STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515128	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brightwood Center	840 Lee Road Follansbee, WV 26037

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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 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** Based on record review, resident interview, staff interview and observations the facility failed to ensure residents had a right to a dignified existence. This is in relation to their dining experience and failing to invite the residents and/or resident's representative to participate in the care plan meeting. These were random opportunities for discovery. Resident identifiers: #59, #89, #80, #6, #13, #109, #3, #14, #42 #58, #59, #109, and #42. Facility Census: 111 Findings Include: a) Resident #59 On 5/19/25 at 5:15 PM during the dinner meal observation in the Coral Dining Room it was observed that five (5) residents at table #1 were not served their meals at the same time. There were three (3) additional large tables seating five (5) at one table, and three (3) at the other two. There were also two (2) residents sitting at individual tables, alone. Resident #59 received her meal at 5:18 PM and began eating. Staff members continued serving meals to the other tables in the dining room prior to finishing serving all residents at table #1. Resident #59 continued to eat her dinner and finished her meal while the other four (4) residents watched and waited on their dinner. b) Resident #89 On 5/19/25 at 5:15 PM during the dinner meal observation in the Coral Dining Room it was observed that five (5) residents at table #1 were not served their meals at the same time. There were three (3) additional large tables seating five (5) at one table, and three (3) at the other two. There were also two (2) residents sitting at an individual table alone. Resident #59 received her meal at 5:18 PM and began eating. Staff members continued serving meals to the other tables in the dining room prior to finishing serving all residents at table #1. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A table mate at table #1, Resident #89, did not receive her meal until 5:25 PM (seven (7) minutes after Resident #59s' meal was served. c) Resident #80 On 5/19/25 at 5:15 PM during the dinner meal observation in the Coral Dining Room it was observed that five (5) residents at table #1 were not served their meals at the same time. There were three (3) additional large tables seating five (5) at one table, and three (3) at the other two. There were also two (2) residents sitting at individual tables, alone. Resident #59 received her meal at 5:18 PM and began eating. Staff members continued serving meals to the other tables in the dining room prior to finishing serving all residents at table #1. A table mate at table #1, Resident #80, did not receive her meal until 5:29 PM (eleven (11) minutes after Resident #59s' meal was served. d) Resident #6 On 5/19/25 at 5:15 PM during the diner meal observation in the Coral Dining Room it was observed that five (5) residents at table #1 were not served their meals at the same time. There were three (3) additional large tables seating five (5) at one table, and three (3) at the other two. There were also two (2) residents sitting at an individual tables, alone. Resident #59 received her meal at 5:18 PM and began eating. Staff members continued serving meals to the other tables in the dining room prior to finishing serving all residents at table #1. A table mate at table #1, Resident #6, did not receive her meal until 5:33 PM (fifteen (15) minutes after Resident #59s' meal was served. e) Resident #13 On 5/19/25 at 5:15 PM during the diner meal observation in the Coral Dining Room it was observed that five (5) residents at table #1 were not served their meals at the same time. There were three (3) additional large tables seating five (5) at one table, and three (3) at the other two. There were also two (2) residents sitting at an individual tables, alone. Resident #59 received her meal at 5:18 PM and began eating. Staff members continued serving meals to the other tables in the dining room prior to finishing serving all residents at table #1. A table mate at table #1, Resident #13, did not receive her meal until 5:37 PM (nineteen (19) minutes after Resident #59s' meal was served. The above findings were confirmed with Nurse Aide #110 on 05/19/25 at 5:40 PM at which time she commented, I know, I was really trying to serve them all together. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/19/25 at 05:53 PM, during the Coral Dining Room observation, Resident's #59, #58, #109, #3, and #14 were served their dinner drinks in disposable cups during the dinner meal. Licensed Practical Nurse (LPN) #82 confirmed the resident's drinks were served in disposable cups. LPN #82 stated, Let me check it out. No additional information was given. On 05/20/25 at 12:23 PM, the Regional Dietary Manager #161 stated, a dietary aide reported there were no mugs so disposable cups were sent. The Regional Dietary Manager #161 stated, I informed her not to do that. g) Resident #42 During an interview with Resident #42 on 05/19/25 at approximately 1:04 PM, the resident reported that facility staff had approached him in a threatening manner concerning a comment he posted on Facebook. He explained that his comment was in response to someone asking for information about the services at the facility. The resident noted that he had not said anything particularly offensive, and the comment he made was simply, Do your research! The resident stated that on 05/08/25, the Admissions Director (AD) #72 had approached him and questioned him about a Facebook comment. The resident stated that AD #72 had suggested to him that he could go to another facility if he was not happy there. The resident further stated that he had mentioned to AD #72 that he had the right to post opinions online and that he was not planning to go anywhere else. During an interview with resident's family member on 05/20/25 at approximately 8:35 AM, the resident's family member stated that she had gone into the facility on [DATE] and met with AD #72. Resident #42's family member stated the following: She (AD #72) said she was the one that talked to [Resident #42] about it. She called it a post and I had to point out to her that it was only a comment to someone else's post. She did not see the comment firsthand and admitted hearing about it from someone else. She was not even aware that his comment was complimentary and not derogatory. I told her that if they were so concerned about Facebook, they should have been concerned about all the negative remarks that other people made that weren't residents. During an interview with the Administrator on 05/20/25, at approximately 1:25 PM, she acknowledged awareness of a Facebook comment made by Resident #42. The Administrator confirmed that AD #72 had questioned the resident. However, she stated that she did not know the reason behind AD #72's confrontation with the resident. On 05/21/25 at approximately 11:00 AM, during an interview with AD #72, she stated that she had approached Resident #42 because she had heard from staff members that the resident was unhappy. AD #72 further stated that she had offered to send out referrals to other Long Term Care facilities. AD #72 stated that Resident #42 had said I know why you are trying to push me out. It's because of that Facebook comment!. AD #72 said that she had no knowledge of the Facebook comment and stated that the resident had mentioned it during the conversation. During a follow-up interview with Resident #42 on 05/22/25 at approximately 11:00 AM, he stated that he was a little anxious because he felt that the staff was not happy with him.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interviews and record reviews, the facility failed to afford the residents and their representatives the opportunity to participate in the care planning process and to be included in decisions and changes in care, treatment, and/or interventions. This was true for two (2) of two (2) residents interviewed. Resident Identifiers: Residents #42 and #70. Facility Census: 111. Findings Include: a) Resident #42 During an interview on 05/19/25, at 1:00 PM, the resident stated that he had not been invited to, nor given the opportunity to participate in, his care plan meeting. He further mentioned that his sister, who was his Medical Power of Attorney (MPOA), was not allowed to attend the meeting. Additionally, the resident's MPOA submitted a written statement that included the following: In our first conversation, Director of Social Services (DSS) #66 told me that a care meeting was being planned for Friday, 3/28/25 at 4:30 p.m. to discuss [Resident's] progress and sending him to LTC. She stated she would be on vacation, returning Monday, March 24. In discussing care at home for [Resident], I mentioned the Medicaid Aged and Disabled Waiver. DSS #66 had no knowledge of it. However, she did reach out to someone and told me she is now aware of it. I mentioned this to her because I had discussed it with [Resident] as a possible part of his home care plan. On 03/27/25 as of 8:05 AM, the care plan meeting was still on, as per an email response from DSS #66 when I asked where it would be and who would be participating. She said that Social Services, Therapy, and the Care Plan Nurse (whom I have come to realize is the Clinical Reimbursement Coordinator (CRC) #11). On 03/27/25, In the afternoon received a call from what I think was Social Services. Was driving so unable to take notes. They were saying that the meeting wasn't necessary now and that we wouldn't be having it. They said the reason was because of something that they didn't want to say in front of everyone in the meeting - they were worried about (resident name) mainly - they said the reason was because [Resident] was incontinent. I hadn't heard this before and asked them to explain what they meant because I know what incontinence means for my dog, but had never heard it about [Resident] because he has never had that problem before. On 03/28/25 (Friday), CRC #11 called me in the morning to tell me that there would be no meeting. She said this is what [Resident] wanted and she said that [Resident] asked her to call me and tell me. Many times, she continued to say throughout the conversation, This is all about [Resident]. This is what [Resident] wants. I've come to find out in conversation with [Resident] that CRC #11 went to him and told him that he did not need the meeting and got him to agree to her reasons why there wouldn't be one. During an interview with Resident #42 on 05/21/25 at approximately 3:00 PM, he stated that while he had capacity, he wanted his MPOA to be involved in any decisions regarding his health care. He also stated that he had not made a request to keep his MPOA away from care plan meetings. Resident #42 further stated that he had not been invited to attend any care plan meetings. On 05/21/25 at approximately 2:15 PM DSS #66 stated that she did not send out invitations to residents or representatives for care plan meetings. She further stated that CRC #11 sent out the invitations. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/25, at approximately 3:10 PM, CRC #11 stated that she sends invitations to residents and their representatives for care plan meetings. However, she was unable to provide any documentation to verify that these invitations were sent. CRC #11 confirmed that she does not keep copies of the invitations and does not save them in the residents' records. b) Resident #70 During an interview on 05/19/25, at 1:08 PM, Resident #70 expressed concern about the lack of documentation and information regarding his care. He mentioned that he had neither attended nor been invited to a care plan meeting. The resident has the capacity to understand his situation and was very vocal about his dissatisfaction with not being involved in the care planning process. During an interview on 05/21/25 at approximately 2:15 PM, DSS #66 stated that she did not send invitations to residents or representatives for care plan meetings. She further stated that CRC #11 was responsible for sending out the invitations. During an interview on 05/21/25, at approximately 3:10 PM, CRC #11 stated that she sends out invitations to residents and their representatives for care plan meetings. However, she was unable to provide any documentation to verify that these invitations had been sent. CRC #11 confirmed that she does not keep copies of the invitations and does not save them in the residents' records. CRC #11 stated that she would implement a system for tracking and documenting to ensure that invitations were sent to residents and family members.

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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** Based on interview and record review, the facility failed to notify resident of treatment and healthcare information in accordance with his preferences. The facility further failed to ensure that each resident had the opportunity to exercise their autonomy regarding those things that were important in their life. This was true for one (1) of three (3) residents surveyed for choices. Resident Identifier: #70. Facility Census: 111. Findings Include: a) Resident #70 During an interview on 05/19/25, at 1:08 PM, Resident #70 expressed feeling unsafe because the facility does not keep him informed about his lab test results and other treatment outcomes. The resident, who is [AGE] years old and a veteran, also mentioned that he had not been invited to participate in his care plan meetings. He stated that he receives documentation and lab results from the VA hospital but that his requests for documentation from the Long Term Care facility have been ignored. A review of Resident #70's Care Plan on 05/21/25 at approximately 3:25 PM revealed the following notes: CARE PLAN (Resident #70) will be involved in the care planning process to promote autonomy and respect for his experiences. Date Initiated: 03/10/2025 Created on: 03/10/2025 Promote opportunities for participation in decisions regarding care Date Initiated: 02/26/2025 Created on: 02/26/2025 Inform [Resident] of changes in status/care needs Date Initiated: 02/26/2025 Created on: 02/26/2025 On 05/21/25 at approximately 2:15 PM Director of Social Services (DSS) #66 stated that she did not send out invitations to residents or representatives for care plan meetings. She further stated that the Clinical Reimbursement Coordinator (CRC) #11 sent out the invitations. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/25 at approximately 3:10 PM, CRC #11 stated that she sends out invitations to residents and representatives for care plan meetings. However, she was unable to provide any documentation to verify that invitations had been sent out. CRC #11 confirmed that she did not keep copies of the invitations, and did not save them into the resident's record. During an interview with the Director of Nursing (DON) on 05/20/25 at approximately 3:45 PM, she stated that she was not aware that the resident wanted copies of his lab results. She stated that she would make sure to provide resident with copies of his lab reports. Upon notification, Regional Clinical Nurse (RCN) #165 promptly interviewed the resident, addressed his concerns, and provided him with copies of his lab results.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interview, the facility failed to give appropriate notices for discharges for residents who received Medicare Part A services. This was true for one (1) out of three (3) residents reviewed. Resident Identifier: #102. Facility Census: 111. Findings included: a) Resident #102 A discharge for Resident #102 was initiated by the facility from Medicare Part A services when benefit days were not exhausted. A Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) and a Notice of Medicare Non-Coverage (NOMNC) were not acknowledged by the beneficiary or the beneficiary's representative. Findings were confirmed by Senior Nursing Home Administrator #160 on 05/27/25 at 10:04 AM.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, resident and staff interview the facility failed to provide the right to a safe, comfortable and homelike environment by not providing residents access to over the bed lights. This was a random opportunity of discovery. Facility Census: 111 Findings Include: a) On 5/19/25 at 12:45 PM a resident voiced her concern that she could not see very well while reading in her bed. She believed the light bulb needed to be brighter. Upon further investigation it was found that there was a light fixture over each resident's bed. There was a toggle switch to the right of each fixture. It is placed in a manner that requires the resident to get out of bed, walk to the head of the bed and reach the toggle switch in order to operate the light. On 5/19/25 at 3:30 PM during an interview and walk through of the facility, the Administrator confirmed that there are residents that can not access the switch. She stated she had never even noticed that the lights did not have pull strings or a way residents could access the light other than calling out for staff to assist them. She confirmed that all over the bed lights for all 115 beds in the facility were this way. On 5/21/25 at 10:53 AM the Clinical Reimbursement Coordinator #39 provided a list of independent walkers in the facility. This list consisted of three (3) residents. When asked if this list are the only residents that could get out of bed with no assistance and walk to the head of the bed, she stated, yes, only these three (3). On 05/21/25 at 11:15 AM it was confirmed with the administrator that most residents in the facility at this time could not maximize their independence in operating the light switches without posing a safety risk. She agreed they should have a chain or rope for easy access.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview and record review, the facility failed to ensure residents were free from sexual and psychosocial abuse perpetrated by another resident . This created an immediate jeopardy situation and put all residents at risk. Resident identifier's: #97 and #102. Facility Census: 111. Findings included: a) Resident #97 At approximately 09:05 AM on 05/20/2025, Resident #97 reported to a surveyor she was abused by Resident #58. Resident #97 stated Resident #58 hit her with her wheelchair and put her hand up my crotch. The resident stated she reported the alleged abuse to Nurse Aide (NA) #63 who, instead of reporting it, made fun of her and laughed while stating, Didn't you like it? The resident stated she told NA #63 she did not like it. NA #63 did not report the allegation of abuse and Resident #97 stated she asked repeatedly to fill out a complaint and the facility would not listen to her. Resident #97 stated a friend, who used to be a Director of Nursing (DON), came to the facility to help her file the complaint. She stated after she filed the complaint, the facility told her to stay away from Resident #58. On 05/21/2025, it was noted the facility logged the allegation of abuse as a grievance related to customer service. The facility educated NA #63 on customer service basics. The education did not mention abuse/neglect, how to identify it or how to report it. The resolution for Resident #97 was to stay away from Resident #58, the alleged perpetrator. The facility did not report the incident as an allegation of abuse and did not place any interventions into place to keep Resident #97 safe from further instances of abuse. At approximately 01:52 PM on 05/21/2025 an interview was conducted with the Administrator and Senior Administrator in which they stated they would report any incident of sexual abuse to law enforcement. At approximately 02:12 PM on 05/21/25 an interview was conducted with Social Worker (SW) #62, in which she stated she took her concerns with this incident to the Administrator and Director of Nursing (DON). At approximately 3:30 PM on 05/21/25, an interview was conducted with the DON in which she stated, We (DON and Administrator) were in meetings in [NAME]. It took a long time to get back to Resident #97 (regarding the incident). The DON stated psych services followed up with Resident #97 after being contacted. The DON stated the facility did not report the allegation because Resident #58 reached between her (Resident #97) legs from behind and did not touch her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	At approximately 4:41 PM on 05/21/25, an interview was conducted with NA #63. During the interview, NA #63 stated she did not see the incident, but Resident #97 told her Resident #58 came in and touched her. NA #63 stated this happened around dinner time and she was unaware if anyone else witnessed the incident. NA #63 stated she did not report the allegation of abuse because Resident #97 said she had already told someone else. At approximately 4:46 PM on 05/21/25, an interview was conducted with Resident #97. During the interview, Resident #97 stated, she had her rollator against the door with her hand on her door handle. At this time, Resident #58 reached her hands between my legs and right up into my crotch. I felt the grab with a layer. I was wearing a brief and a pad and pants, and I could feel it through that. Resident #97 was extremely tearful during the interview and stated, while crying, I felt violated. I feel no one should touch me there. Resident #97 stated Resident #58 is constantly in my room. Two days ago, she followed me into my room and said 'psst' and I turned around and told her to get out of my room. She said, 'I'm going to slap you on the ass.' Months ago, she did slap me on the ass, and it stung. The staff think it's cute and funny. I'm sorry, I just don't feel that way. Resident #97 then stated, This is my home, what are they doing to protect me? Resident #97 stated at Bingo on Sunday (05/18/2025), Resident #58 was slapping at her arm and I told her to not touch me, and she stopped. The resident stated She (Resident #58) comes into my room all the time and says she's going to poop in here. I tell her it's my room and to leave. Resident #97 stated the Guest Services Director (GSD) came into her room and asked her what happened. She stated, I told her what happened, and she (GSD) told me that if I touch her (Resident #58) that I would be arrested. I said you mean the mindless have rights and I don't? The resident stated no one else followed up with her that day. Resident #97 stated she told the GSD she wanted to file a complaint about the incident and to get (Resident #102's name) statement because he saw everything. No statement was obtained, and no report was filed. Resident #97 reported SW #62 came into her room, and she told her she wanted to file a complaint about the incident but stated, They ignored me. Resident #97 stated the Administrator and DON came to her room and told her the incident was not reportable. Resident #97 stated she instructed them to get the statement from Resident #102, who witnessed the incident, to which she stated she would. Resident #97 stated she used to come out of her room all the time and stopped coming out after the incident. However, she states she is trying to get out of her room more now. She states she now feels very cautious, avoiding Resident #58's hallway. She stated she was constantly looking behind her when she is out of her room. She stated, I stayed in my room for a while but I'm getting out more now. b) Resident #102 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	At approximately 06:44 PM on 05/21/2025 an interview was conducted with Resident #102. Resident stated that on 03/20/25, Resident #97 was going into her room when Resident #58 rolled by in her wheelchair, reached out and grabbed Resident #97's butt. Resident #102 stated that Resident #97 was so surprised that she almost fell over. He further stated that she was very upset. Resident #102 further stated that this was not the first time Resident #58 had done this. He said that she had done it to some of the staff. Upon being asked how the staff reacted, he stated that some of them found it to be funny. Resident #97 had a Brief Interview for Mental Status (BIMS) score of 15 cognitively intact) and had capacity to make medical decisions. Resident # 102 had a BIMS of 11(cognitively intact) and had capacity to make medical decisions. On 05/21/25 at 8:45 PM the administrator was informed of the immediate jeopardy situation. All residents in the facility were at risk due to the facility's inability to identify allegations of sexual abuse and protect residents from this type of abuse. On 05/21/25 at 10:15 PM the facility provided the following plan of correction, and the plan was accepted at that time. Social Worker/designee reported allegation of emotional/sexual abuse that occurred on 3/20/25 to APS, OHFLAC and Ombudsman on 5/21/25. The alleged perpetrator was placed on 1:1. CNA suspended 5/21/25. All residents of the facility have the potential to be affected. NHA/ designee interviewed all residents with BIMS score of 8 or above for potential physical, sexual, emotional, and mental distress on 05/21/2025, with any corrective action immediately upon discovery. The Director of Nursing (DON)/designee conducted skin checks on residents with BIMS of 7 or below if resident permits for potential physical, emotional, and mental distress on 5/21/25 with any corrective action immediately upon discovery. NHA/designee reviewed all grievances from 3/01/25 to current to ensure no additional allegations of abuse were listed on a grievance with corrective action immediately upon discovery. The NHA/designee will reeducate all staff on abuse reporting regarding alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of an unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury including reporting allegations to the appropriate agencies including abuse and allegation reporting requirements, timely reporting, and reporting to the appropriate agencies with a posttest to validate. Any staff not available during this time frame will be provided reeducation, including posttest by NHA/Designee upon the day of return to work. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515128	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brightwood Center	840 Lee Road Follansbee, WV 26037

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Director of Nursing/designee will monitor progress notes and grievances daily starting on 5/21/25 to ensure that allegations of emotional, mental distress, and any resident behaviors that may have negative effects on other residents have been correctly identified, reported in a timely manner, and appropriate intervention put in place to prevent recurrence daily for 2 weeks including weekends and holidays, then 3 times a week for 2 weeks then randomly thereafter. Results of monitors will be reported by the Administrator/designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and or in-servicing until the issue is resolved On 05/22/25 at 2:05 PM the immediate jeopardy was abated.

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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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview and record review, the facility failed to ensure residents were free from sexual abuse by not implementing written policies for abuse and following policy and procedures to investigate abuse allegations. This was true for one(1) of six (6) residents reviewed for abuse. This failed practice has the potential to affect more than a limited number of residents. The situation was determined to be an Immediate Jeopardy situation due to all residents residing in the facility could experience serious actual or psychological harm if the facility did not immediately intervene. Resident identifier: #97. Facility Census: 111. Findings included: a) Resident#97 Observation during the survey revealed a flyer citing the Elder Justice Act of 2010 posted in the facility's break-room. The flyer stated, If you have reasonable suspicion that a crime has occurred against a resident or patient, the federal Elder Justice Act of 2010 and Genesis Integrity Program require that you report your suspicion to both your state agency and local law enforcement. The law applies to all employees, agents or affiliated contractors of this nursing center. The flyer also stated, If you believe the suspected crime involves serious bodily injury, including sexual abuse, to the patient, you must report it no later than 2 hours after forming a suspicion. The facility's policy and procedure for Abuse Prohibition stated, Centers also strive to comply with the Elder Justice Act (EJA). Under the EJA, employees are designated as mandated reporters and are obliged to immediately report any reasonable suspicion of a crime against a patient. Reporting a reasonable suspicion of a crime only to an immediate supervisor does not meet the obligation to report. On 05/20/25 at 9:05 AM, Resident #97 stated she had reported abuse by Resident #58 multiple times to staff and had asked to file a complaint. The resident stated she had reported resident abuse by Resident #58, but the staff would not take her complaint. The resident filed a Grievance form with the assistance of a friend/resident representative on 03/26/25 for a complaint verbally reported to staff on 03/20/2025. The resident reported Resident #58 had hit her with her wheelchair and put her hand up my crotch. The resident stated she had reported the incident to Nursing Assistant #63 and the Guest Services Director the evening of the incident. The resident reported Nursing Assistant #63, made fun of me and asked me Didn't you like that? and I told her. No I did not like it. On 05/21/25 at 4:41 PM, Nursing Assistant #63 was interviewed about the incident reported by Resident #97 and stated, I did not see a single thing. Nursing Assistant # 63 reported Resident #97 told me Grandma (Resident # 58) came in and touched her. Nursing Assistant # 63 stated it happened around dinnertime, and I don't know if anyone else saw it. Nursing Assistant # 63 stated, I didn't tell anybody because she said she already told someone. Nursing Assistant #63 reported her response to Resident # 97 was oh. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/21/25, Resident #97 reported the Guest Services Director came into her room asking about missing items and asked what was wrong. The resident said she told the Guest Services Director what happened, and she said - If I would touch her, I would be arrested and I said you mean the mindless have rights and I don't. The resident reported no one came that day to take my complaint. The resident reported the next day she stopped the Guest Services Director in the hallway and stated she wanted to file a formal complaint, and the Guest Services Director stated, For what? And I told her about the incident yesterday and I wanted to file a formal complaint. The resident reported the Guest Service Director was asked by her to get a statement from Resident #102 that witnessed the incident. The resident stated Social Worker #62 came into her room and I told her I wanted to file a complaint, but they all ignored me. On 05/21/25 at 2:12 PM, Social Worker #62 stated, I remember the incident. I took my concerns to the Administrator and Director of Nursing (DON) about this incident. Social Worker #62 reported she didn't know the exact date but that sounds about the time - 1-2 months ago. The resident reported the Administrator and DON came to my room after the complaint was filed. The DON and Administrator came down and told me it wasn't a reportable incident. On 05/21/25 at 3:30 PM, the DON reported we(looking at the administrator) were in meetings in [NAME], and it took along time to get back to her (Resident # 97). The DON stated it was not reportable because Resident # 58 Reached between her legs from behind and did not touch her. The DON reported, customer service education with Nursing Assistant # 63 was completed for laughing at the resident. On 05/21/25 at 05:36 PM, the DON reported she did not have a written witness statement. She stated, I interviewed him verbally. Resident #102 was interviewed on 05/21/25 at approximately 6:44 PM, Resident #102 stated, Resident #97 was going into her room when Resident # 58 rolled by in her wheelchair, reached out and grabbed Resident # 97's butt. Resident #102 stated that Resident #97 was so surprised that she almost fell over. He further stated that she was very upset. Resident #102 further stated that this was not the first time Resident #58 has done this. He said that she has done it to some of the nurses. Upon being asked how they reacted, he stated that some of them found it to be funny. On 05/21/25 at 7:20 PM, the resident reported no one had talked to him before the state surveyor about the incident. On 05/22/25 at 1:40 PM, an anonymous staff member confirmed the allegation was reported to Social Worker # 62 and had been reported to the Administrator and the Director of Nursing. It was reported everyone in attendance in the facility's stand-down meeting was aware of the allegation. It was stated the reporting process had been changed in February or March at the Genesis Social Worker's meeting for the reportable process to be streamlined for the Director of Nursing and Grievance Officer to complete. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's policy and procedure for Abuse Prohibition stated, The Center will implement an abuse prohibition program through the following: Screening of potential hires; Training of employees (both new employees and ongoing training for all employees); Prevention of occurrences; Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations; Protection of patients during investigations; and Reporting of incidents, investigations, and Center response to the results of their investigations. The situation was determined to be an Immediate Jeopardy situation due to all residents residing in the facility could experience serious actual or psychological harm if the facility did not immediately intervene. On 05/21/2025 at 8:45 PM - the Immediate Jeopardy (IJ) facility notification was given. 05/21/2025 at 10:16 PM - The abatement plan was accepted. 05/22/2025 at 2:05 PM - the immediate jeopardy situation was abated. Abatement plan: Social Worker/designee reported allegation of sexual abuse that occurred on 03/20/25 to APS, OHFLAC and Ombudsman on 5/21/25. The alleged perpetrator was placed on 1:1. CNA suspended 5/21/25. Nursing Home Administrator (NHA)/designee educated Social Service #62 and Guest Service Director on Abuse and Neglect and Grievance Policy and Procedure on 5/21/25. All residents of the facility have the potential to be affected. NHA/designee interviewed all residents with BIMS score of 8 or above for potential physical, sexual, emotional, and mental distress on 05/21/2025, with any corrective action immediately upon discovery. The Director of Nursing (DON)/designee conducted skin checks on residents BIMS of 7 or below if resident permits for potential physical, emotional, and mental distress on 5/21/25 with any corrective action immediately upon discovery. NHA/designee reviewed all grievances from 3/01/25 to current to ensure no additional allegations of abuse were listed on a grievance with corrective action immediately upon discovery. The NHA/designee will reeducate all staff on abuse reporting regarding alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of an unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury including reporting allegations to the appropriate agencies including abuse and allegation reporting requirements, timely reporting, and reporting to the appropriate agencies with a posttest to validate. Any staff not available during this time frame will be provided reeducation, including posttest by NHA/Designee upon the day of return to work. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nursing/designee will monitor progress notes and grievances daily starting on 5/21/25 to ensure that allegations of emotional, mental distress, and any resident behaviors that may have negative effects on other residents have been correctly identified, reported in a timely manner, and appropriate intervention put in place to prevent recurrence daily for 2 weeks including weekends and holidays, then 3 times a week for 2 weeks then randomly thereafter. Results of monitors will be reported by the Administrator/designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and or in-servicing until the issue is resolved.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, and interview, the facility failed to perform a thorough investigation and failed to take the necessary steps to correct the alleged violation. Resident identifier: #265. Facility Census: 111. Findings Include: a) Resident #265 A Facility Reported Incident (FRI) submitted on 10/21/24 at 3:15 Pm stated that Resident #265 had alleged that that she had to wait for three hours on 10/20/24 for incontinence care. The facility had performed an investigation and found the allegation unsubstantiated. Resident #265 was no longer at the facility. Record review on 05/22/25 at 10:00 AM revealed that Resident #265 had capacity and was classified as Dependent. Further review of records revealed a statement on 10/28/24 by Resident #74, the roommate of Resident #265, who stated that she had witnessed Resident #265 experience extended wait times for assistance on multiple occasions. Resident #74 also corroborated Resident #265's account of the night of 10/20/24. Record review also revealed that Resident #74 had capacity. Another statement by Physical Therapist #130 on 10/21/24 which stated: Resident #265 was at the gym, being treated by this therapist. He had asked her if she had gotten up over the weekend, and resident stated that she had requested the nursing assistants to get her up several times but they had offered various reasons as to why they could not get her up at that time, and never came back to get her up over the course of the weekend. A review of the toileting logs for Resident #265 on 10/20/24 revealed that she received assistance at 1:49 AM and then at 8:15 AM. Further review of the toileting logs revealed the following: On 10/21/24 she had received assistance at 1:49 AM 9:37 PM and 11:25 PM On 10/22/24 she had received assistance at 3:24 PM On 10/23/24 she had received assistance at 3:32 AM and 10:59 PM On 10/24/24 she had received assistance at: 2:08 AM, 8:12 AM, 3:10 PM and 11:22 PM On 10/25/24 she had received assistance at 11:47 AM and 7:44 PM. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident #74 on 05/27/25 at approximately 2:25 PM, Resident #74 confirmed that Resident #265 had to wait for very long periods of time before anyone would come in to provide care. She further stated that many times Resident #265 was just ignored. Resident #74 went on to state that Resident #265 had been moved to another facility by her family.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and staff interview, the facility failed to implement the care plan for Resident #110 by failing to implement non-pharmacological interventions for pain and by failing to identify an acceptable level of pain. This was true for one (1) of 30 care plans reviewed during the survey process. Resident identifier: #110. Facility census: 111. a) Resident #110 During a review of Resident #110's care plan on 5/19/2025, the following was noted: Focus- (Resident #110's name) is at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting. Date initiated-05/02/25. Goal- (Resident #110's name) will improve current level of function in:bathing, grooming/personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting by next review as evidenced by improved ADL scores. Date initiated- 05/02/25. Interventions- Monitor for pain. Attempt non-pharmacological interventions to alleviate pain and document effectiveness. Administer pain medication as ordered and document effectiveness/side effects. Date initiated- 05/02/25. During a review of the May 2025 Medication Administration Record (MAR) for Resident #110, it was noted the resident had two orders for monitoring pain. The orders read as follows: Ask resident if they are having pain. Document pain level and new onset Yes/No in supplementary documentation and document location of pain in emar PN (progress notes) every day and night shift. If new onset, complete EInteract Change in Condition and Pain Evaluation, if not new initiate non-pharmacological interventions and document interventions and effectiveness. Observe resident if they are having pain. Document pain level and new onset Yes/No in supplementary documentation and document location of pain in emar PN (progress notes) every day and night shift. If new onset, complete EInteract Change in Condition and Pain Evaluation, if not new initiate non-pharmacological interventions and document interventions and effectiveness. Discrepancies were noted on the MAR between the two orders. On 05/03/25 during day shift, one entry states the resident was having pain at a level seven (7) with no non-pharmacological interventions attempted. The other entry on day shift states the resident was having pain at a level three (3) with non-pharmacological interventions being attempted. ON 05/13/25 during day shift, one entry states the resident was having pain at a level five (5) with no non-pharmacological interventions attempted. The other entry on day shift states the resident was having pain at a level five (5) with non-pharmacological interventions being attempted. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/04/25 during night shift, one entry states the resident was having pain at a level three (3) with no non-pharmacological interventions taking place. The other entry on night shift states the resident had a pain level of zero (0). On 05/13/25 during night shift, one entry states the resident was having pain at a level two (2) with no non-pharmacological interventions being attempted. The other entry on night shift states the resident was having pain at a level five (5) with no non-pharmacological interventions being attempted. The following days state no non-pharmacological interventions were attempted when pain was indicated: Day shift- -5/4/2025 -5/5/2025 -5/10/2025 -5/14/2025 -5/17/2025 -5/18/2025 -5/19/2025 Night Shift- -05/03/25 -05/05/25 -05/06/25 -05/12/25 -05/16/25 -05/18/25 Further review of the MAR indicates the resident had the following orders for pain medication: Hydrocodone-Acetaminophen Oral Tablet 325 MG. Give one tablet every four (4) hours as needed for moderate to severe pain four 4-10 for 14 days. Start date 05/03/25. Discontinue Date-05/06/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydrocodone-Acetaminophen Oral Tablet 325 MG. Give one tablet every four (4) hours as needed for moderate to severe pain four 4-10 for 14 days. Start date 5/6/2025. Discontinue Date-05/15/25. Tramadol HCl Oral Tabley 50 MG. Give 50 MG by mouth every 12 hours as needed for Pain rated 5-10 on pain scale. Start date 05/6/25. The resident also had an order for Tylenol for a pain level of one (1) to (4). Review of the MAR and eMAR Progress notes indicate the as needed medication was administered for pain on the following days: 05/3/25- Day and night shift 05/4/25- Day shift 05/5/25- Day shift 05/6/25- Day shift 05/8/25- Day and night shift 05/9/25- Day and night shift 05/11/25- Day shift 05/12/25- Day and night shift 05/13/25- Day and night shift 05/14/25- Day and night shift5/15/25- Day shift 05/16/25- Day shift5 05/17/25- Day shift 05/19/25- Day and night shift Further review indicates no non-pharmacological interventions had been attempted during the above times before administration of the PRN pain medication. At approximately 3:00 PM on 05/21/25, an interview was conducted with the Director of Nursing (DON). The DON confirmed no non-pharmacological interventions had been attempted. During review of the resident care plan, the following goal was noted: Palliative: Patients wound related pain will be managed at an acceptable level for the patient. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pain assessments and care plan reveal there wa no acceptable pain level documented for the resident. At approximately 3:00 PM on 05/21/25, the DON acknowledged no acceptable pain level was documented for the resident.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview, the facility failed to revise a care plan for a resident with ordered adaptive equipment. This was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident Identifier: #100. Facility Census: 111. Findings Included: a) On 05/19/25 at 05:44 PM, Resident #100 was given his drink during the dinner meal in a Sip-A-Mug cup. Resident #100's care plan stated to provide a [NAME] Cup. On 05/21/2025 at 03:00 PM, the Director of Nursing (DON) stated they changed the order yesterday for a Sip-A-Mug due to the straw used with a [NAME] Cup. The resident is currently ordered honey consistency thickened liquids. The DON confirmed the resident's care plan stated to provide a [NAME] Cup. b) The facility's policy and procedure for Assistive Devices stated, Assistive devices/utensils will be provided as identified in the individualized plan of care to maintain or improve a resident's/patient's ability to eat or drink independently.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interview, the facility failed to ensure dependent residents received required assistance with Activities of Daily Living (ADLs), by failing to ensure Resident #110 was assisted to bed and Resident #42 received assistance with toileting and incontinence care. This was true for two (2) of five (5) residents reviewed for ADL care during the survey process. Resident identifiers: #110, #42. Facility census: 111. Findings include: A) Resident #110 At approximately 2:50 PM on 5/19/25, Resident #110 was observed in his geri chair, facing the wall, between his and his roommate's beds. Resident #110 was attempting to sleep, curled up with his head resting on his left arm, on the left arm rest of his chair. At approximately 3:25 PM, multiple staff members had been witnessed walking by, and looking into, the resident's room, noticing him in the chair. At one point, staff walked in and pulled his roommate's curtain because he was asleep. At approximately 3:30 PM, an interview was conducted with Resident #110 while he was in his chair. The resident stated he was in pain at the time, and would rate his pain at an eight (8) on a scale of one (1) to 10. The resident stated he would much rather be in my bed than the chair and stated he had asked staff to put him in his chair already, but was told they would be back to assist him. At approximately 3:35 PM, an interview was conducted with Registered Nurse Supervisor (RNS) #86. RNS #86 stated he would find someone to assist him getting Resident #110 into his bed. At this time, RNS #86 asked Nurse Aide (NA) #104 if she would assist him. NA #104 stated she told Resident #110 she had to help another resident into their bed because they have been up longer and stated she would get to him when she could. Resident #110 was assisted back into his bed at approximately 3:45 PM. Review of Resident #110's Minimum Data Set (MDS) dated [DATE], indicates the resident was dependent for chair to bed and bed to chair transfers. At approximately 3:00 PM on 5/21/2025, the Director of Nursing (DON) confirmed the resident's transfer status. b) Resident #42 During an interview on 05/19/25 at 1:00 PM, Resident #42 stated that he wanted to report two (2) incidents. He stated that on 04/15/25 he was left on a bedpan for an extended period of time during the night. He stated that he had reported it to the administration on 04/16/25. Record review on 05/20/25 at 9:45 AM revealed that the facility had reported the incident to the Office of Health Facility Licensure and Certification (OHFLAC) on 04/16/25 at 3:00 PM. The five day follow up report had been submitted on 04/22/25 at 4:47 PM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brightwood Center	840 Lee Road Follansbee, WV 26037

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility had unsubstantiated the allegation based on the statements of Nursing Aide (NA) #89, NA #42 and NA #92. Record review on 05/20/25 at approximately 1:25 PM revealed a written and signed statement from NA #89 which stated the following: Placed [Resident] on the bed pan on 04/15/25 at 9:45 PM and passed on in report he was on the bed pan However, NA #42's written and signed statement stated the following: I took [Resident] off the bedpan at 10:15 PM on 04/14/25 Another signed statement by NA #92 stated that she had gone into resident's room on 04/16/25 at around 10:15 - 10:45 PM and she stated that he never mentioned anything about a bedpan. The resident's allegation appears to be substantiated because these statements refer to three different days! When presented with these differences in dates, on 05/20/25 at 4:30 PM the Director of Nursing (DON) was unable to explain them, and stated that it was possible the staff had written in the wrong dates on the statements. Resident #42 also stated that on 05/11/25 he was left wearing a wet brief for over three hours. The resident stated that when he complained that he had a rash the next day, the Skin Assessment LPN #81 performed an assessment. Resident stated that the physician had prescribed Diflucan (Fluconazole). Record review on 05/20/25 at 9:55 AM revealed that an eINTERACT Change in Condition Evaluation had been performed on 05/13/25 at 8:53 AM. The assessment noted a change in skin color or condition. Further record review revealed that Fluconazole had been prescribed for application to the groin area. The facility grievance logs showed no evidence of a complaint by Resident #42 from 05/11/25 through 05/13/25 During an interview with the Director of Nursing (DON) #74 on 05/20/25 at approximately 2:25 PM, she stated that she was aware of Resident #42's skin issue. DON stated that the resident had complained of itching, and not a rash, and the Fluconazole had been prescribed for the itching. The Resident's Medical Power of Attorney (MPOA) submitted a written statement that stated: Either on May 10th or May 11th (my notes are not clear), a urine-soaked brief was left on [Resident] for three hours, resulting in a rash in his groin area, and it took them one day before they would treat it with Diflucan. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/25 at approximately 10:51 AM LPN #81 confirmed that she had assessed Resident #42 on 05/13/25 and had notified the physician that the resident was itch' ing and scratching at his groin. LPN #81 stated that Diflucan had been ordered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record reviews, the facility failed to ensure that the environment over which it had control was free from accident hazards. Namely, the facility failed to identify risks and hazards related to the resident's beds and failed to perform preventive maintenance to ensure that the beds were safe and functional. In addition, the facility's preventive maintenance program failed to identify the risks posed by defective or broken bed wheels and failed to include inspection, assessment, and maintenance of the bed wheels in the facility's preventive maintenance policy. Resident Identifier: Resident #24. Facility Census: 111. Findings Include: a) Resident #24 A Facility Reported Incident (FRI) on 04/10/25 stated that Resident #24 was injured when the resident's bed moved while the nursing assistant was providing care. Resident struck his head against the stand on the left side of the bed. The resident sustained two lacerations to the top of his head. The resident was assessed, and neuro checks were implemented. Neuro checks were found to be within normal limits. Resident did not exhibit any signs of distress, and had no active bleeding was noted. The facility investigation revealed that the wheel on the resident's bed was broken. The bed moved even when the wheel was locked. Maintenance replaced the wheels, and then performed a whole house audit of all the beds in the facility. The initial report was forwarded to OHFLAC and APS on 04/10/25 at 6:30 PM The five day follow up was submitted on 04/17/25 at 5:26 PM. Further record review revealed that the incident was reviewed by the Inter-Disciplinary Team (IDT), and maintenance was notified. A review of records on 05/20/25 at approximately 2:35 PM revealed that an order had been entered into the TEL's system for a check on the bed's wheels. Maintenance records revealed that the wheel lock was found to be defective, and the wheel was replaced on 04/11/25 at 11:00 AM. Records further indicated that the facility had performed a whole-house audit of bed wheels on 04/11/25 to ensure that they were all working correctly. A review of the preventive maintenance policy on 05/20/25 at 3:05 PM revealed the following: Follow manufacturer's preventive maintenance recommendations Perform maintenance on equipment and physical plant on on a schedule which factors in operational activity and complies with applicable code requirements. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to equipment specific policies for preventive maintenance schedules. Ongoing review of records revealed a statement by Nursing Assistant (NA) #77 which stated: I was changing the resident. I turned him, as I turned him the bed moved. When the bed moved his head hit the corner of the stand at the left side of the bed. Another statement by RN #65 on 04/11/25 stated the following: I have taken care of [Resident] a lot. His bed will move even when it is locked. His bed has been broke like this for a couple of months. ALL of these beds are hit or miss. You never know if they are going to work right! During an interview with RN #65 on 05/21/25, RN confirmed that she had not reported the malfunctioning bed to maintenance or management. A document headed 'One on One Education 04/11/25' stated the following: Any time you are providing care to a resident and notice ANY type of defective equipment (ex: such as wheels being broken on the bed) you must report it immediately so it can be addressed to prevent injuries . The document had been signed by RN #65 on 04/11/25. A review of the preventive maintenance logs for resident's beds during the period 05/24 to 05/25 revealed that the bed safety audits consisted of the following: Nursing and maintenance are responsible for conducting bed safety audits Audits will be conducted annually and with a change of a specialty bed or mattress Nursing - check if side rails are clinically indicated Check mattress for tears, rips, odors or stains Evaluate mattress for foam visibility Check mattress for proper inflations settings Check power unit for function Check that the mattress is the correct width and length for the bed frame. However the preventive maintenance plan did not address or require the inspection of bed wheels, function and brakes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 05/21/25 at approximately 1:15 PM, the Administrator confirmed that the preventive maintenance policy did not include any requirements for checking bed wheels for function.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interview, the facility failed to control pain for Resident #110 by failing to implement non-pharmacological interventions for pain and by failing to identify an acceptable level of pain. This was true for one (1) of four (4) residents reviewed for pain during the survey process. Resident identifier: #110. Facility census: 111. Findings include: a) Resident #110 At approximately 3:30 PM, an interview was conducted with Resident #110 while he was in his chair, beside his bed. The resident stated he was in pain at the time, and would rate his pain at an eight (8) on a scale of one (1) to 10. The resident stated he would much rather be in his bed than the chair and stated he had asked staff to put him in his chair already, but was told they would be back to assist him. The resident stated he was in constant pain and did not feel like it was controlled. Review of the Resident's Minimum Data Set (MDS) dated [DATE], revealed the resident suffered frequent pain and it affects things such as his sleep and other activities of daily living significantly. His last record pain level on the MDS was a level eight (8). During a review of Resident #110's care plan on 05/19/25, the following was noted: Focus- (Resident #110's name) is at risk for decreased ability to perform ADLs in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting. Date initiated-5/2/2025. Goal- (Resident #110's name) will improve current level of function in:bathing, grooming/personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting by next review as evidenced by improved ADL scores. Date initiated- 5/2/2025. Interventions- Monitor for pain. Attempt non-pharmacological interventions to alleviate pain and document effectiveness. Administer pain medication as ordered and document effectiveness/side effects. Date initiated- 5/2/2025. During a review of the May 2025 Medication Administration Record (MAR) for Resident #110, it was noted the resident had two orders for monitoring pain. The orders read as follows: Ask resident if they are having pain. Document pain level and new onset Yes/No in supplementary documentation and document location of pain in emar PN (progress notes) every day and night shift. If new onset, complete EInteract Change in Condition and Pain Evaluation, if not new initiate non-pharmacological interventions and document interventions and effectiveness. Observe resident if they are having pain. Document pain level and new onset Yes/No in supplementary documentation and document location of pain in emar PN (progress notes) every day and night shift. If new onset, complete EInteract Change in Condition and Pain Evaluation, if not new initiate non-pharmacological interventions and document interventions and effectiveness. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Discrepancies were noted on the MAR between the two orders. On 05/03/25 during day shift, one entry states the resident was having pain at a level seven (7) with no non-pharmacological interventions attempted. The other entry on day shift states the resident was having pain at a level three (3) with non-pharmacological interventions being attempted. On 05/13/25 during day shift, one entry states the resident was having pain at a level five (5) with no non-pharmacological interventions attempted. The other entry on day shift states the resident was having pain at a level five (5) with non-pharmacological interventions being attempted. On 05/04/25 during night shift, one entry states the resident was having pain at a level three (3) with no non-pharmacological interventions taking place. The other entry on night shift states the resident had a pain level of zero (0). On 05/13/25 during night shift, one entry states the resident was having pain at a level two (2) with no non-pharmacological interventions being attempted. The other entry on night shift states the resident was having pain at a level five (5) with no non-pharmacological interventions being attempted. The following days state no non-pharmacological interventions were attempted when pain was indicated: Day shift- -05/04/25 -05/05/25 -05/10/25 -05/14/25 -05/17/25 -05/18/25 -05/19/25 Night Shift- -05/03/25 -05/05/25 -05/06/25 -05/12/25 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-05/16/25 -05/18/25 Further review of the MAR indicates the resident had the following orders for pain medication: Hydrocodone-Acetaminophen Oral Tablet 325 MG. Give one tablet every four (4) hours as needed for moderate to severe pain four 4-10 for 14 days. Start date 05/03/25. Discontinue Date-05/06/25. Hydrocodone-Acetaminophen Oral Tablet 325 MG. Give one tablet every four (4) hours as needed for moderate to severe pain four 4-10 for 14 days. Start date 05/6/25. Discontinue Date-05/15/2025. Tramadol HCl Oral Tabley 50 MG. Give 50 MG by mouth every 12 hours as needed for Pain rated 5-10 on pain scale. Start date 05/06/25. The resident also has an order for Tylenol for a pain level of one (1) to (4). Review of the MAR and eMAR Progress notes indicate the as needed medication was administered for pain on the following days: 05/03/25- Day and night shift 05/04/25- Day shift 05/05/25- Day shift 05/06/25- Day shift 05/08/25- Day and night shift 05/09/25- Day and night shift 05/11/25- Day shift 05/12/25- Day and night shift 05/13/25- Day and night shift 05/14/25- Day and night shift 05/15/25- Day shift 05/16/25- Day shift 05/17/25- Day shift 05/19/25- Day and night shift (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review indicates no non-pharmacological interventions had been attempted during the above times before administration of the PRN pain medication. At approximately 3:00 PM on 05/21/25, an interview was conducted with the Director of Nursing (DON). The DON confirmed no non-pharmacological interventions had been attempted. Pain Level During review of the resident care plan, the following goal was noted: Palliative: Patients wound related pain will be managed at an acceptable level for the patient. Review of the pain assessments and care plan reveal there is no acceptable pain level documented for the resident. At approximately 3:00 PM on 05/21/25, the DON acknowledged no acceptable pain level was documented for the resident.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on record review and staff interview, the facility failed to ensure posted nurse staffing information was accurate, by failing to update the posting. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents residing in the facility. Facility census: 111. Findings include: a) During staffing review, daily nurse staff postings were reviewed. During that review, it was determined that the facility failed to accurately update the posted information. The following days were reviewed and compared with the facility's punch in and out reports, with discrepancies: -11/16/2024- No census was indicated on the staffing sheet. Total direct care hours are 309.38 on the staffing sheet. On the facility punch in and out reports, the accurate number was 299.60. 11/23/2024- No census was indicated on the staffing sheet. Total direct care hours are 279 on the staffing sheet. On the facility punch in and out reports, the accurate number was 272.98. 12/28/24- Hours Per Patient Day (HPPD) indicated on the staff posting was 2.8 hours. On the facility Punch In and Out report, HPPD was 2.69 5/3/2025- Hours Per Patient Day (HPPD) indicated on the staff posting was 2.74 hours. On the facility Punch In and Out report, HPPD was 2.60 5/9/2025- No census was indicated on the staffing sheet. Total direct care hours are 299.75 on the staffing sheet. On the facility punch in and out reports, the accurate number was 330.52. At approximately 4:00 PM on 5/27/2025, the inaccuracies were confirmed by Senior Administrator #160.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on record review and resident and staff interview, the facility failed to ensure Medically related social services were provided to Resident #51, related to a desired transfer to another facility. This is true for one (1) of one (1) residents reviewed for medically related social services during the survey process. Resident Identifier: #51. Facility census: 111. Findings include a) Resident #51 At approximately 2:40 PM on 05/19/25, an interview was conducted with Resident #51. During the interview, Resident #51 stated he would like to transfer to a facility in Maryland, but had trouble getting assistance from the facility. He states he reached out to his sister and she was looking but she doesn't know what to look for. Resident #51 states he told the social worker at the facility but she hasn't got back to me about it. During review of the resident's electronic health record, it was noted the facility has one note from September 2023 where they inquired with one facility about a transfer to Maryland. The note stated they were awaiting a response. No response or follow up notes were found. At approximately 11:50 AM on 05/21/25, during an interview with the Social Services Director (SSD). The SSD stated, Medicaid is the problem. He wouldn't qualify for Maryland Medicaid unless he lived in Maryland for a month to establish residency. It is hard to transport out of state financially and logistically. The SSD was asked if she had the follow up documentation from the facility in Maryland, she replied, No, I do not. I didn't do follow up documentation. The SSD was asked if she reached out to any other facilities about a possible transfer, to which she stated she did not.

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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. Based on observation, resident and staff interview the facility failed to honor resident preferences for meals or provide an alternative vegetable. This was a random opportunity for discovery. Resident Identifiers: #75 and #80. Facility Census: #111 Findings include: a) Resident #75 On 05/19/25 at 5:34 PM an observation was made of Nurse Aide (NA) #110 assisting Resident #75 with her meal. Resident #75 was heard to say, Do not give me any of these peas. Nurse Aide #110 replied, I know, I won't give you any. Resident #75 replied and don't get them mixed in my other food. When this surveyor ask Resident #75 don't you like peas? She stated, No and they know it. Observation of Resident #75's meal ticket did not have peas listed as being served. It listed the following: 4 Tbsp creamed peanut butter & jelly #10 scoop Ground meat butter crumb topped fish fillet with 1 Tbsp lemon mayonnaise 1/2 cup Au Gratin Potatoes 1 each ice cream variety 1 each frosted brownie 8 ox 2% milk 1 each dinner roll 1 each margarine It was confirmed with Nurse Aide#110 at that time that Resident #75 did not like peas and Nurse Aide #110 had not offered an alternative vegetable with her meal. No additional comments were made by the Nurse Aide #110 at this time. On 5/20/25 at 10:08 AM a record review of Resident #75's Meal Tracker Resident Profile, which was updated 2/12/25, it was noted that Resident #75 had green peas documented as a dislike. A review of her care plan states to honor food preferences with meals and offer alternate choices as needed. Care plan review revealed: Resident #80 was at nutritional risk: (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident had a therapeutic diet and received an oral nutritial supplement. The resident had a diagnosis of dementia and a history of weight loss. Goal: Resident will consume adequate nutrition to prevent significant weight changes, promote intact skin, and maintain adequate hydration through next review. Interventions: Honor food preferences within meal plan. Food preferences updated as of 4/11/25 Weigh as ordered and alert dietitian and physician to any significant loss or gain. Monitor for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicated. Monitor intake at all meals, offer alternate choices as needed, alert dietitian and physician to any decline in intake. Provide regular dysphagia advanced/thin liquid diet as ordered' sip a mug and lip plate all meals. Provide 4 oz hi cal medpass tid as ordered, ice cream with lunch and dinner, PBJ with lunch and dinner. The above findings were confirmed on 05/20/25 at 10:30 AM with the Director of Nursing.b) Resident #80 At approximately 12:15 PM on 05/21/2025, an observation was made of Resident #80's meal he was served for lunch. Resident #80 was served two (2) tuna sandwiches. He stated I won't be eating those. Those are on my dislike list. At approximately 12:20 PM an interview was conducted with the Dietary District Manager (DDM) regarding Resident #80 ' s food preferences. The DDM printed out a copy of Resident #80's dislikes and confirmed fish group was listed on the resident's dislikes. At approximately 12:30 PM, an interview was conducted with Resident #80. He stated, Someone from the kitchen came down and offered me grilled cheese, but I don' t want it. The resident was asked if the staff member offered him the alternate meal, which was Salisbury steak. The resident stated Oh, I didn't even know they had it. That probably would have been nice. All he offered was grilled cheese and some fruit. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 12:40 PM an interview was conducted with [NAME] #144, who offered Resident #80 another meal. When asked if he offered Resident #80 the alternate meal, Salisbury steak, he stated, No, it completely slipped my mind, I didn't even think of it. I offered him some sandwiches. [NAME] #144 turned and asked [NAME] #145 if they had any more Salisbury steak for Resident #80. [NAME] #145 stated No, we don't have any left, he only had until 10:30 to order it if he wanted it. I can give him grilled cheese. At this time, the DDM was asked if Resident #80's meal ticket was accurately reflecting his dislikes, if he would have received the Salisbury steak in the first place, to which he stated, yes.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on staff interview, resident interview, observation and record review, the facility failed to provide suitable snacks for residents consistent with the residents plan of care. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Resident identifier's: # 74, #87, #10, and # 90. Facility Census: 111. Findings included: a) The facility's policy and procedure for Snacks, Nourishments, Supplements and Pantry Stock stated, Snacks, nourishments, supplements and pantry stock are available to complement meal service and are stored in a clean and sanitary environment. The policy and procedure stated the definition of a Snack was Evening snack is planned as part of the menu. and the definition of Pantry Stock was Small amounts of foods stored at the nursing station to accommodate resident requests between meals when the Food and Nutrition Services department is closed, as well as provide products for medication pass. On 05/20/25 at 2:00 PM, a Resident Council Meeting was held. The Resident Council Members reported the following: They haven't seen snacks, They don't bring them out, If you are able to ask for one .you can get one, you have to ask for them, One member reported they had not had snacks for two (2)months. Resident #74, #87, #10, and #90's care plans stated, Offer snacks. On 05/21/25 at 3:05 PM, the Administrator and Director of Nursing (DON) confirmed the care plans stated offer snacks. The DON reported they staff can also make peanut butter and jelly. The State Surveyor reported the pantries were limited in stock with no fruit cups, jello or sandwiches for all residents. Registered Nurse (RN) Supervisor # 111 reported the kitchen brings a snack cart at night and there are no grab and go sandwiches kept in the refrigerator, only what families bring. Regional Dietary Manager #161 reported the kitchen keeps the pantries full. and there is no snack cart.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to provide adaptive devices during a meal. This was a random opportunity for discovery. Resident Identifiers: #89 and #100. Facility Census: #111 Findings Include: a) Resident #89 On 5/19/25 at 5:25 PM observation at the dinner meal found Resident #89 had a meal ticket that consisted of a sip a mug. She did not have a sip a mug provided with her meal. This was confirmed on 5/19/25 at 5:30 PM with Nurse Aide (NA) #110 at which time she commented I don't know if she still has an order for the sip mug. Review of her physicians orders reads: Regular/Liberalized diet Regular texture, standard thin liquids consistency, sip a mug per residents request. Her care plan read: Resident at increased nutritional risk d/t ETOH abuse, COPD, cerebral aneurysm may affect nutritional status/meal intake. Advanced age. significant weight loss from 2/7/25 - 3/7/25, decreased meal intake, She is forgetting to eat and needs cued. Patient will consume adequate nutrition to prevent significant weight changes, promote intact skin, and maintain adequate hydration through next review. Honor food preferences within meal plan. Food preferences updated 05/02/25. Offer/encourage fluids of choice Encourage family/friends to bring in special foods from home or favorite restaurant. Weight as ordered and alert dietitian and physician to any significant loss or gain. Monitor changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs and report to food and nutrition/physician as indicated. Provide regular diet as order with sip a mug The above findings were confirmed with the Director of Nursing on 05/20/25 at 10:10 AM. b) Resident #100 On 05/19/25 at 5:44 PM, Resident #100 was given his drink during the dinner meal in a Sip-A-Mug cup. The resident's tray card, order and care plan stated to provide a [NAME] Cup. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/2025 at 03:00 PM, the Director of Nursing (DON) stated they changed the order yesterday for a Sip-A-Mug. The facility's policy and procedure for Assistive Devices stated, Assistive devices/utensils will be provided as identified in the individualized plan of care to maintain or improve a resident's/patient's ability to eat or drink independently.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview and observation, the facility failed to ensure food was stored and served in accordance with professional standards for food service safety. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 111. Findings included: a) The facility's policy and procedure for Food Storage: Dry Goods stated, 5. All packaged and canned food items will be kept clean, dry, and properly sealed. 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. The Regional Chef #162 reported, the facility policy is for items to be dated seven (7) days after being opened with an open and close date. The facility's policy and procedure for Food Storage: Cold Foods stated, 5. All foods will be stored wrapped or in covered containers, labeled and date, and arranged in a manner to prevent cross contamination. The Regional Chef # 162 reported, the facility policy is for items to be dated seven (7) days after being opened with an open and close date. On 05/19/25 at 12:17 PM, the Kitchen Task was initiated. The following items were found: Mrs. [NAME] syrup - opened and not dated; [NAME] pasta - opened not sealed and not dated; sandwich bread opened, not sealed and one (1) loaf not dated; Niagara water gallon jug - opened and not dated; maraschino cherries in a plastic container - not labeled or dated; [NAME] Sour Cream - opened and not dated; three (3) bags of ice on the freezer floor- one opened, not sealed and not dated; frozen pancakes - not labeled or dated; frozen pizza dough - not labeled or dated Regional Chef # 162 confirmed the items were not stored and served according to policy and procedure. Regional Chef # 162 stated, Twisted bags are not good enough? Is a knot okay? On 05/20/25 at 9:49 AM, 'B' Pantry was investigated. A loaf of bread was found open, not dated and not sealed. Licensed Practical Nurse (LPN) # 80 confirmed the pantry item. On 05/20/25 at 1:26 PM, 'A' Pantry was investigated. A biscuit wrapped in a napkin dated 03/21/25 was found. Registered Nurse (RN) Supervisor #111 confirmed the pantry item. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/25 at 2:49 PM, the State Surveyor observed [NAME] # 44 use his foot on the oven door to keep it open while removing food. Regional Dietary Manager #161 confirmed the cook's foot on the open oven door and stated, Unfortunately, he does.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interview, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident by failing to take actions related to allegations of abuse/neglect, when reported by staff. This had the potential to adversely affect all residents residing in the facility. The State Agency (SA) determined these failures caused Resident #97 to suffer sexual abuse and psychosocial harm. Due to the facility's failure to act on the allegation of sexual abuse when they were made aware not only placed Resident #97 at risk for sexual abuse and psychosocial harm but also placed the remaining 110 residents. The SA determined this constituted an Immediate Jeopardy (IJ) situation. Facility census: 111. Resident identifiers: #97, #58, and #102. Findings include: a) Resident #97 The State Agency (SA) identified two (2) Immediate Jeopardy (IJ) situations (F600 and F607) on 05/21/25 dealing with instances of sexual abuse committed by Resident #58 to Resident #97. During the investigations It was determined the facility was made aware of these instances on 03/20/25 and, despite multiple attempts by Resident #97 to report the incident, the facility did not act until 03/26/25. When the facility acted, they logged the allegation of abuse as a customer service grievance instead of an allegation of sexual abuse despite the resident stating she was grabbed in the groin area by Resident #58. The facility was made aware of a witness to the incident, Resident #102, whom she instructed the facility to interview; however, it was confirmed during an interview between Resident #102 and the SA that the facility did not interview this resident regarding the incident. At approximately 9:05 AM on 05/20/25, Resident #97 reported to a surveyor she was abused by Resident #58. Resident #97 stated Resident #58 hit her with her wheelchair and put her hand up my crotch. The resident stated she reported the alleged abuse to Nurse Aide (NA) #63 who, instead of reporting it, made fun of her and laughed while stating Didn't you like it? The resident stated she told NA #63 she did not like it. NA #63 did not report the allegation of abuse and Resident #97 stated she asked repeatedly to fill out a complaint and the facility would not listen to her. She states a friend, who used to be a Director of Nursing (DON), came to the facility to help her file the complaint. She stated after she filed the complaint the facility told her to stay away from Resident #58. On 05/21/25, it was noted the facility logged the allegation of abuse as a grievance related to customer service. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility educated NA #63 on customer service basics. The education did not mention abuse/neglect, how to identify it or how to report it. In addition, the recommended corrective action on grievance states the facility will re-educate all staff on policy and procedure. The facility is unable to provide any documentation that such education occurred. The resolution for Resident #97 was to stay away from Resident #58, the alleged perpetrator. The facility did not report the incident as an allegation of abuse and did not place any interventions in place to keep Resident #97 safe from further instances of abuse. At approximately 1:52 PM on 05/21/25 an interview was conducted with the Administrator and Senior Administrator in which they stated they would report any incident of sexual abuse to law enforcement. At approximately 2:12 PM on 05/21/25 an interview was conducted with Social Worker (SW) #62, in which she stated she took her concerns with this incident to the Administrator and Director of Nursing (DON). At approximately 3:30 PM on 5/21/2025, an interview was conducted with the DON in which she stated We (DON and Administrator) were in meetings in [NAME]. It took a long time to get back to Resident #97 (regarding the incident). The DON stated psych services followed up with Resident #97 after being contacted. The DON stated the facility did not report the allegation because Resident #58 reached between her (Resident #97) legs from behind and did not touch her. At approximately 4:41 PM on 05/21/25, an interview was conducted with NA #63. During the interview, NA #63 stated she did not see the incident, but Resident #97 told her Resident #58 came in and touched her.NA #63 stated this happened around dinner time and she was unaware if anyone else witnessed the incident. NA #63 stated she did not report the allegation of abuse because She (Resident #97) said she had already told someone else. At approximately 4:46 PM on 05/21/25, an interview was conducted with Resident #97. During the interview, Resident #97 stated she had her rollator against the door with her hand on her door handle. At this time, Resident #58 reached her hands between Resident #97's legs and right up into her crotch. Resident #97 said, I felt the grab with a layer. I was wearing a brief and a pad and pants, and I could feel it through that. Resident #97 was extremely tearful during the interview and stated, while crying, I felt violated. I feel no one should touch me there. Resident #97 stated Resident #58 was constantly in my room. Two days ago, she followed me into my room and said 'psst' and I turned around and told her to get out of my room. She said, I'm going to slap you on the ass. Months ago, she did slap me on the ass, and it stung. The staff think it's cute and funny. I'm sorry, I just don't feel that way. Resident #97 then stated, This is my home, what are they doing to protect me? Resident #97 stated at Bingo on Sunday (5/18/2025), Resident #58 was slapping at her arm and she told her to not touch her, and she stopped. The resident said She (Resident #58) comes into my room all the time and says she's going to poop in here. I tell her it's my room and to leave. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #97 states the Guest Services Director (GSD) came into her room and asked her what happened. She stated, I told her what happened and she (GSD) told me that if I touch her (Resident #58) that I would be arrested. I said you mean the mindless have rights and I don't? The resident stated no one else followed up with her that day. Resident #97 stated she told the GSD that she wanted to file a complaint about the incident and to get (Resident #102's name) statement because he saw everything. No statement was obtained and no report was filed. Resident #97 reported Social Worker #62 came into her room and she told her she wanted to file a complaint about the incident, but the resident said the SW ignored her. Resident #97 stated the Administrator and DON came to her room and told her the incident was not reportable. Resident #97 stated she instructed them to get the statement from Resident #102, who witnessed the incident, to which she stated she would. Resident #102 confirmed in an interview on 05/21/25 at 7:20 PM that no one from administration had spoken to him regarding the incident, up to this point. Resident #97 stated she used to come out of her room all the time and stopped coming out after the incident. However, she stated she was trying to get out of her room more now. She states she now feels very cautious, avoiding Resident #58's hallway. She stated she was constantly looking behind her when she is out of her room. She stated, I stayed in my room for a while but I'm getting out more now. At approximately 6:44 PM on 5/21/2025 an interview was conducted with Resident #102. Resident stated that on 03/20/25, Resident #97 was going into her room when Resident #58 rolled by in her wheelchair, reached out and grabbed Resident #97's butt. Resident #102 stated that Resident #97 was so surprised that she almost fell over. He further stated that she was very upset. Resident #102 further stated that this wasn't the first time Resident #58 has done this. He said that she has done it to some of the staff. Upon being asked how the staff reacted, he stated that some of them found it to be funny. Resident #97 has a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) and capacity to make medical decisions. Resident #58 has a BIMS score of 11 (cognitively intact) and capacity to make medical decisions. The facility's policy and procedure for Abuse Prohibition stated, The Center will implement an abuse prohibition program through the following: Screening of potential hires; Training of employees (both new employees and ongoing training for all employees); Prevention of occurrences; Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations; Protection of patients during investigations; and Reporting of incidents, investigations, and Center response to the results of their investigations. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Due to the inaction of the facility for six (6) days following the report of the incident, coupled with the inaction of the GSD when the incident was reported to her multiple times, the inaction of SW #62 when the incident was reported to her, and upon her reporting her concerns with the incident to the Administrator and DON, which led to them logging the allegation as a customer service allegation, instead of abuse, and informing Resident #97 the incident was not reportable, Resident #97 suffered serious sexual, mental and psychosocial harm. The administration's inaction, once being made aware of the incident, demonstrated their inability to properly identify instances of sexual, physical, and psychosocial abuse, and to take action to protect residents from further harm, despite knowing about the allegations. As part of the initial abatement plan for the IJ issued at F 600, The Administrator and DON were to interview all residents with a BIMS score of 8 or higher regarding abuse. The residents were to be asked if they had ever been abused or witnessed other residents being abused. After the IJ was issued at F 835, the Senior Administrator/Clinical Market Lead/Designee were, as part of that abatement plan, to re-interview each resident that was interviewed by the Administrator and DON. The DON interviewed nine (9) residents. All nine (9) residents, according to those interviews, stated not being abused and not seeing other residents being abused, or did not have any concerns that had not been addressed. When those interviews were redone, seven (7) of those nine (9) reported seeing other residents being touched inappropriately, being touched inappropriately, having money missing, and other concerns that had not been addressed. One resident stated I told them last night when starting her statement. This indicated the DON did not interview the residents initially. At approximately 1:30 PM on 05/22/25, an anonymous employee approached the survey team and wished to give information on the incident. The employee stated they reported the incident on 3/20/2025. At this point, the employee states an investigation was started and statements were obtained, and the employees investigating the incident were then told to not investigate any further, that it was not being reported, it was being logged as a grievance. The facility was first notified of the IJ at 11:55 AM on 5/22/25. The SA received and accepted the Plan of Correction (POC) at 1:45 PM on 5/22/25. The Nursing Home Administrator and Director of Nursing was placed on administrative leave on 5/22/2025 at 10:10am. The Guest Service Director and Social Worker were placed on administrative leave on 5/21/2025. NA #63 was placed on administrative leave on 5/21/2025. All residents have the potential to be affected by this practice. The Senior Nursing Home Administrator/designee conducted an audit of all resident interviews conducted on (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	residents have been correctly identified, reported in a timely manner, and appropriate intervention put in place to prevent recurrence daily for 2 weeks including weekends and holidays, then 3 times a week for 2 weeks then randomly thereafter. Results of monitors will be reported by the NHA / designee to the Quality Improvement Committee (QIC) monthly for any additional follow-up and or in-servicing until the issue is resolved, then randomly thereafter as determined by the Quality Improvement Committee. The IJ was abated at 11:45 AM on 05/27/25.

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Brightwood Center	840 Lee Road Follansbee, WV 26037

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 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. Based on record review and staff interview, the facility failed to accurately complete a smoking assessment for Resident #32. This was true for one (1) of five (5) residents reviewed for smoking. Resident identifier: #32. Facility census: 111. Findings include: a) Resident #32 During a review of Resident #32's electronic health record on 05/21/25, it was noted a smoking assessment was completed for the resident on 04/29/25. The last question of the smoking assessment had three (3) choices to choose from. Those choices were the resident was allowed to smoke independently, with assistance, or not at all. This question was left blank, with no determination made regarding the resident's smoking status. The incomplete assessment was acknowledged by the Director of Nursing (DON) at approximately 3:00 PM on 05/21/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. Based on observation, record review, and staff interview, the facility failed to adhere to proper infection control practices by leaving food items being transported from the kitchen to the floor, uncovered and by failing to handle and transport soiled linens in a manner to prevent the spread of infection. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents residing in the facility. Facility census: 111. Findings include: a) During dinner service on 05/19/25 at approximately 5:35 PM, each tray being pulled from the delivery cart was observed as having an uncovered brownie on it. When asked if the brownies should be uncovered, The Clinical Reimbursement Coordinator (CRC) stated, I ' m not sure, I will let you know. The CRC returned and stated, They can be uncovered because we are taking them from the cart to the rooms. At approximately 11:05 AM, on 5/20/2025, the policy regarding meal distribution was reviewed, and it was confirmed with the Regional Chef, that all items transported from the kitchen should be covered. The policy stated All foods that are transported to dining areas that are not adjacent to the kitchen will be covered. b) On 05/19/25 at 1:17 PM, Staff #73 carried soiled linen from Resident #19 down the hallway and returned with a clean sheet. Staff #73 failed to transport linens in a manner to prevent the spread of infections. Staff #17 confirmed the linen was not bagged and gloves were not used to carry the soiled linen to laundry. The facilities policy and procedure for Linen Handling stated, All linen will be handled, stored, transported, and processed to contain and minimize exposure to waste products. All soiled linen will be handled the same, using Standard Precautions.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on investigation, interview and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition. Furthermore, facility staff failed to notify maintenance or management of defective equipment promptly, thereby potentially exposing all residents in the facility to injury. Resident identifier: #24. Facility Census: 111. Findings include: a) Resident #24 Record review on 05/20/25 at approximately 2:30 PM revealed Resident #24 was injured on 04/10/25, when the resident's bed moved while the nursing assistant was providing care. Resident #24 struck his head against the nightstand on the left side of the bed. The resident sustained two lacerations to the top of his head. The facility investigation revealed that the wheel on the resident's bed was broken. The bed moved even when the wheel was locked. Maintenance replaced the wheels and then performed a whole house audit of all the beds in the facility. Further review of the records revealed that the incident was reviewed by the Interdisciplinary Team (IDT) and maintenance was notified. A review of records on 05/20/25 at approximately 2:35 PM revealed that an order had been entered into the TEL's system for a check on the bed's wheels. Maintenance records revealed that the wheel lock was found to be defective, and the wheel was replaced on 04/11/25 at 11:00 AM. Records further indicated that the facility had performed a whole house audit of bed wheels on 04/11/25 to ensure that they were all working properly. Ongoing review of records revealed a statement by Nursing Assistant (NA) #77 which stated: I was changing the resident. I turned him, as I turned him the bed moved. When the bed moved his head hit the corner of the stand at the left side of the bed. Another statement by RN #65 on 04/11/25 stated the following: I have taken care of [Resident] a lot. His bed will move even when it is locked. His bed has been broke like this for a couple of months. All of these beds are hit or miss. You never know if they are going to work right! During an interview with RN #65 on 05/21/25, RN confirmed that she had not reported the malfunctioning bed to the maintenance or management. A document titled One on One Education 04/11/25 stated the following: (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Any time you are providing care to a resident and notice ANY type of defective equipment (ex: such as wheels being broken on the bed) you must report it immediately so it can be addressed to prevent injuries . The document had been signed by RN #65 on 04/11/25. A review of the preventive maintenance policy on 05/20/25 at 3:05 PM revealed the following: Follow manufacturer's preventive maintenance recommendations Perform maintenance on equipment and physical plant on a schedule which factors in operational activity and complies with applicable code requirements. Refer to equipment specific policies for preventive maintenance schedules. A review of the preventive maintenance logs for resident's beds during the period 05/24 to 05/25 revealed that the bed safety audits consisted of the following: Nursing and maintenance are responsible for conducting bed safety audits Audits will be conducted annually and with a change of a specialty bed or mattress Nursing - check if side rails are clinically indicated Check mattress for tears, rips, odors or stains Evaluate mattress for foam visibility Check mattress for proper inflations settings Check power unit for function Check that the mattress is the correct width and length for the bed frame. However, the preventive maintenance plan did not address, or require the inspection of bed wheels, function and brakes. During an interview with the Administrator on 05/21/25 at approximately 1:15 PM, the Administrator confirmed that the preventive maintenance policy did not include any requirements for checking bed wheels for function. b) On 05/20/25 at 02:49 PM, [NAME] #144 used his foot to hold the oven door open while food was being removed. Regional Dietary Manager # 161 confirmed the broken right oven door and stated a spring was broken and it was hard to get the food out because the door will not stay open.