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	10/30/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49751 Based on observations and staff interviews the facility failed to make sure call light was accessible to Resident #120. This was a random opportunity for discovery during the Long-Term Care survey. Facility census: 145. Resident identifier: #120 Findings included: a) Resident #120 During the initial facility tour on 10/28/24 around 11:45 AM the surveyor observed Resident #120 lying in bed with head elevated, the call light was not within reach of Resident #120. The call light was hanging between the headboard and the mattress. As the surveyor exited the room, the staff entered the room. Further observation on 10/28/24 around 12:15 PM of Resident #120 laying in the bed after staff left the room revealed the call light was still hanging on the headboard not within reach to Resident #20. An interview with Unit Manager Registered Nurse (UMRN)# 50 on 10/28/24 at approximately 12:20 PM confirmed the call light was not within reach for Resident #120. On 10/29/24 at approximately 9:00 AM the Administrator provided a copy of the facility policy. On page two (2) procedure one (1) Section C stated the following: To have a method to communicate needs to staff 1. Call light or bell access will be within reach of the resident as one method to communicate needs to staff.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 49465 Based on record review, resident interview, and staff interview the facility failed to honor Resident #68's choices in their preference to only have female caregivers. This failed practice was found true for (1) one of (9) nine residents reviewed for choices during the Long-Term Care Survey Process. Resident identifier: #68. Facility Census: 145. Findings include: a) Resident #68 During an interview on 10/29/24 at 1:00 PM, Resident #68 stated, I don't like it when the guys come in to take care of me, I won't let them. Record review on 10/29/24 at 2:15 PM, for Resident #68 revealed a care plan that reads as follows: Residents prefers female caregivers. A record review on 10/29/24 at 4:30 PM of the Daily Assignment sheets for EB2 indicated that Resident #68 had a male Nursing Assistant (NA) assigned to her on 10/08/24, 10/09/24, 10/15/24, and 10/23/24. During an interview on 10/29/24 at 4:40 PM, the Director of Nursing (DON) stated, She usually doesn't like male caregivers, but she will tolerate (NA #44 named). We do the assignments by seniority. So he typically gets the assignment that is left, which is usually that assignment. During an interview on 10/30/24 at 11:15 AM, Resident #68 stated, (NA #44 named, is assigned to me a lot. I tell him you are not taking care of me.

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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. 50551 Based on record review and staff interview, the facility failed to complete a thorough investigation of a reported incident and identify an allegation of neglect. The facility did not follow physician's orders for Resident #122. This was true for 1(one) of 4 (four) residents reviewed for abuse and neglect. Resident identifier #122. Facility Census 145. Findings included: a) A review of the incident report, investigation and five day-follow-up that occurred on 06/16/24 for Resident #122 revealed the following: Resident # 122 was found in her room with chopped up fruit in her bed by a nurse aide. The resident's brother later reported to the nurse that he had Resident #122 laughing and spitting up chunks of fruit. There was a spoon and empty fruit cup on the floor beside her bed on 06/16/24. There were (3) three witness statements collected. Witness statements were collected from the nurse aide and Licensed Practical Nurse (LPN) #52 and the assistant cook. The Assistant [NAME] reported that a nurse called and asked for scrambled eggs for Resident #122 on 06/17/24 and she made them without checking the resident's diet card. The facility did not substantiate the allegation per five-day follow-up. No further documentation was provided. b) A review of Resident #122's records on 10/30/24 at 12:05 PM revealed the following: Diagnoses: Hemiplegia and hemiparesis following cerebral infarction, aphasia, dysphasia requiring feeding tube, apraxia following cerebral infarction. Physician's orders: Start date 1/08/24- Nothing By Mouth (NPO) diet, NPO texture, NPO Consistency for diet type Start date 6/17/24, Puree texture, thin liquids consistency, pleasure tray diet type Nurses Notes- 6/16/2024 6:00 pm: Physician order not followed related to diet. All parties aware. Nurses Note 6/17/2024 12:17 pm: New order obtained per speech therapy, upgrade diet pureed texture, thin liquids for pleasure feeding. All parties aware. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) During an interview on 10/30/24 at 1:30 PM, the Director of Nursing (DON) stated, The investigation was pertaining to the fruit. We did not substantiate it because we feel her brother brought in the fruit. No staff said that they brought in the fruit. She did not get the eggs. (name) the nurse called down and got eggs for another resident. The statement from the kitchen came into play because we just called the kitchen and said 'Did anyone call down and get extra food and they said (name) did for (Resident #122). The kitchen had the person mixed up. (name) is not working today. If you need her number, I can get it for you. There was no evidence of the information provided by the DON in the investigation provided by the facility. When the surveyor reviewed the investigation provided by the facility it appeared that the resident had received eggs and the resident's physician orders stated she was NPO.

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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. 45171 49465 Based on record review and staff interview the facility failed to ensure residents had care plans developed for as of area of concern. Resident #68 had suffered fluid volume depletion and did not have a care plan focus area for dehydration. Resident identifier: #68. Facility census: 145. Findings included: a) Resident # 68 During the initial interview on 10/28/24 at 12:47 PM, Resident #68 stated, I don't drink the water here. I drink coffee with each meal and I eat Ice chips. They don't always bring me my ice chips. They are getting a little better since I had that intravenous (IV) to get fluids. Further record review of Resident #68's diagnoses revealed that Resident #68 was diagnosed with a Urinary Tract Infection (UTI) on 09/06/24 that was resolved on 10/05/24. The Hydration risk evaluation dated 10/09/24 did not indicate that Resident #68 had a history of UTI, which would put her at a higher risk for dehydration. Further record review of Resident #68's diagnosis revealed a diagnosis of depression. The Hydration risk evaluation dated 10/09/24 does not indicate that Resident #68 had depression, which would put her at a higher risk for dehydration. A record review on 10/29/24 at 11:15 AM of Resident #68's progress notes, revealed a nurses note dated 10/01/2024 reads as follows: Received new order to infuse 2 liters of normal saline (NS). Fluid volume depletion. All parties aware Further record review revealed that there is no care plan in place for dehydration or for at risk of dehydration. During an interview on 10/29/24 at 2:10 PM, The Director of Nursing (DON) confirmed that risk for dehydration was not on Resident #68's care plan. 49650

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465 The facility failed to make a care plan revision in the area of advanced directives. This failed practice was found true for (1) one of (6) six residents reviewed for Advance Directives during the Long-Term Care Survey Process. Resident identifier: #66. Facility census: 145. Findings Include: a) Resident #66 A record review on [DATE] at 8:52 AM, revealed that Resident #66's was marked as a Do Not Resuscitate (DNR) on her post form dated [DATE]. Further record review of Resident #66's care plan reads as follows: Focus: Resident has a Cardiopulmonary Resuscitation (CPR) code status. Revised on [DATE] During an interview on [DATE] at 11:00 AM, the Director of Nursing (DON) confirmed that the code status for Resident #66 did not match.

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on medical record review and staff interview the facility failed to ensure they provided emergency care in accordance with the resident's advanced directives. Resident #139 had a [NAME] Virginia Post Orders to Health Care (POST) form that specified the resident did not want cardiopulmonary resuscitation (CPR). The resident's care plan had not been updated to reflect this and indicated the resident was a full code. The resident received CPR when they had no pulse and were not breathing. Resident identifier: #139. Facility census: 145. Findings included: a) Resident #139 During a medical record rive for resident #139 on [DATE] at approximately 09:45 AM it is identified that the resident had capacity and had completed the [NAME] Virginia Post Orders to Health Care (POST) form on [DATE] which identifies the following: Section A) Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing. NO CPR: Do not attempt Resuscitation (May choose any option in Section B. Section B) Option selected: Selective treatments. Goal attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location. During a review of the care plan it is identified that the care plan states Resident is a full code and was initiated on [DATE]. Further review of the medical record muses notes it is identified that on [DATE] Registered Nurse (RN) #49 documented on [DATE] at 9:30 PM that Resident #139 became unresponsive with no pulse or respirations. RN #49 states that the high quality CPR was imitated at that time. The following sequence of events was identified in RN #49's notes on [DATE] at 09:30 PM, typed as written; 2051: Ambu bag with supplemental oxygen applied. 2052: AED (Automated External Defibrillator) applied. 2055: AD performed a rhythm check, no shock advised. High quality CPR resumed. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2058: Pulse/rhythm check performed, no pulse palpated. No shock advised. High quality CPR resumed; 2059: Peripheral IV access attempted and unsuccessful. 2101: EMS arrived on scene. Pulse/rhythm check performed. No pulse palpated. No shock advised. High quality CPR resumed with EMS taking the lead. 2103: The residents daughter/MPOA notified of the change in condition. 2104: Pulse/rhythm check performed. No pulse palpated. No shock advised. High quality CPR resumed. 2105: Intraosseous access obtained by EMS. 2107: Pulse/rhythm check performed. No pulse palpated. No shock advised. High quality CPR resumed. 2109: EMS charge paramedic confirmed with daughter to end life saving measures. 2114: EMS conferred with their physician (physician name noted) and determined the time of death is 2114. 2145: The residents family arrived at the facility. On call nurse manager/DON notified. On call medical provider notified. In house medical provider notified. All parties aware. During an interview with the Director of Nursing on [DATE] at approximately 10:49 AM the DON agreed that the care plan had not been developed and implemented accurately as the resident was a Do Not Resuscitate and the nurses intimated cardiopulmonary resuscitation (CPR) at the time Resident #139 had become unresponsive. During an interview with the Director of Nursing on [DATE] at approximately 10:49 AM the DON agreed that the care plan was not accurate and that the resident was a Do Not Resuscitate. The DON acknowledge the error that had been made as the nurse immediately intimated cardiopulmonary resuscitation (CPR) at the time Resident #139 had become unresponsive. The DON stated they had already identified the issues and had presented this to their Quality Assurance Committee. Education were completed and an audit was completed of the residents POST status with physician order and updated in the residents chart. This education was completed on [DATE]. The education consisted of Code Status Process: Social Worker obtains the POST form, Social Worker scans form into chart, gives form to the assigned nurse, the nurse obtains the order from the provider, then the nurse puts the status order in PCC (point click care). The POST form then goes into the chart.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49467 Based on record review and resident and staff interviews, the facility failed to make orthopedic appointments as directed, provide transportation to appointments, obtain documentation from appointments, and follow directions from those appointments to prevent contractures in Resident #88's left arm and hand following a fall at the facility. The State Agency (SA) determined physical harm was caused to Resident #88 when the resident developed contractures in her upper left arm and hand following a fall at the facility. The failure to schedule a follow up appointment with Resident #88's orthopedic doctor in a timely manner, provide transportation, obtain the documentation sent from the appointments, and follow the recommendations from the appointments, resulted in the resident developing contractures in her left arm and hand. This will be cited at past non-compliance due to the facility identifying and correcting the issue on 08/04/23. The facility also failed to administer anticonvulsant and narcotic pain medications, as ordered by the physician to Resident #105, # 51, #79, #494, #93, #75, #64, #23, #101, #3, #60, #48, #495, #52, #91. This will also be cited as past noncompliance. Resident identifiers: #88, #105, #51, #79, #494, #93, #75, #64, #23, #101, #3, #60, #48, #495, #52, #91. Facility census: 145. Findings include: a) Resident #88 At approximately 1:57 PM on 10/28/2024, an interview was conducted with Resident #88. During the interview, the resident was asked about the range of motion in her left arm, due to a fall suffered in the facility on 05/24/2023. During the interview, Resident #88 stated she had fallen out of bed while a Nurse Aide (NA) was providing care to her. She states she broke her upper arm because of the fall. Resident #88 proceeded to state I have a hard time using my hand now. It ' s hard to use it to eat. At this time, Resident #88 took her left hand out from under her blanket and held it up. Resident #88's left hand was observed to be contracted. At approximately 3:00 PM on 10/29/2024, a review of the Facility reported incidents related to this fall were reviewed. During this review, it was determined the facility did not schedule the follow up appointment for the resident as advised, did not provide transportation to the appointments as needed, and did not ensure all documentation was obtained from the doctor's office, resulting in the resident not getting the treatment she needed, resulting in the development of contractures of her left arm and hand. When the resident went to the orthopedic appoinment on 06/29/24 the facility did not receive follow up information regarding the range of motion exercices recommended by the orthopedist. The facilities narrative of their investigation reads as follows: (continued on next page)

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F 0684

Level of Harm - Actual harm

Residents Affected - Few

On May 24, (Resident #88's name) sustained a fracture of her left humerus because of a fall. (Resident #88's name) returned to the facility the same day with orders to follow up with ortho in 1-2 weeks. The appointment was not made until 06/09/23 for 06/29/23. The facility obtained documentation from that consult with the follow up appointment date only. No consult report was returned to the facility following this appointment. (Resident #88's name) should have had the next follow up appointment with orthopedics on 07/13/23. The facility did not ensure that this appointment was completed for (Resident #88's name) due to failing to ensure transportation was arranged.

On 8/2/23, occupational therapy identified that (Resident #88's name) had contractures noted to left upper extremity and hand. (Resident #88's name) Had an immobilizer ordered but after investigation it was determined that she frequently was non-compliant with allowing the application of the immobilizer. It was further discovered that the initial orthopedics appointment recommendation was made for range of motion exercises. The facility failed to ensure that this consult documentation was received after the appointment on 06/29/24. As a resultand Resident #88 had not been receiving this range of motion.

As a result of the investigation, the facility substantiated neglect as the facility failed to ensure needed follow up for Resident #88.

At approximately 12:00 PM on 10/30/2024, an interview was conducted with the Administrator and Director of Nursing (DON). During the interview, the Administrator and DON acknowledged the facility failed to ensure a follow up for Resident #88 after the fall. The administrator and DON then supplied the plan the facility put into place to correct the issue.

Education was conducted with the person in charge of scheduling appointments (Medical Records Coordinator) for residents, to ensure they were made in a timely manner and they returned with all of the follow up documentation. Education was also completed with the nursing staff. Furthermore, the DON revealed she has implemented a process to ensure all appointments are completed and documentation has returned with the resident. The policy is as follows:

1. Appointments are placed on the communications tab.

2. Nursing checks appointments and reviews them daily in stand up for the day.

3. Nursing reviews appointments in stand-down to ensure our notes and return notes are completed with any follow up.

4. Any appointment that has not returned before stand-down goes onto the next day follow-up sheet.

39043

c) On 06/15/24, the facility reported an incident to the Office of Health Facility Licensure and Certification (OHFLAC) that occurred on 06/14/24 and was discovered on 06/15/24. Licensed Practical Nurse (LPN) #195 had failed to administer bedtime medications for Residents #105, #51, #79, #494, #93, #75, #64, #23, #101, #3, #60, #48, #495, #52, and #91. This was past non-compliance that began on 06/14/24 and ended 06/29/24.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The incident was investigated by the facility. The five (5) day follow-up report submitted to OHFLAC verified the allegation of failure to administer medications. The medications that were identified as not given were anticonvulsants and narcotics. The physicain was contacted and did not order the missed dose to be given. Pain assessments were also done and residents did not appear to have been affected by the missed dose. The written statement by LPN #55 on 06/15/24 stated as follows: On 06/14/24 7p-7a shift I worked with [LPN #195]. She was assigned to B Hall cart. [LPN #55] was unable to log into the computer (PCC) around 5:30 am on 6/15/24. She asked to use my username and password to give her morning meds. I refused and gave her the phone number for IT help in resetting her password. [LPN #55] never reset her password and I realized she did not start morning med pass yet. I asked if she needed help and she gave me her med cart keys and I realized our residents wouldn't have morning meds. Upon starting B Hall med pass I noticed pill packets for 6/14/24 times 2100 and 2200 [9:00 PM and 10:00 PM] unopened on multiple residents. I called the on-call nurse [Registered Nurse #97] and explained the situation. I completed all 6:00 rx [prescription] med pass and reported the situation to the oncoming nurse as well. (Typed as written.) The verbal statement by LPN #195 taken by the Director of Nursing on 06/16/24 stated as follows: I do not know what happened. I thought I gave all of the medications. It was a busy night but uneventful. The physician was notified regarding the omitted medications. The medications were to be given at the next scheduled dose. Change in condition forms with assessments were completed for all residents with omitted medications. All these residents were assessed for adverse consequences, which included vital signs and assessment for pain levels and behaviors. Frequent assessments for these residents continued through 06/18/24. No resident was found to have experienced harm. All medications, including controlled substances, were accounted for. Interviewable residents were interviewed and reported no pain or other adverse consequences. LPN #195's employment was terminated. All other nurses received education on medication administration. The education was completed for all nurses on 06/29/24. The education followed the facility's policy and standard procedure titled Medication Administration, with no implementation given. The education included, but was not limited to, observing the five (5) rights of giving medication, to administer medications within the time frame of one hour before and up to one hour after the time ordered, and documentation of medication within accepted standards of nursing practice. On 10/30/24 at 1:00 PM, the DON was interviewed regarding the matter. She stated the day shift nurse found the evening pill packets in the cart and realized the meds had not been given. LPN #195 was interviewed and stated she thought she had given all the medications. The DON stated LPN #195 had signed out all the omitted medications on the Medication Administration Record (MAR). She stated LPN #195's employment was terminated and she had not worked any shifts at the facility after this incident. The DON stated she was performing daily MAR audits before this incident and the audits continued after this incident. The MAR audits are ongoing. The following nurses were interviewed on 10/30/24 and were able to correctly state five (5) rights of medication administration as well as the time frame for medication administration and the correct documentation for medication administration. - LPN #153 at 12:30 PM (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- LPN #95 at 12:35 PM - LPN #84 at 1:28 PM - LPN #54 at 1:41 PM Resident #105 was interviewed on 10/30/24 at 1:33 PM and had no complaints about medication administration. Resident #23 was interviewed on 10/30/24 at 1:38 PM and no complaints about medication administration. No further information was provided through the completion of the survey.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45173 Based on observation and staff interview, the facility failed to maintain the environment as free of accident hazards as possible. A used razor laying on Resident #53's bathroom sink. This was a random opportunity for discovery. Resident Identifier: #53. Facility Census: 145. Findings Include: a) Resident #53 On 10/28/24 at 11:18 AM, a used razor was observed laying on the bathroom sink in Resident #53's room. On 10/28/24 at 11:20 AM, the Facility Scheduler #19 confirmed the used razor was laying on the bathroom sink. The Facility Scheduler stated, I'll take care of it. On 10/29/24 at 8:58 AM, the Director of Nursing (DON) was notified and confirmed the used razor should not have been left on the bathroom sink.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465 Based on record review, staff interview, and family interview the facility failed to recognize, evaluate, and address the needs of each resident at risk for and experiencing dehydration. This failed practice was found true for (1) of (3) residents reviewed for dehydration during the Long-Term Care Survey Process. Resident identifier #68. Facility Census 145. Findings Include: a) Resident identifier #68 During the initial interview on 10/28/24 at 12:47 PM, Resident #68 stated, I don't drink the water here. I drink coffee with each meal and I eat Ice chips. They don't always bring me my ice chips. They are getting a little better since I had that intravenous (IV) to get fluids. Further record review of Resident #68's diagnoses revealed that Resident #68 was diagnosed with a Urinary Tract Infection (UTI) on 09/06/24 that was resolved on 10/05/24. The Hydration risk evaluation dated 10/09/24 did not indicate that Resident #68 had a history of UTI, which would put her at a higher risk for dehydration. Further record review of Resident #68's diagnosis revealed a diagnosis of depression. The Hydration risk evaluation dated 10/09/24 does not indicate that Resident #68 had depression, which would put her at a higher risk for dehydration. A review of Resident #68's Nutritional Risk assessment dated [DATE] under section F, question 1e. reads that Resident #68' estimated daily fluids are 1750 cubic centimeter (cc). A record review on 10/29/24 at 11:15 AM of Resident #68's progress notes, revealed a nurses note dated 10/01/2024 reads as follows: Received new order to infuse 2 liters of normal saline (NS). Fluid volume depletion. All parties aware Further record review of Resident #68's Dietary Nutritional assessment dated [DATE] under letter I, question 2, reads that resident has no signs of symptoms of dehydration. During an interview on 10/29/24 at 2:00PM, The Director of Nursing (DON) stated, We only put fluids in that they have for their meals. We do not track the fluids they get in between. During an interview on 10/29/24 at 2:10 PM, Licensed Practical Nurse (LPN) #32 stated, She won't drink water. She gets cups of ice and eats them. We give her several a day now. She does get more now then before she had the IV put in for fluids.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 50551 Based on resident interview, staff interview, observation and record review, the facility failed to promptly obtain needed dental services for damaged dentures for Resident #31. The was true for 1 (one) of 3 (three) reviewed for dental needs. Resident identifier #31. Facility census: 145. Finding included: a) Resident #31 An interview on 10/28/24 at 12:10 PM with resident #31 who reported that he had 2 (two) missing teeth from his upper, front dentures due to eating facility's tough meat. Resident's dentures were observed to have missing 2 (two) front teeth. He stated that the facility was aware that his dentures were broken for over a year and had not yet offered to make an appointment to have them repaired. He reported that he was not having difficulty eating but that he did not like the way they looked. b) On 10/29/24 an interview with Medical Records Coordinator #150 reported that nurses would give her a consult assessment when a resident was in need of a dental appointment, and she would follow up with business office for insurance options, schedule appointment and the resident's dentures would be available after payment was received. She reported that she had not received a consultation to schedule dental/denture appointment for Resident # 31 and was not aware that he had broken dentures. c) On 10/29/24 at 11:52 AM, a review of resident's care plan stated that he has dentures and that two teeth are broken off the top plate. Stated no pain or trouble. Provide oral care as needed. Complete oral assessment as needed. Dental consult as needed.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 50551 Based on record review, staff interview and resident interview the facility failed to meet resident's nutritional needs by serving Resident #31 food he was allergic to. This is true for three (3) of 13 residents review for food preferences. Resident identifier: #31, #68, and #10. Facility census: 145. Findings included: a) Resident #31 On 10/28/24 at 12:10 PM an interview with Resident #31 who reported that he was allergic to lemon and the facility continues to serve him lemon products. He reported that some of his dietary cards reflect that he was allergic to lemon and other cards stated that he was allergic to only lemonade. Resident reported that when he consumes lemon products he would break out in hives. b) On 10/28/24 a review of resident's records revealed the following: Resident #31's care plan and medical records reveal that he was allergic to lemon. Resident # 31's dietary cards revealed the that the resident's card stated following and that he was served food containing lemon on these days: 08/19/23- Allergies: Lemon, Lemon Bar 09/13/23- Allergies: Lemonade, Lemon Bar 09/16/23- Allergies: Lemonade, Steamed Broccoli Florets with Lemon-1/2 cup 10/23/24- Allergies: Lemonade, Lemon cake with Lemon Icing c) On 10/30/24 at 10:05 AM an interview with Food Service Director in regards to resident #31's allergies. He reported that the dietary cards were made from a 3rd party company that take meal tracker data from Point Click Care to develop each resident's meals. He acknowledged that some dietary cards stated allergy to lemon and some showed the allergy to be lemonade. He also acknowledged that the resident's meal cards for the following dates showed the resident was served lemon products: 08/19/23- Allergies: Lemon, Lemon Bar 09/13/23- Allergies: Lemonade, Lemon Bar 09/16/23- Allergies: Lemonade, Steamed Broccoli Florets with Lemon-1/2 cup 10/23/24- Allergies: Lemonade, Lemon cake with Lemon Icing (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Resident #68 During an interview on 10/30/24 at 10:40 AM, Resident #68 stated, I am allergic to eggs. They still send them to me. Sometimes the Nurses take them off my tray. Here is my ticket from breakfast. An observation on 10/30/24 at 10:40 AM, revealed a breakfast meal ticket for Resident #68 in bold red letters: Allergies: egg. Below the red print it reads what the resident received for breakfast which was: baked cheese omelet, sausage patty, cold cereal, English muffin, jelly and margarine. A record review on 10/30/24 at 11:00 PM, of resident # 68's allergies revealed that she did have an allergy to eggs. During an interview on 10/30/24 at 11:15 AM, Resident #68 stated, Well I can eat eggs in stuff, but I just don't eat them whole because it makes my stomach cramp. I have always taken the flu shot and it does not bother me. During an interview on 10/30/24 at 11:30 AM, The Corporate Dietary Manager stated, We found the issue. It isn't pulling over to our meal tracker. We are working on the problem. If the kitchen staff see an allergy to eggs on her meal ticket, they do not send her eggs. During an interview on 10/30/24 at 11:40 AM, Nursing Assistant (NA)#30 stated, There have been eggs on the resident tray before and I just took them off. c) Resident #10 On 10/28/24 at 12:10 PM Resident #10 stated she does not like eggs and they keep sending eggs. On 10/29/24 at 8:50 AM record review of two (2) Dietary History/Food Preferences, one dated 09/25/25 and the other dated 10/24/25 both have Resident #10's dislikes listed as egg, chicken and fish. Review of Resident #10's meal tickets for the following dates show her menu for the day included eggs, chicken or fish. 10/26/24 breakfast: baked cheese omelet dinner: breaded fish on a bun 10/27/24 breakfast: scrambled eggs lunch: chicken Alfredo dinner: BBQ chicken thigh 10/29/24 (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakfast: scrambled eggs with cheese dinner: BBQ chicken thigh The above findings were confirmed with the Director of Nursing on 10/29/24 at 11:54 AM.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50551 Based on record review and staff interview, the facility failed to ensure resident's diet was followed per physician's orders for Resident #122. This is true for 1(one) of 13 residents reviewed for food. Resident identifier #122. Facility Census 145. Findings included: a) A review of incident report, investigation and five day-follow-up that occurred on 06/16/24 for resident #122 revealed the following: Resident # 122 was found in her room with chopped up fruit in her bed by Nurses Aide. The resident's brother later reported to the nurse that he had resident #122 laughing and spitting up chunks of fruit. There was a spoon and empty fruit cup in the floor beside her bed on 06/16/24. There were (3) three witness statements collected. That of the Nursed Aide and Licensed Practical Nurse #52 who found fruit and spoon but did not know how resident obtained it. The Assistant [NAME] was the last witness statement obtained and it was reported that a nurse called and asked for scrambled eggs for resident #122 on 06/17/24 and she made them without checking the resident's diet card. The facility did not substantiate the allegation per five-day-follow-up. No further documentation was provided. b) A review of resident's records on 10/30/24 at 12:05 PM revealed the following: Diagnosis List in Point Click Care- Resident # 122 had a diagnosis of hemiplegia and hemiparesis following cerebral infarction, aphasia, dysphasia requiring feeding tube, apraxia following cerebral infarction. Physician's orders- Start date 1/08/24- Nothing By Mouth (NPO) diet, NPO texture, NPO Consistenency for diet type Start date 6/17/24, Puree texture, thin liquids consistency, pleasure tray diet type Nurses Notes- 6/16/2024 6:00 pm: Physician order not followed related to diet. All parties aware. Nurses Note 6/17/2024 12:17 pm: New order obtained per speech therapy, upgrade diet ro pureed texture, thin liquids for pleasure feeding. All parties aware. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) During an interview on 10/30/24 at 1:30 PM, the Director of Nursing (DON) stated, The investigation was pertaining to the fruit. We did not substantiate it because we feel her brother brought in the fruit. No staff said that they brought in the fruit. She did not get the eggs. [NAME] the nurse called down and got eggs for another resident. The statement from kitchen came in to play because we just called the kitchen and said did anyone call down and get extra food and they said [NAME] did for (resident #122). The kitchen had the person mixed up. [NAME] is not working today. If you need her number I can get it for you.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51554 Based on observatio and staff interview the facility failed to ensure they, prepared and served food under sanitary conditions. This has the potential to affect all residents of the facility who received an oral diet. Facility census:145. Findings included: a) During an observation of the lunch meal service in dining Room EB1 10/28/24, Resident # 90 had an egg sandwich. She took a bite and bit down onto a piece of foil which was inside the sandwich. During an interview with Dietary Director #20, he acknowledged the piece of foil and stated he would find out how it happened to be in her sandwich. During an observation of dining room EB2 lunch service on 10/29/24, there were three (3) beverage serving containers on a cart. These were being used to serve drinks to residents during the lunch service. These three containers were not labeled or dated for expiration. The outside of the containers did not appear to be clean. During an interview with Dietary Director #20, he identified the beverages as tea, fruit juice and punch. He acknowledged the containers should be labeled and dated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45173 Based on record review and staff interview, the facility failed to maintain a complete and accurate record regarding Resident #34's assistance for meals and Resident #75's diagnosis of anxiety. This was true for two (2) of 41 residents reviewed during the survey process. Resident identifiers: #34 and #75. Facility Census: 145. Findings Include: a) Resident #34 On [DATE] at 12:02 PM, a record review was completed for Resident #34. The review found the resident was ordered nothing by mouth (NPO) and received a tube feeding for nutrition which was Jevity 1.5 83ml (milliliters)/hr (hour) for 17 hours. The resident was noted to be dependent for all meal and fluid intake. The review, also, found documentation on the September, 2024 and October, 2024 medication administration record (MAR) indicating the resident was independent, set up only, one (1) person physical assistance and two (2) + (plus) persons physical assist. The September, 2024 MAR indicated 28 times, the resident ranged from independent to 2+ persons physical assistance. The October, 2024 MAR indicated 42 times, the resident ranged from independent to 2+ persons physical assistance. On [DATE] at 1:05 PM, the Director of Nursing (DON) was notified. The DON confirmed the resident was dependent for all meals; and, did receive all nutrition and fluid intake via tube feeding. 49650 b) Resident #75 During a medical record review on [DATE] at approximately 1:27 PM PM for Resident #75, it is identified the resident was care planned to have anxiety. It was further identifeid that the resident had an order for anxiety side effect monitoring and an order for Buspirone hcl oral tablet 10 mg to be given 2 (two) times a day for anxiety. A review of the physician diagnoses did not identify a diagnosis of anxiety. During an interview with the Director of Nursing (DON), on [DATE] at approximately 2:00 PM, the DON agreed that the resident should have a diagnosis of anxiety. b) Resident #139 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medical record rive for resident #139 on [DATE] at approximately 09:45 AM it was identified that the resident had capacity and had completed the [NAME] Virginia Post Orders to Health Care (POST) form on [DATE] which identifies the following: Section A) Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing. NO CPR: Do not attempt Resuscitation During a review of the care plan it was identified that the care plan indicated the resident was a full code and was initiated on [DATE]. Further review of the medical record muses notes it is identified that on [DATE] Registered Nurse (RN) #49 documented on [DATE] at 9:30 PM that Resident #139 became unresponsive with no pulse or respirations. RN #49 states that the high quality CPR was imitated at that time. The following sequence of events was identified in RN #49's notes on [DATE] at 09:30 PM, typed as written; 2051: Ambu bag with supplemental oxygen applied. 2052: AED (Automated External Defibrillator) applied. 2055: AD performed a rhythm check, no shock advised. High quality CPR resumed. 2058: Pulse/rhythm check performed, no pulse palpated. No shock advised. High quality CPR resumed; 2059: Peripheral IV access attempted and unsuccessful. 2101: EMS arrived on scene. Pulse/rhythm check performed. No pulse palpated. No shock advised. High quality CPR resumed with EMS taking the lead. 2103: The residents daughter/MPOA notified of the change in condition. 2104: Pulse/rhythm check performed. No pulse palpated. No shock advised. High quality CPR resumed. 2105: Intraosseous access obtained by EMS. 2107: Pulse/rhythm check performed. No pulse palpated. No shock advised. High quality CPR resumed. 2109: EMS charge paramedic confirmed with daughter to end life saving measures. 2114: EMS conferred with their physician (physician name noted) and determined the time of death is 2114. 2145: The residents family arrived at the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On call nurse manager/DON notified. On call medical provider notified. In house medical provider notified. All parties aware. During an interview with the Director of Nursing on [DATE] at approximately 10:49 AM the DON agreed that the care plan did not match the resident's POST form.

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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. 39043 Based on observation and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. These were random opportunities that had the potential to affect more than a limited number of residents. Resident identifiers: #132 and #130. Facility census: 145. Findings included: a) On 10/30/24 at 10:02 AM an inspection of the laundry room was made with the Assistant Executive Director accompanying the survey. In the dirty area of the laundry room, where dirty laundry was brought and sorted, five (5) mop heads were noted to hanging on hooks. Laundry room worker #176 stated the mop heads were clean. She stated they could not go into the dryer so they had been hung there to dry after washing. She stated she realized clean items should not be drying in the dirty laundry area, but that she did not have anywhere else to hang them. 45173 b) Resident #132 On 10/30/24 at 8:55 AM, an observation of Licensed Practical Nurse (LPN) #153 was made during medication administration for Resident #132. LPN #153 dropped four (4) pills on the medication cart with no barrier in place. The medication dropped was Eliquis (blood thinner), Losartan Potassium (high blood pressure, and two (2) Lasix (diuretic) pills. At this time, LPN #153 went to the medication room to retrieve the new medication. On 10/30/24 at 9:05 AM, LPN #153 returned to the medication cart and dropped one (1) of the Lasix pills on the barrier; however, LPN #153 picked the pill up with a bare hand and placed the pill in the medication cup. After Surveyor intervention, LPN #153 stated, I didn't realize I did that .I'll get some new medication to replace these. On 10/30/24 at 9:08 AM, Unit Manager (UM) #148 was notified. UM #148 stated, okay .thank you for letting me know. On 10/30/24 at approximately 2:30 PM, the Director of Nursing (DON) was notified. The DON stated, I'm sure she was nervous .but she shouldn't have picked up the pill with her bare hand. 49650 c) Resident #130 During a tour of the facility on 10/28/24 at 11:35 AM it was identified that Resident #130's breathing treatment with mouth piece was observed to be still connected to oxygen and laying on the bedside chair without a protective barrier for infection control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Registered Nurse RN #158 on 10/28/24 at 11:40 PM, RN #158 stated that the respiratory therapist had just been in there and turned off the treatment. Stated that the therapist should have placed the mouth piece back inside the bag.