STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515184	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine View Nursing and Rehabilitation Center	400 McKinley Avenue Harrisville, WV 26362

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43340 Based on record review and staff interview, the facility failed to issue the required Notification of Medicare Non-Coverage (NOMNC) in a timely fashion for one (1) of three (3) residents reviewed for beneficiary protection notification. This failure had the potential to place the resident at risk of not being informed of her rights prior to the end of Medicare Part A covered services. Resident identifier: #146. Facility census: 47. Findings included: a) Resident #146 On 10/29/24 at 12:00 PM, a review was completed regarding the beneficiary protection notification liability notice(s) given for Resident #146. Resident #146 was discharged to home following his last covered day of Medicare Part A services. Resident #146's last covered day of Part A Services was on 06/06/24. The facility failed to produce evidence that the required Notification of Medicare Non-Coverage (NOMNC) was issued. The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 state: The NOMNC must be delivered at least two calendar days before Medicare covered services end . The instructions also state: A NOMNC must be delivered even if the beneficiary agrees with the termination of services. During an interview on 10/29/24 at 12:45 PM, Occupational Therapist #31 reported that Resident #146 had been admitted to the facility with an altered mental state and had demonstrated overall weakness. She recalled that it was the resident's desire to be able to return to home/community living when his skilled care days ended. Occupational Therapist #31 reported that the resident was discharged home on 06/06/24 once he had plateaued (meet a particular level of functioning and then stayed the same). During an electronic medical record review, completed on 10/29/24 at 8:30 PM, review of Resident#146's care plan revealed that resident had a desire to be discharged to the home following his skilled care/strength-building placement. Review of the resident's physical therapy, occupational therapy, and speech therapy discharge summaries revealed that the resident had met the therapeutic goals that had been established for him for to return to home/community living. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 8:35 AM, the Business Office Manager #60 confirmed a NOMNC was not issued prior to Resident #146's last covered day of Medicare Part A skilled services and subsequent discharge to home

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 42120 Based on interviews and record review, the facility failed to provide privacy for visitation. This is true for one (1) of one (1) resident reviewed during the Long-Term Care Survey Process (LTCSP). Resident identifiers: #1, #40. Facility census: 47. Findings Included: a) Resident #1 On 10/29/24 at 10:55 AM during an interview with Resident 1's Medical Power of Attorney, she stated that all Resident 1's visitor's including her, have issues with Resident #40 opening the door, cursing the visitors and trying to come into the room. A record review on 10/29/24 of grievances revealed no grievance form was filled out for these issues. A medical record review of progress notes revealed multiple occasions 10/22/2024 3:35 PM A note stated Resident #1's sister came to a nurse and stated Resident #40 came to resident's room opened the door and just laughed then left at 3:05 PM and 3:15 PM. 10/27/2024 2:37 PM Resident #1's sister came to the chart room notifying the nurse that Resident #40 came down the hallway opened Resident #1's door started laughing and went back into his room. 10/5/2024 11:59 AM A note revealed that Resident #40 was asked by another resident's family member to stay away from the room door. This Resident has chosen not to comply with the other resident family's wishes. This resident chose to curse and speak loudly at the other resident's family members when they asked him to be respectful. This resident did not respond to verbal redirection and continued to attempt to look in another resident's room. 10/6/2024 2:40 PM A note revealed that Resident #40 was found in Resident #1's room. When the nurse approached the room and asked Resident #40 to leave, he immediately left the room quickly. Resident#40 refused to stop moving his chair to be questioned as to why he was in the room, nor would he listen when they tried to redirect him. 10/6/2024 6:00 PM (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note stated Resident #40 had been verbally aggressive toward the staff due to his being redirected to stay out of Resident #1's room. Resident #1 had multiple family members coming in and out of her room which has caused an increase in Resident #40's behavior. Staff tried to redirect Resident #40, but he refused to listen or follow directions. 10/6/2024 4:43 PM A progress note stated Resident #40 was in the hallway screaming, (fxcx) them, I can see her if I want, in response to a resident #1's family coming in to see her. The family of Resident #1 has asked that this resident not come in the room and to stay away from her. Resident #1 was upset and verbalizing his aggravation in response. When Resident #40 was asked to stop yelling he responded with, hell no. Resident could not be redirected at this time. 10/20/2024 2:00 PM Resident #40 became verbally and physically aggressive when Resident #1's family came to visit her. He tried to kick and hit me with his fist as I walked down the hall. The resident believed that I called the family of Resident #1 to come in. Resident #40 had to be redirected by two other staff members due to he wasn't listening to what I had to say. He was removed from the area in order for him to settle down. He made multiple trips down the hall and stopped in front of Resident #1 door. When he would see someone coming down the hall, he moved on quickly. During an interview with the Administrator on 10/29/24 at 1:52 PM, she stated she was aware of the complaint about the issues for Resident #1, She verified that Resident #1 and her visitors were not provided privacy during visitation. She stated that she would offer a room change now.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42120 Based on interview, record review and policy review the facility failed to making prompt efforts to resolve a grievance and to keep the resident notified of progress toward resolution. This is true for two (2) of two (2) reviewed during the Long-Term Care Survey Process (LTCSP). Resident identifiers: #1 and #5. Facility census: 47. Findings included: a) Resident #1 Record review of the facility's policy titled, grievance /concern, showed: -Upon receipt of the grievance / concern, the grievance / concern form will be initiated by staff member receiving the concern. -Upon receipt of the grievance /concern form, the Administrator or designee will document the grievance / concern on the grievance / concern log. - Immediate action will be taken to prevent further potential violations of any patient right while the alleged violation is being investigated. -Notify the person filing the grievance of resolution in a timely manner. Resident #1 On 10/29/24 at 10:55 AM during an interview Resident #1's Medical Power of Attorney, she stated that all Resident 1's visitors including her have issues with Resident #40 opening the door, cursing the visitors and trying to come into the room. A record review on 10/29/24 of grievances revealed no grievance form were filled out for these issues. A medical record review of progress notes revealed multiple occasions During an interview with the Social Services Director (SSD) on 07/12/22 at 9:52 AM, she stated she was aware of the complaint about the noise of the other resident but had never offered a room change to Resident #45 or completed a grievance form. She stated that she would offer a room change now. 10/22/24 3:35 PM Resident #1's sister came to this nurse stated resident #40 came to resident's room opened the door and just laughed then left at 3:05 PM and 3:15 PM. 10/27/24 2:37 PM (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1's sister came to chart room notified this nurse Resident #40 came down the hallway opened Resident #1's door started laughing and went back into his room. 10/05/24 11:59 AM Note: Resident was asked by another Resident family member to stay away from their room door. This Resident has chosen not to comply with the other Resident family's wishes. This resident chose to curse and speak loudly at the other Resident family members when they asked him to be respectful. This Resident did not respond to verbal redirection and continued to attempt to look in other Resident room. 10/06/24 3:40 PM A note revealed Resident #40 was found in Resident #1s room. When the nurse approached the room to ask Resident #40 to leave, he immediately left the room quickly. Resident#40 refused to stop moving his chair to be questioned as to why he was in the room, nor would he listen when the nurse was trying to redirect him. 10/06/24 6:00 PM A note revealed Resident #40 had been verbally aggressive toward the staff due to being redirected to stay out of Resident #1's room. Resident #1 had multiple family members coming in and out of her room. This caused an increase in Resident #40's behavior. Staff tried to redirect Resident #40 but he refused to listen or follow directions. 10/06/24 4:43 PM Resident #40 was in the hallway screaming fuck them, I can see her if I want, in response to Resident #1's family coming in to see her. Family of Resident #1 asked that this resident not come in the room and to stay away from other resident. Resident #40 was upset and verbalizing his aggravation in response. Resident #40 was asked to stop yelling and he responded with, hell no. Resident #40 could not be redirected at this time. 10/20/24 2:00 PM Resident #40 became verbally and physically aggressive when Resident #1's family came to visit her. He tried to kick and hit me with his fist as I walked down the hall. Resident believed that the nurse called the family of Resident #1 to come in. Resident #40 had to be redirected by two (2) other staff members due to he wasn't listening to what I had to say. He was removed from the area in order for him to settle down. He made multiple trips down the hall and stopped in front of Resident #1 door. When he would see someone coming down the hall, he moved on quickly. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Administrator on 10/29/24 at 1:52 PM, she stated she was aware of the complaint about the issues for Resident #1, She verified no one completed a grievance form. She stated that she would offer a room change now. 50795 b) Resident #5 During an interview with Resident #5 on 10/2824, at approximately 11:55 AM, the resident stated that she had filed a verbal grievance against a staff member on 09/03/24. She mentioned that she had not received any response from the facility regarding the status of the investigation. A telephone interview was conducted with the Medical Power of Attorney (MPOA) for Resident #5 on 10/28/24, at 2:44 PM. During the conversation, the MPOA noted the facility had not yet responded to the grievance. She expressed her desire to understand whether the facility had conducted an investigation and, if so, what the outcome was. Further investigation, interviews, and record review revealed that the facility conducted an investigation, interviewed staff and residents, and concluded that the grievance could neither be substantiated nor refuted. Record review of the facility's policy titled, Grievance/Concern, revised on 10/15/24, showed that the department manager would notify the person filing the grievance in a timely manner, and written resolution for grievances would be offered per the resident's rights and will include: Date the grievance was received; Summary statement of the grievance; Steps taken to investigate the grievance; Summary of the pertinent findings or conclusions regarding the grievance; Statement as to whether the grievance was confirmed or not confirmed; Any corrective action(s) taken or to be taken by the center as a result of the grievance/concern; and Date the written resolution was issued. During an interview with Administrator #41 and Director of Nursing #46 on 10/30/24, at approximately 3:18 PM, they confirmed the facility had not submitted a written resolution of the grievance to the resident.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 43340 Based on medical record review and staff interview, the facility failed to ensure a written Notice of Transfer / Discharge was provided to the resident and the long-term care Ombudsman for one (1) of two (2) residents reviewed for hospitalization s during the long-term care survey process. This had the potential to affect all residents being transferred or discharged . Resident identifier: #27. Facility census: 47. Findings included: a) Resident #27 A medical record review was completed on 10/3024 at 12:04 PM. The record review revealed Resident #27 was transferred to the hospital on 05/17/24. The record did not reflect the resident/resident's representative was provided with a written Notice of Transfer/Discharge indicating the reason for transfer, the effective date of transfer, the location to which the resident was being transferred, and a statement of the resident's appeal rights. There was also nothing in the electronic medical record to indicate the long-term care Ombudsman had been notified. During an interview on 10/01/24 at 2:55 PM, the Administrator reported the facility could produce no evidence that resident/resident's representative was provided a Notice of Transfer/Discharge or that the long-term care Ombudsman was notified of the transfer.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on medical record review and staff interview, the facility failed to provide evidence that a resident/resident's representative was provided with a written Bed Hold notice for an acute hospital transfer. This was true for two (2) out of two (2) residents reviewed under the hospitalization pathway in the annual Long-Term Care Survey Process. Resident identifiers: #27, and #16. Facility census: 47. Findings included: a) Resident #27 A medical record review was completed on 10/3024 at 12:04 PM. The record review revealed Resident #27 was transferred to the hospital on 05/17/24. There was no evidence in the electronic medical record that the facility had provided Resident #27 or his representative with a written Bed Hold notice. During an interview, on 10/01/24 at 2:55 PM, the Administrator reported the facility could not produce evidence that a Bed Hold notice had been issued for Resident #27's hospitalization on [DATE]. 42120 b) Resident #16 Record review, on 10/30/22 at 9:27 AM, revealed Resident #16 was discharged to a local hospital on 10/20/24. Continued review of Resident #16's medical record showed it did not contain documentation that the resident or the resident's representative received a copy of the bed hold policy at the time of transfer. In addition, there was no documentation in the medical record of contacting the resident/resident representative regarding the bed hold policy. In an interview with the Director of Nursing on 10/30/24 at 12:12 PM, the she confirmed that there was no documentation regarding staff notif0ying the resident/resident representative of the bed hold policy for the hospital transfer on 10/2/24.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to complete a new Pre-Admission Screening and Resident Review (PASARR) for residents with newly evident or a possible serious mental disorder. This was true for two (2) out of two (2) residents reviewed under the category of PASARR, during the Long-Term Care Survey Process. Resident identifiers: #6 and #28. Facility census: 47. Findings included: a) Resident #6 A record review, completed on 10/29/24 at 1:50 PM, revealed Resident #6 had been admitted to the facility on [DATE]. Review of resident's diagnoses revealed a Major Depression diagnosis with an effective/active date of 11/01/23. There was only one (1) PASARR, dated 11/02/2022, on file. Section III MI/MR Assessment Question #30 had NONE selected regarding any pertinent diagnosis. Additionally, Section V Supplemental Questions #40 had NONE selected regarding any major mental illness (MI) or suspected MI. There was no evidence that a new PASARR had been done when the Major Depression diagnosis was given. During an interview, on 10/29/24 at 2:15 PM, the Social Worker reported there was not a new PASARR on file that addressed Resident #6's Major Depression diagnosis. b) Resident #28 A record review, completed on 10/29/24 at 2:00 PM, revealed Resident #28 had been admitted to the facility on [DATE]. Review of resident's diagnoses revealed a Bipolar Disorder diagnosis with an effective/active date of 09/26/24. There was an initial PASARR, dated 03/26/24 on file. Section III MI/MR Assessment Question #30 had NONE selected regarding any pertinent diagnosis. Additionally, Section V Supplemental Questions #40 had NONE selected regarding any major mental illness (MI) or suspected MI. There was a second PASARR, dated 07/16/24 on file. Section III MI/MR Assessment Question #30 had DX (diagnosis) of Depression and PTSD selected regarding any pertinent diagnosis. Additionally, Section V Supplemental Questions #40 had DX (diagnosis) of Depression and PTSD selected regarding any major mental illness (MI) or suspected MI. There was no evidence that a new PASARR had been done which captured resident's Bipolar Disorder diagnosis. During an interview, on 10/29/24 at 2:20 PM, the Social Worker reported there was not a new PASARR on file that addressed Resident #28's Bipolar Disorder diagnosis.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on record review and staff interview, the facility failed to develop and implement a comprehensive person-centered care plan for one (1) of 24 residents reviewed in the Long-Term Care Survey process. The facility failed to address Resident #145's preferred bedtime preference. Facility identifier: #145. Facility census: 47. Findings included: a.) Resident #47 A record review, completed on 10/29/24 at 7:40 PM, revealed that Resident #145 was admitted to the facility on [DATE] A review of the Recreation Comprehensive Assessment completed for resident, dated 10/18/24, found that the resident had reported she liked to go to bed whenever she wanted. A review of the comprehensive person-centered care plan for Resident #145 showed a focused area of Resident #145 as, While in the facility, resident/patient states that it is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences. Additionally, Resident #145 had the following intervention listed in her comprehensive care plan as it related to her daily routine, It is important for me to choose my bedtime and I prefer to go to bed (Delete all that do not apply) earlier than 7 pm, between 7-9 pm, or whenever I want. This intervention was created on 10/21/24. During an interview on 10/30/24 at 11:40 AM, the Administrator confirmed the care plan was not person-centered, and the reader would have no way of knowing what Resident #145's preference for bedtime would be by reading the intervention listed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50795 Based on Interview and record review, the facility failed to contact the physician; and request a re-assessment of resident's capacity; after a Brief Interview for Mental Status (BIMS) evaluation revealed severe impairment. Resident identifiers: #18. Facility census: 47. Findings included: a) Resident #18: During a brief interview, on 10/28/24, at approximately 11:40 AM, Resident #18 was unable to state when she had entered the facility, or how long she had been there. The resident responded to other questions with unrelated answers. Record review on 10/28/24 at approximately 3:15 PM revealed a document by the resident's physician dated 08/29/24, that stated the resident had capacity. Further record review revealed the following note on 8/23/24 at 10:44 AM by Social Worker (SW) #23: BIMS Summary score: 12.0 Record review further revealed that Resident #18 had been admitted to the hospital on 09/14/24 for an acute urinary tract infection (UTI). A note by Physician #62 on 9/21/2024 at 8:13 PM stated the following: Resident is an (age/gender) who presents to the Pineview Center in Harrisonville, [NAME] Virginia after an acute hospitalization from [DATE] through 09/14/2024 at (name of acute care hospital) due to adult failure to thrive secondary to a acute urinary tract infection. She was evaluated by orthopedics who recommended against any further workup or interventions. They recommended PT/OT in order to help mobilize. Neurosurgery was consulted for T6 compression fracture in which they felt that this was more chronic in nature. Blood cultures eventually grew gram-negative rods and urine cultures grew Klebsiella. ID had been consulted and recommended broad-spectrum antimicrobials. Concern for lower extremity blood clot which was unable to be confirmed by ultrasound but treated with empiric heparin drip. Patient did have positive fecal occult blood test and GI was involved. Due to risks outweighing the benefits, heparin drip was discontinued and Protonix 40 mg IV twice daily was initiated. Palliative care had also evaluated the patient towards the end of admission, family and patient were agreeable to hospice. She was determined to be stable for discharge on 9/21/2024 in which she re-presented to the Center for long-term care on hospice. A note by SW #23 on 9/24/2024 at 08:33 AM stated: - BIMS Summary score: 5.0 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24, at approximately 1:30 PM, SW #23 was unable to explain why the facility failed to contact the physician and request a re-assessment of Resident #18's capacity following the BIMS evaluation. An interview with Administrator #41 on 10/30/24 at approximately 3:00 PM confirmed that the facility had not contacted the physician to request a reassessment of the resident's capacity.

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Pine View Nursing and Rehabilitation Center	400 McKinley Avenue Harrisville, WV 26362

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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. 50795 Based on observation, staff interview, and clinical record review, the facility failed to follow physician orders regarding oxygen administration, and did not monitor residents on oxygen therapy as prescribed. Resident identifiers: #5, and #11. Facility census: 47. Findings include: a) Resident #5 During a brief interview and inspection on 10/28/24 at approximately 11:40 AM, the resident was observed to be on oxygen therapy. The resident continued to be observed throughout the survey, and the following readings were obtained: On 10/28/24 at approximately 11:55 AM an oxygen concentrator was observed to be set to two (2) liters per minute. On 10/29/24 at approximately 3:11 PM the oxygen concentrator was observed to be set to deliver two (2) liters per minute. Record review revealed a physician's order dated 09/29/24 at 7:09 PM that stated: Oxygen at 3 L/min via Nasal Cannula PRN; notify MD if more than 3 shifts in a row below 90% O2 sat or having symptoms of respiratory distress. On October 29, 2024, at approximately 3:14 PM, LPN #29 confirmed that the oxygen was not set to the prescribed dosage. After adjusting the concentrator to deliver the correct dose, she remarked, These are not my patients; I was just asked to cover this hallway a few minutes ago. On 10/30/24 at approximately 8:11 AM this surveyor requested a record of Resident #5's oxygen saturation, while on oxygen therapy. Administrator #41 submitted a record with the following information: O2 SATS SUMMARY: -10/21/24 at 11:13 AM 99% (Room Air) -09/19/24 at 9:42 AM 98% (Room Air) -09/06/24 at 12:38 AM 96% (Room Air) (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-09/04/24 at 11:41 PM 96% (Room Air) -09/03/24 at 2:41 PM 96% (Room Air) PULSE SUMMARY: -10/21/24 at 11:13 AM 70 bpm (Regular) -10/01/24 at 8:14 AM 69 bpm (Regular) -09/19/24 at 9:42 AM 68 bpm (Regular) -09/06/24 at 12:38 AM 80 bpm (Regular) -09/04/24 at 11:41 PM 78 bpm (Regular) -09/03/24 at 2:40 PM 76 bpm (Regular) -09/01/24 at 9:52 AM 72 bpm (Regular) RESPIRATION SUMMARY: -10/21/24 at 11:13 AM 18 Breaths/min -10/01/24 at 8:14 AM 18 Breaths/min (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-09/19/24 at 9:42 AM 18 Breaths/min -09/06/24 at 12:38 AM 18 Breaths/min -09/04/24 at 11:41 PM 18 Breaths/min -09/03/24 at 4:41 PM 18 Breaths/min -09/01/24 at 9:52 AM 20 Breaths/min These records indicated that monitoring was not consistently conducted as prescribed by the physician. Additionally, no records were available for the dates of 10/28/24, and 10/29/24. During an interview with Administrator #41 on October 30, 2024, at approximately 9:44 AM, she stated that she had submitted all available monitoring records. b) Resident #11 On 10/28/24, at approximately 1:20 PM, Resident #11 was observed receiving oxygen therapy. The resident was continuously observed throughout the survey, and the following readings were recorded: On 10/28/24 at approximately 1:23 PM an oxygen concentrator was observed to be set to two (2) liters per minute. On 10/29/24 at approximately 11:5 AM the oxygen concentrator was observed to be set up to deliver two (2) liters per minute. On 10/30/24 at approximately 10:40 AM the oxygen concentrator was observed to be set to deliver two point five (2.5) liters per minute. Record review revealed a physician's order dated 11/03/23 at 6:00 PM that stated: Oxygen at 3 L/min via Nasal Cannula, continuously. Every day and night shift Notify MD if Pulse Ox < 90% more than 3 shifts in a row or having symptoms of respiratory distress. On 10/30/24, at approximately 10:42 AM, LPN #49 confirmed that the oxygen was not set to the prescribed dosage. She adjusted the concentrator to deliver the correct dosage, and then stated that she would ensure the other oxygen concentrators in the hallway were also checked. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at approximately 8:11 AM this surveyor requested a record of Resident #11's oxygen saturation while on oxygen therapy. Administrator #41 submitted a record on 10/30/24 at approximately 8:15 AM, with the following information: O2 SATS SUMMARY: -10/13/24 at 6:28 AM 98% (Oxygen via nasal cannula) -10/12/24 at 9:44 PM 98% (Oxygen via nasal cannula) -10/12/24 at 8:48 AM 98% (Oxygen via nasal cannula) -10/12/24 at 12:51 AM 98% (Oxygen via nasal cannula) -10/10/24 at 10:43 PM 97% (Oxygen via nasal cannula) -10/10/24 at 4:30 PM 97% (Oxygen via nasal cannula) -10/09/24 at 9:37 PM 98% (Oxygen via nasal cannula) -10/09/24 at 9:34 PM 98% (Oxygen via nasal cannula) -10/12/24 at 12:51 AM 98% (Oxygen via nasal cannula) -10/10/24 at 10:43 PM 97% (Oxygen via nasal cannula) (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-08/19/24 at 1:00 AM 96% (Oxygen via nasal cannula) -08/17/24 at 11:18 PM 96% (Oxygen via nasal cannula) -06/28/24 at 9:32 AM 96% (Oxygen via nasal cannula) -06/27/24 at 11:40 PM 95% (Oxygen via nasal cannula) -06/27/24 at 10:41 AM 95% (Oxygen via nasal cannula) -06/26/24 at 11:55 PM 96% (Oxygen via nasal cannula) -06/26/24 at 5:01 PM 98% (Oxygen via nasal cannula) -06/25/24 at 12:57 AM 98% (Oxygen via nasal cannula) -06/25/24 at 12:17 AM 97% (Oxygen via nasal cannula) -06/20/24 at 2:17 AM 96% (Oxygen via nasal cannula) This record showed that while the resident was continuously on oxygen, monitoring was not consistently conducted daily, as prescribed by the physician. Furthermore, there were no records available for 10/28/24, 10/29/24, and 10/30/24. During an interview with the Administrator #41 on 10/30/24 at approximately 9:44 AM she confirmed that the monitoring had not been consistent.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340 Based on resident representative interview, record review, and staff interview, the facility failed to collaborate with resident trauma survivors, and as appropriate, the resident's family, to identify triggers which may re-traumatize the resident, and develop care plan interventions to minimize or eliminate the effect of the trigger on the resident. This was true for one (1) of two (2) residents reviewed with a Post Traumatic Stress Disorder (PTSD) diagnosis. Resident identifier: #27. Facility census: 47. Findings included: a) Resident #27 During a resident representative interview, completed on [DATE] at 11:02 AM, Resident #27's wife reported his PTSD diagnosis stemmed from a work event when he was in his mid-20's. She went on to report that there was a disaster in 1978 in (name) County when a cooling tower under construction at the power plant collapsed, killing 51 construction workers. Resident #27 remembered the incident vividly and recalled people going around and just collecting the severed left arms of the deceased construction workers. He explained the way the scaffolding fell meant the majority of the workers lost their left arms during the fall. This image was something that had stuck with Resident #27 and something he would frequently talk about later in his life and prior to his admission to the facility. A record review completed on [DATE] at 10:39 AM revealed the following details: -A significant change in status Minimum Data Set (MDS), dated [DATE], revealed resident had a Brief Interview for Mental Status (BIMS) score of 02. A BIMS score of ,d+[DATE] is suggestive of a person having severe cognitive impairment. -A review of the comprehensive person-centered care plan for Resident #27 showed a focused area as, Resident/Patient reports past experience of trauma as evidenced by: Other Dx: PTSD. -Resident #27 had the following goal listed, Resident/Patient will identify stressors and report to staff through the next review. This goal had a revision date of [DATE]. -Additionally, Resident #27 had the following intervention listed in his comprehensive care plan as it related to his PTSD diagnosis, Encourage Resident/Patient to identify personal trauma and triggers and take steps to eliminate/minimize. During an interview on [DATE] at 11:00 AM, the Social Worker reported she did not have knowledge of why Resident #27 had a PTSD diagnosis and could not readily identify any triggers that might re-traumatize the resident. The Social Worker acknowledged that asking a resident with severe cognitive impairment to identify his personal trauma and triggers would be unrealistic and that a conversation should have been held with the resident's family to gain the information.

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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. 50801 Based on personnel file record reviews review and staff interview, the facility failed to provide a completed performance review of every nurse aide at least once every 12 months. This failed practice had the potential to affect more than a limited number of residents. Employee identifiers: #49, #5. Facility census: 47. Findings included: a) Employee performance reviews were not available for #49 or #5. During an interview, on 10/30/2024 at 11:34 AM, the Scheduling/payroll Manager #35 confirmed the yearly performance reviews were not on file for employee #49 and #5.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 43340 Based on record review and staff interview, the facility failed to ensure the consulting pharmacist performed a medication regimen review, which included a review of the resident's medical record, at least monthly. This was true for two (2) of five (5) residents reviewed under the unnecessary medication's pathway throughout the Long-Term Care Survey Process. Resident identifiers: #27 and #28. Facility census: 47. a) Resident #27 A record review, completed on 10/29/24 at 1:33 PM, revealed there was no evidence in the electronic medical record that a monthly medication regimen review had been completed for Resident #27 during the months of November 2023 and December 2023. During an interview on 10/30/24 at approximately 3:15 PM , the Administrator reported the facility was unable to produce any evidence the monthly medication regimen reviews had been completed by the consulting pharmacist and/or reviewed by the attending physician. b) Resident #28 A record review, completed on 10/29/24 at 1:15 PM, revealed there was no evidence in the electronic medical record that a monthly medication regimen review had been completed for Resident #87 for the month of August 2024. During an interview on 10/30/24 at approximately 3:15 PM, the Administrator reported the facility was unable to produce any evidence the monthly medication regimen review had been completed by the consulting pharmacist and/or reviewed by the attending physician.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51553 Based on observation, staff interview and record review, the facility failed to store and label food in accordance with professional standards for food service storage. This failed practice had the potential to affect more than a limited number of residents. Facility Census: 47. Findings included: a) Observation in the pantry area of the kitchen revealed small unlabeled what appeared to be vanilla ice cream. No dates were present on the cups. b) Observation in the freezer revealed cooked frozen sausage with a date labeled 10/28/24 and use by date of 04/22/24. These findings were confirmed by the Dietary Manager on 10/28/24 during the kitchen investigation.