STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515152	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery General Elderly Care	501 Adams Street Montgomery, WV 25136

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview the facility failed to maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. This failed practice was a random opportunity for discovery and had the potential to effect all residents currently residing in the facility during the Long-Term Care Survey Process. Facility Census: 57. Findings Include: a) Dining room Continuous observation of the dining room on [DATE] from 11:30 AM to 12:01 PM, revealed that at 12:01 PM, (3) three residents at the round table were served their lunch meal. During the continuous observation no hand hygiene was offered and/or performed with the residents in the dining room area. During an interview on [DATE] at 12:03 PM, Nursing Assistant (NA) # 4 stated, They are supposed to lay them wet ones on the table, and nope they are not there today. Further observation of the lunch meal showed, NA #16 served and set up a resident's tray and then grabbed another tray to set up another resident's. NA# 16 stated, Oh, I forgot. b) Enhanced barrier protections On [DATE] at 9:30 AM while walking around the facility, there were multiple rooms (6 out of 20) observed with EBP signs on doors, but no dot on name plates to designate who the EBP applied to. They were all missing the pink dot. The facility used different color dots to signify different issues the residents may have. During an interview on [DATE] at 9:32 AM with Housekeeping #61. They stated, I don't know what each color is exactly but they have a list somewhere here. When asked where the list for the colors was: Housekeeper #61 stated, There isn't one (dot list) in every janitor's closet and not sure exactly where they had seen one before, but knew they had a few hanging up. They thought maybe the dirty utility room. While interviewing LPN #72 on [DATE] at 9:35 AM the LPN stated, The Dot on the residents name plates each have meaning, each is something different. There is a color chart in the dirty utility room. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(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 - Many	I believe PINK is the EBP dot color. LPN #72 took this surveyor to the dirty utility room on [DATE] at 9:40 AM to show me the dot list. Taped to the wall was a list with multiple color dot stickers with explanations of each color, PINK was denoted to mean EBP. Record review showed a copy of the EBP policy that stated the facility will ensure regular weekly rounds for accuracy. There was an in-service completed on [DATE] with signatures from all employees, this included a breakdown of all the color dots that the facility used. Of note the in-service training did not include the pink color dot in the training. The facility has a dot policy that uses color coded dots added to the residents name plates to ensure privacy as well as alert staff to what a resident's medical need or status maybe; EBP, fall, CPR, DNR etc. The Administrator stated during an interview on [DATE] at 11:50 AM when they were shown the different signs that were used in the in-service versus the sign that was in the dirty utility room. They will ensure another in-service with the correct information is done, and soon. c) Resident #9 Resident #9 and Resident #4 are roommates. Resident #9 was admitted on [DATE] for rehab, following discharge from acute care facility. Upon admission, resident had primary diagnosis of Severe Sepsis without Septic Shock, and had a PEG (Percutaneous Endoscopic Gastrostomy) tube. The resident had an on-going order dated [DATE] for Enhanced Barrier Precautions due to feeding tube and history of Sepsis. During the initial visit with the resident on [DATE] at approximately 1:20 PM, there was no signage on the residents' door for Enhanced Barrier Precautions. Surveyor at 1:30 PM, asked the NHA to accompany her to the residents' door. When asked about signage for enhanced barrier precautions, she responded that she was not aware that being on a feeding tube required Enhanced Barrier Precautions. Surveyor pointed out that both residents had orders for Enhanced Barrier Precautions. Surveyor suggested a consultation with the facility's policy for Enhanced Barrier Precautions. NHA said she would immediately ask nursing to get a sign posted on the door for Enhanced Barrier Precautions. An observation on [DATE] at approximately 11:00 AM, Enhanced Barrier signage had been placed on residents' door. d) Resident #4 Resident #4 and Resident #9 are roommates at the facility. Resident #4 had an order for Enhanced Barrier Precautions due to a history of ESBL (Extended Spectrum Beta Lactamase), a multi-drug-resistant bacteria. During the initial visit with the resident on [DATE] at approximately 1:20 PM, there was no signage (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on the residents' door for Enhanced Barrier Precautions. Surveyor at 1:30 PM, asked the NHA to accompany her to the residents' door. When asked about signage for enhanced barrier precautions, she responded that she was not aware that being on a feeding tube required Enhanced Barrier Precautions. Surveyor pointed out that both residents had orders for Enhanced Barrier Precautions. Surveyor suggested we consult the facility's policy for Enhanced Barrier Precautions. NHA said she would immediately ask nursing to get a sign posted on the door for Enhanced Barrier Precautions An observation on [DATE] at approximately 11:00 AM, Enhanced Barrier signage had been placed on residents' door. The facility's policy on Enhanced Barrier Precautions calls for Enhanced Barrier Precautions to be used when there is an indwelling medical device, as well as pan-resistant organisms. Based upon the physician orders and the facility's policy, Enhanced Barrier Precautions were to be used with both residents. A sign on the door served as a reminder for visitors, staff and residents on the importance of hand hygiene and adherence to facility infection control policies.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff interview the facility failed to maintain a safe, clean, comfortable, and homelike environment by not providing a clean privacy curtain for Resident #27, and ensuring the residents' shower area for B Bath did not have paint peeling, missing caulking and rust on a shower caddy. These failed practices had the potential to affect more than a limited number of residents. Resident Identifier: #27. Facility Census: 57.Findings included: a) On 11/24/2025 at 12:45 Pm, The B Bath shower room was investigated. Peeling paint in the shower area and the bathroom floor area were observed including around the toilet by the state surveyors. The Administrator in Training reported the shower rooms are addressed yearly. On 11/25/2025 at 08:12 AM, the B Bath shower room was observed. The following observations were observed: paint peeling and missing on a large portion of the shower room's floor, caulking was missing around the toilet and in the shower area, large ring of missing paint and brownish substance was around the toilet, and paint was missing from the base of the walls, and rust was on a shower rack/caddy. These areas were confirmed by Nursing Assistant #19. Findings include: b) Resident number 27 On 11/24/25 at 12:06 PM an observation of Resident #27s privacy curtain found the curtain was soiled with a brown dried matter. During time of observation House Keeper #60 confirmed the curtain was dirty and required replacement.

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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 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** Based on record review and staff interview the facility failed to provide care and services in accordance with current standards of practices by not following its policy and physicians orders related to weights. This failed practice was found true for (3) three of (6) six residents reviewed for nutrition during the Long-Term Care Survey Process. Resident identifiers: #55, #9, and #11. Facility Census: 57. Findings Include: a) Weight monitoring policy A review on 11/25/25 at 10:30 AM, of the policy titled {Weight Monitoring}, Section 2, C, reads: If there is a noticeable discrepancy in the current weight vs previous weight, the resident shall be re-weighted and the charge nurse shall follow-up accordingly. b) Resident #55 A record review on 11/24/25 at 2:32 PM, revealed that on 11/05/25 Resident #55 weighted 173 pounds (lbs.), and weighed 183 lbs. on 11/10/25. She was not reweighed for the weight discrepancy until 11/18/25 in which she weighed 173.5 lbs. Further record review for Resident #55, revealed an order that read as follows: Obtain a weekly weight. Once a day. On Tuesday at 12:30. Weights which are obtained above, shows that Resident #55 was not weighed weekly per Physicians order. During an interview on 11/25/25 at 11:06 AM, The Assistant Director of Nursing (ADON) confirmed that Resident #55 had not been weighed weekly per physicians order, and the policy had no been followed. c) Resident #11 Review of Resident #11's medical records revealed on 09/09/2025 the resident weighed 160 pounds (lbs). On 10/07/2025, the resident weighed 144 lbs. This is a 10 percent (%) weight loss in approximately four (4) weeks. Resident #11 was weighed again on 10/14/25 and weighed 143.6 pounds (lbs). On 11/25/2025 at 11:42 AM, the Certified Dietary Manager confirmed Resident #11 was not reweighed when a noticable discrepancy occurred between the weight on 10/07/25 and the previous weight on 09/09/25. He confirmed the resident had been reweighed a week after the noticable discrepancy occurred. No further information was provided through the completion of the survey process. d) Resident #9 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9 was a new admission to the facility. She was admitted on [DATE] for rehab, following discharge from acute care facility. Upon discharge from hospital, the resident weighed 184.3 (83.6 kg). Upon entrance to the nursing home, her weight was recorded to be 183 lbs. Her discharge documentation from the acute care facility reported the resident was not tolerating her tube feeding well, and had been having nausea and vomiting. Upon admission, resident had primary diagnosis of Severe Sepsis without Septic Shock, and had a PEG (Percutaneous Endoscopic Gastrostomy) tube in place. Upon admission to the long term care facility, the Resident had the following orders regarding nutrition: Dietary Order NPO (Nothing by mouth)11/04/2025 Open Ended Dietary General Vital 1.5 bolus 327 ml Four Times A Day06:00 AM, 12:00 PM, 06:00 PM, 12:00 AM General Obtain Weekly WeightOnce A Day on Tue12:30 PM 11/05/2025 Resident is NPO (nothing by mouth). A Dietary Assessment was completed by the Dietary Manager (DM) on 11/11/25. The Resident was scored with a nutritional risk indicator as 14, which was High Risk. Progress Notes from the DM Resident is currently NPO-Vital 1.5 AC Bolus Tube Feeding 4x Day 237 cc each feeding . A history and physical was obtained on the resident on 11/11/25 by the admitting physician. A care plan was developed for the resident. The Resident's care plan for nutrition states, Potential for nutritional problem R/T (related to) resident is NPO with a PEG tube for feedings. Her goal was to maintain adequate nutritional status AEB: maintaining stable weight within 5% every 30 days . Some of the approaches to reach her goal were: Before taking away tray, ask if she has had enough to eat. Offer a substitute if < 50% of food is consumed. {Surveyor note: RESIDENT NPO} Follow Dietician recommendations for PEG feedings Observe, document, report to physician prn signs and symptoms of malnutrition (cachexia, weight loss, muscle wasting) significant weight loss (< 5% in one month, 10% in 6 months) The Resident's weight declined from the time period of 11/05/25 (admission) to survey entrance date of 11/24/25 by 13.66% or a total of 25 pounds. Her weights were recorded in the medical record as follows: On 11/05/25 weighed 183 lbs On 11/17/25 weighed 165.5 lbs (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/18/25 weighed 158.0 lbs The electronic health system utilized by the facility is a software program by Matrix. Matrix had flagged the weights on 11/17/25 and 11/18/25 as being out of range, and in red ink. The Registered Dietician (RD) entered a progress note on the resident on 11/13/25, with a note to say the progress note was from 11/11/25, it did not save. RD recommended changing her order to Vital 1.5 AC 237 ml QID at 60 ml. per hour. A Progress note by an LPN on 11/18/25 stated resident had just been cleaned up and linens changed, as resident had vomited and was still experiencing nausea. LPN stated in her progress notes that she was going to hold the 6 am feeding for a little while to see how resident felt. The RD recorded this progress note on 11/20/25: Spoke to nurse today via phone regarding residents elevated blood sugars and feeding tolerance. Resident has not had episodes of vomiting since changing the rate of enteral feeding administration. BS levels have increased and medications are being adjusted. With the formula being an elemental feeding, high blood sugars are not uncommon. It was discussed to increase the rate to 70 ml per hour to give more down time; tolerance will be monitored by staff, Will continue to monitor for change via facility staff. There were no notes in the progress notes where the physician had been notified of the resident's significant weight loss. On 11/25/25, at approximately 1:15 PM, an interview was conducted with the Dietary Manager (DM) regarding the resident's weight loss. When asked what was being done to help control the weight loss on the resident, he replied let me pull up her medical record. He then pointed to a progress note and stated he had asked the Dietitian to review the resident. When asked if he knew if the physician had been informed of the significant weight loss he said he was not sure. On 11/26/2025 at 9:59 AM, an interview was conducted with the ADON about the resident's weight loss. When asked how the resident's weight was assessed upon admission, the ADON responded in the case of this resident, they used a Hoyer lift to weigh her. When asked if they always weigh residents at admission, the ADON responded yes. Weights are obtained in various ways depending upon what is best for the resident. The surveyor reviewed the section of the care plan on nutrition with the ADON, noting the resident was NPO. The ADON acknowledged the approach to Before taking away tray, ask if she (resident) has had enough to eat, Offer a substitute if < 50% of food was consumed was not appropriate for the resident. The surveyor explained the care plan was not personalized for the resident. When asked about a reason the resident has had such a significant weight loss in this short of a time period, the ADON responded the resident was not tolerating her feeding bolus, was vomiting. ADON responded, since we changed her feedings, she has had less vomiting. The surveyor pointed out, yet the resident is continuing to lose weight. When asked if the physician had been contacted about the weight loss, the ADON responded, The DM usually monitors the weight. I am not sure if he did. When asked about why there was no weight obtained per physician order on 11/25/25, she stated she would check on this and get back with me. A few minutes later, the ADON returned with a post it note stating, The resident was weighed on 11/25/25 by a restorative aide. Her Weight was 160. When (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asked why this was not documented in the medical record, she responded, The aide puts the weight in a log book, and the Dietary Manager then transfers it into the electronic medical record.

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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. Based on observation and staff interview, the facility failed to treat a resident with respect and dignity during the dining experience by referring to the resident's adaptive spoon as a baby spoon. This failed practice had the potential to affect a limited number of residents and was a random opportunity for discovery. Resident Identifier: #8. Facility Census: 57. Findings included: a) Resident #8 On 11/25/25 at 12:10 PM, the State Surveyor was observing the dining room lunch meal service. Nursing Assistant (NA) #31 yelled across the room to the dietary window and told the staff to Throw me a baby spoon. NA #21 confirmed the spoon asked for by NA #31 was a baby spoon and that the resident sometimes eats with her fingers. The resident's diet order stated, NAS (No Added Salt), PUREE Special Instructions: Color suction lip plate, small color coated spoon. On 11/25/25 at 01:46 PM, the Administrator in Training reported they did not have a policy and procedure for dignity, but that they follow the state guidelines for dignity. The facility's Dining Program Policy and Procedure stated, the Purpose was to provide Skilled/ICF residents with a fine dining experience that is close to home dining as possible.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and staff interview, the facility failed to document the resident's Medical Power of Attorney was notified when the resident experienced significant weight loss. This deficient practice had the potential to affect one (1) of four (4) residents reviewed for the care area of nutrition. Resident identifier: #11. Facility census: 57. a) Resident #11 The facility's policy and procedure titled Weight Monitoring with effective date January 2004 and most recent revision date April 2016 stated the Power of Attorney (POA) or legal representative would be notified when the resident experienced significant weight loss. Review of Resident #11's medical records revealed on 09/09/25 the resident weighed 160 pounds (lbs). On 10/07/25, the resident weighed 144 lbs. This is a 10 percent (%) weight loss in approximately four (4) weeks. The resident continued to lose weight, weighing 141 lbs on 11/17/25. Further review of Resident #11's medical records showed no documentation the resident's POA was notified when the resident was found to have significant weight loss on 10/07/25. On 11/25/25 at 11:05 AM, the Assistant Director of Nursing (ADON) stated Resident #11's POA attends care plan conferences,but the resident has not had a care plan conference since the resident lost weight. The ADON stated Resident #11's POA frequently visited the resident. However, she was unable to locate documentation that Resident #11's POA had been notified when the resident lost weight. No further information was provided through the completion of the survey process.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on Observation, Interviews and record review the facility failed to ensure residents private and confidential information was kept safe. This was a random opportunity for discovery during the long term care survey process with the potential to affect more than a minimal number of residents. Facility census: 57 On 11/25/2025 at 9:20 AM while conducting rounds this surveyor observed a medication cart and computer left unlocked and screen open while the nurse went to get medication from the med room. A resident's name and information was left on screen and easily viewable to anyone who passed by. The cart left approx. three min unattended.On 11/25/25 at 9:26 AM in an interview with LPN #72 stated that they had to get a med the resident needed to complete a med pass. I was only gone for a minute. During record review on 11/25/2025 at 2:00 PM of the New employee/Med cart and Resident Privacy policy's, It states that all carts and computers shall be locked and secured before stepping away for any length of time. The Administrator stated during an interview on 11/25/2025 at 2:12 PM they all know the policy and know better. Thank you for bringing it to my attention.

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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. The facility failed to ensure residents' comprehensive care plans were revised when changes occurred to the residents' interventions and residents' behaviors. This deficient practice had the potential to affect two (2) of 20 residents reviewed during the long-term care survey process. Resident Identifiers: #11 and #2. Facility census: 57. Findings included:a) Resident #11Resident #11's comprehensive care plan had a focus for a potential for nutritional problem. An intervention was initiated for 07/15/25 for monthly weights to be obtained. On 09/09/25, Resident #11 weighed 160 pounds (lbs). On 10/07/2025, the resident weighed 144 lbs. This was a 10 percent (%) weight loss in four (4) weeks. On 10/10/25, an order was written for weekly weights. Prior to this, the resident was weighed monthly. The resident's care plan was not updated when the resident's frequency to be weighed was changed from weekly to monthly. On 11/25/25 at 11:05 AM, the Assistant Director of Nursing (ADON) confirmed Resident #11's care plan was not revised when the resident was ordered to be weighed weekly instead of monthly. No further information was provided through the completion of the survey process. b) Resident #2 Review of Resident #2's comprehensive care plan showed the following focus related to the resident's behaviors: Has been known to take things from other residents. Will sometimes try to say that they gave them to her. Will also manipulate others or make them feel sorry for her in attempt to get what she wants from them. Can also be manipulative by crying at any given moment that she is asked about something or being redirected. Resident #11's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 11/04/25 coded the following behaviors: physical behavioral symptoms directed toward others four (4) to six (6) days during the look-back period, verbal behavioral symptoms directed toward others four (4) to six (6) days during the look-back period, other behavioral symptoms not directed toward others four (4) to six (6) days during the look-back period, and wandering daily during the look-back period. The following nursing progress documented behaviors: 10/24/25 at 12:28 PM - Resident refused am medications . 10/25/25 at 4:30 PM - Resident wandering and entering other residents rooms on A hall. Redirected numerous times. Refusing to leave one residents room. Assisted resident out of that room. Resident cursing this nurse. You son on of a bitch. Redirected. 10/28/25 at 9:29 AM - .resident was observed pulling at other residents shirt in a non-aggressive way. Writing nurse tried to redirect resident. Resident became verbally aggressive and attempted to grab this nurse by the hair. Redirection attempted, ineffective. Resident left activity room cussing and angry . 10/31/25 at 12:28 AM - Went into resident's room to give her medication, she said I'm not taking that medication it's not mine, give it to some of the poor people around here that cannot afford medication. Educated this resident that this medication belongs to her and it was ordered by the physician. She took the medication and pulled one pill out (neurotin) and told this nurse she wasn't taking anything else, when I tried to educate her about the medication, she proceeds to start cursing me and saying I needed to get the hell out of her room, I didn't know what the hell I was talking about. While passing medication on down the hallway this resident was found beside her roommates bed while the roommate was trying to sleep, she had clothes all over the bed and told me to get the hell out of her room and to close the door, when I tried to explain that the door could not be closed due to alarms she continued to curse. This resident came out of the room and was going into other resident's rooms, when she was redirected she again started to curse and say you leave me the hell alone and then would go into another resident's room, this continued for sometime. This resident is now 12:30 am up in her room with things all over her bed and gets very mad and aggressive if you try to talk to her about anything. 10/31/25 at 2:51 PM - Resident has been cursing at staff . 11/01/25 at 12:22 PM - Resident combative during care. Hitting, kicking, cursing. Resident has soiled herself multiple times this shift and resistant to care. Resident has been educated by recording nurse that she has risks of skin breaking down and infections. Resident has been getting into her roommate's belongings and taking (continued on next page)

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	515152	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery General Elderly Care	501 Adams Street Montgomery, WV 25136

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them. Unable to be redirected today. Food, drink, and activities offered. 11/02/25 at 6:24 AM - Resident has refused care this shift. Aggressive. cursing, resistant to all care . 11/02/25 at 2:16 PM - Resident up several time during the night going into other resident's rooms. Resident was up at approximately 5 am saying she was going to visit a friend, educated this resident of the time and that most of the residents are still sleeping. Resident was shown where her room was, when this nurse went to give her medication, she told me to just leave it she would take it later, educated resident that this nurse could not leave medication in room, explained what it was for and she became very mad and told me that she knew what everyone was doing and no doctor had ordered medication for her, she held onto medication, had to convince resident that I had to have it if she was not going to take it. Resident then was mad, then proceeds to go up and down the halls in her wheelchair. This resident has been very combative, not wanting to take medication, going into others room and taking their belongings. She will be very mad one minute and then have a completely different attitude the next. 11/04/25 at 5:11 AM - Resident has been up ambulating via wheelchair around facility all shift. Unable to redirect resident to bed despite multiple attempts. Resident has not complained of any pain or discomfort. Residents states she is just up trying to help people. 11/8/25 at 10:09 AM - Resident refused breakfast time meal. Continues pacing halls in wheelchair, entering several residents rooms 11/8/25 at 6:23 PM - Resident continues pacing hallways in wheelchair. Being verbally aggressive with staff. Refusing incontinence care. Redirected several times from being in other residents rooms 11/14/25 at 4:26 PM - Resident refusing to walk with restorative therapy for multiple days. Resident difficult to redirect . 11/22/25 at 11:05 PM - Resident refused all HS [bedtime] meds. Attempted to give medications x3 [three times]. Education was provided. Resident still refused all medications but agreed to take her Gabapentin. Afterwards resident proceeded to continually ambulate multiple times around the facility . (All notes were typed as written in the medical records.) When this surveyor asked for the copy of the care plan on 11/25/25, it had been revised on 11/25/2025 to include the following problem focus, Resident has verbal behavioral symptoms toward staff at times. Resident also refuses medications at times and frequently roams into other residents [sic] rooms. Interventions for these behaviors had been added. On 11/25/2025 at 3:13 PM, the Assistant Director of Nursing confirmed Resident #2's behaviors of wandering, verbal aggression, and medication refusals had not been included in the comprehensive care plan until 11/25/25.

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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. Based on record review, staff interview, and resident interview, the facility failed to provide Activities of Daily Living (ADL) care related to showers for dependent residents. This failed practice was found to be true for one (1) of three (3) residents reviewed for ADL care during the long term care survey process. Resident identifier:#27 Facility Census: 57 Resident identifier #27 Facility census #57.Findings include:a) Resident #27 On 11/25/25 at 4:00 pm record review shows the following:According to the shower schedule provided by the facility resident #27 is scheduled for showers on Tuesdays and Thursdays on day shift.Resident #27 was scheduled/received showers on the following days:10/28/25 - received no shower 10/30/25 - received no shower11/04/25 - received shower11/06/25 - received shower11/11/25 - received shower11/13/25 - received shower11/18/25 - received no shower11/20/25 - received no showerRecord review completed on 11/25/25 revealed Resident #27 is an extensive total dependence with one person assisting for showers.Further record review on 11/25/25 of Resident #27's care plan revealed Resident #27 requires moderate to max assist with activities of daily living due to diagnosis of Dementia/Alzheimer's. Resident is dependent on staff for bathing, transfers, and hygieneOn 11/25/25 at 4:23 the Administrator confirmed resident #27 had not received showers as required. No other documentation was provided prior to exit of this survey.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based upon Observation, Interviews and record review the facility failed to ensure the facility remains free from accident hazards due to a medication cart and computer being left unlocked and in the main hallway A. This was a random opportunity for discovery during a long-term survey. Census: 57 Findings include: a) On 11/25/25 at 9:20 AM while conducting rounds this surveyor observed a medication cart and computer left unlocked while the Licensed Practical Nurse (LPN) went to get medication from the med room. A resident's name and information were left on screen, and the med cart was unlocked, and drawers were able to be opened. The cart was left approximately three (3) minutes unattended.On 11/25/25 at 9:26 AM in an interview with LPN #72 the LPN stated that they had to get a medication the resident needed to complete a medication pass. LPN #72 said, I was only gone for a minute. During record review on 11/25/2025 at 2:00 PM of the Med cart and Resident Privacy policy's, it states that all carts and computers shall be locked and secured before stepping away for any length of time. The Administrator stated during an interview on 11/25/2025 at 2:12 PM, They all know the policy and know better. Thank you for bringing it to my attention.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on record review and staff interview, the facility failed to ensure residents' care was supervised by a physician. The facility failed to document the physician was aware of Resident #11's significant weight loss. This deficient practice had the potential to affect one (1) of four (4) residents reviewed for the care area of nutrition. Resident Identifier: #11. Facility Census: 57. Findings included: a) Resident #11 The facility's policy and procedure titled Weight Monitoring with effective date January 2004 and most recent revision date April 2016 stated the attending physician would be notified when the resident experienced significant weight loss. Review of Resident #11's medical records revealed on 09/09/2025 the resident weighed 160 pounds (lbs). On 10/07/2025, the resident weighed 144 lbs. This is a 10 percent (%) weight loss in approximately four (4) weeks. The resident continued to lose weight, weighing 141 lbs on 11/17/25. Further review of Resident #11's medical records showed no documentation the resident's attending physician was notified when the resident was found to have significant weight loss on 10/07/25. Resident #11 was evaluated by the physician on 11/24/25. The resident's weight loss was not mentioned in the physician evaluation progress note. On 11/25/25 at 11:05 AM, the Assistant Director of Nursing (ADON) stated she was unable to locate documentation that Resident #11's physician had been notified when the resident lost weight or that the physician was aware of the resident's weight loss. No further information was provided through the completion of the survey process.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on record interview and staff interview, this facility failed to ensure all kitchen staff were up to date with their food handler cards. This failed practice was a random opportunity for discovery during the Long Term Care survey process. Employee identifiers: #4, #48, #55. Facility census: 57.Findings include: a) Food handler cards A record review on 11/25/25 at 1:45 PM of all dietary staff and up to date food handler cards revealed: Cook/aide #4 hire date was 03/17/23 with food handler card dated as completed on 11/24/25. Cook/aide #48 hire date of 08/26/23 with food handler card dated as completed on 11/25/25. Cook/aide #55 had an expired card as of 05/10/25. During interview with Certified Dietary Manager (CDM) on 11/25/25 at 2:00pm, he confirmed the hire dates and expiration dates

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview and policy review this facility failed to store food in accordance with professional standards for food service safety. This failed practice was a random opportunity of discovery during the Long Term Care survey process. Facility Census: 57 Findings includea) During observation with kitchen inspection on 11/24/25 at 10:55 AM, noted the following items in the walk-in with label and dating missing and/or outdated.Container of pineapples- no label or use by dateContainer with slice of cake- no label or use by datePan of mashed potatoes- no label or use by dateContainer of chocolate pudding- no label or use by dateContainer of lettuce with expired use by date of 11/16/25Container of potato salad with expired use by date of 11/17/25Container of peas and carrots with expired use by date of 11/21/25Container of pasta salad with expired use by date of 11/21/25Container of sliced cheese -no label or use by date. During an interview on 11/24/25 at 11:15AM , [NAME] # 4 confirmed the above findings. During an interview on 11/25/25 at 2:56 PM, the Certified Dietary Manager (CDM) confirmed, the out-of-date food and some missing labels.The CDM further stated, It depends on the product but most generally we toss after 7 days. A review of policy on 11/25/25 at 3:00PM, titled[Refrigeration/Freezing/storage of food.], under Procedure B reads as follows Cooks will check food storage daily and remove items that are past the appropriate used by date.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews the facility failed to ensure medical records were accurate for Resident #11 regarding DNR (do not Resuscitate) POST (Physician Orders for Scope of Treatment) and Resident #45 orders to offer thin liquids if refused thicken liquids. These failed practices were random opportunities for discovery and had the potential to affect more than a minimal number of residents residing in the long term care facility. Resident identifier: #11 and #45 Facility Census: 58 a) Resident #45 During record review of Resident #45's orders, revealed the following Diet order Start date: 11/04/25- End Date: Open Ended Description: REGULAR, MILDLY THICK LIQUIDS, PUREE Further [NAME] review of Resident #45's care plan revealed the following; Problem- start date 07/07/2022 Category: Nutritional status: Potential for nutritional problem related to resident requires mechanically altered diet due to difficulty chewing and thickened liquids due to difficulty swallowing (dysphagia), also has vitamin deficiency, hyperlipidemia(High Cholesterol), anemia in chronic kidney disease, gastro-esophageal reflux disease, and diabetes. Goal- Long Term Goal Target Date: 01/15/2025: Residents will maintain adequate nutritional status as evidenced by maintaining stable weight within 5% every 30 days. Approach: Start Date: 11/01/2024: Provide as serve diet as orderedL Pure, with mildly thickened liquids, offer the thickened liquids, if she (Resident #45) will not take them, then it is ok to give her regular, POA (Power of Attorney) wants us to try first with thickened prior to giving thin, but overall, she just wants her to stay hydrated. May have bread and cake.: On 11/26/25 at approximately 10:00 AM the administrator confirmed the Order should be updated, and stated, We will get this clarified with the Doctor now. b) Resident #11 Review of Resident #11's physician's orders showed an order written on 09/22/25 for Do Not Resuscitate (DNR), meaning the resident was not to have cardio-pulmonary resuscitation in the event of a cardiac or respiratory arrest. Resident #11's medical record showed a Physician Orders for Scope of Treatment (POST) form which was signed by the resident's Medical Power of Attorney (MPOA) on 04/07/25. This date was prior to the resident's admission to the facility. The POST form indicated the resident was to have resuscitation in the event of a cardiac or respiratory arrest. On 11/24/25 at 2:42 PM, the Administrator stated the resident's MPOA had stated he wanted the resident to be DNR in September 2025 due to the resident's decline in condition. The MPOA stated he had already completed a POST form, which was at his home. The MPOA brought in the POST form, which was the one now in the medical record. However, no one at the facility noticed the POST form indicated the resident was to be resuscitated. The Administrator stated the MPOA would be contacted to complete a DNR POST form. No further information was provided through the completion of the survey process.