM, Resident #61 states my food is often cold. The other day the Salisbury steak was so cold. I sent it back and got tomato soup. b) Noon Meal Temperatures During a dining observation on 03/05/24 at 12:25 PM, the noon meal trays arrived in the North 1 hall. This surveyor asked the Dietary Aide to ask the Dietary Manager (DM) to bring a noon meal tray for the resident and the facility thermometer. At the time of point of service (when the trays are being served to the residents) the temperatures were obtained by the DM using the facility ' s thermometer at 12:34 PM the temperatures were as follows: -Meatballs: 128 degrees Fahrenheit -Vegetables: 117 degrees Fahrenheit -White Rice: 127 degrees Fahrenheit During an immediate interview the DM stated the meal should be 135 degrees and above at the point of service. The DM acknowledged the meal was not at a palatable serving temperature. All facility noon meal trays were served by the end of obtaining the temperatures.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45174 Based on observation, policy review and staff interview the facility failed to store food in accordance with professional standards for food safety. The facility failed to label and date food items that were open and failed to dispose of expired food items. The facility failed to keep the equipment clean and sanitary. The facility also failed to accurately document resident refrigerator temperature logs. The facility also failed to not store other food in the resident's refrigerator. This failed practice had the potential to affect all residents currently receiving nourishment from the facility's kitchen and the Resident's refrigerator. Facility Census: 82 FIndings Include: a) Policy Review During a review of the facility policy titled Labeling and Dating with no date read as follows: Guidelines for Labeling and Dating: -All foods should be dated upon receipt before being stored. -Food labels must include: The food item name The date of preparation/receipt/removal from freezer The use by date as outlined in the attached guidelines Leftovers must be labeled and dated with the date they are prepared and the use by date. a) Opened food A tour of the kitchen on [DATE] at 11:39 AM, revealed the following issues: -Grill spray no cap no open date or use by date -Cornstarch opened and exposed to the elements. -Baking soda opened and exposed to the elements. -Rotisserie Chicken Seasoning lid was open and exposed to the elements. -Garlic Powder lid was open and exposed to the elements. -Chili Powder lid was open and exposed to the elements. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ground Allspice lid was open and exposed to the elements The Dietary Manager (DM)acknowledged the failure to close the lids after use and failure to label food items with a Date Opened and/or Use by Date. Also indicated the item needed to be discarded because they were opened and not dated. b) Unsanitary equipment During a tour of the kitchen on [DATE] at 11:39 AM, an employee's personal cell phone was laying on the serving/prep table. During an immediate interview the DM acknowledged the unsanitary equipment. The DM stated they know better. c) South Nourishment Rooms During a tour of the South Nourishment on [DATE] at 11:57 AM, with DM revealed the following issues: -A storage bag with a bagel dated ,d+[DATE] -A opened bottle of grape juice with open date of ,d+[DATE] -A opened bottle of apple juice with open date of ,d+[DATE] -A opened container of Greek yogurt with no open date -two containers of rice pudding with a manufacture expiration date of [DATE] -a container of Greek yogurt with a manufacture expiration date of [DATE] -a opened vegetable tray with no open date -a opened container of buffalo dip with no open date d) North Nourishment Room: During a tour of the North Nourishment on [DATE] at 11:59 AM, with DM revealed the following issues: -A storage bag with a bagel and roll dated ,d+[DATE] e) South Nourishment Room temperatures During a observation of the South Nourishment Room on [DATE] at 11:22 PM, revealed the following: The temperature log for the following days were void the temperatures: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-[DATE] AM Refrigerator -[DATE] AM Refrigerator -[DATE] AM Freezer On [DATE] at 12:15 PM The Administrator acknowledged the temperature logs were incomplete. f) North Nourishment Room temperatures During an observation on [DATE] at 11:26 PM, the temperature log were void the following dates: -[DATE] AM Refrigerator -[DATE] AM Freezer On [DATE] at 12:15 PM, The Administrator acknowledged the temperature logs were incomplete g) South Nourishment Room Refrigerator During an observation of the South Nourishment Room on [DATE] at 11:22 PM, there was a black lunch box in the refrigerator. Nurse Aide (NA)#9 acknowledged it was her personal lunch box and should not have been with the residents' food.

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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** 39043 Based on observation, record review and staff interview, the facility failed to maintain an accurate and complete medical record for Resident #58's oral assessment, did not obtain a physician's order for the gastrostomy (G-tube) flushes and a diagnosis for the urinary foley catheter for Resident #179, Resident #10's incomplete consent for psychoactive medication, Resident #236's the Physician's Orders for Scope of Treatment (POST) form, documentation of snacks that were not delivered for Resident #32, #57, and #7, a diagnosis of neuropathy for Resident #7, and correct dosage on the physician's orders for medication and documentation for medication side effects for Resident #47. This is true for eight (8) of 24 residents reviewed during the survey process. Resident Identifiers: #58, #179, #10, #236, #32, #57, #7 and #47. Facility Census: 82. Findings Included: a) Resident #58 On 03/04/24 at 9:00 AM, a record review was completed for Resident #58. The review found an oral assessment dated [DATE] was incorrect. The oral assessment noted the resident was edentulous (lacking teeth) and had decayed or broken teeth/roots or very worn down teeth. The resident was observed on 02/26/24 at 5:08 PM with fragments of teeth. On 03/04/24 at 2:36 PM, the Director of Nursing (DON) was notified of the oral assessment being incorrect. The DON stated, it can't be both. No further information was obtained during the survey process. b) Resident #179 On 03/04/24 at 10:30 AM, a record review was completed for Resident #179. The record review found the resident had a urinary foley catheter with no diagnosis and no current order for the gastomy (G-tube) tube flushes. On 03/04/24 at 11:15 AM, Assistant Director of Nursing (ADON) #42 was notified and confirmed there is no diagnosis for the urinary foley catheter and no current physician's order for the G-tube flushes. ADON #42 stated, we will get this corrected. No further information was obtained during the survey process. c) Resident #10 On 03/05/24 at 9:00 AM, a record review was completed for Resident #10. The record review found the following medications did not have the correct dosage: --Aspirin give one tablet by mouth daily for hypertension. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Guaifensin oral tablet give 600 mcg (micrograms) by mouth every 12 hours as needed for cough, congestion The physician's order for Aspirin does not list a dosage. The order for Guaifensin is for micrograms (mcg) instead of milligrams (mg). On 03/05/24 at 9:42 AM, ADON #42 was notified and confirmed the physician's orders were not correct. No further information was obtained during the survey process. d) Resident #236 During a record review on 02/27/24 at 11:26 AM, Resident #236's medical record revealed a Physician Orders for Scope of Treatment (POST) form showed the Patient Information section was void Resident #236's last four(4) Social Security Number (SSN). Section E. Titled: Signature: was void of a date Resident #236 signed. Page two (2) of the POST section titled Professional Assisting Health Care Provider with Form Completion was void of any documentation The 2021 POST form guidance titled, Using the POST Form: Guidance for Health Care Professionals, 2021 edition, available on-line, stated The Center wants to avoid a patient's POST form being confused with another ' s because there was not sufficient information about the patient to distinguish one from another. The demographic information requested on the POST form includes the patient's full name, address, date of birth, gender, and last four digits of the patient's social security number. The person preparing the form also signs in this section. A form lacking the signature of the person preparing the form is invalid. During an interview on 03/04/24 at 11:56 AM, the Assistant Director of Nursing #42 acknowledged Resident #236 POST was the void of the SSN and was void a person completing the POST form. e) Resident #32 During a tour of the facility on 02/27/24 at 11:45 PM, HS (at bedtime) snacks were observed laying on a cart by the South Nourishment Room. A fruit cup and a package of graham crackers dated 02/27/24 with Resident #32's name. During an observation on 02/27/24 at 11:59 PM, two surveyors witnessed NA #31 throwing the snacks in the trash can. On 02/28/24 at 1:13 PM, this surveyor received a facility document titled Snack Summary for the Week of 02/26/24 which read as follows: Resident #32 name: fruit cup 0.5 Cup at HS graham crackers 1 package at HS During a record review on 03/05/24 at 4:30 PM, Resident #32 medical records revealed a Nutrition Snack at HS task 02/27/24 was documented coded 4 (four) 76%-100% at 10:59 PM. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/05/24 at 5:11 PM, the Assistant Director of Nursing (ADON) was informed of the above information. The ADON acknowledged the documentation for the snacks stated Resident #32 received and ate 76-100% of the HS snack. However, this was not possible since the CNA had placed the snacks in the trash can on 02/27/24. f) Resident #57 During a tour of the facility on 02/27/24 at 11:45 PM, HS snacks were observed laying on a cart by the South Nourishment Room. A creamy peanut butter and jelly sandwich dated 02/27/24 with Resident #57's name was on the cart. During an observation on 02/27/24 at 11:59 PM, two surveyors witnessed NA #31 throwing the snacks in the trash can. On 02/28/24 at 1:13 PM, this surveyor received a facility document titled Snack Summary for the Week of 02/26/24 which read as follows (Resident #57 name) creamy peanut butter and jelly sandwich 0.5 Sandwich HS During a record review on 03/05/24 at 4:40 PM, Resident #57 Nutrition Snack at HS 02/27/24 was documented coded 3 for 51%-75% at 10:59 PM During an interview on 03/05/24 at 5:11 PM, the Assistant Director of Nursing (ADON) was informed of the above information. The ADON acknowledged the documentation for the snacks stated Resident #57 received and ate 51%-75% of the HS snack. However, this snack was placed in the trash by a CNA on 02/27/24. g1)Resident #7 During a tour of the facility on 02/27/24 at 11:45 PM, HS snacks were observed laying on a cart by the South Nourishment Room. A cup of pudding dated 02/27/24 HS with Resident #7's name on it. An observation on 02/27/24 at 11:59 PM, two surveyor witnessed NA #31 throwing the snacks in the trash can. On 02/28/24 at 1:13 PM, this surveyor received a facility document titled Snack Summary for the Week of 02/26/24 which read as follows: Resident #7's name:assorted pudding 0.5 cup HS A record review on 03/05/24 at 4:30 PM, Resident #7 medical records revealed a Nutrition Snack at HS task 02/27/24 was documented coded 4 (four) 76%-100% at 10:59 PM. However, this snack was placed in the trash on te night of 02/27/24. Further record review revealed a physician order dated 08/04/23 planned snack at 8 PM sent per dietary at bedtime (continued on next page)

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	515049	A. Building B. Wing	03/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgantown Health and Rehabilitation, LLC	1379 Van Voorhis Rd Morgantown, WV 26505

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/05/24 at 5:11 PM, the Assistant Director of Nursing (ADON) was informed of the above information. The ADON acknowledged the documentation for the snacks stated Resident #32 received and ate 76-100% of the HS snack. g2) Resident #7 On 03/04/24 at approximately 11:00 AM, a medical record review of Resident # 7's physician orders identified Gabapentin Oral Tablet 600 MG (Gabapentin) Give 2 tablet by mouth every 8 hours for neuropathy. A review of the physician diagnosis did not identify a neuropathy diagnosis. Upon review of the medical records uploaded in Resident #7s medical record from the admitting hospital the diagnosis was identified. During an interview on 03/04/24 at approximately 3:34 PM, the Director of Nursing (DON) agreed the facility physician diagnosis in the medical record is inaccurate because the diagnosis of neuropathy was not included. h) Resident #47 Review of Resident #47's medical records showed the following order written on 09/24/22, Observe resident for side effects of psychotropic medication. (Antidepressants, Antipsychotics, Hypnotics, and Anxiolytics) every shift for observation of side effects Side Effects- Psychoactive Meds: Indicate letter if observed: A=Sedation; B= Drowsiness; C= Dry Mouth; D= Blurred Vision; E= EPS [extrapyramidal effects] F= Sweating; G= decreased appetite, H=Nausea, I= Jaw clenching, J= Headache, K= itching, N/A= not applicable. Review of Resident #47's Medication Administration Records (MARs) for February 2024 and March 2024 showed most documentation for this order was n or 0. However, on day shift 02/14/24 and day shift 03/04/23, a y was recorded. The MAR chart codes did not contain any information regarding n, 0, or y. Resident #47's progress notes contained no information regarding the resident having side effects from psychotropic medication on 02/14/24 or 03/04/24. During an interview on 03/05/24 at 9:25 AM, the Director of Nursing (DON) stated an n means no and a y means yes. She stated she did not believe the resident was experiencing side-effects on 02/14/24 or 03/04/24 and that a y had been documented in error. No further information was provided through the completion of the survey. 45173 45174 49650

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on resident interview, record review and staff interview the facility failed to ensure, the binding arbitration agreement was explained to each resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. This failed practice has the potential to affect more than a limited number of residents. Resident Identifiers: #72, #8, and #500. Facility Census: 82. Findings Include: a) Resident #72 On 03/06/24 at 11:39 AM during an interview with Resident #72, the resident stated he knew the facility Alternative Dispute Resolution Agreement had to do with a dispute between him and this facility and there would be someone else to fix it. He stated he knew he didn't have to sign it but was not aware of being able to revoke it. Resident #72 has a Brief Interview for Mental Status (BIMS) of 15 on the Minimum Data Set (MDS) dated [DATE]. Resident #72's physician determined he has capacity to make medical decisions. b) Resident # 8 On 03/06/24 at 11:46 AM during an interview Resident #8, the resident stated she doesn't remember it , she was pretty out of it. In reviewing the facility Alternative Dispute Resolution Agreement document she stated it now sounds familiar and she has no complaints with it. She further stated she was fine with it and had no issues. She did not recall anything about being able to revoke it. Resident #8 admitted to the facility on [DATE] and has a Brief Interview for Mental Status (BIMS) of 15 on the Minimum Data Set (MDS) dated [DATE]. Resident #8's physician determined she had capacity to make medical decisions. c) Resident #500 On 03/06/24 at 12:10 PM during an interview with Resident #500, the resident stated she was not aware if she had been explained the facility Alternative Dispute Resolution Agreement. She reviewed the facility Alternative Dispute Resolution Agreement document and stated she had received it when she admitted . She further stated, it was not explained in detail at the time of her admission to the facility. Resident #500 admitted to the facility on [DATE] and has a Brief Interview for Mental Status (BIMS) of 15 on the Minimum Data Set (MDS) dated [DATE]. Resident #500's physician determined she has capacity to make medical decisions. d) Admissions #33 interview. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/06/24 at 11:58 AM during an interview with the Admissions Director #33 she stated when she reviews the facility Alternative Dispute Resolution Agreement document she lets the resident know if they have a concern to let the facility staff know first so they can fix it. She then explains to them this gives up their rights to a trial by jury and it is handled outside the courts. She then presents the facility Alternative Dispute Resolution Agreement document to the resident and if they choose to sign she shows them where to sign. She stated, she doesn't review the entire document but she does provide them a copy. She further stated, she does not discuss all the necessary components of the facility Alternative Dispute Resolution Agreement document to the residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40595 Based on observation, record review and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections while serving a sandwich to Resident #25. The facility did not complete hand hygiene while administering wound care for Resident #7. Surveyors observing a soiled glove in Resident #235's room. The facility staff did not follow enhanced-barrier precautions for Resident #23. The nursing staff administered nasal spray to Resident #330 without donning gloves and placed a dirty dining tray on a clean dining cart. These were random opportunities for discovery that had the potential to affect more than an isolated number of residents. Resident identifiers: #25, #7, #235, #23 and #330. Findings included: a) Resident #25 On 03/03/24 at 11:58 PM, Nurse Aide (NA) #57 was observed serving Resident #25 a sandwich and milk. However, NA #57 did not don gloves prior to removing the sandwich from the plastic wrap. The sandwich was served to Resident #25 with bare hands. On 03/04/24 at 12:02 AM, Licensed Practical Nurse (LPN) #126 was notified. LPN #126 stated let me get her a new one. LPN #126 removed the contaminated sandwich and provided a new sandwich for Resident #25. b) Resident #7 On 03/06/24 at 1:10 PM, LPN #64 was observed providing wound care for Resident #7. Throughout the process, LPN #64 had multiple instances when hand hygiene should have been completed and was not. On 03/06/24 at 1:20 PM, LPN #64 was made aware of the missed opportunities to complete hand hygiene. LPN #64 stated, oh okay. On 03/06/24 at 1:30 PM, Corporate Nurse #97 was notified and confirmed hand hygiene should have been completed throughout the wound care. c) Resident #235 On 03/05/24 at 4:13 PM during a tour of the facility in the room of Resident #235, a surgical glove was observed to appear soiled and had been turned inside out as it laid balled up on the floor. During an interview on 03/05/24 at 4:13 PM with Certified Nursing Assistant (CNA) #49, she stated she didn't know who had disposed of the glove in the floor but acknowledged it should not be there. She then picked up the glove and disposed of it. d) Resident # 23 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/27/24 at 9:38 AM CNA #49 and CNA #15 entered Resident #23's room to provide incontinent care without donning Personal Protective Equipment (PPE). The sign on the resident's door stated, Enhanced Barrier Precautions. Registered Nurse (RN) #67 then entered the room to administer medications and did not put on any PPE. RN #67 applied a lidocaine patch to residents' right ankle. At 9:40 AM the Director of Nursing (DON) approached the room door. The DON was asked to verify the staff was not wearing any of the indicated PPE while providing direct care to the resident. The DON looked at the sign on door and stated, Oh I see that, they should have it on. Yes. Especially since they are touching her. Record review showed an order for Enhanced Barrier Precautions related to: wounds/MRSA every shift for wounds. Start date 12/06/23. Record review showed an order for Lidocaine External Patch 5 % (Lidocaine). Apply to Right Ankle topically one time a day for Pain. Start date 11/16/23. e) Resident #330 On 02/27/24 at 11:13 PM Resident #330 stated, I need my nasal spray, I want to go to bed. I can't breathe, my nose is plugged up. On 02/27/24 at 12:08 AM, Resident #330 came out into the hallway in his wheelchair outside of his room door. Resident #330 asked Registered Nurse (RN) #55 if he could have his nasal spray so he could go to bed. RN #55 replied, Yes roll up here (in wheelchair) and I will give it to you. RN #55 then administered nasal spray to Resident #55 without putting gloves on. RN #55 then set the nasal spray back on top of the cart, opened the medication cart door, and randomly dropped back into the drawer. RN #55 opened the door to resident room [ROOM NUMBER] and used hand sanitizer from the wall in the room and returned to the medication cart. Record review shows an order for Saline Nasal Solution 0.9 % (Saline). 1 spray resident in each nostril every 6 hours as needed for Dry Nose. During an interview the Assistant Director of Nursing stated RN #55 should have worn gloves during administration of nasal spray. The ADON further stated the nasal spray should have been wiped down before putting it back directly back into the cart. f) Noon Meal tray During a dining observation on 03/05/24 at 12:09 PM, LPN #30 was observed removing a tray from a resident's room and placing it on the noon meal cart with several trays which were not yet served and was clean. During an immediate interview LPN #30 stated this is (Resident #241's name) tray she is a feeder, and we will have to wait. I did not put the tray in her room. LPN #30 acknowledged she should not have brought the tray from the room and placed it on the cart with the trays not served/clean trays. She stated I will take the whole cart back to the kitchen to get new ones made. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an immediate interview The Nurse Aide (NA) #14 stated the noon trays which were on the meal cart were for the residents residing in rooms 142-146. On 03/05/24 at 12:14 PM The Infection Prevention (IP)/Assist Director of Nursing (ADON) was made aware of the issue. 45173 45174 49650

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 49650 The facility failed to be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a centralized staff work area from the resident's bedside. Resident call light location was not identifiable on the call light annunciator panel. This was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident identifier: #237. Census: 82. Findings included: a) Resident #237 During a tour of the facility, on 03/03/24 at 11:30 PM, the call light system was sounding with no light indicator for what room or location was lit on the North or South Unit annunciator panels. On 03/03/24 at 11:40 PM the call light system continued to sound and the Certified Nursing Assistance (CNA) #11 stated, the light indicator on the annunciator panel sometimes doesn't work for the bathroom call lights. CNA #11 then notified all staff who began to check all call lights throughout the facility on 03/03/24 at approximately 11:43 PM. During an interview with the Administrator, at 11:48 PM, on 03/03/24, the Administrator stated she was aware of the issue and was assisting with rounding to identify where the call light had been activated. At 11:59 PM on 03/03/24 the Administrator stated as she passed this surveyor in the hallway, that she would be calling the tech out for the panel. During the observation of staff attempting to locate the activated call light on 03/04/24 at 12:04 AM the Corporate Registered Nurse #97 stepped out into the hallway on the South Unit. She stated to everyone that she had discovered the room that the call light was activated in, and she thought she had fixed it. She identified Resident #237 to have partially pulled the call light cord from the wall. The Corporate Registered Nurse then expressed her need for the staff to assist her with the resident right now.