STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515183	A. Building B. Wing	11/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pocahontas Center	5 Everett Tibbs Road Marlinton, WV 24954

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. Resident #46 was transferred to from her geri chair to her bed in a manner which was not safe for her. Resident #46 was found to be totally dependent on staff for transfers. The staff were to utilize a total mechanical lift to transfer the resident from the chair to the bed and from the bed to the chair. Two (2) nurse aides were observed taking Resident #46 into her room. The surveyor stood outside the resident door and kept the room under constant sight. When the nurse aides emerged from the room the resident was in the bed. When asked how they transferred the Nurse Aide, stated I stood her up and pivoted her to bed. She confirmed she did not use a lift and no lift was observed in the room. This failure placed Resident #41 in an immediate risk for serious harm and or death. The state agency notified the facility of the immediate jeopardy situation on i09/29/25 at 4:27 pm. The State Agency accepted the facility's plan of correction at 5:00 pm on 09/29/25. After observation of the implementation of the plan of correction the Immediate Jeopardy was abated at 2:30 pm on 09/30/25. Resident Identifier: #46. Facility Census: 59. At approximately 2:15 PM on 09/29/25 Nurse Aide (NA) #50 and NA #46 was observed in the room with Resident #46 who was observed sitting in her room in her Geri Chair. There was no mechanical lift observed in the resident room. The nurse aides closed the door. The surveyor maintained her position outside the resident door and kept the door under sight while the nurse aides were in the room with Resident #46. At 2:30 PM NA #46 opened the door and exited the room. The surveyor then entered the room and observed Resident #46 in her bed. The surveyor then asked NA #50 how they got Resident #46 from the Geri Chair to the bed since there was not a mechanical lift observed in the room. Resident #50 closed her eyes and sighed and said well sometimes she has a good day and today is a good day so we stood her and pivoted her to the bed. A review of Resident #46's medical record found the resident's care plan related to assistance with activities of daily Living (ADL) in regards to transfers read as follows, Full Body Lift for all transfers and dependent assistance of two. The resident record contained the following Lift Transfer Evaluations all of which indicated the resident was to be transferred via a Total Lift with a Full Body Sling with the assistance of two (2) staff members. 10/31/2307/26/2410/24/2401/21/2504/22/25 and 07/22/25. Further review of the record found the resident has demonstrated the following behaviors: yelling, grabbing staff, injury risk, and requiring re-assurance. Residents pertinent diagnoses included:- UNSPECIFIED FOCAL TRAUMATIC BRAIN INJURY WITH LOSS OF CONSCIOUSNESS OF 31 MINUTES TO 59 MINUTES, SUBSEQUENT ENCOUNTER-- UNSPECIFIED CONVULSIONS-- HISTORY OF FALLING--UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITH OTHER BEHAVIORAL DISTURBANCEAn interview was conducted with Physical Therapy Assistant (PTA) #74 at approximately 3:45 pm, who indicated Physical Therapist (PT) #75 had evaluated Resident #46 and determined the safest way for her to transfer would be via a Hoyer Lift (Total Lift). An interview with PT #75 at approximately 3:50 PM on 09/29/25 found she had evaluated Resident #46 per the request of the facility. She stated, Due to her body condition and knowing her history she needs to stay a (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Hoyer Lift.b) Facility's Plan of CorrectionResident #46was transferred using the incorrect lift status on 9/29/25.Resident #46 was assessed by a Licensed Nurse on 9/29/25 with no injury noted andphysician notification.The Nurse Aides involved in transferring the resident were re-educated on reading thekardex immediately on 9/29/25 by the DON/Designee with a post test to validateunderstanding. All residents of the facility have the potential to be affected.The DON/designee completed lift evaluations to ensure they reflect the resident'scurrent functional status for safe handling and transfers.The DON/designee re-educated all nursing staff on or before 9/29/2025 regardingresident transfer status and ensuring the kardex and care plan is followed for transfers. Any nursing staff not available during this time frame will be provided reeducation,including posttest by DON/designee prior to the beginning of their shift. New nursingstaff will be provided education, including posttest during orientation by theDON/designee.The DON/designee will observe, beginning on 9/29/2025, three random residents toensure they are being transferred in accordance with their most recent transferevaluation and the care plan/kardex is updated with the residents transfer status dailyfor 2 weeks each shift, including weekends and holidays, then 5 times a week for 4weeks each shift, then 3 times a week for 4 weeks each shift, then randomly thereafter.Results of monitors will be reported by the Director of Nursing (DON)/designee to theQuality Improvement Committee (QIC) monthly for any additional follow-up and [NAME]-servicing until the issue is resolved, then randomly thereafter as determined by theQuality Improvement Committee.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review and staff interview, the facility failed to ensure sufficient nursing staff across all shifts. This was true for 18 of 45 days reviewed under the care area of staffing. Facility Census: 59.Findings Include: a) Staffing On 09/30/2025 at 2:00 PM, 45 daily nurse staff postings were reviewed. The minimum staffing requirement is 2.25. The review found the following days did not meet the minimum of nursing hours per patient days (NHPPD): 09/21/24 2.1104/19/24 2.0904/20/25 2.2005/17/25 2.2005/24/25 1.4805/25/25 2.1505/31/25 2.1806/01/25 1.8806/07/25 1.6406/21/25 1.8206/22/25 2.0106/23/25 1.9506/25/25 2.2106/27/25 2.0806/28/25 1.9306/29/25 2.0706/30/25 2.2007/05/25 2.05 On 09/30/25 at 4:40 PM, the Administrator and the Regulatory Compliance Advisor #73 confirmed the minimum NHPPD were not met.

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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 provide an accurate and complete daily staff postings. This was true for four (4) of 45 daily staff postings reviewed. Facility Census: 59.Findings Include: a) Daily Staff Postings On 09/30/2025 at 2:00 PM, a review of daily staff postings was completed. The following days did not include the census: --05/10/25 day shift, evening shift, night shift--05/22/25 day shift, evening shift, night shift --06/06/25 day shift, evening shift, night shift--06/24/25 night shift On 09/30/25 at 4:40 PM, the Administrator and Regulatory Compliance Advisor #73 confirmed the daily staff postings did not list the census number.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on staff interview, resident interview and record review, the facility failed to ensure the residents knew where the ombudsman's contact information was posted and the residents were informed of their right to formally complain to the Office of Health Facility Licensure and Certification (OHFLAC) about the care they are receiving. These failed practices had the potential to affect more than a limited number of residents. FACILITY:FACILITY. Facility Census: 59.Findings included: The facility's Policy and Procedures for Grievances/Concern stated that the resident has the right to voice grievances to the Center or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. On 09/24/2025 at 01:45 PM, a Resident Council Meeting was held. The residents reported they did not know the Ombudsman's name or where to obtain the contact information Resident #41 (a spokesperson for the council) reported she should know who is the Ombudsman but did not. The residents also reported the did not know where they could find the information to contact the Office of Health Facility Licensure and Certification (OHFLAC). On 09/24/2025 at 02:40 PM, the Social Worker was interviewed by the state surveyor. The Social Worker was not sure who the ombudsman was at that time but reported the ombudsman would sometimes attend the Resident Council Meetings via phone. On 09/24/2025 at 02:45 PM, the state surveyor confirmed the residents did not know where the OHFLAC contact information was or who and where the ombudsman information was posted with Corporate Nurse #79 and the Corporate Compliance Officer. At 03:00 PM, Corporate Nurse #79 posted the current ombudsman's name and information. The Resident Council Meeting Minutes were reviewed for discussions concerning the ombudsman and OLFLAC information. The following monthly minutes were not marked for the review of OHFLAC or Ombudsman: -08/07/2025-07/15/2025-06/06/2025 - ombudsman information only reviewed.-05/22/2025-04/17/2025-03/20/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review and staff interview, the facility failed to provide activities of daily living for dependent residents, #6 and #11. This was true for two (2) of four (4) residents reviewed under the care area of activities of daily living. Resident Identifiers: #6 and #11. Facility Census: 59.Findings Include:a) Resident #6On 09/24/25 at 9:30 AM, a record review was completed for Resident #6. The review of showers was from 08/24/25 through 09/24/25. The care plan indicated the resident was dependent for showers. The following showers were documented for 08/24/25 through 08/31/25:--08/29/25--08/30/25 The resident did not have a shower for five (5) days between 08/24/25 through 08/29/25. There were no refusals documented within this timeframe.The following showers were documented from 09/02/25 through 09/11/25. There were no refusals documented within this timeframe.--09/02/25--09/11/25 The resident did not have a shower for nine (9) days. On 09/24/25 at 2:20 PM, the Director of Nursing (DON) confirmed the dependent resident did not receive showers within an acceptable timeframe.b) Resident #11 On 09/25/25 at 10:00 AM, an observation was made of Resident #11 lying in his bed. The resident appeared disheveled, unshaven and unkept. An interview was held with the resident at this time, the resident was asked, how long has it been since you were able to shave? The resident replied, it's been awhile.On 09/25/25 at 10:10 AM, Corporate Registered Nurse (RN) #72 entered Resident #11's room. The Corporate RN #72 confirmed the resident needed to be cleaned up.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure a Physician Orders for Scope of Treatment (POST) form was signed by a resident's Medical Power of Attorney (MPOA), a Beneficiary Notification Review was signed by a resident's Health Care Surrogate (HCS), accurate documentation was charted in the patient's medical record for a resident without an amputation and a correct diagnosis for a resident's medication. These failed practices had the potential to affect more than a limited number of resident's. Resident Identifiers: #60, #70, #71 and #5. Facility Census: 59.Findings included: a) Resident #60's POST form was not signed. The Physician Orders for Scope of Treatment (POST) form stated the signature is required. The POST form was dated beside the signature space, but no signature was obtained. On 09/25/2025 at 11:33 AM, Corporate Registered Nurse #72 confirmed the POST form was not signed. b) Resident #70's Beneficiary Notification Review form was not completed. On 02/21/25, the resident's Beneficiary Notification was delivered telephonically on 02/21/25 at 11:00 AM. No signature was obtained as of 09/25/2025. No follow-up was reported or documented to obtained the signature. On 09/25/2025 at 10:23 AM, the Corporate Compliance Officer confirmed there was no signature obtained by the facility. c) Resident #71's Progress notes were reviewed on 11/03/2025 at 03:51 PM. Review of the resident's progress notes indicated: Skin issue is resolved. Location: Below left elbow - amputation Site. No documentation of the resident having an amputation was found in the medical record. On 11/03/2025 at 03:22 PM, the Administrator confirmed the resident did not have an amputation and reported she had all her extremities when she was here. On11/03/2025 at 04:46 PM, the Director Of Nursing and the Administrator confirmed the discrepancies in the resident's progress notes. d) Resident #5 On 09/23/25 at 3:30 PM, a record review was completed for Resident #5. The review found a physician's order dated 03/20/24 for Benztropine Mesylate (Cogentin) 1mg (milligram) by mouth two times a day for schizoaffective disorder delusions, disorganized speech and thinking. The diagnosis for Cogentin should be extrapyramidal symptoms. On 09/23/25 at 4:15 PM, the Director of Nursing (DON) confirmed the diagnosis for the medication was incorrect.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on record review, resident interview and staff interview, the facility failed to thoroughly and accurately explain the binding arbitration agreement. This failed practice had the potential to affect more than a limited number of residents. FACILITY:FACILITY. Facility Census: 59. Findings Included: a) The facility's Voluntary Binding Arbitration Agreement stated the agreement waives the resident's right to trial in court by judge or jury. Arbitration is a complete substitute for a trial by jury as stated in the facility's agreement. b) On 09/29/2025 at 01:28 PM, the Administrator was interviewed concerning the arbitration agreement. The Administrator reported it was fully voluntary and you had thirty (30) days to change your mind. The administrator stated we have mediation before you go to trial. When asked if the resident/family can sue or go to trial once an arbitration agreement is signed, the Administrator answered, Yes. c) On 09/29/2025 at 12:39 PM, the following resident statements were obtained concerning the signed arbitration agreement:Resident #20 was able to answer questions accurately concerning the signed arbitration agreement Resident #22 stated, I don't remember, but that is something I would sign.Resident #31 reported she did not remember, but stated, I was out of it and sick. for about three (3) weeks.Resident #15 stated, I don't remember.Resident #13 stated- I don't know. and her daughter probably took care of it.

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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, record review and staff interview, the facility failed to provide a dignified experience for Resident #21 while receiving medical care at the nurses' station, a sleeping experience for Resident #46. This was true for one (2) of three (3) residents reviewed under the care area of accidents for Resident #21 and random opportunities for discovery for Resident #46. Resident Identifiers: #21 and #46. Facility Census: 59.Findings Include: a) Resident #21 On 09/29/25 at 1:30 PM, a review of an anonymous complaint dated 07/05/25 was completed. The review found the resident had sustained an unwitnessed fall which resulted in a laceration to the back of the head with a large hematoma. A change in condition was completed on 07/02/25 at 6:17 AM. The facility physician was notified and advised the staff he would be coming to the facility to evaluate the laceration and hematoma. The facility physician administered three ccs (cubic centimeters) of lidocaine and placed six staples in the resident's head at the nurses' station. The following progress notes verify the procedure was done at the nurses' station and not in an acute care setting. Privacy and dignity was not provided while at the nurses' station due to all staff and residents to observe. During the review, the following progress note dated 07/02/25 at 9:03 AM states, (Name of facility physician) in house to see resident this morning. assessment completed by (Name of facility physician). laceration noted to back of head with large hematoma. (Name of facility physician) administered 3 cc lidcaine and placed 6 staples. resident tolerated without pain or distress. resident alert and oriented to person, place, time and event. Neuro check within normal limits. (Typed as written.) A progress note dated 07/02/25 at 9:57 AM states, IDT (Interdepartmental Team) met: Resident (age) (sex) with a hx (history) of falls, right side hemiplegia, HTN, memory deficient following cva, afib, drug induced subacute dyskinesia, vascular dementia, and vitreous degeneration to eyes. The resident sustained an unwitnessed fall this morning while ambulating to the restroom without assist. (Name of Resident) call bell was within reach, reminders to use call bell for assistance remain in room, and cowbell within reach. Stated she was going back to bed after using bathroom and resident fell back into the door and hit the ground. She did have on non skid socks and hipsters and resident utilizing her walker at time of fall. (Name of physician) in house this morning to assess resident and no deviation from baseline. No altered mental status noted. (Name of facility physician) cleansed wound, irrigated, gave lidocaine and placed 6 staples to the posterior scalp. Resident tolerated well. Pain addressed. Bleeding controlled. See orders. Neuros completed as ordered. Care plan reviewed and interventions are being followed. Orthostatics completed. Referral made to therapy, resident referred back to restorative nursing program, bed rail assessment completed, bed moved to wall per preference as easier access to restroom. Call placed to to POA (Power of Attorney) (Name of POA) regarding new orders. On 09/29/25 at approximately 3:00 PM, an attempt was made to interview the resident; however, the resident was confused and could not adequately answer the questions. On 09/30/25 at 10:45 AM, Corporate Registered Nurse (RN) #72 confirmed the resident did have an unwitnessed fall requiring staples. Corporate RN #72, also, confirmed the facility physician completed (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medical procedure at the nurses' station. b) Resident #46 On 09/22/25 Resident #46 was observed sleeping in her Geri chair in the hallway sitting across from the nurse's station on multiple occasions between 12:00 PM and 6:00 pm. On 09/23/25 the resident was observed sleeping in her Geri chair several occasions between 9:00 am and the noon meal. Then after the meal the resident was again observed asleep in her Geri chair in the hall way by the nurse's station. Observations on 09/23/25 at 9:00 am found Resident #46 asleep in her Geri chair in the hallway across from the nurse's station. An interview with the Director of Nursing in the late afternoon on 09/23/25 confirmed the resident was sleeping in her Geri chair she stated, she crawls out of the bed and that's why she is in the Geri chair because she sleeps better in the chair better than the bed. However the staff put Resident #46 in bed and she slept in her bed for the next two days. This was confirmed by observations from the surveyor during the course of the survey on 09/24/25 and 09/25/25. Additional observations of Resident #46 around 2:00 pm on 09/29/25 found the resident in the hallway in her Geri chair at the nurses station the resident was asleep and had her head resting on the hand rail. This was confirmed with the interim Director of Nursing who instructed the staff to lay her in bed when she is asleep.

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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. Facility Failed to ensure resident was invited to participate in care planning for his own care. Resident #1009/23/2025 2:41 PM Resident reported he is not invited to his care plan meetings and he has never attended them. 10/24/2025 4:01 PMInterview with Social Worker who reported resident #10 does not receive invites to his care plan meetings. She had no documentation that he was notified of the meetings or that he attended. She stated he does not like to leave his room often. She stated his Medical Power of Attorney is invited but does not attend and does not respond.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide a safe, clean, homelike environment for Resident #46. This was a random opportunity for discovery. Resident Identifier: #46. Facility Census: 59.Findings Include:a) Resident #46On 11/04/25 at approximately1:30 PM, an observation was made of Resident #46's night stand. The night stand had the wood peeled off, exposing particle board.On 11/04/25 at 3:10 PM, Regulatory Compliance Advisor #73 confirmed the wood had peeled off the night stand exposing particle board. Regulatory Compliance Advisor #73 stated, we will get a new one.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and staff interview, the facility failed to ensure an incident was reported for a resident who obtained a hematoma to the head following a transfer with a lift requiring staff education. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #37. Facility Census: 59. Findings included: a) The facility's policy and procedure for Abuse Prohibition stated, Neglect is defined as the failure, indifference, or disregard of the Center, its employees, or service providers to provide care, comfort, safety, goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. b) During a Facility Reported Incident investigation, Resident #37's care plan was reviewed. The care plan stated, Resident sustained a hematoma to head (left near top) during transfer using the full body mechanical lift (the bar hit her head). Policy being followed with two-person assist. c) A Facility Reported Incident was not completed, however staff education was completed for a transfer involving a lift. The Nursing Description reported the staff realized one (1) strap was not unhooked and when the staff unhooked it, it came back and hit the resident on the left side of the head. An incident note with education completed was documented on 05/08/2025. A Facility Reported Incident was not completed for neglect. It was documented verbal education was provided at the time of the incident. d) On 09/24/2025 at 04:31/2025 PM, the Corporate Compliance Officer confirmed the the incident was not reported and stated, Didn't report it.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure an investigation was completed accurately and thoroughly for a Facility Reported Incident (FRI) for an allegation of abuse. This failed practice had the potential to affect a limited number of residents. Resident Identifier: #29. Facility Census: 59. Findings included: The FRI summary stated Resident #29 was referred to as [NAME] (not the resident's real name) and was capacitated. The resident was deemed incapacitated by the facility's physician on 12/22/24. The resident's most recent Brief Interview for Mental Status (BIMS) score was a three (3) on 08/01/2025. The resident's BIMS was completed on 08/03/2025 per documentation on the resident's medical record. On 09/30/2025 at 10:45 AM , Corporate Registered Nurse #72 stated that it was an error and that they (the facility) had complete multiple FRI's. The incorrect BIMS date, capacity statement discrepancies and documentation on the reportable with incorrect name were confirmed by the Corporate Registered Nurse.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed ensure Resident #71 was permitted to return to the facility after hospitalization. This was true for one (1) of one (1) residents reviewed under the care area of Discharges. Resident Identifier: #71. Facility Census: 59.Findings Include:a) Resident #71On 11/03/25 at approximately 9:15 AM, a complaint was reviewed regarding Resident #71 being denied readmission after a hospitalization due to behaviors, a urinary tract infection and severe dehydration. The resident was sent to an acute care facility on 09/12/25. Based on the hospital history and physicaldated 09/18/25 at 10:27 AM, the resident was admitted to a medical unit until a bed became available on the psychiatric unit. The resident continued to have behaviors after intravenous fluids (IVFs) and an antibiotic had been administered. The resident was then admitted to the psychiatric unit on 09/18/25 for further stabilization. Following admission to Psychiatry, the resident expressed concern that there were dead people in her room and a ghost. She did receive one (1) intramuscular (IM) injection of Zyprexa. She was quite fearful and upset. She was yelling in response to internal stimuli. The resident's plan was to be restarted on oral Zyprexa for psychotic symptoms and behaviors. The resident may benefit from restarting Depakote which she was receiving in the nursing facility. She has also received Trazodone and Melatonin to help with sleep. The Nursing home is planning to take the resident back when she is stable. An interview was held with social services at the hospital on [DATE] at 2:41 PM. Social Services stated, I sent the referral to the nursing facility about two (2) weeks ago. When I spoke with the Admissions Director on 10/22/25, I was advised the clinicals could not be opened due to encrypted mail. I was, also, advised the resident had been denied for readmission on [DATE] due to receiving IM Haldol. I was told the denial was from the Corporate office. The resident remains hospitalized due to finding placement. The resident is stable for discharge. The resident is bed bound with severe dementia. She is currently under palliative services. The recommendation will be hospice services soon. The hospital physicians feel she has approximately one (1) year left. This resident does not need be in an inpatient psychiatric facility.Upon further review of the medical record at the nursing facility, the resident was admitted to the facility on [DATE]. A progress note dated 12/31/24 at 2:28 PM (late entry) states the resident was transferred from another facility with a history of yelling all the time. Progress notes were reviewed from the admission until the day of transfer. The progress notes have documented behaviors throughout the stay at the facility. On 11/03/25 at 3:40 PM, an interview was held with the Administrator, Interim Director of Nursing (DON) and the Corporate Registered Nurse (RN) #72. A question was asked to the listed staff, why was 09/12/25 any different than any other time before? Didn't the resident have the same behaviors throughout her stay at the facility? Why was she denied for receiving an IM injection while hospitalized ? Why was she denied for readmission if she was stable for discharge? The Administrator stated, the referral is being reviewed .the facility physician has been on vacation and just returned. The Administrator continued, we are unaware of the resident being denied for readmission.On 11/03/25 at approximately 4:00 PM, the Administrator stated, we are trying to find out what has happened .we did not know she was denied for readmission.On 11/04/25 at 10:00 AM, the Administrator and the Interim DON stated, we are contacting the Admissions Director to find out the timeline and what took place with the denial. On 11/04/25 at 1:00 PM, the Interim DON provided a list from the acute care facility of the resident's active medications and last date of administration. The review found the resident did not have a current physician's order for any type of medication to be administered by IM injection. The dates ranged from 09/17/25 through 10/07/25. An additional interview was held with the Interim DON at 1:10 PM on 11/04/25. The Interim DON stated, this was not denied at the facility level, it was denied at the Corporate level .we are having the facility physician review the latest clinicals and see what his decision will be. At this time, the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator confirmed what the Interim DON stated.After reviewing all the medical records from the facility and the acute care facility, the documentation confirms the resident did not have a current medication order for any type of IM injections, routine or as needed from 09/17/25 through 10/07/25. Therefore, the reason for the denial of readmission could not be verified based on the current medication list provided to this Surveyor.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and staff interview, the facility failed to ensure an accurate Minimum Data Set (MDS) for Resident #9 regarding hospice care. This was true for one (1) of one (1) residents reviewed under the care area of hospice. Resident Identifier: #9. Facility Census: 59.Findings Include: a) Resident #9 On 09/24/25 at 11:00 AM, a record review was completed for Resident #9. The review found the MDS with an assessment reference date (ARD) of 07/30/25. The resident was placed under hospice care on 07/23/25. However, the MDS section O K1., hospice care was marked no for receiving hospice care. On 09/24/25 at 11:06 AM, the Corporate Registered Nurse (RN) #72 confirmed the MDS was incorrect.

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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. Based on record review and staff interview, the facility failed to develop a complete and accurate care plan for Resident #9. This was true for one (1) of one (1) residents reviewed under the care area of hospice care. Resident Identifier: #9. Facility Census: 59.Findings Include:a) Resident #9On 09/24/25 at 8:55 AM, a record review was completed for Resident #9. The review found the care plan had not been developed completely under multiple focus areas, goals and interventions. The following areas of the care plan were left blank:--Under the focus area of resistive to care related to cognitive loss/dementia, the intervention observe for pain. Attempt non-pharmacologic interventions to alleviate pain (blank) and document effectiveness. Administer pain medications as ordered and document effectiveness/side effects.--Under the focus area of at risk for decreased abilit to per ADLs (activities of daily living((blank) related to (blank) chronic disease/condition: (specify disease or condition: (blank) Other: (blank).--Under the focus area of hospice, the goal states, Pt/Resident will experience highest practical quality of life (as defined by them) throughout life journey as evidenced by (blank). --Under the focus area of hospice, multiple interventions were incomplete: Hospice Chaplain (blank) x/month and PRN (as needed) to provide spiritual support and (blank)., Hospice Nursing (blank) x/week and PRN to assess and manage symptoms, comfort/pain, bowel function and (blank), Hospice Nursing Assistant (blank) x/week to compliment ADL care, provide comfort and (blank), Hospice Social Work (blank) x/month and PRN to provide psychosocial support related to end of life care and (blank).--Under the focus area of risk for furher skin breakdown, multiple interventions were incomplete: Pressure redistribution surfaces to chair as per guidline (blank), Assist resident in turning and reposition every (blank) hours, Encourage resident to consume all fluids of choice (blank) during meals, Off Load/float heels while in bed with (blank), pressure redistribution surface to bed as per guideline (blank).On 09/24/25 at 11:06 AM, the Corporate Registered Nurse (RN) #72 confirmed the care plan had not been developed and multiple blanks were present.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and staff interview, the facility failed to input a physician's order for Resident #9 regarding hospice services and follow physician's orders for Resident #26 and #27 regarding late medication. This was true for three (3) of 20 residents reviewed during the survey process. Resident Identifiers: #9, #26 and #27. Facility Census: 59.Findings Include:a) Resident #9On 09/24/25 at approximately 1:00 PM, a record review was completed for Resident #9. The review found the resident was placed under hospice services on 07/31/25. However, a physician's order was not input until 09/24/25. On 09/24/25 at 1:30 PM, Corporate Registered Nurse (RN) #72 confirmed the resident was under hospice services as of 07/31/25 and the physician's order was input on 09/24/25.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and staff interview, the facility failed to ensure nurse aide performance reviews were completed annually. This was true for three (3) of five (5) nurse aides' annual performance reviews during the survey process. Facility Census: 59.Findings Include: a) Performance Review On 09/30/25 at 3:45 PM, a review of the five (5) nurse aides (Nas) performance reviews was completed. The review found three (3) of the five (5) performance reviews were not completed. The following were incomplete: --NA #50 due 09/18/25--NA #46 due 06/27/25--NA #38 due 07/25/25 On 09/30/25 at 4:40 PM, the Administrator and the Regulatory Compliance Advisor #73 confirmed the performance reviews were not completed.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and staff interview, the facility failed to serve food at an appetizing and palatable temperature for Resident #46. This was a random opportunity for discovery and was true for Resident #46. Resident Identifier: 46. Facility Census: 59. On 11/03/25 at 12:44 PM an observation of Resident #46 found the resident was in her bed with her head at the foot of the bed and the bed wedge was kicked out to the side of her bed. Nurse Aide #35 was asked how much the resident had eaten she stated, I dont know I was not the one who feed her. She said, let me see. She then was asked if her dirty tray was on the cart on the hall, she said no we do not put the dirty ones back on that cart we put them somewhere different. She then opened the cart and stated, Oh she hasn't been feed yet and neither has her roommate. She stated, I will feed her now. The surveyor then asked her to get the dietary manager to test the temperature of the tray and to request a new tray for the resident from the kitchen. A quick tour of the hallway found no other residents were being assisted with their meals and most of the lunch trays had all ready been collected by the staff. At approxmiatly12:55 pm, Nurse Aide #35 and the Certified Dietary Manager (CDM) returned to the hall with a new tray for the resident at this time the CDM tested the temperature of Resident #46's tray. The temperatures were as follows: Pureed Carrots 112.8 degrees FahrenheitPureed Chicken Casserole: 114.6 degrees Fahrenheitand Pineapples 67.5 degrees Fahrenheit The CDM confirmed the hot foods should have been 120 degrees or higher and the pineapples should have been less than 41 degrees. The CDM indicated the cart containing Resident #46 tray left the kitchen at 12:15 pm and her tray was one of the first ones put on the cart.

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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. Based on observation, record review and staff interview, the facility failed to maintain an infection control program during medication administration for Resident #19. This was true for one (1) of five (5) residents reviewed under the care area of medication administration. Facility Census: 59.Findings Include: a) Resident #19 On 11/04/25 at 8:24 AM, medication administration completed by Graduate Practical Nurse (GPN) #14 for Resident #19. While preparing the medication for administration, GPN #14 touched the medication cart trash can lid two times. GPN #14 did not complete hand hygiene after touching the medication cart trash can lid two times. On 11/04/25 at 9:10 AM, GPN #14 confirmed hand hygiene should have been completed after touching the trash can lid. On 11/04/25 at 9:20 AM, the Director of Nursing (DON) was notified. The DON confirmed hand hygiene should have been completed after touching the trash can lid.