STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515076	A. Building B. Wing	07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holbrook Healthcare Center	183 Holbrook Road Buckhannon, WV 26201

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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 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview and resident review, the facility failed to provide liquids in the correct consistency to meet the resident's individual needs. This was true for three (3) of seven (7) residents that were ordered nectar and honey thickened liquids. This failed practice had the potential to affect a limited number of residents. Resident identifiers: #7, #82, and #31. Facility Census: 107.Findings included: a) On 07/21/2024, Residents #7, #82, and #31 were observed to liquids at bedside that were not nectar or honey consistency during the investigation process. This failed practice created an immediate jeopardy situation.During the initial resident interview process, Resident #7 received thin liquids with the lunch meal in a spouted cup. The resident also had a mug with a straw on the tray table containing ice water. On 07/21/2025 at 01:10 PM, NA #12 confirmed both cups contained thin liquids. Nursing Assistant (NA) #12 stated, I think she's allowed to have some thin liquids. Resident #7's diet order stated, Dys Puree texture, Nectar Thickened Liquids consistency, Spout cups for Diet. On 07/21/25 at approximately 12:50 PM, Resident #82 was observed to have three (3) drinks on his tray table. There were two (2) two[1] handled cups with a spout containing a thickened liquid in them (beige in color), and one cup with a lid and straw containing water. When asked whether the resident was supposed to have regular water, Clinical Manager Licensed Practical Nurse (LPN) #48 stated, No, he is not supposed to have regular water and picked the cup up and took it with her to the nursing station. This occurred at approximately 01:00 PM. The resident's diet order stated, Dys Mech texture, Honey Thickened Liquids consistency, Spout cups for drinks. During an interview and observation on 07/21/25 at 1:55 PM in Resident #31's room, Nursing Assistant (NA) #3, stated, No, it does not look like it's honey thickened to me. This State Surveyor tested the chocolate milk using a plastic spoon, The liquid ran off the spoon and did not leave any residue. At the bottom of the cup was a gel-like substance. NA #3, confirmed the liquid was thin and not honey thickened consistency and stated, No, not honey. The resident's diet order stated, Dys Puree texture, honey Thickened Liquids consistency, for Diet. The Facility's Diet and Nutrition Care Manual: Guidelines for Serving Thickened Liquids stated, The SLP and food and nutrition department should work together to identify and provide appropriate fluid consistency. All individuals on thickened liquids require a physician's order for the appropriate fluid consistency. All liquids should be thickened to the proper consistency, including soups, water, oral nutritional liquid supplements, and all other beverages.The immediate jeopardy template was provided to the facility on [DATE] at 4:25 PM. The plan of correction which stated the following was provided at 6:19 PM on 07/21/25: Education to all staff was given for the three (3) residents who received liquids that were not consistent with their diet order. The nursing home administrator, regional director of clinical operations, director of nursing and regional director of nursing were all involved in this education and root cause identification. The goal was for all residents to receive liquid consistency with their diet order. On 07/21/25 all residents that were identified in the IJ were assessed for respiratory status. The incorrect liquids were removed from the resident area. All like residents were identified and an audit was completed that ensured appropriate consistency was amiable. Staff who had been and were (continued on next page)

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

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assigned to the identified residents (#7, #82, and #31) were educated on 07/21/25. All available staff except for dining were educated by the Unit Manager, Executive Director or Designee that the facility offers each resident sufficient fluid, inducing water and other liquids consistent with the residents' needs and preferences to maintain proper hydration and health. If a staff member is not performing direct care, they are to notify a nurse or nurse aide so the liquid consistency can be verified. Any staff who were not available on this date received education prior to their next shift. All available dining staff were educated by Health Care Services Group Dietary Manager on drink consistency, tray ticket, order accuracy, and verifying trays before leaving the kitchen. All staff that were unavailable were educated prior to their next shift. Nursing staff or their designee were to monitor Resident #7, #82, and #31's vital signs and lung sounds for 72 hours with physician notification as needed. The Unit Manager or designee was to monitor residents with thickened liquids three (3) times a day for 3 days then three (3) random residents of the identified residents were to be monitored every day for five (5(days a week for two (2) weeks. Any findings from these audits were to be reported to the quality assurance (QA) committee. The IJ was abated on 07/22/25 at 2:40 PM.

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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. Based on observation, resident interview and staff interview, the facility failed to provide a homelike dining experience for residents served in the main dining room and to ensure resident areas were clean and odor free. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Resident Identifiers: #90 and #5. Facility Census: 107. Findings included: a) On 07/21/2025 at 12:30 PM, during the Dining Room Observation, no tablecloths were on the tables in the main dining room and the residents were served their meals on plastic trays from the kitchen. On 07/21/2025 at 12:33 PM, Licensed Practical Nurse (LPN) confirmed the residents were eating their lunch on trays and stated, When there's tablecloths .we usually take them off. b) Resident #90 On 07/22/2025 at 10:50 AM, during the initial resident interview, Resident #90 reported they don't clean her bed pan box. The resident stated the smell comes out of her bathroom into her room at times. In the resident's bathroom, a white plastic standing box was observed containing the bedpan with a strong odor emitting from the container. When the bed pan box was opened, a bed pan was observed with a yellow and brownish substance in the bedpan and in the bottom of the plastic container. The resident stated they (housekeeping) had cleaned it about a month ago when she asked. On 07/22/2025 at 11:05 AM, LPN #25 confirmed the odor in the bathroom and stated, I will talk to them. During the initial resident interview an observation in the bathroom found a black substance around the base of the commode on 07/22/25 at 11:00 AM.

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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** Based on observation, record review and staff interview, the facility failed to ensure food was stored in accordance with professional standards for food services. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 107. Findings included: During the Kitchen Investigation initiated on 07/21/2025 at 11:45 PM., the following items were found: a) Sausage patties - bag was not sealed and no use by date. b) Four (4) bags of hoagie buns bags - not labeled and no use by date. c) Crinkle cut fries were in a bag - not labeled. d) Baked beans in a plastic container - no used by date. On 07/21/2025 at 11:50 AM, Regional Dietary Manager #128 confirmed the items and stated, I didn't know you had to label if you know what it is. On 07/22/25 at 11:05 PM, the following items were found in the Nutrition Station 100-200: a) Two (2) bologna and cheese sandwiches - not labeled and no use by date. b) [NAME] cheeseburger - not sealed and no use by date. Items were confirmed by Regional /Director of Operations #130 on 07/22/2025 at 11:10 PM On 07/22/2025 at 01:00 PM , the following item was found in the Nutrition Pantry 300-400 Hall : a) Individual packets of Smucker's concord grape jelly - no open or use by date. The item was confirmed by Licensed Practical Nurse (LPN) #15 on 07/22/25 at 01:11 PM. On 07 22/5 at 11:35 PM, Regional Dietary Manager #129 stated food storage dates depending on the hierarchy. It is seven (7) days for leftovers or prepared food. The kitchen follows the food code with hierarchy from serve safe for labeling and dating. The Healthcare Services Group policy and procedure for Food Storage: Dry Goods stated, 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. The Healthcare Services Group policy and procedure for Food Storage: Cold Foods stated, 5. All foods will be stored, wrapped, or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, staff interview and record review the facility failed to ensure it had a complete and accurate medical record. This failed practice was found true for (6) six of 36 residents reviewed for medical record accuracy during the Long- Term Care Survey Process. Resident identifiers #43, #6, #7, #10, #4, and #77. Facility Census 107. Findings include: a) Resident #43 A record review on 07/23/25 at 10:31 AM, revealed a capacity form dated and signed by Family Nurse Practitioner (FNP) on 03/28/25 for Resident #43 stating that the resident has capacity. Further record review revealed a Physicians Orders for Scope of Treatment (POST) form for Resident #43 dated 03/28/25 and signed by Resident #43's Medical Power of attorney (MPOA), rather than being signed by Resident #43, who had capacity. Post form for Resident #43, was signed by the MPOA, rather than Resident #43 that has capacity. During an interview on 07/23/2025 at 10:43 AM, The Administrator confirmed that the POST form was signed by the MPOA and not by Resident #43 who has capacity. A review on 07/23/2025 at 10:45 AM, of the Policy titled Advance directive (Residents right to choose), under Policy, explanation and compliance guidelines, number 5, reads as follows: The center will periodically assess the reside3nt for decision -making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. b) Resident #6 On 7/21/25, a chart review was initiated for Resident #6. No diet order was found on the resident's medical chart or listed on the facility's Order Listing Report. A Speech Therapy order waiting the physician's signature for an Informed Dining Consent Form changing the resident's diet to regular with regular liquids was written on 07/03/25. The physician's signature was obtained on 07/03/25. A diet order was added on 07/22/25 for a regular diet. On 07/23/25 10:47 AM, the Administrator and Corporate Director of Operations confirmed the finding and the Corporate Director of Operations stated, We will get these fixed. c) Resident #7 On 07/21/25, a chart review was initiated for Resident #7. The resident's POST (Physician Orders for Scope of Treatment) form was reviewed. The POST form was signed by Resident #7's Power of Attorney The resident was capacitated to make her own decisions on 05/28/24. The facility's policy and procedure Advance Directive (Residents Right to Choose) stated, The center will periodically assess the resident for decision-making abilities and approach the health care proxy or legal representative if the resident is determined not to have decision making capacities. On 07/23/25 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:47 AM, the Administrator and Corporate Director of Operations confirmed the finding and the Corporate Director of Operations stated, We will get these fixed. d) Resident #10 On 07/21/25, a chart review was initiated for Resident #10. A verbal consent by the resident's responsible party was given on 07/25/24. An updated POST form with the responsible party's signature was not obtained by the facility. On 07/23/25 10:47 AM, the Administrator and Corporate Director of Operations confirmed the finding and the Corporate Director of Operations stated, We will get these fixed. e) Resident #4 A chart review for this resident, documented he was receiving Eliquis Oral Tablet 5 mg, every morning and at bedtime for clot prevention. The order was dated 04/25/25. A further review of the orders, the Medication Administration Record and the Treatment Administration Record reveals there is no order for the monitoring of side effects for the anti-coagulant, nor was it being monitored. This was reviewed with the Regional Operations Coordinator on 07/23/25 at approximately 2:10 PM. She acknowledged there was no monitoring of side effects occurring. f) Resident #77 A review of the electronic health record (EHR) contains the following diagnoses for Resident #77: Unspecified Dementia, 12/21/24 Generalized Anxiety Disorder, 3/20/25 Alzheimer's, 3/20/25 Upon reviewing progress notes from the facility's medical provider dated 03/16/25, the provider records an additional diagnosis of major depressive disorder. Additionally, a progress note dated 06/10/25 by the provider, states a diagnosis of Major depressive disorder, recurrent, moderate. The electronic health record does not contain the diagnosis for major depressive disorder under the list of diagnoses. Thus, the list of diagnoses is incomplete and inaccurate. This was reviewed with the Regional Operations Coordinator on 07/23/25 at approximately 2:10 PM. She acknowledged the diagnosisof major depressive disorder should be included on resident's list of diagnoses.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based upon record review and staff interview, the facility failed to inform the Resident or the Resident's representative of the risks and benefits for a prescribed psychotropic medication. This was found to be true for one (1) of six (6) residents reviewed during the annual survey process. Resident identifier: #77. Facility census: 107.Findings included: a) Resident #77 A review of the electronic health record (EHR) revealed the following diagnoses for Resident #77:Unspecified Dementia - 12/21/24 Generalized Anxiety Disorder - 03/20/25Alzheimer's - 03/20/25 Upon reviewing progress notes from the facility's medical provider dated 03/16/25, an additional diagnosis of major depressive disorder was revealed. Additionally, a progress note dated 06/10/25 by the provider, stated a diagnosis of Major depressive disorder, recurrent, moderate. The electronic health record does not contain the diagnosis for major depressive disorder under the list of diagnoses. The medical provider orders for the Resident included the following anti-depressants:Sertraline HCl Tablet 25 MG Give 1 tablet by mouth one time a day for Depression, 05/07/25TraZODone HCl Tablet 50 MG Give 1 tablet by mouth at bedtime for insomnia, 05/19/25Upon review of the medical record, no Informed consent could be found for Trazodone. The surveyor asked the facility on 07/22/25 if they had this record. The facility did not provide it before exiting the survey that day. So, it was requested again the following morning on 07/23/25. According to the Regional Operations Coordinator on 07/23/2025 2:02 PM, I could not find this, or we do not have this. Therefore, the facility failed to inform the resident or the resident's representative of the risks and benefits associated with the prescription for Trazodone.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and family interview the facility failed to inform the Medical power of Attorney (MPOA) of appointments for Resident #55, and failed to notify the physician and responsible party of a change in condition for Resident #7. This failed practice was found true for (2) two of (2) two residents reviewed for notification of change during the Long-Term Care Survey Process. Resident identifiers #55, and #7. Facility Census 107. Findings include: a) Resident #55 During a phone interview on 07/22/25 at 11:40 AM, The MPOA, for Resident #55 stated, A couple months ago they took him (Resident #55) all the way to Morgantown for a Dermatology appointment to have a procedure done. I only found out about the appointment because the doctor’s office called me to get permission to treat him. That's about 45 minutes away. A review of the Grievance Log on 07/24/2025 at 1:03 PM, revealed that the MPOA for Resident #55 filed a grievance about not being notified of the dermatology appointment on 03/24/25. Grievance reads as follows: MPOA upset that she was not notified of (Resident #55 named) dermatology appointment today. Resolved on 03/24/25 Specific actions taken to resolve grievance included: Dermatology appointment was cancelled prior due to inclement weather. Rescheduled for 03/24/25 at 2:00 PM. MPOA was notified of appointment change. Signed by The Licensed Social Worker (LSW). A witness statement is attached to the Grievance written by Clinical Manager Licensed Practical Nurse (CMLPN) #48 that reads as follows: Resident MPOA asked about Dermatology appointment during care plans. This nurse confirmed with transports about appointment and confirmed appointment was cancelled and rescheduled. MPOA then notified by this nurse. Signed (03/24/25) Further record review, revealed a nurses note dated 01/07/25 that reads as follows: Appt. with Dr. (name) on 01/07/2025 @ 1145 one time only for dermatology for 1 Day cancelled. The social service care plan note dated 01/20/25 reads as follows: (Resident #55) Quarterly care plan is scheduled for Wednesday, January 29, 2025. (Resident #55) lacks capacity r/t dementia and is DNR with limited interventions and no feeding tube. (Resident #55) completed the PHQ-9 with a score of 2, depressed-1 and little interest-1. He has a mood state care plan in place and is prescribed anti-depressant medications. [NAME] did not have any behaviors this ARD. [NAME] has a (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosocial care plan for feelings of loneliness. [NAME]'s sister/MPOA only wants to be asked about community referrals on comprehensive assessments. (Resident #55) is expected to remain in facility long term. Further record review found no notes in the medical record to indicate that the MPOA was notified of the new dermatology appointment made for Resident #55 for 03/24/25. During an interview on 07/28/25 at 11:45 AM, LSW stated, There is not a note in his chart to say the family was notified. The State Agency SA asked, How do you typically know when families are notified of appointments? The LSW replied, There is a note in the medical record. A record review on 07/28/25 at 12:15 PM, revealed a doctor summary titled {Dermatology Consult}, confirming that Resident # 55 went to the Dermatology appointment on 03/24/25 for a Biopsy x2 of the right arm. Resident #7 Documentation for a Computed Tomography Scan (CT) completed 09/04/24 was reviewed by the state surveyor. Notification of results were not documented in the resident's electronic medical chart for physician, patient or responsible party. On 07/28/2025 at 11:45 AM, the Regional Clinical Coordinator #131 confirmed that there was no documentation for physician, resident of responsible party notification and stated, I've looked and I can't find anything. The facility's policy and procedure Notification of Changes in Condition stated under Policy, Changes may include but are not limited to accidents, incidents, transfers, changes in overall health status, significant medical changes, therapy services changes, transfer, hospitalizations, or death.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide the required notifications to a resident transfered to the hospital. This deficient practice affected one (1) of three (3) residents reviewed for the care area of hospitalization. Resident Identifier: #104. Facility Census: 107.Findings included: a) Resident #104 Review of Resident #104's medical records showed the resident was emergently transferred to the hospital on [DATE]. The resident reported emesis and shaking, stating she felt like she did when she previously had a myocardial infarction. The resident had capacity to make her own medical decisions. Further review of Resident #104's medical records did not reveal the following discharge documentation: - Written notification to the resident of the reasons for the transfer.- Notice of the facility's bed-hold policy and duration. On 07/24/2025 at 10:43 AM, Regional Clinical Coordinator #131 confirmed there was no evidence the written transfer/discharge notification and the bed hold notification had been completed and provided to Resident #104 when she was transferred to the hospital on [DATE]. No further information was provided through the completion of the survey.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based upon record review and staff interview, the facility failed to maintain accuracy of the Minimum Data Set (MDS) Resident Assessment and Care Screening for a diagnosis of major depressive disorder. This was found to be true for one (1) of six (6) residents reviewed during the annual survey process. Resident identifier: #77. Facility census: 107. Findings included:Resident #77's list of diagnoses, related to mental illness, included the following:Unspecified Dementia, Mild with AnxietyGeneralized Anxiety DisorderAlzheimer's DiseaseDuring a review of the medical record for the Resident, the progress notes dated 03/16/25 and 06/10/25 by Resident's medical provider, recorded the following diagnoses:Generalized anxiety disorderUnspecified dementia, mild, with anxietyMajor depressive disorder, recurrent, moderateThe Minimum Data Set (MDS) Resident Assessment was last completed on 06/17/25. Under Section I - Active Diagnoses included:Alzheimer's DiseaseNon-Alzheimer's DementiaAnxiety DisorderUnspecified Dementia, Mild, with AnxietyIn summary, the diagnosis of Major Depressive Disorder is not found in the MDS, even though it was completed after the medical provider declared this diagnosis on 03/16/25, and subsequently on 06/10/25.During an interview with the Regional Operations Coordinator on 07/23/25 at approximately 2:00 PM, she acknowledged the diagnosis of major depressive disorder should have been included in the MDS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based upon record review, resident interview and staff interview, the facility failed to develop a personalized care plan for a resident with a diagnosis of Post Traumatic Stress Disorder (PTSD). This was found to be true for one (1) of thirty-six (36) residents reviewed during the annual survey process. Resident identifier: #4. Facility census: 107.Findings included: During an interview with Resident #4 on 07/21/25 at 12:01 PM, the resident appeared to be very withdrawn, his face void of emotion. He was sitting alone, in his wheelchair, outside of his bedroom door. After conversing with the resident for several minutes, he stated he had served two deployments with the Army in IRAQ. We talked about his care, the food, his ability to make choices, etc., and he stated everything was ok. The resident finally smiled once before we ended our conversation. A review of the resident's electronic health record (EHR), revealed he has the following diagnoses:Post-Traumatic Stress Disorder Chronic (PTSD) 04/18/25 AdmissionDepression, Unspecified 04/18/25 AdmissionHis Care Plan, dated 04/17/25, did not have any focus, goal or interventional/tasks for PTSD.Other than a record entitled, Social History Assessment WV dated 05/06/25, completed by the Director of Social Services, which stated the resident was unaware of triggers for his PTSD, there appeared to be little documentation of facility efforts to provide trauma-informed care or culturally competent care. During an interview on 07/29/25 at 11:30 AM, The Regional Clinical Coordinator, (RCC) #131, confirmed that PTSD was not care planned for Resident #4.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on family interview, staff interview, record review, and observation the facility failed to provide Activities of Daily Living (ADL) care to dependent residents. This failed practice was found true for (1) one of (8) eight residents reviewed for ADL care during the Long-Term Care Survey Process. Resident identifier: #55. Facility Census: 107. Findings include: a) Resident #55 During a phone interview on 07/22/25 at 11:40 AM, The Medical Power of Attorney (MPOA) for Resident #55 stated, Every time I come to visit his fingernails need cut. Sometimes it makes indentions in his hand. An observation on 07/23/25 at 1:43 PM, of Resident #55's right and left hand, showed that he had fingernails that were long and jagged on both hands. A record review on 07/23/2025 at 1:46 PM, revealed an ADL care plan for Resident #55 that reads as follows:Focus: (Resident #55 named) has ADL Self Care Performance deficit with further decline expected related to progressive vascular leukoencephalopathy, MS, neoplasm of parotid gland requires assistance with ADL related to hx of CVA with L side hemiparesis, dementia, depression, arthritis, weakness, hx of polycythemia vera, leukoencephalopathy, anxiety disorder, unspecified mood (affective) disorder, CAD, low back pain, hx of seizure disorder, hyperlipidemia, no longer ambulates, and unspecified lack of coordination, traumatic hemorrhage of cerebrum. ADL's fluctuate with mood Goal:(Resident #55) will maintain current level of function as long as condition will allow Interventions related to nail care read as follows: Personal hygiene: Totally Dependent of 1- 1 helper does all the effort. Resident does none of the effort. During an observation and interview on 07/23/25 at 2:01 PM, Licensed Practical Nurse (LPN) #25 confirmed that Resident #55's fingernails were long and needed to be cut. The LPN then stated, I will get them cut today.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interview, the facility failed to ensure residents did not develop preventable pressure ulcers. The facility also failed to ensure residents with pressure ulcers received assessment in accordance with professional standards of practice. This deficient practice had the potential to affect two (2) of four (4) residents reviewed for the care area of pressure ulcers. Resident Identifiers: #110. Facility census: 107. Findings included:a) Resident #110 The facility's policy and standard procedure titled, Monitoring a Wound, with no date of implementation given, stated resident skin condition would be evaluated upon return from the hospital. Review of Resident #110's medical records showed the resident had an unstagable pressure ulcer of the right gluteal fold first assessed on 03/08/25 when the resident returned from a hospital transfer. The right gluteal fold pressure ulcer became a stage IV pressure ulcer and was present through 07/07/25, when the resident was transferred to the hospital. On 07/14/25, Resident #110 returned to the facility from the hospital. The Nursing admission Evaluation completed 07/14/25 answered No to the question Any skin areas noted. A Skin and Wound Note written by the Nurse Practitioner on 07/17/25 stated, Patient being seen today for evaluation stage 3 PI of right gluteal fold which was POA [present on admission] on 03/08/2024. [NAME] readmission to facility from stay in hospital, patient noted to have DTI [deep tissue injury] of left inner thigh which was POA date of 07/14/2025. An order was written on 07/15/25 for Wound care: right gluteal fold: cleanse area with wound cleanser, pat dry. Apply skin prep around wound, then silicone dressing daily until healed, every day shift. On 07/17/25, an assessment was performed of the right gluteal fold stage III pressure ulcer. The assessment indicated this pressure ulcer had been present since 03/08/25. Also, on 07/17/25, an assessment was performed of the left thigh suspected deep tissue injury. The assessment indicated this pressure ulcer was a new pressure area first observed 07/17/25. An order was written to start 07/18/25 to Cleanse area to left inner thigh with wound cleanser, apply border dressing daily. On 07/23/2025 at 3:04 PM, Regional Clinical Coordinator #131 confirmed the pressure ulcers Resident #110 had on readmission to the facility on [DATE] were not assessed until 07/17/25.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and staff interview, the facility failed to provide tube feeding care and services within established acceptable standards of care. TThis deficient practice had the potential to affect one (1) of one (1) residents reviewed for the care area of tube feeding. Resident Identifier: #2. Facility census: 107.Findings included: The facility's policy titled, Enteral General Nutrition (tube feeding) Guidelines, with no date of implementation given, gives the following procedures to be performed prior to administration of bolus tube feedings: - Validate tube placement by aspirating 12-30 cc of stomach contents using a 60 cc piston syringe. Replace stomach contents once placement is verified.- Flush the enteral feeding tube with at least 15-30 cc of water or as directed by the physician order Review of Resident #2's physician orders showed the following orders: - Enteral Feed five times a day Flush enteral tube with 30 mls [milliliters] of water before and after each bolus feed, ordered 4/27/25.- Enteral feed G-Tubes [gastroscopy tube] are checked via aspiration immediately after insertion, before each feeding and/or flush, before administering medications via tube, before performing gastric residual check and at least every 8 hours, ordered 4/19/25.- Validate tube placement; aspirate 15-30 cc of stomach contents use a 60cc catheter tipped syringe before accessing tube. Replace stomach contents once verified, if placement cannot be validated, do not use tube and contact physician, ordered 4/19/25. On 07/28/25 at 1:29 PM, Licensed Practical Nurse (LPN) #16 was observed administering a bolus tube feeding to Resident #2. LPN #16 flushed the resident's gastroscopy tube with approximately 30 cc of water using a piston syringe. LPN #16 then stated she should have checked the placement of the gastroscopy tube before flushing the tube. LPN #16 aspirated approximately 60 cc of mustard-colored fluid from Resident #2's gastroscopy tube using a piston syringe. She replaced the gastric contents. She also used the piston syringe to inject air through the tube, listening for the air with a stethoscope against the resident's stomach. After verifying the gastroscopy tube placement, LPN #16 appropriately gave Resident #2 the bolus feeding and reflushed the gastroscopy tube with water. No further information was provided though the completion of the survey process.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interview, the facility failed to ensure medications were stored properly. This was a random opportunity for discovery. Facility census: 107. Findings included: a) Hall 400 Medication Cart On 07/23/2025 at 10:10 AM, during medication cart inspection on the 400 hall, found Latanoprost with a label REFRIGERATE. The medication was unopened and had been stored in the medication cart. According to the medication insert Storage: Protect from light. Store unopened bottle(s) under refrigeration at 2 to 8 C (36 to 46 F). This was confirmed by Licensed Practical Nurse (LPN) #22.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and staff interview, the facility failed to ensure laboratory testing was performed according to the physician orders. This deficient practice had the potential to affect one (1) of six (6) residents reviewed for the care area of unnecessary medications. Resident identifier: #10. Facility census: 107. Findings included:a) Resident #10 Review of Resident #10's physician's orders showed the following orders for laboratory testing: - Complete blood cell count with differentiation and comprehensive metabolic panel, every six (6) months in February and August, ordered 01/15/25.- Lipid panel annually, in February, ordered 01/15/25. Review of Resident #10's laboratory results did not show laboratory testing performed in February 2025. On 07/24/2025 at 12:57 PM, Regional Clinical Coordinator #131 confirmed Resident #10 did not have physician-ordered laboratory testing in February, 2025. She did have the laboratory testing on 05/22/25. No further information was provided through the completion of the survey process.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review, resident interview, and staff interview, the facility failed to honor the food preferences of a resident. This was found to be true for one (1) of eleven (11) residents reviewed during the annual survey process. Resident identifier: # 45. Facility census: 107. Findings included:On 07/22/25 at 1:26 PM, during an interview with Resident #45, when asked about his food at the facility, he stated, food is not too good, too many things with vinegar in it or on it. Stated he has gotten egg salad sandwiches several times in a row, and brussel sprouts. He stated he does not like pickles or things with vinegar in them. I asked him if he had expressed this to the staff and he stated yes. A review of the resident's dietary preferences in the electronic health record (EHR), stated: Likes gravy on the side.Dislikes pickles, mayonnaise, vinegar, fish of any kind.On 07/23/25, mid-morning, the surveyor requested to review two weeks of meal tickets for this resident. The weeks selected to review were: 07/06/25 to 07/12/25, and 06/22/25 to 06/28/25.For the week of 06/22/25 to 06/28/25, the meal tickets showed resident had been served:BBQ Cheeseburger on a Bun with Pickle spear on 06/22/25Egg Salad sandwich (contains eggs, mayonnaise, pickles) on 06/23/25Fish Sandwich with Tartar Sauce (contains mayonnaise and pickles) on 06/24/25Fried fish with Tartar sauce on 06/27/25For the week of 07/06/25 - 7/12/25, meal tickets showed the resident was served:Egg Salad sandwich on 07/06/25Breaded fish on bun with tartar sauce on 07/07/25Cheeseburger on bun with pickle on 07/09/25Fried fish with Tartar sauce on 07/11/25During an interview with the Dietary Manager #106 on 7/23/2025 at approximately 3:09 PM, surveyor asked, how does the dietary department know a resident's preferences of food? Dietary Manager responded, we utilize Mealtracker. The Surveyor then requested a copy of this Resident's food preferences from Mealtracker. Approximately twenty (20) minutes later, the Dietary Manager returned with the requested Mealtracker document. Upon review of the Mealtracker document for Resident, there were no preferences marked.When the surveyor reviewed the meal tickets for the resident, and the documentation in the electronic health record (EHR) for resident's dislikes, specifically pointing out the fish, the egg salad, pickles, tartar sauce, the Dietary Manager said apparently the Mealtracker system is not crossing over from the EHR. When asked, how can you honor a resident's food preferences if you do not have them in the system? The Dietary Manager and the Regional Dietary Coordinator stated, we have found this in a few residents, we think something happened when we changed over from the Winter/Spring menus to the Summer menu.The following morning on 07/24/25, at approximately 9:30 AM, the Dietary Manager brought revised documentation showing the resident's preferences had been updated and would be honored in the future.[NAME] JR, [NAME] (45) Walker, [NAME] (51554) - RESIDENT NOTE No Notes

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Number of residents sampled: 36Number of residents cited: 1The facility failed to ensure residents had ordered adaptive equipment.Resident #5Based on observation, resident interview, medical record review, the facility failed to ensure Resident #5 had ordered adaptive eating utensils. This failed was true for one (1) of 36 sample residents. Resident identifier: #5. Facility census: Findings included: On 07/21/25 at 9:03 and observation of Resident #5 meal tray card revealed there was to be a left angled fork, left angled spoon, plate guard and Kennedy cup. There was no left angled fork, left angled spoon on the lunch tray. When asked Resident #5 if she gets the equipment on her meal trays she stated No. I keep a set (fork and spoon) in my room and the aides wash them in my bathroom with dish washing soap. Nurse Aide (NA) #83 confirmed there was no left angled fork or spoon on the tray.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and staff interview, a Nurse Aide (NA) failed to don on a gown when performing catheter care for Resident #44 who was on Enhanced Barrier Precautions. This was true for one of one sampled residents. Resident identifier: #44. Facility census: 107. Findings included: a) Resident #44 On 07/28/25 at 10:39 AM observed Resident #44 Foley catheter care provided by NA # 84. Prior to entering Resident #44's room there were signs posted that Enhanced Barrier Precautions (EBP) were required when doing direct resident care such as catheter care. EPB included donning a gown and gloves. NA #84 donned gloves and proceeded to perform catheter care. NA #84 failed to don a gown. When asked about EBP, NA #85 stated Oh no. I didn't put on a gown. NA #85 immediately donned a gown and proceeded to change the resident's brief and dispose of soiled items.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to follow principles of antibiotic stewardship. This deficient practice had the potential to affect one (1) of three (3) residents reviewed for antibiotic use. Resident Identifier: #66. Facility Census: 107.Findings included: a) Resident #66 The facility's procedure titled, Antibiotic Stewardship Plan, with effective date 05/01/17, stated the Infection Preventionist would review culture data to support antibiotic stewardship. Review of Resident #66's medical records showed she was admitted to the facility with a surgical site infection at the site of a toe amputation. On 05/10/25, a wound culture was performed due to increased drainage at the site. The resident was also started on the antibiotic Cefalexin. The culture grew the organism Methicillin-resistant Staphylococcus aureus. The sensitivity report showed the organism was resistant to the antibiotics Clindamycin, Tetracycline, and Doxycycline, in addition to Methicillin (oxacillin). On 05/16/25, Resident #66 was also started on the antibiotic Linezolid for Methicillin-resistant Staphylococcus aureus. The prior wound culture and sensitivity showed the organism was resistant to Linezolid. On 05/19/25, Resident #66 was transferred to the hospital due to tissue necrosis at the site of the previous toe amputation. A wound culture performed at the hospital continued to show Methicillin-resistant Staphylococcus aureus, resistant to the antibiotics Clindamycin, Tetracycline, and Doxycycline, in addition to Methicillin (oxacillin). During her hospitalization, Resident #66 was started on the intravenous antibiotic Tigecycline. The wound culture and sensitivity had shown the wound was resistant to Tigecycline. The resident continued ntravenous Tigecycline upon readmission to the facility on [DATE]. She received Tigecycline through 06/22/25. She received Linezolid orally again from 06/24/25 through 06/26/26. On 06/27/25, Resident #66 was prescribed the antibiotic Doxycycline, by mouth, two (2) times a day, for five days, for surgical site infection. No documentation could be found in the medical records as to why the antibiotic was changed from Linezolid to Doxycycline that day. On 07/29/25 at 11:00 AM, Regional Clinical Coordinator confirmed Resident #66 was started on the antibiotic Doxycycline despite previous wound cultures showing the infectious organism was resistant to Doxycycline. She also stated she was not able to provide additional information as to why the antibiotic was changed from Linezolid to Doxycycline that day. No further information was provided through the completion of the survey.