STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515151	A. Building B. Wing	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grant Rehabilitation and Care Center	127 Early Avenue Petersburg, WV 26847

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39571 Based on observation, policy review and staff interview the facility failed to ensure each resident had a dignified existence. This was a random opportunity for discovery and was true for Resident #37, #65, #40, #57, #330 and #44. Resident identifiers: #37, #65, #40, #57, #330, and #44 . Facility census 82. Findings include: a) Assisting Resident with eating On 04/16/24 at 12:27 PM, Licensed Practical Nurse (LPN) # 35 was standing over Resident #37 while feeding her. LPN #35 was asked if she always feeds residents while standing? LPN #35 said, I just feed, however, I can. LPN #35 went on to say, I do not always feed Residents. The Facility Policy titled, Assistance with Meals Revision date: 03/22, stated, * Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: -Not standing over residents while assisting them with meals. On 04/16/24 at 2:00 PM, the Assistant Director of Nursing (ADON) was informed of the above and no further information was provided. b) Resident #65 Resident #65 was observed on 04/16/24 at 11:55 AM, being lifted from his Geri chair in the Day room by Nurse Aide (NA) #50 and #55. It was noted the residents' pants were not pulled up over his brief and he was exposed to everyone in the Day room. There were 14 residents in the day room and two (2) visitors. The white brief on Resident #65 appeared to be very heavy and was hanging very low, while the resident was hanging in the air being pushed to the bathroom. Resident #65 was transported approximately 10-12 feet into the bathroom via lift. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The two (2) NA's used the lift to transport Resident #65 to the bathroom. At 12:02 PM the same two (2) NA's pushed Resident #65 out of the bathroom with the lift back to the chair. A brief interview on 04/16/24 at 12:06 PM, NA #50 was asked about providing privacy for Resident #65. NA #50 stated, she did not know his pants were pulled down. NA #50 stated using the lift to take residents to the bathroom is what they have always done. NA#50 went on to say Resident #65 had a brief on, so he was not really exposed. C) Dining Room At approximately 12:00 PM on 04/17/24, an observation was made in the dining room of the facility during lunch service. Nurse Aide (NA) #55, was observed removing a resident's dishes from a table while Resident #40 was still eating. NA #55 then went to another table and removed another resident's dishes while Resident #57 was still eating at that table. NA #36 then started to remove another resident's dishes from a table while Resident #330 and Resident #44 were still eating at that table. Interviews were conducted with NA #55 and NA #36, in which both stated they were unaware they could not clear tables while residents were still at those tables eating. Assistant Director of Nursing (ADON) notified at approximately 12:45 PM on 04/17/24. ADON stated they were not aware tables could not be cleared if other residents were still at those tables eating. 49467

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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. 50551 Based on observation, record review and resident and staff interview the facility failed to promote and facilitate resident self-determination through support of resident choices in regards to the resident's preference as to how many showers they would like per week. This was true for one (1) of three (3) residents reviewed for self-determination. Resident identifier: Resident #60. Facility Census: 82. Findings Include: a) Resident #60 During an interview on 04/15/24 at 1:23 PM, Resident #60 stated they had asked the staff for three (3) baths per week and was told the facility did not have enough help. The resident reported their shower days are scheduled for Wednesdays and Sundays but they would like to shower on Fridays in addition. The resident reported they have a condition which causes them to itch and believes they may feel better with more frequent showers. On 04/16/24 1:08 PM, a review of the Psychosocial Note dated 02/19/24 stated the resident asked for (their) care plan team to allow (them) to have an additional shower during the week on Fridays. Review of resident's care plan on 04/16/24 3:39 PM, reflects the resident will shower 3 x week in the morning. On 04/16/2024 3:48 PM, a review of Resident #60's bathing tasks reports for February, March and April of 2024 reflect the resident had showered every Sunday and Wednesday morning. On 04/16/2024 at 3:51 PM, a review of the 400 Wing Bath Schedule reflected the resident was scheduled to shower on Wednesday and Sunday. An interview was conducted on 04/16/2024 at 4:02 PM, with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) who acknowledged the resident's care plan stated resident was to receive showers 3 (three) times per week, the resident had expressed their desire to receive 3 (three) showers per week by adding a shower on Fridays, the resident was listed on the shower schedule for Wednesdays and Sundays and the resident had received 2 (two) showers per week per task reports. The ADON stated the care planned showers must have been overlooked and she would add the additional shower to the shower schedule.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 39043 Based on record review and staff interview, the facility failed to ensure a new Preadmission Screening and Resident Review (PASARR) was completed for Resident #68, #67, and #18 when the residents developed a new mental illness diagnosis during their stay at the facility. This was true for three (3) out of five (5) residents reviewed for care area of PASARR during the long term care survey process. Resident Identifier: #68, #67, and #18. Facility census: 82. Findings include: A) Resident #68 At approximately 2:30 PM on 04/15/24 a record review was conducted for Resident #68. The record noted the resident was admitted to the facility with a PASARR dated 09/01/23. A review of Resident #68's diagnoses noted the resident was diagnosed with Major Depressive Disorder on 10/30/23. Further review indicated the facility had not completed a new PASARR for Resident #68. At approximately 2:01 PM on 04/16/24, the Director of Nursing (DON) acknowledged the facility had not yet completed a new PASARR for Resident #68 after the diagnosis was added. The DON stated they were not aware a new PASARR needed to be completed after a new diagnosis of a major mental illness. B) Resident #67 At approximately 3:00 PM on 04/15/24 a record review was conducted for Resident #67. The record review noted the resident was admitted to the facility with a PASARR dated 11/23/22. A review of Resident #67's diagnoses noted the resident was diagnosed with Major Depressive Disorder on 08/07/23. Further review indicated the facility had not completed a new PASARR for Resident #67. At approximately 2:01 PM on 04/16/24, the Director of Nursing (DON) acknowledged the facility had not yet completed a new PASARR for Resident #67 after the diagnosis. The DON stated they were not aware a new PASARR needed to be completed after a new diagnosis of a major mental illness. c) Resident #18 Review of Resident #18's medical records showed the resident was admitted to the facility in 2017. Further review of Resident #18's medical records showed a PASRR was completed on 05/22/17. The resident was noted to have a diagnosis of major depression. PASRR Level II screening was recommended. However, PASRR Level II desk review determined Resident #18 was not in the Level II screening population and nursing home placement was determined to be appropriate. On 06/05/18, Resident #18 received a diagnosis of bipolar disorder. An updated PASRR was not completed for the resident to determine whether nursing home placement continued to be appropriate for the resident. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/16/24 at 3:49 PM, the Director of Nursing confirmed Resident #18's most recent PASRR was performed on 05/22/17 and an updated PASRR was not completed when the resident received a new diagnosis of bipolar disorder in 2018. No further information was provided through the completion of the survey process. 49467

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45171 Based on record review and staff interview the facility failed to develop a personalized centered care plan for a focus of respiratory relating to Chronic Obstructive Pulmonary Disease (COPD). This was true for one (1) of twenty six (26) care plans reviewed during the long term care process. Resident Identifier: #12. Facility Census: 82 Findings Include: a) Resident #12 On 04/15/24 at 12:40 PM and 2:40 PM and on 04/16/24 at 8:24 AM it was observed that Resident #12 had a respiratory nebulizer mask at bedside. On 04/16/24 at 1:30 PM, a record review found Resident #12 had a medical diagnosis of Chronic Obstructive Pulmonary Disease (COPD). There was also physicians orders as follows: Ipratropium Albuterol Solution 0.5-2.5 (3) milligrams (MG)/3 milliliters (ml) 1 application inhale orally two times a day related to Chronic Obstructive Pulmonary Disease. and Ipratropium Albuterol Solution 0.5-2.5 (3) milligrams (MG)/3 milliliters (ml) 1 application inhale orally every 12 hours as needed for COPD. On 04/16/24 at 1:30 PM, a record review found Resident #12 had no personalized care plan in place for a respiratory focus for Chronic Obstructive Pulmonary Disease. The above findings was confirmed with Assistant Director of Nursing #25 on 04/16/24 at 01:32 PM. And no further information was obtained.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39571 Based on observation, medical record review and staff interview the facility failed to ensure skin assessments were done at a professional standard of practice and failed to administer Immunizations recommended by the CDC in a timely manner. This failed practice had the potential to affect more than a limited number of residents who currently reside at the facility. Resident Identifier: #52, #19, #18, and #12. Facility census 82. Findings include: a) Skin assessments. On 04/16/24 at 3:40 PM, the Director of Nursing (DON) was interviewed and asked about the facility form called a, SHOWER BODY AUDIT for Residents. The DON said the Nurse Aides do skin assessments when they give showers. If they find a concern, they mark it on the shower body audit sheet and the nurse will go and assess it, then sign the shower body audit. The DON was asked if a Licensed Nurse does routine skin assessments on everyone. The DON said no they go by what the Aides find. Also, at this same time the Licensed Practical Nurse/Treatment Nurse (TN) #120 was present for this interview via phone. TN #120 stated she does not do routine skin assessments. The DON agreed that while it is good practice for the Nurse Aides to report any skin issues they find, a licensed nurse has the training to assess skin issues. During the above interview the DON confirmed routine and/or weekly skin assessments are not being done by a licensed nurse. From the website. NCBI (National Institutes of Health) A complete skin assessment is essential for holistic care and must be completed by nurses and other health professionals on a regular basis. Providing patients and relatives with information on good skin hygiene can improve skin integrity and reduce the risk of pressure damage and skin tears. The assessments need to be repeated on a regular basis to determine whether any changes in skin condition have occurred. In Long term care facilities, comprehensive skin assessment should be performed by a unit nurse on admission to the unit, daily, and on transfer or discharge. This includes assessment of skin color, moisture, temperature, texture, mobility and turgor, and skin lesions. Inspect and palpate the fingernails and toenails, noting their color and shape and whether any lesions are present. b) Facility Immunizations On 04/17/24 at 8:30 AM, a record review found the facility failed to provide information and/or administer the Respiratory Syncytial Virus (RSV), Pneumococcal, the Recombinant Zoster Vaccine (RZV)/Shingrix and the Moderna/Pfizer Fall 2023 immunization per recommendation of the CDC in a timely manner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Centers for Disease Control and Prevention (CDC) Respiratory Syncytial virus, or RSV, is a common respiratory virus that usually causes mild, cold-like symptoms. Most people recover in a week or two, but RSV can be serious. Infants and older adults are more likely to develop severe RSV and need hospitalization . Vaccines are available to protect older adults from severe RSV. Monoclonal antibody products are available to protect infants and young children from severe RSV. CDC recommends RSV vaccines to protect adults ages 60 and older from severe RSV, using shared clinical decision-making. According to the CDC the RSV vaccine was made available on early August of 2023. In general, simultaneous administration of vaccines remains a best practice. Providers should continue to simultaneously administer the vaccines for which a patient is eligible, including COVID-19, influenza, and pneumococcal vaccines. Simultaneous administration of RSV vaccine with other vaccines for older adults is also acceptable. When deciding whether to simultaneously administer other vaccines with RSV vaccine on the same day, providers should consider whether the patient is up to date with recommendations for currently recommended vaccines, the feasibility of administering additional vaccine doses later, risk for acquiring vaccine-preventable disease, vaccine reactogenicity profiles, and patient preferences. .recommendations specify the use of either PCV20 alone or PCV15 in series with PPSV23 for all adults aged =[AGE] years and for adults aged 19-[AGE] years with certain underlying medical conditions or other risk factors who have not received a PCV or whose vaccination history is unknown. In addition, ACIP recommends use of either a single dose of PCV20 or =1 dose of PPSV23 for adults who have started their pneumococcal vaccine series with PCV13 but have not received all recommended PPSV23 doses. Shared clinical decision-making is recommended regarding use of a supplemental PCV20 dose for adults aged =[AGE] years who have completed their recommended vaccine series with both PCV13 and PPSV23 . Above information was taken from the website: Centers for Disease Control and Prevention (.gov) A random sample of five (5) residents were chosen to review immunizations. Resident #12 had consented to the Pneumococcal (PCV 20), Respiratory Syncytial Virus (RSV), and the Recombinant Zoster Vaccine (RZV)/Shingrix vaccinations on 02/29/24. As of 04/17/24 none of the above vaccines had been administered. Resident #18 had consented to the Pneumococcal (PCV 20), Respiratory Syncytial Virus (RSV), the Recombinant Zoster Vaccine (RZV)/Shingrix and the Pfizer Fall 2023 vaccinations on 04/17/24 (the date of the interview with the Infection Preventionist). As of 04/17/24 none of the above vaccines had been administered. Resident #19 had consented to the Respiratory Syncytial Virus (RSV) and the Recombinant Zoster Vaccine (RZV)/Shingrix vaccinations on 02/16/24. As of 04/17/24 none of the above vaccines had been administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #52 had consented to the Pneumococcal (PCV 20), Respiratory Syncytial Virus (RSV), and the Recombinant Zoster Vaccine (RZV)/Shingrix vaccinations on 04/10/24. As of 04/17/24 none of the above vaccines had been administered. On 04/17/24 at 11:45 AM during an interview with the Infection Preventionist (IP), she stated she had not given the RSV vaccines yet because she had not received them from the pharmacy. When ask when she ordered them, she responded a few days ago. When asked what the plan was to administer the vaccines that were not complete yet, she stated she planned to administer the RSV when they come in, the COVID 2023 fall vaccination two (2) weeks after the RSV, the Recombinant Zoster Vaccine (RZV)/Shingrix vaccine two (2) weeks after the COVID, and the Pneumococcal vaccines two (2) weeks after the RZV. She plans to have all vaccines up to date in six (6) to eight (8) weeks. She states she has not administered any RSV or RZV vaccinations for the [AGE] year. The IP stated she did not know the guidelines for CDC in administering the vaccinations as it pertains to seasons it is to be administered in. On 04/17/24 at 12:30 PM the above information was confirmed with the IP at which time she stated, I agree the vaccines should have already been administered in order to be completed in a timely manner. 45171

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39043 Based on observation and staff interview the facility failed to ensure the resident environment over which it had control was as free of accident hazards as is possible . These failed practices were random opportunities for discovery and was true for Resident #65 and #26. Resident identifiers: #65 and #26. Facility census 82. Findings include: a) Resident #65 Resident #65 was observed on 04/16/24 at 11:55 AM, being lifted from his Geri chair in the Day room by Nurse Aide (NA) #50 and #55. It was noted the residents' pants were not pulled up over his brief and he was exposed to everyone in the Day room. There were 14 residents in the day room and two (2) visitors. The white brief on Resident #65 appeared to be very heavy and was hanging very low, while the resident was hanging in the air being pushed to the bathroom. Resident #65 was transported approximately 10-12 feet into the bathroom via a mechanical lift. The two (2) NA's used the lift to transport Resident #65 to the bathroom. At 12:02 PM the same two (2) NA's pushed Resident #65 out of the bathroom with the lift back to the chair. A brief interview on 04/16/24 at 12:06 PM, NA #50 was asked about providing privacy for Resident #65. NA #50 stated, she did not know his pants were pulled down. NA #50 stated using the lift to take residents to the bathroom is what they have always done. NA#50 went on to say Resident #65 had a brief on, so he was not really exposed. b) Resident #26 Review of the facility's policy titled Self-Administration of Medications with initiation date 2001 and revision date of February 2021 stated as follows: - The Intradisciplinary Team (IDT) would determine whether residents had the cognitive and physical abilities to safely self-administer medications. - If it was deemed safe and appropriate for a resident to self-administer medications, this would be documented in the medical record and care plan. - Residents who are identified as being able to self-administer medications would be asked if they wished to do so. On 04/17/24 at 7:50 AM, Licensed Practical Nurse (LPN) #104 was observed administering medications to Resident #26. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #104 placed the following oral medications into a medication cup: - Amiloride for hypertension - Colace for constipation - Cranberry tablet for history of urinary tract infections - Gabapentin for diabetic neuropathy (Gabapentin is also a controlled substance, kept in a special drawer of the medication cart. Administration of controlled substances is carefully monitored.) - Synthroid for hypothyroidism - Lasix for edema - Lisinopril for hypertension - Prilosec for gastro-esophageal reflux disease - Magnesium for vitamin deficiency - Ferrex for anemia - Famotidine for gastro-esophageal reflux disease - Fiber capsule for constipation - Buspar for anxiety disorder - Metformin for diabetes mellitus - Prozac for major depressive syndrome - Senna for constipation - Multivitamin for vitamin deficiency - Vitamin B12 for deficiency - Vitamin D3 for deficiency - Zyrtec for chronic sinusitis - Trajenta for type II diabetes mellitus Miralax powder for constipation was also placed in a cup. LPN #104 stated Resident #26 liked to mix the Miralax with coffee she already had in her room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #104 entered Resident #26's room with the medications. Resident was lying in bed with the overbed table across the bed. LPN #104 placed Resident #26's oral medications on the overbed table. LPN #104 stated the resident had capacity and would take the medications on her own. LPN #104 then left the resident's room. In the hallway, LPN #104 was questioned about leaving Resident #26's medications in her room for the resident to take independently. LPN #104 stated Resident #26 was care planned to self-administer medications. Review of Resident #26's medical records showed a form titled Self-Administration of Drugs. The form had been signed on 03/13/18 and Resident #26 indicated I do not wish to exercise my right to self-administer my own medications to keep any medications at bedside. Review of Resident #26's comprehensive care plan contained no indication the resident was care planned to self-administer medications. On 04/17/24 at 9:12 AM, the Director of Nursing agreed Resident #26's medications should not have been left at the resident's bedside for the resident to take independently. No further information was provided through the completion of the survey. 39571

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 45171 Based on observation and staff interview the facility failed to store respiratory equipment in a clean sanitary manner consistent with professional standards of practice. This was a random opportunity for discovery. Resident Identifiers: #12 and #13. Facility Census: 82 Findings Include: a) Resident #12 On 04/15/24 at 12:40 PM and 2:40 PM and on 04/16/24 at 08:24 AM it was observed that Resident #12's respiratory nebulizer mask was not stored in a clean sanitary manner. It was on the bedside table outside of the plastic storage bag. Resident #12 had a physicians order for: Ipratropium Albuterol Solution 0.5-2.5 (3) milligrams (MG)/3 milliliters (ml) 1 application inhale orally two times a day related to Chronic Obstructive Pulmonary Disease. and Ipratropium Albuterol Solution 0.5-2.5 (3) milligrams (MG)/3 milliliters (ml) 1 application inhale orally every 12 hours as needed for COPD. The facility policy for departmental (respiratory Therapy) prevention of infection states Infection control considerations related to medication nebulizer/continuous aerosol: 7. Store the circuit in plastic bag, marked with date and resident's name, between uses . The above findings was confirmed with Registered Nurse (RN) #71 on 04/16/24 at 08:25 AM. b) Resident #13 On 04/15/24 at 12:35 PM and 2:35 PM and on 04/16/24 at 8:20 AM it was observed that Resident #13's respiratory nebulizer mask was not stored in a clean sanitary manner. It was on the bedside table outside of the plastic storage bag. Resident #13 has a physicians order for: Ipratropium Albuterol Solution 0.5-2.5 (3) milligrams (MG)/3 milliliters (ml) 1 viral inhale orally every 4 hours as needed for shortness of breath (sob) wheezing. The facility policy for departmental (respiratory Therapy) prevention of infection states Infection control considerations related to medication nebulizer/continuous aerosol: 7. Store the circuit in plastic bag, marked with date and resident's name, between uses . (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The above findings was confirmed with Registered Nurse (RN) #71 on 04/16/24 at 08:26 AM.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 42120 Based on record review, and staff interview, the facility failed to insure the physician documented the actions or rational if no action taken for monthly drug regimen reviews. This was true for three (3) of five (5) reviewed for unnecessary medications. Resident identifier #65, #7 and #43. Facility census: 82. Findings include: a) Resident #65 A medical record review for Resident #65 revealed monthly drug regimen reviews response without actions or rational if no action taken by the physician. --06/07/23 Recommendation to consider reducing Zyprexa 2.5mg and 1.25mg dose by 50%. Physician response -Stable. --03/06/24 Recommendation to consider reducing Zyprexa 2.5mg and 1.25mg dose by 50%. Physician response -Needs this. During an interview on 04/16/24 at 11:02 AM the Director of Nursing verified that the physician did not document the action or rational. b) Resident #7 On 04/17/24 at 10:10 AM a record review of Resident #7's medical diagnosis showed the following: Unspecified Dementia, moderate with anxiety, unspecified dementia, moderate with mood disturbance, and conduct disorder, unspecified. There was a Physicians order dated 04/03/20 for Seroquel Tablet (Quetiapine Fumarate) (an antipsychotic medication) Give 25 milligrams by mouth one time a day for increased behaviors related to severe intellectual disabilities. A review of the Medication Regimen Review (MRR) and Gradual Dose Reductions (GDR) for psychotropic medications shows there was a recommendation from the pharmacy on 01/30/24 for Seroquel 25 mg every day. Recommendation: Please consider a trial reduction to 50% reduction. It is required that the physician document the action taken on the recommendation or if no action is taken, rationale as to why no action was not taken. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/07/24 the physician visited the resident and documented on the GDR Note to Attending Physician/Prescriber from the pharmacy with a rationale of needs. This is not sufficient rationale according to the Center for Medicare and Medicaid Services (CMS) guidelines. The above information was confirmed with the Assistant Director of Nursing, RN #25 on 04/17/24 at 12:41 PM. C) Resident #43 At approximately 11:00 AM on 04/15/24, a record review of medication regimen reviews for Resident #43 was conducted. During the review, it was determined there were two recommendations made by the licensed pharmacist pertaining to a PRN (as needed) order Ambien for Resident #43, not accepted by the physician, with no appropriate rationale given. The following recommendation for the PRN order of Ambien was made on 01/03/24: Please evaluate. If the order is to be continued, please indicate a specific duration of use and provide clinical rationale below. Per review of the eMAR, doses have been requested. The physician supplied the following rationale in response to the recommendation: OK to give. The following recommendation for the PRN order of Ambien was made on 03/06/24: Please evaluate. If the order is to be continued, please indicate a specific duration of use and provide clinical rationale below. Per review of the eMAR, doses have been requested. The physician supplied the following rationale in response to the recommendation: Needs this. At approximately 2:01 PM on 04/16/24, an interview was conducted with the Director of Nursing (DON) regarding the PRN order for Ambien and the rationales given to the pharmacy recommendation. The DON acknowledged there was not a proper clinical rationale given for the PRN order of Ambien. 45171 49467

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45171 Based on record review and staff interview, the facility failed to ensure an order for a PRN (as needed) psychotropic medication did not exceed 14 days for Resident #43, and failed to attempt a Gradual Dose Reduction (GDR) for an antidepressant for Resident #7. This was true for two (2) of five (5) residents reviewed for the care area of unnecessary medications during the long-term care survey process. Resident identifiers: #43,and #7. Facility census: 82. A) Resident #43 At approximately 11:00 AM on 04/15/24, a record review of orders for Resident #43 was conducted. During the review, it was determined the resident had the following order for Ambien: Ambien oral tablet 10 MG (Zolpidem Tartrate) Give 10 mg by mouth as needed at bedtime for insomnia. The hours listed on the order are PRN. The order was written on 12/06/23 and was the current order at the time of this review. Pharmacy recommendations were found for the PRN order of Ambien during a record review, however, appropriate rationales were not given and a specific duration of use was not provided. The following recommendation for the PRN order of Ambien was made on 01/03/24: Please evaluate. If the order is to be continued, please indicate a specific duration of use and provide clinical rationale below. Per review of the eMAR, doses have been requested. The physician supplied the following rationale in response to the recommendation: OK to give. The following recommendation for the PRN order of Ambien was made on 03/06/24: Please evaluate. If the order is to be continued, please indicate a specific duration of use and provide clinical rationale below. Per review of the eMAR, doses have been requested. The physician supplied the following rationale in response to the recommendation: Needs this. At approximately 2:01 PM on 04/16/24, an interview was conducted with the Director of Nursing (DON) regarding the PRN order for Ambien and the rationales given to the pharmacy recommendation. The DON acknowledged there was not a proper clinical rationale given for the PRN order of Ambien and that the order had exceeded 14 days. b) Resident #7 On 04/17/24 at 10:10 AM, a record review of Resident #7's medical diagnosis found the following diagnoses: Unspecified Dementia, moderate with anxiety, unspecified dementia, moderate with mood disturbance, and conduct disorder, unspecified, (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There is a Physicians order dated 09/09/19 for Fluvoxamine (an anti depressant) 100 milliliter tablet, take one tablet by mouth every night at bedtime for related diagnosis, anxiety disorder, unspecified (indications for use: depression). Record review of Gradual Dose Reductions (GDR) for psychotropic medications shows there has been no GDR attempt for the above anti depressant since 07/06/22. A GDR must be attempted annually, unless clinically contraindicated. There is no documentation that the GDR attempt was made nor was there documentation from the Physician that it is clinically contraindicated to attempt the GDR. The above information was confirmed with the Assistant Director of Nursing, RN #25 on 04/17/24 at 12:41 PM 49467

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39043 Based on observation, record review, and staff interview, the facility failed to ensure medications were stored and labeled in accordance with currently accepted professional principles. Insulin pens were not dated when opened. Additionally, controlled substances were not properly secured in medication rooms. Also, expired medications were found in the medication room. This deficient practice had the potential to affect more than a limited number of residents. Resident identifiers: #70, #8, #72. Facility census: 82. Findings Include: a) Insulin pens Review of the facility's policy titled Administering Medications, with implementation date 2001 and revision date 2009, stated when a multi-dose container is opened, the opening date should be recorded on the container. On 04/17/24 at 8:16 AM, the 400 hallway medication cart was inspected with Registered Nurse (RN) #18 in attendance. Three (3) multi-dose insulin medications had not been dated when opened. It is important to label multi-dose medications for injection with the opening date because they must be discarded within 28 days of opening unless the manufacturer specifies a different time frame for that medication. This is an infection control measure to decrease the risk of contamination of the medication and bacterial or fungal growth in the vial. These multi-dose insulins were as follows: - Levemir FlexPen Subcutaneous Solution Pen-injector (Insulin Detemir) for Resident #70 - Lantus SoloStar Subcutaneous Solution Pen-injector (Insulin Glargine) for Resident #8 - Humalog Insulin Injection Solution (Insulin Lispro), in a vial, for Resident #72 RN #18 confirmed these insulin medications had not been dated when first opened. No further information was provided through the completion of the survey. b) Facility On 04/17/24 at 8:00 AM, an observation of the 400 Hall Medication Preparation Room found the facility failed to provide separately locked, permanently affixed compartments for storage of controlled Schedule II drugs and other drugs subject to abuse. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The refrigerator on the 400 hall had 30 ml of Lorazepam oral concentrate 2 milligrams (mg)/ milliners (ml) in the refrigerator that did not have a lock. There was also no permanently affixed compartment for storage of the controlled medication. This was confirmed with Registered Nurse #18 on 04/17/24 at 8:09 AM and the Administrator and Director of Nursing on 04/17/24 at 8:11 AM. The medication refrigerator in the 100/200 Hall Main Medication Preparation Room did have a lock in place, however, upon entry into the medication room, the refrigerator was unlocked. There was also two (2) permanently affixed compartments for storage of controlled medications. Both of the compartments were unlocked. One affixed compartment contained two (2) vials of Lorazepam 2 mg/ml 1 ml each vial The second affixed compartment contained one (1) vial of Lorazepam 2 mg/ml 1 ml vial This was confirmed with the Director of Nursing on 04/17/24 at 8:47 AM. c) Facility On 04/17/24 at 8:00 AM, an observation of the 400 Hall Medication Preparation Room found the following medications to be expired: One (1) bottle of twenty five (25) tablets of Nitroglycerin that expired 12/28/23 and One (1) bottle of twenty five (25) tablets of Nitroglycerin that expired 01/18/24 This was confirmed with Registered Nurse #18 on 04/17/24 at 8:09 AM. On 04/17/24 at 8:40 AM, an observation of the 100/200 Hall Main Medication Preparation Room found the following medications to be expired: Two (2) bottle of 100 soft gel capsules of Vitamin E 180 mg expired 02/24. This was confirmed with the Director of Nursing on 04/17/24 at 08:45 AM. 45171

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 42120 Based on facility record review and staff interview, the facility failed to complete final internal food temperatures and ensure food was held prior to food service at appropriate temperatures. This has the potential to affect all residents that receive their nutrition form the kitchen. Facility census: 82 Findings include: a) Food tempetures On 04/15/24 at12:20 PM during a tour of the kitchen it was discovered the Food temperatures were not completed on: -evening meal 04/01/24 -evening meal 04/02/24 -evening meal 04/03/24 -evening meal 04/04/24 -all meals 04/05/24 -all meals 04/08/24 -evening meal 04/10/24 -all meals 04/11/24 -evening meal 04/12/24 -all meals 04/13/24 -evening meal 04/14/24 During an interview on 04/15/24 at 12:23 PM the Certified Dietary Manager verified the food temperatures were not being completed daily as required.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42120 Based on observation and staff interview the facility failed to complete labeling and dates in a unit refrigerator and complete refrigerator temperature log unit refrigerator and freezers on the 100, 200 and Sub halls and main dining room in accordance with professional standards for food service safety related to storage. This has the ability to affect all Residents that get their nutrition from the kitchen. Facility Census: 82. Findings Include: a) 100 Hall Unit Refrigerator Observation during the Unit tour on 04/15/24 at 12:44 PM found 3 sodas open, cherry pie, and plastic container in the resident refrigerator with no labeling or dates. During an interview on 04/15/24 at 11:44, the Dietary Manager (DM) verified there was no labeling or dates on the items in the 100-hall resident refrigerator. b) Refrigerator / Freezer Temperature Log On 04/15/24 at 12:58 PM facility record review of the refrigerator temperature log for unit refrigerator and freezers on the 100, 200 and Sub halls and main dining room found the temperatures was not completed on the log at this time on: -04/01/24 -04/06/24 -04/07/24 -04/11/24 -04/14/24 -04/15/24 On 04/15/24 at 12:58 PM during an interview the DM verified that the refrigerator temperatures should have been completed.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 39043 Based on record review and staff interview, the facility failed to implement appropriate interventions for quality deficiencies of which it was aware. This deficient practice had the potential to affect all residents residing in the facility. Facility census: 82. Findings included: a) Skin assessments. On 04/16/24 at 3:40 PM, the Director of Nursing (DON) was interviewed and asked about the facility form called a, SHOWER BODY AUDIT for Residents. The DON said the Nurse Aides do skin assessments when they give showers. If they find a concern, they mark it on the shower body audit sheet and the nurse will go and assess it, then sign the shower body audit. The DON was asked if a Licensed Nurse does routine skin assessments on everyone. The DON said no they go by what the Aides find. Also, at this same time the Licensed Practical Nurse/Treatment Nurse (TN) #120 was present for this interview via phone. TN #120 stated she does not do routine skin assessments. The DON agreed that while it is good practice for the Nurse Aides to report any skin issues they find, a licensed nurse has the training to assess skin issues. During the above interview the DON confirmed routine and/or weekly skin assessments are not being done by a licensed nurse. From the website. NCBI (National Institutes of Health) A complete skin assessment is essential for holistic care and must be completed by nurses and other health professionals on a regular basis. Providing patients and relatives with information on good skin hygiene can improve skin integrity and reduce the risk of pressure damage and skin tears. The assessments need to be repeated on a regular basis to determine whether any changes in skin condition have occurred. In Long term care facilities, comprehensive skin assessment should be performed by a unit nurse on admission to the unit, daily, and on transfer or discharge. This includes assessment of skin color, moisture, temperature, texture, mobility and turgor, and skin lesions. Inspect and palpate the fingernails and toenails, noting their color and shape and whether any lesions are present. b) Interview On 04/17/24 at 12:49 PM, the Administrator and Corporate Compliance Officer were interviewed. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Administrator and Corporate Compliance Officer stated a Performance Improvement Project (PIP) had been done regarding pressure ulcers. An intervention had been implemented for Nursing Aides (NAs) to perform skin assessments during resident bathing activities. The Administrator and Corporate Compliance Officer confirmed no measures had been implemented for routine skin assessments by licensed nursing staff.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 39043 Based on record review and staff interview, the facility failed to document the attendance of the Medical Director or designee at all quarterly Quality Assurance Performance Improvement (QAPI) meetings. This deficient practice had the potential to affect all residents residing in the facility. Facility census: 82. Findings include: a) Meeting attendance by medical director On 04/16/24 at 4:21 PM, the Administrator stated Quality Assurance Performance Improvement (QAPI) meetings were held every month. The Administrator stated the facility's Medical Director attended the quarterly meetings held on January, April, July, and October. However, the Administrator was unable to locate the QAPI attendance record for April 2024 to document the Medical Director's attendance at the meeting. No further information was provided through the completion of the survey process.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39571 , Based on observation, policy review, and staff interview the facility failed to ensure establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. This was a random opportunity for discovery and had the potential to affect a limited number of residents who currently reside at the facility. Facility census 82. Findings include: a) No hand hygiene While monitoring dining in the day room at the end of the 100 halls on 04/16/24 at 11:55 AM. It was noted that Nurse Aide (NA) #55 was opening each tray on a a counter putting cream and sugar in the coffee, butter on the rolls cutting up food etc NA #55 served eight (8) residents and failed to use any hand hygiene between the residents. On 04/16/24 at 12:45 PM, NA #55 was asked if she used hand hygiene between serving residents. NA #55 said no. The facility policy titled, Handwashing/Hand Hygiene, revision date 08/2019. *Use hand hygiene before and after eating or handling food *Before and after assisting a resident with meals. On 04/16/24 at 2:06 PM the Director of Nursing (DON) was informed of the above findings.