STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515060	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Center	101-13th Street Huntington, WV 25701

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49465 Based on observation, record review, staff interview, and resident interview, the facility failed to provide reasonable accommodations of needs, by not providing Resident #17 a readily accessible wheelchair. This failed practice was found true for (1) one of (3) three residents reviewed for environment during the Long-Term Care Survey Process. Resident identifier #17. Facility Census 150. Findings Included: a) Resident #17 An observation on 03/18/24 at 3:52 PM revealed that Resident #17 was non-verbal and uses an alphabet board to communicate, by pointing out the letters to spell words. During an interview on 03/18/24 at 3:52 PM with Resident #17 he communicated, They will not get me up. They say they don't have a wheelchair for me. During an interview on 03/19/24 at 12:10 PM with the Assistant Nursing Director, (AND) she stated , He is in a Geri chair. He does not have one up here. He refuses to get up. The Therapy department has some in their room on the first floor if we need it, if there was an emergency we would do the sheet drag on him. An observation, on 03/19/24 at 12:15 PM, with the AND on floor (3) revealed that no extra wheelchairs were available on that floor. During an interview, on 03/19/24 at 1:00 PM, with Occupational Therapy- Assistant Director of Rehab (OT-ADOR), He stated, Sometimes they store wheelchairs in different places. There is not one in here (The Therapy Department) let's go look around. An observation, on 03/19/24 at 1:00 PM, with OT-ADOR, showed that it took 24 minutes to find a Geri chair for Resident #17. A chair that would work for Resident # 17 was found in another resident's room on floor (2) two. The OT-ADOR further stated, A resident that was discharged a week ago this past Friday used this chair. It is fair to say that if that resident was still here, we would not have a wheelchair for Resident #17 at this moment. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review on 03/19/24 at 1:30 PM of Resident # 17's care plan under interventions reads: -Resident may be up to Geri-chair when out of bed.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 49465 Based on observation, record review, staff interview, and resident interview, the facility failed to give Resident #17 a choice regarding daily routine by not providing him with a readily accessible wheelchair to be gotten up in when he chooses. This failed practice was found true for (1) one of (7) seven residents reviewed for choices during the Long-Term Care Survey Process. Resident identifier #17. Facility Census 150. Findings Included: a) Resident #17 An observation on 03/18/24 at 3:52 PM revealed that Resident #17 is non-verbal and uses an alphabet board to communicate, by pointing out the letters to spell words. During an interview on 03/18/24 at 3:52 PM with Resident #17 he communicated, They will not get me up. They say they don't have a wheelchair for me. During an interview on 03/19/24 at 12:10 PM with Assistant Nursing Director (AND) she stated , He is in a Geri chair. He does not have one up here. He refuses to get up. The Therapy department has some in their room on the first floor if we need it, if there was an emergency we would do the sheet drag on him. An observation on 03/19/24 at 12:15 PM with the AND on floor three (3) revealed that no extra wheelchairs were available on that floor. During an interview on 03/19/24 at 1:00 PM with the Occupational Therapy- Assistant Director of Rehab (OT-ADOR), he stated, Sometimes they store wheelchairs in different places. There is not one in here (The Therapy Department) let's go look around. An observation on 03/19/24 at 1:00 PM with OT-ADOR, showed that it took 24 minutes to find a Geri chair for Resident #17. A chair that would work for Resident # 17 was found in another resident's room on floor two (2). The OT-ADOR further stated, A resident that was discharged a week ago this past Friday used this chair. It is fair to say that if that resident was still here we would not have a wheelchair for Resident #17 at this moment. A record review on 03/19/24 at 1:30 PM of Resident # 17's care plan under interventions reads: -Resident may be up to Geri-chair when out of bed.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 30153 Based on Resident Council meeting responses, and staff interviews, the facility failed to ensure Resident Council minutes had been reviewed and resident concerns/grievances were addressed. This failed practice had the potential to affect a limited number of residents. Facility census: 150. Findings included: a) Resident Council Meeting Prior to the 03/19/24 at 1:00 PM meeting, minutes from the 10/24/23,11/29/23, 12/26/23, 1/30/24, 2/27/24 were reviewed with permission from the President. The following Resident Council minutes were as follows: -10/24/23 The meeting was facilitated by the Guest Services Director (GSD). There were 16 residents in attendance but list of names was not noted. NonCouncil Member attending were the Dietary Manager, Assistant Administrator and Ombudsman. Prior meeting minutes reviewed was marked as accepted as written. Discussion of Old/Unfinished Business Mail Delivery, location of Ombudsman and State contact information. Location of Survey results. The location of after hours money (2nd Floor med cart Blvd.) Visiting hours. There were no signatures on the minutes from the President, Recording Secretary, or facility Administrator. In addition there was no evidence residents received a written response from concerns they had voiced during these meetings. On 03/19/24 at 2:00 PM a Resident Council meeting was held with 11 residents present. Residents voiced concerns about food being burnt, always cold, small servings, when asked for a substitute the substitute was not received and at times the food was half cooked. When asked if these issues were brought up in the previous meetings, the response was Yes. No evidence was found in the minutes to confirm this information. On 03/21/24 at 9:37 AM an interview with the GSD who is in charge of Resident Council stated that we are in transition and no we do not keep a roster of who attends the meetings. The GSD confirmed none of the minutes were signed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49650 Based on observation, family interview, policy review and staff interview, the facility failed to honor the right of the resident to file grievances anonymously as the residents did not have access to the grievance forms. This has the potential to affect more than a limited number of residents. Resident Identifier: #71. Census: 150. Findings included: a) Resident #71 On 03/18/24 at approximately 12:55 PM during an interview with Resident #71's family member, stated that when expressing concerns for Resident #71 was told to speak with the Guest Services Director (GSD) #07 to file a grievance. He further stated he had never been made aware that he could file a grievance himself. He then stated he was not aware of what an anonymous grievance was. He stated he had never seen an actual grievance form and did not know where to get one. On 03/20/24 at 2:38 PM during an interview with GSD #07, she stated that the residents and families are educated in person during the residents admission meeting to take any nursing concerns to the nurse in charge and anything else that may be a concern is to go to her. She stated that she was not aware of how the families would file a grievance anonymously that if they were going to do that then they would contact the facilities corporate complaint line or reach out to the Ombudsman or the State of [NAME] Virginia. She further stated she was not aware if the facility information on filing a grievance was displayed in prominent locations throughout the facility. She did acknowledge, at this time, that there are grievance forms on the ground floor. The forms were observed to be located in a manila file folder with 'grievance forms' hand written on the header label in a hanging wall file holder to the right of the door when exiting the main entrance. She acknowledged that there was not a posting at this prominent location, near the grievance forms, that identifies the procedure for voicing grievances/concerns, the right to file grievances orally (meaning spoken) or in writing and the right to file grievances anonymously. On 03/25/24 at 6:35 PM during a policy review that the facility has established, it identifies but is not limited to the process that upon admission, the patient and or patient representative are provided with the Grievance/Concern policy which informs them of their rights to voice grievances/concerns and the process for doing so. It further states that a description of the procedure for voicing grievances/concerns will be on each unit in a prominent location and must include 1) The right to file grievances orally (meaning spoken) or in writing, and the right to file grievances anonymously. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/24 at 6:39 PM during a tour of the building the facility information on how to file a grievance or complaint was observed to be on the ground floor, posted on the corner of the wall near the Transitional Care Unit Entrance. No grievance forms were available with this posting for the ability to file an anonymous complaint. This location is not a prominent location for all residents and family as this area is not part of the main egress. The facility information posting on how to file a grievance or complaint was not identified to be posted on the second floor or the third floor of the facility. Also identified at this time is that the use of the elevator is controlled by codes that have to be entered on each floor to access it for use. Therefore, the residents on the second floor and the third floor cannot freely access the elevator to go between floors. If a resident wants to leave the second floor or the third floor the staff has to assist them to do so. On 03/25/24 at approximately 6:42 PM during an interview with the [NAME] Unit Clerk (WUC) #139, she stated she thought the grievance forms were in the filing cabinet behind the second floor nurses desk. She stated she would look for one if anyone ever asked her for one. She further stated she did not know how someone would file a complaint anonymously. On 03/25/24, at approximately 6:47 PM, during an interview with Certified Nursing Assistant (CNA) #10, she stated she would look through the drawer in the filing cabinet behind the second floor nurses desk for a grievance form if one was asked for. She further stated that she was not aware of how someone would file an anonymous complaint. On 03/25/24 at approximately 6:51 PM during an interview with the Administrator on the second floor of the facility, she stated the grievance forms were downstairs. She then asked Clinical Reimbursement Coordinator (CRC) # 49. CRC #49 stated she was not aware of the grievance forms being on the Second floor and that if someone asked to file a grievance and she did not have a form then she would write it on a blank piece of paper. The Administrator acknowledged the facility information posting on how to file a grievance or complaint was not identified to be posted on the second floor but was uncertain about the third floor. The Administrator and tCC #49 both did not know how the residents would file an anonymous complaint. On 03/25/24 at approximately 6:55 PM during an interview with Licensed Practical Nurse (LPN) #121, LPN #21 stated the grievance forms were likely to be in the drawer in the filing cabinet behind the nurses desk on the third floor. LPN #121 further stated the forms were not available directly on the floor and that if someone asked for one he would find it for them and then let his supervisor know. He was not aware of how it could be filed anonymously. He further agreed that the facility information posting on how to file a grievance or complaint was not identified to be posted on the third floor.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 39043 Based on resident interview, family interview, record review, and staff interview, the facility failed to protect residents from sexual abuse. Resident #208 had a previous history of sexual behaviors toward other residents. The facility failed to protect Resident #15 from unwanted sexual touching by Resident #208. Although Resident #208 had been transferred to another facility by the time of the survey, the State Agency determined the facility's processes that failed to protect Resident #15 placed all residents in the facility in an immediate jeopardy situation. The State Agency notified the Nursing Home Administrator of the immediate jeopardy situation on 03/25/24 at 4:27 PM. The facility submitted a plan of correction (POC) on 03/25/24 at 7:19 PM. The State Agency requested revisions and an additional POC was submitted on 03/25/24 at 8:08 PM. The State Agency requested additional revisions and the final POC was submitted and approved on 03/25/24 at 8:16 PM. The State Agency verified the POC was implemented by reviewing the facility's resident interviews and resident evaluations. The State Agency also reviewed the facility's training records and interviewed staff members. The immediate jeopardy was abated on 03/26/24 at 1:45 PM. Resident #15 was harmed by the sexual abuse. She reported sadness and depression. She also had to undergo evaluation for physical injury at the emergency room . Findings included: a) Resident #15 During an interview, on 03/18/24 at 12:12 PM, Resident #15 stated a man had come into her room and touched my breast and crotch. She stated her tube feeding tubing had become disconnected from her gastrostomy tube and tube feeding leaked all over. She stated she started yelling and ringing her call light, but staff were slow to respond because they were busy. She stated the resident then went over to her roommate's side of the room, and her roommate began cursing at him. Resident #15 stated staff eventually came in and removed the perpetrator. She believed the perpetrator was arrested and never returned to the facility. On 03/19/24 at 4:00 PM, Resident #15's representative was interviewed on the telephone. She stated Resident #15 had been traumatized by the incident. She also believed the emergency room evaluation caused further distress for the resident. During a follow-up interview on 03/25/24 at 9:15 AM, Resident #15 stated the perpetrator initially touched her over the blanket, but then touched her under the blanket and then under her clothing. The resident stated the perpetrator touched her on the outside of her private area. She did not report digital penetration. She stated she tried not to think about the incident. She stated she felt sad and depressed when she thought about it. She stated that for a while she was nervous whenever she heard footsteps in the hallway. Resident #15 stated she liked to keep the television on at all times, so she didn't hear any footsteps. She also stated watching television kept her from thinking about the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #15's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 01/16/24 showed the resident had a brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The resident had a diagnosis of dementia. Resident #15 was determined by her physician to lack capacity to make medical decisions. A family member was her Medical Power of Attorney [MPOA]. The facility's reported incidents were reviewed. The following reportable was made on 02/02/24, Resident to Resident with potential inappropriate touching. Alleged perpetrator (resident) placed on one on one supervision and investigation initiated. On 02/07/24, the facility requested additional time for investigation. The five (5) day follow-up stated as follows: On 2/2/2024, the alleged a [sic] resident to resident with a potential of inappropriate touching. This was a resident to resident incident. The perpetrator, [Resident #208] was immediately placed on a 1:1 supervision. APS [Adult Protective Service], Ombudsman, OHFLAC [Office of Health Facility Licensure and Certification], and [City] Police were notified and investigation was initiated. [Resident #15] is a long-term resident who was admitted on [DATE]. [Resident #15]'s diagnoses include epilepsy, dementia, unspecified protein-calorie malnutrition, and chronic osteomyelitis. [Resident #15] was evaluated by the provider and has determined to lack medical capacity. She has a sister who is involved in her care. She has a BIMS [Brief Interview for Mental Status] score of 9. [Resident #208] is a long-term resident who was admitted on [DATE]. [Resident #208]'s diagnoses include: Alzheimer's Disease, type 2 diabetes, and CKD [chronic kidney disease]. [Resident #208] was evaluated by the provider and determined to lack mental capacity. He had a DHHR [Department of Health and Human Resources] surrogate who is involved in his care. He had a BIMS score of 6. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/2/24, the resident reported another resident wandered into her room in the early morning and touched her inappropriately. [Resident #15] did not initially report this situation to the night shift staff other than reporting a man was wandering into her room. When [Resident #15] made the full allegation that a resident touched her inappropriately, an investigation was initiated. The alleged perpetrator was identified as [Resident #208] and he was immediately placed on one on one supervision. [Resident #15] was interviewed immediately by ANHA [Assistant Nursing Home Administrator] regarding the unwanted touching. [Resident #15] was unable to recall the individual's name but she did report that he is a resident at this facility. [Resident #15] reported that the resident came into her room a total of 3 times. She reported she told him he was in the wrong room and he would leave. However, on the 3rd time he entered her room, he came over to her bed and touched her breast and reached under the covers and touched her private area. She stated he never went under her brief or her shirt. He never touched her skin and didn't touch her vagina. She stated he put his hand on her PEG tube and she was scared he might pull it out. She was able to push her call light and staff immediately entered the room. She didn't report he touched her to staff at that time. The resident was offered a room move and accepted. The [city] Police Department was notified and they arrived to interview [Resident #15]. Based on an interview with the resident, [city] PD [police department] offered intervention by hospital to be evaluated and resident/RP [Responsible Party] both denied medical intervention from outside medical provider at that time. Facility medical provider and RN [Registered Nurse] Unit Manager did complete assessment of resident on 2/2/24 related to alleged incident with no concerns identified. On 2/5/24, [Resident #15]'s Responsible Party called the facility and requested that [Resident #15] go to the hospital for a full gynecological/trauma examination because of her own guilt. The Facility Medical Provider, RN UM [unit manager] and ANHA spoke with sister at that time and the sister still expressed a desire for her to be sent to the hospital. [Resident #15] was sent to the emergency room department at [hospital] for an examination. The resident was not treated for any concerns related to a sexual encounter/sexual trauma while at [hospital]. While at the hospital, resident reported to hospital staff that another resident assaulted her, she screamed and hit her button, the nurses came to her room and called the police. She also reported to the hospital staff that her tube feeding site was bleeding at that time. The alleged perpetrator was put on one on one supervision from staff 24 hours a day, 7 days a week when notified of the alleged incident and remains on one on one supervision at this time. Staff interviews were conducted with the staff who were working on the night shift into day shift of the alleged incident, with reports that resident did not report the alleged incident to them but that she did share he had come into his room but when asked to leave he did so. Description of [Resident #208] was given to the RN Unit Manager and the resident was identified based on description. Interviews with staff revealed that no staff were aware of the alleged inappropriate touching incident until after the day shift came on shift and [Resident #15]'s responsible party notified staff via phone. Staff statements also revealed that they had not witnessed any concerning inappropriate behaviors from [Resident #208], that he does ambulate on the unit but is easily redirectable and will not go beyond other resident doorways when looking for his room. [Resident #208] was interviewed who had no recollection of going into another resident's room. Residents who reside in the unit, including roommate of [Resident #208] were interviewed with no concerns related to [Resident #208]. [Resident #15]'s roommate was interviewed and stated that the privacy curtain was pulled, she heard her roommate tell someone to get out of the room but she thought that whoever was in the room had then left the room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Referrals have been sent out for long term care to multiple facilities for placement with all referrals being denied at this time. The resident had been referred to an inpatient psych facility for a temporary stay out of the facility while the facility continues to seek long term placement elsewhere. [Resident #208] had a medication review by the provider and an order was received on 2/2/24 for Depo-Provera Intramuscular Suspension 150 mg [milligrams]/ml [milliliter] once weekly for behaviors. [Resident #208]'s responsible party is Adult Protective Services [name]. She has been aware and kept in close contact for referrals and any needed medication changes. Facility is unable to substantiate sexual inappropriate behavior between residents. A note was written by Family Nurse Practitioner #186 on 02/02/24. The note, in part, stated, .Chief Complaint / Nature of Presenting Problem: Resident stated she was assaulted by another resident. Investigation by nursing facility is being done as well as appropriate reporting . ROS [review of symptoms] was mainly focused on physical and mental aspects of her experience she stated the male resident had come into her room and left once. The male resident again entered and touched her breasts through her clothing. Stated he then touched her private area through her clothing. Male resident then raised shirt and started to touch PEG [percutaneous endoscopic gastrostomy] tube at which point resident states she began to scream. She stated he then appeared scared and walked to the curtain and eventually left room .Physical Exam: General appearance - Resident is a frail, elderly female. She is lying comfortably in bed during exam. Resident relayed her story to examiner with [name] (unit manager) and then skin exam was completed. There is no bruising or marks to the resident's skin. There are no signs of pressure or open areas. Resident herself states he touched her only through clothing. Per nursing report denied going to hospital for an assault exam. Spoke to resident at length. She states that she was very tearful when it happened but is somewhat better now. She states she is strong and appreciates all the help she has received from staff. States that it has not affected her mental health except for directly after but she does admit to history of having ups and downs. Denied needs at this point, reminded resident if she needed to talk further she had many avenues available to her. On 02/05/24, Resident #15 was evaluated for physical injury related to sexual abuse. The emergency room records state, The patient reports another tenant assaulted her in her bed, she screamed and hit her button, and the nurses came in her room and called the police. She reports she did not want to come to be evaluated then due to her feeding tube. She reports her tube site was bleeding during the assault and also reports a history of multiple kidney stones. Examination in the emergency room showed no bleeding at the PEG tube site. Computed Tomography (CT scan) showed numerous renal calculi (kidney stones). The emergency room discharge diagnoses were 1. Status post assault without significant injury. 2. Large right ureteral stone. On 03/12/24, the following incident was reported: The resident, [Resident #15], told her legal council today, 3/12/24 that she is changing her statement from the 2/2/24 incident statement that claimed the alleged perpetrator, touched her breast and reached under her cover and touched her private area but stating he never went under her clothes or brief nor touched her skin, but did put his hand over the PEG tube area and that is what scared her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	To her current statement of, allegedly stating per her lawyer, there was digital vaginal penetration during the incident from 2/2/24. Per her council, facility staff are not allowed to speak to [Resident #15] regarding the facts of the case from 2/2, thus making it impossible for facility staff to interview her or obtain further statements. The ombudsman has been contacted for further assistance since facility staff are unable to speak with the resident regarding the new change in statement. [City] Police have been contacted regarding the change in statement. Alleged perpetrator has not resided in the facility since 2/29/24 and was 1:1 or at a psychiatric hospital from incident allegation 2/2 until discharge. The five (5) day follow up stated as follows: On 03/13/24, [Resident #15]'s legal council [sic] reported to the [facility company] legal counsel that [Resident #15] is changing her original statement from an incident that occurred on 2/2/24. APS, Ombudsman, OHFLAC and [city] Police Department were notified. [Resident #15] is a long-term resident who was admitted on [DATE]. [Resident #15]'s diagnoses include epilepsy, dementia, unspecified protein-calorie malnutrition, and chronic osteomyelitis. [Resident #15] was evaluated by the provider and has determined to lack medical capacity. She has a sister who is involved in her care. She has a BIMS [Brief Interview for Mental Status] score of 9. On 2/2/2024, a referral was made by [Resident #15] to facility staff regarding sexual touching and the incident was faxed to APS, OHFLAC, Ombudsman, and [city] Police Department. [Resident #15]'s original statement claimed the alleged perpetrator, touched her breast and reached under her cover and touched her private area but stating he never went under her clothes or brief nor touched her skin, but did put his hand over the PEG tube area and that is what scared her. The new statement made by [Resident #15]'s Legal counsel now alleges there was digital vaginal penetration during the incident from 2/2/24. Per [Resident #15]'s council [sic], facility staff are not allowed to speak to [Resident #15] regarding the facts of the case from 2/2/24 and staff were not able to obtain any statements from [Resident #15] regarding the change in her statement, however facility did refer [Resident #15] to the Ombudsman for resident advocacy. The facility also called the [city] Police Department and was put in touch with the Detective on the case and was informed the police will likely not return to the facility to reinterview [Resident #15] since she has legal representation and the detective stated [Resident #15]'s council [sic] had been in touch with him. Staff have been interviewed regarding the change in statement with all interviews revealing no staff were ever told by (Resident #15's name) that she was digitally penetrated at the original incident of 2/2/24. The alleged perpetrator has been discharged from the facility permanently since 2/29/24. On 03/25/24, a PHQ-2 to 9 evaluation was conducted to screen Resident #15 for depression. Resident #15 reported feeling down, depressed or hopeless 7-11 days during the past 14 days. Resident #15 reported trouble falling or staying asleep, or sleeping too much 2-6 days during the past 14 days. Resident #15 reported feeling tired or having little energy 2-6 days during the past 14 days. Resident #15 reported poor appetite or overeating 2-6 days during the past 14 days. The resident's score of 5 indicated mild depression. b) Resident #208 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #208's medical records showed the resident was admitted to the facility on [DATE]. The resident's MDS assessment with ARD 04/10/20 showed the resident had a BIMS score of 10, which suggested the resident was moderately cognitively impaired. The resident had a diagnosis of Alzheimer's Disease. On 10/07/20, the following care plan focus was initiated, [Resident #208] has a tendency to exhibit sexually inappropriate behavior related to: Cognitive loss/Dementia. A progress note written by Licensed Practical Nurse #184 on 11/09/20 at 8:40 AM regarding Resident #208 stated, Res [resident] has been awake throughout the night going in and out of his room multiple times every few minutes slamming his door behind him. Res has been pacing up and down the hall stopping and looking in rooms at other residents as he was walking the hall. Throughout the night res attempted to go in other residents' rooms several times but was easily redirected by staff but for a short time before he would attempt again. Around 5:30 this morn [morning] this nurse was [sic] CNA were with another resident when this resident was found to be kissing co-res in the mouth for a long period while hugging her and rubbing her head. This nurse approached res to redirect him when he raised his voice at this nurse shaking his fist saying leave me alone I'll do what I want. Res then stomped his feet as he walked back to his room. Review of physicians' orders showed an order for cimetidine, 400 mg twice a day. Cimetidine (Tagamet) is an anti-ulcer medication that is also used to reduce sexual desire. Resident #208's order for Cimetidine stated he was receiving the medication for gastroesophageal reflux disease. Resident #208 continued this dose of Cimetidine until 08/26/21. On 08/26/21, the dosage was decreased to 200 mg twice a day as a gradual dose reduction. Cimetidine was discontinued on 10/21/21. Resident #208's MDS assessment with ARD 10/15/21 showed the resident had a BIMS score of 8, which suggested the resident was moderately cognitively impaired. Resident #208's MDS assessment with ARD 01/08/21 showed the resident had a BIMS score of 10, which suggested the resident was moderately cognitively impaired. On 02/09/21, the following incident involving Resident #208 and Resident #210 was reported, Residents both found in male resident's room. Aide alleging both residents had pants down and appeared to be engaging in sexual activity. Facility unsure of who is perpetrator/victim. A typed unsigned note with the reportable stated, [City] PD [police department] notified 2/9. Officer [name] reported to facility approx. [approximately] 11:30 AM and met with CED [Center Executive Director], SW [Social Worker], and CNE [Center Nursing Director] to discuss incident. Officer stated that he would report to dispatch and follow-up after facility investigation if needed. The five (5) day summary stated, See attached but no narrative summary was included with the reportable provided during the annual survey. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing note written in Resident #208's medical records by Licensed Practical Nurse #184 on 02/08/21 at 10:00 PM stated, CNA [Certified Nursing Assistant] came to this nurse stating that near dinner time close to 5 PM that she entered this res [resident] room and heard talking coming from his bathroom. She states she knocked on bathroom door and entered to check o this res and saw this res and female res from room [room number] standing by the sink facing each other. CNA continued saying this res was hugging all over' resident's upper body area and kissing around her face. CNA states this resident's pants were down and female resident's pants were down and that this resident was thrusting his lower body area onto female's lower body area. CNA states she intervened and redirected residents apart from each other by walking female resident out of this res room. CNA states that this res began yelling at her to get out and that this was none of her business. This res stayed in his room as CNA walked female resident out of her room separating both residents without further incident. Immediate supervisor notified of situation. A nursing note written in Resident #210's medical records by Licensed Practical Nurse #184 on 02/08/21 at 10:00 PM stated, CNA approached this nurse stating that around dinner time she entered male resident's room [room number] and upon hearing voices coming from the bathroom she entered the bathroom and found male resident and this resident standing by the sink facing each other. CNA states both residents' pants and underwear were down and male res was hugging and touching this res upper body area and kissing around her face. CNA also states that male res was thrusting his lower body area to this res lower body area. CNA was able to hold this res hand and walk her out of co-residents's room without further incident. Staff denies this res appearing to be under any acute distress during and after incident. Immediate supervisor notified. A nursing note written by Registered Nurse #185 on 02/09/21 at 12:15 PM regarding Resident #208 stated, Resident placed on 1:1 supervision during investigation for safety. Physicians' orders showed an order written on 02/09/21 for 1:1 supervision for safety, every shift. The order was discontinued on 02/10/21, and an order for every 15 minute visual checks for safety, duration of 72 hours. A progress note written by Licensed Practical Nurse #187 on 06/02/21 at 2:05 AM regarding Resident #208 stated, Resident was observed in another female resident's room. Resident was holding female resident's hands when observed. Resident gave no excuse why he was in the other resident's room. He was escorted out and returned to his room. Will continue to monitor. Resident #208's MDS assessment with ARD 09/10/21 showed the resident had a BIMS score of 5, which suggested the resident was severely cognitively impaired. A progress note written by LPN #190 on 11/11/21 at 7:07 PM regarding Resident #208 stated, Reported to this nurse from female residents that resident was standing in his doorway grabbing his pants in the private area. This nurse reported it to oncoming nightshift nurse. Spoke to resident and explained to him that is was inappropriate. Verbalized understanding. Review of physicians' orders showed an order written on 11/12/21 for every 15 minute visual checks which continued through 11/30/21. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A progress note written by LPN #187 on 11/19/21 at 6:52 PM regarding Resident #208 stated, Resident is monitored continuously. Continues to wander at night wanting coffee and going through the halls into female residents rooms. Resident was reported being observed in room [number] standing, staring at incapacitated resident. A progress note written by LPN #187 on 11/20/21 at 10:34 PM regarding Resident #208 stated, Mental Health/Behavior reviewed. Physical behaviors, directed toward others occurs up to 5 days a week. Wandering occurs daily or almost daily and poses significant risk and/or is intruding on others. Pt. is experiencing agitation/restlessness. Pt. is experiencing anxiety about surroundings. Pt. has had sleep-cycle issues daily or almost daily. Additional mental health/behavior comments: Due to 15 min [minute] checks resident does not have opportunity to wander or go in other resident rooms. If no one is in the vicinity when exiting his room he will wander to other resident's rooms. Usually female. A progress note written by LPN #187 on 11/21/21 at 10:05 PM regarding Resident #208 stated, Resident was observed in attempting to kiss a disabled resident. Resident was told to stop and to return to his room. Resident stopped what he was doing and returned to his room. Resident #208's MDS assessment with ARD 12/10/21 showed the resident had a BIMS score of 5, which suggested the resident was severely cognitively impaired. On 12/23/21, the following incident was reported, Resident [#208] was found in co-resident's [#209] room with penis out attempting to put it into co-resident's mouth. According to the report, Resident #208 was placed on one-on-one observation and investigation was initiated. A handwritten note in the incident investigation signed by a Social Worker, signature illegible, stated, Reported to [city name] PD [police department] on 12/23. Two officers came to facility do discuss (Officer [name] and Officer [name].) Reviewed allegation and medical/mental status of both residents. Officer called this SW [Social Worker] on 12/29 to follow-up on outcome of investigation. Unable to prosecute d/t [due to] mental capacity of perpetrator. Case closed at this time. The five (5) day incident follow-up reported, On December 22nd 2021, co-resident [Resident #208] allegedly had his penis out and was attempting to put into resident [Resident #209] mouth. Allegation of potential abuse was reported to OHFLAC [Office of Health Facility Licensure and Certification], APS [Adult Protective Services] and Ombudsman; investigation initiated. [City] Police Department also notified. [Resident #209] is a long term resident of [facility] that admitted to the facility in October 2021. She has diagnosis of traumatic brain injury, unspecified intellectual disabilities, and mild cognitive impairment. [Resident #209] is non-verbal, unable to communicate and is dependent on staff for all activities of daily living. She lacks the capacity to make her own medical decisions and her cousin is resident's health care surrogate and active in her care. [Resident #209] is unable to be interviewed as she is non-verbal and unable to understand or communicate. Interview with resident's roommate indicated that she is unable to remember co-resident entering the room. Interviews with staff members indicate that the resident was re-directed out of the room immediately and no physical activity occurred. [Resident #209] and roommate show no signs or symptoms of distress following the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Male co-resident has diagnosis of Alzheimer's disease with a BIMS [brief interview for mental status] of 5 and is care planned for sexually inappropriate behaviors related to limited cognition. Resident placed on 1:1 supervision immediately following the incident with no further concerns noted. Resident was seen by provided on 12/23/21 with new orders for Sertraline and melatonin at night along with labs to check for an illness that may contribute to behaviors. Medication review was completed for resident by Medical Director on 12/27/21 with new orders for Cimetidine for sexual intrusiveness. Resident continues on 1:1 supervision at this time which will be reevaluated by IDT [interdisciplinary team] and provided. Allegation of abuse unsubstantiated. No intentional abuse indicated as the alleged perpetrator lacks capacity to understand appropriate behavior. Handwritten sheets accompanying the reportable document that a resident was on 1:1 observation from 12/22/21 at 8:30 PM through 01/04/22. The resident's name was not on the form. Additional handwritten sheets accompanying the reportable document Resident #208 was on 15 minute visual checks from 12/23/21 at 12:00 AM through 01/03/22 at 11:45 PM. A nursing note written on 12/23/21 at 12:07 PM by Social Worker #183 stated, Spoke with [Health Care Surrogate] regarding incident with [Resident #209]. Discussed options for alternative placement due to safety concerns. Discussed option of an all male Adult Family Care Home. HCS [Health Care Surrogate] to fax paperwork for SW [Social Worker] to complete for possible placement in an all male AFC [Adult Family Care] home. Resident has no family/friends in the area so HCS will submit the application to all available homes in WV. A progress note written by LPN #187 on 12/23/21 at 12:11 AM stated, Mental Health/Behavior reviewed. Physical behaviors, directed towards others occurs daily or almost daily. Verbal behaviors, directed toward others occurs up to 5 days a week. Wandering occurs daily or almost daily and poses significant risk and/or is intruding on others. Pt. is experiencing agitation/restlessness. Pt. is experiencing anxiety about surroundings. Pt. is experiencing impulsive behavior. Inappropriate behaviors towards females. Exhibits behavior hyperactivity (e.g. restless walking patterns). Exhibits behaviors: frustration. Review of the physicians' orders showed Cimetidine 400 mg, twice a day, for sexual intrusiveness was started on 12/27/21. A social services note written on 01/03/22 stated referrals to transfer the resident were sent to two (2) facilities. A progress note written on 01/04/22 at 12:46 PM by Social Worker #188 stated, Spoke with admissions at [name]. Referral denied as facility is not taking admissions at this time. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A progress note written by Administrator #189 on 01/04/22 at 11:52 AM stated, IDT [interdisciplinary team] review of resident due to sexual abuse allegation. Resident has remained on 1:1 supervision since allegation was made. Resident was seen by provider on 12/23 with new orders for Sertraline (Zoloft) to be increased from 150 mg per day to 200 mg per day and start Melatonin 5 mg per day. Resident's medications were reviewed by Medical Director on 12/27 with new order for Cimetidine 400 mg twice a day. Resident is currently receiving psych services. HCS [health care surrogate] requested referrals to be sent to [outside facility] and [outside facility] of [city] which have been sent at this time. MD gave order to discontinue 1:1 supervision and conduct 15 minute safety checks at this time. An order for 15 minute visual checks for safety was written on 01/04/22 and continued until 06/06/22. A progress note written by Social Worker #188 on 01/12/22 at 2:24 PM stated, Spoke with [outside facility] admissions this date. Referral was denied at this time. On 05/26/23, Resident #208 was transferred to the hospital following a fall. Cimetidine (Tagamet) was not continued after his return to the facility on [DATE]. Resident #208's MDS assessment with ARD 12/31/23 showed the resident had a BIMS score of 6, which suggested the resident was severely cognitively impaired. A progress note written by FNP (family nurse practitioner) #186 on 01/24/24 at 2:52 PM regarding Resident #208 stated, in part, Approximately 2 weeks ago resident on unit, per another resident he pulled his pants down in front of her and showed himself. Per staff behavior has been increasing in frequency .Added Tagamet 200 BID [twice a day] for sexual behavior. A progress note written by FNP #186 on 02/02/24 at 3:04 PM regarding Resident #208 stated, in part, Resident has been accused of assault on another resident of the facility. Due to increased behaviors [name] his DHHR representative was called. She was informed of wishes to start resident on Depo-Provera IM [intramuscular] injections. Educated on use to help subdue sexual behavior by staff of facility on group call . Resident is currently a one on one due to behaviors. Review of physicians' orders showed an order was written on 02/02/24 that stated, Resident will be under 1:1 supervision at all times due to inappropriate sexual behaviors every 12 hours. This order was in effect at the time of the resident's discharge from the facility. A progress note written by LPN #32 on 02/07/24 at 11:49 AM regarding Resident #208 stated, While 1 on 1 was watching resident, resident walked to the door of his room and grabbed his penis through pants ant shook it at passing resident. Charted in behavior book. A progress note written by LPN #32 on 02/07/24 at 2:41 PM stated, Has not wandered into any one else's room since becoming 1:1 but still is grabbing himself and saying inappropriate things [TRUNCATED]

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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. 49650 Based on medical record review and staff interview the facility failed to electronically transmit accurate Minimum Data Set (MDS) data. This was true for two (2) of two (2) residents that the Minimum Data Sets (MDS's) were reviewed for discharges. Resident identifiers: #148 and #149. Facility census: 150. Findings included: a) #148 On 03/19/24 at 11:41 AM during a medical record review for Resident #148 , a nurse note dated 01/01/24 stated the resident was being admitted to the other hospital telemetry unit for congestive heart failure. A review of the residents electronically submitted MDS Assessment Reference Date (ARD) dated 01/01/24, in Section A- Identification Information under A2105 Discharge Status, the code submitted for this discharge was 01- Home/Community. On 03/19/24 at 01:07 PM during an interview with the MDS Coordinator #170, she agreed that the coding was in error and felt it was due to her doing so many other things and being short staffed. b) #149 On 03/19/24 at 12:11 PM medical record review for Resident #149 revealed the nurses note prior to the resident's discharge was the resident left the facility against medical advice (AMA). A review of the electronically submitted MDS with an ARD date 01/01/24, Section A- Identification Information under A2105 Discharge Status, the code submitted for this discharge was 04- Short-Term General Hospital. On 03/19/24 at 01:07 PM during an interview with the MDS Coordinator #170, she agreed the coding was in error and felt it was due to her doing so many other things and being short staffed.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review and staff interview, the facility failed to ensure residents with newly evident or possible serious mental disorder were referred for Level II resident review. This failed practice had the potential to affect seven (7) of eight (8) residents reviewed for the care area of Preadmission Screening and Resident Review. Resident identifiers: #23, #15, #74, #29, #66, #17, #33. Facility census: 150. Findings included: a) Resident #23 Review of Resident #23's medical records showed the resident was admitted on [DATE]. Resident #23's Preadmission Screening and Resident Review (PASRR) completed on 07/11/23 stated Level II PASRR resident review was not required. Level II evaluation determines whether a resident with mental illness or intellectual disability requires specialized services. On 10/20/23, Resident #23 received a new diagnosis of major depressive disorder, recurrent. The resident was not referred for Level II evaluation. On 03/19/24 at 2:44 PM, the Corporate Administrator confirmed Resident #23 was not referred for Level II resident review when the resident received a new diagnosis of major depressive disorder. She stated the facility had identified issues with PASRR evaluations and had an improvement plan to correct the issues. No further information was provided through the completion of the survey. b) Resident #15 Review of Resident #15's medical records showed the resident had a Preadmission Screening and Resident Review (PASRR) completed on 07/20/20, for admission to the facility. The PASRR indicated the resident had a diagnosis of bipolar disorder and stated Level II PASRR resident review was not required. On 09/12/22, Resident #15 received a new diagnosis of major depressive disorder, recurrent, mild. The resident was not referred for Level II evaluation. On 03/19/24 at 2:44 PM, the Corporate Administrator confirmed Resident #15 was not referred for Level II resident review when the resident received a new diagnosis of major depressive disorder. She stated the facility had identified issues with PASRR evaluations and had an improvement plan to correct the issues. 49650 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C) Resident #74 On 03/18/24 at 08:26 PM during a medical record review for Resident #74, the residents Preadmission Screening and Resident Review (PASSAR) dated 09/30/19 identifies the diagnosis of toxic encephalopathy, major depressive, hyperthyroidism, bipolar, anxiety and osteoarthritis. A Level two (2) was completed at that time, signed by the physician and dated 10/03/19. It is further identified that the diagnosis of schizoaffective disorder bipolar type was added to the physician diagnosis on 11/01/22 with no noted evaluation completed for the Level two (2) PASSAR for the new diagnosis. During an interview with the Administrator and the Corporate Administrator (CA) #182 on 03/19/24 at 02:44 PM the Administrator and the CA #182 acknowledged that there was not a Level two (2) evaluation completed for the new diagnosis of schizoaffective disorder bipolar type added 11/01/22. d) Resident #29 On 03/18/24 at 08:04 PM, during a medical record review, Resident #29 admitted on [DATE] without any diagnoses that warranted a Level two (2) on the Preadmission Screening and Resident Review (PASSAR). Further review identified that a diagnosis of major depressive disorder recurrent and moderate was added to his physician diagnosis on 05/10/21 with no noted evaluation completed for the Level two (2) PASSAR for the new diagnosis. During an interview with the Administrator and the Corporate Administrator (CA) #182 on 03/19/24 at 02:44 PM the Administrator and the CA #182 acknowledged that there was not an evaluation completed for the Level two (2) with the new diagnosis of major depressive disorder recurrent and moderate added 5/10/21. e) Resident #66 On 03/18/24 at 07:18 PM, during a medical record review for Resident #66, the Preadmission Screening and Resident Review (PASARR) was completed on 09/21/2020 with the physician diagnoses noted to be metabolic encephalopathy, duodenal ulcer, hypothyroidism, gastrointestinal hemorrhage and alcohol abuse. A Level two (2) was not completed on the PASARR completed on 09/21/20. A review of the residents physician diagnoses identified schizoaffective disorder (bipolar type) dated 10/19/21, an adjustment disorder with mixed anxiety and depressed mood dated 11/16/20 and a major depressive disorder, recurrent, mild; anxiety disorder dated 12/07/20 with no noted evaluation completed for the Level two (2) PASARR for the new diagnosis. During an interview with the Administrator and the Assistant Administrator on 03/19/24 02:44 PM the Administrator acknowledged that there was not an evaluation completed for the new diagnoses of the schizoaffective disorder (bipolar type) dated 10/19/21, adjustment disorder with mixed anxiety and depressed mood dated 11/16/20, or the major depressive disorder, recurrent, mild; anxiety disorder dated 12/02/20. f) Resident #17 A record review on 03/18/24 at 9:13 PM, revealed that Resident #17's last Pre Admission Screening and Resident Review (PASSAR) was completed on 04/21/2009. The PASSAR had the following diagnosis: Acute Kidney Disease, Positive blood cultures, Subdural Hematoma, Gerd, and Gastroparesis (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further record review revealed that Resident #17's initial admission was on 4/21/2009, and he was readmitted on [DATE]. During the record review it was also found that Resident #17 was diagnosed with Epilepsy on 06/06/22, Psychosis on 11/02/22, and Major Depressive Disorder on 12/30/23. During an interview on 03/19/24 at 11:03 AM, with the Corporate Administrator #182 she stated, We know there is a problem and we are currently working on the issue. During an interview on 03/19/24 at 11:04 AM, with Social Service Director (SSD) #165, she stated, I haven't seen one in his chart since 2009. Yes, those new diagnoses would mean he needs a new PASSAR completed. A review on 03/19/24 at 11:30 AM, of the facilities policy titled, {Pre-admissions Screening for Mental Disorder and/or Intellectual Disability Patients} reads under Practice Standards as follows: 1. Social Services will coordinate and/or inform the appropriate agency to conduct the evaluation and obtain results if: 1.1 It is learned after admission that the PASSAR was not completed or is incorrect, or 1.2 There is a significant change in status that results in new evidence of possible mental disorder, intellectual disability or a related condition. g) Resident #33 A record review on 03/18/24 at 7:58 PM revealed that Resident #33, was diagnosed with Bipolar disorder on 08/16/2023. Further record review showed that the last PASSAR completed for Resident # 33 was on 04/06/23. During an interview on 03/19/24 at 11:03 AM, with the Corporate Administrator #182 she stated, We know there is a problem and we are currently working on the issue. During an interview on 03/19/24 at 11:04 AM, with Social Service Director (SSD) #165, she stated, I haven't seen one in her chart since April of last year. Yes, a new diagnosis of Bipolar would mean she needs a new PASSAR completed. A review on 03/19/24 at 11:30 AM, of the facilities policy titled, {Pre-admissions Screening for Mental Disorder and/or Intellectual Disability Patients} reads under Practice Standards as follows: 1. Social Services will coordinate and/or inform the appropriate agency to conduct the evaluation and obtain results if: 1.1 It is learned after admission that the PASSAR was not completed or is incorrect, or 1.2 There is a significant change in status that results in new evidence of possible mental disorder, intellectual disability or a related condition.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review and staff interview, the facility failed to ensure complete and accurate pre-admission screening had been performed for residents with serious mental disorders prior to their admission. This failed practice had the potential to affect one (1) of eight (8) residents reviewed for the care area of Preadmission Screening and Resident Review. Resident identifier: #23. Facility census: 150. Findings included: a) #23 Review of Resident #23's medical records showed the resident was admitted on [DATE]. She had also been a resident in the facility in 2021. Further review of the medical records showed a diagnosis report showing a diagnosis of schizophrenia from 12/09/21 to 10/27/23 and a diagnosis of epilepsy from 07/12/23 to the present. On 10/20/23, Resident #23 received a diagnosis of paranoid schizophrenia. Resident #23's history and physical from the hospital on 06/27/23 indicated the resident had a history of schizophrenia and grand mal seizures. Resident #23's Preadmission Screening and Resident Review (PASRR) completed on 07/11/23 did not document diagnoses of seizure disorder or schizophrenic disorder. Level II evaluation was not performed. Level II PASRR screening determines whether a resident with mental illness or intellectual disability requires specialized services. On 03/19/24 at 2:44 PM, the Corporate Administrator confirmed Resident #23's PASRR completed 07/11/23 did not accurately reflect her diagnoses at the time of admission. She stated the facility had identified issues with PASRR evaluations and had an improvement plan to correct the issues. No further information was provided through the completion of the survey.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 39043 Based on record review and staff interview the facility failed to revise care plans in a timely manner related to behaviors, and smoking. This failed practice was found true for (2) two of 30 residents reviewed for care plans during the Long-Term Care Survey Process. Resident identifiers: #14 and #24. Facility census: 150. Findings included: a) Resident #24 An observation on 03/19/24 at 9:00 AM revealed Resident #24 was smoking in the front parking lot designated smoking area. During an interview on 03/19/24 at 2:54 PM, with Corporate Administrator#182 , she stated, Yes that smoking area is on the facility property. A record review on 03/19/24 at 2:55 PM, of Resident #24's care plan read as follows: Patient may not smoke on property per smoking assessment d/t (due/to) not following facility smoking rules, resident goes off the property to smoke. Patient will not smoke on property through the next review period. During an interview, on 03/21/24 at 10:30 AM, with Corporate Administrator #182, she stated, He is safe to smoke according to his smoking assessment. That is the old smoking care plan. It had not been taken out. b) Resident #14 An observation, on 03/18/24 at 12:36 PM, showed Resident #14 was served lunch on Styrofoam dishes. Resident #14 was not interviewable. He was able to feed himself. Review of Resident #14's physicians' orders showed an order written on 02/01/22 for paper products for all meals. Review of Resident #14's comprehensive care plan showed a focus related to behaviors related to the diagnosis of anoxic brain injury. The care plan stated the resident demonstrated the behavior of throwing items. However, using paper products for meals was not documented as an intervention on the resident's care plan. On 03/20/24 at 11:07 AM, the Director of Nursing stated Resident #14 was served meals on paper products because he had the behavior of sweeping his dishes off the table when he was finished eating. The DON confirmed the resident was not care planned for the intervention of using paper products for meals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided through the completion of the survey. 49465

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 49465 Based on record review, staff interview, and resident interview the facility failed to provide an activity program to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. Resident #17 was not provided with a wheelchair to attend activities of his choice and Resident #29 was not provided with scheduled one to one visits. This failed practice was found true for (2) two of (4) four residents reviewed for activities during the Long-Term Care Survey Process. Resident identifiers: #17, and #29. Facility census: 150. Findings Include: a) Resident #17 An observation on 03/18/24 at 3:52 PM revealed that Resident #17 was non-verbal and used an alphabet board to communicate, by pointing out the letters to spell words. During an interview, on 03/18/24 at 3:52 PM, with Resident #17 he communicated, I do not go to activities, because I do not have a wheelchair. A record review, on 03/20/24 at 9:47 AM, of Resident #17's Minimum Data Set (MDS) with an Assessment Review Date (ARD) of 06/27/23 revealed that section F, question FO500, Letter E, was marked with a number (5) five, indicating that it was important to him to do things with groups of people but he did not have a choice. Further record review of Resident #17's activity participation records for the months of February 2024 and March 2024 only had activity participation marked under the following categories: -Independent Engagement -Individual Engagement There were no group or one to one activities indicated on the Activity Participation Records. During an interview, on 03/20/24 at 11:00 AM, with Guest Services Director (GSD) #7 she indicated that she was currently taking the Activity Director course and she was new at doing this position. She further stated, He has not been to activities in a while, he refuses to get up sometimes. 49650 b) Resident #29 On 03/18/24 at approximately 11:15 AM during an interview with Resident #29, the resident stated she was not offered to participate in activities but would like to be. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/24 at 12:40 PM during a review of Resident #29's activities care plan it was noted as an intervention for Resident #29, that she would be offered two - three (2-3), one on one (1:1) social interventions weekly with recreation staff. A review was completed by the recreation staff of the daily recreation participation record for Resident #29 from 02/01/24 to 03/18/24. This record reflected the residents' activities that were completed daily. On 03/19/24 at 1:39 PM during an interview with the Guest Services Director (GSD) #7 GSD acknowledged the participation record did not identify one on one (1:1) social interventions being completed two- three (2-3) times weekly with recreation staff.

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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 medical record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice. The facility failed to provide information and/or offer the Respiratory Syncytial Virus (RSV) immunization per recommendation of the Centers for Disease Control and Prevention (CDC) in a timely manner and failed to follow physician's orders, notify residents physician, collaborate with Hospices services, or do pacemaker checks. This failed practice had the potential to affect more than a limited number of residents who currently reside in the facility. Resident Identifier: #73, #79, #23, and #19. Facility Census: 150. Findings included: a) RSV Immunization During a review of the facility documents regarding immunization, found zero out of 150 residents had been provided educational information about the risk and benefits of receiving the RSV vaccination. On 03/26/24 at 1:25 PM, Assistant Director of Nursing ADON stated she had not offered the RSV vaccine. She stated the facility did not offer the RSV vaccine. The residents would have to ask for the RSV vaccine. According to The Centers for Disease Control and Prevention (CDC) Respiratory syncytial virus, or RSV, is a common respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a week or two, but RSV can be serious. Infants and older adults are more likely to develop severe RSV and need hospitalization . Vaccines are available to protect older adults from severe RSV. Monoclonal antibody products are available to protect infants and young children from severe RSV. CDC recommends RSV vaccines to protect adults ages 60 and older from severe RSV, using shared clinical decision-making. According to the CDC the RSV vaccine was made available on early August of 2023. In general, simultaneous administration of vaccines remains a best practice. Providers should continue to simultaneously administer the vaccines for which a patient is eligible, including COVID-19, influenza, and pneumococcal vaccines. Simultaneous administration of RSV vaccine with other vaccines for older adults is also acceptable. When deciding whether to simultaneously administer other vaccines with RSV vaccine on the same day, providers should consider whether the patient is up to date with recommendations for currently recommended vaccines, the feasibility of administering additional vaccine doses later, risk for acquiring vaccine-preventable disease, vaccine reactogenicity profiles, and patient preferences. Above information was taken from the web site: Centers for Disease Control and Prevention (.gov) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) Resident #73 A medical record review revealed Resident #73 was receiving Hospice Services starting on 02/13/24. A continued record review of physician's orders showed an order: -- Advanced Care Planning-Goals of Care: Hospice care and treat. Subsequent Review revealed a care plan: Focus: Resident/health care decision maker has expressed desire for palliative/comfort care measures only related to end stage cardiac disease, end stage respiratory disease- Hospice service in place. Goal: Resident will have the highest possible level of comfort daily thru the end-of-life. Intervention: Accommodate and encourage resident's choices related to activities, ADLs, visitations as much as possible. Assess for distressing symptoms i.e. dyspnea, nausea and vomiting, fatigue, psychosocial changes, and support per individualized plan. Encourage and allow resident/health care decision maker time for verbalization of feelings of fear, anxiety, or depression and provide support. Review of Resident # 73's Hospice documentation notebook showed it did not contain an active care plan for Hospice Services. During an interview with the Homestead Unit Facilitator ([NAME]) #111 on 03/18/24 at 12:38 PM, She verified that Resident #73 was receiving Hospice Services and had no current coordinated plan of care with the Hospice provider identify the provider responsible for performing each or any specific services/functions that have been agreed upon. She stated that she would. c) Resident #19 During an interview on 03/18/24 at 4:05 PM, Resident #19 stated, I have not had a pacemaker checker since I have been here. A record review on 03/19/24 at 2:00 PM, revealed a physician note dated 11/16/23 that read as follows: Acute visit for phantom pain in left stump (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He said none of the meds he takes right now alleviate all the pain, he has pain in right leg, too, as well as the left leg with phantom pain. He is worried about not having a pacemaker checkup anymore. said it has been 3 years. he found the pacemaker card. and i gave that info for nursing to make contact with cardiologist office to see what we can do for his pacemaker. Further record review revealed the following order put in Resident #19's medical chart on 11/16/23, Please contact (Hospital named), (Physician named), 3042536227, pt is asking about what he should do to check his pacemaker. Model #PM2210, Serial #7367808, implant date 6/21/2013. There were no notes in the chart after 11/16/23 reflecting that anyone had checked on the resident's pacemaker. On 03/20/24 at 8:40 AM, Resident #19 provided the surveyor with a copy of his Pacemaker card. During an interview on 03/20/24 at 10:25 AM, with the Director of Nursing (DON) he stated, The doctor that put it in has not worked at the cardiology office in [NAME] for 7 years. He now lives in Florida. We are trying to get him set up with the cardiologist in [NAME] where he had the surgery. They have no record of it being checked for several years. No, we have not checked it. We honestly didn't know he had it. d) Resident #79 - blood glucose Resident #79's physicians' orders showed the following order written on 12/13/24 and discontinued on 02/06/24, Fingerstick blood glucose Notify MD [physician] if blood sugar greater than 400; if blood glucose is below 70 initiate hypoglycemic protocol, before meals and at bedtime for diabetes mellitus. On 02/01/24 at 09:00 PM, Resident #79's blood glucose level was 489. The medical records contained no documentation that the physician had been notified of the resident's blood glucose greater than 400. On 02/06/24, the following orders were written: Fingerstick blood glucose Notify MD [physician] if blood sugar greater than 400; if blood glucose is below 70 initiate hypoglycemic protocol, at bedtime for diabetes mellitus. Review of Resident #79's Medication Administration Record (MAR) for February and March showed check marks and initials on the MAR to indicate the Fingerstick blood glucose had been done. However, the blood glucose result was not documented on the MAR. Resident #79 also continued to receive Fingerstick blood glucose testing before each meal. These were documented on the MAR. Further review of Resident #79's medical records showed a blood sugar summary. Bedtime blood sugar results had been documented on 02/17/24, 03/15/24, and 03/17/24. No other bedtime blood sugar results had been recorded since the order was written on 02/06/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/24 at 2:04 PM, the Director of Nursing (DON) confirmed Resident #79's bedtime Fingerstick blood glucose was not documented consistently. He stated he would look for documentation that the physician was notified when the resident's blood glucose was over 400 on 02/01/24. No further information was provided through the completion of the survey. Resident #79 - blood pressure Review of Resident #79's physicians' orders showed an order written on 12/13/23 for midodrine 5 milligrams (mg) two (2) tablets by mouth every eight (8) hours as needed for hypotension for systolic blood pressure below 120, notify physician if below 90. Midodrine is a medication that treats low blood pressure. Systolic blood pressure is the bottom number. This order was rewritten on 03/08/24. Resident #79's Medication Administration Records (MARs) were reviewed for February and March 2024. On 02/24/24 at 10:14 AM, Resident #79 received midodrine for blood pressure of 84/57. There was no indication the physician was notified of the resident's systolic blood pressure below 90. The MAR showed the medication was effective. The only repeat blood pressure was recorded at 02/28/24 at 10:17, and was 84/57. The next blood pressure was recorded on 02/29/24 at 10:40 AM, and was 148/55. This was the only time midodrine was administered according to the MARs. Review of the resident's blood pressure summary showed the resident's systolic blood pressure was below 120 on the following dates and the following times: - On 02/12/24 at 10:16 AM, the resident's blood pressure was 100/60. - On 02/24/24 at 10:46 AM, the resident's blood pressure was 105/72. - On 03/12/24 at 2:51 PM, the resident's blood pressure was 109/61. - On 03/18/24 at 1:41 PM, the resident's blood pressure was 111/79. - On 03/19/24 at 12:02 PM, the resident's blood pressure was 113/72. According to the resident's MARs, midodrine had not been administered for systolic blood pressure below 120 on these occasions. On 03/19/24 at 2:05 PM, the Director of Nursing (DON) confirmed Resident #79 had not been administered midodrine as ordered by the physician for blood pressure less than 120. He stated he would look for documentation that the physician had been notified when Resident #79's blood pressure was less than 90 on 02/28/24. The DON also stated he would look for blood pressure documentation on 02/28/24 that would indicate midodrine effectively raised the resident's blood pressure. No further information was provided through the completion of the survey. f) Resident #23 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/18/24 at 3:00 PM, Resident #23 stated she had a Permacath for dialysis treatments in her right upper chest. A Permacath is a tunneled catheter which has two (2) lumens, or tubes, on the outside of the body. Review of Resident #23's physicians' orders showed an order written on 07/13/23 to Check smooth clamps at the bedside and on patient wheelchair every shift for external hemodialysis device. If the external lumens become damaged, a smooth clamp can be used on the damaged lumen to prevent bleeding from the tube. Review of Resident #23's Treatment Administration Record (TAR) for March 2024 showed nurses had indicated the smooth clamps were present. During an observation on 03/19/24 at 03:55 PM, no smooth clamps were observed at the resident's bedside. On 03/19/24 at 4:02 PM, Registered Nurse (RN) #42 entered the room with the surveyor. She confirmed no smooth clamps were located at Resident #23's bedside. RN #42 also looked in the resident's wardrobe and dresser drawers but could not locate smooth clamps. She stated she would obtain smooth clamps for the resident's bedside. No further information was provided through the completion of the survey. Resident #23 stated she had an arteriovenous fistula in her left arm for dialysis treatments, although the fistula was not being used at that time. An arteriovenous fistula is a connection between an artery and vein beneath the skin. Review of Resident #23's physicians' orders showed the following orders: - Do not take blood pressure in right arm, ordered on 07/13/23 - Do not take blood pressure or blood draws in left arm, ordered on 09/19/23 Review of Resident #23's Medication Administration Record (MAR) for March 2024 showed nurses had initialed the MAR to indicate blood pressures were not being obtained in the right arm or the left arm. Review of Resident #23's vital signs for March 2023 showed the right arm was usually used to obtain blood pressure measurements, but the left arm had been used on 03/13/24 and 03/01/24. During an interview, on 03/19/24 at 4:26 PM, the Director of Nursing (DON) confirmed the conflicting orders not to use the right arm or left arm for blood pressures were not clarified. He stated he would ask the dialysis unit staff which arm to use. A nursing note written on 03/20/24 at 3:52 PM stated the dialysis center instructed the facility to use the right arm to obtain Resident #23's blood pressure. No further information was provided through the completion of the survey. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	42120 49465

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39043 Based on observation, resident interviews and staff interviews, the facility failed to ensure the residents environment remained free of accident hazards and that each resident received adequate supervision. Resident #29's landline telephone was sitting directly above the residents head on the edge of the over the bed light fixture. Resident #15 was observed taking medication out of a medicine cup without a nurse present. This was random opportunities for discovery and had the potential to affect a limited number of residents. Resident identifiers: #29 and #15. Facility Census: 150. Findings included: a) Resident #29 On 03/18/24 at 11:15 AM during an interview with Resident #29, the facility room telephone designated for her was sitting directly above her head on the corner edge of the over the bed light fixture. The resident stated she did not know why it was there. During an interview with Licensed Practical Nurse (LPN) #163 at approximately 11:20 AM on 03/18/24 LPN #163 stated she did not know who put the telephone there and stated it was dangerous to be there. b) Resident #15 The facility's policy titled General Dose Preparation and Medication Administration with effective date 12/07/07 and most recent revision date 01/01/22 stated during medication administration staff should observe the resident's consumption of medications. Upon entering Resident #15's room on 03/18/24 at 12:00 PM, this surveyor observed the resident taking two pills in a medicine cup. No staff member was present in the room. Resident #15 stated the medication nurse had left the pills for her to take. She stated that, when she is awake, the medication nurse sometimes leaves her medication for her to take later. On 03/18/24 at 12:10 PM, Nurse Manager #38 was informed that medications had been left at Resident #15's bedside for the resident to take independently. Nurse Manager #38 agreed the medications should not have been left at the bedside and stated she would address this with the medication nurse immediately. Review of Resident #15's Medication Administration Record (MAR) showed the resident was scheduled to receive the medications Norco, a controlled substance for pain, at 12:00 PM, and midodrine, a medication for low blood pressure, at 1:00 PM. Further review of Resident #15's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 01/16/24 showed the resident had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The resident had a diagnosis of dementia. No further information was provided through the completion of the survey. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49650

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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. 39043 Based on observation, record review, and staff interview, the facility failed to care for residents' catheters in accordance with professional standards of care. The urine collection bag was observed lying on the floor for one (1) of two (2) residents reviewed for the care area of urinary catheter. Resident identifier: #49. Facility census: 150. Findings included: a) Resident #49 The facility's procedure titled Catheter Indwelling Urinary - Care of with effective date 06/01/96 and revision date 02/01/23 stated the drainage bag was to be kept below the level of the patient's bladder and off the floor. During an interview on 03/18/24 at 12:32 PM, Resident #49 stated she had a urostomy. The urine collection bag was noted to be lying on the floor, under the resident's bed. During an observation on 03/19/24 at 12:25 PM, Resident #49's urostomy urine collection bag was still lying on the floor, under the resident's bed. On 03/20/24 at 10:31 AM, Resident #49's urostomy urine collection bag was again observed lying on the floor, under the resident's bed. On 03/20/24 at 10:35 AM, Licensed Practical Nurse (LPN) #163 confirmed Resident #49's urine collection bag was lying on the floor. She stated she would obtain a basin for the urine collection bag so it wouldn't be directly on the floor. No further information was provided through the completion of the survey.

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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, staff interview and policy review the facility failed to store oxygen tanks in a safe manner consistent with professional standards of practice. This failed practice was a random opportunity for discovery. Facility Census 150. a) Facility An observation on 03/19/24 at 1:59 PM, of the facilities courtyard, there was found to be an empty oxygen tank stored in the seat of a wheelchair. During an interview on 03/19/24 at 2:00 PM, with the Corporate Administrator #182, she stated, No, that is not the proper way to store tanks full or empty. A review on 03/20/24 at 9:00 AM, of the facilities policy titled, SH500 Compressed Gases", under process number (3) three, 3.3 reads: {Cylinders must be stored in and approved cabinet, holder, or secured by cylinder brackets or chains. The restraining mechanism must be above the midpoint of the cylinder.}

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49650 Based on record review and staff interview, the facility failed to ensure nurse aides (NAs) completed the competencies and skill sets for the residents needs, safety and in a manner that promotes each residents rights, physical, mental and psychosocial well-being. This was true for three (3) of five (5) staff competency records reviewed during the survey process. This has the potential to affect a limited number of residents residing in the facility. Staff identifiers: #92, #129 and #164. Facility census: 150. a) NA #92 During a review of the Nursing Assistant competencies on 03/26/24 at approximately 4:10 PM the following NA competencies were identified as not completed: * Hand Hygiene * Donning/Doffing PPE * Lift/ Transfer Equipment * Weights/Heights b) NA #129 During a review of the Certified Nursing Assistant competencies on 3/26/24 at approximately 04:10 PM the following NA competencies were identified as not completed: * Hand Hygiene * Donning/Doffing PPE * Weights/Heights c) NA #164 During a review of the Certified Nursing Assistant competencies on 03/26/24 at approximately 4:10 PM the following NA competencies were identified as not completed: * Hand Hygiene * Donning/Doffing PPE * Lift/ Transfer Equipment * Weights/Heights (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Corporate Administrator (CA) #182 on 03/26/24 at approximately 4:04 PM in reference to the NA competencies. CA #182 stated she had already provided what competencies they had. She also provided the required skills validation for upon hire and annual list of competencies that were to be completed. These skills included the following required competencies: * Hand Hygiene * Donning/Doffing PPE * Lift/ Transfer Equipment * Weights/Heights * Skills per Matrix/Facility Assessment On 03/26/24 at approximately 4:04 PM CA #182 acknowledged the competencies were not completed. No further information was provided

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 49650 Based on observation and staff interview, the facility failed to ensure the Daily Staffing Posting information was accurate and current and the facility failed to maintain the Daily Staffing Posting data for a minimum of 18 months. This was a random opportunity for discovery and had the potential to affect all residents. Facility Census 150 a) Accurate and Current Data On 03/25/24 at 11:00 AM, during a review of the facility daily time detail by department for Nursing- Direct Care and the Daily Nurse Staffing Posting Form, it was identified that on the following follow days the nursing administrative staff hours were calculated in with the Nursing Direct Care hours. * 03/01/24 - Clinical Reimbursement Coordinator (CRC) #144 - CRC #170 - CRC #49 - Registered Nurse Unit Manager Director (RN UMD) #128 - Assistant Director of Nursing (ADON) #26 - RN UMD #38 *03/03/24 - RN UMD #38 *03/15/24 - RN UMD #128 - CRC #144 - CRC #49 - CRC #170 - ADON #26 - RN UMD #38 (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/24 at approximately 11:50 AM during an interview with the Corporate Administrator (CA) #182 in requesting the documentation needed to identify the patient direct care duties performed by the identified staff (ADON #26, CRC 49, CRC #144, CRC #170, RN UMD #38 and RN UMD #128,). CA #182 stated that the CRC hours are permitted because they do the resident assessments. She then asked the Corporate Registered Nurse (CRN) #180 if she was accurate in stating the CRC hours are permitted and CRN stated she was accurate. On 03/25/24 at approximately 12:30 PM during an interview with the Corporate Administrator (CA) #182, The Labor Classification/ Job Title section of the Centers for Medicare & Medicaid Services- Electronic Staffing Data Submission- Payroll-Based Journal- Long-Term Care Facility- Policy Manual Version 2.6 was reviewed with CA #182. This section defines that the Labor Classification/Job Title Reporting shall be based on the employee's primary role and their official categorical title. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out others when needed). Facilities shall still report just the total hours of that employee based on their primary role. CMS recognizes that staff may completely shift primary roles in a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). The Administrator agreed that the facility was using the administrative staffing hours as direct care hours because they do help with others throughout the day. She stated that this is the first time she has seen this information from The Labor Classification/ Job Title section of the Centers for Medicare & Medicaid Services- Electronic Staffing Data Submission- Payroll-Based Journal- Long-Term Care Facility- Policy Manual Version 2.6. No further information was provided. b) Accurate data and current data. On 03/25/24 at approximately 11:50 AM during a review of the daily staffing posting form with CA #182, the number of staff identified were numerically identified in a decimal format for the total staff hours (e.g 13.41 Cert Nrs Aides for 100.92 total staff hours). On 03/25/24 at approximately 11:50 AM with reviewing the GUIDANCE S483.35(g). The facility is required to list the total number of staff and the actual hours worked by the staff to meet this regulatory requirement. The information should reflect staff absences on that shift due to call-outs and illness., with CA #182, she agreed that 13.71 did not reflect the actual total number of staff that worked. c) Maintain the posted Daily Nurse Staffing Posting Forms for a minimum of 18 months. On 03/25/24 at approximately 11:50 AM during a review of the Daily Nurse Staffing Posting Forms and the Nursing Direct Care Absence Pay Codes document for each day, the following staff call-outs were identified for the following days but were not not marked on the Daily Nurse Staffing Posting Forms. * 03/01/23 - Three (3) Certified Nursing Assistants (CNA) and Four (4) Licensed Practical Nurses (LPN) * 03/02/24 - One (1) CNA (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* 03/03/24 - Five (5) CNA and One (1) LPN * 03/15/24 - One (1) CNA and Two (2) LPN * 03/16/24 - One (1) Registered Nurse (RN) and One (1) LPN On 03/25/24 at approximately 12:45 PM during an interview with the CA #182, she stated that she had spoke with the staff responsible for posting the Daily Nurse Staffing Posting Forms and that the staff member didn't know she had to keep the original forms for 18 months and she no longer had them The administrator agreed that Daily Nurse Staffing Posting Forms were o be maintained for a minimum of 18 months.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 49650 Based on resident interview, record review and staff interview the facility failed to assist a resident in obtaining dental care. This was true for one (1) of one (1) residents reviewed for dental care. Resident identifier: #120. Facility Census: 150. Findings included: a) Resident #120 On 03/18/24 at 03:41 PM during an interview with Resident #120, the resident stated he wanted his dentures. He further stated they did an impression for them over three (3) months ago. On 03/20/24 at 11:45 AM during a medical record review, it identified there were no follow up notes in his record for his dental care after he was seen by the dentist on 11/22/23. On 03/20/24 at approximately 11:55 AM during an interview with the Administrator, she stated that the resident was seen in November 2023 for an impression of dentures and she would check to see when the return appointment was. On 03/20/24 at 12:30 PM the Administrator returned and stated that the return appointment never was scheduled because there were issues with getting payment from the insurance company. She further stated that they (the facility) were contacting the dental care provider and the facility will get the follow up appointment scheduled and also cover the expense to have the dental care completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 49465 Based on observation, staff interview, and policy review the facility failed to ensure food was prepared and stored in a safe sanitary manor. Sliced ham was not dated in the walk-in refrigerator and the flat top grill was dirty. This failed practice had the potential to affect more than a limited number of residents. Facility census 150. a) Storage of ham Initial tour of the kitchen on 03/18/24 at 11:32 AM, revealed there was ham stored in the walk in refrigerator in a clear container with no date. During an interview on 03/18/24 at 11:34 AM, the Dietary Manager (DM), confirmed that everything in the walk-in should be dated. A review on the facilities policy on 03/18/24 at 2:00 PM, titled {Refrigerated/Frozen Storage} reads under Process, Number (1) one Refrigeration, Number 1.4 as follows: All foods are labeled with name of product and the date received and 'use by' date once opened. Manufacturer 'use by' dates are used until opened. b) Dirty stove top The initial tour of the kitchen, on 03/18/24 at 11:45 AM, revealed that the flat top stove was covered in black build-up and was dirty, along with the splash guard around the stove top and behind it. During an interview on 03/18/24 at 11:34, the DM stated, Something is going on with it, it burns very hot which makes it very hard to get it clean. A review of the facilities policy on 03/18/24 at 2:00PM, titled {Department Sanitation}, reads under Process, Number (1) one Food and Nutrition Services staff maintain the sanitation of department by ensuring that:, number 1.5 as follows: Equipment is cleaned as soon after use as possible.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 49650 Based on facility documentation and staff interviews, the facility failed to identify the Certified Nursing Assistant (CNA) staff competencies that were necessary to provide the level and types of care needed for the resident population in the Facility Assessment. This had the potential to affect more than a limited number of residents in the facility. Facility census: 150. a) Facility Assessment. On 03/26/24 at approximately 3:15 PM during a review of the Facility Assessment, the NA competencies that were required to be completed based on the level and types of care needed for the resident population in the Facility Assessment could not be identified. In reviewing each category under Section II. Staffing, Training, Services & Personnel sub section A). Function, Mobility, & Physical Disabilities it was identified that the Sufficiency Analysis Categories included but was not limited to the following: Activities of daily living Daily Care (excluding bath) Bed mobility Transfer Walk in Room Toilet Use Eating Bathing Dressing Hygiene/grooming Ambulation With Contractures Physically restrained (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Overall Staffing, the Staff Training/Competencies and the Services all stated they were evaluated for each category. However, no information was provided to identify if there were specific NA competencies required as an outcome of the evaluations. During an interview with the Corporate Administrator (CA) #182 on 03/26/24 at 4:04 PM, regarding the Facility Assessment not identifying the specific NA skills per Technical Skills Matrix/Facility Assessment, CA #182 said she could not speak for the form as she did not complete it. She felt that the evaluated meant that it was evaluated but did not require to be added. She was not able to identify any of the competencies required to be completed for the NA's on the Facility Assessment. She then provided a facility document outlining the required NA skills validation for upon hire and annually. This document states that upon hire and annually the NA's would require to be validated during the orientation period and annually for the following: Hand Hygiene Donning/Doffing PPE Lift/Transfer Equipment Weights/ Heights Skills per Technical Skills Matrix/Facility Assessment On 03/26/24 at 4:07 PM, during the review of this document, CA #182 acknowledged this list also refers to the skills per Technical Skill Matrix/Facility Assessment and again, acknowledged that she was not able to identify any competencies required to be completed for the NA's on the Facility Assessment

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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	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 record review and staff interview, the facility failed to ensure complete and accurate medical records. Physician's Orders for Scope and Treatment (POST) forms were not complete for four (4) of 16 residents reviewed for the care area of advance directives. Meal intakes were not completely recorded for one (1) of (1) residents reviewed for the care area of tube feeding. Resident identifiers: #14, #23, #15, #141. Facility census: 150. Findings included: a) Resident #14 Review of Resident #14's medical records showed the Physician's Orders for Scope and Treatment (POST) form was completed on [DATE], using the form developed in 2021. A POST form indicates the resident's wishes for end-of-life treatment. If the resident is not competent to make medical decisions, the POST form is completed by the resident's representative. The form indicated verbal consent was obtained from Resident #14's representative for cardiopulmonary resuscitation (CPR), full treatments, and tube feeding if needed. The form was signed by the resident's physician. It was unclear if the representative's consent was obtained by the physician. Additionally, no one witnessed the verbal consent. The 2021 POST form guidance titled, Using the POST Form: Guidance for Health Care Professionals, 2021 edition, available on-line, stated, If the incapacitated patient's MPOA [medical power of attorney] representative or health care surrogate is unavailable at the time of form completion, this section can be signed by two witnesses for verbal confirmation of agreement from the patient's MPOA representative or health care surrogate. On [DATE] at 2:44 PM, the Corporate Administrator confirmed the verbal consent on Resident #14's POST form did not have two (2) witness signatures. She stated the facility had identified issues with POST forms and had an improvement plan to correct the issues. No further information was provided through the completion of the survey. b) Resident #23 Review of Resident #14's medical records showed the Physician's Orders for Scope and Treatment (POST) form was completed on [DATE], using the form developed in 2021. The form indicated verbal consent was obtained from Resident #14's representative for no cardiopulmonary resuscitation (CPR), selective treatments, and no artificial means of nutrition. The form was signed by the resident's physician. It was unclear if the representatives consent was obtained by the physician. Additionally, no one witnessed the verbal consent. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2021 POST form guidance titled, Using the POST Form: Guidance for Health Care Professionals, 2021 edition, available on-line, stated, If the incapacitated patient's MPOA [medical power of attorney] representative or health care surrogate is unavailable at the time of form completion, this section can be signed by two witnesses for verbal confirmation of agreement from the patient's MPOA representative or health care surrogate. On [DATE] at 2:44 PM, the Corporate Administrator confirmed the verbal consent on Resident #23's POST form did not have two (2) witness signatures. She stated the facility had identified issues with POST forms and had an improvement plan to correct the issues. No further information was provided through the completion of the survey. c1) Resident #15 - POST form Review of Resident #15's medical records showed the Physician's Orders for Scope and Treatment (POST) form was completed on [DATE], using the form developed in 2020. The form indicated verbal consent was obtained from Resident #15's representative for cardiopulmonary resuscitation (CPR), full treatments, intravenous fluids for 30 days, and feeding tube long-term. However, the form was never signed by the resident's representative. During a telephone interview with Resident #15's representative on [DATE] at 4:00 PM, the representative stated she visited Resident #15 frequently. The guidance for the 2020 POST form, available online, stated, The patient or representative/surrogate and physician/APRN/PA must sign the form in this section. These signatures are mandatory. A form lacking this signature is NOT valid. On [DATE] at 2:44 PM, the Corporate Administrator confirmed Resident #15's POST form was not signed by the resident's representative. She stated the facility had identified issues with POST forms and had an improvement plan to correct the issues. c2) Resident #15 - meal intake Review of Resident #15's medical records showed an order for tube feeding, Jevity 1.5, 82 milliliters (ml) an hour, to infuse from 8:00 PM to 8:00 AM. The resident's Medication Administration Record (MAR) showed the resident had been refusing the tube feeding since [DATE]. The resident also received meal trays with a regular diet, dysphagia advanced texture since [DATE]. Review of Resident #15's meal intake percentages showed the resident's intake of the evening meal had not been documented on [DATE], [DATE], and [DATE]. d) Resident #141 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515060	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Center	101-13th Street Huntington, WV 25701

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 02:42 PM during a medical record review for Resident # 141 the [NAME] Virginia Physician Orders for Life Sustaining Treatment (Post) form, it is identified that a verbal signature was obtained of the residents MPOA. It does not identify the required two (2) witness signatures for the verbal obtained signature. The date that the MPOA verbal signature was obtained was also not documented on the form. On [DATE] at approximately 02:44 PM, during an interview with the Corporate Administrator (CA) #182 and the facility Administrator, CA #182 acknowledged that it does not identify the required two (2) witness signatures for the verbal obtained signature. She also acknowledged the verbal signature from the MPOA had not been dated as required. On [DATE] at 1:00 PM, Corporate Registered Nurse confirmed Resident #15's evening meal intake had not been recorded on [DATE], [DATE], and [DATE]. No further information was provided through the completion of the survey. 49650

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 42120 Based on observation, record review, and staff interview the facility failed to establish and maintain an infection prevention program to help prevent the development and transmission of communicable diseases and infections. The facility failed to provide appropriate infection surveillance. This failed practice had the potential to affect every resident currently residing in the facility. Facility Census: 150. Findings Included: a) Infection Surveillance Record review of the facility's Infection control practices found the facility was unable to provide the required infection surveillance documentation of communicable illnesses. During an interview on 03/26/24 at 1:25 PM, Director of Nursing (DON) and Assistant Director of Nursing (ADON) stated they were unable to locate the documentation of the infection control surveillance. She stated that the facility was trying to get ahold of the Infection Control Preventionist that was no longer employed with the facility. No other information was provided prior to the end of the survey on 03/26/24 at 5:30 PM.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 42120 Based on record review and interview the facility failed to implement its protocol for antibiotic use and failed to monitor actual antibiotic use reviewed for antibiotic stewardship. This has the potential to affect all residents in the facility. Facility Census: 150. Findings included: a) Antibiotic Stewardship Record review of the facility's documentation of Infection control practices found the facility was unable to provide the required Infection surveillance and antibiotic stewardship documentation. During an interview, on 03/26/24 at 1:25 PM, Director of Nursing (DON) and Assistant Director of Nursing (ADON) stated they were unable to locate the documentation of the infection control surveillance or antibiotic stewardship. She stated that the facility was trying to get ahold of the Infection Control Preventionist that was no longer employed with the facility to find out where to find all the documentation. No other information was provided prior to the end of the survey on 03/26/24 at 5:30 PM.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 42120 Based on facility documentation and staff interview the facility failed to have a designated certified Infection Preventionist (IP). This failed practice had the potential to affect all residents residing at the facility. Facility Census: 150. Findings Included: Record review of the facility's documentation of Infection control practices found the facility was unable to provide the required Infection surveillance and antibiotic stewardship documentation. During a facility record review found a certificate for Nursing Home Infection Preventionist with the Assistant Director of Nursing (ADON). During an interview on 03/26/24 at 11:43 the Corporate Administrator stated that the facility has not dedicated an IP, since the previous IP quit. She stated that the ADON and Director of Nursing (DON) has been working on Infection control. During an interview on 03/26/24 at 1:25 PM, Director of Nursing (DON) and Assistant Director of Nursing (ADON) stated that the previous IP quit in October or November 2023. The ADON stated that she took the course after the previous IP left. During the interview the ADON stated that she still works as the third-floor unit manager, ADON and tries to work on infection control. The DON and ADON verified there were no IP dedicated to the role of infection control.

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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. 42120 Based on observation, and staff interview the facility failed to maintain all of the call system functioning. This failed practice had the potential to affect every resident currently residing in the facility. Facility Census: 150. Findings included: During observation tour on 03/19/24 at 11:04 AM 2nd floor, found the call light system turned down at the nurse's station to a volume too low to be heard throughout the unit. During an interview on 03/19/24 at 11:08 AM, Nurse Aide #119 verified he was unable to hear an audible sound from the call system in his section, he stated he just has to look for the light above the resident's doors. During an interview on 03/19/24 at 11:10 AM, the Maintenance Director confirmed that the call system was visual and audible. He stated that all the call systems in the building are turned down because that is how the staff like them. During observation tour on 03/26/24 at 9:24 AM on the transitional care unit, found the call light system turned down at the nurse's station to a volume too low to be heard. During an interview on 03/26/24 at 9:28 AM, the Maintenance Helper #41 confirmed that the call system was visual and audible and had been turned down again.