STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515089	A. Building B. Wing	01/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Charleston Healthcare Center	3819 Chesterfield Avenue Charleston, WV 25304

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39571 Based on observation and staff interview the facility failed to ensure the residents residing in room [ROOM NUMBER] was treated with respect and dignity when a housekeeper failed to obtain the residents permission before entering the room and talked on her cell phone the entire time, she was in the resident's room. This was a random opportunity for discovery. Resident Identifier: room [ROOM NUMBER]. Facility Census: #141 a) room [ROOM NUMBER] On 01/23/24 at 9:42 AM Housekeeper #170 was observed going into room [ROOM NUMBER] while talking on her teal-colored phone. This housekeeper opened the door and walked into the room without knocking. Housekeeper #170 was observed talking on her phone while in the room and remained on her phone when she exited the room. Housekeeper #170 was stopped upon exiting the room and was asked about knocking on doors before opening and walking in the room. Housekeeper #170 said, It does not matter if you knock or not most of these people here either can't hear or can't talk so it does not matter. Housekeeper #170 remained on her phone the whole time. The above incident was discussed with the Director of Nursing on 01/23/24 at 11:19 AM and no further information was provided. 45171

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45173 Based on record review and staff interview, the facility failed to revise a care plan to indicate skin issues were healed for Resident #73, #40 and #31. This is true for three (3) of five (5) residents reviewed under the care area of pressure ulcers. Resident identifiers: #73, #40 and #31. Facility Census: 141. Findings included: a) Resident #73 On 01/22/24 at 11:00 AM, a record review was completed for Resident #73. A review of the care plan indicated the resident had excoriation to the bilateral buttock. The weekly skin assessments were reviewed indicating the resident currently had no skin issues. On 01/22/24 at 3:00 PM, the Director of Nursing (DON) was interviewed and was asked, does the resident have any skin issues? The DON stated, the care plan is incorrect .the resident does not have any skin issues. b) Resident #40 On 01/22/24 at 11:25 AM, a record review was completed for Resident #40. A review of the care plan indicated the resident had open MASD (moisture-associated skin damage). The weekly skin assessments were reviewed indicating the resident had no skin issues currently. On 01/22/24 at 3:00 PM, the Director of Nursing (DON) was interviewed and was asked, Does the resident have any skin issues? The DON stated, The care plan is incorrect .the resident does not have any skin issues. c) Resident #31 On 01/22/24 at 11:45 AM, a record review was completed for Resident #31. A review of the care plan indicated the resident had MASD to inner buttocks. The weekly skin assessments were reviewed indicating the resident had no skin issues currently. On 01/22/24 at 3:00 PM, the Director of Nursing (DON) was interviewed and was asked, Does the resident has any skin issues? The DON stated, the care plan is incorrect .the resident does not have any skin issues.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39571 Based on facility record review and staff interview the facility failed to administer medication as prescribed by the physician, failing to offer the Respiratory syncytial virus (RSV) vaccine when available, failed to complete neuro checks, failed to notify physician of no bowel movement, failed to notify physician of resident requesting to go to the emergency room , no protocol for bowel regiment, failed to follow physicians' orders. These were random opportunities for discovery. Resident identifiers: #16, #14, #59, #75, #126, #147, #60, 18, and #145. Facility census 142. Findings included: a) Resident #147 Record review on 01/22/24 at 10:00 AM found that on 12/27/23 at 09:30 PM, according to a nurse progress note, Resident #147 had an elevated blood glucose level of 660. The nurse administered the ordered dose of insulin (18 units). There was no nurse note completed at that time of the Physician being notified. However, there is a progress note on 12/27/23 at 9:33 PM from Telehealth Physician which states: cover with accu checks and sliding scale, give 6 units more. Obtain BMP (Basic Metabolic Panel) in the AM, increase Lantus to 20 units from 18 units. There was no order placed in Point Click Care for the additional 6 units of insulin ordered. Further record review found there was no change in condition assessment completed for this elevated blood glucose. This was confirmed with the Director of Nursing on 01/23/24 at 10:10 AM at which time she stated there should have been a change in condition report filed for this elevated glucose. b) Failure to notify Physician b-1) Resident #147 On 01/15/24 at 9:02 AM, a record review found a nursing note written on 12/28/23 at 09:02 AM, which states the resident, and her daughter was requesting to be transferred to the local emergency room for further evaluation after an elevated blood glucose (660) was obtained the prior evening. The note states the nurse explained to the resident she did not have a Physicians order to send her out at this time and explained the Against Medical Advise (AMA) Policy to the resident and her daughter. There was no documentation that the nurse had paged a Physician for an order to transfer the resident to the emergency room . When the resident left, there was no documentation the Physician had been notified she had left the facility. On 12/28/23 at 10:52 AM a progress notes by Social Worker #27 states: Licensed Social Worker (LSW) called Adult Protective Services (APS) for referral relating to leaving facility AMA, Referral intake number provided. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Social Worker #27 on 01/23/24 at 10:00 AM, she states she does know the AMA policy and doesn't know anything about this situation, she was only going off the progress note from the nurse on 12/28/23 at 9:02 AM, and according to residents rights, she has the right to request to go to the emergency room (ER). This was confirmed with the Director of Nursing on 01/23/24 at 3:10 PM. No further information was provided prior to exiting the facility on 01/24/24 at 2:00 PM. b-2) Resident # 7 A record review on 01/23/24 at 09:25 AM, found Resident #7 did not have a bowel movement (BM) 01/11/24, 01/12/24 or 01/13/24. She did not have an order for the BM Protocol which normally reads: Bowel protocol step 1: If no BM in 3 days initiate bowel protocol. as needed for Constipation If no BM on day 3 give MOM (1200 mg/15 ml) 30 cc x 1 dose. Bowel protocol step 2: If no BM in 8 hours (after MOM) give Dulcolax (10 mg) suppository. as needed for Constipation per rectum Bowel protocol step 3: If no BM 8 hours after Dulcolax suppository give Fleets enema (ready to use saline laxative 4.5 fl oz). as needed for Constipation per rectum. If no results from step 3 notify the physician for additional orders. Standard practice of care is to notify the Physician of no BM for 3 days with no BM protocol orders present. There is no documentation of the Physician being notified of this change in condition. This was confirmed with the Director of Nursing on 01/23/24 at 03:10 PM. b-30) Resident #10 A record review on 01/23/24 at 09: 50 AM, found Resident #10 did not have a BM for three days on 12/18/23, 12/29/23, 12/30/23 and again on 01/04/24, 01/05/24, 01/06/24 or 01/07/24. She did not have an order for the BM Protocol which normally reads: Bowel protocol step 1: If no BM in 3 days initiate bowel protocol. as needed for Constipation If no BM on day 3 give MOM (1200 mg/15 ml) 30 cc x 1 dose. Bowel protocol step 2: If no BM in 8 hours (after MOM) give Dulcolax (10 mg) suppository. as needed for Constipation per rectum Bowel protocol step 3: If no BM 8 hours after Dulcolax suppository give Fleets enema (ready to use saline laxative 4.5 fl oz). as needed for Constipation per rectum. If no results from step 3 notify the physician for additional orders. Standard practice of care is to notify the Physician of no BM for 3 days with no BM protocol orders present. There is no documentation of the Physician being notified of this change in condition. This was confirmed with the Director of Nursing on 01/23/24 at 3:10 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) Failure to follow Physicians orders c-1) Resident #60 On 01/23/24 at 02:20 PM, a record review found Resident #60 was readmitted to the facility on [DATE]. found readmission Resident #60 was ordered to have vital signs every shift for 72 hours then Daily. According to documentation on the Weights and Vitals Summary, there were no vital signs obtained on the following shifts. 01/10/24 3-11 shift 01/11/24 3-11 shift This was confirmed with the Director of Nursing on 01/23/24 at 03:10 PM. c-2) Resident #147 On 01/23/24 at 02:20 PM, record review shows that Resident #147 has an order for Accu checks before meals and at bedtime for diabetes, notify physician for blood sugar less than 60 or greater than 400. The accu checks were scheduled for 7:00 AM, 11:00 AM, 4:00 PM and 9:00 PM. Further review of the Weights and Vitals Summary for Resident #147 found the Physicians order was not followed when the facility failed to obtain blood glucose on 12/27/23 at 0:00 PM. This was confirmed with the Director of Nursing on 01/23/24 at 03:10 PM and no further information was provided. c-3) Resident #147 On 02/23/24 at 2:20 PM a record review found Resident #147 had an order for insulin Lispro (Humalog) injection solution 100 units/milliliter (ml): inject four (4) units subcutaneous before meals for diabetes (DM). Review of the medication administration record (MAR) found this order was not followed prior to the evening meal on 12/26/23 at 4:30 PM. According to the Chart Codes, the nurse documented NC, which is coded as No insulin coverage required. Resident #147 also has an order for insulin Lispro (Humalog) injection solution 100 units/ml; inject eighteen (18) units subcutaneous two times a day (9:00 AM and 9:00 PM). According to review of the MAR, the 12/26/23 9:00 PM dose was not administered as ordered. According to the Chart Codes, the nurse documented 9, which is coded as see nurse note. According to the nurse progress note, the insulin was not available from the pharmacy. However, the insulin (Humalog) was available in the cubex. This was confirmed with the Director of Nursing on 01/23/24 at 03:15 PM at which time she stated, This was not a sliding scale order, the four (4) units of insulin should have been administered as ordered and the Humalog is available in the cubex. c-4) Resident #18 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/23/24 at 2:10 PM, a record review found Resident #18 had an order for the bowel protocol which read: Bowel protocol step 1: If no BM in 3 days initiate bowel protocol. as needed for Constipation If no BM on day 3 give MOM by mouth (1200 mg/15 ml) 30 cc x 1 dose. Bowel protocol step 2: If no BM in 8 hours (after MOM) give Dulcolax (10 mg) suppository. as needed for Constipation per rectum Bowel protocol step 3: If no BM 8 hours after Dulcolax suppository give Fleets enema (ready to use saline laxative 4.5 fl oz). as needed for Constipation per rectum. If no results from step 3 notify the physician for additional orders. A further review of Resident #18's medical record found Resident #18 did not have a did not have a BM on 01/07/24, 01/08/24 and 01/09/24 which should have required the bowel protocol step #1 be initiated. The record was void of any documentation indicating the bowel protocol was initiated. This was confirmed with the Director of Nursing on 01/23/24 at 03:10 PM at which time she agreed the bowel protocol should have been initiated and was not. c-5) Resident #147 On 01/23/24 at 01:20 PM record review shows Resident #147 has a progress note from the Telehealth Physician on 12/27/23 at 09:33 PM stating the following: C/w (cover with) accu checks and sliding scale, give 6 units more . Further record review shows there was no order placed in Point Click Care, nor a nurse progress note indicating the additional six (6) units of insulin was administered. This was confirmed with the Director of Nursing on 1/23/24 at 3:05 PM at which time she agreed that there is no documentation to indicate the additional six (6) units of insulin was administered as ordered. d) Resident #147 On 01/22/24 at 02:45 PM record review shows that Resident #147 had an elevated blood glucose of 660 on 12/27/24 at 9:30 PM. The nurse administered the ordered insulin eighteen (18 units) and received a new order from the Telehealth Physician to administer an additional six (6) units of insulin. Standard practice of care is to re check a blood glucose level one hour after administering insulin when the original blood glucose level was elevated. Documentation showed that Resident #147 did not have another blood glucose level checked until 12/28/23 at 06:38 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This was confirmed with the Director of Nursing on 1/23/24 at 3:05 PM at which time she agreed the blood glucose should have been re checked on 12/27/23 one (1) hour after administering the resident's ordered insulin. e) Neurological checks e-1) Resident #145 On 01/23/24 at 3:02 PM, a record review found Resident #145 had an unwitnessed fall on 10/16/23 at 1:00 AM. According to the Neurological Checks Policy all unwitnessed falls are to have neurological (neuro) checks performed every 15 minutes X 4, then every hour X 4, then daily X 4. Review of Resident #145's neuro checks for this fall shows neuro checks were performed every 15-minute X 4 checks. The remaining eight (8) neurological checks were not performed. This was confirmed with the Director of Nursing on 01/24/24 at 08:45 AM and no further information was provided. e-2) Resident #146 On 01/23/24 at 03:02 PM, a record review found Resident #146 had two (2) unwitnessed falls on 10/21/23, one at 06:15 AM and one at 11:30 PM. According to the Neurological Checks Policy all unwitnessed falls are to have neurological (neuro) checks performed every 15 minutes X 4, then every hour X 4, then daily X 4. Review of Resident #146's fall at 06:15 AM shows that seven (7) of the neurological checks were not performed and the fall at 11:30 PM, eight (8) of the neurological checks were not performed. This was confirmed with the Director of Nursing on 01/24/24 at 08:45 AM and no further information was provided. f) Resident #75 On 01/22/24 at 12:15 PM, a record review was completed for Resident #75. A review of the Medication Administration Audit report from 01/12/24 through 01/22/24 found late administration times for the following physician's orders: --01/15/24 Coreg 12.5mg (milligram) two times daily, scheduled for 10:00 AM, administered at 12:22 PM, which is 2 hours and 22 minutes late --01/15/24 Plavix 75mg daily, scheduled for 10:00 AM, administered at 12:22 PM, which is 2 hours and 22 minutes late --01/15/24 Norvasc 10mg daily, scheduled for 10:00 AM, administered at 12:22 PM, which is 2 hours and 22 minutes late --01/15/24 Neurontin 100mg two times daily, scheduled at 10:00 AM, administered at 12:23 PM, which is 2 hours and 23 minutes late (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--01/15/24 Hydralazine 25mg two times daily, scheduled at 10:00 AM, administered at 12:23 PM, which is 2 hours and 23 minutes late --01/15/24 Senna S 8.6-50mg daily, scheduled for 10:00 AM, administered at 12:23 PM, which is 2 hours and 23 minutes late --01/15/24 Lasix 20mg daily, scheduled for 10:00 AM, administered at 12:23 PM, which is 2 hours and 23 minutes late --01/15/24 Potassium Chloride 20meq (milliequivalent) every other day, scheduled at 10:00 AM, administered at 12:23 PM, which is 2 hours and 23 minutes late --01/16/24 Lasix 20mg daily, scheduled for 10:00 AM, administered at 12:11 PM, which is 2 hours and 11 minutes late --01/16/24 Senna S 8.6-50mg daily, scheduled for 10:00 AM, administered at 12:11 PM, which is 2 hours and 11 minutes late --01/16/24 Hydralazine 25mg two times daily, scheduled at 10:00 AM, administered at 12:11 PM, which is 2 hours and 11 minutes late --01/16/24 Neurontin 100mg two times daily, scheduled at 10:00 AM, administered at 12:11 PM, which is 2 hours and 11 minutes late --01/16/24 Norvasc 10mg daily, scheduled at 10:00 AM, administered at 12:11 PM, which is 2 hours and 11 minutes late --01/16/24 Plavix 75mg daily, scheduled at 10:00 AM, administered at 12:11 PM, which is 2 hours and 11 minutes late --01/16/24 Coreg 12.5mg two times daily, scheduled at 10:00 AM, administered at 12:11 PM, which is 2 hours and 11 minutes late --01/22/24 Coreg 12.5mg two times daily, scheduled at 10:00 AM, administered at 12:03 PM, which is 2 hours and 3 minutes late --01/22/24 Plavix 75mg daily, scheduled at 10:00 AM, administered at 12:03 PM, which is 2 hours and 3 minutes late --01/22/24 Norvasc 10mg daily, scheduled at 10:00 AM, administered at 12:03 PM, which is 2 hours and 3 minutes late --01/22/24 Neurontin 100mg two times daily, scheduled at 10:00 AM, administered at 12:03 PM, which is 2 hours and 3 minutes late --01/22/24 Hydralazine 25mg two times daily, scheduled at 10:00 AM, administered at 12:03 PM, which is 2 hours and 3 minutes late (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--01/22/24 Senna S 8.6-50mg daily, scheduled at 10:00 AM, administered at 12:03 PM, which is 2 hours and 3 minutes late --01/22/24 Lasix 20mg daily, scheduled at 10:00 AM, administered at 1:03 PM, which is 2 hours and 3 minutes late --01/22/24 Carafate Oral Suspension 10ml (milliliter) four times daily, scheduled at 10:00 AM, administered at 12:03 PM, which is 2 hours and 3 minutes late On 01/22/24 at 3:00 PM, the Director of Nursing (DON) was notified and confirmed the administration was late. The DON stated, we are working on getting things corrected. g) Resident #126 On 01/22/24 at 12:15 PM, a record review was completed for Resident #126. A review of the Medication Administration Audit report from 01/12/24 through 01/22/24 found late administration times for the following physician's orders: --01/14/24 Hydroclorothiazide (HCTZ) 25mg two times daily, scheduled at 2:00 PM, administered at 5:46 PM, which is 3 hours and 46 minutes late --01/14/24 Metaxalone 800mg every 8 hours, scheduled at 2:00 PM, administered at 5:46 PM, which is 3 hours and 46 minutes late --01/14/24 Carbidopa-Levodopa 25-100mg three times daily, scheduled at 2:00 PM, administered at 5:46 PM, which is 3 hours and 46 minutes late --01/19/24 Famoidine 10mg daily, scheduled at 10:00 AM, administered at 10:46 PM, which is 12 hours and 46 minutes late --01/19/24 Carbidopa-Levodopa 25-100mg three times daily, scheduled at 10:00 AM, administered at 10:45 PM, which is 12 hours and 45 minutes late --01/19/24 Miralax 17gr (gram) daily, scheduled at 10:00 AM, administered at 10:46 PM, which is 12 hours and 46 minutes late --01/19/24 Heparin Injection 40mg/0.4ml daily, scheduled at 10:00 AM, administered at 10:45 PM, which is 12 hours and 45 minutes late --01/19/24 Senna S 8.6-50mg two times daily, scheduled at 10:00 AM, administered at 10:46 PM, which is 12 hours and 46 minutes late --01/19/24 HCTZ 25mg two times daily, scheduled at 10:00 AM, administered at 10:46 PM, which is 12 hours and 46 minutes late --01/19/24 Metaxalone 800mg every 8 hours, scheduled at 10:00 AM, administered at 10:46 PM, which is 12 hours and 46 minutes late (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Above information was taken from the website: Centers for Disease Control and Prevention i) Resident #16 A review of the facility documents called, Medication Admin Audit Report, found that on the following days Resident #16 did not receive her medication within the standard practice time frame. On 01/08/24 the medication Reglan was ordered to be given four (4) times a day for nausea, possible gastroparesis. The scheduled time to be given was 9:00 AM but was not given until 11:37 AM. The next dose was scheduled to be given at 1:00PM and was not given until 4:00 PM. j) Resident #14 A review of the facility document called, Medication Admin Audit Report, found on the following days Resident #16 did not receive her medication within the standard of practice time frame. On 01/12/24 Lantus Solostar Insulin was scheduled to be given at 9:00 PM and was not given until 01/13/24 at 4:39 AM. On 01/12/24 Reglan was scheduled to be given at 9:00 PM and was not given until 01/13/24 at 4:39 AM. On 01/12/24 Melatonin (given for insomnia) was scheduled to be given at 9:00 PM and was given at 4:39 AM on 01/13/24. On 01/12/24 Oxycodone was scheduled to be given at 9:00 PM and was not given until 4:39 AM on 01/13/24. This medication was given again on 01/13/24 at 6:00 AM. On 01/12/24 Hydroxyzine HCL (given for anxiety and to be given at bedtime) was scheduled to be given at 9:00 PM, was not given until 01/13/24 at 4:36 AM. Zanaflex to be given three (3) times a day for neck pain. This was scheduled to be given on 01/12/24 at 10:00 PM and was not given until 01/13/24 at 4:39 AM. Gabapentin to be given every eight (8) hours. This was scheduled for 01/12/24 at 10:00 PM and was not given until 4:39 AM on 01/13/24. This medication was given again on 01/13/24 at 6:00 AM. There were not eight (8) hours between times it was given. Hydralazine was ordered to be given every eight (8) hours for hypertension. On 01/12/24 it was scheduled for 10:00 PM and was not given until 4:39 AM on 01/13/24. This medication was given again on 01/13/24 at 6:00 AM. There were not eight (8) hours between times it was given. On 01/23/24 at 2:10 PM, the Director of Nursing (DON) was asked if she had reviewed the Medication Administration Audit forms which was provided to the survyor? The DON said yes. DON was asked if she was aware of the medication that was given late. The DON said yes and that the nurses were told to call the physician and document the physician gave an order to give late. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/23/24 at 5:00 PM the DON was asked to find the nursing notes which correspond with the dates and times of the medication mentioned above. On 01/24/24 at 10:00 AM the DON reported there were not any nursing notes about the late medications and could not provide any information on if the physician was made aware of the late medications. k) Resident #14 medications not available A review of the medical record for Resident #14 found many nursing notes stating medications were not available for administration. The notes were as follows: Resident #14 was admitted to the facility on [DATE]. On 12/28/23 at 4:17 PM Licensed Practical Nurse (LPN) #180 wrote the medication Reglan cannot be administered because the medication was not available. This medication is used to relieve the symptoms of slow stomach emptying in people with diabetes. LPN #180 wrote the medication Reglan could not be administered on 12/28/23 at 1:01 PM due to not being available. On 01/04/24 at 6:23 PM LPN #73 wrote the medication Epoetin Alfa was unavailable and was reordered. This medication is used to help your body make more red blood cells (treatment for anemia). On 01/05/24 at 10:32 PM Unit Manager #183 wrote the medication Lantus SoloStar was not available to administer and was reordered. This medication is used to control the levels of glucose in the blood. Also, at this time on 01/05/24 UM #183 wrote the medication used for urinary health called Tamsulosin was also not available. Also, the medication Ropinirole used for tremors was not available at the same time as the above mentioned medication. On 01/18/24 at 3:14 PM, LPN #30 wrote the medication Epoetin Alfa was again not available. On 01/19/24 at 11:23 PM Registered Nurse (RN) #124 wrote the following nursing note: Typed as written: Lantus Solostar subcutaneous Solution Pen-injector 100 units/ml. Inject 18 units subcutaneously at bedtime for DM medication not on hand. Med fridge checked. Medication reordered. On 01/23/24 at 2:10 PM, the DON was asked about the medications not being available and she said it may take time to get them here from the pharmacy if they are new admits. A review of the medical chart found Resident #14 was out of the facility on 01/02/24 for a few hours in the early part of that day but returned before midnight of 01/02/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I) Resident #59 Resident #59 was admitted to the facility on [DATE]. Nursing notes revealed that the following medication were not available on the following dates and times: -- On 01/20/24 at 5:40 AM, Levothyroxine used for hypothyroidism was not available. --On 01/20/24 at 3:42 PM, Levothyroxine was not available. --On 01/20/24 at 4:58 PM, Abacavir Sulfate is an antiretroviral used to treat HIV to keep the viral load down, was unavailable --On 01/20/24 at 10:25 PM Etravirine is an antiretroviral medication and was not available. --On 01/21/24 at 12:58 AM dronabinal used for appetite stimulate was not available. --On 01/22/24 at 4:36 PM, Abacavir Sulfate is an antiretroviral used to treat HIV to keep the viral load down was not available. --On 01/23/24 at 10:36 AM, Abacavir Sulfate is an antiretroviral used to treat HIV to keep the viral load down was not available. --On 01/23/24 at 10:37 AM, Etravirine is an antiretroviral medication and was not available. --On 01/23/24 at 10:37 AM, Dolutegravir Sodium, an anti-viral was not available. --On 01/23/24 at 10:36 AM, Etravirine is an antiretroviral medication and was not available. During an interview, with the DON on 01/23/24 at 4:10 PM, the DON stated, Sometimes it takes a while for the pharmacy to deliver the mediation. According to HIV. Gov, Missing doses of HIV medicines can reduce their usefulness and increase the possibility of developing drug resistance, which makes certain HIV drugs lose their effectiveness. 45171 45173

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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. 49650 Based on observation and staff interview, the facility failed to ensure the resident environment remains as free of accident hazards as possible. This was a random opportunity for discovery and had the potential to affect a limited number of residents. Facility census: 141 Findings included: a) During a tour of the facility on 1/23/24 at 1:24 PM the egress directly in front of the emergency exit door on unit EB2 off from the dining room and activity area was fully blocked by large dietary carts and a large trash can. During an interview with the Activities Director (AD) #19 on 1/23/24 at 1:27 PM, AD#19 acknowledged the emergency door exit was completely blocked and acknowledged this was not safe in the event of an emergency for evacuation. AD #19 immediately began moving the items away from the blocked emergency exit.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 42120 Based on medical record review and staff interview the facility failed to have a care plan addressing the provision of meals before, during and/or after dialysis treatments. This was true for one (1) of one (1) resident reviewed for dialysis treatment during a complaint survey. Resident identifier:#68. Facility census: 141. Findings included: a) Resident #68. Medical record review of Resident #68's medical record found a physician's order for: Dialysis every Tuesday, Thursday, and Saturday with chair time at 6:40 am. Continued review of the residents (resident's) dialysis care plan found there was no provision of meals before, during and/or after dialysis treatments. During an Interview with the Director of Nursing (DON) on 1/24/24 at 10:23 AM, she verified there was no dialysis meal plan for dialysis days in Resident #68's care plan.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 49650 Based on observation and staff interview, the facility failed to ensure the Daily Staffing Posting information was accurate and current and the facility failed to maintain the Daily Staffing Posting data for a minimum of 18 months. This was a random opportunity for discovery and had the potential to affect all resident currently residing at the facility. Facility Census 141 Findings included: a) Accurate and current data On 1/23/24 (01/23/24) at 10:00 AM, during a review of the facilities Daily Staffing Posting and the Daily Punches data for all direct care staff, the following discrepancies were identified with the total number of direct care hours being reported on the Daily Staffing Posting for 11/03/23, 11/16/23 and 1/19/24. -- 11/03/23 Daily Punches data for all direct care staff was 413.25 hours and the Daily Staffing Posting reported a total of direct care hours being 443.25, an inaccuracy of 30 hours. -- The 11/16/23 Daily Punches data for all direct care staff was 430.25 hours and the Daily Staffing Posting reported a total of direct care hours being 507.75 hours, an inaccuracy of 77.5 hours. -- The 1/19/24 Daily Punches data for all direct care staff was 383 hours and the Daily Staffing Posting reported a total of direct care hours being 457.25, an inaccuracy of 74.25 hours. During an interview with the Administrator on 1/23/24 at 11:05AM, the Administrator denied knowing why the direct care staff hours would be different and stated both the Daily Staffing Posting Forms and the Daily Punches Data come from the same system. She further stated there was nothing else she could provide to explain why the Daily Staffing Posting Form is reflecting inaccurate direct care staff hours for 11/03/23, 11/16/23 and 1/19/24. No further information was provided. b) Accurate and current data On 1/23/24 at 11:10AM during an interview with the Administrator, the Unit Manager RN (Registered Nurse) and the Unit Manager LPN (Licensed Practical Nurse) Daily Punches Data was reviewed as this data identifies the entire shifts for the Unit manager RN and Unit Manager LPN to be solely direct care. A request was made for supportive documentation for the Unit Manager RN and the Unit Managers LPN which identifies the specific hands on care they provided for their entire shifts on 11/03/23, 11/16/23 and 1/19/24. The Administrator replied she already had this conversation with other surveyors during the facilities previous survey. She stated she had told them she is permitted to use their daily scheduled hours towards the direct care hours even though they are categorized as administrative staff. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/23/24 at 1:15 PM, the Labor Classification/ Job Title section of the Centers for Medicare & Medicaid Services- Electronic Staffing Data Submission- Payroll-Based Journal- Long-Term Care Facility- Policy Manual Version 2.6 was reviewed with the Administrator. This section defines that the Labor Classification/Job Title Reporting shall be based on the employee's primary role and their official categorical title. It is understood that most roles have a variety of non-primary duties that are conducted throughout the day (e.g., helping out others when needed). Facilities shall still report just the total hours of that employee based on their primary role. CMS recognizes that staff may completely shift primary roles in a given day. For example, a nurse who spends the first four hours of a shift as the unit manager, and the last four hours of a shift as a floor nurse. In these cases, facilities can change the designated job title and report four hours as a nurse with administrative duties, and four hours as a nurse (without administrative duties). The Administrator acknowledged her understanding and left the room. At 11:40AM on 1/23/24, the Administrator provided a job description for a Unit Manager upon hire. No further information was provided for the requested supportive documentation for the specific hands on care task performed by the Unit Manager RN and Unit Manager LPN's for the reported shifts identified in the Daily Punches data for 11/03/23, 11/16/23 and 1/19/24. c) Maintain the posted daily nurse staffing data for a minimum of 18 months During an interview with the DON on 1/24/24 at 10:18AM the Daily Staffing Posting that is updated in real time with the staffing call-outs/illnesses was requested for review for 11/03/23, 11/16/23 and 01/19/24. On 1/24/24 at 10:51 the Administrator stated the scheduler was not there yet, but she would get it. On 1/24/24 at 12:00 PM the Administrator returned with a printed duplicate copy of the Daily Staffing Posting which had already been provided to the surveyor. Upon review, the Daily Staffing Posting provided did not identify the staff absences due to call-outs/illnesses as requested for 11/03/23, 11/16/23 and 01/19/24. Per the Administrators request it was clarified the original Daily Staffing Form document that was posted would have written altered changes which were made in real time to identify any staff absences due to call-outs/illnesses. These staff absences for call-outs/illnesses are identified in the facility Daily Attendance Reports for 11/03/23, 11/16/23 and 1/19/24. The Administrator stated the scheduler enters any changes marked on the original Daily Staffing Postings into the computers data system and updates the total staffing hours on the Daily Staffing Postings for the previous shifts. The Administrator further stated that they do not keep the original Daily Staffing Postings, which reflects the written altered changes that were made in real time to identify any staff absences due to call-outs/illnesses. It was further acknowledged the updated Daily Staffing Posting did not identify actual staff absences due to call-outs/illnesses.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42120 Based on observation and staff interview the facility failed to prepare food in accordance with professional standards for food service safety related to, sanitary conditions and the prevention of foodborne illness. This has the potential to affect all residents that get their nutrition from the kitchen. Facility census: 141. Findings include: a) Kitchen Tour of the kitchen on 1/23/24 at 10:00 AM with the Dietary Manager found the steam table and lids and plate warmer was heavily soiled, with grease build up, and old food debris. Continued tour revealed 2 maintenance workers, working in the kitchen on the plate warmer without hair coverings. During an interview on 1/23/24 at 10:00 AM the Dietary Manager, confirmed the steam table with lids and plate warmer was heavily soiled, with grease build up, and old food debris. She also verified the Maintenance workers were working on the plate warmer in the food preparation area without hair coverings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45173 Based on record review and staff interview, the facility failed to ensure medical records were accurate and complete. This is true for two (2) of three (3) residents reviewed under the care area of discharges. Resident Identifiers: #66 and #31. Facility Census: 141. Findings Include: a) Resident #66 On 01/23/24 at 11:00 AM, a record review was completed for Resident #66. The review found the resident had been transferred to an acute care facility on 01/23/24 at 9:20 AM. However, the transfer form indicates the resident was transferred on 12/19/23 at 9:27 AM. On 01/23/24 at 2:20 PM, the Director of Nursing was interviewed and was asked when the resident got transferred to the acute care facility. DON stated the transfer date on the form was incorrect. The DON stated, I have never noticed that before .the documentation is showing the last time the resident was sent out to the acute care facility. b) Resident #31 1) On 01/23/24 at 11:45 AM, a record review was completed for Resident #31. The review found the resident had been transferred to an acute care facility on 12/07/23 at 10:00 PM. However, the transfer form indicates the resident was transferred on 02/22/20 at 9:50 AM. On 01/23/24 at 2:20 PM, the Director of Nursing was interviewed and asked when did the resident get transferred to the acute care facility? DON stated the transfer date on the form was incorrect. The DON stated, I have never noticed that before .the documentation is showing the last time the resident was sent out to the acute care facility. 2) On 01/23/24 at 12:00 PM, a record review was completed for Resident #31. The review found the resident had been transferred to an acute care facility on 01/03/24 at 5:26 PM. However, the transfer form indicates the resident was transferred on 12/07/23 at 10:26 PM. On 01/23/24 at 2:20 PM, the Director of Nursing was interviewed and asked when did the resident get transferred to the acute care facility? DON stated the transfer date on the form was incorrect. The DON stated, I have never noticed that before .the documentation was showing the last time the resident was sent out to the acute care facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 39571 Based on observation and staff interview the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This failed practices was a random opportunity for discovery while observing medication pass. Resident identifiers: #120. Facility census 141. Findings include: a) Resident #120 On 01/23/23 at 8:40 AM Licensed Practical Nurse (LPN) #108 was pulling medication for Resident #120 and dropped a pill on the med-cart. There was not a barrier on the cart and LPN #108 picked up the pill without donning a glove and put the pill in the cup with the other medications. LPN #108 gave all of the pills in the cup to Resident #120. This is the list of medications given: Fexofenadine 180 mg Metoprolol 50 mg Myrbetrig 25 mg Valsartan 160 mg When asked, LPN #108 agreed she should have not picked the pill up with a bare hand.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39571 Based on facility record review and staff interview the facility failed to offer the Pneumococcal vaccine when eligible. This was true for four (4) out of five (5) reviewed for immunizations. Resident identifiers: #143, #19, #100, and #120. Facility census: 141. Findings include: a) Pneumococcal vaccine Resident #143 was admitted on [DATE] and a review of the medical records found this resident received Pneumonia vaccine 23 on 10/12/12. Resident #19 was admitted on [DATE] and a review of the medical records revealed Resident #19 received the following Pneumococcal vaccines. The PREVNAR (PVC) 13 was given on 09/2016, Pneumococcal (PNX) on 12/2009, Pneumococcal Polysaccharide (PPSV 23) on 05/2015. Resident #100 was admitted on [DATE] and had nothing listed for pneumococcal vaccines. Resident #120 was admitted on [DATE] and did not have anything listed as past vaccinations. On 01/23/24 at 11:15 AM, the IP was asked about the four (4) residents mentioned above and their pneumococcal vaccines. It was pointed out that all residents were eligible for the PVC 20. The IP left to review their histories and returned on 01/23/24 at 2:02 PM and confirmed all the residents mentioned above should have been offered the PVC 20. The CDC recommends giving the PVC 20 if it has been five (5) years or more since PVC 13 or PVC 23 has been given.