STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515063	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cortland Acres Nursing Home	39 Cortland Acres Lane Thomas, WV 26292

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 51553 Based on observation and record review, the facility failed to ensure a dignified exsistance took place during dining. The staaff did not ask the residents in the dining room if they wanted to wear clothing protectors. The staff served Resident #23 and #68 meals in large vegetable serving bowls. Residents were not served meals together when they were sitting together at the same table. This failure was a random opportunity for discovery and had the potential to affect more than a limited number of resdients. Resident identifiers: #23 and #68. Facility Census: 91. Findings included: a) On 03/03/25 at 11:55 AM during the Dining Observation, the residents were not asked if they would like to wear a clothing protector. The clothing protectors were placed on the residents in the main dining room by nursing staff. b) On 03/03/25 at 12:10 PM, Resident #23 was served his lunch meal in a large vegetable serving bowl. No adaptive equipment for a bowl/plate was documented on the resident's tray card or found in the resident's orders. c) On 03/03/25 at 12:15 PM, Resident #68 was served his lunch in a large vegetable serving bowl. No adaptive equipment for a bowl/plate was documented on the resident's tray card or found in the resident's orders. Nursing Assistant #4 stated it was, easier for him to eat out of. d) According to the facility's policy titled, Policy and Procedure Manual for The Dining Experience: Staff Responsibilities, Individuals at the same table will be served and assisted at the same time. On 03/03/25, Resident #68 was not served a tray with his table mate until surveyor intervention after five minutes.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43676 Based on observation and staff interview, the facility failed to provide a clean and home like environment for all residents in the facility. Facility census 91. Findings included: a) On 03/04/25 at approximately 9:30 a.m., observed a stained ceiling located in the main hallway near the main entrance. b) On 03/04/25 at approximately 9:41 a.m., observed a stained ceiling located in the C Hall soiled utility room. c) On 03/04/25 at approximately 9:54 a.m., observed a stained ceiling located in the main hallway near the main entrance. e) Interview with the facility's staff at the time of discovery verified these findings. These findings were acknowledged by the Interiem Administrator upon the exit interview on 03/12/25 at approximately 2:45 p.m. 52481

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171 Based on record review and staff interviews, the facility failed to develop and implement a person-centered comprehensive care plan to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. This was an issue for one (1) of 32 residents whose care plans were reviewed. Resident Identifiers: #52, #293, #74, #43, #60, #64, #16. Facility Census: #91 Findings Include: a) Resident #52 On 03/03/25 at 11: 50 AM observation was made of Resident #52 on a power wheelchair. Throughout the two-week survey he has been observed numerous times on the power wheelchair. On 03/10/25 at 10:45 AM a review of Resident #52's care plan found the following Focus areas were not resident centered. Activities: Focus states the resident prefers to participate in activities such as (left blank) Interventions: interview resident and family as needed to determine the resident's prior level of activity involvement and interest. Provide activities calendar, assist resident to activities functions as needed. Risk for falls: FOCUS states the resident is at risk for falls related to (left blank) Interventions: bed locked and in lowered position, beside table within reach, encourage the resident to wear their glasses when out of bed, lab or diagnostics per physician, placed common items within reach of the resident, refer to therapy for screening, remind the resident to use their call light to ask for assistance with ADLS. Resident #52 is required a best care stander for transfers to and from his power wheelchair. There are no interventions relating to these items. The resident was admitted on [DATE]. The care plan should have been updated to be resident centered. An interview with the Director of Nursing (DON) on 03/11/25 at 4:08 PM confirmed Resident #52's care plan should have been updated. b) Resident #293 On 03/03/25 at 1:30 PM the record review showed Resident #293 had a medical diagnosis of Post Traumatic Stress Disorder (PTSD) and was on Venlafaxine HCL 225 mg (milligram) one time a day for PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/10/25 at 10:50 AM review of Resident #293's care plan found the following Focus areas were not resident centered. Risk for falls: Focus states the resident is at risk for falls related to: . (left blank) Interventions: are generic and not resident centered. Footwear to prevent slipping, gripper socks, therapy for screening, use their call light for assistance, bedside table within reach. Activities: FOCUS The resident prefers to participate in activities such as . (left blank) Interventions: Interview the resident and family as needed to determine the resident's prior level of activity involvement and interest. Provide activities calendar, assist resident to activities functions as needed. History of trauma: Focus the resident reported trauma during their trauma screening related to a history of military combat, PTSD. Interventions: Attempt to determine any triggers that the resident may have related to their past trauma and work with staff to avoid those when possible, trauma screen as indicated. HOSPICE Resident is admitted to hospice services with expected decline in condition due to terminal progressive disease related to protein calorie malnutrition. There are no specific interventions relating to hospice visits, assessments, care, etc. It is not resident centered, only states see hospice POC. The resident was admitted on [DATE]. He is on medication for PTSD, which is not addressed on the care plan, triggers have not been identified. The care plan should have been updated to be resident centered. An interview with the DON on 03/11/25 at 4:08 PM confirmed Resident #293's care plan needed to be updated. c) Resident #74 On 03/04/25 at 1:35 PM record review of Resident #74s care plan found the following areas were not resident centered. Risk for falls: Focus the resident is at risk for falls related to: (left blank) Interventions: lab or diagnostics per physician, refer to therapy for screening Nutritional status: Focus: The resident is at risk for weight loss, malnutrition or poor hydration status related to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, PI injury to left heel, PI stage 2, a-fib, anemia, hypokalemia, gastrointestinal hemorrhage, and GERD w/o esophagitis. Intervention: two cal supplement 90 ml BID (Resident has an additional order for Two Cal two times a day for supplement 90 ml which is missing under this focus) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activities: Focus the resident prefers to participate in activities that are individual or with 1-1 other. Interventions, interview the resident and family as needed to determine the resident's prior level of activity involvement and interest, Assist resident to activities as needed and provide 1-1 visits utilizing cats and reading, and pet therapy dogs. Assist to spend time outdoors. Risk for pain: Focus the resident has a risk for pain or pain related to chronic conditions. Interventions, administer pain medication as ordered, administer pain interview as indicated, attempt nonpharmacological interventions for pain such as repositioning, comfort therapy or passive ROM as tolerated, pain assessment as needed. (no mention of pain due to wound vac dressing changes) Enteral Feeding: Focus the resident is at risk for complications related to the need for an enteral tube feeding. Interventions: Osmolite 1.5 cal 237 ml after each meal with speficics listed, however resident was also on Two cal 90 ml twice a day which is not listed on this focus of the care plan. Feeding is according to the amount of her meals she eats and this was also not care planned. Skin impairment Focus: the resident has a skin impairment of pressure ulcer to coccyx. Interventions are not resident specific as they do not mention the wound vacuum nor the specifics related to that, no intervention to PICC IV, PEG tube, turn and reposition schedule, Resident #74 has an order for: Adaptive Equipment: Dayshift: [NAME] at beginning of shift and doff at end of shift. Edema glove on RUE and Resting hand splints on both hand with skin integrity check. Store splints and edema glove on in top drawer of dresser. No care plan in place for these pieces of equipment. An interview with the DON on 03/11/25 at 4:08 PM confirmed Resident #74's care plan needed to be updated. d) Resident #43 On 03/03/25 at 12:35 PM observation found Resident #43 to have apraxia causing him to be unable to verbally communicate. He can understand questions and shakes his head yes or no. He has a white dry erase board on his nightstand. On 03/10/25 at 10:25 AM review of Resident #43's care plan found the following Focus areas were not resident centered. Activities: Focus states the resident prefers to participate in activities such as individual and with one other person. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions: are generic and not resident centered. Assist resident to activities functions as needed providing direction to the location, interview the resident and family as needed to determine the resident's prior level of activity involvement and interest, Provide activities calendar and check to see about puzzle needs. Communication: the resident has risk for complications related to impairment of communication due to a history of cerebrovascular disease (CVA) the resident is rarely to never understood. Interventions: anticipate needs as able, ask the resident yes no questions, observe resident for nonverbal clues that may indicate a care need as able. The resident was admitted on [DATE]. There were no interventions specific for his whiteboard for communicating. The care plan should have been updated to be resident centered. An interview with the DON on 03/11/25 at 4:08 PM confirmed Resident #43's care plan needed to be updated. E) Resident #60 Activities Based upon record review and staff interview, the facility failed to complete a Care Plan personalized for Resident #60's preferred activities. The Care plan stated, ACTIVITIES: the resident prefers to participate in activities such as The sentence in the Care Plan was incomplete. The care plan is not personalized with any resident preferences, or examples. On 03/11/25 at 1:47 PM, an interview with the Director of Nursing (DON) was held, and the Care Plan for Resident #60 was reviewed. When asked about personal preferences for activities for Resident #60, DON responded, Yes, we seem to have a problem with these. (These, referring to Care Plans.) f) Resident #64 A review of Resident #64's comprehensive care plan found the care plan to be void of person-centered activities. On 03/11/25 at 8:40 AM the Interim Assistant Director of Nursing (IADON) confirmed there were no activities care planned for Resident #64. She stated, I'll let her know. G) Resident #85 A review of Resident #85's comprehensive care plan found the care plan to be void of person-centered activities. On 03/11/25 at 8:40 AM the IADON confirmed there were no activities were care planned for Resident #85. She stated, I'll let her know. h) Resident #342 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #342's comprehensive care plan found the care plan to be void of person-centered activities. On 03/11/25 at 8:40 AM the Interim Assistant Director of Nursing (IADON) confirmed there were no activities care planned for Resident #342. She stated, I'll let her know. i) Resident #16 Review of Resident #16's diagnoses list showed the resident had diagnoses of depression and anxiety disorder. Review of Resident #16's physician's orders showed the resident had an order for the following medications: buspirone for anxiety disorder, trazodone for depression, and duloxetine for depression. Resident #16 also had the following physician's orders: - Anti-Depressant - Monitor behavior of: (1) Sadness; (2) Tearfulness; (3) Withdrawn. Non-Pharmacological Intervention Codes: (1) Encourage Activities; (2) 1:1; (3) Encourage to verbalize feelings; (4) other-chart in progress notes. Document A) Behavior Code; B) Non-Pharmacological Intervention Code; C) Non-Pharmacological Outcome Code. - Anti-Anxiety - Monitor behavior of: (1) Restless; (2) Agitated; (3) uncontrollable feeling of worry. Non-Pharmacological Intervention Codes: (1) redirect; (2) 1:1; (3) activities; (4) toilet; (5) give food or fluids; (6) reposition; (7) back rub; (8) other-chart in progress notes. - Monitor for side effects of Anti-Depressant medication: sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity(skin), excess weight gain If side effects observed, enter a progress note, every shift. - Monitor side effects of antianxiety medication: sedation, drowsiness, ataxia (drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision, and skin rash. If side effect observed, enter a progress note, behaviors and side-effects monitored every shift. Resident #16's comprehensive care plan had the following focus initiated on 02/18/25, Psychoactive medications: the resident is at risk for complications related to psychoactive (antidepressant, anxiolytic) medications use secondary to diagnoses of: anxiety disorder, depressive disorder. The goal was, The resident will not have adverse reactions to psychoactive medication thru [sic] review period. The interventions were as follows: - Administer medications as ordered - Monitor for behaviors related to medication use - Observe for signs and symptoms of adverse side effects related to medication use and notify MD as indicated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/11/25 at 8:40 AM, Assistant Director of Nursing #165 confirmed Resident #16's comprehensive care plan did not contain information regarding the resident's specific signs and symptoms of anxiety and depression nor specific non-pharmacological interventions effective for managing the resident's symptoms. No further information was provided through the completion of the survey. 39043 e) Resident #60 Activities Based upon record review and staff interview, the facility failed to complete a Care Plan personalized for Resident #60's preferred activities. The Care plan stated, ACTIVITIES: the resident prefers to participate in activities such as The sentence in the Care Plan was incomplete. The care plan is not personalized with any resident preferences, or examples. On 03/11/25 at 1:47 PM, an interview with the Director of Nursing (DON) was held, and the Care Plan for Resident #60 was reviewed. When asked about personal preferences for activities for Resident #60, DON responded, Yes, we seem to have a problem with these. (These, referring to Care Plans.) f) Resident #64 A review of Resident #64's comprehensive care plan found the care plan to be void of person-centered activities. On 03/11/25 at 8:40 AM the Interim Assistant Director of Nursing (IADON) confirmed there were no activities care planned for Resident #64. She stated, I'll let her know. G) Resident #85 A review of Resident #85's comprehensive care plan found the care plan to be void of person-centered activities. On 03/11/25 at 8:40 AM the IADON confirmed there were no activities were care planned for Resident #85. She stated, I'll let her know. h) Resident #342 A review of Resident #342's comprehensive care plan found the care plan to be void of person-centered activities. On 03/11/25 at 8:40 AM the Interim Assistant Director of Nursing (IADON) confirmed there were no activities care planned for Resident #342. She stated, I'll let her know. 51553 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i) Resident #16 Review of Resident #16's diagnoses list showed the resident had diagnoses of depression and anxiety disorder. Review of Resident #16's physician's orders showed the resident had an order for the following medications: buspirone for anxiety disorder, trazodone for depression, and duloxetine for depression. Resident #16 also had the following physician's orders: - Anti-Depressant - Monitor behavior of: (1) Sadness; (2) Tearfulness; (3) Withdrawn. Non-Pharmacological Intervention Codes: (1) Encourage Activities; (2) 1:1; (3) Encourage to verbalize feelings; (4) other-chart in progress notes. Document A) Behavior Code; B) Non-Pharmacological Intervention Code; C) Non-Pharmacological Outcome Code. - Anti-Anxiety - Monitor behavior of: (1) Restless; (2) Agitated; (3) uncontrollable feeling of worry. Non-Pharmacological Intervention Codes: (1) redirect; (2) 1:1; (3) activities; (4) toilet; (5) give food or fluids; (6) reposition; (7) back rub; (8) other-chart in progress notes. - Monitor for side effects of Anti-Depressant medication: sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photosensitivity(skin), excess weight gain If side effects observed, enter a progress note, every shift. - Monitor side effects of antianxiety medication: sedation, drowsiness, ataxia (drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision, and skin rash. If side effect observed, enter a progress note, behaviors and side-effects monitored every shift. Resident #16's comprehensive care plan had the following focus initiated on 02/18/25, Psychoactive medications: the resident is at risk for complications related to psychoactive (antidepressant, anxiolytic) medications use secondary to diagnoses of: anxiety disorder, depressive disorder. The goal was, The resident will not have adverse reactions to psychoactive medication thru [sic] review period. The interventions were as follows: - Administer medications as ordered - Monitor for behaviors related to medication use - Observe for signs and symptoms of adverse side effects related to medication use and notify MD as indicated On 03/11/25 at 8:40 AM, Assistant Director of Nursing #165 confirmed Resident #16's comprehensive care plan did not contain information regarding the resident's specific signs and symptoms of anxiety and depression nor specific non-pharmacological interventions effective for managing the resident's symptoms. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided through the completion of the survey. 51554

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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. 45171 Based on record review and staff interview the facility failed to revise the resident's person-centered, comprehensive care plan, and ensure that the transfer status was care planned correctly. This was an issue for one (1) of 32 residents whose care plan was reviewed. Resident Identifier: #52 Facility Census: #91 Findings include: a) Resident #57 On 03/11/25 02:30 PM record review shows that Resident #52 was care planned for a Hoyer lift for all transfers X 2 staff. The Activities of Daily Living Task report shows he was best care stander for transfers. The Resident had been observed in a power wheelchair throughout the survey. On 03/11/25 at 02:45 PM during an interview with Resident #52 (BIMS 15) he stated, They use a people mover with one staff member, gets me up in the morning and back in bed at bedtime. On 03/11/25 at 02:50 PM during an interview with the Assistant Director of Nursing (ADON) #165, the ADON stated the facility called it a best care stander and confirmed that it was the same thing as a people mover. The ADON said the resident did not require a Hoyer lift. She also confirmed the care plan was incorrect.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 39043 Based on resident interview, record review, and staff interview, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This was true for six (6) of 10 residents reviewed for the care area of activities of daily living. Resident identifiers: #12, #45, #16, #58, #40, and #47. Facility census: 91. Findings included: a) Resident #12 During an interview, on 03/03/25 at 3:18 PM, Resident #12 stated, I don't get showers like I am supposed to. They are too short-staffed. Review of the shower schedule showed the resident was scheduled to receive showers on Tuesdays and Fridays. Review of Resident #12's bathing/showering task reports for 30 days, from 02/11/25 to 03/11/25 showed the resident had received tub baths on 02/25/25, 02/28/25, 03/03/25, 03/04/25, 03/05/25, 03/07/25, and 03/11/25. No bathing activities were documented from 02/11/25-02/24/25. The above findings were confirmed by the Director of Nursing on 03/12/25 at 12:07 PM. b) Resident #45 During an interview on 03/03/25 at 12:32 PM, Resident #45 stated she does not get showers twice a week as scheduled. She stated she would like to have a shower at least once a week but she had gone over a week without having a shower before. Review of the shower schedule showed the resident was scheduled to receive showers on Wednesdays and Saturdays. Review of Resident #45's bathing/showering task reports for 30 days, from 02/04/25 to 03/03/25 showed the resident had received a shower on 02/06/25 and a tub bath on 03/01/25. No other bathing activities were documented during this time period. Resident #45's care plan showed the resident required assistance with her activities of daily living related to advanced age. On 03/05/25 at 3:24 PM, the Director of Nursing (DON) confirmed Resident #45's bathing/showering task reports showed one (1) shower and one (1) tub bath for 30 days. On 03/05/25 at 4:09 PM, the DON stated she had spoken to the Nursing Assistant who stated the resident had received more showers than documented and the resident also refused showers at times. The DON acknowledged this was not documented. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c) Resident #16 On 03/03/25 at 12:50 PM, Resident #16 stated she only got one (1) shower a week because, they're too short-staffed. She stated she would like more frequent showers. Review of the shower schedule showed the resident was scheduled to receive showers on Mondays and Thursdays. Review of Resident #16's bathing/showering task reports for 30 days, from 02/04/25 to 03/03/25 showed the resident had received bathing activities on 02/06/25, 02/08/25, 02/25/25, 02/27/25, 02/28/25, 03/01/25, 03/03/25, and 03/04/25. The report did not specify whether showers, tub baths, or bed baths were given, only how much assistance the resident required. On Thursday 02/06/25, Monday 02/10/25, Thursday 02/13/25, Monday 02/17/25, and Monday 02/24/25, not applicable was marked for bathing activities. On Thursday 02/20/25, there was no documentation of bathing activities for the day. Resident #45's care plan showed the resident required assistance with her activities of daily living related to advanced age. On 03/05/25 at 3:37 PM, the Director of Nursing confirmed bathing activities had not been documented twice weekly for Resident #16. She also confirmed the specific bathing activity had not been documented. She stated this was an error in how the task had been set up in the electronic health record and is being corrected. 45171 d) Resident #47 Based upon record review and staff interview, the facility failed to provide showers or baths on a routine basis for Resident #47. A review of the Care Plan for Resident #47 stated, PERSONAL HYGIENE/DENTAL: the resident requires assistance with their dental care and personal hygiene, and Maintenance: requires assistance with their ADL's related to advanced age and chronic health conditions. the resident's personal hygiene needs will be met thru the review period observe resident for complaints of oral pain, discomfort or difficulty with chewing diet and refer to therapy as needed [LPN,RN] provide dependent assistance for personal hygiene and grooming [CNA,LPN,RN] provide oral care for the resident as they are not able to perform it for themselves [CNA,LPN,RN,RT] (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the ADL (Assisted Daily Living) tasks for bathing/showering for last 30 days, the findings were: No showering/bathing reported for: 02/15/25 02/16/25 02/17/25 02/18/25 02/19/25 02/20/25 02/21/25 02/22/25 02/23/25 02/24/25 02/25/25 02/27/25 02/28/25 03/01/25 03/02/25 03/03/25 In summary, the Longest stretch between showers/bath was1 (eleven) days straight. On 03/11/25 at 11:54 AM, an interview was conducted with Director of Nursing (DON) and RN #168. When asked about the period of time between 02/15/25 and 02/25/25, where no showers or baths were documented for Resident #47, their response was,Tis was during the time that we were training the staff on Point of Care system and they did not know how to document in the new system. We may have a paper copy of showering schedule. We will look. At the time of exit, no additional documentation was provided to verify the resident was bathed during the above listed dates. On 03/11/25 at 1:48 PM, on A hallway nursing assistants were interviewed regarding showers not being given twice weekly as scheduled. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A confidential Interview with two (2) Nursing Assistants (NAs) #30 and #50 03/11/25 1:55 PM revealed They stated they are unable to give residents twice weekly showers because they do not have enough staff. They stated that between serving lunch and dinner and getting residents up for therapy, they do not have enough time to perform residents' showers. They stated it is difficult enough when there are two (2) NAs scheduled for the hallway but sometimes there is only one scheduled for the hallway. e) Resident #58 On 03/03/25 at 01:33 PM Resident #58 voiced her concerns on not getting her showers as scheduled. On 03/04/25 at 11:34 AM record review showed she was scheduled for a shower on Monday and Thursday day shift and as needed. The care plan stated .required assistance with their activities of daily living (ADL) related to advanced age, one assist. Record review of showers received for the last thirty (30) days showed Resident #58 had received two (2) baths out of nine (9) that were scheduled. Showers due: Showers received: 02/03/25 02/27/25 (bath) 02/06/25 03/03/25 (bath) 02/10/25 02/13/25 02/17/25 02/20/25 02/24/25 02/27/25 03/03/25 On 03/04/25 at 12:10 PM it was confirmed with the Director of Nursing that Resident #58 had not received her showers as scheduled. 51553 f) Resident #40 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the initial interview process, Resident #40 stated, I need a shave. A follow-up observation by the state surveyor on 03/10/25 at 2:20 PM was completed. Resident #40 reported she had not been shaved. The resident stated, Does it look like it? Licensed Practical Nurse (LPN) #88 confirmed Resident #40 still had facial hair and had not been shaved. LPN #88 reported she would make sure the resident's facial hair was removed. 51554

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30153 Based on closed record review, policy review, review of facility investigation and staff interview, the facility failed to ensure Resident #89 received Cardiopulmonary resuscitation (CPR) as resident requested and physician ordered when found pulseless, not breathing and skin pale and warm to the touch. The State Agency (SA) found this failure rose to the level of an Immediate Jeopardy This failed practice was true for Resident #89 but had the potential to affect 32 residents who requested CPR and had a physician order for CPR. Resident identifier: #89. Facility Census: 91. Findings included: a) Resident #89 Resident #89 was admitted on [DATE] with diagnoses of Diabetes, dementia, seizure disorder, coronary artery disease and high blood pressure. The Brief Interview for Mental Status (BIMS) was 99 which means the resident could not answer any questions and had severe cognitive impairment. A physician order was written on [DATE] at 10:44 AM CODE STATUS: Full Code. Record review revealed that on [DATE] at 5:56 AM a Nurse Aide called the Licensed Practical Nurse (LPN) #135 to Resident #89's room. LPN #135 observed Resident #89 with absence of a heart rate and respirations, skin pale and warm to touch and was confirmed by the Registered Nurse (RN) #55 on duty. Postmortem care was performed by Nurse Aides. Medical Power of Attorney (MPOA) and Nurse Practitioner were notified. Time of death was at 5:43 AM on [DATE]. A review of the investigative statement by RN #55 for the question, When resident was found to be deceased , did we check code status? RN #55 stated that she was asked to check and confirm death. Went to check on resident she was not breathing, tongue gray/blue, pupils fixed and dilated, no respirations, no carotid pulse times 60 seconds, no sign of life. When I went to pull up the face sheet, I saw that she was a full code, it was 12 minutes later, too long. An additional telephone interview was conducted on [DATE] at approximately 5:00 PM. RN #55 stated that to check a resident's code status she had to go to the nurses' station to retrieve the face sheet. An additional nurse's note was provided by the Corporate Officer #171 stating there was a late entry note made by RN #55 at 3:44 AM on [DATE] (Typed as entered) Late Entry for: [DATE] 5:52 am Notified by CNA that resident had passed away. asked to assess. Upon entering resident's room, noted color was pale, eyes closed, pupils fixed and dilated, no response to verbal stimuli, no respirations, no carotid pulse x60 seconds, no movement, no presence of life. Pronounced at 5:53am. On [DATE] at approximately 4:30 PM all licensed staff currently working were interviewed regarding the education regarding code status. Staff interviews consisted of what do you do when you find a resident unresponsive, not breathing, has no pulse and skin is pale and warm? RN #165, LPN #135, RN #18, LPN #88 and LPN #91 stated they would start CPR and then have someone check the resident's code status on the MAR, POC or EMR profile immediately. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CPR Policy The facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation (CPR) original date of [DATE] stated the following: If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a staff member who is certified in CPR/BLS (basic life support) shall initiate CPR unless: a. it is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. there are obvious signs of irreversible death (e.g., rigor mortis). Rigor mortis is defined as stiffing of the joints and muscles of a body a few hours after death, usually lasting from one to four days. Usually appears two (2) hours after death. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is DNR or a physician's order not to administer CPR. The facility policy titled Emergency Procedure - Cardiopulmonary Resuscitation (CPR) original date of [DATE] stated the following: If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally, a staff member who is certified in CPR/BLS (basic life support) shall initiate CPR unless: a. It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. there are obvious signs of irreversible death (e.g., rigor mortis). Rigor mortis is defined as stiffing of the joints and muscles of a body a few hours after death, usually lasting from one to four days. Usually appears two (2) hours after death. If the resident's DNR status is unclear, CPR will be initiated until it is determined that there is DNR or a physician's order not to administer CPR. The Interim Nursing Home Administrator (INHA) and Director of Nursing (DON) were notified of the IJ on [DATE] at 7:25 PM. The SA accepted the plan of correction (POC) at 10:25 PM on [DATE] Immediate Jeopardy (IJ) Plan of Correction Facility Name: Cortland Acres Issue: Failure to ensure immediate identification and response to residents' code status, creating the potential for serious injury, harm, or death. Immediate Corrective Actions Taken: Immediate Staff Education: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-All licensed nursing staff, CNAs, and relevant personnel were immediately re-educated on the importance of identifying and verifying resident code status. -Education included proper use of the electronic medical record (EMR) system, Medication Administration Record (MAR), and Point of Care (POC) record to confirm code status before initiating emergency interventions. -Training was completed on [DATE] by Assistant Director of Nursing or designee (ADON) with documentation of attendance appropriate staff will be educated either immediately or upon arrival for their next shift. Electronic Record Review & Accuracy Validation: - A facility-wide audit was conducted on [DATE] by Director of nursing or designee to validate the accuracy of code status documentation in the electronic medical record profile, medic and Point of Care system. - Any discrepancies were immediately corrected, and responsible personnel were re-educated. Implementation of a Code Status Verification Protocol: - Ensure staff follow Policy Emergency Procedure Cardiopulmonary Resuscitation - Staff must verify code status using one (1) method of verification: - The electronic medical record profile - The MAR - The Point of Care record Ongoing Monitoring & Compliance Assurance: -The Director of Nursing (DON) or designee will conduct daily audits of resident code status documentation for 7 days, followed by weekly audits for 4 weeks, ensuring accuracy and adherence to protocol. - Any identified concerns will result in immediate staff re-education. - QAPI Committee will review compliance data and discuss any identified trends or issues. - Administrator and Medical Director notified of all corrective actions and ongoing monitoring efforts. After verification of the steps of the POC being Implemented the IJ was abated at 5:03 PM on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:00 AM in an interview with the INHA when asked about the late entry having been dated [DATE] when Resident #89 had died on the [DATE], the INHA had no comment.

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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. 51553 Based on Record Review and Staff Interview, the facility failed to ensure activities were individualized and patient-centered for Residents #40, #19, #191, #32, #12, and #49. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Resident identifiers: #40, #19, #191, #32, #12, and #49. Facility census: 91. Findings included: a) Residents #40, #19, #191, #32, #12, and #49 had the exact same care plan listed for the Activities Section in the residents' care plans. The facility's care plans stated the following: ACTIVITIES: the resident prefers to participate in activities such as H the resident will report satisfaction with their activities of choice thru review period H Assist resident to activities functions as needed [ACTD,ACTA] H Interview the resident and family as needed to determine the resident's prior level of activity involvement and interests [ACTD,ACTA] H Provide activities calendar [ACTD,ACTA] H b) On 03/11/25 at 08:40 AM, the interim Assistant Director of Nursing (ADON), Registered Nurse #165 confirmed the resident's care plans were the same for the Activities Section of the care plans.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 30153 45171 Based on observation, record review and staff interview the facility failed to follow Physicians orders in relation to a peripherally inserted central catheter (PICC) dressing and a Advanced Directive order. Resident identifier: #74 and #89. Facility census: #91 Finding Include: a) Resident #74 On 03/11/25 at 9:16 AM observation of an Intravenous (IV) dressing indicated it was changed on 03/03/25 in the PM. Review of the Physicians order dated 03/03/25 reads Change PICC/Mid Line dressing to Right Upper Extremity (RUE) every evening shift every 7 days for PICC maintenance. This would indicate the dressing should have been changed on 03/10/25 on the evening shift. A PICC line is an IV where the catheter's tip is positioned in a large vein near the heart, allowing for easier and more reliable access to the bloodstream On 03/11/25 at 9:17 AM an interview with Licensed Practical Nurse (LPN) #28 on duty as to why the dressing had not been changed. She stated I should have changed it yesterday evening but I could not find the dressings, I will look again. On 03/11/25 at 09:17 AM it was confirmed with this LPN and the Assistant Director of Nursing #165(ADON) that the dressing should have been changed on 03/10/25 on the evening shift. All agreed. The ADON stated, we have the dressings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 39043 Based on record review and staff interview, the facility failed to assess and treat pressure ulcers in accordance with professional standards of practice. This was true for one (1) of four (4) residents reviewed for the care area of pressure ulcers. Resident identifier: #4. Facility census: 91. Findings included: a) Resident #4 Review of the policy titled, Pressure Injury Prevention Management, with original date 10/01/21 and revision date 10/19/22, showed evaluation and assessment of pressure ulcers would be completed weekly and documented in the resident's medical record. On 12/06/24, Resident #4 was noted to have an open area to the right and left buttock, measuring 0.3-0.6 centimeters (cm) with a depth of 0.1 cm. The area was assessed as a pressure ulcer stage II. An order was written to cleanse the open areas to both buttocks and apply silicone dressings, three (3) times a week on Monday, Wednesday, and Friday. On 12/12/24, a weekly skin assessment recorded open areas to the bilateral lower buttocks measuring 0.5 cm by 0.5 cm by 0.1 cm. The area was assessed as stage II. On 12/20/24, a weekly skin assessment recorded open areas to bilateral buttocks. The measurement and staging of the areas were not recorded. Three (3) times a week dressing changes continued through 01/13/25. No further pressure ulcer assessments were documented through this time. On 01/13/25, a new electronic health record system was obtained by the facility. Pressure ulcer dressing changes were not ordered in the new system. A weekly skin observation assessment performed on 03/01/25 documented no bruises, open wounds, surgical incisions, skin tears, reddened areas of other skin conditions were noted. A weekly skin observation assessment performed on 03/03/25 documented no bruises, open wounds, surgical incisions, skin tears, reddened areas of other skin conditions were noted. A weekly wound evaluation performed on 03/05/25 documented a stage II pressure ulcer to the right buttock, measuring 0.5 cm by 0.5 cm by 0 cm. An order was written to cleanse the wound and apply Duoderm every three (3) days and as needed. On 03/11/25 at 8:46 AM, Assistant Director of Nursing (ADON) #165 confirmed the resident's pressure ulcers had not been assessed weekly. She was unable to determine if the pressure ulcer had healed and reoccurred, or if the pressure ulcer had been present since identified on 12/06/24. She stated she was not aware the resident had a pressure ulcer develop in December 2024.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39043 Based on observation and staff interview, the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. Sharp objects were in unlocked rooms accessible to residents. This was a random opportunity for discovery that had the potential to affect more than a limited number of residents. Facility census: 91. Findings included: a) Biohazard room On 03/03/25 at 11:08 AM, a door in A hallway labeled biohazard, authorized personnel only was found to be unlocked. Behind the door was a series of three (3) rooms. The first room contained locked cabinets. The second room contained a linen cart. The third room contained a small shower. In the shower was a sharps container, a puncture-resistant container for safely disposing of sharp objects. The sharps container was overflowing with razor blades. This finding was confirmed by Unit Secretary #148. She stated the door was not kept locked because hazardous items were locked in cabinets. She confirmed the sharps container overflowing with razor blades posed a potential risk to residents and stated she would have it emptied. b) Storage room On 03/03/25 at 1:54 PM, a door in A hallway labeled storage, no admittance, nurses and ward clerks only was found to be unlocked. Behind the door was a supply room containing hygiene products including razor blades. The Administrator confirmed the room was unlocked and contained items potentially hazardous to residents. On 03/03/25 at 2:06 PM, the Administrator stated the storage room was supposed to be locked but the locked had malfunctioned.

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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. 39043 Based on observation, record review, resident interview, and staff interview, the facility failed to provide oxygen services in accordance with accepted standards of care. This was true for one (1) of one (1) residents reviewed for the care area of respiratory care. Resident identifier: #16. Facility census: 91. Findings included: a) Resident #16 Review of the facility's undated policy titled, Oxygen Administration, stated to verify that there was a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. On 03/03/25 at 1:34 PM, Resident #16 was observed using supplemental oxygen via nasal cannula, three (3) liters/minute. The resident stated she always utilized supplemental oxygen. Review of Resident #16's diagnoses showed she had diagnoses of chronic obstructive pulmonary disorder (COPD) and chronic respiratory failure with hypoxia and hypercapnia. On 03/04/25 at 2:16 PM, Regional Nurse #168 confirmed Resident #16 was utilizing supplemental oxygen but did not have an order. The resident stated she had been using oxygen a long time. It was noted that the oxygen tubing had been dated 03/03/25.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51553 Based on observation, record review, staff interview and resident interview, the facility failed to ensure the food served was attractive, palatable and at a safe and appetizing temperature for Residents #21, #23, #33, #66, #85, #17 and #40. This failed practice had the potential to affect more than a limited number of residents. Resident Identifiers: #21, #23, #33, #66, #17, and #40. Facility Census: 91. Findings included: a) Policy Review According to the facility's Policy and Procedure Manual for The Dining Experience: Staff Responsibilities, the dining experience will enhance each individual's quality of life through person-entered dining: providing nourishing, palatable and attractive meals that meet the individuals daily nutritional needs and food and beverage preferences. Food will be served at the proper temperature, texture and/or consistency to meet each individual's needs and desires. b) Resident Council Meeting Minutes Resident Council Meeting Minutes were reviewed for the previous six months. Multiple dietary and food issues/complaints were expressed by the residents. A Food Committee was to be formed. On 03/04/25 at 10:30 AM, during the Resident Council meeting with the State Surveyor, the residents reported the food was cold and awful. The residents reported the food comes out cold. One resident stated, I'm tired of eating cold food. Minutes of the Resident Council for December 27, 2024, stated (First name, last name of discharged resident) the food she has received on [NAME] has been cold, the meal served on Christmas Eve she would be embarrassed to serve, and the portions are too small.(First Name, Last Name Resident # 10) stated that her meals are always cold. c) Dining Observations On 03/03/25 at 12:21 PM, during the Dining Observation, the residents were served pork chops at the lunch meal. The pork chops were observed to be hard to chew and difficult to cut. d) Resident Interviews On 03/03/25 at 3:04 PM, during the resident interview process, Resident #66 stated, the food was cold and It's awful .not edible. She reported, breakfast so bad, so cold .toast is white bread cut in two. On 03/04/25 at 5:51 PM, Resident #33 and Resident #21 were observed eating in the dining room. They both reported that their hamburgers were hard. The hamburgers appeared dark in color, hard, and dry. Resident #33 stated she could eat one end of the burger. Neither one of the residents wanted alternate food because Bingo was starting soon. (continued on next page)

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	515063	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cortland Acres Nursing Home	39 Cortland Acres Lane Thomas, WV 26292

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/25 at 5:56 PM, Resident #23 reported the hamburger was too hard and dry to eat. The resident's hamburger was chopped into bite-sized pieces. The patient requested a potted meat' sandwich. The Dietary Staff was notified the resident wanted an alternate. On 03/03/25 at 1:20 PM , during the resident interview process, Resident #85 reported, beginning food was good, then it changed hands. The resident stated, It's always cold . I eat cheerios because they can't mess it up. Resident #85 stated, Just to have a hot meal again. On 03/03/25, during the resident interview process, Resident #17 reported some of the food was good and some of the food wasn't. No temperature problems were reported by this resident. On 03/03/25, during the resident interview process, Resident #40 stated, I don't like it. I don't like what they're having. On 03/10/25 at 3:30 PM, the resident stated, I didn't eat. The resident reported it doesn't taste good. During an interview with Resident #78 on 03/03/25 01:37 PM Interview with Resident #78 stated, Food is bland and cold. During an interview with Resident #58 on 03/03/25 at 04:14 PM, the resident stated, food is not good and it is cold. During an interview with Resident #15 on 03/03/25 at 12:45 PM, the resident stated, new food menu is crap. During an interview with Resident #65 on 03/03/25 at 3:46 PM, the resident stated, food not hot enough. e) Temperatures On 03/04/25 at 12:35 PM, the Surveyor observed lunch service to residents on C Hall. Plates were covered with a plastic lid, but lids were not insulated. There were no plate warmers. The surveyor requested the Regional Dietary Director #167 to perform the temperature readings on the last tray served on C Hall. Results were: Mashed potatoes with gravy: 165 degrees Breaded chicken: 173 degrees Cauliflower: 171.9 degrees Fruit Cocktail: 71.9 degrees Grape juice: 39.5 degrees (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor asked Director #167 if the temperatures were within acceptable standards. He responded, No, the fruit cocktail is a little warm. On 03/04/25 at 5:10 PM, the surveyor began observing food being served in [NAME] Hall dining room. The surveyor observed Diet Aide #21 while she performed temperature testing of food on the steam table. Results were: Burger patties 160 degrees (Appearance was dry and hard) Baked beans 140 degrees Coleslaw 38 degrees Mashed potatoes 161 degrees Baked beans puree 150 degrees Gravy 150 degrees Sliced carrots 170 degrees Ground beef pieces 160 degrees Meat puree 120 degrees When asked if these were within range, Diet Aide #21 said no. I will need to call (first name, Dietary Manager #44). She went to the phone and called her. She removed the container from the steam table. DM #44 arrived approximately 10 minutes later and wrapped the puree with plastic wrap and took it back to the kitchen. At 6:40 PM, the meat puree is returned to the B dining hall steam table. The temperature was taken as 180 degrees by Diet Aide #21. On 03/05/25, the Surveyor observed lunch service in [NAME] dining hall around midday. Temperatures were taken of the food on steam table by [NAME] #3 while surveyor observed. All temperatures except pureed vegetables were within range. Puree vegetables were at 120. These were sent back to the kitchen and new packages were brought out. These registered a temperature of 160. On 03/11/25 at 12:05 PM, the Survey team tasted a sample lunch tray. The food was warm. The squash and zucchini mixture were overcooked, mushy in appearance and taste, not seasoned. One surveyor said it tasted gritty. Ham was prepared well. Sweet potatoes were sliced, without seasoning. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/12/25 at 11:38 AM, the Surveyor observed while Dietary Manager #44 performed temperatures on the last resident lunch tray on A Hall. Temperatures were as follows: Green Beans 90 degrees Lasagna 110 degrees Pudding 50 degrees The Dietary Manager agreed these temperatures were not within a suitable range. 51554

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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 51553 Based on observation, record review, resident interview, and staff interview, the facility failed to provide each resident food prpared in the form to meet their individual needs for Resident's #12, #191, #32, #19, #62, #49, #71, #34, #87, and #46. This created an immediate jeopardy situation due to the risk of choking and aspiration. Resident Identifiers: #12, #191, #32, #19, #62, #49, #71, #34, #87, and #46. Facility census: 91. Findings included: a) Resident #12 On 03/03/25 at 3:18 PM, Resident #12 stated she had difficulty eating the food, especially meats, at the facility sometimes. She stated she had difficulty swallowing and sometimes the food makes her cough. On 03/04/25 at 12:32 PM, Resident #12 was observed eating lunch in her room. Her tray ticket stated her food consistency was to be chopped. She had breaded chicken cut into pieces of various sizes. Review of Resident #12's diet order showed the resident had an order for Heart Healthy CCD [carbohydrate controlled diet] diet, Minced & Moist (MM5) Meats Only texture, Regular/Thin consistency. The facility's policy on therapeutic diets stated as follows: - Diet order should match the terminology used by the food and nutrition services department. - If a mechanically altered diet is ordered, the provider will specify the texture modification. The facility's document titled Crosswalk of DMO [dietary modification orders] diets and textures, the facility used the following texture terminology: chopped, mechanical soft, and pureed. The facility provided the following diet level descriptions: - Chopped diet emphasizes chopped or cut-up meats alongside soft-textured or chopped starches and vegetables. - Mechanical soft, or ground, diet is recommended to have a consistency similar to applesauce. All meats were to be ground, with the addition of extra broth, sauce or gravy to prevent dryness. Sandwiches were to feature ground fillings and bread that are ground. - Pureed diet was to resemble that of mashed potatoes or applesauce. Resident's diet orders on the Order Listing Report were reviewed by the State Surveyor. Diet Levels included: (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a) Dysphagia Advanced texture - with all food chopped, with all chopped meat and with all food chopped except sandwiches. b) Soft and Bite-Sized (SB6) texture. c) Soft and Bite-Sized (SB6) texture with ground meat. d) Soft and Bite-Sized (SB6) with puree corn. e) Soft and Bite-Sized (SB6) texture with meats only. f) Minced and Moist (MM5). g) Minced and Moist (MM5) with meats only. h) Minced and Moist with Meats Only and Soft and Bite-Sized. I) Regular texture with all food cut into bite-sized pieces. j) Regular texture. k) Puree texture. On 03/04/25 at 1:10 PM, Dietary Aide #16 and Dietary Aide # 34 reported they did not know about Dysphagia Advanced diets, Soft and Bite-Size (SB6) and Minced and Moist (MM5) diet levels. Dietary Aide #16 stated, she had never heard of it They confirmed diet levels used in the kitchen were Regular, Chopped, Mechanical Soft and Puree. Dietary Aide #16 stated,Some cards are wrote up different. Normally they just know it when they see who it is. On 03/04/25 at 1:13 PM, the Certified Dietary Manager (CDM) was asked about the different diet levels on the Diet Order Listing Report. The CDM stated, Not sure I know how to answer. The CDM stated she usually goes by the extension manual. The CDM reported they had just switched over and were in the process of getting our consistency soft to bite-sized. On 03/04/25 at 3:54, the Registered Dietician (RD) was interviewed via phone concerning the facility diet levels. The RD reported she did not recommend the textures of the diets and sometimes they come on a different diets from the hospital. She reported the Speech-Language Pathologist (SLP)recommended the textures. The RD stated, the Minced and Moist texture was closer to Mechanical Soft and the Soft and Bite Size texture and Advanced texture was closer to chopped. The facility SLP was unavailable on this date for an interview per the Director of Rehab. Resident #191 (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 03/04/25 at 4:28 PM, Resident #191 was observed eating dinner in her room. She had a hamburger on a bun, coleslaw, baked beans, and a cookie. The food was not altered. The resident's tray ticket stated the food consistency was to be chopped. The resident ate approximately half of the hamburger. The resident ' s diet order was Heart Healthy CCD diet, Soft & Bite-Sized (SB6) texture, Regular/Thin consistency with special directions for ground meat. Resident #32 On 03/04/25 at 5:16 PM, Resident #32 was served dinner in his room. The resident's tray ticket stated the food consistency was to be chopped. The resident had a whole slice with ground meat and cheese, baked beans, carrots, and ice cream. The baked beans and carrots were not altered. The resident stated he only wanted ice cream. The resident 's diet order was CCD diet, Minced & Moist (MM5) Meats Only texture, Regular/Thin consistency. Resident #19 On 03/04/25 at 5:44 PM, Resident #19 was served dinner in the dining room. The resident's tray ticket stated the food consistency was to be chopped. The resident's tray had a whole slice of bread with ground meat and cheese, whole baked beans, and carrot slices. The resident's diet order was CCD diet, Minced & Moist (MM5) Meats Only texture, Regular/Thin consistency. Resident #62 On 03/04/25 at 5:47 PM, Resident #62 was served dinner in the dining room. The resident ' s tray ticket stated the food consistency was to be chopped. The resident had a hamburger on bun cut into quarters. The resident's diet order was Regular diet, Soft & Bite-Sized (SB6) texture, Regular/Thin consistency. Resident #49 On 03/04/25 at 5:49 PM, Resident #49 was served dinner in the dining room. The resident's tray ticket stated the food consistency was to be chopped. The resident had a burger on a bun cut in half. The resident's diet order was Regular diet, Soft & Bite-Sized (SB6) texture, Regular/Thin consistency. Resident #71 On 03/04/25 at 5:50 PM, Resident #71 was served dinner in the dining room. The resident's tray ticket stated the food consistency was to be chopped. The resident's tray had an unaltered burger on a bun and whole baked beans. The resident's diet order was Heart Healthy CCD diet, Minced & Moist (MM5) texture, Regular/Thin consistency. Resident #34 On 03/04/25 at 5:55 PM, Resident #34 was served dinner in the dining room. The resident's tray ticket stated the food consistency was to be chopped. The resident's tray had a burger on a bun cut into quarters. The resident's diet order was Regular diet, Soft & Bite-Sized (SB6) texture, Regular/Thin consistency. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #12 On 03/04/25 at 5:59 PM, Resident #12 was served dinner in the dining room. The resident's tray ticket stated the food consistency was to be chopped. The resident's tray had a burger on a bun cut into quarters. The resident's diet order was Heart Healthy CCD diet, Minced & Moist (MM5) Meats Only texture, Regular/Thin consistency. Resident #87 On 03/04/25 at 6:20 PM, Resident #87 was served dinner in the B hallway dining area. The resident's tray ticket stated the resident was to have mechanical soft meat. The resident was served a whole burger on a bun. The resident 's diet order was Regular diet, Regular texture, Regular/Thin consistency with mechanical soft meat. Resident #46 On 03/04/25 at 6:28 PM, Resident #46 was served dinner in the B hallway dining area. The resident 's tray ticket showed the resident was to have ground meat. Instructions were given to puree meat. The ticket stated she was to have cheeseburger on a bun (ground fill/pureed bread), ground baked beans, and ground carrots. The resident was served ground meat, whole baked beans, and chopped carrots. The resident's diet order was Regular diet, Puree texture, Nectar liquids consistency. Resident #2 On 03/05/25 at 1:16 PM, Resident #2 received her lunch meal. The meal ticket was for Mech Soft/Dysphagia. She received Ziti (chopped) with meat sauce, California Blend Vegetables (Chopped), garlic bread (Pureed) and pudding. When her plate was delivered the resident and the resident's daughter (present at the table) were upset because the resident did not want this tray. She refused the tray and told the Dietary Aide (DA) to take it away, that all she wanted was a plain hamburger. The Dietary Aide #21 took the tray away and returned with a whole plain hamburger. The surveyor immediately (03/05/25 at 1:20 PM) went toCorporate Registered Nurse (CRN) #172 and made her aware the resident had received a whole hamburger. CRN #172 immediately went over and explained the hamburger was not on the Resident's diet and she would return with the correctly cooked hamburger. The resident had not eaten the burger. According to the consistency spreadsheet provided by the facility, residents on a chopped diet should have received cheeseburger on a bun (chop fill/soft bread), baked beans, carrots, oatmeal cookie, and milk. According to the consistency spreadsheet provided by the facility, residents on a mechanical diet should have received cheeseburger on a bun (chop fill/soft bread), baked beans (ground), carrots (ground), ice cream, and milk. Receiving food in the wrong consistency could result in choking, aspiration pneumonia which can lead to serious harm and/or death. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jepardy was called and a written copy was reviewed and signed by the Administrator on 03/04/25 at 8:17 PM. A plan of correction was received and accepted on 03/04/25 at 10:22 PM. The plan of correction/abatement plan included: Immediate Jeopardy (IJ) Abatement Plan for F805 Facility Name: Cortland Acres Health and Rehab Date of Correction Plan: 3/4/2025 Immediate Actions Taken to Remove the Immediate Jeopardy 1. Resident Safety and Corrective Actions: As of 03/04/25, all residents on physician-ordered mechanical altered diets were immediately assessed by the assigned nurse for adverse effects related to improper texture-modified meals. 2. On 03/4/25, in conjunction with the resident's physician, Director of Nursing, and Speech Therapist, resident diet orders were update as appropriated to mechanical soft diet or chopped diet. 3. Staff Education and Re-Training: Dietary Staff: Immediately or upon arrival to their next worked shift received in-service training conducted on 03/4/25 by the Dietary Manager and/or designee on: Proper preparation and delivery of chopped diet, puree diet and mechanical soft diets Nursing Staff and CNAs: Re-educated on proper meal modifications and verifying consistency of food before serving. In-service was provided by the DON/designee either immediately or upon arrival for their next shift. 4.Monitoring and Quality Assurance Measures: Daily Meal Audits: (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Beginning 03/4/25, the Dietary Manager and Nursing Supervisor conduct meal service audits at every meal to ensure proper diet consistency compliance. Any discrepancies in meal preparation are immediately corrected, documented, and reviewed in daily safety huddles.Weekly audits of meal service by the Dietary Manager and Director of Nursing (DON) for four weeks, then ongoing monthly audits. QAPI Committee will review compliance data and discuss any identified trends or issues. Administrator and Medical Director notified of all corrective actions and ongoing monitoring efforts. On 03/05/25, the surveyor consulted with the facility's corporate team concerning diet cross walks with differing diets per crosswalk from previously ordered diets. Some diets were upgraded and some diets were downgraded. Diets were changed with nursing input, speech therapy input and physician input. Diets were physician ordered. On 03/05/25 at 3:15 PM, Corporate Registered Nurse #172 gave this surveyor a revised diet list with upgraded diets changed and reported the Speech-Language Pathologist will evaluate residents for the safest and most appropriate diet level. On 03/05/25 at 6:25 PM, the Abatement was completed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51554 Based upon record review, observation, testing, resident interviews and staff interviews, the facility failed to store, and serve food in accordance with professional standards for food service safety. This has the potential to affect all residents currently residing in the facility. Facility census 91. Findings included: a) Expired product: On [DATE] at 10:50 AM during an Initial walk through of dry storage area with Dietary Manager #44, a box of Quaker grits, with expiration date of [DATE], was found. When surveyor pointed it out, Dietary Manager said thank you, and she threw the box into the trash. B) Improper Food Holding temperatures On [DATE] at 5:10 PM, surveyor began observing serving of food in [NAME] Hall dining room. Surveyor observed Diet Aide #21 while she performed temperature testing of food on the steam table. Results were: Burger patties 160 degrees (Appearance was dry and hard) Baked beans 140 degrees Coleslaw 38 degrees Mashed potatoes 161 degrees Baked beans puree 150 degrees Gravy 150 degrees Sliced carrots 170 degrees Ground beef pieces 160 degrees Meat puree 120 degrees (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When asked if these were within range, Diet Aide #21 said no. I will need to call (first name, Dietary Manager #44). She went to the phone and called her. She removed the container from the steam table. DM #44 arrived approximately 10 minutes later, and wrapped the puree with plastic wrap and took it back to the kitchen. At 6:40 PM, the meat puree is returned to the B dining hall steam table. Temperature was taken as 180 degrees by Diet Aide #21. On [DATE], surveyor observed lunch service in [NAME] dining hall around mid-day. Temperatures were taken of the food on steam table by [NAME] #3 while surveyor observed. All temperatures except pureed vegetables were within range. Puree vegetables were at 120. These were sent back to the kitchen and new packages were brought out. These registered a temperature of 160. c) Hygiene On [DATE] around mid-day, surveyor observation of the lunch service in [NAME] dining hall. NA#6 was assisting the cook on the serving line. First tray was prepared and checked by NHA. Male NA #6 has longish hair which appeared as oily and unclean (about inch below the ear level). He did not don a hair net before stepping into the serving line. When surveyor pointed out the need for a hair net, he did not know where these were kept. [NAME] #3 reached up and got him one from the shelf above the sink. NHA reminded NA #6 to change his gloves before going back to serving. d) Facility Policy: According to the facility's Policy and Procedure Manual for The Dining Experience: Staff Responsibilities, The dining experience will enhance each individual's quality of life through person-entered dining: providing nourishing, palatable and attractive meals that meet the individuals daily nutritional needs and food and beverage preferences. Food will be served at the proper temperature, texture and/or consistency to meet each individual's needs and desires.

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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 - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 39043 Based on record review and staff interview, the facility failed to ensure complete and accurate medical records. This was true for one (1) of 31 residents in the long-term care survey sample. Resident identifier: #32. Facility census: 91. Findings included: a) Resident #32 Review of Resident #32's physician's orders showed an order for gabapentin (Neurontin) 600 milligrams (mg), give one (1) tablet orally, three (3) times a day for seizures. Resident #32's diagnoses list did not contain a diagnosis of seizures. On 03/11/25 at 9:28 AM, Assistant Director of Nursing (ADON) #165 stated Resident #32's gabapentin order was incorrect. She confirmed Resident #32 did not have a diagnosis of seizures. ADON #165 stated Resident #32 had started receiving gabapentin in 2020 for diabetic neuropathy. She stated she did not know why the order now showed the medication was given for seizures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515063	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cortland Acres Nursing Home	39 Cortland Acres Lane Thomas, WV 26292

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45171 Based on observation, record review and staff interview the facility failed to implement an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible. The practices described below had the potential to affect more than an isolated number of residents. Resident identifiers: #74. Facility census: #91 Findings include: a) On 03/04/25 at 8:48 AM medication administration observation with Register Nurse (RN) #43 revealed the nurse broke Resident #73's Atorvastatin 40 milligram pill in half with no gloves in place. She then placed the broken pill in the medication cup and proceeded to administer it to the Resident. On 03/04/25 at 8:50 AM it was confirmed with the RN that she was required to use gloves when touching residents medications. It was also confirmed with the Administrator on 03/04/25 at 9:00 AM. b) Resident #74 On 03/10/25 at 1:24 PM observation of a pressure ulcer dressing change (wound vacuum) was performed. Licensed Practical Nurse (LPN) #117, LPN #28 and Nurse Aide (CNA) #20 were performing or assisting in this procedure. None of the three (3) staff members were wearing isolation gowns. Resident #74 was on Enhanced Barrier Precautions (EBP) which required everyone must clean their hands before entering and when leaving the room. EBP also required providers wear gloves and a gown for the following resident care activities: Dressing Bathing/showering Transferring Changing Linens Providing Hygiene Changing Briefs or assisting with toileting Devise care or use: central line, urinary catheter, feeding tube, tracheostomy Wound care: any skin opening requiring a dressing Resident #74 had an active order that stated EBP related to wounds/peripherally inserted central catheter (PICC)/Percutaneous endoscopic gastrostomy (PEG) feeding tube. (A PICC line is when the IV catheter's tip is positioned in a large vein near the heart, allowing for easier and more reliable access to the bloodstream). (continued on next page)

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	515063	A. Building B. Wing	03/12/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #74 was care planned for skin impairment related to a pressure ulcer to the coccyx. The care plan interventions included: enhanced barrier precautions.The appropriate signage from the Centers for Disease Control and Prevention (CDC) was posted above the residents bed. The appropriate PPE was available outside the residents door. The facility Enhanced Barrier Precautions (EBP) policy states: Specific Procedures/Guidance 4. High-contact Resident Care Activities Requiring EBP: Dressing Bathing/showering Transferring Changing Linens Providing Hygiene Changing Briefs or assisting with toileting Devise care or use: central line, urinary catheter, feeding tube, tracheostomy Wound care: any skin opening requiring a dressing On 03/10/25 at 02:01 PM it was confirmed with the three (3) staff members they should have had the required PPE in placed. Their response was Oh yea. It was confirmed with the Director of Nursing on 03/10/25 at 02:03 PM. 51553 c) On 03/03/25 at 12:07 PM during the Dining Observation at lunch, hand hygiene was not completed by staff for the residents in the main dining room. The Interim Nursing Home Administrator (NHA) confirmed hand hygiene should be completed prior to meals. The NHA stated, hand hygiene was, usually before the meal. The NHA reported hand wipes used to be on the resident's trays, but they were implementing a new system of delivering the plate only from the serving/holding station located in the dining room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 51554 Based upon record review and staff interview, the facility failed to complete a minimum of 12 (twelve) hours training during 2024 for nurse aides, including training in caring for residents with dementia and Alzheimer's. This was true for four (4) of five (5) Nurse Aide (NA) personnel files reviewed during this recertification survey. Facility census: 91 Findings included: a) NA #5, #13 and #15 Record review revealed that NA #5, #13, and #15 did not have a minimum of 12 hours of training, and there was no training on dementia or Alzheimer's. NA # 110 was a new hire in 2025. NA #57 - no dementia or Alzheimer's training On 03/12/25 around mid-morning, during an interview with HR Manager #170, surveyor reviewed the lack of reaching the 12 hours of annual training required for Nurses' Aides during 2024. The files contained several posttests where education on various subjects appeared to have taken place. However, no one had scored the post test to determine the knowledge level of the student. There was also no indication of the amount of time spent educating on the subject prior to administering the posttest. HR Manager #170 stated their nursing educator had resigned several months ago.