STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515086	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beckley Healthcare Center	100 Heartland Drive Beckley, WV 25801

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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. 49467 Based on observation and staff interview, the facility failed to treat each resident of the facility with dignity and respect, by failing to knock on the door before entering Resident #84's room and by failing to serve lunch to Residents #36 and #78 at the same time as their roommates. This was a random opportunity for discovery. Resident identifiers: #84, #78, #36. Facility census: 181. Findings included: a) Resident #84 At approximately 9:15 AM 10/08/24 during an interview with Resident #84, Licensed Practical Nurse (LPN) #51 was observed walking into the resident's room, without knocking on the door and announcing themselves, to take his blood pressure. LPN #51 walked to the right side of Resident #84's bed and put the blood pressure cuff on his arm and proceeded to take his blood pressure. Upon finishing, LPN #51 why they did not knock on the door before entering the room, to which they stated, I normally do, I just didn't think about it this time. b) Resident #78 At approximately 12:19 PM on 10/08/24, a lunch tray was delivered to the roommate of Resident #78. After delivering the tray to Resident #78's roommate, the employees continued to deliver trays to other rooms. LPN #51 was assisting with tray pass and stated Her tray wasn't sent from the kitchen. At approximately 12:30 PM, LPN #51 stated We still have people that don't have trays. LPN #51 acknowledged Resident #78 was one of those residents. LPN #51 also acknowledged Resident #78's roommate had been served approximately ten (10) minutes prior. A tray for Resident #78 was delivered to her room at approximately 12:40 PM. c) Resident #36 (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At approximately 12:20 PM on 10/08/24, a lunch tray was delivered to the roommate of Resident #36. After delivering the tray to Resident #36's roommate, the employees continued to deliver trays to other rooms. LPN #51 was assisting with tray pass and stated Her tray wasn't sent from the kitchen. At approximately 12:30 PM, LPN #51 stated We still have people that don't have trays. LPN #51 acknowledged Resident #36 was one of those residents. LPN #51 also acknowledged Resident #36's roommate had been served approximately ten (10) minutes prior. A tray for Resident #36 was delivered to her room at approximately 12:40 PM.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 49650 50552 Based on record review and staff interview, the facility failed to provide education related to the risks, benefits and potential alternative treatment options for the use of psychotropic medication use. In addition, the facility failed to educate on the risks of refusal of care, such as routine bathing, wound care appointments. This was true for 3 (three) of 5 (five) residents reviewed during the Long Term Care Survey Process. Facility census: 181. Resident identifiers: Resident #93, Resident #163 and Resident #174. Findings included: a) Resident #93 On 10/07/24 at approximately 3:00 PM, a record review was completed for Resident #93. During a this review, Resident #93 was noted to have received the following high risk medications while a resident at this facility: Medications: Pre-Fall: 1. Diazepam 0.5mg by mouth at bedtime for Anxiety, Start date 08/09/24. 2. Buspar 7.5mg by mouth three times daily for Anxiety, Start date 08/10/24. 3. Sertraline 100mg by mouth every morning for Depression, Start date 08/09/24. 4. Hydralazine 100mg by mouth as needed for Hypertension, Start date 08/09/24. Post-Fall with fracture: 1. Eliquis by mouth two times a day for Atrial Fibrillation, Start date 09/14/24. 2. Lisinopril 20 mg by mouth once a day for Hypertension, Start date 09/14/24. 3. Buspar 7.5mg by mouth three times a day for Anxiety, Start date 09/13/24. 4. Hydralazine 25mg by mouth one tablet two times a day for Hypertension, Start date 09/16/24. 5. Norco (Hydrocodone-Acetaminophen) one half tablet by mouth three times a day for back pain, Start date 09/25/24. 6. Escitalopram 10mg by mouth one time a day for Depression, Start date 10/02/24. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Trazodone 100mg by mouth at bedtime for Major Depressive Disorder, Start date 10/03/24. 8. Aricept 5 MG by mouth two times a day for Depression, Start date 10/01/24. Diagnoses included Depression, Anxiety, Insomnia, and Dementia with other behavioral disturbance. Furthermore, during the review of Resident #93's record, the following care plans with interventions specific to the use of these medications were revealed: FOCUS: The resident uses, anti-anxiety medication Anxiety Disorder. GOAL: Resident #93 will have decreased episodes of anxiety through target date. INTERVENTIONS: Educate resident, resident representative of risks, benefits and side effects of medication use. FOCUS: Resident uses, anti-depressant medication Depression. GOAL: Resident #93 will have decreased episodes of depressed mood through target date. INTERVENTION: Educate resident, resident representative of risks, benefits and side effects of medication use. On 10/08/24 at approximately 12:00 PM, a review of Policy and Procedure entitled, Plan of Care Overview was performed which revealed that the resident and/or resident representative will be involved in the resident's plan of care in order to support the resident's goals, choices and preferences. Furthermore, this policy states that resident's and/or resident representatives have the right to participate in the development and implementation of his/her own plan of care including the right to the type of care provided according to the plan of care. Afterward, a review of Policy and Procedure entitled, Resident Rights, ICF Policy was performed which revealed that resident's have the right to be fully informed about their total healthcare in a language the resident and/or representative understand. On 10/09/24 at approximately 1:30 PM, this Surveyor requested a copy of any education provided to Resident #93 or Resident #93's representative of the potential risks verses benefits of the use of these medications and any alternative treatment options offered. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 9:40 AM, the facility Administrator #186 acknowledged she was unable to provide documentation that Resident #93 and/or Resident #93's representative were included in the plan of care for Resident #93's management of psychiatric disorders related to the use of these medications. In addition, Administrator #186 acknowledged there was no documentation that Resident #93 and/or Resident #93's representative were provided education in a language Resident #93 and/or Resident #93's representative could understand on the risks verses benefits of the use of these medication or that alternative treatment options to support Resident #93's choices and preferences were explained. b) Resident #163 On 10/07/24 at approximately 3:00 PM, a record review for Resident #163 was completed which revealed the following diagnoses: Depression, Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Reduced mobility, Pressure ulcer of left buttock, stage 4 (four), Diabetes mellitus, type II with hyperglycemia, Need for assistance with personal care, Anemia, Dysphagia following cerebral infarction, Gastrostomy, and hypertension. In addition to the following documentation: 2/26/2024 19:10 eMar - Medication Administration Note Note Text: Vital Signs Q shift X72 hours then Daily every day shift for Daily Vital Signs Patient refused x 3. 3/1/2024 16:27 Nurses Note Late Entry: Note Text: Resident refused shower x multiple attempts from staff. Resident refused bed bath x multiple attempts. Resident #163's, MPOA aware. 4/30/2024 09:50 Weight Change Note Note Text: WEIGHT WARNING: Value: 158.4 Vital Date: 2024-04-30 07:17:00.0 -7.5% change [10.8% , 19.2] -10.0% change [10.8% , 19.2] RD wt., wound, and TF note. TF - Glucerna 1.5 @ 95cc/hr x 8 hrs to provide 760ml and 1140kcal and 63gm prot per 24 hrs w/ H20flushes @ 60cc/hr while TF infusing. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Modular protein 30ml bid to provide 200kcal and 20gm prot; refused x 2 past week. Diet: Reg Dys Adv. Po intake past week; R x 2 meals; 0-25% x 4 meals; 26-50% x 4 meals; 51-75% x 2 meals; 76-100% x 1 meal providingaround 736kcal and 29gm prot. TF, mod prot, and po intake providing around 2076kcal and 112gm prot Wt. history: 4/30: 158.4#, 4/23 162.4#, 3/28 163.2#, 2/17 177.6# - wt. loss 10% x 2 mo and wt. loss trend past week. BMI 21.5 wnl. skin: UN PI Lt. buttocks. Est. needs: 1800-2160kcal (25-30kcal/kg); 90-108gm prot (1.25-1.5gm/kg); 1cc/kcal. Rec. TF - Glucerna 1.5 @ 95cc/hr x 9 hrs to provide 855cc, 1283kcal, 71gm prot, 649cc free fluid w/ H20 flushes @ 60cc/hr while TF infusing to provide 540cc per 24hrs. Rec. administering mod prot via PEG. TF, po intake and mod prot can meet est. needs. Will f/u prn. 9/3/2024 07:48 Nurses Note Note Text: Resident refused to go to apt at Wound care. Resident #163's representative is aware. Apt is to be rescheduled. 9/24/2024 17:41 Skin Grid Pressure Note Text: NEW AREA: No Resident has refused wound assessment 10/2/2024 22:21 eMar - Medication Administration Note Note Text: OBTAIN WEIGHT AND PLACE UNDER VITALS TAB one time only until 10/02/2024 23:59 Resident was asked for weight measurement x2 on this shift to which resident refused both times. 10/8/2024 19:56 Skin Grid Non-Pressure Late Entry: Note Text: New area noted: No Resident refused wound assessment Also, the following physician orders: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regular diet: Dysphagia Advanced texture, thin liquids consistency, scoop meal for all meals. Enternal feed order: in the evening, Glucerna 1.5 at 120 milliliters (mls) for 12 hours from 7p to 7a via peg tube to provide around 1440 mls and 2160 kilocalorie's (kcal) per 24 hours. Water flushes at 70 mls/hour (hr) while tube feeding infusing to provide 840 mls per 24 hrs. Vital signs weekly. Weekly skin assessment to be completed. Wound care consult. Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine) Inject 10 units subcutaneously at bedtime for Diabetes mellitus Metformin Oral tablet 1000 milligrams (MG) give 1 (one) tablet orally two times a day for Diabetes Mellitus. On 10/08/24 at approximately 12:00 PM, a review of Policy and Procedure entitled, Plan of Care Overview was performed which revealed that the resident and/or resident representative will be involved in the resident's plan of care in order to support the resident's goals, choices and preferences. Furthermore, this policy states that resident's and/or resident representatives have the right to participate in the development and implementation of his/her own plan of care including the right to the type of care provided according to the plan of care. Afterward, a review of Policy and Procedure entitled, Resident Rights, ICF Policy was performed which revealed that resident's have the right to be fully informed about their total healthcare in a language the resident and/or representative understand. In addition to employees will notifiy their immediate supervisor when care or treatment is refused. On 10/09/24 at 10:39 AM, a review of Policy and Procedure entitled, Resident Rights revealed that all residents will be treated with dignity and respect and that for choice of care options, including the right to refuse care, the nurse will communicate and document repeated refusal of care to provider. On 10/09/24 at 11:26 AM, a review of Resident #163's Brief Interview for Mental Status (3.0) BIMS indicated Resident #163's moderately Impaired with a score of 9.0. In addition to the following care plans: FOCUS: The resident has expressed preference to refuse Tube Feedings at times. Resident will not keep clothing on and refuses to cover up. Resident Rights GOALS: Cletis will allow staff to give tube feeding as ordered through next review. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	INTERVENTIONS: Encourage resident to allow staff to administer tube feeding as ordered. FOCUS: The resident has impaired skin integrity r/t stage 4 PI to left buttock, abrasion to left thumb. GOALS: Cletis will have improved or maintain current skin status through next review date. Stage 4 PI left buttock will show signs of improvement through next review. Abrasion to left thumb will show signs of improvement through next review. INTERVENTIONS: Administer medications as ordered, monitor for side effects and effectiveness. Administer treatments as ordered by medical provider. Complete skin at risk assessment upon admission / readmission, quarterly, and as needed. Complete Weekly Skin checks. Device: Low air loss, automatic weight sensing technology Air Mattress with bolsters Encourage resident to turn and reposition or assist as needed as resident allows monitor existing wound daily, for changes (redness, edema, drainage, pain, foul odor. Nutritional consult on admission, quarterly, and PRN. Provide appropriate off-loading mattress & off-loading cushion, if applicable Use wipes not washcloth for incontinence/peri care when possible and resident will allow. On 10/09/24 at 12:27 PM, an interview was conducted with the Director of Nursing (DON) of Station 1 and the Unit Manager (UM) of Station 1. At this time, this Surveyor asked the DON and UM if Resident #163's refusal of care placed Resident #163 at risk for worsening of the Stage 4 (four) pressure ulcer. The DON and UM acknowledged that yes, it would. This Surveyor then asked if Resident #163's refusal of care should be care planned along with goals and interventions to accommodate Resident #163's refusal of care. The DON and UM acknowledged that, yes, it should. This Surveyor then requested documentation related to the following: 1. Education of risks vs. benefits related to refusal of care provided to Resident #163 and Representative. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Documentation of involvement of Resident #163 and Representative in plan of care related to interventions and goals for refusal of care. 3. Documentation of a comprehensive care plan addressing refusal of care. On 10/09/24 at approximately 1:59 PM, the DON of Station 1 and Administrator of Station 1 acknowledged the following: 1. No documentation of comprehensive care plans related to refusal of shower/bathing, wound clinic appointments, and wound treatments/assessments. 2. Acknowledged no documentation of education of risks vs benefits of refusal related to adverse outcomes related to the refusal of care could be provided. 3. Acknowledged no documentation of involvement of RP in plan of care related to potential interventions and goals for refusal of care. The facility failed to provide informed consents and medications for Psychotropic medications and refusal of care. Resident 174, 93, 163 c) Resident #174 During a medical record review 10/14/24 at approximately 10:58 AM Resident #174 medication orders the resident is identified to be taking Sertraline hcl oral tablet 50 mg by mouth 1 tablet in the morning for depression target behavior: tearfulness order dated 08/31/24; Trazadone hcl oral tablet 100 mg 1 tablet by mouth at bedtime for bedtime for sleep Target behaviors: sleeplessness order start dated 8/31/2024; Olanzapine Oral Tablet 2.5 MG for delirium order dated 08/31/24. It is further identified that on 08/31/24 a Psychoactive Medication Informed Consent form was signed by Resident #174's representative and the attending physician. This form identified Zoloft 50 mg daily and Olanzapine 2.5 mg daily to be the prescribed recommended medication by the physician. Trazadone was not identified in this section as a prescribed recommended medication by the physician. The form denotes a section to identify the indication of the psychoactive medication for the specific condition/diagnosis, beneficial effects expected and the possible side effects. This section was not completed to identify the specific condition/diagnosis, beneficial effects expected and the possible side effects. The proposed course of the medications was also not completed. On 10/14/24 at approximately 11:54 AM during an interview with the Administrator #186, the Administrator #186 acknowledged the resident did not have the risk and benefits identified as the informed consent was not thoroughly completed.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 50552 Based on observation, record review and staff interview, the facility failed to ensure Resident #163's dignity was maintained. This was a random opportunity for discovery in the Long Term Care Survey Process. Resident identifiers: Resident #163. Facility census: 181. Findings included: a) Resident #163 On 10/09/24 at 9:37 AM, this Surveyor was walking past Resident #163's room. At that time, this Surveyor observed Resident #163 laying in bed on a deflated air mattress with the call light on. Resident #163 cord to the air mattress was noted to be laying in the floor unplugged. Resident #163 was noted to be laying in a brief with no other clothing on, exposed to all facility staff, other residents and visitors walking on this hallway, with no blanket or curtain pulled to provide privacy. Multiple facility staff were observed to be walking down the hallway and passing by Resident #163's room and call light without stopping to ask Resident #163 what was needed or to offer to place a blanket to cover #163 or pull the curtain. Wound Nurse (WN) #21, was observed to be standing directly adjacent to Resident #163's room, with Resident #163 in full view. At that time, this Surveyor requested to speak with her. WN #21 acknowledged Resident #163 should be dressed, covered up or his curtain pulled to maintain Resident #163's dignity and went into Resident #163's room to ask if she could pull the cover. Resident #163 consented to allow WN #21 to pull the cover over him. On 10/09/24 at 10:39 AM Review of Policy and Procedure entitled, Resident Rights revealed that all residents will be treated with dignity and respect This policy also states that it is to guide employees in the general principles of dignity and respect of caring for residents and the rights and safety of other residents, staff and visitors. On 10/09/24 at 11:26 AM, a review of Resident #163's Brief Interview for Mental Status (3.0 BIMS) indicated Resident #163 is moderately impaired with a score of 9.0. On 10/09/24 at 11:46 AM, a review of Resident #163's capacity statement indicated Resident #163 lacks capacity, short term, related to disorientation due to cerebral vascular accident (CVA).

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465 Based on observation, resident interview and staff interview, the facility failed to ensure residents had the right to make choices about aspects of their life in the facility that are significant to them such as having menu options for meals. This failed practice was found true for (5) five of (8) eight residents that were reviewed for choices during the Long-Term Care Survey Process. Resident identifiers #11, #6, #93, #55, #165. Facility Census 181. Findings Included: a) Resident #11 During the initial interview on 10/07/24 at 4:05 PM, Resident #11 stated, I did not know I had a choice of what I got to eat. If I don't like it, I just don't eat it. During an interview on 10/09/24 at 2:37 PM, The Dietary Manager (DM) stated, The activity staff put out a bulletin in the evenings for the next day that has the menu on it and the alternate menu. I am not sure if it has the always available menu on it. She further stated. There is an always available menu hanging in building (1) one on the bulletin board at the time clock. A review of the daily event sheet from activities showed that it had the menu for the day and the alternate menu for the day but not the always available menu. During an interview on 10/09/24 at 3:00PM, The Activity Director (AD) #39 confirmed that the always available menu is not on the daily event sheet that is handed out to residents. An observation on 10/09/24 at 3:15 PM, of the always available menu posted on the bulletin board revealed that it was above readable height for a resident in a wheelchair to be able to access it. During an interview on 10/09/24 at 3:15 PM, The Assistant Director of Nursing (ADON) #10 confirmed that the always available menu is not posted at a reasonable place or at eye level for residents to be able to access it. b) Resident #6 On 10/07/2024 at approximately 2:45PM, Resident # 6 stated during an interview that there isn't always enough staff to get her out of bed. She stated she is to heavy for just one aide to lift her. On 10/08/2024 at approximately 10:45 AM During an interview with resident #6, as Resident Council President, she stated she did want to attend the meeting scheduled for 10/09/2024 at 2:00PM. 10/09/24 11:31 AM (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an Interview with Resident #6 at 11:31AM, She states she was told today that there is only 1 aide on the floor, and since she is a full lift, she may not be able attend the Residential Council meeting scheduled at 3:00PM. Resident #6 did not arrive at the resident council meeting until 3:35PM, The resident stated they did not want to get me up this morning . *It is noted that Resident #6 was over 35 minutes late for the meeting that was scheduled over 24 hours previously by the Activities Director. In an interview with the Activities Director #111, on 10/10/24 at approximately 4:10 PM, she confirmed she went to check on Resident #6 when she did not come to Resident Council, confirmed Resident #6 did want to attend the coucil meeting and at that time, she requested staff to get her up and bring resident #6 to the meeting. c) Resident #93 During the initial interview on 10/07/24 at 2:55 PM, Resident #93 stated, All they serve is chicken, all the time, I am so sick of it. If I don't like it, I just don't eat it, because I didn't know I had another choice. During an interview on 10/09/24 at 2:37 PM, The Dietary Manager (DM) stated, The activity staff put out a bulletin in the evenings for the next day that has the menu on it and the alternate menu. I am not sure if it has the always available menu on it. She further stated. There is an always available menu hanging in building (1) one on the bulletin board at the time clock. A review of the daily event sheet from activities showed that it had the menu for the day and the alternate menu for the day but not the always available menu. During an interview on 10/09/24 at 3:00PM, The Activity Director (AD) #39 confirmed that the always available menu is not on the daily event sheet that is handed out to residents. An observation on 10/09/24 at 3:15 PM, of the always available menu posted on the bulletin board revealed that it was above readable height for a resident in a wheelchair to be able to access it. During an interview on 10/09/24 at 3:15 PM, The Assistant Director of Nursing (ADON) #10 confirmed that the always available menu is not posted at a reasonable place or at eye level for residents to be able to access it. d) Resident #55 An interview conducted with Resident #55 on 10/07/24 at 11:35 AM who reported that the food is not tasteful. She also reported that the facility does not offer evening snacks every evening and do not offer substitute meals. She was not aware of an always available/substitute menu. Resident reported that her daughter feeds her every evening. e) Resident #165 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Resident #165 on 10/07/24 at 11:15 AM, who reported that the food is no good. Resident reported that the facility did not offer substitute meals when he did not like the food. He denied knowing that there was substitutes available. His wife brings his food twice a day. 50551 50552 b) Choices Based on resident and staff interviews, the facility failed to ensure Resident #6 is able to attend activities of her choice. On 10/07/2024 at approximately 2:45PM, Resident # 6 stated during an interview that there isn't always enough staff to get her out of bed. She stated she is to heavy for just one aide to lift her. On 10/08/2024 at approximately 10:45 AM During an interview with Resident #6, as Resident Council President, she stated she did want to attend the meeting scheduled for 10/09/2024 at 2:00 PM. On 10/09/24 in an Interview with Resident #6 at 11:31AM, She states she was told today that there is only 1 aide on the floor, and since she is a full lift, she may not be able attend the Residential Council meeting scheduled at 3:00PM. Resident #6 did not arrive at the Resident Council meeting until 3:35PM, The resident stated they did not want to get me up this morning . It is noted that Resident #6 was over 35 minutes late for the meeting that was scheduled over 24 hours previously by the Activities Director. In an interview with the Activities Director, Employee indentifier #111, on 10/10/24 at approximately 4:10 PM, she confirmed she went to check on Resident #6 when she did not come to Resident Council, confirmed Resident #6 did want to attend the coucil meeting and at that time, she requested staff to get her up and bring Resident #6 to the meeting. 50801 561 The facility failed to provide menu options to residents This is true for 5 of 8 resident for choics PS-[NAME] A) 11-CR B) 6-MA C) 93-TM D)55-AR (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E) 165 AR Resident #6 Choices 10/08/2024 introduction interview with resident council president, she stated she wanted to attend the meeting scheduled for 10/09/2024 at 2:00PM. 10/09/24 11:31 AM In an Interview with Resident at 11:31AM, She states she was told today that there is only 1 aid on the floor, she may not be able to go to Residential Council meeting today. On 10/09/2024 on 3:35 PM at the resident council meeting, The resident stated they did not want to get me up this morning . It is noted that she was over 35 minutes late for the meeting. It was scheduled over 24 hours previous by the activities coordinator. On 10/10/2024 at 10:30 AM in an interview with activities coordinator she stated that she asked the resident if she wanted to attend the meeting and the resident stated that she did. She states at that time she went to get the aid and requested her to dress and bring the resident to the meeting.

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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. 49465 Based on observation and staff interview the facility failed to provide a clean comfortable and homelike environment. Ceiling tiles stained, ceiling air handler vents blackened in color, return vents covered in thickened dust. This was a random opportunity of discovery during the long term care survey and had the ability to affect a limited number of residents. In addition, Resident #5's Packaged Terminal Air Conditioner (PTAC) unit was not cleaned in accordance with professional Standards. Facility Identifier: Dining room Building 1. Resident identifier #5. Facility Census: 181. Findings included: a) Dining room Building 1. During a tour of the dining on 10/07/24 at 11:53 AM the following observations were made: * Ceiling tile to the left of the television (facing the television) had large circular stained areas over half of the tile with an adjoining tile with smaller circular stained areas. * Ceiling tile with visibly soiled with circular stains to the far left of the room (facing the television) at side door above fire alarm. * Ceiling tile with visibly soiled circular stains at the double door, above the clock. * Air handler vents were visibly soiled with a brownish black dusty substance covering the outer surfaces. * Return vents were visibly soiled as they were fully covered in a brownish thick dusty substance. During an interview with the Administrator on 10/07/24 at approximately 12:09 PM the Administrator agreed the tiles had visible stains and that the air handlers and return vents were visibly soiled with brown and black dusty substance. The Administrator further stated she would have it addressed. b) Resident #5 An observation on 10/07/24 at 1:30 PM, of Resident #5's room revealed the PTAC unit filters to be full of dust and debris and the slats at the top of the unit were full of a black substance. During an interview on 10/08/24 at 2:30 PM, The Maintenance Director (MD) stated, We clean them. We have a schedule. He confirmed that Resident #5's PTAC unit was dirty and had not been cleaned as scheduled. 49650

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49467 Based on record review and staff interview, the facility failed to keep Residents #110, #242, #134, and #119 free from abuse as results of resident to resident interactions by Resident #139. This was true for one (1) of four (4) residents reviewed for abuse during the survey process. Resident identifiers: #139, #110, #119. Facility census: 181. Findings included: a) Resident #110 At approximately 1:30 PM on 10/08/24, during a review of Resident #139's record, it was determined she had been in altercations with 4 different residents at the facility from 05/07/24 through 05/21/24. It was determined, based on the reportables provided by the facility, Resident #110 was involved in the altercation on 05/07/24. A review of the facility investigation revealed Social Worker (SW) #77 took a statement from the Physical Therapist (PT) at the facility (dated 05/10/24), stating Resident #110 reported to them she was struck by Resident #139, but did not obtain a written statement, nor did they have an interview on file with Resident #110 concerning the incident. The reportable sent in by the facility indicated they were not made aware of the incident until 5/10/24 No interventions were put into place to keep Resident #139 from striking another resident due to the facility not being made aware of the incident until 05/10/24. b) Resident #119 At approximately 1:30 PM on 10/08/24, during a review of Resident #139's record, it was determined the resident was in an altercation with Resident #119 on 05/21/24. According to progress notes on 05/21/24 at 2:03 PM, Resident #139 was in the dining room and grabbed Resident #119's arm and squeezed it. The progress note states Action was witnessed by 3 other residents with capacity. Progress notes state Resident #139 was removed from the dining room and placed on one (1) on one (1) supervision immediately. However, during review of the resident's Medication Administration Record (MAR) for May of 2024, it was noted the facility was missing documentation to prove Resident #139 received one (1) on one (1) supervision on 05/22/24 while it was still ordered. At approximately 3:30 PM on 10/16/24, Administrator #13 acknowledged the missing documentation for one (1) on one (1) supervision.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from medications that restrain them, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on record review and staff interview, the facility failed to ensure that Resident #139 was free from chemical restraints. This was true for one (1) of four (4) residents reviewed for behaviors during the survey process. Resident identifier: #139. Facility census: 181. Findings included: a) Resident #139 At approximately 1:30 PM on 10/08/24, during a review of the record for Resident #139, it was noted the resident had received an as needed (PRN) order for Lorazepam (also known as Ativan) Oral Concentrate 2 MG/ML. The order reads as follows: Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml orally every 2 hours as needed for terminal agitation/restlessness. This order was recommended by the hospice provider as the resident is currently receiving hospice services. The Resident received this order for a one time dose of oral concentrate Ativan on 05/09/24, ending on 05/10/24. However, on 05/10/24, a new order was recommended by hospice for: Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml orally every 2 hours as needed for terminal agitation/restlessness for 14 days. Upon review of the resident's record, it was determined the resident was in two altercations on 05/09/24, with Residents #242 and #134. A progress note dated 05/09/24 at 3:50 PM states: Alerted by unit manager that activities notified her of this resident smacking (Resident #134's facility ID number) in the doorway of the station 2 nurses station/dining room during an activity. Retrieved statement from activities staff. Activities stated that, (Resident #139's name) hit resident on her leg. CNA intervened and de-escalated the situation. (Resident #139's name) has been placed on a 1:1, physician notified. Spoke with (Hospice Registered Nurse [RN] #197's name) regarding possible med changes. New orders received. According to a progress dated 05/09/24 at 4:08 PM, a new order was received for the Ativan oral concentrate. According to the Medication Administration Record (MAR) the PRN Ativan oral concentrate was administered to Resident #139 at 6:33 PM on 05/09/24. At 6:45 PM on 05/09/24, a note was entered stating administration of the PRN Ativan oral concentrate was effective. Further review of the MAR revealed Resident had scheduled administration times of Ativan tablets every day. The orders are as follows: Ativan Oral Tablet 0.5 MG (Lorazepam) Give 0.5 mg by mouth two times a day for agitation; anxiety. Ativan Oral Tablet 1 MG (Lorazepam) Give 1 mg by mouth at bedtime for agitation; anxiety. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR shows Resident #139 was given the 0.5 mg dose of the Ativan tablet at 6:00 AM and 2:00 PM on 05/09/24. Further review shows the resident was given the Ativan oral concentrate at 6:33 PM and the 1 mg dose of the Ativan tablet at 8:00 PM on 05/09/24. The behavior monitoring tools for the day of 05/09/24, when the altercations occurred between Resident #139 and Residents #242 and #134, indicated the resident exhibited no behaviors. Furthermore, the behavior monitoring tool reveals no non pharmacological interventions were attempted before the facility obtained an order for, and administered, Ativan oral concentrate to Resident #139. The following day, the facility started the order for the Ativan oral concentrate for terminal agitation and restlessness for 14 days. At approximately 10:39 AM on 10/14/24, an interview was conducted with Hospice RN #197 regarding the medication given to Resident #137 for the purpose of terminal agitation and restlessness. When asked if she came in to assess the Resident at the time the facility called to inquire about the Ativan oral concentrate, Hospice RN #197 stated she did not come in to assess the resident before giving the facility the order for the Ativan. In fact, Hospice RN #197 did not come into the facility to see the resident until 05/10/24 at 6:51 PM, according to the progress notes entered into the system. A progress note dated 05/10/24 at 6:51 PM reads as follows: (Hospice RN #197's name) from Hospice in to assess resident due to extreme agitation today and refusal of Ativan 0.25 ml PRN medication. (Hospice RN #197's name) put her in her bed to assess her and resident had a large BM after which resident became calm and agreed to take the Ativan 0.25 ml. She is now resting in bed comfortably. (Hospice RN #197's name) then obtained order from (Facility physician) to discontinue 1:1 since resident is now calm. During the interview with Hospice RN #197, she was asked about terminal agitation and how she was able to assess the resident without laying eyes on her to rule out other conditions that may cause agitation and behaviors. Hospice RN #197 stated I have a good relationship with the nurses at the facility, I trust their judgment when they call and tell me things about the residents. Hospice RN #197 stated the behaviors the resident was having were out of character for the resident, however, during review of the resident's record, it was noted the resident exhibited behaviors of cursing and hitting staff as far back as February of 2024. Hospice RN #197 stated terminal agitation could last go on for some time when asked if it was common for a resident to be terminally agitated and still be alive five (5) months later. Hospice RN #197 was asked how the nursing staff at the facility know how to identify terminal agitation in a resident, seeing as how they don't see things like that on a regular basis, compared to hospice, and how she could be sure Resident #139 was terminally agitated without physically assessing her. Hospice RN #197 stated We do education every time we are in the facility with the nursing staff about what to look for in the residents. Hospice RN #197 was asked what the facility stated was different with Resident #139's behaviors during that period that warranted the Ativan oral concentrate. Hospice RN #197 stated the facility had placed the resident on one (1) on one (1) supervision due to her being in an altercation with another resident and called to request a medication change. Furthermore, Hospice RN #197 states she was in the facility on 05/10/24 to assess the resident because the facility told her Resident #139 was refusing doses of the Ativan oral concentrate. Hospice RN #197 stated she took Resident #139 into her room and was able to get her to take the medication, as evidenced by the progress note listed above. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice RN #197 was asked if being placed on one (1) on one (1) supervision was a reason to receive Ativan oral concentrate as needed, to which she stated If it's different than their normal behaviors, then yes. According to Resident #139's wandering observation tool, and multiple observations during the survey process, she is noted to wander about the entire facility frequently. Hospice notes were not available in the resident's chart from 05/09/24 or 05/10/24, when the assessments would have been completed on the resident for the change in condition and prescription of the PRN Ativan. Hospice RN #197 stated she would send them to the facility if she had them. As of the end of the survey, the notes were not produced. Interviews were conducted with Licensed Practical Nurse (LPN) #82 at 9:38 AM on 10/16/24, LPN #87 at 9:49 AM on 10/16/24, and RN #101 at 9:54 AM on 10/16/24. All three (3) nurses state they deal with hospice regularly and they were not aware of any education being provided by hospice. All three (3) nurses stated hospice will inquire about how much the resident has eaten and if they have had any bowel movements. RN #101 stated We will call them and ask for a medication change and they will talk to their doctor and then call us back with the order. When asked if hospice comes in to assess the patients for a change in condition before giving a new order she stated No, not really, they usually just give the order over the phone. LPN #87 stated, when asked if hospice came in to assess residents for change in condition before giving new orders, Usually if I call and tell them I need something, they'll just give the order. I haven't seen them come in and assess anyone when we call and tell them something is different. Further review of the resident's progress notes and MAR indicate other instances where the Ativan oral concentrate was administered where Resident #139 exhibited behaviors. However, none of the times the Ativan was administered, were non pharmacological interventions documented as being attempted. Progress note dated 05/10/24 at 1:09 PM states: Refused. Swatted nurse away. Ativan liquid concentrate was administered to Resident #139 at 2:20 PM on 05/10/24, according to the MAR and progress notes. According to the progress notes and MAR, Resident #139 received the Ativan oral concentrate at 2:14 on 05/13/24. A follow up note for that administration at 3:37 PM states: PRN Administration was: Effective pt (patient) is not screaming and yelling at anyone. A progress note dated 05/16/24 at 11:42 states: Resident is on hospice services. She has poor safety awareness and at times, becomes agitated with in stimulated environments. Resident was noted smacking another resident in the leg. Staff immediately intervened. Resident was placed on one on one until cleared by CRNP or MD. Interviewable residents were asked if they felt safe and all stated they did feel safe except one resident. All residents without capacity skin sweeps were completed and no new areas identified. Hospice made aware. Intervention will be to complete a medication review. According to progress notes and the MAR, the Ativan oral concentrate was administered to Resident #139 at 4:06 PM. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 05/21/24 at 2:03 PM states: Resident was in dining room with peers. Resident allegedly grabbed another residents (sp) arm and squeezed it. Action was witnessed by 3 other residents with capacity. Resident was removed from dining room and immediately placed on 1:1. Activities director had taken resident for diversion activities. Resident was offered fluids but denied. Resident is alert with confusion and unable to state why she grabbed resident. When staff approached resident, she had increased anxiety and kept repeating the name [NAME]. Residents (sp) POA was made aware, and she stated that [NAME] was her brother. PRN Ativan was administered for residents (sp) increased anxiety. At approximately 3:30 PM on 10/16/2024, Administrator #13 confirmed the lack of behavior monitoring, especially on days when the resident received the PRN doses of the Ativan oral concentrate. Furthermore, Administrator #13 confirmed non pharmacological intervention had not happened, per the notes, before the resident received those doses. Administrator #13 also confirmed the missing hospice documentation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 49467 49650 Based on medical record review and staff interview, the facility failed to ensure that alleged violations involving abuse, neglect were reported. An unwitnessed fall with injury and an allegation of staff to resident verbal abuse was not reported. This was a random opportunity of discovery during the long term care process. This has the opportunity to affect a limited number of residents. Resident identifier: #84. Facility Census: 181. Findings included: a) Resident #84 At approximately 1:00 PM on 10/08/24, during a review of Resident #84's record a progress note dated 04/26/24 at 10:04 was noted. The progress note is typed as written: 4/26/2024 10:04 Behavior Note Note Text: This nurse was performing this resident's weekly skin assessment and this resident cursed at this nurse for gently holding him over on his side to perform peri-care. This resident stated You're fucking hurting me!! This nurse apologized to resident and educated him on the need for peri-care to be performed with incontinence. Resident then stated. I don't give a shit. Leave me alone! Then resident swung his bed control, attempting to hit this nurse with it. Wing nurse notified. Plan of care ongoing. Upon investigation of the facility reportable log for April of 2024, it was noted the facility did not report the incident to the State Agency (SA). At approximately 3:15 PM on 10/08/24, an interview was conducted with Administrator #186 regarding the allegation. Administrator #186 confirmed the allegation of abuse was not reported and stated I didn't interpret that as abuse, for that particular situation I took that as the type of care she provided and his response to that care.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49467 Based on record review and staff interview, the facility failed to thoroughly investigate and identify allegations of abuse to Residents #110 and #119 by Resident #139. This was a random opportunity for discovery. Resident identifiers: #139, #110, #119. Facility census: 181. Findings included: a) Resident #110 At approximately 1:30 PM on 10/08/24, during a review of Resident #139's record, it was determined she had been in altercations with four (4) different residents at the facility from 05/07/24 through 05/21/24. It was determined, based on the reportables provided by the facility, Resident #110 was involved in the altercation on 05/07/24. A review of the facility investigation revealed Social Worker (SW) #77 took a statement from the Physical Therapist (PT) at the facility (dated 05/10/24), stating Resident #110 reported to them she was struck by Resident #139, but did not obtain a written statement, nor did they have an interview on file with Resident #110 concerning the incident. The reportable sent in by the facility indicated they were not made aware of the incident until 5/10/24 No interventions were put into place to keep Resident #139 from striking another resident due to the facility not being made aware of the incident until 05/10/24. b) Resident #119 At approximately 1:30 PM on 10/08/24, during a review of Resident #139's record, it was determined the resident was in an altercation with Resident #119 on 05/21/24. According to progress notes on 05/21/24 at 2:03 PM, Resident #139 was in the dining room and grabbed Resident #119's arm and squeezed it. The progress note states Action was witnessed by 3 other residents with capacity. Progress notes stated that Resident #139 was removed from the dining room and placed on one (1) on one (1) supervision immediately. However, during review of the resident's Medication Administration Record (MAR) for May of 24, it was noted the facility was missing documentation to confirm Resident #139 received one (1) on one (1) supervision on 05/22/24 while it was still ordered. It was discovered after review of the above incidents the facility marked each allegation of abuse as unsubstantiated, despite them occurring and being witnessed by multiple people. At approximately 1:50 PM on 10/10/24, an interview was conducted with SW #77 acknowledged she did not obtain statements from the victims in these cases and the allegations were determined to be unsubstantiated because Resident #139 does not have capacity.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 50551 Based on record review, resident interview and staff interview, the facility failed to correctly identify resident's hearing deficit/use of hearing aids on the Minimum Data Set (MDS). Resident #148. 1(one) of 50 reviewed for MDS accuracy. Facility Census 181. Findings included: a) Resident #148 On 10/07/24 at 1:30 PM, during an interview with Resident #148, he reported that he has excessive earwax buildup that needs removed monthly. He reported that he used scissors to dig a huge plug of wax out. He stated that he cannot use his hearing aids due to the extra wax. He stated that he ordered a flusher and staff told him he was not allowed to use it due to safety of the other residents. He stated that he had tried the curettes and they are not affective for him. He denied having an appointment scheduled with audiologist since his admission at this facility. An interview with Registered Nurse (RN) #112 on 10/07/24 at 2:25 PM acknowledged that Resident #148 had complained of earwax buildup in the past. She reported that he had ordered himself a flushing device to help with removal but RN #112 was unsure what happened to it. She stated that the physician had previously ordered Debrox and the resident does not like it. She denied knowledge that he was using scissors to clean his own ears. She reported that she would notify the doctor that resident would like his ears cleaned more frequently and that he used scissors to remove his own wax. On a 10/08/24 at 3:21 PM, review of records revealed Resident #148's care plan did not include hearing impairment, ear wax care and hearing. On 10/08/24 at 3:30 PM a review of Admission Minimum Data Set (MDS) dated with an Assessment Reference Date (ARD) of 12/08/23, section B states resident has hearing aids, the Quarterly MDS 08/15/24 states that resident does not wear hearing aids. On 10/09/24 at 1:50 PM and interview was conducted with both administrators who acknowledged that resident's Quarterly and Admission MDS were not consistent with the other and that resident's hearing impairment/hearing aid use is not on current care plan. Also, made administrative staff aware that resident had a flushing device that he had purchased for himself and it had been taken away from him but that he reported that he is using a pair of scissors to clean them. They will look into it and let me know if they have any information on why Resident #148 was no longer in possession of the ear flusher and if it is safe for him to use. No further information was reported.

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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. 50801 Based on record review and staff interviews,the facility failed to ensure the Minimum Data Set (MDS) assessments were correct and matched Resident # 71's Care Plan. This was a random opportunity for discovery. Resident identifier: #71. Facility census: 181. Findings Included: a) Resident #71 During record review on 10/09/24 at approximately 1:00 PM, Section L of Resident #71's MDS with an Assessment Reference Date (ARD) of 08/04/24 was marked No to oral or dental problems with own natural teeth but the care plan stated that Resident #71 had oral and dental problems with own natural teeth. During an interview with the Administrator and corporate witness on 10/09/24 at 1:52 PM, Resident #71 had decayed and blackened teeth.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on medical record review and staff interview, the facility failed to update the Pre Admission Screening and Resident Review (PASARR) with the new diagnosis of Dementia/ with other unspecified behaviors and schizoaffective disorder. This was true for 1 of 5 residents whose PASARRs were reviewed during the long term care survey process. Resident Identifier: #19. Facility Census: 181. Findings Included: a) Resident #19 During a medical record review for Resident #19 diagnosis identified that Resident admitted to the facility on [DATE] and the following diagnoses were identified since admission: * Dementia in other diseases classified elsewhere, unspecified severity with other behavioral disturbance dated 10/31/22. *Schizoaffective disorder dated 10/31/22 A further review of the PASARR provided by the facility for Resident #19, dated 02/08/11, it identified that the residents diagnosis of Dementia in other diseases classified elsewhere, unspecified severity with other behavioral disturbance dated 10/31/22 and the schizoaffective disorder dated 10/31/22 were not listed. During an interview with Administrator #186 on 10/08/24 at approximately 10:30 AM the Administrator #186 confirmed that the diagnosis of Dementia in other diseases classified elsewhere, unspecified severity with other behavioral disturbance dated 10/31/22 and the schizoaffective disorder dated 10/31/22 did require the PASARR to be updated and re-submitted for review.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on record review and staff interviews, the facility failed to ensure that schizoaffective diagnoses prior to admission were correctly added to Pre-admission Screening and Resident Review (PASSAR) for Residents #134, #99, and #28 . Resident identifier #134, #99, #28. Facility Census 181. Findings included: a) Resident #134 At approximately 11:00 AM on 10/08/2024, a review was conducted of Resident #134's record. During review, it was noted Resident #134 was readmitted to the facility on [DATE] with a diagnosis of schizoafffective disorder, bipolar type. According to the diagnosis list, the diagnosis was present upon admission. Upon review of Resident #134's PASARR, dated 12/13/23, the diagnosis of schizoaffective disorder, bipolar type is missing. Administrator #13 confirmed the missing diagnosis on the PASARR at approximately 3:30 PM on 10/16/24. b) Resident #99 On 10/08/24 at 4:00 PM, a review of resident's records revealed the following: Resident # 99's PASARR dated 06/01/24, question 30, current diagnosis was answered a. None. Resident #99 was admitted to the facility on [DATE]. A resident's diagnosis record revealed that resident had a diagnosis of Affective Bipolar Disorder on 03/27/24. Resident also has a diagnosis of cognitive communication deficit. An interview with Administrators #186 and #13 on 10/08/24 acknowledged that Resident #99's Bipolar Diagnosis was not listed on the PASARR. c) Resident # 28 During a medical record review on 10/08/24 at approximately 8:30 AM it was identified that Resident #28 admitted to the facility on [DATE] with the identified diagnosis of schizoaffective disorder, bipolar type dated 04/25/23. During a further review of the PASARR provided by the facility dated 10/01/23. A completed PASARR prior to admission was not provided. It is further identified that on the PASARR for 10/01/23 the diagnosis of schizoaffective disorder was not listed as a current diagnosis. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Administrator #186 on 10/08/24 at approximately 10:30 AM Administrator #186 agreed that the PASARR should have been completed prior to admission and included the diagnosis of schizoaffective disorder. 49650 50551

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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** 49465 Based on observation, staff interview and record review the facility failed to develop and/or implement care plans related to Post Traumatic Stress Disorder (PTSD), falls, activities, dental status, behaviors, pressure ulcers, respiratory care and positioning. This failed practice was found true for seven (7) of 50 residents reviewed for care plan accuracy during the Long-Term Care Survey Process. Resident identifiers: #108, #93, #163, #99, #23, #148 and #139. Facility Census 181. Findings Included: a) Resident #108 During a record review on 10/07/24 at 2:52 PM, it was found that Resident #108 had a diagnosis of Post Traumatic Stress Disorder (PTSD), that was present on admission. Further record review of Resident #108's care plan showed that a care plan had not been created for the diagnosis of PTSD. During an interview on 10/10/24 at 1:07 PM, the Licensed Social worker (LSW) #139 stated, There is not a care plan for his PTSD, He is unable to tell me his triggers so I am going to call his son and see what I can find out. I will get a PTSD care plan started today. b) Resident #93 On 10/07/24 at 03:26 PM, a record review was conducted for Resident #93 which revealed two falls occurring on 09/07/24 resulting in Resident #93 being hospitalized status post fall with a diagnosis of wedge compression fracture of first lumbar vertebra with kyphoplasty. Further review of Resident #93's medical record revealed Resident # 93 was receiving the following medications and had the following diagnoses: Medications: Pre-Fall: 1. Diazepam 0.5 mg by mouth at bedtime for Anxiety, Start date 08/09/24. 2. Buspar 7.5 mg by mouth three times daily for Anxiety, Start date 08/10/24. 3. Sertraline 100 mg by mouth every morning for Depression, Start date 08/09/24. 4. Hydralazine 100 mg by mouth as needed for Hypertension, Start date 08/09/24. Post-Fall with fracture: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Eliquis by mouth two times a day for Atrial Fibrillation, Start date 09/14/24. 2. Lisinopril 20 mg by mouth once a day for Hypertension, Start date 09/14/24. 3. Buspar 7.5 mg by mouth three times a day for Anxiety, Start date 09/13/24. 4. Hydralazine 25 mg by mouth one tablet two times a day for Hypertension, Start date 09/16/24. 5. Norco (Hydrocodone-Acetaminophen) one half tablet by mouth three times a day for back pain, Start date 09/25/24. 6. Escitalopram 10 mg by mouth one time a day for Depression, Start date 10/02/24. 7. Trazodone 100 mg by mouth at bedtime for Major Depressive Disorder, Start date 10/03/24. 8. Aricept 5 MG by mouth two times a day for Depression, Start date 10/01/24. Diagnoses included Depression, Anxiety, Insomnia, Hypertension, Chronic Kidney Disease, Dementia with other behavioral disturbance, Muscle weakness, Unsteadiness on feet, Atrial Fibrillation and Heart Failure. In addition, it was revealed that Resident #93 was previously residing in an Assisted Living facility and had previous falls with fractures while residing there. Furthermore, it was revealed that Resident #93 was incapacitated, nature: short-term memory loss with disorientation, inability to process information and hallucinations caused by dementia. During a review of Resident #93's admission assessment revealed the facility had assessed and identified these risk factors upon admission. The following therapy certification period documentation which revealed Resident #93's functional ability pre and post fall. 1. Certification Period: 08/12/2024 - 09/08/24 (Pre fall) A. Dynamic Standing: Baseline (08/12/24)- Poor Mod A (Moderate Assist) Discharge (08/29/24)- B. Transfers: Baseline (08/12/24)- CGA (Contact Guard Assist) Discharge (08/29/24)- Supervised C. Distance Level Surfaces: Baseline (08/12/24)- 20 feet Discharge (08/29/24)- 100 feet D. Level Surfaces: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Baseline (08/12/24)- Mod A Discharge (08/29/24) SBA (Stand by Assist) 09/08/24 - 09/13/24: hospitalization status post fall with WEDGE COMPRESSION FRACTURE OF FIRST LUMBAR VERTEBRA with Kyphoplasty. 2. Certification Period: 09/16/24 - 10/13/24 (Post fall with fracture and surgical intervention to treat spinal compression fracture.) A. Dynamic Standing: Baseline (09/16/24)- Poor Mod A (Moderate Assist) B. Transfers: Baseline (09/16/24)- Max A (Maximum Assist) C. Distance Level Surfaces: Baseline (09/16/24)- 0 feet D. W/C (wheelchair) Mobility Baseline (09/16/24)- Total Dependence w/o (without) attempts to initiate. E. Sit to Stand (09/16/24)- Unable without assist Along with the following care plan: FOCUS: The resident is at risk for falls r/t unsteadiness on feet. Date initiated: 09/14/24. GOAL: (Resident name) will not sustain major injury related to falls through review date. Date initiated: 08/10/24. INTERVENTIONS: Assess risk for falls on admission / readmission, quarterly, and as needed. Date initiated: 08/10/24. Educate resident or resident representative, if applicable how to operate bed controls/call light/television. Date initiated: 08/10/24. Ensure resident is wearing appropriate non-skid footwear. Date initiated: 09/16/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents room is free of potential visible hazards. Date initiated: 08/10/24. Ensure that the bed locks are engaged. Date initiated: 08/10/24. On 10/09/24 at 1:51 PM, a review of Policy and Procedure entitled, Fall Prevention and Managementwas completed which revealed that the care plan can include interventions that address environmental factors, ADL factors, risk factors such as mental diagnosis and medical diagnosis that put the resident at higher risk for falls. Issues such as toileting, eating, transferring and impulsiveness should be considered. The care plan can address furniture arrangements, foot wear, medications, drowsiness and instability. The care plan should also address how the resident can be transferred in and out of bed as well as how the resident can ambulate and move around the facility. The care plan should be reviewed and updated as needed with each change of condition. On 10/09/24 at 2:22 PM, an interview was conducted with the Director of Nursing (DON) #138 and Administrator #13 of Building 1 who acknowledged the following: 1. The care plan interventions should be addressed and updated when functional abilities changed. Resident #93's care plan upon admission did and currently does not. 2. The care plan should address risk factors for falls, such as high risk medications, previous falls, cognitive ability, diagnoses, incontinence. Resident #93's care plan upon admission did not and currently does not. 3. The goal should have been updated post fall with fracture for Resident #93 and was not. 4. The facility was aware of the following: A. Resident #93's falls with fractures prior to admission. B. Resident # 93's risk factors were identified at the time of admission. C. The facility failed to put appropriate interventions in place to address these issues to prevent Resident #93 from falling. An additional interview was conducted on 10/14/24 at 1:26 PM with DON #138 who acknowledged: 1. Resident #93's fall care plan does not address the fact Resident #93 was incontinent at the time of the fall, and that based on the therapy evaluation post fall at which time it was determined Resident #93 was unable to perform sit to stand, ensuring Resident #93 was wearing non-skid sole footwear would be an ineffective intervention. 2. Resident #93 is incapacitated and it is identified that she has short term memory loss and inability to process information. Documentation was reviewed that Resident is to be educated on fall prevention. DON #138 acknowledged that this would not be an effective intervention. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Acknowledged that root causes discussed for Resident #93's falls are not complete. For example, resident stated, I was trying to get up. DON #138 acknowledged that for a thorough root cause to be performed, why the resident was attempting to get up would be important to determine an effective preventative intervention and was not addressed. A final interview was conducted with DON #138 and Administrator #13 who acknowledged Resident #93 continued to be at risk for falls due to the lack of appropriate and effective interventions currently in place and incorrect interventions and tasks such as incorrectly tasked transfer status, as Resident #93 was determined to require maximum assist to perform this task and Resident #93 continues to be tasked to transfer independently. c) Resident #163 On 10/07/24 at approximately 12:26 PM, an observation was made of Resident #163 which revealed mats bilaterally to the side of Resident #163's bed. On 10/07/24 at approximately 1:14 PM, a record review for Resident #163 was completed which revealed Resident #163 was receiving the following medications, had the following diagnoses and the following orders: Medications: 1. Metoprolol Tartrate 12.5 mg by mouth two times a day for Hypertension. Start date: 02/20/24. 2. Tramadol 50 mg by mouth two times a day for Pain. Start date: 09/09/24. 3. Lantus SoloStar Subcutaneous Solution (Insulin Glargine) 100/units/milliliter (ml) inject 10 units subcutaneously at bedtime for Diabetes Mellitus. 4. Metformin 1000 mg orally two times a day for Diabetes Mellitus. Diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction affecting non-dominant side. Encounter for attention to Gastrostomy Placed 01/27/24, Stiffness of Left Knee, Pain in Left Knee, Reduced Mobility, Stiffness of Left Hip, Muscle weakness, generalized Lack of coordination, Depression, and Diabetes Mellitus. Orders: 1. Device: Low Bed, Active: 06/27/24. 2. Device: Bilateral Fall Mats to bedside, Active: 06/27/24. In addition to the following care plans: FOCUS: The resident is at risk for falls r/t muscle weakness, lack of coordination. Date initiated: 02/16/24 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	GOAL: (Resident name) will not sustain major injury related to falls through review date. Date initiated: 02/16/24 INTERVENTIONS: Apply bolsters to air mattress. Date initiated: 05/17/24 Assess risk for falls on admission / readmission, quarterly, and as needed. Date initiated: 02/16/24 Bed in lowest position. Date initiated: 06/17/24. Bilateral floor mats. Date initiated: 06/27/24. Educate resident or resident representative, if applicable how to operate bed controls/call light/television. Date initiated: 02/16/24. Ensure residents room is free of potential visible hazards. Date initiated: 02/16/24. Ensure that the bed locks are engaged. Date initiated: 02/16/24. low bed. Date initiated: 06/27/24. FOCUS: Resident requires Enhanced Barrier Precautions for: Indwelling Medical Device: Wound. Date initiated: 05/31/24. dignity and went into Resident #163's room to ask if she could pull the cover. Resident #163 consented to allow WN #21 to pull the cover over him. On 10/09/24 at 1:51 PM, a review of Policy and Procedure entitled, Fall Prevention and Managementwas completed which revealed that the care plan can include interventions that address environmental factors, ADL factors, risk factors such as mental diagnosis and medical diagnosis that put the resident at higher risk for falls. Issues such as toileting, eating, transferring and impulsiveness should be considered. The care plan can address furniture arrangements, foot wear, medications, drowsiness and instability. The care plan should also address how the resident can be transferred in and out of bed as well as how the resident can ambulate and move around the facility. The care plan should be reviewed and updated as needed with each change of condition. Attempt to put an intervention in place that could prevent further falls, such as: if the resident was going to the bathroom, assist them to the toilet. If the resident was getting a drink and overreaching, place the drink within range of the resident. If the resident was attempting to transfer from bed to wheel chair or vice versa, assist to where they would like to go. If the resident is confused, attempt to re-orient. Attempt to identify why the resident fell and put an immediate intervention in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/09/24 at 2:22 PM, an interview conducted with the Director of Nursing (DON) #138 and Administrator #13 who acknowledged the following: 1. Resident #163's care plan should address risk factors for falls, such as high risk medications, previous falls, cognitive ability, diagnoses, incontinence and use of external devices. Resident #163's care plan on admission did not and currently does not. On 10/14/24 at approximately 9:30 PM, a review of Resident #163's medical record was completed again, revealing the following assessments present: Fall Risk Observation Tools: 1. Fall Risk Observation Tool. Effective date: 02/23/24. The following information was obtained: a) Resident #163 required a total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. b) Blood pressure was unable to be preformed due to Resident #163 being unable to stand. c) Resident #163 had no external devices such as feeding tube or Foley catheter. d) Resident #163 fall history: no falls 2. Fall Risk Observation Tool. Effective date: 03/01/24. The following information was obtained: a) Resident #163 required a total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. b) Blood pressure was unable to be preformed due to Resident #163 being unable to stand. c) Resident #163 had no external devices such as feeding tube or Foley catheter. d) Resident #163 fall history: no falls. 3. Fall Risk Observation Tool. Effective date: 06/01/24. The following information was obtained: a) Resident #163 required a total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. b) Blood pressure: No noted drop between lying and standing. c) Resident #163 had no external devices such as feeding tube or Foley catheter. d) Resident #163 fall history: no falls. 4. Fall Risk Observation Tool. Effective date: 09/01/24. The following information was obtained: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a) Resident #163 required a total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. b) Blood pressure: No noted drop between lying and standing. c) Resident #163 had d) Resident #163 fall history: no falls. Post Fall Evaluations: 1. Post Fall Evaluation Effective Date: 05/17/24. The following information was obtained: a) Date and time of fall: 05/17/24 at 03:00 PM b) Type of fall/witnessed? No injuries noted with unwitnessed fall. c) Fall information: Level of Consciousness: Alert, oriented or comatose Mobility: Wheelchair/ambulation assistance needed Gait: non-ambulatory Residents ability to transfer: total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. Current ambulatory/gait/balance ability: non-ambulatory Blood pressure: No noted drop between lying and standing. External devices: no external devices such as feeding tube or Foley catheter. Fall history: Fall within past 30 days Is the resident receiving any of these medications: anesthetics, antihistamines, antihypertensives, antiseizures, benzodiazepines, cathartics, diuretics, hypoglycemic's, narcotics, psychotropic's, sedatives/hypnotics: Currently takes 1-2 of these medications. Continence Status: Wheelchair or other ambulatory aid/incontinent Has the resident been diagnosed with any of the following diseases or have any of the following conditions: anemia, arthritis, CVA, delirium, dementia, hypotension, osteoporosis, Parkinson, seizures, vertigo, anger, fracture, loss of limb, wandering. Predisposing diseases/conditions: 1-2 present Resident's response to fall: resident stated he was just moving in bed and slid out. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Suspected root cause: unknown. What was the height of the bed: low position What time was the resident last toileted: incontinent What did you do to immediately prevent further falls: low bed, contacted medical supply director to order bolsters for air mattress. 2. Post Fall Evaluation Effective Date: 06/17/24. The following information was obtained: a) Date and time of fall: 06/10/24 at 12:30 PM b) Type of fall/witnessed? No injuries noted with unwitnessed fall. c) Fall information: Level of Consciousness: Diminished safety awareness Mobility: Wheelchair/ambulation assistance needed Gait: non-ambulatory Residents ability to transfer: total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. Current ambulatory/gait/balance ability: non-ambulatory Blood pressure: No noted drop between lying and standing. External devices: no external devices such as feeding tube or Foley catheter. Fall history: Fall in past 2-6 months Is the resident receiving any of these medications: anesthetics, antihistamines, antihypertensives, antiseizures, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropic's, sedatives/hypnotics: Currently takes 3-4 of these medications. Continence Status: Wheelchair or other ambulatory aid/incontinent Has the resident been diagnosed with any of the following diseases or have any of the following conditions: anemia, arthritis, CVA, delirium, dementia, hypotension, osteoporosis, Parkinson, seizures, vertigo, anger, fracture, loss of limb, wandering. Predisposing diseases/conditions: 3 or more present Resident's response to fall: I was trying to get up. Suspected root cause: getting up unassisted (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	What was the height of the bed: low position What time was the resident last toileted: n/a What did you do to immediately prevent further falls: assessed resident, assisted back to bed. 3. No Post Fall Evaluation for fall dated 06/27/24 at 12:30 AM. On 10/14/24 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON) #138. At that time the DON stated Resident #163 had a Foley catheter and feeding tube present at the time of admission on 02/16/24. Resident #163's Foley catheter was discontinued on 08/19/24. On 10/16/24 at approximately 2:00 PM, and interview was conducted with DON #138 who acknowledged the following: 1. Fall Risk Observation Tools are to assess each resident for falls risk. Resident #163's Fall Risk Observation Tools were inaccurate as Resident #163 had 2 (two) external devices, a feeding tube and a Foley catheter. 2. That she (DON) was unsure how facility staff obtained lying to standing blood pressures on 05/17/24 and 06/17/24 as Resident #163 is unable to stand. 3. That Resident #163's Fall Risk Observation Tools and Post Fall Evaluations identified Resident #163's risk factors for falls such as high risk medication, predisposing condition, cognition and history of falls upon admission and after each fall and the care plan did not reflect this and currently does not. 4. Acknowledged that root causes discussed for Resident #163's falls were not complete. For example, resident stated, I was trying to get up. DON #138 acknowledged that for a thorough root cause to be performed, why the resident was attempting to get up would be important to determine an effective intervention and was not addressed. d) Resident #23 10/07/24 04:09 PM resident leaning so far in chair that her hair was almost on the floor. (right side)- Licensed Practical Nurse (LPN) #99 stated Resident #23 had been in there a long time. LPN #99 acknowledged she had been in there since lunch around 12:00 PM. LPN #99 stated Resident #23 is not positioned at her best. LPN #99 asked Nursing Assistant (NA) # 84. NA #84 asked who her CNA's were as CNA #84 stated she knew 2 NA's left and 2 NA's had came on but did not know who it is. NA #84 assisted Resident #23 to her room and waited for LPN #84 to come with the lift to assist the resident to the bed. Interview with Administrator #186 on 10/07/24 at approximately 4:49 PM acknowledged the care concern and inquired if the staff already assisted with the resident. Administrator #186 stated they will follow up on it immediately . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medical record review on 10/08/24 at approximately 8:30 AM a review of the Minimum Data Set (MDS) dated [DATE] identifies that Resident #23 has a Brief Interview for Mental Status (BIMS)under Section C is zero (0). Section GG0115 identified a functional limitation in range of motion with the lower extremity impairment. Section I identified the use of no devices and Section J identified that the occupational therapy start date of 12/23/21 to 01/06/22 and the physical therapy started 07/01/24 to 07/01/24. A review of Resident #23 diagnoses identified dementia with agitation dated 10/01/22; muscle weakness dated 06/05/23; pain in right shoulder dated 04/05/20; other reduced mobility dated 1/23/24; other lack of coordination dated 04/12/24; stiffness of left hip dated 06/05/23; stiffness of right hip dated 06/05/23; unspecified lack of coordination dated 01/23/24; need for assistance with personal care dated 08/25/23; stiffness right knee dated 03/17/23; pain in left knee dated 03/31/2; stiffness in left knee dated 04/02/21; chronic pain dated 04/28/19; secondary multiple arthritis dated 03/01/19; history of falling Contusion (R) right hip; Strain of right shoulder dated 06/05/17. During a review of therapy documentation the last evaluation completed for occupational therapy on 07/01/24 for an evaluation of positioning. The Assessment summary for reason of skilled services identified that this was an evaluation only as the current level of functioning (LOF) has no marked changes from the previous LOF. The risk factors noted that the (typed as written) Patient remains total assist for all aspects of care in presence of advanced dementia and cog dependence on others to identify needs. And the last evaluation completed for occupational therapy 07/01/24 with evaluation only and no recommendations. A review of the care plan identified a focus of Resident #23 being at risk for communication problems with reference to other disease process/ conditions diagnosis of Alzheimer's. An intervention identified to work towards the goal of the resident maintaining or improving the current level of communication is identified to; (typed as written) Observe/document for physical/nonverbal indicators of discomfort or distress and follow up as needed. Resident #23 is also care planned for assisted daily living (ADL) care performance deficit, requires assistance with ADL cognitive deficit, disease process, functional deficit. The interventions for the goal of Resident #23 to be without decline in range of motion (ROM) included but is not limited to: Personal hygiene; Dependent- helper does all of the effort or 2 or more helpers assist. Observe and anticipate residents needs; thirst, food, body positioning, pain, toileting needs dated initiated 06/19/24. During a review of the reportable for the allegation of neglect with Resident #23 being left unattended in the dining room and being observed to be leaning so far in the geri-chair (right side) that her hair was almost on the floor the 5 (five) day follow up it states it was verified that the resident was not checked on by the CNA's (Certified Nursing Assistants) during the time of 12:00 PM through 4:00 PM and other actions pending regarding CNA's. It is noted that the resident was assessed with no signs of mental distress and no physical injuries or skin issues. During an interview with the Director of Nursing (DON) #96 on 10/08/24 at approximately 11:00 AM the DON stated she had not been made aware of any new positioning concern with Resident # 23 and that the resident does normally lean to the right side. DON #96 observed the resident in the dining room with the surveyors at this time and acknowledged the concern of the residents re-positioning need and that there had not been any interventions put in place for her with her re-positioning needs. e) Resident #99 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #99's physician orders on 10/14/24 revealed that the resident was to have (O2) Oxygen set at 6 (six) liters continuously with a start date of 09/17/24. A review of the resident's care plan 10/14/24 excluded the following information: -The type of O2 delivery system that should be used. -If the O2 should be continuous or intermittent. - The type of equipment and flow rates of resident's O2. On 10/14/24 at 1:50 PM, Upon observation of the resident with tracheostomy, Nurse #169 was attending for several minutes when we noticed Resident #99's oxygen tubing was not attached to her trach. When asked if it should be attached to something the Nurse stated yes, probably and went on to state that she was not dependent on it. Nurse #169 went and got another tube and reattached it to the trach. We asked what her O2 stats normally ran, Nurse stated 96. When asked if she was going to reassess her, she did and Resident's O2 was at 89. It returned to 96 after her O2 was reattached. f) Resident #148 On 10/07/24 at 1:30 PM, during an interview with Resident #148, he reported that he has excessive earwax buildup that needs removed monthly. He reported that he used scissors to dig a huge plug of wax out. He stated that he cannot use his hearing aids due to the extra wax. He stated that he ordered a flusher and staff told him he was not allowed to use it due to safety of the other residents. He stated that he had tried the curettes and they are not affective for him. He denied having an appointment scheduled with audiologist since his admission at this facility. An interview with Registered Nurse #112 on 10/07/24 at 2:25 PM acknowledged that resident had complained of earwax buildup in the past. She reported that he had ordered himself a flushing device to help with removal but she is unsure what happened to it. She stated that the physician had previously ordered Debrox and the resident does not like it. She denied knowledge that he was using scissors to clean his own ears. She reported that she would notify the doctor that resident would like his ears cleaned more frequently and that he used scissors to remove his own wax. On 10/08/24 at 3:21 PM, review of records revealed resident's care plan did not include hearing impairment, ear wax care and hearing. On 10/08/24 at 3:30 PM a review of Admission MDS dated for 12/08/23, section B states resident has hearing aids, the Quarterly MDS 08/15/24 states that resident does not wear hearing aids. On 10/09/24 at 1:50 PM an interview was conducted with both administrators who acknowledged that resident's Quarterly and Admission MDS were not consistent with the other and that resident's hearing impairment/hearing aid use is not on current care plan. Also, made administrative staff aware that resident had a flushing device that he had purchased for himself and it had been taken away from him but that he reported that he is using a pair of scissors to clean them. They will look into it and let me know if they have any information on why is no longer in possession of the ear flusher and if it is safe for him to use. No further information was reported. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g) Resident #139 At approximately 12:55 PM on 10/14/24, a review of Resident #139's care plan was conducted. The resident is receiving hospice services and was given an order for ativan oral concentrate for terminal agitation and restlessness on 05/09/24 following altercations with other residents at the facility. Resident #139's care plan includes the following focus: Admit to services of (Hospice Service Provider name) with dx (diagnosis): heart disease. An intervention and task for the focus reads as follows: Invite hospice staff to care conferences as needed. Upon review of notes it was determined the hospice provider had not attended any care conferences, especially after the order was given by them for the ativan oral concentrate PRN order. At approximately 3:30 PM on 10/16/2024, Administrator #13 confirmed there was no additional documentation available to show hospice was invited, or had attended, a care conference for Resident #139. 49467 49650 50551 50552 50801

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review, resident observation and staff interview, the facility failed to revise care plans related to activities, behaviors, and refusal of care such as for pressure ulcers, showers, wound assessments and medications. This was true for 4 (four) out of 50 residents reviewed for the Long Term Care Survey Process. Resident identifiers: Residents #93, #163, #120, #139. Facility census: 181. Findings included: a) Resident #93 On 10/07/24 at 3:14 PM, an interview and observation was conducted with Resident #93. At that time, Resident #93 stated, No, I don't go to activities, I can't walk. No, nobody stops by by room and offers me anything. They don't come in and do any activities with me, they don't bring me anything to do either. I never see them. At the time of this interview and observation, no TV on was on and nothing was noted at bedside such as reading material. On 10/08/24 at 11:47 AM, an additional interview and observation was conducted with Resident #93. At that time, no TV was noted to be on and no materials were noted at bedside. Resident #93 again states she has nothing to do, that nobody ever offers her anything to do. Resident #93 states I can't walk, my back is broke, I can't go to activities. On 10/08/24 at 3:26 PM, a review of Resident #93's care plans was completed and revealed the following care plan: FOCUS: Resident does not attend scheduled group activities. She prefers to remain self-directed in her room instead. Date initiated: 08/12/24. GOAL: (resident name) will participate in activities of choice through review date. Date initiated: 08/12/24. INTERVENTIONS: Encouraging attendance to entertainment programs, large and small group activities, volunteer demonstrations, and religious activities. Date initiated: 08/12/24. Favorite colors are pink and blue. Date initiated: 08/19/24. Interview and determine resident activity preferences. Date initiated: 08/12/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Introduce to other residents with similar interests. Date initiated: 08/12/24. Invite resident to scheduled activities. Date initiated: 08/12/24. Provide a schedule of activities available. Date initiated: 08/12/24. Provide activity materials of interest, i.e. library books, word puzzles, magazines. Date initiated: 08/12/24. Resident enjoys gardening. Date initiated: 08/19/24. Resident enjoys listening to country music. Date initiated: 08/19/24. Resident enjoys watching football. Her favorite team is the Redskins. Date initiated: 08/19/24. Resident is right-handed. Date initiated: 08/19/24. Resident prefers being active in the morning. Date initiated: 08/19/24. Resident previously enjoyed baking cakes. Date initiated: 08/19/24. Resident was married for sixty years. Date initiated: 08/19/24. FOCUS: The resident has impaired cognitive function Alzheimer's, Dementia, Metabolic Encephalopathy. Date initiated: 08/19/24. GOAL: Resident will maintain current level of cognitive function through the review date. Date initiated: 08/19/24. INTERVENTIONS: Encourage resident to be involved in daily decision making and activities, as able. Date initiated: 08/19/24. Keep routine as consistent as possible in order to decrease confusion. Date initiated: 08/19/24. Offer 2-3 step instructions when competing basic tasks. Date initiated: 08/19/24. On 10/08/24 at 04:15 PM interview conducted with the Administrator #186. At that time, Administrator #186 stated Upon assessment, it is determined what activities they need, then it is care planned. This Surveyor then asked if a resident refuses to attend group activities and declines 1:1 (one on one) activities, does activities still come and provide materials related to the resident's interests? Or offer them? Administrator #186 stated, Yes, and it should be care planned. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/09/24 at 8:32 AM a review of Resident #93's Brief Interview for Mental Status (3.0 BIMS) was completed revealing severe Impairment with a score of 6.0. On 10/14/24 at 10:29 AM and interview was conducted with the Activity Director, at that time the Activity Director stated, I talked to her niece, she wants us to encourage her to come out and participate in group activities and do one on one with her. She likes to be around other people and be involved in activities. I provide her things to do, she is one who will talk, we are trying to build the reporie with her. She did participate in activities at the other facility. But, I only provide her with things to do if she asks for them an no, I am not documenting we are offering things for her to do. At that time, a review of Resident #93's activity participation from 08/10/24 through 10/09/24 was completed with the Activity Director, which revealed that in the last 60 days, Resident #93 had been self directed in actives for 59 days, with 1 (one) day of one to one activity provided for Resident #93 and no documentation of Resident #93 being provided materials of interest, as Resident #93's care plan identified. At that time, the Activity Director stated, Yes, I see that. She is not one who would accept anything. At that time, the Activity Director acknowledged Resident #93's care plan should have been updated to reflect any refusal to participate in activities or accept materials of interest. b) Resident #163 On 10/08/24 at 8:40 AM, Resident #163 was noted to have the following physicians orders and documentation: 1. WOUND CARE: Cleanse Stage 4 PI left buttock with IHWC, pat dry, apply hydrofera blue to wound and cover with bordered foam dressing. Every day shift every 2 (two) days and as needed. Active 10/1/24. 2. DEVICE: low air loss automatic weight sensing technology air mattress with bolsters, check placement and function every shift. Active 07/25/24. 10/8/24 19:56 Skin Grid Non-Pressure Late Entry: Note Text: New area noted: No Resident refused wound assessment 9/24/24 17:41 Skin Grid Pressure Note Text: NEW AREA: No Resident has refused wound assessment 3/1/24 16:27 Nurses Note Late Entry: Note Text: Resident refused shower x multiple attempts from staff. Resident refused bed bath x multiple attempts. MPOA aware. Resident was asked for weight measurement x2 on this shift to which resident refused both times. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/09/24 at 9:37 AM, this Surveyor was walking past Resident #163's room. At that time, this Surveyor observed Resident #163 laying in bed on a deflated air mattress with the call light on. Resident #163 cord to the air mattress was noted to be laying in the floor unplugged. Resident #163 was noted to be laying in a brief with no other clothing on, exposed to all facility staff, other residents and visitors walking on this hallway, with no blanket or curtain pulled to provide privacy. Multiple facility staff were observed to be walking down the hallway and passing by Resident #163's room and call light without stopping to ask Resident #163 what was needed, to offer to place a blanket over #163 or pull the curtain. Wound Nurse (WN) #21, was observed to be standing directly adjacent to Resident #163's room, with Resident #163 in full view. At that time, this Surveyor requested to speak with her. WN #21 acknowledged Resident #163's air mattress was unplugged and should be inflated, Resident #163 should be dressed, covered up or his curtain pulled to maintain Resident #163's dignity and went into Resident #163's room to ask if she could pull the cover. Resident #163 consented to allow WN #21 to pull the cover over him. On 10/09/24 at 11:09 AM, a review of Resident #163's care plans was completed revealing the following care plan: FOCUS: The resident has impaired skin integrity r/t stage 4 Pressure Injury (PI) to left buttock, abrasion to left thumb. Date initiated: 02/16/24. GOAL: (Resident name) will have improved or maintain current skin status through next review date. Date initiated: 02/16/24. Stage 4 PI left buttock will show signs of improvement through next review. Date initiated: 03/05/24. Abrasion to left thumb will show signs of improvement through next review. Date initiated: 10/01/24. INTERVENTIONS: Administer medications as ordered, monitor for side effects and effectiveness. Date initiated: 03/26/24. Administer treatments as ordered by medical provider. Date initiated: 02/16/24. Complete skin at risk assessment upon admission / readmission, quarterly, and as needed. Date initiated: 02/16/24. Complete Weekly Skin checks. Date initiated: 02/16/24. Device: Low air loss, automatic weight sensing technology Air Mattress with bolsters. Date initiated: 05/20/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encourage resident to turn and reposition or assist as needed as resident allows. Date initiated: 02/16/24. Monitor existing wound daily, for changes (redness, edema, drainage, pain, foul odor. Date initiated: 03/26/24. Nutritional consult on admission, quarterly, and PRN. Date initiated: 03/26/24. Provide appropriate off-loading mattress & off-loading cushion, if applicable. Date initiated: 03/26/24. Use wipes not washcloth for incontinent/peri care when possible and resident will allow. On 10/15/24 at 1:53 PM, a review of Resident #163's admission assessment, dated 2/17/24, was completed which revealed the following: BRADEN OBSERVATION SENSORY PERCEPTION 2. Ability to respond meaningfully to pressure-related discomfort. a. Completely Limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level. b. Very Limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body. c. Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. d. No Impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. Answered: C MOISTURE 3. Degree in which skin is exposed to Moisture a. Constantly Moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned. b. Very Moist: Skin is often, but not always moist. Linen must be changed at least once a shift. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day. d. Rarely Moist: Skin is usually dry, linen only requires changing at routine intervals. Answered: C ACTIVITY 4. Degree of physical activity a. Bedfast: Confined to bed. b. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. c. Walks Occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair d. Walks Frequently: Walks outside room at least twice a day and inside room at least once every two hours during waking hours Answered: A MOBILITY 5. Ability to change and control body position a. Completely Immobile: Does not make even slight changes in body or extremity position without assistance b. Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. c. Slightly Limited: Makes frequent though slight changes in body or extremity position independently. d. No Limitation: Makes major and frequent changes in position Answered: B NUTRITION 6. Usual food intake pattern a. Very Poor: Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Probably Inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or Enteral Nutrition c. Adequate: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a Enteral Nutrition or TPN regimen which probably meets most of nutritional needs d. Excellent: Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. Answered: C FRICTION and SHEAR 7. Friction and Shear a. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction b. Potential Problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down c. No Apparent Problem: Moves in bed and in chair independently and has sufficient muscle strength to lift up Answered: B Score: 14 Moderate Risk = 13-14 B. Potential Interventions: Actual turning schedule as resident allows/tolerates; Use wedge support for 30 degrees side positioning; Pressure reduction support surface; Maximal remobilization; Protect heels; Manage moisture, nutrition and friction and shear; **If any of the major risk factors listed above advance to next level of risk.** 10/02/24 BRADEN OBSERVATION 1. SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Completely Limited: Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level. 2. Very Limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body. 3. Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. 4. No Impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. Answer: Slightly limited Slightly limited- 3a. Potential Interventions: Teach patient/family the importance of changing positions for prevention of pressure ulcers, explain risk vs benefits to resident/family; Encourage small frequent position changes; Encourage/assist with turning and repositioning at least q 2 hours when in bed; Use of pillows to separate pressure areas, with special attention to off- loading contracted joints; Elevation of heels off bed; Keeping HOB at or below 30 degrees. HOB may be elevated for meals then lowered within one hour after meal as resident will allow. Slightly Limited cont. 3b. Potential Interventions: Remember when elevating the HOB, elevate the knee [NAME] first by 10-20 degrees; When in wheelchair instruct/assist with position changes to alter pressure points at least every hour as resident tolerates/allows; Wheelchair cushion 2. MOISTURE Degree to which skin is exposed to moisture 1. Constantly Moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned. 2. Very Moist : Skin is often, but not always moist. Linen must be changed at least once a shift. 3. Occasionally Moist : Skin is occasionally moist, requiring an extra linen change approximately once a day. 4. Rarely Moist: Skin is usually dry, linen only requires changing at routine intervals. Answer: Very Moist Very Moist- (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Potential Interventions: Consider fecal/urinary incontinence containment device (esp. if existing skin breakdown) 3. ACTIVITY Degree of physical activity 1. Bedfast: Confined to bed. 2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. 3. Walks Occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair 4. Walks Frequently: Walks outside room at least twice a day and inside room at least once every two hours during waking hours Answer: Bedfast Bedfast- 1. Potential Interventions: Provide below interventions; High level of support surface (esp. if existing skin breakdown) Chairfast- 2. Potential Interventions: Provide below interventions as needed; Obtain wheelchair cushion; Instruct/assist to shift weight in wheelchair as resident will allow. Consider limiting wheelchair to 1-2 hour intervals as resident will allow. Walks Occasionally- 3. Potential Interventions: below interventions; Teach patient/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent Position changes. Wheelchair cushion (esp. if existing skin breakdown.); PT/OT consult. 4. MOBILITY Ability to change and control body position 1. Completely Immobile: Does not make even slight changes in body or extremity position without assistance 2. Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Slightly Limited: Makes frequent though slight changes in body or extremity position independently. 4. No Limitation: Makes major and frequent changes in position Answer: Very limited Very limited- 2. Potential Interventions: Provide below interventions as needed; Limit wheelchair to 1-2 hour intervals as resident will allow; Pressure redistribution surface for wheelchair and/or bed (esp. if existing breakdown) Slightly limited- 3a. Potential Interventions: Teach patient/family the importance of changing positions for prevention of pressure ulcer, explain risks vs benefits; Encourage small frequent position changes; Turning and repositioning at least every 2 hours when in bed as resident will allow. Use of pillow to separate pressure areas, with special attention of off-loading contracted joints; Elevation of heels off bed; Use of wedges to help maintain positioning. Use draw sheet to lift up or turn in bed. Slightly Limited cont- 3b. Potential Interventions: Keeping HOB at or below 30 degrees. HOB may be elevated for meals then lowered within one hour after meal as resident will allow. When elevating HOB, knee [NAME] should be elevated first to 10-20 degree; Instruct/assist to shift weight in wheelchair often as tolerated; Use of assistive device (i.e. trapeze); PT/OT consult No limitation- 4. Provide routine skin care 5. NUTRITION Usual food intake pattern 1. Very Poor: Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV?s for more than 5 days. 2. Probably Inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding 3. Adequate: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Excellent: Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. Answer: Adequate Adequate- 3. Potential Interventions: Encourage meals and assist with meals as needed; Offer ordered supplements; Assess needs for oral care, assist PRN. 6. FRICTION & SHEAR 1. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction 2. Potential Problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down. 3. No Apparent Problem: Moves in bed and in chair independently and has sufficient muscle strength to lift up Answers: Problem Problem- 1. Potential Interventions: Below interventions; Use of assistive device (i.e. trapeze) Potential problem- 2. Potential Interventions: Use a draw sheet to lift up or turn in bed; Consider keeping HOB at or below 30 degrees. Hob may be elevated for meals then lowered within one hour after meal as resident will allow. When elevating HOB, remember to elevate knee [NAME] first, 10-20 degrees; Heel/elbow pads or coverings No apparent problem- 3. Potential Interventions: Provide routine skin care. 7. Important to Remember (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Do not massage bony prominence's. Do not use donut shaped foam/pillow to offload pressure points; Do not use multiple incontinence pads/linen under prone area. Avoid positioning directly on the trochanter by using a 30 degree side-lying position. Do not use heel pads to off load heels from surface; Only float heels off the end of a longitudinally placed pillow or with boots that float heels. *Low air loss beds do not substitute for turning schedules* Manage Moisture 2. Use approved moisture barriers; Use approved adult briefs that wick and hold moisture; Address specific cause if possible; Offer bedpan/urinal; Toileting program; Offer water and fluids in conjunction with turning schedules. Manage Nutrition 3. Increase protein intake; Increase calorie intake to spare proteins; Consult Dietician; Supplement with vitamins; Following culinary standards; Act quickly to alleviate deficits. Manage Friction and Sheer 4. Elevate HOB to 30 degrees or less and always have knee [NAME] raised to 10-20 degrees first; Use trapeze where indicated; Use lift sheet to move patient; Always protect heels, elbows, sacrum and back of head whenever exposed to friction. Score: 12 Low Risk = 15-18 1. Potential Interventions: Frequent Turning; Maximal remobilization; Protect heels; Manage moisture, nutrition and friction and shear; Pressure reduction support surface if bed or chair bound. If other major risk factors are present :Advanced age, fever, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability advance to next level of risk. Moderate Risk = 13-14 2. Potential Interventions: Actual turning schedule as resident allows/tolerates; Use wedge support for 30 degree side positioning; Pressure reduction support surface; Maximal remobilization; Protect heels; Manage moisture, nutrition and friction and shear; **If any of the major risk factors listed above advance to next level of risk.** High Risk = 10-12 3. Potential Interventions: Increase frequency of turning; Supplement turning with small shifts in positioning; Pressure reduction support surface; Use wedge support for 30 degree side positioning; Maximal remobilization; Protect heels; Manage moisture, nutrition and friction and shear; **If any of the major risk factors listed above advance to next level of risk.** Very High Risk = 9 or below (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Potential Interventions: All of the above interventions; Use of pressure relieving surface if patient has intractable pain or sever pain exacerbated by turning or any additional risk factors. 5. Comments: (left blank) 6. Interventions in place/put in place: (left blank) On 10/15/24 at 2:32 PM, a review of Policy and Procedure entitled, Skin Care and Wound Management Overview, was completed which revealed that all staff strive to prevent resident/patient skin impairment and to promote the healing of existing wounds. The interdiscipary team works with the resident/patient and/or family/responsible party to identify and and implement interventions to prevent and treat potential skin integrity issues. The interdisciplinary team evaluates, and documents identified skin impairments and pre-exiting signs to determine the type of impairment, underlying condition(s) contributing to it and description of impairment to determine appropriate treatment. Resident/patient skin condition is also re-evaluated with change in clinical condition. Skin care and wound management program includes, but is not limited to: 1. Identification of resident/patients at risk for development of pressure ulcers 2. Implementation of prevention strategies to decrease the potential for developing pressure ulcers. In addition it stated that the Braden Scale is to be completed on admission and weekly three times thereafter, then quarterly and with change of clinical condition to identify risk factors. Identify diagnosis or conditions that place the resident/patient at risk for pressure ulcer development. Risk factors include, but are not limited to: 1. Co-Morbid conditions 2. Cognitive Impairment 3. Decreased activity 4. Decreased Sensory perception 5. Diabetes 6. Friction and Shear 7. Increased moisture on skin 8. Medications Furthermore, the policy and procedure states the clinical team are to evaluate for consistent implementation of interventions and effectiveness at clinical meeting, modify and document goal and interventions as indicated and develop a care plan with individualized interventions to address risk factors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at approximately 2:00 PM, and interview was conducted with DON who acknowledged the following: 1. Resident #163's co-morbid conditions: HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT NON-DOMINANT SIDE TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA NEED FOR ASSISTANCE WITH PERSONAL CARE ANEMIA, UNSPECIFIED 2, Resident #163's cognitive impairment: 8/20/24 Brief Interview for Mental Status Moderately Impaired 9.0 2/19/24 Incapacitated nature: disorientation due to CVA 3. Resident #163's decreased activity 10/02/24 Braden: Bedfast 4. Resident #163's decreased sensory perception: 10/02/24 Braden: Slightly limited 5. Resident #613's Diabetes: TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA 6. Resident #163's increased moisture on skin: 10/02/24 Braden: Very Moist 7. Resident #163's medications that increased risk of breakdown: Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 2 spray in nostril every 24 hours as needed for allergies Pharmacy Active 2/16/24 15:45 (steroid) Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 12.5 mg orally two times a day for HTN Pharmacy Active 2/20/24 21:00 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wixela Inhub 100-50 MCG/ACT Aerosol Powder, breath activated Give 1 puff by mouth two times a day for COPD rinse mouth out with water and spit out after each use Pharmacy Active 4/3/24 21:00 (steroid) Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneous at bedtime for DM Pharmacy Active 6/30/24 21:00 8. Resident #163's Refusal of Care At that time, the DON acknowledged the following: 1. There was no preventative care plan in place and that the above documented risk factors were not addressed in Resident #163's current skin care plan. 2. When Resident #163's Braden score changed from 14, which indicated moderate risk for skin breakdown, to 12, which indicated high risk for skin breakdown, Resident #163's current skin care plan should have been reviewed by the clinical team for effectiveness and any necessary revisions should have been made. 3. The Braden completed on 10/02/24 listed several potential interventions to be implemented to prevent skin breakdown and that the nurse completing this Braden left the section Interventions in place/put in place: blank with no new interventions put into place. c) Resident #120 A review of resident #120 eMAR administration records on 10/16/24 at 12:58 PM, documents patient refused medications on 10/2, 10/3, 10/4, 10/5, 10/6, 10/7, 10/8, 10/10, 10/11, 10/11, 10/13/24, as well as 25 out of 30 days in September. Resident's most recent care plan was dated 8/20/24, and not been updated to reflect refusal of medications and alternative modifications to care. In an interview with the Administrator on 10/16/24 at 11: 32 AM, she acknowledged the care plan was not updated for this resident. d) Resident #139 At approximately 12:55 PM on 10/14/24, a review of Resident #139's care plan was conducted. During this review it was noted the resident's care plan had been updated on 05/06/24 with the following focus: The resident has a behavior problem due to impaired cognition and progressive disease process with episodes of verbal/physical aggression at times. This focus was initiated on 05/06/24. However, a review of the resident's progress notes shows the resident exhibited these behaviors as far back as 02/03/24, with the following progress note written at 2:51 PM: Note Text: Patient refused x 3. Patient is very agitated, yelling at other residents and staff. No new orders at this time. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Other notes indicating the resident showed aggressive behaviors are below, typed as written: 02/04/24 07:21 AM Note Text: irrigate foley cath Q3 days and PRN with 30 cc of sterile water. every day shift every 3 day(s) Resident yelling no, no, no. 04/07/24 09:58 AM Note Text: Refused. Screamed and hit this nurse. 04/19/24 09:57 AM refused. Cursed at this nurse 04/21/24 09:28 AM refused. Cursed and swatted at this nurse. 4/28/24 09:20 Refused. Cursed incoherently at this nurse and swatted. Despite these past instances of aggressive behaviors, the resident's care plan was not revised to reflect them until 05/06/24. At approximately 3:30 PM on 10/16/24, Administrator #13 acknowledged the past behaviors and lack of revision for the care plan of Resident #139.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465 Based on observation, staff interview, record review and resident interview, the facility failed to provide Activities of Daily Living (ADL) care to dependent residents. This failed practice was found true for (4) four of 17 residents reviewed for ADL care during the Long-Term Care Survey Process. Resident identifiers #3, #153, #93, #41. Facility Census 181. Findings Included: a) Resident #3 During the initial interview on 10/07/24 at 1:45 PM, Resident #3 stated, I sometimes do not get a bath for days. My fingernails and toenails are very long. My toenails are getting hung on the blanket. An observation on 10/07/24 at 1:45 PM of Resident #3 revealed that the resident's fingernails had a brown substance underneath them and were extremely long. Residents' toenails appeared clean but were also long and jagged. An observation 10/09/24 at 9:54 AM, revealed that Resident #3's fingernails were still extremely long and had a brown substance underneath them. Further observation revealed that Resident #3's toenails were long and jagged. During an interview on 10/09/24 at 9:54 AM, Registered Nurse (RN) #21 stated, Nail care is supposed to be done with every shower or bed bath RN #21 confirmed that his fingernails and toenails were very long. RN #21 further stated that she will make a referral to the Podiatrist. A review of the facilities policy on 10/09/24 at 1:00 PM, titled {Nail and Hair Hygiene Services), under procedure 1. Routine Nail Hygiene a. it reads: Resident will have routine nail hygiene and hair hygiene as part of the bath or shower i. Nails should be trimmed immediately after bathing or alternatively, soaking nails in warm soapy water prior to trimming or filing to reduce tearing and provide ease of trimming and filing. b) Resident #153 During an interview and observation on 10/08/24 at 9:07 AM, Resident #153's hair appeared greasy. Resident #153 stated, They do not wash my hair. I barely get a bath. A record review on 10/09/24 at 11:00 AM, Resident #153's care plan read as follows: Focus: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADL Self Care Performance deficit, requires assistance with ADL Disease Process, muscle weakness, need for assistance with personal care, other reduced mobility. Wants personal belongings in easy reach. Shower Intervention: Preferred shower day/time: Monday, Thursday day shift. Further record review of Resident #153's shower task revealed that from 08/01/24 to present that Resident #153 had 2 baths with only 2 refusals documented. On 10/09/24 at 11:30 AM, Licensed Practical Nurse (LPN) #44 confirmed that according to the documentation that Resident #153 had only 2 baths since 08/01/24. c) Resident #93 On 10/07/24 at 2:57 PM, an observation and interview of Resident #93 was completed which revealed Resident #93's fingernails that where long and had a brown substance underneath them. At that time, Resident #93 stated, They don't care about our appearance, I have asked them to clean them, but they aren't going to do it. They don't care. On 10/08/24 at 11:47 AM, an observation and interview of Resident #93 which revealed Resident #93's fingernails remain long with a brown substance underneath them. Resident #93 states I have asked repeatedly for them to get cleaned and cut. On 10/09/24 at 9:30 AM, and additional observation and interview was conducted with Resident #93 which revealed Resident #93's fingernails remain long with a brown substance underneath them. At that time, Nurse Assistant (NA) #153 came into Resident #193's room and an interview was conducted. NA #153 states I don't know the last time she had nail care. I am not sure how often it should be completed, I think with every shower or bath. NA #153 acknowledges resident's nails are are long and have a brown substance under [NAME] them and need done. NA #153 also verbalized, I don't know how to get her on the list to get them cut. d) Resident #41 During an interview on 10/07/24 at approximately 4:00 PM with Resident #41 the family member pointed out Resident #41's fingernails that where long and had a brown substance underneath them. The family member stated Resident #41 will stick her hands down her brief when she is soiled. The family member stated they had requested numerous times for the facility staff to clean and cut her fingernails. During an interview with Clinical Manager Licensed Practical Nurse (CM LPN) #45 on 10/09/24 at approximately 10:20 PM while examining the condition of the residents fingernails being jagged and rough with darkened brown tint visible to the underneath fingernail. CM LPN #45 stated the Nursing Assistants are to at least look at the residents nails at least every shift. CM LPN #45 was not certain on when the facility staff cut the residents nails. (continued on next page)

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	515086	A. Building B. Wing	10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beckley Healthcare Center	100 Heartland Drive Beckley, WV 25801

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CM LPN #45 agreed that the residents nails had rough jagged edges and stated that the resident fingernails have room for improvement on cleanliness. 49650 50552

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465 Based on resident interview, staff interview, observation and record review, the facility failed to provide a program to meet the needs and interest of the residents. This failed practice was found true for (2) two of (4) four residents reviewed for activities during the Long-Term Care Survey Process. Resident identifiers: #147 and #93. Facility Census 181. a) Resident #147 During the initial interview on 10/07/24 at 1:15 PM, Resident #147 stated, I sometimes go out in the hall. The activities they have here really do not interest me so I do not go. A record review on 10/14/24 at 1:00 PM, of Resident #147's activity participation from 08/01/24 to present revealed that Resident #147 only attended (1) one group activity during the period. It further revealed that Resident #147 had only one activity marked each day which was an individual activity of relaxation. No one to one visits were documented. Further record revealed an Activities care plan that reads as follows: Focus: Resident does not attend scheduled group activities. He prefers to remain self-directed in his room instead. Goal: (Resident name) will participate in activities of choice through review date. Some interventions include: * Provide activity materials of interest such as library books, word puzzles, magazines * Resident enjoys being around animals * Resident enjoys being outdoors * Resident enjoys listening to music * Resident enjoys playing bingo * Resident enjoys playing cards * Resident enjoys coloring. During an interview on 10/14/24 at 2:30 PM, Resident #147 stated, I have never been offered anything such as coloring books, playing cards or going outside for an activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review on 10/14/24 at 2:45 PM, of Resident #147's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/23/24, section F, question F, is marked it is very important for this resident to do his favorite activities. During an interview on 10/14/24 at 3:30 PM, The Activity Director (AD) #39 confirmed that the only thing marked for his participation from 08/01/24 to present was relaxation for individual activity. b) Resident #93 On 10/07/24 at 03:14 PM, an interview and observation was conducted with Resident #93. At that time, Resident #93 stated, No, I don't go to activities, I can't walk. No, nobody stops by by room and offers me anything. They don't come in and do any activities with me, they don't bring me anything to do either. I never see them. At the time of this interview and observation, no TV was on and nothing was noted at bedside such as reading material. On 10/08/24 at 11:47 AM, an additional interview and observation was conducted with Resident #93. At that time, no TV was noted to be on and no materials were noted at bedside. Resident #93 again states she has nothing to do, that nobody ever offers her anything to do. Resident #93 states I can't walk, my back is broke, I can't go to activities. On 10/08/24 at 03:26 PM, a review of Resident #93's care plans was completed and revealed the following care plan: FOCUS: Resident does not attend scheduled group activities. She prefers to remain self-directed in her room instead. Date initiated: 08/12/24. GOAL: [NAME] will participate in activities of choice through review date. Date initiated: 08/12/24. INTERVENTIONS: Encouraging attendance to entertainment programs, large and small group activities, volunteer demonstrations, and religious activities. Date initiated: 08/12/24. Favorite colors are pink and blue. Date initiated: 08/19/24. Interview and determine resident activity preferences. Date initiated: 08/12/24. Introduce to other residents with similar interests. Date initiated: 08/12/24. Invite resident to scheduled activities. Date initiated: 08/12/24. Provide a schedule of activities available. Date initiated: 08/12/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activity materials of interest, i.e. library books, word puzzles, magazines. Date initiated: 08/12/24. Resident enjoys gardening. Date initiated: 08/19/24. Resident enjoys listening to country music. Date initiated: 08/19/24. Resident enjoys watching football. Her favorite team is the Redskins. Date initiated: 08/19/24. Resident is right-handed. Date initiated: 08/19/24. Resident prefers being active in the morning. Date initiated: 08/19/24. Resident previously enjoyed baking cakes. Date initiated: 08/19/24. Resident was married for sixty years. Date initiated: 08/19/24. On 10/14/24 at 10:29 AM and interview was conducted with the Activity Director, at that time the Activity Director stated, I talked to her niece, she wants us to encourage her to come out and participate in group activities and do one on one with her. She likes to be around other people and be involved in activities. I provide her things to do, she is one who will talk, we are trying to build the rapport with her. She did participate in activities at the other facility. But, I only provide her with things to do if she asks for them and no, I am not documenting we are offering things for her to do. At that time, a review of Resident #93's activity participation from 08/10/24 through 10/09/24 was completed with the Activity Director, which revealed that in the last 60 days, Resident #93 had been self directed in activities for 59 days, with 1 (one) day of one to one activity provided for Resident #93 and no documentation of Resident #93 being provided materials of interest, as Resident #93's care plan identified. At that time, the Activity Director stated, Yes, I see that. She is not one who would accept anything. At that time, the Activity Director acknowledged Resident #93's care plan should have been updated to reflect any refusal to participate in activities or accept materials of interest. 50552

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on record review and staff interview, the facility failed to provide care to Residents #139, #93, and #23, consistent with professional standards of care. This was true for three (3) of fifty (50) residents reviewed for quality of care during the survey process. Resident identifiers: #139, #93, #23. Facility census: 181. Findings included: a) Resident #139 Hospice documentation At approximately 1:30 PM on 10/08/24, during a review of the record for Resident #139, it was noted the resident had received an as needed (PRN) order for Lorazepam (also known as Ativan) Oral Concentrate 2 MG/ML. The order reads as follows: Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml orally every 2 hours as needed for terminal agitation/restlessness. This order was recommended by the hospice provider as the resident is currently receiving hospice services. The Resident received this order for a one time dose of oral concentrate Ativan on 05/09/24, ending on 05/10/24. However, on 05/10/24, a new order was recommended by hospice for: Lorazepam Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml orally every 2 hours as needed for terminal agitation/restlessness for 14 days. Upon review of the resident's record, it was determined the resident was in two (2) altercations on 05/09/24, with Residents #242 and #134. A progress note dated 05/09/24 at 3:50 PM stated: Alerted by unit manager that activities notified her of this resident smacking (Resident #134's facility ID number) in the doorway of the station 2 nurses station/dining room during an activity. Retrieved statement from activities staff. Activities stated that, (Resident #139's name) hit resident on her leg. CNA intervened and de-escalated the situation. (Resident #139's name) has been placed on a 1:1, physician notified. Spoke with (Hospice Registered Nurse [RN] #197's name) regarding possible med (medication) changes. New orders received. According to a progress dated 05/09/24 at 4:08 PM, a new order was received for the Ativan oral concentrate. According to the Medication Administration Record (MAR) the PRN Ativan oral concentrate was administered to Resident #139 at 6:33 PM on 05/09/24. At 6:45 PM on 05/09/24, a note was entered stating administration of the PRN Ativan oral concentrate was effective. Further review of the MAR revealed Resident had scheduled administration times of Ativan tablets every day. The orders are as follows: Ativan Oral Tablet 0.5 MG (Lorazepam) Give 0.5 mg by mouth two times a day for agitation; anxiety. Ativan Oral Tablet 1 MG (Lorazepam) Give 1 mg by mouth at bedtime for agitation; anxiety. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MAR shows Resident #139 was given the 0.5 mg dose of the Ativan tablet at 6:00 AM and 2:00 PM on 05/09/24. Further review shows the resident was given the Ativan oral concentrate at 6:33 PM and the 1 mg dose of the Ativan tablet at 8:00 PM on 05/09/24. The behavior monitoring tools for the day of 05/09/24, when the altercations occurred between Resident #139 and Residents #242 and #134, indicated the resident exhibited no behaviors. Furthermore, the behavior monitoring tool reveals no non pharmacological interventions were attempted before the facility obtained an order for, and administered, Ativan oral concentrate to Resident #139. The following day, the facility started the order for the Ativan oral concentrate for terminal agitation and restlessness for 14 days. At approximately 10:39 AM on 10/14/24, an interview was conducted with Hospice RN #197 regarding the medication given to Resident #137 for the purpose of terminal agitation and restlessness. When asked if she came in to assess the Resident at the time the facility called to inquire about the Ativan oral concentrate, Hospice RN #197 stated she did not come in to assess the resident before giving the facility the order for the Ativan. In fact, Hospice RN #197 did not come into the facility to see the resident until 05/10/24 at 6:51 PM, according to the progress notes entered into the system. A progress note dated 05/10/24 at 6:51 PM reads as follows: (Hospice RN #197's name) from Hospice in to assess resident due to extreme agitation today and refusal of Ativan 0.25 ml PRN medication. (Hospice RN #197's name) put her in her bed to assess her and resident had a large BM after which resident became calm and agreed to take the Ativan 0.25 ml. She is now resting in bed comfortably. (Hospice RN #197's name) then obtained order from (Facility physician) to discontinue 1:1 since resident is now calm. During the interview with Hospice RN #197, she was asked about terminal agitation and how she was able to assess the resident without laying eyes on her to rule out other conditions that may cause agitation and behaviors. Hospice RN #197 stated I have a good relationship with the nurses at the facility, I trust their judgment when they call and tell me things about the residents. Hospice RN #197 stated the behaviors the resident was having were out of character for the resident, however, during review of the resident's record, it was noted the resident exhibited behaviors of cursing and hitting staff as far back as February of 24. Hospice RN #197 stated terminal agitation could last go on for some time when asked if it was common for a resident to be terminally agitated and still be alive five (5) months later. Hospice RN #197 was asked how the nursing staff at the facility know how to identify terminal agitation in a resident, seeing as how they don't see things like that on a regular basis, compared to hospice, and how she could be sure Resident #139 was terminally agitated without physically assessing her. Hospice RN #197 stated We do education every time we are in the facility with the nursing staff about what to look for in the residents. Hospice RN #197 was asked what the facility stated was different with Resident #139's behaviors during that period that warranted the Ativan oral concentrate. Hospice RN #197 stated the facility had placed the resident on one (1) on one (1) supervision due to her being in an altercation with another resident and called to request a medication change. Furthermore, Hospice RN #197 states she was in the facility on 05/10/24 to assess the resident because the facility told her Resident #139 was refusing doses of the Ativan oral concentrate. Hospice RN #197 stated she took Resident #139 into her room and was able to get her to take the medication, as evidenced by the progress note listed above. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hospice RN #197 was asked if being placed on one (1) on one (1) supervision was a reason to receive Ativan oral concentrate as needed, to which she stated If it's different than their normal behaviors, then yes. According to Resident #139's wandering observation tool, and multiple observations during the survey process, she is noted to wander about the entire facility frequently. Hospice notes were not available in the resident's chart from 05/09/24 or 05/10/24, when the assessments would have been completed on the resident for the change in condition and prescription of the PRN Ativan. Hospice RN #197 stated she would send them to the facility if she had them. As of the end of the survey, the notes were not produced. At approximately 3:30 PM on 10/16/24, Administrator #13 confirmed the missing hospice documentation. a2) Resident #139 Missed Medications At approximately 1:30 PM on 10/08/24, a review of Resident #139's record was conducted. During the review, it was noted multiple occasions where the resident did not receive medications as ordered by the physician. The following medications missed were: 05/29/24 at 2:00 PM- Lasix oral tablet 20 mg- Give one tablet by mouth two times a day for CHF 05/29/24 at 2:00 PM- Ativan oral tablet 0.5 MG- give by mouth two times a day for agitation:anxiety. 05/29/24 at 4:00 PM- Norco oral tablet 5-325 MG (Hydrocodone-Acetaminophen)- Give one tablet by mouth every six hours for pain 05/29/24 at 8:00 PM- Ativan oral tablet 1 MG- Give one tablet by mouth at bedtime for agitation: anxiety 05/29/24 at 8:00 PM- Atorvastatin calcium tablet 40 MG- Give one tablet by mouth at bedtime for high cholesterol 05/29/24 at 9:00 PM Senna S Oral Tablet 8.6-50 MG- Give 2 tablets by mouth two times a day for constipation 05/29/24 at 10:00 PM-Norco oral tablet 5-325 MG (Hydrocodone-Acetaminophen)- Give one tablet by mouth every six hours for pain 08/07/24 at 4:00 AM- Norco oral tablet 5-325 MG (Hydrocodone-Acetaminophen)- Give one tablet by mouth every six hours for pain 08/07/24 at 6:00 AM- Lasix oral tablet 20 mg- Give one tablet by mouth two times a day for CHF 08/07/24 at 6:00 AM- Senna S Oral Tablet 8.6-50 MG- Give 2 tablets by mouth two times a day for constipation (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	08/07/24 at 6:00 AM- Ativan oral tablet 0.5 MG- give by mouth two times a day for agitation:anxiety. b) Resident #93 On 10/07/24 at 03:26 PM, a record review was conducted for Resident #93 which revealed two falls occurring on 09/07/24 resulting in Resident #93 being hospitalized status post fall with a diagnosis of wedge compression fracture of first lumbar vertebra with kyphoplasty. Further review of Resident #93's medical record revealed Resident # 93 was receiving the following medications and had the following diagnoses: Medications: Pre-Fall: 1. Diazepam 0.5 mg by mouth at bedtime for Anxiety, Start date 08/09/24. 2. Buspar 7.5 mg by mouth three times daily for Anxiety, Start date 08/10/24. 3. Sertraline 100 mg by mouth every morning for Depression, Start date 08/09/24. 4. Hydralazine 100 mg by mouth as needed for Hypertension, Start date 08/09/24. Post-Fall with fracture: 1. Eliquis by mouth two times a day for Atrial Fibrillation, Start date 09/14/24. 2. Lisinopril 20 mg by mouth once a day for Hypertension, Start date 09/14/24. 3. Buspar 7.5 mg by mouth three times a day for Anxiety, Start date 09/13/24. 4. Hydralazine 25 mg by mouth one tablet two times a day for Hypertension, Start date 09/16/24. 5. Norco (Hydrocodone-Acetaminophen) one half tablet by mouth three times a day for back pain, Start date 09/25/24. 6. Escitalopram 10 mg by mouth one time a day for Depression, Start date 10/02/24. 7. Trazodone 100 mg by mouth at bedtime for Major Depressive Disorder, Start date 10/03/24. 8. Aricept 5 MG by mouth two times a day for Depression, Start date 10/01/24. Diagnoses: 1. Depression 2. Anxiety (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Insomnia 4. Hypertension 5. Chronic Kidney Disease 6. Dementia with other behavioral disturbance 7. Muscle weakness 8. Unsteadiness on feet 9. Atrial Fibrillation 10. Heart Failure In addition, it was revealed that Resident #93 was previously residing in an Assisted Living facility and had previous falls with fractures while residing there. Furthermore, it was revealed that Resident #93 was incapacitated, nature: short-term memory loss with disorientation, inability to process information and hallucinations caused by dementia. During a review of Resident #93 ' s admission assessment revealed the facility had assessed and identified these risk factors upon admission. The following therapy certification period documentation which revealed Resident #93's functional ability pre and post fall. 1. Certification Period: 08/12/24 - 09/08/24 (Pre fall) A. Dynamic Standing: Baseline (08/12/24)- Poor Mod A (Moderate Assist) Discharge (08/29/24)- B. Transfers: Baseline (08/12/24)- CGA (Contact Guard Assist) Discharge (08/29/24)- Supervised C. Distance Level Surfaces: Baseline (08/12/24)- 20 feet Discharge (08/29/24)- 100 feet D. Level Surfaces: Baseline (08/12/24)- Mod A Discharge (08/29/24) SBA (Stand by Assist) 09/08/24 - 09/13/24: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hospitalization status post fall with wedge compression fracture of first lumbar verebra with Kyphoplasty. 2. Certification Period: 09/16/24 - 10/13/24 (Post fall with fracture and surgical intervention to treat spinal compression fracture.) A. Dynamic Standing: Baseline (09/16/24)- Poor Mod A (Moderate Assist) B. Transfers: Baseline (09/16/24)- Max A (Maximum Assist) C. Distance Level Surfaces: Baseline (09/16/24)- 0 feet D. W/C (wheelchair) Mobility Baseline (09/16/24)- Total Dependence w/o (without) attempts to initiate. E. Sit to Stand (09/16/24)- Unable without assist Along with the following care plan: FOCUS: The resident is at risk for falls r/t unsteadiness on feet. Date initiated: 09/14/24. GOAL: (resident name) will not sustain major injury related to falls through review date. Date initiated: 08/10/24. INTERVENTIONS: Assess risk for falls on admission / readmission, quarterly, and as needed. Date initiated: 08/10/24. Educate resident or resident representative, if applicable how to operate bed controls/call light/television. Date initiated: 08/10/24. Ensure resident is wearing appropriate non-skid footwear. Date initiated: 09/16/24. Ensure residents room is free of potential visible hazards. Date initiated: 08/10/24. Ensure that the bed locks are engaged. Date initiated: 08/10/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/09/24 at 01:51 PM, a review of Policy and Procedure entitled, Fall Prevention and Managementwas completed which revealed that the care plan can include interventions that address environmental factors, ADL factors, risk factors such as mental diagnosis and medical diagnosis that put the resident at higher risk for falls. Issues such as toileting, eating, transferring and impulsiveness should be considered. The care plan can address furniture arrangements, foot wear, medications, drowsiness and instability. The care plan should also address how the resident can be transferred in and out of bed as well as how the resident can ambulate and move around the facility. The care plan should be reviewed and updated as needed with each change of condition. Attempt to put an intervention in place that could prevent further falls, such as: if the resident was going to the bathroom, assist them to the toilet. If the resident was getting a drink and overreaching, place the drink within range of the resident. If the resident was attempting to transfer from bed to wheel chair or vice versa, assist to where they would like to go. If the resident is confused, attempt to re-orient. Attempt to identify why the resident fell and put an immediate intervention in place. On 10/09/24 at 02:22 PM, an interview was conducted with the Director of Nursing (DON) #138 and Administrator #13 of Building 1 who acknowledged the following: 1. The care plan interventions should be address functional abilities and updated when functional abilities changed. Resident #93's care plan upon admission did and currently does not. 2. The care plan should address risk factors for falls, such as high risk medications, previous falls, cognitive ability, diagnoses, incontinence. Resident #93's care plan upon admission did not and currently does not. 3. The goal should have been updated post fall with fracture for Resident #93 and was not. 4. The facility was aware of the following: A. Resident #93's falls with fractures prior to admission. B. Resident # 93's risk factors were identified at the time of admission. C. The facility failed to put appropriate interventions in place to address these issues to prevent Resident #93 from falling. An additional interview was conducted on 10/14/24 at 01:26 PM with DON #138 who acknowledged: 1. Resident #93's fall care plan does not address the fact Resident #93 was incontinent at the time of the fall and that based on the therapy evaluation post fall, at which time it was determined Resident #93 was unable to perform sit to stand, ensuring Resident #93 was wearing non-skid sole footwear would be an ineffective intervention. 2. Resident #93 is incapacitated and it is identified that she has short term memory loss and inability to process information. Documentation was reviewed that Resident is to be educated on fall prevention. DON #138 acknowledged that this would not be an effective intervention. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Acknowledged that root causes discussed for Resident #93's falls are not complete. For example, resident stated, I was trying to get up. DON #138 acknowledged that for a thorough root cause to be performed, why the resident was attempting to get up would be important to determine an effective intervention and was not addressed. A final interview was conducted with DON #138 and Administrator #13 on 10/16/24 at 03:44 PM, who acknowledged Resident #93 continued to be at risk for falls due to the lack of appropriate and effective interventions currently in place and incorrect tasks such as incorrectly tasked transfer status as Resident #93 was determined by therapy to require maximum assist to perform this task and Resident #93 continues to be tasked to transfer independently. c) Resident #23 On 10/07/24 at 4:09 PM resident leaning so far in chair that her hair was almost on the floor. (right side)- Licensed Practical Nurse (LPN) #99 stated Resident #23 had been in there a long time. LPN #99 acknowledged she had been in there since lunch around 12:00 PM. LPN #99 stated Resident #23 is not positioned at her best. LPN #99 asked Nursing Assistant (NA) # 84. NA #84 asked who her CNA's were as CNA #84 stated she knew 2 NA's left and 2 NA's had came on but did not know who it is. NA #84 assisted Resident #23 to her room and waited for LPN #84 to come with the lift to assist the resident to the bed. An interview with Administrator #186 on 10/07/24 at approximately 4:49 PM acknowledged the care concern and inquired if the staff already assisted with the resident. Administrator #186 stated they will follow up on it immediately . During a medical record review on 10/08/24 at approximately 8:30 AM a review of the Minimum Data Set (MDS) dated [DATE] identifies that Resident #23 has a Brief Interview for Mental Status (BIMS)under Section C is zero (0). Section GG0115 identified a functional limitation in range of motion with the lower extremity impairment. Section I identified the use on no devices and Section J identified that the Occupational Therapy start date of 12/23/21 to 1/06/22 and the Physical Therapy started on 07/01/24 to 07/01/24. A review of Resident #23's diagnoses identified dementia with agitation dated 10/1/22; muscle weakness dated 06/05/23; pain in right shoulder dated 04/05/20; other reduced mobility dated 1/23/24; other lack of coordination dated 04/12/24; stiffness of left hip dated 06/05/23; stiffness of right hip dated 06/05/23; unspecified lack of coordination dated 01/23/24; need for assistance with personal care dated 08/25/23; stiffness right knee dated 03/17/23; pain in left knee dated 03/31/21; stiffness in left knee dated 04/02/21; chronic pain dated 04/28/19; secondary multiple arthritis dated 03/01/19; history of falling Contusion (R) right hip; Strain of right shoulder dated 06/05/17. During a review of therapy documentation the last evaluation completed for occupational therapy on 07/01/24 for an evaluation of positioning. The Assessment summary for reason of skilled services identified that this was an evaluation only as the current level of functioning (LOF) has no marked changes from the previous LOF. The risk factors noted that the (typed as written) Patient remains total assist for all aspects of care in presence of advanced dementia and cog dependence on others to identify needs. And the last evaluation completed for occupational therapy 07/01/24 with evaluation only and no recommendations. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the care plan identified a focus of Resident #23 being at risk for communication problems with reference to other disease process/ conditions diagnosis of Alzheimer's. An intervention identified to work towards the goal of the resident maintaining or improving the current level of communication is identified to; (typed as written) Observe/document for physical/nonverbal indicators of discomfort or distress and follow up as needed. Resident #23 is also care planned for assisted daily living (ADL) care performance deficit, requires assistance with ADL cognitive deficit, disease process, functional deficit. The interventions for the goal of Resident #23 to be without decline in range of motion (ROM) included but is not limited to: Personal hygiene; Dependent- helper does all of the effort or 2 or more helpers assist. Observe and anticipate residents needs; thirst, food, body positioning, pain, toileting needs dated intiated 06/19/24. During a review of the reportable for the allegation of neglect with Resident #23 being left unattended in the dining room and being observed to be leaning so far in the geri-chair (right side) that her hair was almost on the floor the 5 (five) day follow up stated it was verified that the resident was not checked on by the CNA's (Certified Nursing Assistants) during the time of 12:00 PM through 4:00 PM and other actions pending regarding CNA's. It is noted that the resident was assessed with no signs of mental distress and no physical injuries or skin issues. During an interview with the Director of Nursing (DON) #96 on 10/08/24 at approximately 11:00 AM the DON stated she had not been made aware of any positioning concern with Resident # 23 and that the resident does normally lean to the right side. DON #96 observed the resident in the dining room with the surveyors at this time and acknowledged the concern of the residents re-positioning need. 49650 50552

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 50551 Based on resident interview, staff interview and review of documentation, the facility failed to identify resident's hearing deficit and use of hearing aids in the Minimum Data Set (MDS). This is true for one (1) of two (2) resident's reviewed for hearing. Resident identifier: #148. Facility Census: 181. Findings included: a) Resident #148 On 10/07/24 at 1:30 PM, during an interview with Resident #148, he reported that he has excessive earwax buildup that needs removed monthly. He reported that used scissors to dig a huge plug of wax out. He stated that he cannot use his hearing aides due to the extra wax. He stated that he ordered a flusher and staff told him he was not allowed to use it due to safety of the other residents. He stated that he had tried the curettes and they are not affective for him. He denied having an appointment scheduled with audiologist since his admission at this facility. An interview with Registered Nurse #112 on 10/07/24 at 2:25 PM acknowledged that resident had complained of earwax buildup in the past. She reported that he had ordered himself a flushing device to help with removal but she is unsure what happened to it. She stated that the physician had previously ordered Debrox and the resident does not like it. She denied knowledge that he was using scissors to clean his own ears. She reported that she would notify the doctor that resident would like his ears cleaned more frequently and that he used scissors to remove his own wax. On 10/08/24 at 3:21 PM, review of records revealed resident's care plan did not include hearing impairment, ear wax care and hearing. On 10/08/24 at 3:30 PM a review of Admission MDS dated for 12/08/23, section B states the resident had hearing aids, the Quarterly MDS on 08/15/24 states that resident does not wear hearing aids. On 10/09/24 at 1:50 PM and interview was conducted with both administrators who acknowledged that resident's Quarterly and Admission MDS were not consistent with the other and that resident's hearing impairment/hearing aid use is not on the current care plan. Also, made administrative staff aware that resident had a flushing device that he had purchased for himself and it had been taken away from him but that he reported that he is using a pair of scissors to clean them. They will look into it and let me know if they have any information on why is no longer in possession of the ear flusher and if it is safe for him to use. No further information was reported.

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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** 50552 Based on observation, record review and staff interview, the facility failed to provide pressure ulcer care in accordance with professional standards of care. This was true for 1 (one) of 2 (two) residents reviewed for the Long Term Care Survey Process. Resident identifier: Resident #163. Facility census: 181. Findings included: a) Resident #163 On 10/08/24 at 8:40 AM, Resident #163 was noted to have the following physicians orders and documentation: 1. WOUND CARE: Cleanse Stage 4 PI left buttock with IHWC, pat dry, apply hydrofera blue to wound and cover with bordered foam dressing. Every day shift every 2 (two) days and as needed. Active 10/1/2024. 2. DEVICE: low air loss automatic weight sensing technology air mattress with bolsters, check placement and function every shift. Active 07/25/24. 10/8/2024 19:56 Skin Grid Non-Pressure Late Entry: Note Text: New area noted: No Resident refused wound assessment 9/24/2024 17:41 Skin Grid Pressure Note Text: NEW AREA: No Resident has refused wound assessment 3/1/2024 16:27 Nurses Note Late Entry: Note Text: Resident refused shower x multiple attempts from staff. Resident refused bed bath x multiple attempts. MPOA aware. Resident was asked for weight measurement x 2 on this shift to which resident refused both times. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24 at 9:37 AM, this Surveyor was walking past Resident #163's room. At that time, this Surveyor observed Resident #163 laying in bed on a deflated air mattress with the call light on. Resident #163 cord to the air mattress was noted to be laying in the floor unplugged. Resident #163 was noted to be laying in a brief with no other clothing on, exposed to all facility staff, other residents and visitors walking on this hallway, with no blanket or curtain pulled to provide privacy. Multiple facility staff were observed to be walking down the hallway and passing by Resident #163's room and call light without stopping to ask Resident #163 what was needed, to offer to place a blanket over #163 or pull the curtain. Wound Nurse (WN) #21, was observed to be standing directly adjacent to Resident #163's room, with Resident #163 in full view. At that time, this Surveyor requested to speak with her. WN #21 acknowledged Resident #163's air mattress was unplugged and should be inflated, Resident #163 should be dressed, covered up or his curtain pulled to maintain Resident #163's dignity and went into Resident #163's room to ask if she could pull the cover. Resident #163 consented to allow WN #21 to pull the cover over him. On 10/09/24 at 11:09 AM, a review of Resident #163's care plans was completed revealing the following care plan: FOCUS: The resident has impaired skin integrity r/t stage 4 PI to left buttock, abrasion to left thumb. Date initiated: 02/16/24. GOAL: (Resident name) will have improved or maintain current skin status through next review date. Date initiated: 02/16/24. Stage 4 PI left buttock will show signs of improvement through next review. Date initiated: 03/05/24. Abrasion to left thumb will show signs of improvement through next review. Date initiated: 10/01/24. INTERVENTIONS: Administer medications as ordered, monitor for side effects and effectiveness. Date initiated: 03/26/24. Administer treatments as ordered by medical provider. Date initiated: 02/16/24. Complete skin at risk assessment upon admission/readmission, quarterly, and as needed. Date initiated: 02/16/24. Complete Weekly Skin checks. Date initiated: 02/16/24. Device: Low air loss, automatic weight sensing technology Air Mattress with bolsters. Date initiated: 05/20/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encourage resident to turn and reposition or assist as needed as resident allows. Date initiated: 02/16/24. Monitor existing wound daily, for changes (redness, edema, drainage, pain, foul odor. Date initiated: 03/26/24. Nutritional consult on admission, quarterly, and PRN. Date initiated: 03/26/24. Provide appropriate off-loading mattress & off-loading cushion, if applicable. Date initiated: 03/26/24. Use wipes not washcloth for incontinent/peri care when possible and resident will allow. On 10/15/24 at 1:53 PM, a review of Resident #163's admission assessment, dated 02/17/24, was completed which revealed BRADEN OBSERVATION SENSORY PERCEPTION 2. Ability to respond meaningfully to pressure-related discomfort. a. Completely Limited: Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level. b. Very Limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body. c. Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. d. No Impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. Answered: C MOISTURE 3. Degree in which skin is exposed to Moisture a. Constantly Moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned. b. Very Moist: Skin is often, but not always moist. Linen must be changed at least once a shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day. d. Rarely Moist: Skin is usually dry, linen only requires changing at routine intervals. Answered: C ACTIVITY 4. Degree of physical activity a. Bedfast: Confined to bed. b. Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. c. Walks Occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair d. Walks Frequently: Walks outside room at least twice a day and inside room at least once every two hours during waking hours Answered: A MOBILITY 5. Ability to change and control body position a. Completely Immobile: Does not make even slight changes in body or extremity position without assistance b. Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. c. Slightly Limited: Makes frequent though slight changes in body or extremity position independently. d. No Limitation: Makes major and frequent changes in position Answered: B NUTRITION 6. Usual food intake pattern a. Very Poor: Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Completely Limited: Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level. 2. Very Limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body. 3. Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. 4. No Impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort. Answer: Slightly limited Slightly limited- 3am. Potential Interventions: Teach patient/family the importance of changing positions for prevention of pressure ulcers, explain risk vs benefits to resident/family; Encourage small frequent position changes; Encourage/assist with turning and repositioning at least q 2 hours when in bed; Use of pillows to separate pressure areas, with special attention to off- loading contracted joints; Elevation of heels off bed; Keeping HOB at or below 30 degrees. HOB may be elevated for meals then lowered within one hour after meal as resident will allow. Slightly Limited cont. 3b. Potential Interventions: Remember when elevating the HOB, elevate the knee [NAME] first by 10-20 degrees; When in wheelchair instruct/assist with position changes to alter pressure points at least every hour as resident tolerates/allows; Wheelchair cushion 2. MOISTURE Degree to which skin is exposed to moisture 1. Constantly Moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned. 2. Very Moist : Skin is often, but not always moist. Linen must be changed at least once a shift. 3. Occasionally Moist : Skin is occasionally moist, requiring an extra linen change approximately once a day. 4. Rarely Moist: Skin is usually dry, linen only requires changing at routine intervals. Answer: Very Moist Very Moist- (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Slightly Limited: Makes frequent though slight changes in body or extremity position independently. 4. No Limitation: Makes major and frequent changes in position Answer: Very limited Very limited- 2. Potential Interventions: Provide below interventions as needed; Limit wheelchair to 1-2 hour intervals as resident will allow; Pressure redistribution surface for wheelchair and/or bed (esp. if existing breakdown) Slightly limited- 3a. Potential Interventions: Teach patient/family the importance of changing positions for prevention of pressure ulcer, explain risks vs benefits; Encourage small frequent position changes; Turning and repositioning at least every 2 hours when in bed as resident will allow. Use of pillow to separate pressure areas, with special attention of off-loading contracted joints; Elevation of heels off bed; Use of wedges to help maintain positioning. Use draw sheet to lift up or turn in bed. Slightly Limited cont- 3b. Potential Interventions: Keeping HOB at or below 30 degrees. HOB may be elevated for meals then lowered within one hour after meal as resident will allow. When elevating HOB, knee [NAME] should be elevated first to 10-20 degree; Instruct/assist to shift weight in wheelchair often as tolerated; Use of assistive device (i.e. trapeze); PT/OT consult No limitation- 4. Provide routine skin care 5. NUTRITION Usual food intake pattern 1. Very Poor: Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR is NPO and/or maintained on clear liquids or IV?s for more than 5 days. 2. Probably Inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding 3. Adequate: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beckley Healthcare Center	100 Heartland Drive Beckley, WV 25801

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Excellent: Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. Answer: Adequate Adequate- 3. Potential Interventions: Encourage meals and assist with meals as needed; Offer ordered supplements; Assess needs for oral care, assist PRN. 6. FRICTION & SHEAR 1. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction 2. Potential Problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down. 3. No Apparent Problem: Moves in bed and in chair independently and has sufficient muscle strength to lift up Answers: Problem Problem- 1. Potential Interventions: Below interventions; Use of assistive device (i.e. trapeze) Potential problem- 2. Potential Interventions: Use a draw sheet to lift up or turn in bed; Consider keeping HOB at or below 30 degrees. Hob may be elevated for meals then lowered within one hour after meal as resident will allow. When elevating HOB, remember to elevate knee [NAME] first, 10-20 degrees; Heel/elbow pads or coverings No apparent problem- 3. Potential Interventions: Provide routine skin care. 7. Important to Remember (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Do not massage bony prominence's. Do not use donut shaped foam/pillow to offload pressure points; Do not use multiple incontinence pads/linen under prone area. Avoid positioning directly on the trochanter by using a 30 degree side-lying position. Do not use heel pads to off load heels from surface; Only float heels off the end of a longitudinally placed pillow or with boots that float heels. *Low air loss beds do not substitute for turning schedules* Manage Moisture 2. Use approved moisture barriers; Use approved adult briefs that wick and hold moisture; Address specific cause if possible; Offer bedpan/urinal; Toileting program; Offer water and fluids in conjunction with turning schedules. Manage Nutrition 3. Increase protein intake; Increase calorie intake to spare proteins; Consult Dietician; Supplement with vitamins; Following culinary standards; Act quickly to alleviate deficits. Manage Friction and Sheer 4. Elevate HOB to 30 degrees or less and always have knee [NAME] raised to 10-20 degrees first; Use trapeze where indicated; Use lift sheet to move patient; Always protect heels, elbows, sacrum and back of head whenever exposed to friction. Score: 12 Low Risk = 15-18 1. Potential Interventions: Frequent Turning; Maximal remobilization; Protect heels; Manage moisture, nutrition and friction and shear; Pressure reduction support surface if bed or chair bound. If other major risk factors are present :Advanced age, fever, poor dietary intake of protein, diastolic pressure below 60, hemodynamic instability advance to next level of risk. Moderate Risk = 13-14 2. Potential Interventions: Actual turning schedule as resident allows/tolerates; Use wedge support for 30 degree side positioning; Pressure reduction support surface; Maximal remobilization; Protect heels; Manage moisture, nutrition and friction and shear; **If any of the major risk factors listed above advance to next level of risk.** High Risk = 10-12 3. Potential Interventions: Increase frequency of turning; Supplement turning with small shifts in positioning; Pressure reduction support surface; Use wedge support for 30 degree side positioning; Maximal remobilization; Protect heels; Manage moisture, nutrition and friction and shear; **If any of the major risk factors listed above advance to next level of risk.** Very High Risk = 9 or below (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Potential Interventions: All of the above interventions; Use of pressure relieving surface if patient has intractable pain or sever pain exacerbated by turning or any additional risk factors. 5. Comments: (left blank) 6. Interventions in place/put in place: (left blank) On 10/15/24 at 2:32 PM, a review of Policy and Procedure entitled, Skin Care and Wound Management Overview, was completed which revealed that all staff strive to prevent resident/patient skin impairment and to promote the healing of existing wounds. The interdisciplinary team works with the resident/patient and/or family/responsible party to identify and and implement interventions to prevent and treat potential skin integrity issues. The interdisciplinary team evaluates, and documents identified skin impairments and pre-exiting signs to determine the type of impairment, underlying condition(s) contributing to it and description of impairment to determine appropriate treatment. Resident/patient skin condition is also re-evaluated with change in clinical condition. Skin care and wound management program includes, but is not limited to: 1. Identification of resident/patients at risk for development of pressure ulcers 2. Implementation of prevention strategies to decrease the potential for developing pressure ulcers. In addition it stated that the Braden Scale is to be completed on admission and weekly three times thereafter, then quarterly and with change of clinical condition to identify risk factors. Identify diagnosis or conditions that place the resident/patient at risk for pressure ulcer development. Risk factors include, but are not limited to: 1. Co-Morbid conditions 2. Cognitive Impairment 3. Decreased activity 4. Decreased Sensory perception 5. Diabetes 6. Friction and Shear 7. Increased moisture on skin 8. Medications Furthermore, the policy and procedure states the clinical team are to evaluate for consistent implementation of interventions and effectiveness at clinical meeting, modify and document goal and interventions as indicated and develop a care plan with individualized interventions to address risk factors. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at approximately 2:00 PM, and interview was conducted with DON #138 who acknowledged the following: 1. Resident #163's co-morbid conditions: HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION AFFECTING LEFT NON-DOMINANT SIDE TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA NEED FOR ASSISTANCE WITH PERSONAL CARE ANEMIA, UNSPECIFIED 2, Resident #163's cognitive impairment: 8/20/2024 Brief Interview for Mental Status Moderately Impaired 9.0 2/19/2024 Incapacitated nature: disorientation due to CVA 3. Resident #163's decreased activity 10/02/24 Braden: Bedfast 4. Resident #163's decreased sensory perception: 10/02/24 Braden: Slightly limited 5. Resident #613's Diabetes: TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA 6. Resident #163's increased moisture on skin: 10/02/24 Braden: Very Moist 7. Resident #163's medications that increased risk of breakdown: Fluticasone Propionate Nasal Suspension 50 MCG/ACT (Fluticasone Propionate (Nasal)) 2 spray in nostril every 24 hours as needed for allergies Pharmacy Active 2/16/2024 15:45 (steroid) Metoprolol Tartrate Oral Tablet 25 MG (Metoprolol Tartrate) Give 12.5 mg orally two times a day for HTN Pharmacy Active 2/20/2024 21:00 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wixela Inhub 100-50 MCG/ACT Aerosol Powder, breath activated Give 1 puff by mouth two times a day for COPD rinse mouth out with water and spit out after each use Pharmacy Active 4/3/2024 21:00 (steroid) Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 10 unit subcutaneous at bedtime for DM Pharmacy Active 6/30/2024 21:00 8. Resident #163's Refusal of Care At that time, DON #138 acknowledged the following: 1. There was no preventative care plan in place and that the above documented risk factors were not addressed in Resident #163's current skin care plan. 2. When Resident #163's Braden score changed from 14, which indicated moderate risk for skin breakdown, to 12, which indicated high risk for skin breakdown, Resident #163's current skin care plan should have been reviewed by the clinical team for effectiveness and any necessary revisions should have been made. 3. The Braden completed on 10/02/24 listed several potential interventions to be implemented to prevent skin breakdown and that the nurse completing this Braden left the section Interventions in place/put in place: blank with no new interventions put into place.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 49650 50552 Based on record review and staff interview, the facility failed to ensure the environment remains as free of accident hazards as is possible and that each resident receives adequate assistance and devices to prevent accidents. put proper interventions in place to prevent falls with injury for Resident #93, such as upon return from hospitalization status post fall, therapy determined Resident #93 needed maximum assistance with transfers however Resident #93's independent functional status for transfers. This is true for (5) five of seven (7) residents reviewed for falls during the survey process. Resident identifier: Resident #93,#163, #240, #88, and #141. Facility census: 181. Findings included: a) Resident #93 On 10/07/24 at 03:26 PM, a record review was conducted for Resident #93 which revealed two falls occurring on 09/07/24 resulting in Resident #93 being hospitalized status post fall with a diagnosis of wedge compression fracture of first lumbar vertebra with kyphoplasty. Further review of Resident #93's medical record revealed Resident # 93 was receiving the following medications and had the following diagnoses: Depression, Anxiety, Dementia with other behavioral disturbance, muscle weakness, and unsteadiness on feet. In addition, it was revealed that Resident #93 was previously residing in an Assisted Living facility and had previous falls with fractures while residing there. Furthermore, it was revealed that Resident #93 was incapacitated, nature: short-term memory loss with disorientation, inability to process information and hallucinations caused by dementia. During a review of Resident #93's admission assessment revealed the facility had assessed and identified these risk factors upon admission. A review of the care plan found the following: FOCUS: The resident is at risk for falls r/t unsteadiness on feet. Date initiated: 09/14/24. GOAL: (Name of resident) will not sustain major injury related to falls through review date. Date initiated: 08/10/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	INTERVENTIONS: Assess risk for falls on admission/readmission, quarterly, and as needed. Date initiated: 08/10/24. Educate resident or resident representative, if applicable how to operate bed controls/call light/television. Date initiated: 08/10/24. Ensure resident is wearing appropriate non-skid footwear. Date initiated: 09/16/24. Ensure residents room is free of potential visible hazards. Date initiated: 08/10/24. Ensure that the bed locks are engaged. Date initiated: 08/10/24. On 10/09/24 at 1:51 PM, a review of Policy and Procedure entitled, Fall Prevention and Managementwas completed which revealed that the care plan can include interventions that address environmental factors, ADL factors, risk factors such as mental diagnosis and medical diagnosis that put the resident at higher risk for falls. Issues such as toileting, eating, transferring and impulsiveness should be considered. The care plan can address furniture arrangements, foot wear, medications, drowsiness and instability. The care plan should also address how the resident can be transferred in and out of bed as well as how the resident can ambulate and move around the facility. The care plan should be reviewed and updated as needed with each change of condition. Attempt to put an intervention in place that could prevent further falls, such as: if the resident was going to the bathroom, assist them to the toilet. If the resident was getting a drink and overreaching, place the drink within range of the resident. If the resident was attempting to transfer from bed to wheel chair or vice versa, assist to where they would like to go. If the resident is confused, attempt to re-orient. Attempt to identify why the resident fell and put an immediate intervention in place. On 10/09/24 at 2:22 PM, an interview was conducted with the Director of Nursing (DON) #138 and Administrator #13 of Building 1 who acknowledged following: 1. The care plan interventions should be address functional abilities and updated when functional abilities changed. Resident #93's care plan upon admission did and currently does not. 2. The care plan should address risk factors for falls, such as high risk medications, previous falls, cognitive ability, diagnoses, incontinence. Resident #93's care plan upon admission did not and currently does not. 3. The goal should have been updated post fall with fracture for Resident #93 and was not. 4. The facility was aware of the following: A. Resident #93's falls with fractures prior to admission. B. Resident # 93's risk factors were identified at the time of admission. C. The facility failed to put appropriate interventions in place to address these issues to prevent Resident #93 from falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An additional interview was conducted on 10/14/24 at 1:26 PM with the DON #138 who acknowledged: 1. Resident #93's fall care plan does not address the fact Resident #93 was incontinent at the time of the fall and that based on the therapy evaluation post fall, at which time it was determined Resident #93 was unable to perform sit to stand, ensuring Resident #93 was wearing non-skid sole footwear would be an ineffective intervention. 2. Resident #93 is incapacitated and it is identified that she has short term memory loss and inability to process information. Documentation was reviewed that Resident is to be educated on fall prevention. DON #138 acknowledged that this would not be an effective intervention. 4. Acknowledged that root causes discussed for Resident #93's falls are not complete. For example, resident stated, I was trying to get up. DON #138 acknowledged that for a thorough root cause to be performed, why the resident was attempting to get up would be important to determine an effective intervention and was not addressed. A final interview was conducted with DON #138 and Administrator #13 on 10/16/24 at 3:44 PM, who acknowledged Resident #93 continued to be at risk for falls due to the lack of appropriate and effective interventions currently in place and incorrect tasks such as incorrectly tasked transfer status as Resident #93 was determined by therapy to require maximum assist to perform this task and Resident #93 continues to be tasked to transfer independently. b) Resident #163 On 10/07/24 at approximately 12:26 PM, an observation was made of Resident #163 which revealed mats bilaterally to the side of Resident #163's bed. At that time, a review of the resident matrix was completed which revealed Resident #163 had sustained a fall. On 10/07/24 at approximately 1:14 PM, a record review for Resident #163 was completed which revealed Resident #163 was receiving the following medications, had the following diagnoses and the following orders: Medications: 1. Metoprolol Tartrate 12.5 mg by mouth two times a day for Hypertension. Start date: 02/20/24. 2. Tramadol 50 mg by mouth two times a day for Pain. Start date: 09/09/24. 3. Lantus SoloStar Subcutaneous Solution (Insulin Glargine) 100/units/milliliter (ml) inject 10 units subcutaneously at bedtime for Diabetes Mellitus. 4. Metformin 1000 mg orally two times a day for Diabetes Mellitus. Diagnoses included Hemiplegia and Hemiparesis following Cerebral Infarction affecting non-dominant side, Encounter for attention to Gastronomy Placed 01/27/24, Reduced Mobility, Stiffness of Left Hip, Muscle weakness, generalized, Lack of coordination, Depression Long term use of oral hypoglycemic drugs and Diabetes Mellitus. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Orders: 1. Device: Low Bed, Active: 06/27/24. 2. Device: Bilateral Fall Mats to bedside, Active: 06/27/24. Review of the care plan as follows: FOCUS: The resident is at risk for falls r/t muscle weakness, lack of coordination. Date initiated: 02/16/24 GOAL: (Resident name) will not sustain major injury related to falls through review date. Date initiated: 02/16/24 INTERVENTIONS: Apply bolsters to air mattress. Date initiated: 05/17/24 Assess risk for falls on admission / readmission, quarterly, and as needed. Date initiated: 02/16/24 Bed in lowest position. Date initiated: 06/17/24. Bilateral floor mats. Date initiated: 06/27/24. Educate resident or resident representative, if applicable how to operate bed controls/call light/television. Date initiated: 02/16/24. Ensure residents room is free of potential visible hazards. Date initiated: 02/16/24. Ensure that the bed locks are engaged. Date initiated: 02/16/24. Low bed. Date initiated: 06/27/24. FOCUS: Resident requires Enhanced Barrier Precautions for: Indwelling Medical Device: Wound. Date initiated: 05/31/24. GOAL: Resident will not verbalize or demonstrate symptoms of isolation related to Enhanced Barrier Precautions Placement while reducing risk of infection transmission. Date initiated: 05/31/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Furthermore, it was revealed Resident #163 lacks capacity due to disorientation caused by a Cerebral Vascular Accident (CVA). On 10/09/24 at 09:37 AM, this Surveyor was walking past Resident #163's room. At that time, this Surveyor observed Resident #163 laying in bed with the call light on. Resident #163 was noted to be laying in a brief with no other clothing on, exposed to all facility staff, other residents and visitors walking on this hallway, with no blanket or curtain pulled to provide privacy. Multiple facility staff were observed to be walking down the hallway and passing by Resident #163's room and call light without stopping to ask Resident #163 what was needed, to offer to place a blanket over #163 or pull the curtain. Wound Nurse (WN) #21, was observed to be standing directly adjacent to Resident #163's room, with Resident #163 in full view. At that time, this Surveyor requested to speak with her. WN #21 acknowledged Resident #163 should be dressed, covered up or his curtain pulled to maintain Resident #163's dignity and went into Resident #163's room to ask if she could pull the cover. Resident #163 consented to allow WN #21 to pull the cover over him. On 10/09/24 at 1:51 PM, a review of Policy and Procedure entitled, Fall Prevention and Managementwas completed which revealed that the care plan can include interventions that address environmental factors, ADL factors, risk factors such as mental diagnosis and medical diagnosis that put the resident at higher risk for falls. Issues such as toileting, eating, transferring and impulsiveness should be considered. The care plan can address furniture arrangements, foot wear, medications, drowsiness and instability. The care plan should also address how the resident can be transferred in and out of bed as well as how the resident can ambulate and move around the facility. The care plan should be reviewed and updated as needed with each change of condition. Attempt to put an intervention in place that could prevent further falls, such as: if the resident was going to the bathroom, assist them to the toilet. If the resident was getting a drink and overreaching, place the drink within range of the resident. If the resident was attempting to transfer from bed to wheel chair or vice versa, assist to where they would like to go. If the resident is confused, attempt to re-orient. Attempt to identify why the resident fell and put an immediate intervention in place. In addition, the policy and procedure stated that the following should be completed for each fall: 1. Complete the Post Fall Assessment. 2. If the resident hit their head or the fall was unwitnessed, complete Neurological Checks per policy. 3. If the resident suffered an injury or has a change of condition, complete the eInteract Change of Condition Assessment. 4. Complete the Fall Follow up UDA at least twice each day for three days unless the resident's condition is such it should be continued longer. 5. A report should be initiated in Risk Watch. 6. Update the care plan with new interventions. On 10/09/24 at 2:22 PM, an interview conducted with the Director of Nursing (DON) #138 and Administrator #13 who acknowledged the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident #163's care plan should address risk factors for falls, such as high risk medications, previous falls, cognitive ability, diagnoses, incontinence and use of external devices. Resident #163's care plan on admission did not and currently does not. On 10/14/24 at approximately 9:30 PM, a review of Resident #163's medical record was completed again, revealing the following assessments present: Fall Risk Observation Tools: 1. Fall Risk Observation Tool. Effective date: 02/23/24. The following information was obtained: a) Resident #163 required a total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. b) Blood pressure was unable to be preformed due to Resident #163 being unable to stand. c) Resident #163 had no external devices such as feeding tube or Foley catheter. d) Resident #163 fall history: no falls 2. Fall Risk Observation Tool. Effective date: 03/01/24. The following information was obtained: a) Resident #163 required a total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. b) Blood pressure was unable to be preformed due to Resident #163 being unable to stand. c) Resident #163 had no external devices such as feeding tube or Foley catheter. d) Resident #163 fall history: no falls. 3. Fall Risk Observation Tool. Effective date: 06/01/24. The following information was obtained: a) Resident #163 required a total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. b) Blood pressure: No noted drop between lying and standing. c) Resident #163 had no external devices such as feeding tube or Foley catheter. d) Resident #163 fall history: no falls. 4. Fall Risk Observation Tool. Effective date: 09/01/24. The following information was obtained: a) Resident #163 required a total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. b) Blood pressure: No noted drop between lying and standing. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c) Resident #163 had d) Resident #163 fall history: no falls. Post Fall Evaluations: 1. Post Fall Evaluation Effective Date: 05/17/24. The following information was obtained: a) Date and time of fall: 05/17/24 at 3:00 PM b) Type of fall/witnessed? No injuries noted with unwitnessed fall. c) Fall information: Level of Consciousness: Alert, oriented or comatose Mobility: Wheelchair/ambulation assistance needed Gait: non-ambulatory Residents ability to transfer: total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. Current ambulatory/gait/balance ability: non-ambulatory Blood pressure: No noted drop between lying and standing. External devices: no external devices such as feeding tube or Foley catheter. Fall history: Fall within past 30 days Is the resident receiving any of these medications: anesthetics, antihistamines, antihypertensives, antiseizures, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, sedatives/hypnotics: Currently takes 1-2 of these medications. Continence Status: Wheelchair or other ambulatory aid/incontinent Has the resident been diagnosed with any of the following diseases or have any of the following conditions: anemia, arthritis, CVA, delirium, dementia, hypotension, osteoporosis, Parkinson, seizures, vertigo, anger, fracture, loss of limb, wandering. Predisposing diseases/conditions: 1-2 present Resident's response to fall: resident stated he was just moving in bed and slid out. Suspected root cause: unknown. What was the height of the bed: low position What time was the resident last toileted: incontinent (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	What did you do to immediately prevent further falls: low bed, contacted medical supply director to order bolsters for air mattress. 2. Post Fall Evaluation Effective Date: 06/17/24. The following information was obtained: a) Date and time of fall: 06/10/24 at 12:30 PM b) Type of fall/witnessed? No injuries noted with unwitnessed fall. c) Fall information: Level of Consciousness: Diminished safety awareness Mobility: Wheelchair/ambulation assistance needed Gait: non-ambulatory Residents ability to transfer: total mechanical lift for all transfers due to being unable to bear weight, unable or unwilling to cooperate, limited movement and heavy or obese. Current ambulatory/gait/balance ability: non-ambulatory Blood pressure: No noted drop between lying and standing. External devices: no external devices such as feeding tube or Foley catheter. Fall history: Fall in past 2-6 months Is the resident receiving any of these medications: anesthetics, antihistamines, antihypertensives, antiseizures, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, sedatives/hypnotics: Currently takes 3-4 of these medications. Continence Status: Wheelchair or other ambulatory aid/incontinent Has the resident been diagnosed with any of the following diseases or have any of the following conditions: anemia, arthritis, CVA, delirium, dementia, hypotension, osteoporosis, Parkinson, seizures, vertigo, anger, fracture, loss of limb, wandering. Predisposing diseases/conditions: 3 or more present Resident's response to fall: I was trying to get up. Suspected root cause: getting up unassisted What was the height of the bed: low position What time was the resident last toileted: n/a What did you do to immediately prevent further falls: assessed resident, assisted back to bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. No Post Fall Evaluation for fall dated 06/27/24 at 12:30 AM. Neurocheck Evaluations: Instructions: 1. Perform every 15 minutes for x (times) 4 (four), then every hour x (times) 4 (four), then every 4 (four) hours x (times) 4 (four), then daily x (times) 4 (four). 1. Neurocheck Eval: Effective date and time: 05/17/24 at 04:17 PM. Information obtained: Daily 2nd: Date and time: 05/20/24 at 11:45: not completed and signed as completed on 05/31/24. Daily 4th: Date and time: 05/22/24 at 11:45: signed as completed 05/27/24. 2. Neurocheck Eval: Effective date and time: 06/17/24 at 01:24 PM. 3. Neurocheck Eval: Effective date and time: 06/27/24 at 12:30 AM. Post Fall Evaluations: 1. Fall 05/17/24: present 2. Fall 06/17/24: present 3. Fall 06/27/24: present On 10/14/24 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON) #138. At that time the DON stated Resident #163 had a Foley catheter and feeding tube present at the time of admission on 02/16/24. Resident #163's Foley catheter was discontinued on 08/19/24. On 10/16/24 at approximately 2:00 PM, and interview was conducted with DON #138 who acknowledged the following: 1. That for each fall a post fall evaluation should be completed and that this was not completed for the fall occurring on 06/27/24. 2. Fall Risk Observation Tools are to assess each resident for falls risk. Resident #163's Fall Risk Observation Tools were inaccurate as Resident #163 had 2 (two) external devices, a feeding tube and a Foley catheter. 3. That she (DON) was unsure how facility staff obtained lying to standing blood pressures on 05/17/24 and 06/17/24 as Resident #163 is unable to stand. 4. That the Neurocheck for Daily 2nd: Date and time: 05/20/24 at 11:45: was not completed and signed as completed on 05/31/24. Daily 4th: Date and time: 05/22/24 at 11:45: was signed as completed 05/27/24. In addition, the DON acknowledged that nursing staff have 24 hours to complete documentation or it is considered, Late and that due to the signed as completed date the DON stated she was unable to say for sure when these were performed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I came in, there was 5, maybe six of us. Passing ice water and made sure everyone was pulled up and ready for breakfast, dry. I went in and tube feed was dripping in the floor. Went and got towels and washcloths. All I did was roll her, and she just .(Made falling motion with hand) NA #42 stated staff regularly turned and repositioned Resident #240 with one staff member. States she rolled her as she normally would. Was not on an air mattress at this time. Old nursing supervisor took me down the hall and made sure I knew how to reposition someone. I couldn't tell you how much staff we had. We have been here before with 4 and 5 CNAs. That is not adequate care. During an interview with the Minimum Data Set Register Nurse (MDS RN) #66 on 10/16/24 at approximately 10:10 AM, MDS RN #66 explained the totally dependent- Helper does all of the effort or 2 or more helpers assist to be that the NA would do all the effort and if it is identified that the NA would need help the NA would be able to have another person to assist. During the interview with the MDS RN #66 on 10/16/24 at approximately 10:10 AM the Administrator #186 acknowledged that if the staff had gotten someone else to assist the incident may not have occurred and that re-educating the staff to get assistance from the nurse with situations like this may be necessary. Further clinical review identified that the resident was sent to a local hospital and returned to the facility on [DATE] with a diagnosis of traumatic subdural hemorrhage without loss of consciousness. Another diagnosis was also given to Resident #240, during the stay at the facility of a personal history of traumatic brain injury dated onset 04/24/24. d) Resident #88 During an observation on 10/14/24 at 4:00 PM, Resident #88 was in her room, calling for help, and putting her bare feet out over the side of the bed. Her call bell was in the floor and not within her reach. On 10/14/2024 at 4:02 PM in an interview with Licensed Practical Nurse (LPN) #151, confirmed the resident's call light was not within reach and the resident was not wearing non-skid foot wear. Review of Resident #88's care plan on 10/14/2024, stated that the facility will ensure Resident #88 is wearing appropriate non-skid footwear and the call bell will be placed within reach. e) Resident #141 At approximately 10:20 AM on 10/08/24, an interview was conducted with Resident #141. During the interview, Resident #141 picked up a Styrofoam cup from his bedside table and spit tobacco into it. Resident #141 was asked if he used smokeless tobacco regularly, to which he stated Yes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon review of Resident #141's care plan, it states (Resident #141's name) utilizes nicotine products hx (history) of chewing tobacco products. At approximately 11:00 AM on 10/08/24, an interview was conducted with Administrator #186, in which she was asked what the procedure was for a resident that uses smokeless tobacco in the facility. Administrator #186 stated there should be a smoking assessment on file for the resident. No smoking/tobacco assessment was found on in the resident's file. At approximately 3:30 PM on 10/16/24, Administrator #13 confirmed no smoking/tobacco assessment had been completed for Resident #141 prior to the survey. 50801

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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. 50551 Based on review of records, observation and review of facility policy, and staff interview, the facility failed to provide tracheostomy care in accordance with professional standards. Oxygen was not attached to resident's tracheostomy, personal protective equipment was not worn and the appropriate supplies were not at bedside for daily and emergency care. This is true for 1 (one) of 1 (one) resident's reviewed for trach care. Resident identifier: #99. Facility Census: 181. Findings included: a) Resident #99 On 10/14/24 at 1:50 PM, observation of the resident with tracheostomy, the Licensed Practical Nurse (LPN) #169 attending to the resident was not wearing a gown and acknowledged that she should have been. While observing for several minutes we noticed that her oxygen was not attached to her trach. When asked if it should be attached to something the Nurse stated yes, probably and went on to state that she was not dependent on it. Nurse went and got another tube and reattached it to the trach. We asked what her O2 stats are normally, Nurse #169 stated 96. When asked if she was going to reassess her, she did and resident's O2 was 89. It returned to 96 after her O2 was reattached. Call light was observed to be out of resident's reach, aerosol drainage bag was dragging the floor. The following was not in her room but found in a supply closet: -Shiley Same size (6) trach An interview with LPN #169 on 10/14/24 at 3:25 PM who acknowledged that the following supplies were not in resident's room, found in building (two) 2 and in the crash cart: -Venturi Mask -cuffed size (4) Shiley -Suction catheter Review of facility Policy and Standard Procedures for Tracheostomy Care on 10/15/24 at 1:00 PM. Procedures number 4 (four) and 5 (five) stated the following: -4. Maintain an aseptic environment to the extent possible to reduce pathogen transmission. -5. Perform hand hygiene and put on personal protective equipment. Review of resident's physician orders on 10/14/24 revealed that the resident was to have (O2) Oxygen set at 6 (six) liters continuously with a start date of 09/17/2024. Review of resident's care plan revealed the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus Resident is currently receiving tracheostomy care CVA (cerebrovascular accident) -Interventions/tasks to include: Enhanced Barrier Precautions when providing care to tracheostomy. Keep extra trachs at bedside-current size and one smaller. Items to remain at bedside for emergency: ambu bag, an extra cuffed tracheostomy tube and obturator, 1 (one) smaller, trach tie, 5-10 (five-ten) CC syringe, lubricating jelly, suction catheter.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49467 Based on observation and resident, family, and staff interviews, the facility failed to deploy sufficient nursing staff to meet the needs of the residents residing there. This has the potential to affect more than a limited number of residents. Resident identifiers: #139, #23, #6. Facility census: 181. Findings included: a) Resident #139 At approximately 2:50 PM on 10/07/24, an interview was conducted with the Healthcare Surrogate (HCS) for Resident #139. During the interview, the HCS stated Resident #139 will need help and sometimes it takes a long time for the staff to respond. The HCS stated she was recently visiting the facility and had kids with her during the visit. The HCS stated Resident #139 had a bowel movement in her brief and the call light was pressed so staff could come in and provide incontinence care to the resident. The HCS stated No one came, so after about twenty (20) minutes, I started asking people in the hallway if they could come help her, but they kept telling me they weren't her aide, or they weren't her nurse, and they wouldn't help. The HCS stated, After about an hour, after no one came, it (feces) started coming out of her brief and onto the bed linens. At this point, I had to leave because I was afraid the kids I had with me were going to get on the bed and get it (feces) on them. b) Resident #23 On 10/07/24 at approximately 4:09 PM Resident #23 was observed, in the dining room, leaning so far in her chair that her hair was almost on the floor. (right side)- Licensed Practical Nurse (LPN) #99 stated that Resident #23 had been in there a long time. LPN #99 acknowledged she had been in there since lunch around 12:00 PM. LPN #99 stated that Resident #23 is not positioned at her best. LPN #99 asked Nurse Aide (NA) #84. NA #84 asked who her NA's were as NA #84 stated she knew 2 NA's left and 2 NA's had come on but did not know who it is. NA #84 assisted Resident #23 to her room and waited for LPN #84 to come with the lift to assist the resident to the bed. At this time, the assigned NA's for Resident #23 were unable to be located. c) Resident #6 At approximately 11:30 AM on 10/09/24, an interview was conducted with Resident #6 concerning the upcoming resident council meeting that day. Resident #6 is the council president, and stated that she was told by facility staff there was only one (1) aide assigned to her hallway today and, as a result, she may not be able to attend the resident council meeting. Resident #6 was thirty-five (35) minutes late for the resident council meeting, stating They did not want to get me up to come. Resident #6 stated there was not enough staff on the floor to assist her out of bed at the time of the meeting. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the resident council meeting, multiple residents expressed concern with staffing levels at the facility, stating they would regularly have to wait thirty (30) minutes or longer for their lights to be answered. d) Staff interviews At approximately 10:45 AM on 10/16/2024 an interview was conducted with NA #166, NA #34, and NA #130. During the interview, NA #166 stated, Over the weekends, it's not uncommon for us to have three (3) aides for building one. That happens more often than it doesn't. We've really been struggling. NA #166 stated assigned tasks are not being completed due to the amount of work compared to the number of staff employed by the facility. NA #166 stated residents are regularly left soiled and unbathed for the next shift because the facility does not have enough staff on a regular basis. She stated, We barely have enough staff to do two (2) person assists and transfers on the weekends. Sometimes we don't have enough to do them at all. NA #34 stated, Around April, a lot of aides left or went to PRN because they were tired of being overworked. There was no relief with the staffing levels and a lot of them got fed up and left. NA #130 stated during the interview it is hard for the aides to get their tasks done and shower people on a regular basis due to the amount of people they have on an assignment at any given time is too much for one person to handle, stating that they do not feel it is safe for the residents at times. At approximately 11:10 AM on 10/16/24, an interview was conducted with NA #143 regarding facility staffing levels. NA #143 stated, We usually run short, especially on the weekends. A lot of our aides work 7:00 AM to 3:00 PM, so after three (3) we are usually down bad. We can't get our assignments done like we are supposed to because we have too many people on an assignment. When it comes time to pass trays, help people eat, and do rounds, it is impossible for us to do them, because there aren't enough of us. We feel burned out and tired. NA #143 was asked if the staffing concerns had been reported to management, to which she stated Yes. Asked what management's response to the staffing concerns were, NA #143 replied, They just told us they are working on it.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 49467 Based on record review and staff interview, the facility failed to maintain accurate staff posting information. This has the potential to affect more than a limited number of residents. Facility census: 181. Findings included: At approximately 12:00 PM on 10/16/2024, a review of the facility's daily staff postings and direct care schedules were conducted. During the review, it was determined the staff postings were not accurate for the following days: 04/20/24- The facility had 31 Nurse Aides (NA) scheduled to work, according the the staff posting. According to the staff assignment sheets for the day, the facility had 25 actually working. 04/28/24- The facility had 29 Nurse Aides (NA) scheduled to work, according the the staff posting. According to the staff assignment sheets for the day, the facility had 21 actually working. 05/11/24- The facility had 33 NA's scheduled to work, according to the staffing sheets. According to the assignment sheets for the day, the facility actually had 25. The staff posting sheets had not been updated to reflect the accurate number of staff in the facility. At approximately 3:30 PM on 10/16/24, Administrator #13 confirmed the irregularities.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 The facility failed to implement non-pharmalogical interventions to meet Resident #93's behavioral health needs. This was true for 1 (one) of 5 (five) residents reviewed for the Long Term Care Survey Process. Resident identifiers: Resident #93. Facility Census: 181. Findings included: a) Resident #93 On 10/14/24 at approximately 10:00 AM, the following nurses note was found in Resident #93's medical record: 10/12/24 00:30 Nurses Note Note Text: Resident calls this nurse into room stating that she did not get any food today. This nurse apologized and offered what is available. Resident told this nurse in explicative language where to go and how to get there. This nurse apologized again and asked resident to keep voice down. Resident then continued to throw food on over bed table towards this nurse. This nurse cleaned room and exited once resident calmed down. Continuing care. On 10/14/24 at approximately 11:00 AM, a review of Policy and Procedure entitled, Behavior Management General revealed that resident's will be provided with a resident centered behavior management plan to safely manage the resident. That facility staff will assess needs and treat appropriately including but not limited to: a. pain b. toileting needs c. hot or cold d. hunger f. vital signs: fever, infection or other In addition, care plans are to be updated with changes and/or new behaviors and should include resident specific interventions. On 10/14/24 at 12:10 PM, an interview was conducted with the Director of Nursing (DON) #138. At that time, the DON #138 acknowledged the following: 1. No non-pharmacological interventions were implemented for behaviors on 10/12/24. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Root Cause related to behaviors: acknowledged there was none despite the policy and procedure stating to identify needs and attempt to meet them. 3. That despite non-pharmacological interventions are in the anti-depressant and antianxiety care plans, the resident target behaviors are not listed. 4. Acknowledged non-pharmacological interventions listed are not resident centered, were picked from a dropped down list and that they are used for all residents. On 10/14/24 at 12:10 PM DON acknowledged the following: 1. behavioral care plan was not created or initiated until 10/10/24 2. No non-pharm interventions for behaviors on 10/11 and 10/12 3. acknowledged resident exhibiting behaviors since August 24, with no non-[NAME] documented, and no care plan describing behaviors until 10/10/24. 4. Root Cause related to behaviors: acknowledged there were none despite the policy and procedure stating to identify needs and attempt to meet them On 10/14/24 at 1:26 PM Reviewed Incident reports with the DON, acknowledged: 1. fall care plan does not address the fact resident was incontinent at the time of the fall. That root causes determined for falls do not match interventions put in place. 2. Resident is incapacitated and it is identified that has short term memory loss and inability to process information, reviewed that resident is to be educated, acknowledged that this would not be an effective intervention. 3. non-[NAME] are in the anti-depressant and antianxiety care plans, the behaviors are not listed. Acknowledged that for exhibited behaviors on October 11 and 12 , there is no documentation of non-pharm interventions attempted. 4. acknowledged non-[NAME] are not resident centered 5. Acknowledged that root causes were not complete. For example, resident stated, I was trying to get up. acknowledged that for a thorough root cause to be performed, why the resident was attempting to get up would be important and was not addressed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49467 Based on record review and staff interviews, the facility failed to maintain accurate records related to narcotic medication counts for Resident #139. This was a random opportunity for discovery. Resident identifier: #139. Facility census: 181. Findings included: a) Resident #139 At approximately 11:00 AM on 10/16/24 a review of the controlled substance count sheets for Resident #139's Norco oral tablet 5-325 MG, Ativan oral tablet 0.5 MG, Lorazepam Oral Concentrate 2 MG/ML, and Ativan oral tablet 1 MG was conducted. During the review, irregularities were noted in the count sheets. Related to the Ativan 1 MG tablet: On the count sheet on 05/19/24, a tablet was signed out, with eight (8) on hand at that time, amount given has a line through it, indicating one was not given, amount remaining is listed as seven (7). No indications are on the count sheet that would point to the medication being wasted, and the line does not have two (2) signatures, as required to waste a pill. On the count sheet at 8:00 PM on 08/07/24 a tablet was signed out with two (2) tablets on hand. On the sheet, it was noted one (1) pill was given with one (1) pill remaining. Beside the number of pills remaining, pulled in error is written beside the number. No second signature to support the pill being wasted is noticeable on the count sheet. Another pill was signed out at 9:00 PM, no amount on hand was listed as there is a line through that part of the count sheet, one (1) is listed as being given, zero (0) is listed as the remaining number of pills. Related to the Norco oral tablet 5-325 MG: On 08/16/24 at 4:00 AM, a line is through amount given, a one (1) is in the amount wasted and witness signature column, ten (10) pills listed as remaining on hand. No witness signature is listed in the required box. On 08/16/24 at 8:59 PM, a line is through amount given, a one (1) is in the amount wasted and witness signature column, seven (7) pills listed as remaining on hand. No witness signature is listed in the required box. On 08/17/24 at 4:52 AM, a one (1) is listed in amount given, a one (1) is in the amount wasted and witness signature column, six (6) pills listed as remaining on hand. No witness signature is listed in the required box. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/17/24 at 10:38 AM, a one (1) is listed in amount given, a one (1) is in the amount wasted and witness signature column, five (5) pills listed as remaining on hand. No witness signature is listed in the required box. On 08/17/24 at 4:00 PM, a one (1) is listed in amount given, a one (1) is in the amount wasted and witness signature column, four (4) pills listed as remaining on hand. No witness signature is listed in the required box. Director of Nursing (DON) #138 acknowledged the irregularities on the count sheets for the above controlled substances.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 49650 Based on medical record review and staff interview, the facility failed to ensure the physicians orders were completed as ordered. Behavior monitoring was not completed. This was true for 3 of 5 resident unnecessary meds, psychotropic medications (med) and med regimen reviews that was reviewed during the long term care survey process. Resident Identifier: Resident #28, Resident #75 and Resident #174. Facility Census: 181. Findings Included: a) Resident #28 During a medical record review 10/09/24 at approximately 8:15 AM for Resident #28 physician orders, it identified an order for Trazadone HCl oral tablet 50 mg 1 tablet by mouth at bedtime for insomnia; Geodone Oral Capsule 40 mg (Ziprasidone HCL) Give 1 capsule by mouth three times a day for schizoaffective disorder; and an order for Buspirone HCL Oral Tablet 10 mg (Buspirone HCL) Give 1 table by mouth two times a day. It is further identified that the behavior monitoring order [typed as written] to Monitor behaviors 1. Refusal of care 2. crying episodes 3. anxiety- Non- Pharmacological Interventions 1. Encourage resident to voice feelings, and discuss coping skills. 2. Maintain consistent daily routine when possible. 3. Provide calm environment, limit over stimulation. Every shift for behaviors. During a review of the behavior monitoring from 08/01/24 through 10/30/24 the following behavior monitoring was not documented: *08/12/24 behavior monitoring day shift. *08/25/24 behavior monitoring day shift. *08/26/24 behavior monitoring day shift. *08/27/24 behavior monitoring day shift. *08/30/24 behavior monitoring day shift. * 09/15/24 behavior monitoring day shift. * 09/17/24 behavior monitoring day shift. On 10/19/24 at approximately 3:19 PM during an interview with Administrator #186, the Administrator #186 acknowledged that the documentation was not completed and agreed that the behaviors were not monitored as ordered. b) Resident #75 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medical record review 10/14/24 at approximately 8:45 AM for Resident #75 physician orders, it identified an order for Sertraline HCl oral tablet 50 mg by mouth 2 tablet one time a day for depression; an order for Trazadone HCl oral tablet 50 mg 1 tablet by mouth at bedtime for depression; and an order for Depakote Oral Tablet delayed release 125 mg (Divalproex Sodium) Give 1 tablet by mouth for bipolar disorder; an order for Risperdal Oral tablet 1 mg (risperidone) Give 1 tablet by mouth two times a day for bipolar. It is further identified that there are two behavior monitoring order- -Order 1- [typed as written] to 1. Irritable 2. Withdrawn 3. Tearful 4. wandering 5. exit seeking Non-Pharmacological Interventions 1. Diversional Activities 2. Allow time to express feelings 3. Provide quiet and calm environment. Every Shift for Behaviors. During a review of the behavior monitoring from 09/01/24 through 10/08/24 the following behavior monitoring was not documented: -Order 2- [typed as written] to Monitor behaviors 1. Intrusiveness 2. Making false statements 3. Invading others space Non- Pharmacological Interventions 1. Redirect and intervene as indicated 2. Offer diversional activity 3. Offer snack/drinks 4. Reassure resident and encourage resident to talk about feelings. Every shift for behaviors. * 09/09/24 behavior monitoring day shift. Order 1 and Order 2 * 09/27/24 behavior monitoring night shift. Order 1 and Order 2 10/14/24 at approximately 10:15 AM during an interview with Administrator #186, the Administrator #186 acknowledged that the documentation was not completed and agreed that the behaviors were not monitored as ordered. c) Resident #174 During a medical record review 10/14/24 at approximately 8:45 AM for Resident #174 physician orders, it identified an order for Sertraline HCl oral tablet 50 mg by mouth 1 tablet in the morning for depression target behavior: tearfulness; an order for Trazadone HCl oral tablet 100 mg 1 tablet by mouth at bedtime for insomnia; and an order for Olanzapine Oral Tablet 2.5 MG for delirium. It is further identified that the behavior monitoring order [typed as written] to Monitor behaviors 1. Tearfulness 2. Refusal of care Non- Pharmacological Interventions 1. Encourage resident to voice feelings, and discuss coping skills. 2. Maintain consistent daily routine when possible. 3. Provide calm environment . Every shift for behaviors. During a review of the behavior monitoring from 09/01/24 through 10/08/24 the following behavior monitoring was not documented: * 09/10/24 behavior monitoring day shift. * 09/14/24 behavior monitoring night shift. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*09/25/24 behavior monitoring day shift. *10/07/24 behavior monitoring day shift. On 10/14/24 at approximately 10:15 AM during an interview with Administrator #186, the Administrator #186 acknowledged that the documentation was not completed and agreed that the behaviors were not monitored as ordered.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. 49465 Based on record review, staff interview and observation, the facility failed to provide routine dental care for Medicaid funded residents. This failed practice was found true for (2) two of (6) six residents reviewed for dental care during the Long-Term Care Survey Process. Resident identifiers #5 and #71. Facility Census 181. Findings Included: a) Resident #5 During the initial interview with Resident #5 on 10/07/24 at 12:09 PM, Resident #5 stated, Every time I ask them to give me my toothbrush they won't give it to me. My teeth bother me. I have a loose one on the bottom that bothers me. An observation on 10/07/24 at 12:09 PM, of Resident #5 revealed that her teeth are covered in build up and have several teeth missing and/or broken off. A record review on 10/14/24 at 11:00 AM of Section L of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/01/23, question D is marked yes for Obvious Likely cavity or broken natural teeth. Further record review showed no dental consults for Resident #5 since her admission on 11/30/22. During an interview on 10/14/24 at 12:17 PM, the Administrator #186 stated, We do not have any dental assessments or consults on her that I could find since her admission. The Administrator agreed that a Dental Consult was warranted. A review of the facility policy on 10/14/24 at 1:30 PM, titled {Dental Services}, defines a routine dental service as the following: An annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, filling (New and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g.,taking impressions for dentures and fitting dentures. The policy further reads under number (1) one, that the facility will assist the resident in: a. Obtaining routine Dental Services. During an interview on 10/16/24 at 12:36 PM The Director of Nursing (DON) #138 reconfirmed that Resident #5 had not had dental services since admission. b) Resident #71 During an interview on 10/07/24 at 11:45 AM, Resident #71's bottom row of teeth appeared to be decayed with red tinged spots on the pillow case in the area of the resident's mouth . (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/09/24 at 12:50 PM, during an interview with Resident #71, she responded uh huh when asked if her mouth hurts. During an interview with Director Of Nursing (DON) #96 at 2:41 PM on 10/09/24 the DON confirmed there has been no dental consults made for Resident #71. 50801

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51554 Based upon observation, record review, and staff interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards. This failed practice had the potential to affect more than a limited number of residents currently residing in the facility. Facility census 181. Findings included: a) Kitchen There were pitchers of ,juices without dates stored in the prep cooler. During an interview with the Dietary Director #202 at 10:30 AM on 10/07/24, the Director stated she was aware of the 6 pitchers of tea and 1 pitcher of fruit punch were required to be dated. Director removed the items. All produce placed in the produce freezer directly on the floor. All walk in freezer items stored on the floor. All items in the dry stockroom are stored on the floor. During an interview with the Director #202 at 10:35 AM on 10/07/24, the Director stated the delivery truck had just come and they were unable to ensure items were up off the floor at this time. During an observation of the milk cooler on 10/07/24 at approximately 10:35 AM, it is identified that the bottom of the cooler had milk standing on the bottom of the cooler with rings outlined around the milk where the milk had started to dry. During an interview, the Director #202 agreed the cooler was not clean as it had areas of standing milk that had rings around it where the milk had started to dry. There were bowls stored in the dry food storage area, sitting in a container in an upright position without a lid covering the container. During an interview with the Director #202 on 10/07/24 at approximately 10:45 PM, the director stated the bowls should not be stored upright and uncovered. Sugar cookies in a plastic Ziplock bag dated 08/19/24, identified in the walk-in freezer. During an interview with the Director #202 on 10/07/24 at approximately 10:45 AM, the Director stated the cookies should have already been disposed of and not in the freezer. Director disposed of cookies. One bag of Rice Krispies cereal had been opened and the bag was taped closed with no date to identify the expiration after opening/use. One bag of toasted oats had been opened and the bag was taped closed with no date to identify the expiration after opening/use. During an interview with the Director #202 on 10/07/24 at approximately 10:45 AM, the Director agreed that the items had not been properly marked to identify the expiration after opening/use date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Kitchen dish-room floors and lower section of the dish-room walls (approximately 3 feet up from the floor surface) were visibly soiled with large areas of rust. The cover base was missing under the dish-room countertop and a broken plate and 2 plastic spoons were identified to be stuck under the edge of the wall with black substance. The floor and the walls had remnants of food products on it. During an interview with the Director of Kitchen #202, on 10/07/24 at approximately10:30 AM, the Director stated the facility has hard water and it causes the walls to appear dirty. The director agreed that the broken plate and disposable spoons were stuck under the edge of the wall and that the floors and walls were visibly soiled with large areas were rusted. The Director #202 agreed that there was remnants of food that would be cleaned up. The floor in the entrance way going into the kitchen were visibly soiled with black grease like substance. The Director #202 stated the floors were in the process of being replaced. After discussion, Director #202 agreed that floors could be cleaned. The steam table wells were observed to be dirty with remnants of food and debris. Two (2) steam wells also had food remnants inside them. During an interview with the Director #202 on 10/07/24 at 10:25 AM, agreed that remnants of food and debris were on the surface of the lids and inside the two (2) steam wells. During a tour of the facility nourishment in Building 2, a bottle of Classic Ranch dressing was identified to not have a label or date of opening on it. During an interview with LPN #26, he acknowledged the bottle was not labeled, and stated he would dispose of it. 12:05 PM 10/08/24 Facility failed to properly label six ice tea pitchers, one fruit punch, one opened cereal, with expiration date. Observed on10/08/24 at 12:51 PM Floor in Nutritional Pantry near Wing D was visibly soiled. On 10/09/24 at 10:30 AM Surveyor observed dishwashing - low temp dishwasher. Visual observation of dials on front of machine showed wash temperature to be at 119 degrees F. Reviewed facility policy on dishwashing, and failed to follow their policy on Warewashing, which states all dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperatures will be maintained in accordance with manufacturer recommendations for high temperature or low temperature machines. Manufacturer's guidelines reflected low temp wash temperature minimum was recommended to be 140 degrees F, with rinse temperature to be a minimum of 120 degrees F. The Director #202, maintenance director #61 acknowledged the low rinse temperatures, stating the facility put in for an upgrade for the breaker so the kitchen could install a hot water booster to help with the rinse and wash cycle. The Director #61 stated that the kitchen staff constantly run the hot water in the 3 compartment sink and it depletes the hot water; causing the rinse cycle to be too low. Record review of Dish Machine Logs for August thru October 8, 2024: On 8/26 and 8/27, wash temperatures were 120 degrees at lunch service. Wash temperatures for dinner service were below 140 degrees for 28 days out of 31, ranging from a low of 120 degrees to a high of 137. Only 8/1/24, 8/22/ and 8/31 were within range of the manufacturer's guidelines. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	For September, lunch wash temperatures on 9/4 was 118; every day from 9/5/24 thru 9/21/24 was 120 degrees, and on 9/25 was 135. Lunch rinse temperatures were 100 on 9/10 through 9/14; and on 9/20 was 118. For breakfast, from 9/9 through 9/20, wash was 120, and dropped to 100 on 9/26 and 9/27. Rinse was 100 degrees on 9/11; 102 on 9/12/24; 100 on 9/13/24, 118 degrees on 9/20 and 9/21. For dinner: 9/5 was 110, 9/6 was 105, 9/7 was 102, 9/8 and 9/14 were 130, 9/28 was 130, 9/14 was 130, 9/19 and 9/20 was 120, 9/21 and 9/22 was 135, 9/23 and 9/24 was 130, 9/25 was 138, and 9/30 was 120. Rinse was 105 on 9/7, 110 on 9/8, 115 on 9/10, 116 on 9/11, 118 on 9/12 and 9/13, 9/20, 9/25, and 9/29. October dinner wash temperatures were: 135 on 10/1 and 138 on 10/3, and 120 on 10/8. Dinner rinse was 118 on 10/8. Lunch was was 120 on 10/3. Lunch rinse was 118 on 10/8. Breakfast rinse was 116 on 10/8.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51554 Based on review of food handler permits and staff interviews, the facility failed to ensure dietary staff had training and had a current food handlers permit as required by the local health department. This had the potential of affect more than a limited number of residents. Facility census: 181. Findings included: a) Food Handlers On [DATE] at 3:34 PM a review of Dietary staff food handler permit and interview with the DD #202 found the following: Cook #197 was hired on [DATE]. Food handler permit was not provided at time of review. Facility provided a copy on [DATE] to update the record. Food handler permit was issued on [DATE]. Cook #204 was hired [DATE] and had a food handler permit at time of review, which expired on [DATE]. Facility provided an updated copy dated [DATE] at 4:40 PM same day, with a renewal date of [DATE]. Cook #209 was hired on [DATE], and did not have evidence of a WV food handler permit at review date. Copy of record issued [DATE] was provided at 4:40 PM on [DATE] Dietary Aide #206 did not have evidence of valid WV food handler permit upon review. Hire date of [DATE]. Facility provided a copy with issue date of [DATE] at 4:40 PM. Dietary Aide #200 was hired [DATE], and did not have a valid food handler permit upon review. Facility provided a copy with issue date of [DATE] at 4:40 PM on [DATE] Assistant Dietary Manager #212 was hired [DATE], and had WV food handler permit which expired on [DATE]. Facility provided an updated copy of valid food handler permit which was issued on [DATE] at 4:40 PM on [DATE].

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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. 50551 Based on observation, staff interview and record review, the facility failed to maintain Enhanced Barrier Precautions for Resident #99. This is true for 1(one) of 7(seven) for infection control and had the potential to affect a limited number of residents. Resident identifier: #99. Facility census 181. Findings included: Review of facility Policies and Standard Procedures for Tracheostomy Care on 10/15/24 at 1:00 PM. Procedures number 4 (four) and 5 (five) stated the following: -4. Maintain an aseptic environment to the extent possible to reduce pathogen transmission. -5. Perform hand hygiene and put on personal protective equipment. a) Resident #99 On 10/14/24 at 1:50 PM, observed Resident #99 during tracheostomy care. Licensed Practical Nurse (LPN) #169 was not wearing a gown and acknowledged that she should have been. While observing for several minutes noticed that Resident #99's oxygen was not attached to the trach. When asked if it should be attached to something the LPN #169 stated yes, probably and went on to state that she was not dependent on it. LPN #169 went and got another tube and reattached it to the trach. When asked what were Resident #99's oxygen stats were normally, LPN #169 stated 96. When asked if she was going to reassess her, she did and resident's O2 was 89. It returned to 96 after her oxygen was reattached. b) Care Plan Review of Resident's #99 care plan revealed the following: -Focus Resident is currently receiving tracheostomy care CVA (cerebrovascular accident) -Interventions/tasks to include: Enhanced Barrier Precautions when providing care to tracheostomy. Keep extra trachs at bedside-current size and one smaller. Items to remain at bedside for emergency: ambu bag, an extra cuffed tracheostomy tube and obturator, 1 (one) smaller, trach tie, 5-10 (five-ten) CC syringe, lubricating jelly, suction catheter.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beckley Healthcare Center	100 Heartland Drive Beckley, WV 25801

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 50801 The facility failed to ensure the call light was within reach for Resident # 88. This was a random opportunity for discovery. Resident identifier: #88. Facility census 181. Findings Included: a) Resident #88 An observation on 10/14/24 at 4:00 PM, found Resident #88 was not able to reach the button for her call light. This left the resident without a means to call for help/assistance. b) On 09/14/24 at 4:02 PM, during and interview with, Licensed Practical Nurse (LPN) #151 confirmed Resident #88's call light was not within the resident's reach.