STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515120	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Oaks Healthcare Center	100 Parkway Drive Clarksburg, WV 26301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on observation, resident interview, and staff interview, the facility failed to protect and promote a dignified dining experience and failed to answer a resident's call light on a timely basis. These were random opportunities for discovery. Resident identifiers: #24, #71, #37, #45, #68, #27, #42, and #51. Facility census: 107. Findings included: a) During an interview on 12/03/24 at 10:30 AM, Residents #24 and Resident #31 reported that they had gone to the dining room for their Thanksgiving meal. They reported that one of the more confused residents from the 400 hall, Resident #45, had a soiled brief in her lap as she wheeled into the dining room. Resident #45 reportedly lifted the soiled brief, spread it on the table in front of her, and started playing in the feces as though she was finger painting. Both residents reported two activity aides were in the room but failed to do anything to intervene. They reported that Resident #71 went to the [NAME] hallway to ask staff to address it, and was told, Hey, that's not our problem. When asked what they thought that meant, both residents reported that Resident #45 was a resident on the [NAME] Fort 400 Hallway and the [NAME] hallway staff expected the other unit to handle the problem. After that, Resident #31 wheeled herself down the [NAME] Fort 400 hallway and was successful in finding CNA #83 who agreed to help and accompanied the resident to the dining room to take care of Resident #45. Both residents reported that they recalled Resident #37 was also in the dining room. During an interview on 12/04/24 at 11:30 AM, Resident #71 reported she recalled being in the dining room when the above-mentioned incident happened during the Thanksgiving meal. She reported she went to the [NAME] hallway to ask for staff assistance and was told, Hey, that's not our problem. She wheeled herself back into the dining room and reported she had not been successful in getting a staff member to help. That was when Resident #31 left to go get help from the 400 hallway. Resident #71 reported that there were two (2) activity staff in the room but that they did not intervene in any way. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 12/04/24 at 12:42 PM, CNA #83 confirmed that Resident #31 had come and asked for her assistance in the dining room during the Thanksgiving meal. CNA #83 reported as she entered the dining room, Resident #45 had the dirty brief on the table and was playing in the feces. CNA #83 reported two activity staff members (#49 and #92) were present and sitting at the first table when she entered the room. Additionally, CNA #83 reported that CNA #10 assisted in helping clean Resident #45 up in the bathroom once they were back on the 400 hall. It was at this time that they identified Resident #45 had a brief on and that they could not be sure WHOSE dirty brief Resident #45 had been playing in while in the dining room. During an interview on 12/09/24 at 3:18 PM, Resident #37 confirmed her presence in the dining room during the Thanksgiving meal when the incident occurred. A subsequent record review found that Resident #31, Resident #24, Resident #71 and Resident #37 were all cognitively intact and would be able to accurately recall the events in the dining room and the fact that it did not provide a dignified dining experience to anyone that was present. The record review also determined that Resident #45 had severely impaired cognitive function. Using a reasonable person concept, one could determine that the facility failed to protect Resident #45's dignity when staff did not immediately intervene when she began playing in the dirty brief in a public setting. 49467 b) Overflow Dining Room Lunch Service At approximately 12:00 PM on 12/02/2024, during meal service observation in the lounge (which is used as the overflow dining room), all residents eating lunch in the overflow dining room had their plates and drinks placed on serving trays, and were eating their meals off of the serving trays, as the staff did not remove the items after serving the residents. At approximately 12:05 PM on 12/02/2024, an interview was conducted with Nurse Aide (NA) #73. NA #73 was asked if the residents regularly ate off of the serving trays in the overflow dining room, to which she replied Yes, it 's like this every day. 45171 c) Observations on 12/03/24 at 11:48 AM revealed the following residents were sitting at the large table: Resident #16, #101, #50, #74, #30, #40, #23, #76, #42, and #27. Resident #16 was eating her lunch meal. No other residents at the table had their food yet. Beginning at 12:10 PM, the lunch meal was delivered to Resident # 's 101, #50, #74, #30, #40, #23 and #76. Resident #42 was crying and asking for food. She was crying and saying, I want some food, please give me some food She did not receive her meal until 12:30 PM. Resident #27 was sitting at the end of the table with her arms crossed and head down. At 12:20 PM, she asked why she did not receive her food. Her meal tray was served at 12:30 PM. These issues were discussed with the Administrator on 12/03/24 at 2:10 PM. 50795 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d) Resident #68 During an interview on 12/03/24, at approximately 9:35 AM, Resident #68 reported experiencing an upset stomach and diarrhea. At around 9:38 AM, she used her call light to request assistance. Nursing Assistant (NA) #41 responded at approximately 9:57 AM. When interviewed, NA #41 explained that there were 32 rooms in the hallway and that all the NAs were occupied providing care. In a further interview with Licensed Practical Nurse (LPN) #14 on 12/03/24, at approximately 11:30 AM, LPN #14 stated that the NA coverage was adequate, as four (4) NAs were assigned to the hallway. Additionally, during interviews with Resident #47 and Resident #13, both indicated that the response time for assistance could be as long as 30 minutes. Resident #47 mentioned that he was fortunate to have a catheter; otherwise, he would not have been able to avoid soiling his bed.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 Based on record review and staff interviews, the facility failed to honor the residents right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility was changed. Resident identifier: #90 and #39. Facility census: 107. Findings included: a) Resident #39 A review of Resident #39's medical record found he was transferred from room [ROOM NUMBER] to room [ROOM NUMBER] on 11/16/24. No written notice was given prior to the room move. b) Resident #90 A review of Resident #90's medical record found he was transferred from room [ROOM NUMBER] to room [ROOM NUMBER] on 11/29/24. No written notice was given prior to the room move. During an interview on 12/5/24 at 11:20 AM the Social Worker confirmed no written notice was given to Resident #39 or #90 prior to them being transferred to different rooms.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on record review and resident and staff interviews, the facility failed to ensure Resident #32 received showers in accordance with her preferences. This was true for one (1) of six (6) residents reviewed for Activities of Daily Living (ADLs) during the survey process. Resident identifier: 32. Facility census: 107. Findings include: a) Resident #32 At approximately 3:30 PM on 12/02/2024, an interview was conducted with Resident #32. During the interview, the resident stated Sometimes you have to [NAME] them before they will give you a shower, and even then, I don't get showers when I want them so, sometimes, I just tell them I don't want them. At approximately 10:00 AM on 12/04/2024, a review of Resident #32's record revealed she had refused showers on 11/20/2024 at 6:59 AM, 11/27/24 at 6:59 AM, 11/28/2024 at 10:16 PM, and 12/06/2024 at 6:59 AM, according to the bathing task sheet for the past thirty (30) days. A review of the progress notes for these days do not indicate a reason for refusals. At approximately 3:55 PM on 12/09/2024, an interview was conducted with Resident #32 regarding her refusals. Resident #32 has a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated she was cognitively intact, and has been deemed capacitated by a physician. During the interview, the resident recalled refusing showers on 11/20/2024, 11/27/2024, and 12/06/2024, stating It 's too cold of the mornings and if I take a shower then, when I leave for dialysis my hair will be wet, and I'll have to go out in the cold with wet hair, I don't want that. Resident #32 then recalled refusing her shower on 11/28/2024 stating, It was too late to take one then. Who wants to take a shower late at night? I have told them before, I want to take showers in the afternoons and I want to take an extra shower on Sundays so I will be clean when I leave for dialysis on Mondays. So, I should be getting showers on Sunday, Tuesday, and Thursday. Resident #32 was asked if she had voiced her preferences for showers to staff and she stated I have, I have told my nurses and aides but nothing has ever changed. Resident #32 is currently scheduled for showers on Tuesdays and Thursdays for the facility's night shift, which runs from 7:00 PM through 7:00 AM. At approximately 10:00 AM on 12/10/2024, an interview was conducted with Nurse Aide (NA) #73 at the nurses station. During the interview, all present staff were asked if Resident #32 had ever expressed interest in switching her shower times from night shift to day shift. NA #73 spoke up and stated Yes, she has told me and I have heard her tell other staff members as well.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 50801]Based on record review, resident interviews, and staff interviews, the facility failed to ensure resident council grievances, issues, and concerns were acted upon promptly and provide a rational response. This had the potential to affect more than an isolated number of residents. Facility census: 107. Findings included: a) On 12/03/24 Resident Council minutes were received upon entry. It was noted that concerns and issues were brought up at the meetings but these previous grievances, concerns, and issues were not listed in the minutes. Review of the Resident Council minutes revealed the following: All Grievances, concerns, and issues are documented and given to the appropriate manager to complete and then they are given to the Administrator to file. During the resident council meeting with the resident council president and 3 others on 12/04/2024 at 10 AM, the council president stated the activities coordinator writes down the issues and concerns, but nothing is ever done and they do not get any feedback in future meetings. During an interview with the activities coordinator on 12/03/2024 at approximately 11:45 AM, She stated she lists the concerns and issues from the meeting and passes them on to the Nursing Home Administrator. They are not typed into the meeting minutes. During an interview with the Nursing Home Administrator on 12/03/2024 at approximately 2:30pm, the surveyor requested copies of the documented grievances, concerns and issues. On 12/04/2024, at 9:45 AM, during an interview with the NH Administrator he said the statement on the minutes was a general statement and that the grievances were given to the appropriate department managers. He did not have them but said he would look for them. On 12/5/2024 at approximately 1:30 PM during a follow up interview with the administrator, he stated that he could not locate the concerns, issues, and grievances from past or present resident council meetings. During a resident council meeting, on 12/03/24 at 10:00 AM, Residents #31, #37, #70, and #80 confirmed that during every resident council meeting over the last several months the request has been made to have the Soup of the Day placed back on the menu. They reported never hearing back about their request. During an interview on 12/04/24 at 10:09 AM, Resident #71 also reported that she has requested to have the Soup of the Day placed back on the menu but never heard back about her request. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A subsequent review of the facility's grievance log did not reveal Resident #24, Resident #31, Resident #37, Resident #70, Resident #80, and Resident #71's concerns had been recorded on facility grievance forms. Each resident's medical chart reflected that the resident was cognitively intact and would be able to accurately remember such details clearly. During an interview on 12/04/24 at 11:44, the Administrator reported that he was not aware of the residents' request to have the Soup of the Day put back on the menu. The Administrator reported it had never come up during the time he was part of the resident council meeting, noting that he only attends a small portion of the meeting. The Administrator also confirmed there was no written grievance regarding the requests.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 43340 Based on observation and staff interview, the facility failed to secure and keep confidential residents' medical information. The facility failed to safeguard private information that was placed in a clear acrylic wall file holder located outside of the medical records office. This was a random opportunity for discovery. Resident identifiers: #305, #155, #357, #30, #308, #28, and #100. Facility census: 107 Findings included: a) An observation on 12/02/24 at 11:40 AM revealed diagnosis sheets and mini nutritional assessments placed in an acrylic wall file holder outside the Medical Records office. There were diagnosis sheets for Resident #305, Resident #155, Resident #357, Resident #30, Resident #308, and Resident #28. Additionally, there were mini nutritional assessments for Resident #28 and Resident #100. All the forms had been printed by Minimum Data Set (MDS) RN #55. During an interview on 12/02/24 at 11:50 AM, the Medical Records Coordinator #17 confirmed the diagnosis sheets and mini nutritional assessments were accessible to any passerby and had confidential information on them.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43340 Based on observation and staff interview, the facility failed to provide a safe, clean, comfortable, and homelike environment. The facility failed to keep the dining room temperature at a comfortable temperature level. This was a random opportunity for discovery and had the potential to affect more than an isolated number of residents Residenti Identifiers: #45, #95, #37, and #8. Facility census: 107. Findings included: a) An Observation, on 12/03/24 at 11:30, identified the following: -Resident #45 shivered and stated she was cold. The Activities Director left the dining room to obtain a sweater for the resident. -Resident #95 stated, Wow, I'm cold. -Resident #37 was wearing a sweatshirt and a wrap around her shoulders. The resident also had a folded blanket on the back of her wheelchair. She smiled and stated, I came prepared. -Resident #8 had a blanket wrapped around her. Surveyor requested that a maintenance staff member come to the dining room to test the temperature to see if it met the minimum of 71 degrees Fahrenheit. The Maintenance Director took the temperature in the dining room on 12/03/24 at 11:37 AM. The ambient temperature was found to be 65.5 degrees Fahrenheit. He then checked to see if the air conditioner was on. The Maintenance Director said, Sometimes staff turn it on because they are running hot.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 43340 Based on resident interview, record review, and staff interview, the facility failed to make prompt efforts to resolve verbal grievances. The facility failed to act on verbal grievances related to bringing back the Soup of the Day to the menu and failed to act on a verbal grievance regarding burnt food, gnats, and food not being removed from the resident's room for three (3) days. Additionally, the facility failed to act on a verbal grievance regarding a resident's missing personal property. Resident identifiers: #24, #71, #31, #37, #70, #80, #29, and #32. Facility census: 107. Findings included: a) Soup of the Day During an interview on 12/02/24 at 11:34 AM, Resident #24 stated that residents, including herself, requested that the Soup of the Day be put back on the menu at every resident council meeting but the residents never heard back about their request. She stated the only soup that was available to residents was tomato soup and many people were sick of having it. During a resident council meeting, on 12/03/24 at 10:00 AM, Residents #31, #37, #70, and #80 confirmed that during every resident council meeting over the last several months the request has been made to have the Soup of the Day placed back on the menu. They reported never hearing back about their request. During an interview on 12/04/24 at 10:09 AM, Resident #71 also reported that she has requested to have the Soup of the Day placed back on the menu but never heard back about her request. A subsequent review of the facility's grievance log did not reveal Resident #24, Resident #31, Resident #37, Resident #70, Resident #80, and Resident #71's concerns had been recorded on facility grievance forms. Each resident's medical chart reflected that the resident was cognitively intact and would be able to accurately remember such details clearly. During an interview on 12/04/24 at 11:44, the Administrator reported that he was not aware of the residents' request to have the Soup of the Day put back on the menu. The Administrator reported it had never come up during the time he was part of the resident council meeting, noting that he only attends a small portion of the meeting. The Administrator also confirmed there was no written grievance regarding the requests. b) Resident #29 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/04/24 at 11:05 AM, Resident #29 reported she had resorted to killing the gnats in her room (on the 400 hall) with a fly swatter. Resident #29 also stated she had met with the Administrator to discuss the gnats as well as her dissatisfaction with burnt food on her dinner tray, the fact that the garbage in her room had not been taken out for three (3) days, and that she had resorted to bagging it up herself and placing it in the hallway. The resident stated she never received verbal or written follow-up from the Administrator regarding her concerns. A subsequent review of the facility's grievance log did not reveal Resident #29's concerns had been recorded on a facility grievance form. Resident #29's medical record reflected that she was cognitively intact and would be able to remember such details clearly. During an interview on 12/04/24 at 11:09 AM, the Administrator stated that he and Resident #29 talk pretty routinely and that the housekeeping concern does register with me. The Administrator could produce no grievance form noting the resident's concerns and could produce no evidence the issues had been addressed. 49467 b) Resident #32 At approximately 3:30 PM on 12/02/2024, an interview was conducted with Resident #32. During the interview, Resident #32 stated she has shirts and other clothing items missing. The resident stated she told housekeeping and laundry staff she had missing items but they were never found, nor were her concerns followed up on by the facility. A review of the facility's grievance and concern log was conducted and no grievances were noted regarding missing items for Resident #32. At approximately 11:55 AM on 12/04/2024, an interview was conducted with Housekeeper #106. Housekeeper #106 confirmed Resident #32 had brought concerns about missing items to her attention on multiple occasions. Housekeeper #106 confirmed she never filled out grievance forms, nor did she forward the concerns on to anyone else at the facility.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 43340 Based on record review and staff interview, the facility failed to ensure the resident's Pre-Admission Screening (PAS) reflected pre-admission diagnoses. This was true for one (1) out of two (2) residents reviewed for the category of PASARR (Pre-Admission Screening and Record Review, during the Long-Term Care Survey Process. Resident identifier #52. Facility census: 107. Findings included: a) Resident #52 A medical record review, completed on 12/04/24 at 8:48 AM, revealed Resident #52 had the following diagnoses: -A Major Depression Disorder diagnosis -An Epilepsy diagnosis A PAS, completed on 05/20/21, marked NONE under Section III Question 30 entitled, Current Diagnosis (Check all that apply). Addionally, Section V Question 40 entitled, Major Mental Illness (MI) or Suspected MI only listed major depression. During an interview on 12/04/24 at 9:15 AM, the Director of Social Services reported that resident's Epilepsy diagnosis had not been captured on the PAS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49467 Based on record review and staff interview, the facility failed to follow the care plan of Resident #66 by failing to monitor for behaviors, and to include Resident #33 's history of physical aggression with other residents into her care plan. This was true for three (3) of 54 care plans reviewed during the survey process. Resident identifiers: #66, #33, and #68. Facility cesus: 107. Findings include: A) Resident #66 At approximately 11:00 AM on 12/04/2024, a review of Resident #66's care plan was conducted. Resident #66 had orders for behavior monitoring. Behaviors included being tearful, refusal of care, self isolation, aggressiveness, calling out. This was also included on the resident's care plan. According to the Medication Administration Record (MAR), where the facility monitors for behaviors, behaviors were not monitored on 10/18/2024, 11/05/2024, and 11/16/2024. At approximately 2:30 PM on 12/10/2024, an interview was conducted with the Director of Nursing (DON). During the interview, the DON confirmed behaviors were not monitored on those dates. 43340 b) Resident #33 A record review completed on 12/10/24 at 9:44 AM, revealed the following details regarding a resident-to-resident altercation: -The resident-to-resident incident occurred on 11/07/24 at 7:00 AM. -The incident occurred in the resident's room. -Description of incident: Resident #33 was seen grabbing a foot rest from a wheelchair and hitting her roommate (Resident #16) in the left arm. Resident #16 had a bruise to the left wrist and outer left forearm. -Review of Resident #33's care plan did not reflect a history of resident-to-resident physically aggressive behaviors. During an interview on 12/10/24 at 10:40 AM, the Director of Nursing confirmed that Resident #33's care plan had not been updated to include a history of physically aggressive behaviors toward other residents. 50795 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c) Resident #68 On 12/02/24, at approximately 9:29 AM, during an interview with Resident #68, she responded to questions about her vision by stating that she was unable to see anyone clearly and could only see shadows. Although the resident was able to locate her call light, which she had placed under her pillow, she was unaware of the location of items on her bedside table. Furthermore, she mentioned that she enjoys listening to music but does not participate in activities due to her vision problems. During an interview with Social Worker #30 on 12/04/24, at approximately 10:18 AM, the social worker stated that Resident #68 has a care plan in place for her impaired vision. The social worker also mentioned that the resident is encouraged to participate in various activities, including music programs, entertainment, bands, church services, snacks, socializing, listening to television, playing word games, and having stories read to her due to her blindness. A review of Resident #68's care plan revealed the following: **FOCUS** The resident has impaired visual function due to being legally blind. **Date Initiated:** 01/24/2023 **Last Revision:** 01/12/2024 **INTERVENTIONS/TASKS** 1. Arrange a consultation with an eye care practitioner as needed. **Date Initiated:** 01/24/2023 2. Organize the resident's room and personal items to promote independence and safety. **Date Initiated:** 01/24/2023 3. Observe, document, and report any acute eye problems to the medical provider. **Date Initiated:** 01/24/2023 4. During room visits and one-on-one sensory interactions, check the floor in the resident's room for any obstacles that could contribute to falls due to her visual impairment. **Date Initiated:** 09/20/2024 **Last Revision:** 10/23/2024 A detailed review of Resident #68's care plan revealed that it did not include specific interventions. For example, it lacked guidance on how to arrange and place food on meal trays, as well as how to organize belongings and frequently used items for easy access. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, from 12/02/24, to 12/05/24, Resident #68 was observed in bed, listening to the television. During this time, the resident did not participate in any activities and was not engaged by staff, who did not read to her or involve her in any word games.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45171 Based on medical record review and staff interview, the facility failed to revise the comprehensive care plan in the area of showers, wound care and turning and repositioning. Resident identifiers: #20, #22, #58, #72 and #92. Facility census: 107. Findings include: a) Resident #20 On 12/03/24 at 11:11 AM Resident #20 states he prefers a shower over a bed bath but does not get his showers as ordered. According to the shower schedule provided by the facility Resident #20 should receive his showers on the evening shift every Wednesday and Saturday. On 12/05/24 at 1:00 PM review of the comprehensive care plan under the focus of Activities of Daily Living (ADL) is not resident specific in relation to specifying Resident #20's choice for a shower versus a bed bath. In addition, the care plan does not relay that Resident #20 has refusals for a shower in the past. Review of the task for showers/baths for the last thirty (30) days show Resident #20 has refused a shower three (3) times on 11/10/24, 12/01/24 and 12/05/24. On 12/05/24 at 2:10 PM Nurse Aide # 62 confirmed Resident #20 prefers showers over baths. On 12/05/24 at 2:20 PM the above information was confirmed with the Director of Nursing who agreed the care plan should be revised to reflect Resident #20's choice of a shower. b) Resident #58 On 12/03/24 at 10:01 AM Resident #58 states he prefers a shower over a bed bath but does not get his showers as ordered. According to the shower schedule provided by the facility Resident #58 should receive showers on day shift every Monday and Friday. On 12/05/24 at 1:10 PM review of the comprehensive care plan under the focus of Activities of Daily Living (ADL) is not resident specific in relation to specifying Resident #58's choice for a shower versus a bed bath. On 12/05/24 at 2:10 PM Certified Nurse Aide #62 confirmed Resident #58 prefered showers over baths. On 12/05/24 at 2:20 PM the above information was confirmed with the Director of Nursing who agreed the care plan should be revised to reflect Resident #58's choice of a shower. c) Resident #92 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/03/24 at 9:57 AM Resident #92 states he prefers a shower over a bed bath but does not get his showers as ordered. According to the shower schedule provided by the facility Resident #92 should receive his showers on evening shift every Tuesday and Friday. On 12/05/24 at 1:10 PM review of the comprehensive care plan under the focus of Activities of Daily Living (ADL) is not resident specific in relation to specifying Resident #92's choice for a shower versus a bed bath. The care plan does not reflect what level of care Resident #92 is for a shower/bath. In addition, the care plan does not reflect Resident #92 has refusals for a shower in the past. Review of the task for showers/baths for the last thirty (30) days show Resident #92 has refused his shower two (2) times on 11/20/24 and 11/23/24. On 12/05/24 at 2:10 PM Certified Nurse Aide #62 confirmed Resident #92 prefers showers over baths and does refuse at times. On 12/05/24 at 2:20 PM the above information was confirmed with the Director of Nursing who agreed the care plan should be revised for reflect Resident #92's choice of a shower, his level of assistance for showers/baths and refusals of showers. d) Resident #22 On 12/02/24 at 8:24 AM observation shows Resident #22 was on a speciality mattress. The facility matrix revealed she has a Stage IV pressure. On 12/03/24 at 10:00 AM record review reflects Resident #22 has an active order dated 11/12/24 for: 1) Wound care: Monitor stage IV pressure injury to sacrum. Notify medical providers of presence of complications (e.g increased redness, swelling, drainage, abnormal odor, new or worsening pain/discomfort every shift. 2) Wound Care: Cleanse stage IV pressure ulcer to sacrum with wound cleanser, pat dry, apply collagen particles to wound bed, cover with bordered foam every day shift. On 12/04/24 at 10:10 AM it was observed and confirmed with Licensed Practical Nurse #26 that Resident #22 does have a Stage IV pressure ulcer to her sacrum. Review of Resident #22's care plan found under the focus of skin integrity it identifies skin tears, unstagable to the left ear and unstagable pressure ulcer to the sacrum. It does not identify the stage IV pressure ulcer that she has on her sacrum nor does it identify interventions or tasks for wound care. On 12/03/24 at 1:34 PM the above was confirmed with the Regional Director of Clinical Operations #400 who agreed the care plan is not current and needs revised to reflect the above information. e) Resident #72 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/05/24 at 2:18 PM observation and record review identified Resident #72 has a stage III pressure ulcer to her left back. Current orders for wound care to her back are: 1) WOUND CARE: Monitor Stage 3 pressure injury to thoracic spine. Notify medical provider if presence of complications (e.g. increased redness, swelling, drainage, abnormal odor, new or worsening pain/discomfort. WOUND CARE: Cleanse Stage 3 pressure injury to left back with wound cleanser, apply hydrogel with silver to wound bed, cover with bordered gauze. Resident #72 is non-verbal and immobile. She has contractures and can not roll herself from side to side. On 12/05/24 at 3:10 PM record review of Resident #72's care plan shows there are no interventions or tasks for turning and repositioning the resident to prevent worsening of the stage III pressure ulcer to her back. On 12/05/24 at 3:20 PM during an interview with Certified Nurse Aide (CNA) #10 and CNA #61 they stated they do not routinely have a place to chart for turning but they do turn some residents. CNA #10 identified Resident #72 as a resident that she turns from side to side. Further record review shows a charting task for rolling left and right for this resident. According to the Director of Nursing in an interview on 12/05/24 at 4:00 PM it is standard practice of nursing care to prevent a new or worsening pressure ulcer, an immobile resident should be turned from side to side to the back every two (2) hours. She also confirmed the care plan should reflect the turning and repositioning under the skin integrity focus.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 45171 Based on resident and staff interviews and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living (showers) to maintain good grooming, and personal hygiene. This was true for two (2) of four (4) records reviewed for showers. Resident Identifiers: #58 and #92. Facility Census: 107. Findings Include: a) Resident #58 On 12/03/24 at 10:01 AM Resident #58 states he prefers a shower over a bed bath but does not get his showers as ordered. According to the shower schedule provided by the facility Resident #58 should receive his showers on day shift every Monday and Friday. On 12/05/24 at 1:10 PM record review of showers given for the last thirty (30) days shows Resident #58 had eight (8) opportunities for a shower. He received five (5) of the eight (8) showers. There were no refusals documented. The care plan was reviewed and Resident #58 is not care planned for a history of refusing showers. According to the schedule he was scheduled a shower on the following dates: 11/11/24 11/15/24 11/18/24 11/22/24 11/25/24 11/29/24 12/02/24 12/06/24 He received a shower on the following dates: 11/15/24 11/18/24 11/22/24 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/02/24 12/06/24 This documentation shows that Resident #58 went nine (9) days without a shower from 11/22/24 until 12/02/24 with no refusals. On 12/05/24 at 2:20 PM the above information was confirmed with the Director of Nursing. b) Resident #92 On 12/03/24 at 9:57 AM Resident #92 states he prefers a shower over a bed bath but does not get his showers as ordered. According to the shower schedule provided by the facility Resident #92 should receive his showers on evening shift every Tuesday and Friday. On 12/05/24 at 1:10 PM record review of showers given for the last thirty (30) days shows Resident #92 had eight (8) opportunities for a shower. He received two (2) of the eight (8) showers. There is documentation that Resident #92 refused his shower two (2) times on 11/20/24 and 11/23/24. According to the schedule he was scheduled a shower on the following dates: 11/12/24 11/15/24 11/19/24 11/22/24 11/26/24 11/29/24 12/03/24 12/06/24 He received or refused a shower on the following dates: 11/16/24 received 11/20/24 refused 11/23/24 refused 12/04/24 received (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This documentation shows that Resident #92 went seventeen (17) days without a shower from 11/16/24 until 12/04/24. On 12/05/24 at 2:20 PM the above information was reviewed with the Director of Nursing.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45171 Based on record review and staff interview the facility failed to identify and provide needed care and services that are resident centered, in accordance with the resident's preferences and professional standards of nursing practice for more than a limited number of residents. Resident Identifiers: #19, #25, #30, #43, #64, #69, #77, #255, #256, #258, #59, #89. Facility Census: 107 Findings Include: a) Resident #19, #25, #30, #43, #64, #69, #77, #255, #256, and #258 On 12/04/24 at 11:23 AM a facility reported incident concerning a multi-resident medication error was reviewed. The incident report alleged Registered Nurse (RN) #404 failed to pass Physician ordered medications to ten (10) residents. This occurred on each night shift from 04/06/24 through 04/09/24. On 12/09/24 at 9: 05 AM during an interview with the Director of Nursing (DON), she stated the error was identified when a random audit of the medication cart was performed by herself. It was found that the dated medication packets which come from pharmacy were still in the medication cart, unopened. She then performed an audit of the Medication Administration Report (MAR) and found that the medication had been documented as given. The MAR was compared to the medications in the packets and it was determined that the RN had not administered medications to ten (10 Residents. The facility policy and procedure for NS-1197-05 Nursing Medication Administration states on page seven of seven (7 of 7) as follows: IV. Documentation a. Documentation of medication will be current for medication administration. b. Documentation of medications will follow accepted standards of nursing practice. A review of the Medication Administration Report (MAR) for the ten (10) residents identified as missing medications were reviewed. The following medications/dosages were identified as not being administered on each of the dates of alleged errors (04/06/24 - 04/09/24). Resident #19 Mirtazapine 7.5 milligram (mg) for dementia Singular 10 mg for allergies Nifedipine 0.2% cream for hemorrhoids Nutritional supplement for weight loss Ocusoft lid scrub to both eyes for dry eyes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Systane Ultra Solution 0.4-0.3% 2 drops in both eyes for dry eyes Sulfasalazine 500 mg for inflammation Resident #25 Catapres-TTS-s transdermal patch weekly for hypertension Lantus insulin 50 units for diabetes Levothyroxine 25 micrograms (mcg) for hypothyroidism Lipitor 20 mg for hyperlipedemia Resident #30 Eliquis 5 mg for Atrial fibrillation Entresto 49-51 mg for congestive heart failure Med pass supplement for weight loss 90 ml for weight loss Resident #43 Celexa 40 mg for depression Senna-S 8.6-50 mg for constipation Acetaminophen 1000 mg for pain Eliquis 5 mg for anticoagulation Fluticasone Proprionate Suspension 50 mcg 1 spray in each nostril for congestion Quetiapine Fumarate 100 mg for schizophrenia Seroquel 125 mg for schizophrenia Symbicort Inhalation Aerosol 160-45 mcg for COPD Tegretol 100 mg/5 ml for delusions Resident #64 Lipitor 20 mg for hyperlipedemia Refresh Ophthalmic Ointment 1 application in each eye for dry eyes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Spiriva inhalation 18 mcg for COPD Trazodone 50 mg for depression Tylenol Extra Strength 10000 mg for pain Eliquis 5 mg for Atrial fibrillation Norco 10-325 mg for pain Requip 1 mg restless leg syndrome Rewetting eyedrops 2 drops in both eyes for dry eyes Resident #69 Med pass product 90 ml for weight loss Rivaroxaban 2.5 mg for circulation Tylenol 1000 mg for pain Resident #77 Celexa 20 mg for anxiety and depression Sennosides 8.6 mg for constipation Med Pass product 90 ml for supplement Metoprolol Tartrate 25 mg for hypertension Pantoprazole 40 mg for GERD Tegretol-XR 100 mg for anxiety Tramadol 50 mg for pain Ativan 0.5 mg for anxiety Carafate 1 gram for digestive aid Resident #255 Acetazolamine 250 mg for kidney disease Budesonide inhalation solution 0.5 mg/2 ml for COPD (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Guaifenesin ER 600 mg for mucus Ipratropium Albuterol Solution 05.-2.5 mg/3 ml for COPD Pantoprazole Sodium 40 mg for reflux Spironolactine 25 mg for congestive heart disease Torsemide 20 mg for congestive heard disease Ipratropium Albuterol solution 0.5-2.5 mg/ml for COPD Resident #256 Levothyroxine 125 mcg for hypothyroidism Senna 8.6-50 mg for constipation Famotidine 20 mg for acid indigestion Lantus insulin 35 units for diabetes Meclizine 12.5 mg for dizziness Resident #258 Atrovastatin 10 mg for hyperlipedemia Metformin 500 mg for diabetes Pantoprazole 40 mg for acid indigestion Tamsulosin 0.4 mg for urinary health Trazadone 50 mg for depression Carvedilol 25 mg for hypertension Magnesium Oxide 400 mg for supplement On 12/10/24 at 9:10 AM the above findings were discussed with the DON and the Regional Director of Clinical Operations #400 who confirmed the residents listed above did not receive their medications during the time period of 04/06/24 through 04/09/24 for the night shift. b) Resident #59 On 12/03/24 at 9:15 AM record review of weights for Resident #59 found there has been a significant weight loss of 10.3% in one month. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation shows Resident #59 weighed 208 pounds on 10/11/24 and dropped to 186.6 pounds on 11/11/24. This reflects a weight loss of 10.3% of her weight in 30 days. A significant weight loss is defined as: 5% change in weight in 1 month (30 days) 7.5% change in weight in 3 months (90 days) 10% change in weight in 6 months (180 days) Resident #59 has the following active orders: Regular diet Regular texture, Regular consistency, Diabetic Condiments No Salt Packet Weight times 4 weeks upon admission one time a day every Sun for Baseline Weight for 4 Weeks AND every day shift every 30 day(s) for Weight. The facility policy and procedure for Resident Height and Weight states on page three (3) of three (3), Procedure for obtaining weight B. Weight Procedure (3) Compare weight to previous weight obtained. If a variance of five (5) pounds more or less is noted,reweigh resident to verify weight. A review of Resident #59 weights show the following documentation where on two (2) occasions the resident should have been re-weighed due to a five (5) pound fluctuation in her weight. 10/11/24 208 pounds 10/13/24 200.8 pounds 10/27/24 195.4 pounds 11/03/24 186 pounds The Director of Nursing confirmed their policy and stated that is standard practice of nursing are as well. She confirmed the above weight documentation and the resident should have been re-weighed on both instances listed above. 43340 c) Resident #89 A record review completed on 12/04/24 at 9:30 AM, revealed the following physician order: Five times a day 90ml pre & post each enteral feeding. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an Interview on 12/04/24 at 12:14 PM, the DON was asked to described what would be 90ml pre and post each enteral feed. The DON initially replied, That would be the Jevity (a calorically dense, fiber-fortified therapeutic nutrition that provides complete, balanced nutrition for long- or short-term tube feeding). The DON then corrected herself by explaining that would be the water for the tube flush.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45171 Based on observation, record review and staff interview the facility failed to turn and reposition an immobile resident according to standard practice of nursing care to prevent new or worsening pressure ulcers. Resident Identifier: #72 Facility Census: #107 Findings Include: a) Resident #72 On 12/05/24 at 2:18 PM observation and record review identified Resident #72 has a stage III pressure ulcer to her left back. Record review and Licensed Practical Nurse #26 confirmed the wound was first identified 08/29/24. Current orders for wound care to her back are: 1) WOUND CARE: Monitor Stage 3 pressure injury to thoracic spine. Notify medical provider if presence of complications (e.g. increased redness, swelling, drainage, abnormal odor, new or worsening pain/discomfort. WOUND CARE: Cleanse Stage 3 pressure injury to left back with wound cleanser, apply hydrogel with silver to wound bed, cover with bordered gauze. On 12/05/24 at 3:10 PM record review of Resident #72's care plan and current orders show there are no interventions or tasks for turning and repositioning the resident to prevent worsening of the stage III pressure ulcer to her back. On 12/05/24 at 3:20 PM during an interview with Certified Nurse Aide (CNA) #10 and CNA #61 they stated they do not routinely have a place to chart for turning but they do turn some residents. CNA #10 identified Resident #72 as a resident that she turns from side to side. Further record review shows a charting task for rolling left and right for this resident. Record review of task documentation shows Resident #72 is totally dependent with one to two or more helpers for turning. Resident #72 is non-verbal and immobile. She has contractures and can not roll herself from side to side. According to the Director of Nursing in an interview on 12/09/24 at 3:36 PM it is standard practice of nursing care to prevent a new or worsening pressure ulcer that an immobile resident should be turned from side to side or to the back every two (2) hours. Documentation review for thrifty (30) days from 11/10/24 through 12/08/24 shows the following number of times Resident #72 was turned and repositioned in a 24 hour period. 11/10/24 two times 11/11/24 two times (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/12/24 once 11/13/24 two times 11/14/24 three times 11/15/24 once 11/16/24 two times 11/17/24 two times 11/18/24 three times 11/19/24 two times 11/20/24 two times 11/21/24 no documentation of turning/repositioning 11/22/24 two times 11/23/24 two times 11/24/24 no documentation of turning/repositioning 11/25/24 once 11/26/24 three times 11/27/24 once 11/28/24 three times 11/29/24 once 11/30/24 two times 12/01/24 three times 12/02/24 two times 12/03/24 once 12/04/24 two times 12/05/24 two times (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/06/24 once 12/07/24 once 12/08/24 two times If a resident was turned every two (2) hours there are twelve (12) opportunities a day to turn and reposition the resident. In a thrifty (30) day time period there would be 360 opportunities to turn and reposition a resident. Documentation shows Resident #72 was turned and repositioned fifty one (51) times during this thirty (30) day record review. On 12/09/24 at 3:46 PM the DON confirmed Resident #72 had not been turned and repositioned according to standard practice of nursing care to prevent a new or worsening pressure ulcer.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171 Based on observation and staff interview, the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. Three (3) medication carts and a treatment cart were unlocked and unattended. This was a random opportunity for discovery. This deficient practice had the potential to affect more than a limited number of residents. Facility Census: #107 Findings include: a) Medication carts On 12/04/24 at 4:50 AM it was observed at the nurses station on the 100/200 hallways there were two (2) medication carts that were unattended and unlocked. At 4:52 AM Licensed Practical Nurse (LPN) #87 returned to the medication cart and confirmed the medication cart she was responsible for on the 100 hallway was left unlocked and unattended. posing an accident threat to residents on the 100 and 200 hallways. At 4:57 AM LPN #70 returned to the medication cart and confirmed the medication cart she was responsible for on the 200 hallway was left unlocked and unattended. posing an accident threat to residents on the 100 and 200 hallways. On 12/04/24 at 7:45 AM the above information was provided to the Director On 12/09/24 at 12:10 PM observation of a medication cart at the nurses station on the 100 hallway found it to be unlocked and unattended. This was confirmed with LPN #26 who also identified the medication cart was the responsibility of LPN #57. b) Treatment cart On 12/04/24 at 11:40 AM during observation of tracheostomy care in room [ROOM NUMBER]-2 Licensed Practical Nurse #53 retrieved the appropriate supplies from the treatment cart. At that time she entered the room and closed the door to the room and left the treatment cart unlocked and unattended posing an accident threat to residents that may come on the 400 hallway. This was confirmed with the Regional Director of Clinical Operations #400 on 12/04/24 at 1:47 PM who agreed the treatment cart should remain locked when unattended.

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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. 45171 Based on record review and staff interview the facility failed to maintain adequate nutritional status, to the extent possible, to ensure the resident is able to maintain the highest practicable level of well-being. This was true for one (1) of three (3) records reviewed for weight loss. Resident identifier: #59 Facility Census: #107. Findings Include: a) Resident #59 On 12/03/24 at 9:15 AM record review of weights for Resident #59 found there had been a significant weight loss of 10.3% in one month. Documentation showed Resident #59 weighed 208 pounds on 10/11/24 and dropped to 186.6 pounds on 11/11/24. This reflects a weight loss of 10.3% of her weight in 30 days. A significant weight loss is defined as: 5% change in weight in 1 month (30 days) 7.5% change in weight in 3 months (90 days) 10% change in weight in 6 months (180 days) Resident #59 has the following active orders: Regular diet Regular texture, Regular consistency, Diabetic Condiments No Salt Packet and Weight times 4 weeks upon admission one time a day every Sun for Baseline Weight for 4 Weeks AND every day shift every 30 day(s) for Weight. There were no supplements, snacks or additional protein sources ordered. A record review of meal intake percentages show Resident #59 usually ate between 51-100% of her meals. Record review of dietary assessments and notes show the last dietary nutritional assessment was dated 10/21/24 and dietary progress notes for 10/31/24 and 11/07/24. There have been no dietary nutritional assessments or dietary progress notes since the last entered weight on 11/11/24 which reflected the 10.3% weight loss. The facility Dietitian was not available for an interview. The Director of Nursing confirmed the above weight loss and had no input as to why there has not been a dietary assessment due to the weight loss.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50795 The facility failed to ensure that the physician or delegate responded to a new onset of symptoms, in a resident's condition, in a timely manner. This failed practice had the potential to cause more than minimal harm. Resident Identifier: #103. Facility Census:107. Findings included: a) Resident #103 During a closed record review on 12/03/24 at approximately 2:15 PM, a nursing note entered by Licensed Practical Nurse (LPN) #117 on 11/06/24 at 4:29 AM revealed the following: Nursing Assistant (NA) informed this nurse that there was blood in residents catheter bag. This nurse assessed residents' catheter and found no abnormalities. Resident has no c/o pain or discomfort with catheter. Secure messaged Nurse Practitioner (NP) #120, and Medical Director (MD) #121. And attempted to reach Medical Power of Attorney (MPOA). No concerns at this time, will continue to monitor this shift. Further record review on 12/03/24 at 2:25 PM revealed that neither MD #121, nor NP #120, had responded to the LPN's message. During an interview with the Director of Nursing (DON) on 12/04/24 at approximately 08:29 AM, the DON stated that while NP #120 had not responded to LPN #117's message, NP #120 had visited the resident on 11/08/24 at 7:23 PM, as evidenced by the following note: Date of Service: 11/08/2024 Visit Type: Acute [Resident #103] is a [AGE] year old male resident who is seen today for acute hypoxia. His wife is a resident in his room. She came to hallway to alert that something is wrong with [Resident]. Upon entering his room he hypoxic with Cheyne-Stokes respiration. He has cyanosis of the lips and tongue. His respirations continue to become more shallow, respiration ceased within 10 minutes of entering his room.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49467 Based on record review and staff interview, the facility failed to deploy sufficient direct care staff to meet the care needs of all residents in the facility, based on the facility assessment. This has the potential to affect all residents residing in the facility. Facility census: 107. Findings include: A) Facility staffing At approximately 11:30 AM on 12/10/2024, a review was conducted of the facility assessment and staffing for the following days: 07/10/24, 08/13/24, 09/21/24, 11/30/24, 12/1/24. According to the facility assessment, the facility would deploy between ten (10) and twelve (12) Nurse Aides on day shift and between eight (8) and ten (10) on night shift to sufficiently meet the needs of the residents who reside at the facility. Punch in and out reports were conducted for above days, which showed every employee that clocked in and out of the facility for those days. The review of the punch in and out reports revealed the following: 7/10/24- Nine (9) Nurse Aides were in the facility on day shift. 8/13/24- Eight (8) Nurse Aides were in the facility for dash and four (4) were present for night shift. 9/21/24- Seven (7) Nurse Aides were in the facility for dash and six (6) for night shift 11/30/24- Six (6) Nurse Aides were present for dayshift 12/1/24- Six (6) Nurse Aides were present for dayshift During the survey issues were found with the following: Dependent residents (Resident #58 and #92) were dependent for activities of daliy living (ADLs) and were not getting showers. Resident #32 was not getting showered at the preferred time of day. Issues were also found with turning and repositionging not being doen for Resident #72 who had a Stage III pressure ulcer. Resident #59 had signficant weight loss with no interventions. At approximately 1:30 PM on 12/10/2024, an interview was conducted with the Director of Nursing (DON). During the interview, the DON acknowledged the requirements the facility set forth in the facility assessment and the days the facility fell short of those requirements, based on the punch in and out reports provided by the facility.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49467 Based on record review and staff interview, the facility failed to ensure a physician responded to recommendations made by a licensed pharmacist for Resident #66, and to ensure the physician provided a rationale for the use of a medication Resident #38 had a documented allergy to. This was true for two (2) of six (6) residents reviewed for unnecessary medications during the survey process. Resident identifiers: #66, #38. Facility census: 107. Findings include: a) Resident #66 At approximately 12:30 PM on 12/04/2024, a review of the physician ' s responses to pharmacy recommendations was conducted with the Assistant Director of Nursing (ADON). During the review, the following recommendations were noted: 05/28/2024- Reassess the PRN order for Lorazepam 05/28/2024- Possible duplicate orders for Tramadol 50 mg and Ativan 0.5 mg 06/06/2024- Reassess the PRN order for Lorazepam There are no options marked for agree, disagree, or other. There was no rationale provided for any decision made. There was no physician's signature or date to indicate the physician ever acknowledged the recommendation. This was acknowledged by the ADON at approximately 12:30 PM on 12/04/24. 50795

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on record review and staff interviews, the facility failed to ensure the medication regimens for Residents #307, #38,#22, and #64 were free from unnecessary medications. This was true for four (4) of six (6) residents reviewed for unnecessary medications during the survey process. Resident identifiers: #307, #38, #22, #64. Facility census: 107. Findings include: a) Resident #307 At approximately 3:30 PM on 12/03/2024, a review of Resident #307 ' s medical record was conducted during the review, the following orders were noted: Donepezil HCl Oral Tablet 5 MG (Donepezil Hydrochloride) Give 1 tablet by mouth at bedtime for dementia Active 11/27/2024 21:00 traZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime for depression Active 11/27/2024 21:00 The following diagnoses were noted on the resident's diagnosis list during the review: ACUTE ON CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED ESSENTIAL (PRIMARY) HYPERTENSION TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSPECIFIED HYPOTHYROIDISM, UNSPECIFIED CHRONIC ATRIAL FIBRILLATION, UNSPECIFIED HYPERLIPIDEMIA, UNSPECIFIED OLD MYOCARDIAL INFARCTION (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY WITHOUT ANGINA PECTORIS GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS PRESENCE OF AUTOMATIC (IMPLANTABLE) CARDIAC DEFIBRILLATOR Resident #307 was admitted to the facility on [DATE]. Discharge paperwork from the hospital, prior to the admission to the facility was reviewed, and there was no indication the resident had ever been diagnosed with dementia or depression. The initial pharmacy recommendations were reviewed for Resident #307. The recommendation from 11/28/2024 mentions the resident was admitted to the facility with an order for trazodone but did not have the appropriate indication for use. The recommendation was for the physician to verify indication and update the system with a diagnosis to support continued use. The Nurse Practitioner (NP) signed the recommendation on 12/02/2024, circled trazodone and wrote depression beside it. Notes from following visits between the physician and Resident #307 were reviewed and there were no indications of the resident being diagnosed with depression or dementia. At approximately 11:25 AM on 12/04/2024, an interview was conducted with the Director of Nursing (DON) regarding the orders and diagnoses. The DON acknowledged the resident was prescribed donepezil for dementia, but lacked the diagnosis of dementia. The DON also acknowledged the resident was prescribed trazodone for depression, but lacked the diagnosis of depression. The DON also acknowledged the absence of physician notes stating the resident had been diagnosed with either. 50795 b) Resident #38 During record review on 12/03/24 at approximately 12:15 PM, the following entries were noted in the resident's chart: An order by Nurse Practitioner (NP) #120 on 11/26/24 at 9:00 PM for Doxycycline Hyclate Oral Tablet 100 MG (Doxycycline Hyclate). Give 1 tablet by mouth two times a day for cellulitis left breast for 10 Days Further record review of Resident #38's medical record on 12/03/24 at approximately 2:30 PM revealed the following allergies listed: Doxycycline, Penicillins, Bees, Latex, Iodine It was also noted that a nursing note by Licensed Practical Nurse (LPN) #117 on 11/26/24 at 12:47 AM stated: The system has identified a possible drug allergy for the following order: Doxycycline Hyclate Oral Tablet 100 MG (Doxycycline Hyclate) Give 1 tablet by mouth two times a day for cellulitis left breast for 10 Days (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the pharmacist recommendations showed that the Consultant Pharmacist had completed the medication review at 8:33 PM on 11/26/24, and missed the irregularity, because the medication order had been placed, after the review, at 9:00 PM on 11/26/2024. The consultant pharmacist's review stated: No apparent medication irregularities noted at this time During an interview with the Director of Nursing (DON) on 12/04/24, at 9:48 AM, the DON confirmed that the facility had not notified the physician about the resident's allergy. Additionally, the physician had not documented a rationale for using this specific medication, despite the resident having a documented allergy to it. 45171 c) Resident #22 On 12/09/24 at 10:30 AM record review for Resident #22 found a current order for Levetiraetam Oral Solution 100 MG/ML (Levetiracetam) Give 5 ml via PEG-Tube two times a day for Seizures. Review of Resident #22's current diagnosis did not find a current diagnosis for seizures or epilepsy. The care plan was reviewed and found no focus for seizures. On 12/09/24 at 12:45 PM the Director of Nursing confirmed that Resident #22 does not have a current diagnosis of epilepsy. d) Resident #64 On 12/09/24 at 10:30 AM record review for Resident #64 found a current order for Zonisamide Oral Capsule 100 MG (Zonisamide) Give 100 mg orally one time a day for seizures. Review of Resident #64's current diagnosis did not find a current diagnosis for seizures or epilepsy. The care plan was reviewed and found no focus for seizures. On 12/09/24 at 12:45 PM the Director of Nursing confirmed that Resident #64 does not have a current diagnosis of epilepsy.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 42120 Based on observation, resident and staff interviews, the facility failed to ensure they were able to follow menus by not having the food items needed for the preperation of the meal. This had the potentital to affcet more than a limited number of residents. Facility census: 107. Findings included: a) Resident #88 During an Interview on 12/02/24 at 1:23 PM. Resident #88 stated the facility runs out of food all the time and must send us whatever they have. She stated that they, Haven't had milk for days. She continued to say that they sent her chocolate milk with her cold cereal this morning and they had ran out of bread also. She stated that she never gets what's on the menu. During an interview with the dietary manager on 12/02/24 at 230 PM he stated that if they do not have a menu item or run out of something, they just tell the Nurse Aides. When ask if they post changes in menus any where for the residents to see, he stated, No. A medical record review for Resident #88 revealed, a diet order for a regular diet. A review of the facility menu on 02/02/24 for lunch was kielbasa sausage, capri vegetables, baked beans, dinner roll /bread. An alternate menu marinated chicken thigh, seasoned greens, mashed potatoes. An observation on 02/02/24 at 12:48 PM of Resident #88 lunch meal ticket listed marinated chicken thighs, capri vegetables, baked beans, dinner roll /bread and brownie. She received on her tray pork roast, capri vegetables, and baked beans. No chicken thigh, roll or brownie. An observation on 02/03/24 at 8AM of Resident #88 meal ticket listed scrambled eggs, cold cereal, ginger pear cake, milk. On her tray she received scrambled eggs, cold cereal, ginger pear cake and orange juice. No milk was received. During an interview with the assistant Dietary Manager on 02/03/24 at 8:30 PM, she stated that the truck was coming today with milk. She verified they had been out of milk. She stated that she would send the van driver to get milk now. 49467 b) Resident #88 On 12/02/24 01:23 PM Resident #88 said the food was terrible. The resident said he was supposed to get a chicken thigh on this date but he got pork. He said they had no rolls and no maragarine. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/03/24 09:16 AM Resident #88 said he had put orange juice on cereal this morning due to the facility having no milk. 12/04/24 at 8:00 AM an observation revealed the resident did not receive milk for cereal. The tray ticket said, Cereal of choice each day. 50795

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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. 43340 Based on observation and staff interview, the facility failed to offer the opportunity to receive a substitute when residents refused food items during the morning meal. This was a random opportunity for discovery. Resident identifiers: #7 and #61. Facility census: 107 Findings included: a) During observation of the 400 Hall breakfast meal delivery on, 12/04/24 at 7:20 AM, Resident #7 and Resident #61 refused their breakfast trays by stating, No thanks. CNA #71 removed the meals from their room but did not offer an alternative. When questioned as to how CNAs are trained to serve meals, CNA #71 reported, I didn't offer an alternative because we know she (Resident #7) only likes sweets for breakfast. If it had been something like a cinnamon roll, she would have said yes. During an interview with the Director of Nursing on 12/04/24 at 8:12 AM, she stated that all aides are trained to offer residents the opportunity to receive a substitute if they are unhappy with the meal served.

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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, staff interview, and equipment manual review the facility failed to have a clean, sanitized kitchen, store food in the refrigerator, freezer, and dry storage in accordance with professional standards for food service safety. The facility also failed to keep the ice machine and dishwasher in safe operating condition. This has the ability to affect all residents that get their nutrition from the kitchen, and also attends food related activities. Facility Census: 107 Findings included: a) Initial Kitchen tour. During the initial kitchen tour with the Kitchen Account Manager on 12/02/24 at 11:54 AM, an observation found --Walk-in refrigerator - One container of cottage cheese, opened, not labeled, or dated. and 6 heads of lettuce brown / spoiled. -- Walk -in the freezer - Boxes of hamburger patties, waffles and french toast, open to air. -- Dry storage - 4 dented cans (peaches and soups) in circulation. --The microwave had dried food debris throughout the inside of it. -- The floors under the stove and sink area had food and debris. --The stove and outside of refrigerators and freezers were unclean. During an interview on 12/02/24 at 11:54 AM and throughout the kitchen the Kitchen Account Manager confirmed all issues during tour. b) Dishwasher A review of facility records on 12/02/24, found the dishwasher's final rinse temperature had been below the recommended 180 degrees since 11/03/24. On 11/15/24 through 11/21/24 education was given to the dietary staff on logging the dishwasher temperatures and the protocol to hand wash dishes if the machines wash temperature is below 150 or the rinse temperature is below 180. The documentation continued to show that the machine was not working properly and the dietary staff continued to use the dish machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/02/24 at 12:16 PM the Kitchen Account Manager confirmed that the machine was not working adequately. He continued to say there was a part ordered for the machine. c) Ice Machines On 12/03/24 at 1:15 tour of the pantry's with the Maintenance Director found the ice machine located in the nutrition rooms room had no required air gap on the ice machine drains. The drain pipes were touching the drains. On 12/03/24 at around 1:25 PM, the Maintenance Director also confirmed the pipe should not be touching the drain. He stated both brackets were broken.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 42120 Based on observation and staff interview the facility failed to store garbage and refuse in a proper manner. The dumpster area was polluted with garbage and used medical supplies. This has the potential to affect all residents that reside in the facility. Facility census: 107. Findings included: a) Dumpster area An observation on 12/09/24 2:57 PM found the dumpster area was polluted with garbage and used medical supplies. On 12/09/24 at 3:16 PM during an Interview the Administrator verified the trash / medical supplies on the ground around the dumpster.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 45171 Based on record review and staff interview the facility failed to follow through with their plan of correction when a deficient practice was identified and investigated. This was true for ten (10) of ten (10 records reviewed. Resident Identifiers: #19, #25, #30, #43, #64, #69, #77, #255, #256, and #258. Facility Census: 107 Findings Include: a) Resident #19, #25, #30, #43, #64, #69, #77, #255, #256, and #258 On 12/04/24 at 11:23 AM a facility reported incident concerning a multi-resident medication error was reviewed. The incident report alleged Registered Nurse (RN) #404 failed to pass Physician ordered medications to ten (10) residents. This occurred on each night shift from 04/06/24 through 04/09/24. On 12/09/24 during an interview with the Director of Nursing (DON), she stated the error was identified when a random audit of the medication cart was performed by herself. It was found that the dated medication packets which come from the pharmacy were still in the medication cart, unopened. She then performed an audit of the Medication Administration Report (MAR) and found that the medication had been documented as given. The RN was suspended immediately pending the investigation of the alleged medication error. He resigned his position on 04/09/24 without proper notice. During the investigation the facility reported the error to the Physician, the Nurse Practioner (NP), the Pharmacy, the residents or their Medical Power of Attorney (MPOA)/Health Care Surrogate (HCS). It was reported to Adult Protection Services (APS), the Ombudsman and the Office to Health Facility Licensure and Certification (OHFLAC). The ten (10) residents identified were assessed for any adverse reactions to not receiving their scheduled medications, The remaining residents on the hall the RN was assigned to were assessed and interviewed and it was determined no other residents to have had missed medications. Witness statements were obtained from four (4) nurses that routinely relieve RN #404 when they report to work for the day shift relating to a past history of finding medications in the medication cart that had not been administered. There were no prior incidents recalled from the witness statements. On the five (5) day follow up report submitted to OHFLAC the facility plan of correction was as follows: Residents were assessed for adverse reactions to not receiving their scheduled medications by the NP on 04/10/24 and 04/12/24. The Physician, NP, Pharmacy were notified by interim Director of Nursing (IDON) on 04/10/24. MPOA's and Health Care Surrogates (HCS) were notified by Licensed Practical Nurses (LPN) on 04/10/24. The employee alleged to have failed to appropriately pass medication was suspended pending investigation. This incident was reported on 04/10/24 of OHFLAC, Ombudsman, and APS by the Executive Director (ED). (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nursing completed assessments on all residents on the hall the incident occurred, on 04/10/24 and 04/11/24 by floor nurses. No additional residents were determined to have missed medications. All staff will be re-educated with a posttest to validate understanding on the policy related to Medication Administration by IDON/designee. All staff not available at this time will have education with posttest to validate understanding on the Medication Administration policy prior to next shift scheduled by ED/designee. All new staff will have education with posttest to validate understanding provided during orientation by SDC/designee. Medication carts will be audited daily for two (2) weeks including weekends, then three (3) times a week for two (2) weeks, and then randomly thereafter with corrective action upon discovery. Findings will be reviewed at the facilities QAPI meeting each month. The facility policy and procedure for NS-1197-05 Nursing Medication Administration stated on page seven of seven (7 of 7) as follows: IV. Documentation a. Documentation of medication will be current for medication administration. b. Documentation of medications will follow accepted standards of nursing practice. Registered Nurse #404 was reported to the [NAME] Virginia Board of Registered Nurses. A review of the Medication Administration Report (MAR) for the ten (10) residents identified as missing medications were reviewed. The following medications/dosages were identified as not being administered on each of the dates of alleged errors (04/06/24 - 04/09/24). Resident #19 Mirtazapine 7.5 milligram (mg) for dementia Singular 10 mg for allergies Nifedipine 0.2% cream for hemorrhoids Nutritional supplement for weight loss Ocusoft lid scrub to both eyes for dry eyes Systane Ultra Solution 0.4-0.3% 2 drops in both eyes for dry eyes Sulfasalazine 500 mg for inflammation Resident #25 Catapres-TTS-s transdermal patch weekly for hypertension Lantus insulin 50 units for diabetes Levothyroxine 25 micrograms (mcg) for hypothyroidism (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Lipitor 20 mg for hyperlipedemia Resident #30 Eliquis 5 mg for Atrial fibrillation Entresto 49-51 mg for congestive heart failure Med pass supplement for weight loss 90 ml for weight loss Resident #43 Celexa 40 mg for depression Senna-S 8.6-50 mg for constipation Acetaminophen 1000 mg for pain Eliquis 5 mg for anticoagulation Fluticasone Proprionate Suspension 50 mcg 1 spray in each nostril for congestion Quetiapine Fumarate 100 mg for schizophrenia Seroquel 125 mg for schizophrenia Symbicort Inhalation Aerosol 160-45 mcg for COPD Tegretol 100 mg/5 ml for delusions Resident #64 Lipitor 20 mg for hyperlipedemia Refresh Ophthalmic Ointment 1 application in each eye for dry eyes Spiriva inhalation 18 mcg for COPD Trazodone 50 mg for depression Tylenol Extra Strength 10000 mg for pain Eliquis 5 mg for Atrial fibrillation Norco 10-325 mg for pain Requip 1 mg restless leg syndrome (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Rewetting eyedrops 2 drops in both eyes for dry eyes Resident #69 Med pass product 90 ml for weight loss Rivaroxaban 2.5 mg for circulation Tylenol 1000 mg for pain Resident #77 Celexa 20 mg for anxiety and depression Sennosides 8.6 mg for constipation Med Pass product 90 ml for supplement Metoprolol Tartrate 25 mg for hypertension Pantoprazole 40 mg for GERD Tegretol-XR 100 mg for anxiety Tramadol 50 mg for pain Ativan 0.5 mg for anxiety Carafate 1 gram for digestive aid Resident #255 Acetazolamine 250 mg for kidney disease Budesonide inhalation solution 0.5 mg/2 ml for COPD Guaifenesin ER 600 mg for mucus Ipratropium Albuterol Solution 05.-2.5 mg/3 ml for COPD Pantoprazole Sodium 40 mg for reflux Spironolactine 25 mg for congestive heart disease Torsemide 20 mg for congestive heart disease Ipratropium Albuterol solution 0.5-2.5 mg/ml for COPD (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #256 Levothyroxine 125 mcg for hypothyroidism Senna 8.6-50 mg for constipation Famotidine 20 mg for acid indigestion Lantus insulin 35 units for diabetes Meclizine 12.5 mg for dizziness Resident #258 Atrovastatin 10 mg for hyperlipedemia Metformin 500 mg for diabetes Pantoprazole 40 mg for acid indigestion Tamsulosin 0.4 mg for urinary health Trazadone 50 mg for depression Carvedilol 25 mg for hypertension Magnesium Oxide 400 mg for supplement The above findings were confirmed on 12/10/24 at 9:10 AM with the DON and the Regional Director of Clinical Operations #400 who confirmed they do not have documentation of staff re-education or the medication cart audits. Administration failed to follow through with their plan of correction when a deficient practice was identified and investigated.

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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. 43340 Based on record review and staff interview, the facility failed to maintain an accurate medical record for three (3) out of four (4) records reviewed for accurate POST forms. Resident identifiers: #16, #29, and #33. Facility census: 107 Findings included: a) Resident #16 An electronic medical review, completed on 12/03/24 at 11:17 AM, found a scanned Physician Orders for Treatment (POST) form in Resident #16's electronic chart that left Section F completely blank. Section F should have the Physician's signature, phone number and license number. On 12/03/24 at 2:40 PM, a review of the Residents' POST Binder which is kept at the nurses' station, found the original POST form did not have the physician's signature, phone number, and license number. During 12/03/24 at 3:30 PM, the Director of Social Services confirmed without the physician's signature, phone number and license number, the form could not be considered a valid POST. b) Resident #29 An electronic medical review, completed on 12/03/24 at 2:32 PM, found a scanned POST form in Resident #29's electronic chart that did not have the physician's phone number. On 12/03/24 at 2:46 PM, a review of the Residents' POST Binder which is kept at the nurses' station, found the original POST form did not have the physician's phone number listed. During an interview on 12/03/24 at 3:30 PM, the Director of Social Services confirmed the form was incomplete and did not identify a way to reach the physician should their be a discrepancy that needed to be resolved in a timely manner. c) Resident #33 An electronic medical review, completed on 12/03/24 at 11:36 AM, found a scanned POST form in Resident #33's electronic chart that accepted verbal consent from the resident's legal decision maker. On 12/03/24 at 2:50 PM, a review of the Residents' POST Binder which is kept at the nurses' station, found the original POST form reflected verbal consent was accepted on 04/17/23, but an original signature had never been obtained. An additional record review revealed the legal representative had participated in care conference meetings on 07/16/24 and 10/16/24 where the POST form had been reviewed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/03/24 at 3:30 PM, the Director of Social Services confirmed the facility had failed to follow-up on obtaining an original signature from the legal decision-maker.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on observation, resident interview, and staff interview, the facility failed to 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. Resident #45 was allowed to play in feces until other residents intervened, wound care for a resident under enhanced barrier precautions was provided without staff wearing the appropriate personal protective equipment (PPE), linens were on the floor and a linen barrel was overflowing. These were random opportunities for discovery. Resident identifiers: #45 and #56. Facility census: 107. Findings included: a) Resident #45 During an interview on 12/03/24 at 10:30 AM, Residents #24 and Resident #31 reported that they had gone to the dining room for their Thanksgiving meal. They reported that one of the more confused residents from the 400 hall, Resident #45, had a soiled brief in her lap as she wheeled into the dining room. Resident #45 reportedly lifted the soiled brief, spread it on the table in front of her, and started playing in the feces as though she was finger painting. Both residents reported two activity aides were in the room but failed to do anything to intervene. They reported that Resident #71 went to the [NAME] hallway to ask staff to address it, was told, Hey, that's not our problem. When asked what they thought that meant, both residents reported that Resident #45 was a resident on the [NAME] Fort 400 Hallway and the [NAME] hallway staff expected the other unit to handle the problem. After that, Resident #31 wheeled herself down the [NAME] Fort 400 hallway and was successful in finding CNA #83 who agreed to help and accompanied the resident to the dining room to take care of Resident #45. Both residents reported that they recalled Resident #37 was also in the dining room. During an interview on 12/04/24 at 11:30 AM, Resident #71 reported she recalled being in the dining room when the above-mentioned incident happened during the Thanksgiving meal. She reported she went to the [NAME] hallway to ask for staff assistance and was told, Hey, that's not our problem. She wheeled herself back into the dining room and reported she had not been successful in getting a staff member to help. That was when Resident #31 left to go get help from the 400 hallway. Resident #71 reported that there were two (2) activity staff in the room but that they did not intervene in any way. During a telephone interview, on 12/04/24 at 12:42 PM, CNA #83 confirmed that Resident #31 had came and asked for her assistance in the dining room during the Thanksgiving meal. CNA #83 reported as she entered the dining room, Resident #45 had the dirty brief on the table and was playing in the feces. CNA #83 reported two activity staff members (#49 and #92) were present and sitting at the first table when she entered the room. Additionally, CNA #83 reported that CNA #10 assisted in helping clean Resident #45 up in the bathroom once they were back on the 400 hall. It was at this time that they identified Resident #45 had a brief on and that they could not be sure whose dirty brief Resident #45 had been playing in while in the dining room. (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 on 12/09/24 at 3:18 PM, Resident #37 confirmed her presence in the dining room during the Thanksgiving meal when the incident occurred. A subsequent record review found that Resident #31, Resident #24, Resident #71 and Resident #37 were all cognitively intact and would be able to accurately recall the events in the dining room and the fact that Resident #45 was permitted to play in the feces as though she was finger painting without staff intervention until residents intervened. 49467 b) Morning Observation At approximately 4:55 AM on 12/04/2024, a trash barrel was observed at the end of the 100 hallway with the lid off, overflowing with trash. Another barrel, containing soiled linen, was beside the trash barrel, overflowing, with the lid off. This was confirmed by Nurse Aide (NA) #40. NA #40 stated They have been here for a couple of hours. At approximately 5:00 AM on 12/04/2024, dirty linens were observed in the floor, by the door at room [ROOM NUMBER]. Licensed Practical Nurse (LPN) #87 acknowledged the linens on the floor and confirmed they were soiled. 50795 d) Resident #56 During an observation of wound care, and assessment, performed on Resident #56 on 12/03/24 at approximately 1:45 PM, by Nurse Practitioner (NP) #122, and Licensed Practical Nurse (LPN) #26, it was observed that Resident # 56's room did not have Enhanced Barrier Precautions (EBP) notices posted. The NP and LPN failed to don PPE upon entering the room, and prior to performing wound care. Resident $56 had venous stasis ulcers on his right lower extremity, a diabetic foot ulcer to his right great toe, and an abscess to the posterior aspect of his neck. NP #122 assessed the wounds and collected pictures, after which LPN #26 performed wound care. On 12/04/24 at approximately 5:29 AM during an interview with LPN #57, she stated that Resident #56 should be on Enhanced Barrier Precautions (EBP). LPN further stated that Resident #56 had been moved from a different hallway because the facility was being renovated, and his EBP signage had not come with him. LPN stated that an order for EBP would be obtained immediately. Record review on 12/04/24 at approximately 2:00 PM revealed the following order dated 12/04/24 at 5:28 AM: Enhanced barrier precautions related to: When dressing/bathing, showering/transferring in room or therapy gym/personal hygiene, changing linen, providing hygiene, changing briefs or assisting with toileting. Record review revealed the following orders: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/30/24 at 7:28 AM WOUND CARE: Cleanse abscess to neck wound cleanser, pat dry, apply 1/4-inch packing strip, cover with bordered gauze. Every day shift 09/30/24 at 7:28 AM WOUND CARE: Cleanse arterial ulcer to left posterior lower leg with wound cleanser, pat dry, apply xeroform, cover with bordered gauze. Every day shift 09/30/24 at 7:35 AM WOUND CARE: Cleanse diabetic foot ulcer to right foot second toe with wound cleanser, pat dry, apply betadine and leave open to air. Every day shift However, further record review on 12/04/24 at approximately 7:30 AM showed no previous orders for enhanced barrier precautions for Resident #56.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 42120 Based on observation and staff interview, the facility failed to ensure a safe and homelike environment in regard to a black substance on packaged terminal air conditioner (PTAC) and ceiling vents. This had the potential to affect all residents living in the facility. Facility census: 107. Findings include: a) Dining Rooms An observation, on 12/03/24 at 12:55 PM, revealed a black substance around the packaged terminal air conditioner (PTAC) units. At an interview, on 12/03/24 at 12:58 PM, the Maintenance Director confirmed that the PTAC units had a black substance around them. b) Ceiling vents. An observation on 12/03/24 of the vents in the ceiling throughout the facility found a black substance and debris on and around the vents. On 12/03/24 at around 1:15 PM, the Maintenance Director also confirmed the presence of debris in the heating and cooling unit. He stated that cover/vents would be clear of debris and black substance today.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER River Oaks Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Parkway Drive Clarksburg, WV 26301	

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42120 Based on observation, resident and staff interviews, the facility failed to incorporate an effective pest control program. This had the potential to affect all residents residing in the facility. Facility census: 107. Findings included: a) Gnats On 12/02/24 12:13 PM during the initial tour there were gnats all over the walls and ceiling in room [ROOM NUMBER]. The window was open, and a flying insect plug in was observed with multiple gnats trapped on the sticky pad. On 12/03/24 at 11:40 AM an observation and interview with the Central Supply Coordinator verified the gnats in the dining room and on resident trays. She stated they also have an issue with gnats in rooms where residents wet themselves On 12/03/24 at 12:11 PM during an interview with the exterminator, he stated he was never called to treat gnats in the facility prior to this date. He verified the gnats through the facility at this time. During an interview on 12/03/24 at approximately 12:45 AM, the Administrator verified they tried to exterminate the gnats with the plug in and opened the window. He stated he moved Resident #108 out of room [ROOM NUMBER] on 11/29/24 due to the gnats. During an interview, on 12/04/24 at 11:05 AM, Resident #29 reported she had resorted to killing the gnats in her room (on the 400 hall) with a fly swatter. Resident #29 also stated she had met with the Administrator to discuss the gnats as well as her dissatisfaction with the fact that the garbage in her room had not been taken out for three (3) days, and that she had resorted to bagging it up herself and placing it in the hallway. The resident stated she never received verbal or written follow-up from the Administrator regarding her concerns.