STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515186	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluestone Health and Rehabilitation	1600 Bland Street Bluefield, WV 24701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on record review, family interview and staff interview the facility failed to notify the residents responsible party of a room change prior to moving the resident. This was a random opportunity for discovery during the compliant survey. Resident Identifier: #60. Facility Census: 58. Findings Include: a) Resident #60 During an interview with Resident #60's responsible party on 02/10/25 at 12:03 PM during a telephone interview , she stated, The last time they moved him they did not tell me. They just came in and packed up all his stuff and moved him. A review of the medical record on 02/10/25 in the afternoon found no indication the residents responsible party was notified of his room move. An interview with the Director of Nursing (DON) on the afternoon of 02/13/25 confirmed there was no evidence the residents responsible party was notified of his room move. She stated The social worker said she must have clicked the wrong button.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 all allegations of abuse and/or neglect was thoroughly investigated. This was true for Resident #59 and was a random opportunity of discovery during a complaint survey. This was determined to be past non-compliance because the facility had identified the failure and implemented an effective plan of correction to correct the non- compliance prior to the first day of the complaint survey. Resident Identifier: #59. Facility Census: 58. Findings Include: a) Resident #59 A review of the facility's reportable incidents on 02/10/25 found a reportable incident dated 02/15/24 pertaining to Resident #59. A review of the report found the following under the brief description of the incident: It is reported this afternoon (02/15/24) by (name of another state agency) worker that this resident allegedly received bruises and had multiple pressure ulcers of various stages upon returning home from (Name of facility). A review of the five day follow - up submitted by the facility on 02/19/24, found under the section titled, Corrective action by the facility the following, Investigation Completed- Allegations unsubstantiated Resident No longer in the facility. Also contained in the reportable investigation was document titled Complaint Investigation related to Resident #59. This was signed by the former Nursing Home Administrator (NHA) and read as follows, On 02/15/24, (Name of local state agency) worker, (First and Last name of the state agency worker) was in the facility for a care plan meeting for one of the residents. Following the care plan meeting, she informed the DON (Director of Nursing) that she had a complaint to investigate while she was here. I, (First and Last Name of the former NHA) was then informed by (First Name of DON) and (First and Last Name of Local state agency worker) that an allegation had been made that a former SNF (Skilled Nursing Facility) resident (First and Last name of Resident #59) had a large bruise on her abdomen and flank area and that she had multiple pressure wounds at various stages, which was believed by the complainant to have occurred at (Name of Nursing Facility). (First Name of the DON) reviewed the residents chart, finding no documentation indicating there were any bruises or pressure areas on the resident prior to her leaving the facility on (date omitted to protect confidentiality). All documentation related to the resident's skin condition completed by nursing staff, physician, FNP (Family Nurse Practitioner) indicates that the resident had no skin issues [NAME] at (Name of the Facility). Statements from nursing staff who provided care to Ms. (Last Name of Resident #59) during her stay at (Initials of the Nursing Facility), indicate that the resident's skin was intact and at no time was any bruises, skin tears, or pressure ulcers observed by any direct care staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ms. (Last name of Resident #59) was admitted to the facility on (date omitted to protect confidentiality) for SNF for a short term rehab (rehabilitation) stay following a hospitalization. She had resided at a (Name of a local behavioral health home) home and needed therapy prior to returning to her formed residence. Her participation in therapy was minimal and she required a lift when transferring. On or about (date omitted to protect confidentiality) (First and Last Name of the admissions coordinator), Admissions Coordinator, received a call from a nurse at the (Name of local Behavioral Health Company) home, where Ms. (Last name Resident #59) lived, demanding that the resident be returned to them immediately. (First name of the Admissions Coordinator) explained that there was a process that we needed to follow before we could just release the resident. (First name of the Admissions Coordinator) called (Local State Agency) worker, (First and Last Name of State agency worker) informing her of the call from the (Name of Local Behavioral Health Company) nurse. (First Name of Local State agency worker) told (First name of the Admissions Coordinator) to proceed with the process to discharge Ms. (Last name of Resident #59) back to the (Name of local Behavioral Health Company) home and discharge plans were initiated, resulting in Ms. (Last name of Resident #59) returning to her previous residence on (Date omitted to protect confidentially). On 02/12/24, (First name of Admissions Coordinator) received a new referral from (Name of local Hospital) for Ms. (Last Name of Resident #59), as she had returned to the hospital on [DATE] (please note the resident actually returned to the hospital on [DATE]) from her (Name of local Behavioral Health Company) home. (First Name of admission coordinator) informed (Initials of Local Hospital) that we had an available bed and would accept her back. (First Name of admission Coordinator) reviewed the hospital records, which had no documentation of the wounds that ad been reported to the (Name of Local State agency). The resident did not return to this facility, and it is unknown to where she was transferred. Findings: It is determined that the allegations made are unsubstantiated, as there is no documentation or staff observation to support them. Further review of the reportable found no hospital records attached to the incident. In addition there was no evidence the facility had reached out to the Behavioral Health Company or the hospital to receive statements as to the residents condition. The state survey agency requested Resident #59's medical record related to her hospital stay which began on 02/07/24. When the records were received and reviewed it was determined the pressure wounds were mentioned abundantly in the hospital record. Examples are as follow, 02/07/2024 - ED (Emergency Department) to Hosp-admission (discharged) in (Name of local hospital) (continued)Discharge Summary Note (continued) . REASON FOR HOSPITALIZATION AND HOSPITAL COURSE Brief HPI(history or present illness) : This is a (Age Redacted to maintain confidentiality) y.o. (year old), female admitted for hypernatremia. Patient presented to the ED for developing wounds on the sacrum and heels. She was recently discharged from the (Name of Facility) and admitted to (Name of local behavioral health) group home. It was reported that she is requiring too much care to be cared for in a group home and would do better in a nursing home setting An emergency room triage note read as follows (typed as written) , (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	'RECENTLY D/C (discharged) FROM (Name of Facility) to (Name of behavioral health company. (Name of Behavioral Health Company) STAFF SENT PT (Patient) TO ER FOR DECUBITUS WOUNDS THAT THEY WOULD LIKE TO BE STAGED These are a couple of examples from a hospital record that referred to wounds a total of 820 times. An interview with the current Nursing Home Administrator and Director of Nursing on the afternoon of 02/12/25 confirmed the investigation was not thorough. At the time of exit on 02/13/25 the Corporate Registered Nurse provided the surveyor with a plan of correction (POC) related to not completing thorough investigations she stated, We identified this was an issue and believe we have corrected it and would like this to be past non compliance. The facility presented their plan of correction which read as follows, Abuse Neglect POC: 11/18/24 for QAPI (Quality Assurance Performance Improvement) approval on 11/21/24. During survey preparation and review audits it was discovered that there were some discrepancies in facility reportable events. The discrepancies include, timely reporting, full investigations conducted, reporting the initial to all parties including OHFLAC, APS, Ombudsman, Local law enforcement, sending in a 5- day follow up to all parties. A POC was initiated on 11/18/2024. With the following interventions: Staff will be re-educated regarding the abuse neglect policy and procedure. Staff will also re re-educated about being mandated reporters and reporting any abuse/neglect in a timely manner. Failure to follow the POC for reporting by any staff member will result in disciplinary action. Resident residing in the facility as of 11/18/2024 will be interviewed regarding any signs or symptoms of abuse/neglect. Any areas of concern will be reported to the appropriate parties and investigated for resolution. Any concerns noted from the interviews will also be addressed by the facility staff for resolution. Any concerns/grievances will be reviewed at morning meeting to ensure that the issues are being addressed and to ensure that if there are signs or symptoms of abuse neglect that they have been reported appropriately. The NHA/Designee will audit the concern grievance log and FRI (Facility reportable incidents) book monthly to ensure that all areas of concern have been resolved appropriately and reported as necessary for the next 3 (three) months. The results of the audit will be presented at the monthly QAPI committee meeting for review and further follow up if necessary. The implementation of the POC was reviewed by the surveyor and confirmed record review and staff interviews therefore this tag is cited at past noncompliance.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident representative interview, staff interview, hospital staff interview, long term care ombudsman interview and record review the facility failed to ensure Resident #60 who was discharged from their facility and was expected to return was readmitted to the first available bed when medically stable. Resident #60 has remained in the hospital from [DATE] until the time of this survey. The facility has admitted other male residents instead of Resident #60 with claims they did not have suitable bed for him. Resident #60 has experienced actual psychosocial harm as a result of these failures. The resident has experienced anxiety, agitation, and feelings of despair thinking he has done something wrong to cause this. This was true for one (1) of three (3) facility residents whom were reviewed during this complaint survey. Resident Identifiers: #60. Facility Census: 58. Findings Include: a) Resident #60 On 01/28/25 the state survey agency received a complaint indicating Resident #60 was discharged from the facility with a return anticipated and the facility has refused to readmit him with claims of not having an appropriate bed for him. The complaint had indicated the long term care ombudsman was also involved and the facility has still not allowed this resident to return. On 02/10/25 the long term care Ombudsman for this facility spoke with the surveyors. She indicated she became involved in this situation after Resident #60's wife had reached out to her. She stated, she had been to the facility on two separate occasions and met with staff to determine why they would not readmit Resident #60. She stated, they never tell me they won't take him back they just keep saying they don't have an appropriate bed for him. She further stated, I know they have admitted a total of eight (8) residents five (5) females and three (3) males since Resident #60 was cleared for discharge from the hospital. She indicated, the resident was feeling anxious and depressed that he did not understand why they would not take him back and is wondering what he has done to cause this. She stated, he wants to come back to this facility because he has friends here and he is allowed to smoke at this facility. She indicated the residents elderly parents and wife are local and do not want him to be so far away they could not visit regularly. On 02/10/25 in the afternoon the surveyor spoke with the Hospital Case Manager #70 (HCM) via telephone. HCM #70 stated she as spoken with the facility on numerous occasions about Resident #60 and they just keep telling me they don't have an appropriate bed for him. She stated, I know they have admitted residents since he has been ready for discharge. She stated, we have tried placing him at other facilities but they will not take him because of his pain pump. She stated the resident is having a hard time with it because he doesn't understand why they will not take him back. HCM #70 stated she would provide the surveyor with the notes related to their communication with the facility. A review of Resident #60's hospital medical record found the following notes from the case management department. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-- Note dated 12/31/24 read as follows: Pt (Patient)is alert and verbal. He is requesting to return to SNF (Skilled Nursing Facility). Wife's goal is for pt to return to facility. CM(Case manager) has spoken with (First and Last Name of the facility admission Director),Admissions at (Name of Facility). She confirms that pt can return to SNF when medically ready. Updated medicals have been submitted via Care port. The patient will continue to be evaluated for developing discharge needs. -- Notes dated 01/02/25 read as follows: CM attempted to reach (First and Last Name of the Facility admission Director),,Admissions Director with (Name of Facility) three times and left repeated messages. (First name of admissions director) called back and advised that they do not have a bed for pt today but do plan to accept him back as soon as bed becomes available. CM will continue to follow. (Please note the facility admitted a new admission on this day who was male Resident #61. He was admitted to a private room and was a new admission to this facility.) -- Note with a date of service of 01/06/25 which was entered on 01/08/25 read as follows: CM spoke with (First name of Facility Employee) at (Name of facility). She transferred call to (First and Last Name of the Facility admission Director) who did not answer. She did contact this CM later to advise that they had no beds today. Pts wife/MPOA did call (Initials of another local nursing home), Admissions Director,(First and last name of the other local nursing home)today to look for a bed there for pt. (First Name of admissions director at the other local nursing home) called this CM requested medicals. After viewing pts records in Care Port,(First Name of admissions director at the other local nursing home) called back to advise that the open bed they had at (Initials of another local nursing home) was filled earlier today. PAS was also done today. --Note dated 01/08/25 read as follows (This note was written by HCM #71 all previous notes referenced were written by HCM #70): Received this patient into CM service this am. Patient is discharged . Patient is admitted from (Name of this facility). However, (Initials of this facility) does not currently have a room available for return. Spoke with (First and Last Name of the Facility admission Director),@ (Initials of Facility) who advised will have bed available possibly 01/11/2025. Secondary to medical stabilization, this CM will seek appropriate NF placement. -- Note with a date of service of 01/08/25 filed in record on 02/12/25 written by HCM #70 read as follows: Pts wife/MPOA,(First name of Resident #60's wife) visited with this CM today. CM has left message for (First name of Admissions director at this facility),inquiring about bed status. She advised that she is calling (First and Last Name of the Facility admission Director), daily to inquire about a bed for pt. She stressed that he wants to return there. He is also reportedly calling his friend at facility daily. CM will continue to follow. -- Note dated 01/10/25 written by HCM #71 read as follows: Contacted (First name of Admissions director at this facility)@ (Name of this facility)this am to obtain status of possible bed placement today. Left message. Awaiting call back. (Please note that on 01/09/25 Male Resident #20 was admitted to the facility. Resident #20 was a new admission to the facility.) -- Note dated 01/13/25 written by HCM #71 read as follows: Spoke with patient's wife, (First and last Name of Resident #60's wife), this am re: lack of success in returning patient to(Name of this facility) Center. Notified wife of need to place patient possibly out of area. Wife voiced understanding. Stated she did not have 2400. 00 for bed hold and this is all about money. This CM will send referral out regionally for NF placement. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8:45 AM Uploaded clinical info and sent out to regional nursing facilities. Awaiting bed placement offer. 11:29 AM Received t/c from (First and last name of nursing home corporation), Liaison who is seeking possible bed placement in (First name of nursing facility corporation) Health facility. Continue to await bed placement offer. --Note written on 01/13/25 by HCM #71 read as follows: Patient admitted from (Name of Nursing Facility). Cannot return due to no bed availability secondary to no bed hold in place. Referral made in Care port for placement throughout the State. Spoke with (First and Last name of nursing facility corporate liaison #72), Liaison with (Name of nursing facility corporation) this am re: bed availability. (Liaison #72) reports no bed available in state to accommodate ESBL and Influenza at this time. (Liaison #72) will continue to look for bed placement. -- Note written on 01/15/25 by HCM #71 read as follows: Received corporate denial from (Name of nursing facility cooperation) Health secondary to patient having active pain pump, having recent BHP (Behavioral Health) stay, and altercation with other resident at NF were reasons provided by (Liaison #72) for corporate denial. (Please note it was this date the Director Of Nursing (DON) advised they had spoke with this cooperation about Resident #60) Also on this date the facility admitted female Resident #24 to a private room. Resident #24 was a new admission to this facility. -- Note written 01/16/25 by HCM #70 read as follows: CM received message this afternoon that (Name of facility's sister facility) SNF had a bed for this pt. CM called facility and spoke with (Name of Sister Facility's Admissions,Admissions Director. She advised that admissions person covering for her yesterday(First and Last name of staff covering admissions at sister facility) offered a bed,however admissions team determined that they can not accept pt with a pain pump because their staff is not trained to manage. CM will continue to follow for discharge planning. -- Note written on 01/20/25 by CM has spoken with (First and Last name of the admissions director of this facility),(Name of this facility). Pt remains on their waiting list. She does not have an appropriate male bed today. CM will continue to follow for discharge planning. (Please note on 01/17/25 the facility had Male Resident #69 discharge and Female Resident #64 was admitted to a private room. Resident #64 was new admission to the facility.) -- Note written on 01/23/25 by HCM #70 read as follows: CM received call from (First and Last),Ombudsman today. She advised that if (Name of this facility) has no beds, she would recommend (Name of another facility in a connecting county)because pt would be permitted to smoke there. CM spoke with (Corporate name of Facility in connecting county)Admissions Liaison after talking w/Ombudsman. He advised that, to date 15 of the (Name of Cooperation who owns facility in connecting county) facilities have declined pt d/t not having clinical capability to manage pain pump. (Facility in connecting) is one of those facilities. (Please note on 01/21/25 the facility admitted male Resident #65 to a private room. Resident #65 was a new admission to the facility.) (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-- Note also written on 01/23/25 by HCM #70 read as follows, CM received a follow up call from (First and last name of ombudsman),Ombudsman. She advised that she has been to (Name of Facility) to follow up on bed status for this pt and found them to have no bed for pt at this time. She explained that she will follow up with (Name of corporation who own nursing home in connecting county) Management to determine if they will consider pt for one of their facilities. (Name of corporation who own nursing home in connecting county) Liaison has advised that company is concerned about documentation in pt record that notes that pts family has brought in THC (Marijuana) gummies for pt. This CM spoke with pts wife/MPOA at length r/t this concern. She assured CM that no family member has provided pt with any gummies. Pt reportedly brought CBD (Cannabidiol) (CBD is legal to purchase and use) gummies with him when he was admitted to (Name of nursing home) in May 2024. Wife reports that she was unaware that pt had gummies in his possession. Staff reportedly found gummies and took them from pt. Family was reportedly agreeable to this. Wife stresses that pt has never done drugs or been supplied any by family members. CM left message for (First and Last Name of Ombudsman) regarding conversation with pts wife. (Please not that the facility admitted Male Resident #66 on 01/27/25 to a private room. Also on 01/27/25 the facility admitted Male Resident #58 on 01/27/25 to a private room.) - Note with a date of service of 01/29/25 which was entered into the record on 02/12/25 by HCM #70 read as follows, CM spoke with (First and Last of ombudsman,Ombudsman via telephone on 1/27/25 to check the current discharge status of this pt. She has called this morning to again determine the status of this pt and confirm conversations r/t pts return to (Name of Nursing facility) between this CM and Admissions Director. (First name of the Ombudsman) is going to (name of facility) this morning to meet with administration r/t possibility of this pt returning there. -- Note dated 01/31/25 written by HCM #70 read as follows: CM received a message from (First and Last Name of ombudsman),Ombudsman today. She advised that she came to (Initials of Hospital) and met with pt today. She also asked if (Name of facility) is assisting CM in finding alternate placement for Mr. (Last name of Resident #60), if they are not going to take him back? CM returned call and left voice message advising that (Name of facility) has not been assisting CM in finding placement. (Please note also on 01/31/25 the facility had a male discharge Resident #61 discharge on this date). (Please note the facility admitted Male Resident #35 on 02/03/25 this resident was new admission to the facility) -- Note dated 02/07/25 written by HCM #70 read as follows, (First and Last Name of Ombudsman), Ombudsman called this CM today to check status of this pt. She advised that she has attempted to reach (Name of Facility) Administrator via telephone but has not received a call back from him. She asked if CM can follow up with (Name of another sister facility of this facility which is two and one half hours from this facility)(sister facility to (Name of Facility)) because she has been told that they may accept pt until he can be moved back to (Name of this Facility). CM also spoke with (First and Last Name of nurse for a state program that helps people transition home), RN with (Name of state program that helps people transition home). She explained that they have sent information in to the state. Due to heavy case load they routinely take about 1 month to process and make RN visit to pt. (Name of state program that helps people transition home then goes in to see pt for their assessment.) (Please note on 02/06/25 Male Resident #49 to a private room. Resident #49 was a new admission to this facility.) Further review of Resident #60's hospital records found the following note written by the hospitalist that contained the following: (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/02/25- pt is mildly agitated, today stating he doesn't understand why he is stuck here and facilities won't take him just because he has a pain pump. Explained policy to him and told him that case mgt is still working on placement. 02/03/25- no complaints today, case management working on placement at this time. 02/04//25- case management working on personal care workers for home, possibly. No complaints, today. Upon entrance to the facility on [DATE] it was noted by surveyors Male Resident #58 was in (Room Number redacted to maintain confidentiality) in the B - Bed and the A- bed was empty. Resident #60 could not have had any conflicts with this resident because Resident #58 was not admitted to the facility until 01/27/25. Resident #58 was moved into room (room redacted to maintain confidentiality) B - Bed on 02/07/25. On 02/11/25 the facility moved Male Resident #49 into (room number redacted to maintain confidentiality) a-bed. The a -bed with Resident #58 was available from 02/07/25 until 02/11/25 and Resident #60 was not offered this bed. From 01/02/25 until 02/07/25 the facility admitted a total of seven (7) males who were all new admissions. In addition they admitted a total of six (6) female residents into private rooms which Resident #60 could have been admitted to. A review of Resident #60's medical record from the facility found he was discharged to the hospital on [DATE]. The discharge Minimum Data Set (MDS) with and assessment reference date of 12/29/24 indicated the resident was discharged with a return anticipated. A further review of the residents medical record found he had exhausted all of his medicaid provided bed hold days prior to his discharge on [DATE]. Additional correspondence with the Long Term Care ombudsman for this facility found the Acute Care Hospital sends out a list daily to all Skilled Nursing Facilities of patients they have ready for discharge,in the area and Resident #60's name has been included on that list daily beginning on 01/07/25. She confirmed this facility would have received the list daily. In the after noon of 02/13/25 the Director of Nursing (DON) and Nursing Home Administrator (NHA) provided the following time line explanation as to why they have not readmitted Resident #60 to the facility. -- 11/20/24 (First and Last Name of Resident #60) reports (First and Last Name of Resident #16) entering his room. Stop sign provided. -- 11/21/24 (First and Last Name of Resident #27 grievance r/t (related to) roommate (First and Last Name of Resident #60) keeping him up at night. (First name of Resident #27) denies a room change. (continued on next page)

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	515186	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluestone Health and Rehabilitation	1600 Bland Street Bluefield, WV 24701

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-- 11/29/24 Res to Res reportable (First and Last Name of Resident #60) vs (First and Last name of Resident #16) Verbal disagreement started by (First Name of Resident #60) and then (First name of Resident #16) at (First and Last Name of Resident #60) (First name of -- Resident #16)kicks at (First Name of Resident #60). (Please note this was reported to the State agencies and Resident #16 was listed as the perpetrator. -- 12/09/24 (First and Last Name of Resident #61)referral begins with bed offer made. (Please note this was 20 days before Resident #60 was discharged to the hospital.) -- 12/16/24 Res to Res reportable(First and Last Name of Resident #60) vs (First and Last name of Resident #16) (Please note: This reportable lists Resident #60 as the perpetrator Resident #16 kicked at Resident #60.) -- 12/20/24 Verbal disagreement (First and Last Name of Resident #60) vs (First and Last name of Resident #16) -- 12/24/24 (First and Last Name of Resident #60) goes out with family for overnight visit. -- 12/26/24 IDT reviewed (First and Last name of Resident #60)'s continued difficulties with (First and Last Name of Resident #16) and offered room change to 102 to minimize opportunities for interactions with her. He (Resident #60) accepted. (Please note this was a private room and was the room the resident was in at the time of his discharge. Resident #60 also does not have capacity and his wife/MPOA was not notified of this room move.) -- 12/29/24 (First and Last Name of Resident #60) d/c (discharge) to hospital with no bed hold days remaining. -- 01/02/25 (Initials of Acute Care Hospital) management posts in Care Port for (First and Last name of Resident #60) update. No discharge info provided. Census 60. (Care Port documentation listed Resident #60's projected discharge date as 01/01/25). -- 01/03/25 (Initials of acute care hospital) Case management posts in Care Port for (First and Last name of Resident #60).No discharge info provided. Census 60. (Care Port Documentation listed the projected discharge date as 01/02/25) -- 01/05/25 (First and Last Name of Resident #20) referral received. -- 01/06/25 (Initials of acute care hospital) Case Management calls for (First and Last Name of Resident #60) update. No discharge info provided. Census 59 with 1 paid bed hold. -- 01/07/25 (Resident and Last name of Resident #20) began prior auth process and bed offer made. -- 01/08/25 (initials of acute care hospital) Case Management calls for (First and Last name of Resident #60)update. Potential discharge planned for 1 /11/25 that would open a bed for (Resident #60). Census 60. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-- 01/08/25 (First and Last Name of Resident #70) passes away. Census 59 with room [ROOM NUMBER] A male bed open. -- 01/09/25 (First and Last Name of Resident #20)admits to 124 A. (First and Last Name of Resident #58) referral received. -- 01/10/25 (Initials of Acute Care Hospital) Case management calls for (First and Last Name of Resident #60) update. No discharge info provided. Census 60. --01/11/25 (First and Last name of Resident #69) did not discharge. Rescheduled discharge for 1 /17 /25. -- 01/12/25 (First and Last Name of Resident #63) referral received. -- 01/13/25 (Initials of Acute care hospital) Case management posts in Care Port for (First and Last Name of Resident #60) referral. He is ready for discharge. Admissions spoke with (First and Last name of Resident #60's wife) to offer sister facilities. (First name of Resident #60's Wife) declined, stated that she did not want him that far away. Census 59, female bed open 118 A.(Please note one of the sister facility offers declined to admit Resident#60 and the other one was two and one half hours away from the residents wife and his parents) -- 01/15/25 (First and Last name of Resident #63) admits to 118 A. -- 01/15/25 Admissions receives call from (Name of Corporation who owns numerous nursing home in the area) about (First and Last name of Resident #60) and we believed that they would admit him based on the conversation. -- 01/16/25 (First and last name of Resident #64) referral received and bed offer made. -- 01/17/25 (First and Last name of Resident #69) discharge. (First and last name for Resident #64)admits. Census 60. -- 01/20/25 (Initials of Acute care hospital) Case management calls about (First and last name of Resident #60) and informed us that he was still at (initials of acute care hospital) Census 58. 117 A male bed (First and Last Name of Resident #4) roommate, not compatible previously 07/30/24 and 118 A female bed. -- 01/21/25 (First and Last name of Resident # 61) moves to 117 A, leaving 110 B (male bed) open. (First and last name of Resident #44) in 110 a ((First and Last Name of Resident #60)previously not compatible) (First and last name of Resident #65) admits to 110 B. (First and Last name of Resident #50) readmits with C Diff. Census 60. -- 01/21/25 We had no further contact with the hospital about (First and Last name of Resident #60) since 1 /21/25. Census 60. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-- 01/23/25 Ombudsman reports to (Initials of the acute care hospital) that we had no bed. Census 60. -- 01/26/25 First and Last Name of Resident #71) discharge. Census 59. (Female bed open) -- 01/27/25 Census 57 plus 2 bed holds.(First and last name of Resident #58) admits. -- 01/29/25 Ombudsman in facility. No open beds. Census 58 plus 2 bed holds. During a telephone conversation with Resident #49's wife on 02/10/25 she stated, I don't know why they won't take him back. She indicated that he is really upset about this. She indicated he has anxiety because he thinks he has done something wrong to make them not want to take him back. She said he was worried he will have to go somewhere further away and his parents won ' t be able to visit him. She stated, he has friends there and he can smoke there and he is very worried about not being able to go back there. She stated, he calls people there and they tell him they are admitting people which adds to his anxiety. The facility maintained they did not know he was ready for discharge on several dates and even noted they had not had contact with the hospital sine 01/21/25 however it was confirmed by the ombudsman and hospital they received a list daily from the hospital about residents ready for discharge and Resident #60's name was on that daily list every day beginning on 01/07/25 moving forward. The DON and NHA indicated they have never had a bed to admit Resident #60 in to and claim the time line above explains why. However there the facility was presented with numerous opportunities to readmit the resident and instead chose to admit residents who were new admissions to the facility.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident representative interview, and staff interview the facility failed to ensure a resident who entered the facility without a pressure ulcer did not develop an avoidable pressure ulcer during their stay. In addition the facility failed to identify and treat the pressure ulcer once it was developed. Resident #59 entered the facility without a pressure ulcer she was discharged back to her previous living arrangement and with in hours the nurse who worked for the behavioral health company discovered multiple wounds which required her to be sent to the hospital once discovered. The facility documentation mentioned no wounds and no treatments for the wounds were ever ordered. This resulted in actual harm for Resident #59. This was true for one (1) of three (3) residents reviewed for pressure ulcers during a complaint survey. Resident Identifiers: #59. Facility Census: 58. Findings include: a) Resident #59 On 04/24/24 the State Agency (SA) received a complaint from another state agency which read as follows: The client was in the care of (Name of this Facility), (Address of this facility) 01/18/2024 to 2/7/2024. The client returned to her residence (Name of Local Behavioral Health Home and address of home) on 02/07/24. On this date the staff Nurse, (Name of Registered Nurse (RN) at the Behavioral Health Company), completed a body assessment on client at the (Name of Behavioral Health Company) home. Multiple pressure wounds and bruising in various stages were observed during the assessment. This led to a referral being submitted to Centralized Intake on 2/7/2024. This also led to the client being admitted to (Name of local acute care hospital) due to the wounds on 2/7/2024. The admissions report was completed by (First and Last Name of physician), DO at (Name of Local acute care hospital). (Name of County) DOHS Adult Protective Unit received a referral regarding client that stated, It is reported that (First Name of Resident #59) was in care at (The Name of this facility) nursing home for rehabilitation and 24-hour care. She returned to her group home on [DATE]. After returning home, multiple pressure wounds, at various stages were observed. There was a very large bruise on her abdomen and flank area. (First Name of Resident #59) could not communicate where the bruises came from. It is believed the wounds and bruises occurred at (The Name of this Facility) nursing home. The situation was not documented or expressed to follow up workers. It is reported that (First Name of Resident #59) has dementia and needs total assistance with ADL (Activities of Daily Living)s. She is not able to get up and move around. (First Name of Resident #59) is an IDD waiver. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(First Name of Resident #59) was taken by EMS to (Name of Local Acute Care hospital) and was admitted . Assigned Worker interviewed staff at (Name of this facility) where all documentation provided to this worker denies that client had any wounds during her stay and care at the facility. The worker received statements, reports, and photos from (Name of Local Behavioral Health Company) staff that documented wounds on client approximately 2 hours after client was discharged from (Name of this facility) and returned to her (Name of local Behavioral Health Care) Home. Worker spoke with (Name of Local Acute care hospital)Social Worker, (First and Last Name of Hospital Social Worker), on several occasions and received reports and photos of the wounds on the client when client was admitted on [DATE]. A teleconference was held with Dr. (First and Last Name of Physician) on 3/15/2024 where worker questioned the possibility that the wounds found on client could have developed in a two-hour period. With the information and photos provided to Dr. (Last name of Physician) he concluded that it was not possible that the wounds on the client could have occurred in a two-hour period, and they must have occurred while client was in the care of (Name of this Facility). He concluded this specifically because the wounds were in various stages and that there was a chronic lack of skin care. On 02/10/25 Resident #59's medical record from the facility was reviewed. The record void of any documentation related to wounds. A Braden scale for predicting pressure risk was completed on the following days resulting in the following scores: -- 01/18/24 - 16 which indicates the resident was at risk for developing pressure ulcers. -- 01/26/24 - 16 which indicated the resident was at risk for developing pressure ulcers. --02/03/24 - 16 which indicated the resident was at risk for developing pressure ulcers. A review of Resident #59's care plan found the following pertaining to skin integrity: Focus Statement 'I have potential for impairment to skin integrity r/t incontinent episodes, dementia. This focus statement was added to the care plan on 01/19/24, and was canceled on 02/21/24 after the residents discharge. The goal associated with this focus statement read: I will have intact skin, free of redness, blisters or discoloration through review date. This goal was initiated on 01/19/24 with a target date of 04/25/24. This goal was canceled on the same date as the focus statement. Interventions related to his goal included: -- Administer medications, supplements and treatments as ordered. Monitor/document for side effects and effectiveness. -- Barrier cream as ordered/indicated. -- Follow facility policies/protocol for routine skin monitoring. Report any changes to MD/NP. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-- Follow facility policies/protocols for the prevention/treatment of skin breakdown. -- Provide peri-care with any incontinent episodes All interventions were initiated on 01/19/24 and canceled on 02/21/24. The care plan also indicated the following related to ADL assistance required by Resident #59: -- BED MOBILITY: The resident uses extensive assistance X2 staff with turning and repositioning in bed. This was added to the care plan on 01/18/24. -- DRESSING: The resident is totally dependent on staff for dressing. This was added to the care plan on 01/18/24. -- TOILET USE: The resident is totally dependent on staff for toilet use. This was added to the care plan on 01/18/24. -- TRANSFER: The resident uses extensive assistance x 2 with transferring. This was added to the care plan on 01/18/24. -- BATHING/SHOWERING: The resident is totally dependent on staff to provide (SP bath/shower as necessary. This was added to there care plan on 01/18/24. Further review of the record found no indication the facility was turning repositioning the resident every 2 hours. The Director of Nursing (DON) stated this was just a standard of care and would not need to be documented. Review of the residents bathing record found during her stay she received five (5) bed baths with the last one being on 02/06/24, six (6) showers with the last one being on 02/03/24, and eight (8) partial baths with the last one being on 02/05/24. A review of the facility's policy titled, Pressure Injury Prevention and Management found the following: .Preventative Measures 1. Preventative interventions will be implemented based on the pressure ulcer/injury risk assessment, other related factors, and resident preferences. Such interventions may include: a. Education to the resident/resident representative on risks associated with pressure ulcer/injury. b. Frequent encouragement and assistance with turning, repositioning, shift of weight etc. c. Use of pressure reducing/relieving support surfaces or devices that assist with pressure redistribution and tissue load. d. Range of motion as tolerated. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	e. Management of contractors to minimize pressure. f. Assistance with personal hygiene and ADLs, including appropriate fitting clothing and shoes. g. Assistance with incontinence care, and application of moisture barrier ointments to protect skin from contact with urine and/or feces. h. Application of moisturizing lotions to intact skin. i. Encouragement and assistance for adequate nutrition and hydration consistent with prescribers orders, including administration of nutritional supplements. Identification 1. Staff will be encouraged to promptly report any observation of a change in the resident's skin integrity. 2. Weekly Skin observations will be conducted by a licensed nurse and findings will be documented in the resident's medical record. 3. Observations of new pressure ulcer/injury will be: a. Reported to the physician/practitioner for further evaluation and treatment. b. Referred to the designated wound nurse as appropriate . Further review of Resident #59's medical record found the following weekly skin observation: -- 01/18/24 - This observation was completed by Licensed Practical Nurse (LPN) #59 and indicated the resident had no bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted. This was the skin observation completed on admission. -- 01/22/24- This observation was completed by Registered Nurse (RN) #14 and indicated the resident had no bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted. -- 01/29/24- This observation was completed by LPN #15 and indicated the resident had no bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted. -- 02/05/24- This observation was completed by RN #14 and indicated the resident had no bruises, open wounds, surgical incisions, skin tears, reddened areas or other skin conditions noted. This was the last weekly skin prior to Resident #59's discharge on [DATE]. A review of Resident #59's minimum data set (MDS) with an assessment reference date (ARD) of 01/25/24 indicated the resident had zero (0) unhealed pressure ulcers/injuries. A review of Resident #59's discharge MDS with an ARD of 02/07/24 indicated the resident had zero (0) unhealed pressure ulcers/injuries. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the physicians orders for Resident #59 from the time of admission until the time discharge found no orders related to pressure ulcer treatment and/or prevention. A review of Resident #59's Discharge summary completed by LPN #13 indicated the resident had no special treatment including wound care ordered. This assessment also indicated the resident needed assistance with transfers, toileting, bathing, and medication management. Further review of the record found a progress note dated 02/07/24 at 11:23 AM which indicated the resident left the facility at 12:40 PM accompanied by (Name of Local Behavioral) transport via wheel chair van. During a review of the statements provided by another state agency it was found the RN for the local behavioral health company completed a body assessment at 4:08 PM on 02/07/24 along with an LPN from the same company and found the following skin issues: Bruises noted on bilateral arms and one bruise noted on the right hand where the thumb and index finger meet. A few scratches noted across her abdomen. A large bruise noted on the left abdominal and flank area. Area noted on the bottom of her right heel , boggy (abnormal tissue texture that feel spongy or mushy. A boggy heel can indicate a heel pressure injury.) feeling, and half is dark in color and the other part is whitish yellow in color. Area noted to left outer ankle, skin is open and center is dark red and black in color. Pitting Edema is noted to bilateral lower extremities up to the knees. Her brief was removed, and she had a small soft BM (bowel movement) While cleaning her up, a clump of something whiteish yellow in color came out from her inner labia area, and then she began to urinate after it was cleared away. Several areas noted to her buttocks that are soft, fluid filled, and dark red and black in color. There is open area to skin right above the anus with serosanguineous drainage. The facility filed a reportable incident related to this on 02/15/24. They investigated and determined it to be unsubstantiated due to the resident being discharged from the facility. They noted statements from staff and record review saw no indication the resident had pressure ulcers. The former Nursing Home Administrator (NHA) noted she had her admissions coordinator review a referral for the resident which they received on 02/12/24 and it had no mention of pressure ulcers. Therefore she had unsubstantiated the allegation of the resident developing the Pressure ulcers at the facility. The SA requested the hospital medical record for Resident #59 for the hospital stay beginning on 02/07/24. The records were reviewed and found the following facts: -- Resident #59 presented to the emergency department at 6:01 pm from they behavioral health company's community home. -- An MDM (medical decision making) Narrative found the following, MDM Narrative: This patient is [AGE] year-old female who presents with multiple skin wounds secondary to pressure related source. Differential includes cellulitis, deep tissue abscess, rhabdomyolysis, metabolic abnormality given the lack of mobility. Patient was initially ordered IV fluid, in addition to treatment for the possibility of radiographic pneumonia. She is unable to participate in history, however does appear dehydrated. Once the patient's workup returned, she was found to have significant hypernatremia. Given this, the case was discussed with hospitalist team for admission evaluation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-- A history and physical dated 02/07/24 contained the following, Information Obtained from: caregiver Chief Complaint: wounds HPI: (First and last Name of Resident #59) is a (age redacted to maintain confidentiality), [NAME] female who was recently discharged from the (Name of this facility) and admitted to (Name of local behavioral health company) group home. She was sent here for developing wounds on the sacrum and heels. It was reported that patient is requiring too much care to be cared for in a group home and would do better in a nursing home setting. Skin: General: Skin is warm and dry. Coloration: Skin is pale. Findings: Lesion present. Comments: For full wound physical exam and assessment please see pictures put in system by staff today.Assessment/Plan: Active Hospital Problems Diagnosis -- Primary Problem: Hypernatremia -- Dehydration -- Decubitus skin ulcer -- A review of the hospitalist progress notes dated 02/08/24 contained the following: Subjective: Pt was admitted on [DATE] after presenting to the ER from (Name of behavioral health company) group home for wounds of the sacrum and heels. It was reported that the group home cannot take care of her and she will be need placement. Apparently she was just released from the (Name of this nursing home) nursing home. Her sodium was very elevated at 171 and BUN 81. She is dehydrated. She has D5W at 75. Nephrology consulted. -- A wound care note dated 02/09/24 contained the following information: 'Wound #1 Coccyx Removed old dsg from the wound. Stage/Type: Deep Tissue Injury Length (cm): 4.6 Width (cm):7 Depth (cm): Wound Bed: Purple, blistery Wound Edges: attached Surrounding tissue: superficial opening at base. Wound #2 Right dorsal foot at heel Removed old dsg from the wound. Stage/Type: Deep Tissue injury (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Length (cm):9.3 Width (cm):4.7 Wound Bed: dark purple, blister like Drainage: none Drainage amount: none Wound Edges: attached Surrounding tissue: intact During an interview with the Director of Nursing (DON) on the morning of 02/12/25 She was asked to review the photos of the wounds from the hospital. She indicated, That was a blister caused by friction. You can tell where it had been filled and busted. She stated, I can't speak to what might have happened after she left here. The DON was then referred back to the facility's policy titled Pressure Injury Prevention and Management which contained the following definition for a deep tissue injury, Persistent non-blanchable deep red, maroon, or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon or purple discoloration, or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. The injury results from intense and/or prolonged pressure or shear forces at the bone muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss . The DON then agreed the wounds pictured were pressure injuries. She did not agree they were developed at this facility. When advised what Dr. (Name of Physician named in complaint) had said about the wounds she remained silent.