

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  515186	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/15/2025
NAME OF PROVIDER OR SUPPLIER  Bluestone Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>39043</p> <p>Based on resident interview, record review, and staff interview, the facility failed to allow residents to make choices important to them. This deficient practice had the potential to affect one (1) of 21 residents in the long-term care survey sample. The facility did not honor Resident #49's choice as to when to have his dressing changed. Resident identifier: #49. Facility census: 58.</p> <p>Findings included:</p> <p>a) Resident #49</p> <p>Review of Resident #49's physician's orders showed an order written on 12/26/24 to Cleanse unstageable ulcer to outer right ankle with wound wash; allow to dry; apply Medihoney, cover with bordered foam, every night shift for wound healing until healed.</p> <p>Review of Resident #49's progress notes showed a nurse's note written on 1/4/2025 at 4:13 AM, which stated, Cleanse unstageable ulcer to outer right ankle with wound wash; allow to dry; apply Medihoney, cover with bordered foam, every night shift for wound healing until resolved. Resident refused TX [treatment] stating that if the nurse wanted to do his treatment, then she should have come into do it at a more appropriate time.</p> <p>Following this, the resident's unstageable ulcer dressing change was performed on the following dates and at the following times:</p> <ul style="list-style-type: none"> <li>- 01/05/25, at 12:02 AM</li> <li>- 01/05/25, at 9:04 PM</li> <li>- 01/06/25, at 9:57 PM</li> </ul> <p>(The dressing change time was not specified on 01/07/25, 01/08/25, and 01/09/25).</p> <ul style="list-style-type: none"> <li>- 01/10/25, at 11:04 PM</li> <li>- 01/12/25, at 3:38 AM</li> </ul> <p>(continued on next page)</p>

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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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 01/13/25, at 3:43 AM</p> <p>On 01/08/25 at 10:51 AM, Resident #49 was interviewed about his pressure ulcer. When specifically questioned, the resident stated his dressing change was performed at night. He stated night shift dressing changes were not his preference and he did not like being awoken up for dressing changes. Resident #49 asked if this surveyor would ask the nurses if his dressing could be changed when he did not need to be woken from sleep.</p> <p>During an interview on 01/13/25 at 2:45 PM, the Director of Nursing stated Resident #49's dressing change was scheduled for night shift per the resident's request. She acknowledged the progress note written on 01/04/25 documented that the resident did not want to be awakened for dressing changes, but the resident's dressing was changed at 3:38 AM on 01/12/25 and at 3:43 AM on 01/13/25.</p> <p>No further information was provided through the completion of the survey process.</p> <p>51554</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>31826</p> <p>Based on resident interview, medical record review, staff interview and Resident Council Meeting discussion, the facility failed to ensure the resident shower room was at a comfortable temperature for resident use. This failed practice had the potential to affect more than a limited number of residents. Resident Census: 58.</p> <p>Findings Included:</p> <p>a) Resident Shower Room</p> <p>During an interview with Resident #26 on 01/07/25 at 11:39 AM, he stated he refused a shower the day before because the shower room was too cold. He stated one shower room was being renovated, and the other room is always too cold.</p> <p>A review of Resident #13's medical record on 01/07/25 found a nurses note dated 01/04/25 at 2:51 AM which read, Resident refused shower states that it is too cold, and the shower room is cold resident asked again at a later time educated on importance of self-care,</p> <p>On 01/15/24 at 10:30 AM the maintenance director was asked to obtain the temperature in the shower room the temperature at this time was 63.8 degree Fahrenheit (F). The shower room was noted to have two (2) heaters on the wall. The maintenance director stated that he can control them by using the app on his phone or they can be controlled manually as well. He showed the surveyor that the temperatures were set to 72 degrees F. He stated we have ordered new heaters. This shower room was recently remodeled, and the heaters installed were not as robust as they need to be and are not efficient. The Nursing Home Administrator added, The staff come in here and turn on the hot water and get it steamy before they bring the residents in.</p> <p>b) Resident Council Meeting</p> <p>On 01/08/24 at 10:08 AM during the resident council meeting Residents #16, #49, #26, #27, #30 stated that the shower room is very cold. Sometimes they will not take a shower because it is cold. Resident #30 states even Nurse Aides (NA) will make comments about the shower room being cold.</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>49465</p> <p>Based on record review, staff interview, and resident interview, the facility failed to provide services that are necessary to avoid emotional distress by transferring Resident #29 from the bed to a wheelchair via the mechanical lift on shower days, despite the resident being fearful of the lift. Multiple staff confirmed the resident would cry and scream. As soon as the transfer was complete, the resident would stop crying. This has resulted in psychosocial harm as evidenced by the mental anguish suffered by the resident while in the lift. The mental anguish was evidenced by the resident crying and yelling while in the lift. This has happened on multiple occasions and is not an isolated incident. This failed practice was true for (1) one of (3) three residents reviewed for abuse and neglect during the Long-Term Care Survey Process. Resident identifier: #29. Facility Census 58.</p> <p>Findings Included:</p> <p>a) Resident #29</p> <p>During the initial interview, on 01/07/25 at 1:35 PM, Resident #29 stated, I am afraid of the lift. I don't like being in it. They put me in it on shower days. I fell with one of the lifts one time. Now I am afraid.</p> <p>A record review on 01/08/24 at 11:00 AM, of the Brief Interview for Mental Status (BIMS) completed on 10/28/24, revealed that Resident #29 had a BIMS score of 15. This indicates cognition is intact.</p> <p>Further record review of the care plan for Resident #29 revealed no interventions or behaviors noted related to lift transfers on shower days.</p> <p>During an interview, on 01/09/25 at 11:30 AM, Nurse Aide (NA) #68 stated, She cries and hollers in the lift for showers. When we put her on the shower chair she calms down and then screams and hollers when we put her back in the lift to put her back in bed.</p> <p>During an interview, on 01/09/25 at 12:05 PM, NA #47 stated, She screams and cries in the lift. She is scared.</p> <p>During an interview, on 01/09/25 at 12:30 PM, Licensed Practical Nurse (LPN) # 75 stated, She screams when it is shower day. I am not sure what it is related to.</p> <p>During an interview, on 01/09/25 at 12:40 PM, Registered Nurse Supervisor (RNS) # 45 stated, I can hear her sometimes hollering when she is in the lift. They have not tried anything different with her since I have been here. I have been here for 3 months.</p> <p>During an interview on 01/09/25 at 12:42 PM, The Director of Nursing (DON) stated, I was not aware of the situation. I will check into it and get back to you.</p> <p>During an interview on 01/09/25 at 12:46 PM, Resident #29 stated, I would rather take bed baths if it meant I did not have to get up in the lift. I am afraid of being in it.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A record review on 01/09/25 at 1:30 PM, revealed a Behavior Observation Monthly Summary dated 10/06/2024, under B (Behaviors and Side Effects), question (1) one (Behaviors that triggered psychoactive use/non-pharmacological interventions), Resident #29 is marked for the following behaviors:</p> <p>Cursing, Resists Activities of Daily Living (ADL) care, screaming, crying, Anxiety/agitation, and grabbing.</p> <p>Under question 1a reads as follows:</p> <p>Resident has episodes of refusing care, becoming anxious before ADLs are performed.</p> <p>Further record review revealed, (3) more Behavior Observation Monthly Summary dated 11/06/24, 12/06/24, and 01/07/25, under B (Behaviors and Side Effects), question (1) one (Behaviors that triggered psychoactive use/non-pharmacological interventions), Resident #29 is marked for the following behaviors:</p> <p>Cursing, Resists Activities of Daily Living (ADL) care, screaming, crying, Anxiety/agitation, and grabbing.</p> <p>A record review, on 01/09/25 at 1:45 PM, of the shower task for Resident #29 for the months of 10/2024, 11/2024, and 12/2024 revealed that Resident #29 was to have showers on Sunday day shift, and Wednesday evening shift. Within the (3) three-month time Resident #29 had 23 showers documented.</p> <p>Further record review revealed that no interventions have been put in place to minimize the emotional distress with the mechanical lift and that Resident #29 diagnoses that include Mild Intellectual Disabilities, Cognitive Communication Deficit, Major Depressive Disorder, and anxiety disorder.</p> <p>During an interview on 01/09/25 at 2:00 PM, The Administrator stated, We will report this and investigate it.</p> <p>b) Reportable interviews</p> <p>A review of the facilities reportable on 01/13/25 at 12:05 PM, dated 01/09/25 revealed staff statements that read as typed below:</p> <p>b1.) Statement from DON:</p> <p>While therapy was completing a screen, I spoke with (Resident #29 name) about her transfers in and out of bed. She stated that she was afraid of falling and that made her not like the lift, shower chair or shower bed. I asked if she was afraid of the mechanical lift, shower bed or shower chair. She said, ' No, I don't like it. When asked if staff had ever forced her to do anything she said, Well no! When asked if she didn't want to go to the shower, was she offered a bed bath and she said, yes. The last I asked her was if she was willing to use the lift to get out of bed and she said she didn't like it but she would do it. I clarified with her to say, even though you don't like the lift, are you willing to use the lift to get out of bed and she said, Yes.</p> <p>b2.) Statement from Corporate Registered Nurse (CRN) # 77:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/09/25 at approximately (14:30) 2:30, I observed DON, discussing transfers in and out of bed. She stated that she was afraid of falling and she didn't like the lift, shower bed, or shower chair. She denied being afraid of the shower bed, shower chair or lift. She denied staff making her do anything. She denied staff making her do anything she didn't want to do. When asked if she was offered a bed bath when she didn't want showered she said yes. When asked if she was willing to use the lift to get in and out of bed she said she would but didn't like it.'</p> <p>b3.) Statement from NA #16:</p> <p>The resident will have behaviors starting at different times on her shower days. Sometimes as soon as our shift starts. Sometimes later in the shift. I have never heard the resident say she didn't want to shower or that she didn't want on the lift. The resident will continue to yell and have behaviors during the transfer, through the entire shower and while putting the resident back in bed. After she is back in bed the behaviors stop. Yesterday the ambulance came to take the resident's roommate to a doctor appointment. As soon as the resident saw the stretcher she started having behaviors and yelling, even after explaining . (This was all of the statement the SA received.)</p> <p>b4.) Statement from NA #66:</p> <p>I have worked with (Resident #29 name) and I have showered her. She screams, Mommy, Mommy. I try to calm her down and tell her everything is okay. We need to wash up and get cleaned but she has never told me she is scared or anything to that matter.</p> <p>b5.) Statement from NA #57</p> <p>I have showered (Resident #29 name) on many occasions with little encouragement. She will let us give her a shower. She has never said that she is scared of the lift. It just makes her a little nervous.</p> <p>b6.) Statement from NA #4</p> <p>I have given (Resident #29 name) shower before and she screams. When given words of encouragement she takes a shower. She has never said she was afraid to get on the Hoyer lift.</p> <p>b7.) Statement from Occupational Therapy Assistant (OTA) # 23:</p> <p>When (Resident #29 name) came to the facility she was able to complete stand/pivot transfers with maximum assistance x 2. At that time she consistently refused to participate in transfers to get out of bed even with encouragement with therapy. (Resident #29 named) would present with behaviors of yelling and screaming profanity when encouraged to transfer. Currently (Resident #29 named is unable to transfer unless using a mechanical lift due to refusal to attempt the task and anxiety.</p> <p>b8.)Statement from NA #68:</p> <p>I ( NA #68 name ), has encountered (Resident #29 name) behaviors when she is in the lift going to shower chair and behaviors going to shower room and during shower. Also behaviors when putting back in bed. She has not refused. She rolls when she's getting ready to shower. To my knowledge she has never said she was afraid.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>b9.) Statement from NA #58:</p> <p>(Resident #29 name) has behaviors any time she up out of her bed. Doesn't have to be the lift. (Resident #29 name) turns for you to allow you to do care. Never refuses care or lift, just yells , screams and acts out every time she gets up out of bed. Never told me she was scared to use lift just has behaviors when its time to use the lift, shower chair, hallways and lift anytime she is out of her bed.</p> <p>b10.) Statement from RNS #45:</p> <p>(Resident #29 name) fusses when she gets into the lift, in the hallway and in the shower room. Resident has not refused care. Resident has not stated that she is afraid of the lift. Residents' behaviors are not consistent. She has behaviors when she is in the shower chair in the hallway and in the shower room. I have never known resident to have behaviors while in the bed.</p> <p>b11.) Statement from NA #61:</p> <p>When I give (Resident #29 name) a shower, she doesn't refuse the lift. She will cooperate by rolling over to get the lift pad under her. Once we begin to lift her in the air she will cry and fuss at us. It continues on in the shower bed, out in the hallway and in the shower, just anytime she's out of her bed. I believe her behaviors aren't consistent only when she is out of bed. She has never said that she was afraid of the lift. Only that she doesn't like it, but she will cooperate with us.</p> <p>b12.) Statement from NA #28:</p> <p>(Resident #29 name) has never told me that she's afraid of the lift. She shows behaviors anytime she is out of the bed, whether it's in the lift, the shower bed in the shower room. Her behavior is also not consistent. She'll go from yelling to laughing with us before she gets out of the bed. She cooperates and rolls and lets us put the lift pad under her. She has also never refuses a shower and if she did I would report it to the nurse and give her bed bath.</p> <p>b13.) Statement from NA #48:</p> <p>I have gave (Resident #29 name) a shower before and she has her days she will go and not fuss and she also has days she fusses and doesn't want to go and I leave her alone and offer her a bed bath if nothing else. She has said she doesn't like the lift but has said she was scared of being in the lift. She also has her days she screams in shower chair and shower room and lift. The nurse notified of behavior and she refuses to go to shower.</p> <p>b14.) Statement from NA #47</p> <p>I have given (Resident #29 name) a shower before and she usually cusses, and calls names. She also has regular conversations during the time of getting her up for the shower. She can go from yelling, cussing and screaming to smiling and talking nice, no matter if she is in the shower chair or lift. She has never said she wasn't getting in the shower chair or lift, but has stated she doesn't like it. If she was to refuse I would let the nurse know and give her a bed bath.</p> <p>b15.) Statement from NA #73</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	I (NA #73 name) have gave (Resident #29 name) showers on her shower days (Saturday) morning. (Resident #29 name) never tells me or the other CNA'S no. She gets real fussy and starts yelling. We try to encourage her by telling her we will make it quick. She doesn't say nothing and I report it to the nurse. Her behaviors be on and off when she is in the lift and in the shower room.  51554		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31826</p> <p>Based on record review and staff interview, the facility failed to ensure a complete and accurate bed hold notice was given to the resident representative when Resident #60 was transferred to the emergency room . This was true for one (1) of three (3) residents reviewed for the care area of hospitalization s during the long-term care survey process. Resident Identifier: #60. Facility Census: 58.</p> <p>Findings Included:</p> <p>a) Resident #60</p> <p>A review of Resident #60's medical record on 01/08/25 found she was discharged to the emergency roianom on [DATE]. A copy of the resident's bed hold notice which was sent to the resident representative was requested on 01/09/24. The bed hold notice when provided was not complete. The notice contained the resident's name and medical record number and was signed by the nurse. The bed hold notice did not identify if Resident #60 had any behold days available to her from her insurance and the rate per day was not identified should the resident's representative want to pay privately to hold the bed. Furthermore, there was no indication this notice was sent and/or discussed with the residents representative to allow them to make an informed decision about holding the residents bed.</p> <p>On the afternoon of 01/09/25 the admission coordinator was asked if there was another bed hold notice that was sent to the representative or if there was any documentation to suggest this was discussed with the representative. At the time of the exit no further information was provided.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>31826</p> <p>Based on record review and staff interview, the facility failed to ensure Resident #60's and Resident #59's Minimum Data Set (MDS) were accurately completed. This was true for two (2) of 21 sample residents reviewed during the long term care survey process. Resident Identifiers: #59 and #60. Facility Census: 58.</p> <p>Findings Include:</p> <p>a) Resident #59</p> <p>A review of Resident #59's medical record on 01/14/25 at 10:00 AM, found the resident was discharged home on 12/05/24. The son had asked the facility to prepare for the discharge on 12/02/24. The facility made all arrangements for the discharge including a referral for home health. The Discharge MDS with and Assessment Reference Date (ARD) of 12/05/24 found the MDS identified the residents discharge as unplanned, even though the discharge was planned.</p> <p>An interview with the Director of Nursing (DON) on 01/14/25 at 10:58 AM confirmed the MDS was not coded accurately.</p> <p>b) Resident #60</p> <p>A review of Resident #60's medical record on the morning of 01/14/25 found a Weekly Wound evaluation dated 11/15/24 which identified the resident had suspected deep tissue injury located on sacrum. The wound was identified on 11/15/24 and was identified as being facility acquired.</p> <p>A review of Resident #60's MDS with an ARD of 10/11/24 found the residents suspected deep tissue injury on the sacrum was coded to reflect the wound was present on admission, however the wound was in fact facility acquired.</p> <p>During an interview with the Director of Nursing (DON) on 01/14/25 at 10:58 AM, she confirmed the MDS was inaccurate.</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>31826</p> <p>49751</p> <p>Based on record review and staff interview, the facility failed to identify medical diagnoses of Major Depressive disorder on the Preadmission Screening and Resident Review (PASARR). This was found true for one (2) of three (3) residents reviewed under PASARR care area. Resident identifiers: #40 and #30. Facility census 58.</p> <p>Findings included:</p> <p>a) Resident #40</p> <p>On 01/07/25 at 3:21 PM record review found the following medical diagnosis:</p> <p>Schizoaffective Disorder, Bipolar type, and Major Depressive Disorder.</p> <p>Further record review on 01/07/25 of the PASARR revealed major depressive disorder was not identified on the form.</p> <p>An interview on 01/08/25 at 9:55 AM with the Director of Nursing (DON) who confirmed the PASARR was incorrect and did not contain major depressive disorder.</p> <p>b) Resident #30</p> <p>A review of Resident #30's medical record on 01/14/25 found the resident's medical diagnosis list included the following: Unspecified Dementia, Bipolar Disease, and epilepsy.</p> <p>Further review of the record found a PASARR dated 07/07/24 did not identify the resident having a diagnosis of dementia, bipolar disorder and/or epilepsy.</p> <p>On 01/15/25 at 9:38 AM an interview with the Social Worker confirmed the PASARR did not contain an accurate listing of the diagnoses.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>49467</p> <p>Based on record review and staff interview, the facility failed to implement the care plan for Resident #19, by failing to identify triggers for behaviors. This was true for one (1) of twenty-one (21) resident care plans reviewed during the survey process. Resident identifier: #19. Facility census: 58.</p> <p>Findings included:</p> <p>a) Resident #19</p> <p>At approximately 10:00 AM on 01/09/25, during a review of Resident #19's record, it was noted the care plan had a focus for behaviors. The care plan read as follows:</p> <p>Focus- BEHAVIORS: the resident has behaviors of delusions: fixed false beliefs despite evidence that they are untrue, hallucinations: visual, auditory or other, often makes false allegations, often talks about people wanting to have inappropriate behaviors with her. Date initiated: 11/28/2024 Revision on: 01/08/2025.</p> <p>Goal- The resident's behaviors will cause them less distress thru the review period. Date Initiated: 11/28/2024. Target Date: 04/06/2025.</p> <p>Interventions: -administer medications as ordered. Date initiated: 11/28/2024. -Approach with a calm quiet voice, divert attention, and remove from the situation and take to an alternative location as needed. Date initiated: 11/28/2024. -Monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved and situations. Date initiated: 11/28/2024.</p> <p>During review of notes for psych visits for Resident #19, the following was noted from the consult notes:</p> <p>-Ex-husband was physically abusive.</p> <p>-Patient states she has a bad temper due to men coming and looking into her window and hiding under her bed. Patient states she does not have a good appetite due to believing that people are putting things in her food and drinks to poison her.</p> <p>At approximately 1:10 PM on 01/14/25, during an interview with the Director of Nursing (DON), it was determined the resident's delusions started when she was diagnosed with a UTI and continued after she was treated. However, the facility had not attempted to identify the resident's triggers.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>49465</p> <p>49467</p> <p>49751</p> <p>Based on record review and interviews, the facility failed to revise care plan for Resident #40 for one (1) on one (1) activities and Resident #19 and Resident #29 for behaviors. This failed practice was found true for three (3) of 21 residents reviewed for the care planning care area. Resident identifiers: #40, #19, and #29. Facility census: 58.</p> <p>Findings included:</p> <p>a) Resident #40</p> <p>Record review completed on 01/08/25 revealed resident #40 to be care planned to receive one (1) on one (1) visits from the Activity Department.</p> <p>Further record review on 01/08/25 shows no evidence Resident #40 received one (1) on one (1) visits from the activity department.</p> <p>During an interview with the Activity Director (AD) on 01/09/25 at approximately 2:00 PM, the AD stated We used to do one (1) on one (1) visits, however she (Resident #40) became more independent with activities of her (Resident #40) choice, I'll (AD) update the care plan. Confirming the care plan should have been updated when Resident #40 no longer required one (1) on one (1) visits.</p> <p>b) Resident #19</p> <p>At approximately 10:00 AM on 01/09/25, during a review of Resident #19's record, it was noted her care plan had a focus for behaviors. The care plan reads as follows:</p> <p>Focus- BEHAVIORS: the resident has behaviors of delusions: fixed false beliefs despite evidence that they are untrue, hallucinations: visual, auditory or other, often makes false allegations, often talks about people wanting to have inappropriate behaviors with her. Date initiated: 11/28/2024 Revision on: 01/08/2025.</p> <p>Goal- The resident's behaviors will cause them less distress thru the review period. Date Initiated: 11/28/2024. Target Date: 04/06/2025.</p> <p>Interventions: -administer medications as ordered. Date initiated: 11/28/2024. -Approach with a calm quiet voice, divert attention, and remove from the situation and take to an alternative location as needed. Date initiated: 11/28/2024. -Monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved and situations. Date initiated: 11/28/2024.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During review of notes for psych visits for Resident #19, the following was noted from the consult notes:</p> <p>-Ex-husband was physically abusive.</p> <p>-Patient states she has a bad temper due to men coming and looking into her window and hiding under her bed. Patient states she does not have a good appetite due to believing that people are putting things in her food and drinks to poison her.</p> <p>During a review of Resident #19's orders, it was noted the resident had an order, beginning on 12/30/24, for behavior monitoring and, included in the order, were eight (8) non-pharmacological interventions. The interventions are as follows: (1) Redirect (2) 1:1 (3) activities (4) toilet (5) give food or fluids (6) reposition (7) back rub (8) other-chart in progress notes.</p> <p>Upon further review of Resident #19's care plan, it was discovered the care plan had not been updated to include the non-pharmacological interventions.</p> <p>At approximately 1:10 PM on 01/14/2025, during an interview with the Director of Nursing (DON), it was acknowledged the resident's care plan was not updated to reflect the the non-pharmacological interventions.</p> <p>c) Resident #29</p> <p>During the initial interview on 01/07/25 at 1:35 PM, Resident #29 stated, I am afraid of the lift. I don't like being in it. They put me in it on shower days. I fell with one of the lifts one time. Now I am afraid.</p> <p>A record review on 01/08/24 at 11:00 AM, of the Brief Interview for Mental Status (BIMS) completed on 10/28/24, revealed that Resident #29 has a BIMS score of 15.</p> <p>Further record review of the care plan for Resident #29 revealed no interventions or behaviors noted related to lift transfers on shower days.</p> <p>During an interview on 01/09/25 at 11:30 AM, Nursing Assistant (NA) #68 stated, She cries and hollers in the lift for showers. When we put her on the shower chair she calms down and then screams and hollers when we put her back in the lift to put her back in bed.</p> <p>During an interview on 01/09/25 at 12:05 PM, NA #47 stated, She screams and cries in the lift. She is scared.</p> <p>During an interview on 01/09/25 at 12:30 PM, Licensed Practical Nurse (LPN) # 75 stated, She screams when it is shower day. I am not sure what it is related to.</p> <p>During an interview on 01/09/25 at 12:40 PM, Registered Nurse Supervisor (RNS) # 45 stated, I can hear her sometimes hollering when she is in the lift. They have not tried anything different with her since I have been here. I have been here for 3 months.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/09/25 at 12:42 PM, The Director of Nursing (DON) stated, I was not aware of the situation. I will check into it and get back to you.</p> <p>During an interview on 01/09/25 at 12:46 PM, Resident #29 stated, I would rather take bed baths if it meant I did not have to get up in the lift. I am afraid of being in it.</p> <p>A record review on 01/09/25 at 1:30 PM, revealed a Behavior Observation Monthly Summary dated 10/06/2024, under B {Behaviors and Side Effects}, question (1) one {Behaviors that triggered psychoactive use/non-pharmacological interventions}, Resident #29 is marked for the following behaviors:</p> <p>cursing, Resists Activities of Daily Living (ADL) care, screaming, crying, Anxiety/agitation, and grabbing. Under question 1a reads as follows:</p> <p>Resident has episodes of refusing care, becoming anxious before ADLs are performed.</p> <p>Further record review revealed, (3) more Behavior Observation Monthly Summary dated 11/06/24, 12/06/24, and 01/07/25, under B {Behaviors and Side Effects}, question (1) one {Behaviors that triggered psychoactive use/non-pharmacological interventions}, Resident #29 is marked for the following behaviors:</p> <p>cursing, Resists Activities of Daily Living (ADL) care, screaming, crying, Anxiety/agitation, and grabbing.</p> <p>A record review on 01/09/25 at 1:45 PM, of the shower task for Resident #29 for the months of 10/2024, 11/2024, and 12/2024 revealed that Resident #29 was to have showers on Sunday day shift, and Wednesday evening shift. Within the (3) three month time period Resident #29 had 23 showers documented.</p> <p>Further record review revealed that no interventions have been put in place to minimize the emotional distress with the mechanical lift and that Resident</p> <p>#29 has diagnoses that include Mild Intellectual Disabilities, Cognitive Communication Deficit, Major Depressive Disorder, and Anxiety Disorder.</p> <p>During an interview on 01/09/25 at 2:00 PM, The DON confirmed that no interventions were in place to address the behaviors related to the lift transfers.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>49465</p> <p>Based on record review, observation, resident interview, and staff interview, the facility failed to provide Activities of Daily Living (ADL) care to dependent residents. This failed practice was found true for (1) one of (5) five residents reviewed for ADL care during the Long-Term Care Survey Process. Resident identifier #34. Facility Census 58.</p> <p>Findings Included:</p> <p>a) Resident #34</p> <p>During the initial observation and interview on 01/07/25 at 2:15 PM, Resident #34's teeth were covered with a white substance with some black spots. Resident #34 stated, I can not tell you when the last time they brushed my teeth. I cannot do it myself. I do have a tooth brush in here, but I cannot tell you where it is.</p> <p>A record review on 01/08/25 at 1:30 PM, of Resident #34's Brief Interview for Mental Status (BIMS) score, dated 12/17/24 revealed a BIMS score of 14.</p> <p>Further record review revealed Resident #34's last dental consult was on 12/19/24, and included a hygiene note that reads as follows:</p> <p>Very heavy plaque, calculus and food debris. Recommend assistance with daily Oral Hygiene (OH). This recommendation was signed off on by a Registered Nurse (RN).</p> <p>A review of Resident #29's care plan on 01/09/24 at 9:30 AM, revealed the following care plan related to ADL care:</p> <p>Focus:</p> <p>The resident is a long term care resident and requires assistance with their ADL's related to chronic health conditions. Date initiated 12/11/24</p> <p>Intervention:</p> <p>Oral care with assistance daily. Date Initiated 12/11/24. Revision on 12/24/24.</p> <p>During an interview on 01/09/25 at 10:37 AM, Nurse Aide (NA) #48 stated, I do mouth care when i give them a shower</p> <p>During an interview on 01/09/25 at 10:38 AM, NA #47 stated, I typically do mouth care and shave them when I am doing their shower.</p> <p>During an interview on 01/09/25 at 10:50 PM, Licensed Practical Nurse LPN #75 confirmed that Resident #34's teeth were dirty and that she needed oral care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review on 01/09/24 at 12:00 PM, of the task list for Resident #34 revealed that her shower days are on Monday's and Friday's.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>49751</p> <p>Based on record review and interviews, the facility failed to ensure residents were provided activities of interests that he/she was care planned for. This was found true for one (1) of six (6) residents reviewed for the activities care area. Resident identifier: #40. Facility census: 58.</p> <p>Findings included:</p> <p>a) Resident #40</p> <p>Record review completed on 01/08/25 revealed Resident #40 was care planned to receive one (1) on one (1) visits from the Activity Department.</p> <p>Further record review on 01/08/25 shows no evidence for Resident #40 to receive one (1) on one (1) visits from the activity department.</p> <p>During an interview with the Activity Director (AD) on 01/09/25 at approximately 2:00 PM the AD stated, We used to do one (1) on one (1) visits, however she (Resident #40) became more independent with activities of her choice. I'll update the care plan. Confirming the care plan should have been updated when Resident #40 no longer required one (1) on one (1) visits.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>39043</p> <p>Based on record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice. This deficient practice had the potential to affect four (4) of 21 residents in the long-term care survey sample. Physician's orders to obtain weights were not followed for Resident #26 and Resident #19. Insulin was held without physician orders or notification for Resident #32. Neurological checks were not completed after an unwitnessed fall for Resident #53. Resident identifiers: #26, #32, #53, and #19. Facility census: 58.</p> <p>Findings included:</p> <p>a) Resident #26</p> <p>Resident #26 had an order written on 08/01/24 for monthly weights. The provider was to be notified if the resident's weight changed more than five (5) pounds.</p> <p>The resident's last weight was recorded on 10/01/24.</p> <p>Resident #26's treatment administration record (TAR) had an area for the nurses to indicate the resident's weight had been obtained.</p> <p>The resident's TAR for November 2024 indicated the resident's weight had been obtained. However, no weight was recorded in the medical record.</p> <p>The resident's TAR for December 2024 had the notation 9 which, according to the chart codes, indicated a nurses note had been written. A nurses note written on 01/01/25 indicated the resident had refused to be weighed.</p> <p>The resident's TAR for January 2025 indicated the resident's weight had been obtained. However, no weight was recorded in the medical record.</p> <p>On 01/15/25 at 4:00 PM, the Director of Nursing (DON) confirmed Resident #26's weight was not recorded for November 2024 and January 2025. She also confirmed no weight refusals were documented for those months.</p> <p>b) Resident #32</p> <p>Review of Resident #32's physician's orders showed the following orders written on 10/16/23:</p> <ul style="list-style-type: none"> <li>- Insulin glargine 100 unit/ml (milliliters) inject 10 unit subcutaneously at bedtime related to type 2 diabetes mellitus with diabetic neuropathy, unspecified.</li> <li>- Insulin aspart 100 unit/ml inject 10 unit subcutaneously before meals related to type 2 diabetes mellitus with diabetic neuropathy. Give 10 units for blood sugar greater than 160.</li> </ul> <p>Glargine insulin is a long-acting insulin and aspart insulin is a fast-acting insulin.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #32's Medication Administration Record (MAR) for January 2025 showed the resident's bedtime insulin had been held on the following dates:</p> <ul style="list-style-type: none"> <li>- 01/01/25, when the resident's blood glucose was 101.</li> <li>- 01/02/25, when the resident's blood glucose was 97.</li> <li>- 01/05/25, when the resident's blood glucose was 152.</li> </ul> <p>Resident #32's medical records showed no communication with the physician regarding holding the insulin. The medical records showed no physician's orders to hold the insulin.</p> <p>On 01/13/25 at 2:45 PM, the Director of Nursing (DON) acknowledged Resident #32's bedtime insulin had been held without physician's orders to do so.</p> <p>No further information was provided through the completion of the survey</p> <p>c) Resident #53</p> <p>At approximately 1:00 PM on 01/08/2025, during a review of Resident #53's record, it was determined the resident had an unwitnessed fall on 11/01/24. The following note for the fall is typed as written in the progress notes in the resident's medical record:</p> <p>11/01/24 16:39 *Nursing Note</p> <p>Note Text: This nurse was walking by in the hallway and observed resident sitting in the floor on her buttocks beside her bed with WC (wheelchair) behind her. Appears that resident was trying to self transfer into bed. Resident's roommate was standing beside her. When nurse asked resident she stated I don't know what I did. Resident was assisted up and back to WC per her request by 2x staff members. Body evaluation completed and no injuries observed. VS; 104/76, 81, 98.3, 94% off RA, 20. Resident denies any CO pain and is self propelling via WC in hallway. Neuro checks initiated, WC alarm put in place, therapy referral made, and educated resident on the importance of using call light for assistance. FNP notified. VM was left with MPOA to return the call at earliest convenience.</p> <p>Upon review of the neuro checks with the effective date of 11/01/24, it was determined the facility did not complete the second, third, and fourth four (4) hour check, as the assessments were not signed off on.</p> <p>At approximately 2:20 PM on 01/15/25 during an interview with the Director of Nursing (DON), the neurological checks were confirmed to be incomplete.</p> <p>d) Resident #19</p> <p>During a review of Resident #19's orders on 01/13/25, it was discovered that the resident had orders for weekly weights. The order reads as follows: Weekly weights x4 weeks every day shift every Monday for monitoring for 4 weeks. This order was to start on 12/23/24 and end on 01/20/25.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Upon review of the resident's weights, it was determined no weight had been taken the week of 01/05/25 through 01/11/25. One weight was obtained on 01/01/25, with the next one being obtained on 01/13/25.</p> <p>At approximately 1:00 PM on 01/14/25, the Director of Nursing (DON) confirmed the weight missing from the week of 01/05/25-01/11/25.</p> <p>49467</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39043</p> <p>Based on record review and staff interview, the facility failed to prevent, identify, assess, and treat pressure ulcers in accordance with professional standards of treatment. This deficient practice had the potential to affect one (1) of three (3) residents reviewed for the care area of pressure ulcers. Resident identifier: #6. Facility census: 58.</p> <p>Findings included:</p> <p>a) Resident #6</p> <p>Review of Resident #6's medical records showed the resident returned to the facility on [DATE] after a hospital stay.</p> <p>A nursing note written on 12/26/24 at 2:56 PM stated the resident had a Pressure area to left buttock.</p> <p>A nursing note written on 12/26/24 at 3:10 PM stated the resident had an Open area to left buttock.</p> <p>The Readmission Nursing Collection Tool dated 12/26/24 documented the resident had a pressure ulcer to the left buttock, measuring two (2) centimeters (cm) in length by two (2) cm in width. The depth and the stage were not documented.</p> <p>The Licensed Nurse Weekly Skin Observation dated 12/26/24 stated, Resident readmitted today from [hospital name] with multiple scabbed areas to bilateral arms and legs. Skin tear noted to left forearm. Open area noted to left buttock. Scabbed area noted to right foot and left ankle.</p> <p>A physician's order was written on 12/26/24 to Cleanse pressure injury to left buttock with wound wash, let dry, apply Medihoney to wound bed and cover with bordered gauze QD [every day] every night shift for wound healing until healed. The resident's Treatment Administration Records (TARs) and Medication Administration Records (MARs) for December 2024 and January 2025 did not have the order for Resident #6's pressure ulcer treatment on them. Therefore, there was no documentation the treatment had been performed.</p> <p>The Licensed Nurse Weekly Skin Observation dated 01/01/25 stated, 3 scabs observed to L [left] elbow going around his arm. 1 scab on R [right] wrist. 1 scab on back of R [right] elbow. ST [skin tear] to LLA and back of RUA [right upper extremity]. R wrist remains swollen.</p> <p>No documentation of pressure ulcer treatment could be located in the resident's medical record. No further assessment of the pressure ulcer could be located in the resident's medical records. No staging of the pressure ulcer could be located.</p> <p>The resident was transferred to the hospital on 01/08/24.</p> <p>(continued on next page)</p>		

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

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/15/25 at 3:28 PM, the Director of Nursing (DON) confirmed there was no further documentation of resident's pressure ulcer assessment and treatment from the resident's admission on 12/26/24 through his transfer on 01/08/25.</p> <p>No further information was provided through the completion of the survey.</p> <p>b) Policy review</p> <p>The facility's policy titled Pressure Injury Prevention and Management with no implementation date given and revision date 05/22/23 stated as follows:</p> <p>- Evaluation/assessment of pressure ulcer/injury will be completed weekly and with significant change in condition of the ulcer/injury by a licensed nurse and/or practitioner.</p> <p>51554</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>39043</p> <p>Based on observation and staff interview, the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. A storage room containing hazardous items was found to be unlocked. This was a random opportunity for discovery that had the potential to affect any resident able to access the closet. Facility census: 58.</p> <p>Findings included:</p> <p>a) Storage room</p> <p>On 01/07/25 at 11:04 AM, a door with signage stating "new linen room was found to be able to be opened by the surveyor. The door had a keypad on it. In addition to containing clean linens, the room had toiletries, including razor blades.</p> <p>On 01/07/25 at 11:06 AM, Licensed Practical Nurse (LPN) #31 confirmed the door was unlocked. She acknowledged the door should have been locked. It was found that the door did not close easily and remained unlocked unless the door was forcefully closed. When the door was forcefully closed, it did lock. LPN #31 stated she would have maintenance fix the door.</p> <p>No further information was provided through the completion of the survey.</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>31826</p> <p>Based on record review and staff interview the facility failed to ensure a resident who is fed by enteral means receives the appropriate treatment and services to prevent complications of enteral feeding. This was true for one (1) of two (2) residents reviewed for the care area of tube feeding during the long term care survey. Resident Identifier: #60. Facility Census: 58.</p> <p>Findings Included:</p> <p>a) Resident #60</p> <p>1. Residual Order</p> <p>A review of Resident #60's medical record on the morning of 01/14/25 found the following physician order:</p> <p>Enteral Feed Order: every shift Check feeding tube residual every (provider please specify) Hold tube feeding if residual is greater than (provider to specify).</p> <p>This order had a start date of 01/08/25 and was the current order at the time of this review.</p> <p>An interview with the Director of Nursing at 10:58 AM on 01/14/25 confirmed the order to check the resident's residual of her feeding tube was incomplete. The provider failed to specify the number of times the residual should be checked or when the feeding should be held.</p> <p>2. Amount of Feeding</p> <p>A review of Resident #60's medical record on the morning of 01/14/25 found a physician's order which read:</p> <p>-- Enteral Feeding Jevity 1.5 cal 300 milliliters (ML) via peg tube five times a day . This order had a start date of 12/16/24.</p> <p>A review of the Medication Administration Record (MAR) from 12/16/24 through 12/20/24 found nursing only provided 237 ML of Jevity on each feeding beginning at 6:00 PM on 12/16/24 through the 6:00 PM feeding on 12/20/24.</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49467</p> <p>Based on record review and staff interview, the facility failed to implement non-pharmacological interventions for behaviors exhibited by Resident #19. This was true for one (1) of one (1) residents reviewed for behaviors during the survey process. Resident identifier: 19. Facility census: 58.</p> <p>Findings included:</p> <p>a) Resident #19</p> <p>During a review of Resident #19's record on [DATE], multiple episodes of psychosis were noted. The facility documented behaviors in the progress notes section of the resident's record. Upon review of those behavior notes, it was determined the facility staff was attempting to redirect the resident and, if that did not work, no other non-pharmacological interventions were attempted.</p> <p>During a review of Resident #19's orders, it was noted the resident had an order, beginning on [DATE], for behavior monitoring and, included in the order, were eight (8) non-pharmacological interventions. The interventions are as follows: (1) Redirect (2) 1:1 (3) activities (4) toilet (5) give food or fluids (6) reposition (7) back rub (8) other-chart in progress notes.</p> <p>The following are behavior monitoring notes, typed as written in the resident record, from [DATE] through [DATE] (Most recent episodes are listed first). The staff members list the type of behavior, how much it occurred during the shifts, and any interventions attempted, along with the effectiveness. The notes included have interventions noted as being ineffective, slightly effective, or list no effectiveness.</p> <p>Behavior notes:</p> <p>[DATE] 12:59 *Behavior Note</p> <p>Please describe the behavior demonstrated: Resident continues holding conversations with people not present in room. Believes man is hiding under bed and is talking to her. Resident is suspicious of staff entering room stating don't take any of my things.</p> <p>How often did this behavior occur/last: intermittently</p> <p>Describe any interventions attempted:: Reassured Resident of her safety. Assured Resident staff would not take her belongings.</p> <p>Effectiveness of Interventions:: Behavior continues.</p> <p>[DATE] 21:13 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident Telling various staff to get out when going into room Stating they are just trying to steal from her and they need to get out.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>How often did this behavior occur/last: various times when staff goes into room</p> <p>Describe any interventions attempted:: This nurse Talked to resident and reassured her that no one is going to try and steal her belongings.</p> <p>Effectiveness of Interventions:: non-effective.</p> <p>[DATE] 00:05 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident complaining to nurse that the crazy girl has been poisoning her. and it was starting to sip out of her skin. When asked who the girl was resident stated you know the two girls who like to cause trouble.</p> <p>How often did this behavior occur/last: X2</p> <p>Describe any interventions attempted:: Attempted to reorient resident.</p> <p>Effectiveness of Interventions:: Non-effective.</p> <p>[DATE] 09:59 AM Resident exhibiting multiple behaviors, such as, feeling someone is poisoning her food, people living under her bed, believing people are cutting themselves in the hallway. Staff documents trying only one non-pharmacological intervention. Staff not documenting trying more than one intervention when one is unsuccessful.</p> <p>[DATE] 00:43 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident stating that nurse is trying to poison her and give her someone else's medications. That Nurse was not working with her. She also stated that there was some man down the hall cutting himself and that she just couldn't help him</p> <p>How often did this behavior occur/last: At Various times.</p> <p>Describe any interventions attempted:: attempted to redirect.</p> <p>Effectiveness of Interventions:: Non-effective.</p> <p>[DATE] 12:47 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Behaviors exhibited this shift. Resident informs nurse that a woman is under her bed and has been using the bathroom under there.</p> <p>How often did this behavior occur/last: ,d+[DATE]x this shift</p> <p>Describe any interventions attempted:: Redirection and reassured staff nobody was under her bed</p> <p>Effectiveness of Interventions:: somewhat effective</p> <p>[DATE] 13:21 *Behavior Note</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Please describe the behavior demonstrated:: Resident stated to staff when her lunch tray was brought into her room that she couldn't eat it because it was poisoned by the man, she had made angry.</p> <p>How often did this behavior occur/last: ,d+[DATE] minutes</p> <p>Describe any interventions attempted:: re-directed resident. Reassured resident that the only people that had access to her tray was the kitchen staff and the CNA that brought in the tray.</p> <p>Effectiveness of Interventions:: somewhat effective</p> <p>[DATE] 10:18 *Behavior Note</p> <p>Please describe the behavior demonstrated: Entered residents' room to administer residents AM medication. Resident was visibly upset crying. This nurse asked resident if she was okay. Resident stated, No my brother is having sex with a man. During breakfast tray pass resident stated to CNA don't hug me I'm contaminated. Another CNA entered resident's room to asked resident about her shower. Resident stated, I don't think I can take one I'm contaminated and no one needs to be around me.</p> <p>How often did this behavior occur/last: multiple times during a 4-hour period.</p> <p>Describe any interventions attempted:: Re-directed resident. Reassured resident that she wasn't contaminated.</p> <p>Effectiveness of Interventions:: somewhat effective</p> <p>[DATE] 01:06 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident found in bathroom in W/C Resident stated that she was hiding from one of the nurses because she was trying to kill her because she thought that the resident was trying to have sex with her husband and (name)</p> <p>How often did this behavior occur/last: once noted by CNA and once noted by this nurse</p> <p>Describe any interventions attempted:: Attempted to be redirected by Nurse.</p> <p>Effectiveness of Interventions:: Slightly Effective.</p> <p>[DATE] 22:52 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident cont to have dilutions. Stating that Certain peopl are Tring to poison her and that she has to test her food be fore she can eat it.</p> <p>How often did this behavior occur/last: Various times</p> <p>Describe any interventions attempted:: Staff talked to resident.</p> <p>Effectiveness of Interventions:: non-effective</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[DATE] 15:35 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident sitting in her WC in the hallway. When nurse approached her to give ordered medication she whispered, my baby is in the hospital because the bad man and his wife raped her I know I seen the blood everywhere.</p> <p>How often did this behavior occur/last: 1x this shift</p> <p>Describe any interventions attempted:: Resident redirected; snack provided</p> <p>Effectiveness of Interventions:: somewhat effective</p> <p>[DATE] 23:15 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident telling nurse that her roommate has died because she was raped by the witch man and his wife after the witch man sucked her viginia out, placed it on a napkin and threw it in the trash to get rid of evidence.</p> <p>How often did this behavior occur/last: x3</p> <p>Describe any interventions attempted:: Talked to resident</p> <p>Effectiveness of Interventions:: non-effective.</p> <p>[DATE] 15:25 *Behavior Note</p> <p>Please describe the behavior demonstrated:: CNA entered resident's room on snack pass and resident stated, My roommate is in the hospital because a group of witches came into our room and sucked her (XXX) off.</p> <p>How often did this behavior occur/last: 1x</p> <p>Describe any interventions attempted:: redirection</p> <p>Effectiveness of Interventions:: somewhat effective</p> <p>[DATE] 13:39 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident stated that men keep putting something in my coffee so I can't drink coffee anymore The men are trying to kill me.</p> <p>How often did this behavior occur/last: during meals and snack passes.</p> <p>Describe any interventions attempted:: reassured resident that the only people pouring her coffee was staff and that they bring it directly into her room.</p> <p>Effectiveness of Interventions:: somewhat effective.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[DATE] 22:47 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident cont. to have dilutions of people outside of her window waiting to sneak in and sexually assault her. Resident stated that the man with the crooked arm has already sexually assaulted all the other women in the room.</p> <p>How often did this behavior occur/last: Various</p> <p>Describe any interventions attempted:: Resident comforted and made sure that she was safe that no one was going to come in and sexually assault her.</p> <p>Effectiveness of Interventions:: Non-Effective.</p> <p>[DATE] 21:54 *Behavior Note</p> <p>Please describe the behavior demonstrated:: resident stated to this nurse a story that a man was after her, and today she seen that man in the parking lot with her daughter today having sex with her.</p> <p>How often did this behavior occur/last: once</p> <p>Describe any interventions attempted:: explained to resident that there was no man in the parking lot and she was in a safe place</p> <p>Effectiveness of Interventions:: resident just smiled and said some of them mix up love with sex</p> <p>[DATE] 15:50 *Behavior Note</p> <p>Please describe the behavior demonstrated:: This nurse was standing in the hallway and observed resident hollering help me. When nurse approached resident's bedside she stated, he's here messing with my oxygen, he's under my bed.</p> <p>How often did this behavior occur/last: 2x this shift</p> <p>Describe any interventions attempted:: Resident redirected and conversation was changed, assured resident of safety, snacks provided</p> <p>Effectiveness of Interventions:: effective at the time staff was in her room, but after staff exited room resident could be heard conversing with herself in her room</p> <p>[DATE] 22:08 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident was noted to state that an employee went to North Carolina Stole and stole her double Agitator Washing Machine. He Then came back and shot everyone in her family with a big ole gun. including her, her Daughter, her daughters husband, Her sister, Her sister's husband. Her Granddaughter, Her Granddaughter's husband, and her Great-grandchild.</p> <p>How often did this behavior occur/last: Serveral times.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Describe any interventions attempted:: Attempted to re-orient resident.</p> <p>Effectiveness of Interventions:: Non-effective.</p> <p>[DATE] 15:04 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Multiple episodes of behaviors exhibited this shift; resident stating staff is poisoning food, her sister has brought her pop and somebody stole it, people are hiding under her bed.</p> <p>How often did this behavior occur/last: multiple episodes throughout shift</p> <p>Describe any interventions attempted:: redirection</p> <p>Effectiveness of Interventions:: somewhat effective at the time behavior is exhibited</p> <p>[DATE] 16:19 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident told evening shift CNA, that [Nurse Aide name] was standing outside her window and killed his wife and said if she won't let him fuck her alive then he will fuck her dead</p> <p>How often did this behavior occur/last: 5 minutes</p> <p>Describe any interventions attempted:: Redirection, resident brought out of her room and in hallway with staff</p> <p>Effectiveness of Interventions:: ineffective</p> <p>[DATE] 12:35 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident going between talking with someone outside of her window and crying. Resident stated, That damn man out there won't leave me alone and he has thrown all my belongings out the window of the 4th floor.</p> <p>How often did this behavior occur/last: on and off during shift thus far.</p> <p>Describe any interventions attempted:: attempted to redirect. Offered reassurance that belongings are safe and that man is no longer outside of window.</p> <p>Effectiveness of Interventions:: somewhat effective</p> <p>[DATE] 15:13 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident continues with behaviors, has been observed emotional and crying at times when nurse approaches room, informs nurse that the people outside her window told her that her daughter has passed away.</p> <p>(continued on next page)</p>

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Describe any interventions attempted:: Resident reassured of her personal safety here at this facility</p> <p>Effectiveness of Interventions:</p> <p>[DATE] 17:52 *Behavior Note</p> <p>Please describe the behavior demonstrated:: Resident continues to experience delusions</p> <p>How often did this behavior occur/last: throughout shift</p> <p>Describe any interventions attempted:: reassured Resident of safety</p> <p>Effectiveness of Interventions:: ineffective</p> <p>[DATE] 08:00 *Nursing Note</p> <p>Late Entry:</p> <p>Note Text: This Nurse was in Resident's room giving morning medications and talking with Resident. Resident stated, Now you know I love you but you're daughters are doing me dirty, especially the dark haired one. CNA walked in room at this time and was standing beside bed. Resident further stated that the RN supervisor on duty at this time found her old boyfriend (name) from years ago, married him then brought him back here and (xxxx) him in my bed with me still in it. Resident further stated that afterwards, RN Supervisor and a dayshift CNA crawled under her bed, raised it because it was too low, then stabbed her in the back with knives until the bed was full of blood. Resident stated she had witnesses as there were people watching through the window the whole time. Attempts to redirect Resident were not appropriate at that time due to Resident's agitation. This Nurse reassured Resident she was safe and that we were going to have a good day. Resident was pleasant and agreeable and made no further such statements throughout rest of shift.</p> <p>[DATE] 06:11 *Behavior Note</p> <p>Please describe the behavior demonstrated:: CNAs was doing ice pitchers when resident asked the CNA in her room if she was another resident and that CNA said no, resident said good cause I want to kill him. And CNA asked her why and she stated that he does not take good care of her.</p> <p>How often did this behavior occur/last: lasted a few minutes</p> <p>Describe any interventions attempted:: explained to resident that CNA takes good care of her</p> <p>Effectiveness of Interventions:: little effectiveness</p> <p>[DATE] 00:27 *Behavior Note</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Please describe the behavior demonstrated:: Resident came to nurses desk telling Nursing staff that the house Doctor was in love with her and that he was going to take her out of this place. She stated that he said he would sneak her out the window if he had too but he was taking her out of place. She stated that her daughter was scared of him so she thinks her daughter would just let him take her.</p> <p>How often did this behavior occur/last: x1 just now.</p> <p>Describe any interventions attempted:: Nurse Talked to resident and insured her that she was safe. That no one could take her out of the window. CNA showed Resident that the window was safe.</p> <p>Effectiveness of Interventions:: Resident still cont. to worry but is at much more ease.</p> <p>At approximately 11:03 AM on [DATE], an interview was conducted with Licensed Practical Nurse (LPN) #75 regarding the behaviors exhibited by Resident #19. LPN #75 was asked how the staff approach Resident #19 when she exhibits behaviors and what they attempt to do in those situations. LPN #75 stated she will attempt to redirect Resident #19 and, if that is not effective, she will notify the doctor and let them know redirection was not successful. LPN #75 was asked if any other interventions were attempted when redirection was unsuccessful and she stated No.</p> <p>At approximately 11:10 AM on [DATE], and interview was conducted with LPN #31 regarding Resident #19's behaviors. LPN #31 stated she will attempt to redirect the resident by talking about her daughter and granddaughter. LPN #31 stated if that does not work, she will put the resident on the doctor's list for increased behaviors when he comes in again. LPN #31 was asked if any additional interventions were attempted if redirection was unsuccessful, to which she stated No.</p> <p>At approximately 1:00 PM on [DATE], the Director of Nursing (DON) acknowledged in an interview that no additional non-pharmacological interventions when redirection was unsuccessful, despite the resident having an order for eight (8) interventions.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>31826</p> <p>Based on record review, staff interview and policy review, the facility failed to ensure a licensed pharmacist completed a monthly drug regimen review, reported any irregularities to the attending physician and the attending physician responded to any recommendations within the time frame established by the facility policy. This was true for three (3) of five (5) residents reviewed for the care area of unnecessary medications during the Long term care survey process. Resident Identifiers: #30, #53, and #32. Facility Census: 58.</p> <p>Findings Included:</p> <p>a) Resident #30</p> <p>A review of Resident #30's medical record on the morning of 01/13/25 found no evidence that the pharmacist had reviewed Resident #30's drug regimen in the months of 08/2024, 09/2024, and 10/2024.</p> <p>In an interview with the Director of Nursing (DON) on 01/13/25 at 3:00 PM she confirmed she could not find any evidence to show the licensed pharmacist had reviewed Resident #30's drug regimen on the above mentioned months.</p> <p>b) Resident #53</p> <p>At approximately 1:00 PM on 01/08/2024, during a review of Resident #53's medical record, it was determined the facility was missing a pharmacy recommendation and physician's response for the month of November 2024.</p> <p>During review, a pharmacy recommendation dated for 12/26/2024 states The recommendation dated 11/25/24 (the missing recommendation) for nursing on behavior monitoring does not have a response in the chart.</p> <p>At approximately 12:00 PM on 01/15/2025 during an interview with the Director of Nursing (DON), she acknowledged the absence of the November 2024 pharmacy recommendation and physician's response.</p> <p>c) Resident #32</p> <p>Review of Resident #32's medical records showed a Consultant Pharmacist Recommendation to Physician from a Medication Regimen Review (MRR) dated 04/30/24. The recommendation stated, This resident has been taking escitalopram [Lexapro] 10 mg [milligrams] qd [every day] since 10/2023 without a GDR [gradual dose reduction]. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? If not, please indicate response below. The physician response was Change therapy as follows: escitalopram 10 - 5 mg. The form was signed by the resident's physician, who was also the facility's medical director, on 06/27/24.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The next Consultant Pharmacist Recommendation to Physician was from a Medication Regimen Review (MRR) dated 05/31/24. The recommendation stated, This resident has been taking lorazepam 0.25 mg QOD [every other day] since 12/2023 without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? If not, please indicate response below. The physician response was GDR lexapro, hold off until next review. The form was signed by the physician on 06/27/24.</p> <p>On 01/13/25 at 2:40 PM, the Director of Nursing confirmed the physician did not respond to Resident #32's Consultant Pharmacist Recommendation dated 04/30/24 within the 30 days prescribed by the facility's policy. She acknowledged the physician responded to the recommendations from 04/30/24 and 05/31/24 on the same day.</p> <p>No further information was provided through the completion of the survey.</p> <p>d) Policy Review</p> <p>The facility's policy titled Medication Regimen Review, with no implementation or revision dates, stated as follows:</p> <ul style="list-style-type: none"> <li>- The consulting pharmacist would perform monthly medication regimen reviews for every resident in the facility</li> <li>- The consulting pharmacist would provide copy of recommendations to the attending physician, medical director, and director of nursing within five (5) working days of completion of the review.</li> <li>- If the attending physician did not respond within 30 days, the medical director will be asked to review the recommendations and/or contact the attending physician.</li> </ul> <p>39043</p> <p>49467</p> <p>.</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>49467</p> <p>Based on record review and staff interview, the facility failed to monitor Resident #53 for psychotropic medication side effects in November of 2024, during which time, the resident had an unwitnessed fall. This was true for one (1) of five (5) residents reviewed for unnecessary medications during the survey process. Resident identifier: 53. Facility census: 58.</p> <p>Findings included:</p> <p>a) Resident #53</p> <p>Resident #53's medical record review revealed she received Remeron and Zyprexa.</p> <p>Resident #53 discovered the resident suffered an unwitnessed fall on 11/01/24. The following note for the fall is typed as written in the progress notes in the resident's medical record:</p> <p>11/1/2024 16:39 *Nursing Note</p> <p>Note Text: This nurse was walking by in the hallway and observed resident sitting in the floor on her buttocks beside her bed with WC behind her. Appears that resident was trying to self transfer into bed. Residents roommate was standing beside her. When nurse asked resident she stated I don't know what I did. Resident was assisted up and back to WC per her request by 2x staff members. Body evaluation completed and no injuries observed. VS; 104/76, 81, 98.3, 94% off RA, 20. Resident denies any CO pain and is self propelling via WC in hallway. Neuro checks initiated, WC alarm put in place, therapy referral made, and educated resident on the importance of using call light for assistance. FNP notified. VM was left with MPOA to return the call at earliest convenience.</p> <p>Upon further review, it was determined there was no psychotropic side effect monitoring taking place during the month of November 2024. Psychotropic medication side effect monitoring was also missing for the month of December 2024, and was not started until January 2025.</p> <p>At approximately 12:00 PM on 01/15/25 during an interview with the Director of Nursing (DON), she acknowledged side effect monitoring did not take place.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31826</p> <p>Based on resident interview, record review and staff interview, the facility failed to ensure food was served at a palatable temperature. This failed practice had the potential to affect more than an limited number of residents. Facility Census: 58.</p> <p>Findings Included:</p> <p>a) Grievance review</p> <p>A review of the grievances found the following grievances noted:</p> <p>Resident #13 and Resident #15, filed a grievance dated 03/22/24. The Residents stated the food is cool and they are not using the plate warmer.</p> <p>Resident #11 filed a grievance dated 08/21/24 and stated, when her tray is delivered it is cold almost every time at dinner time.</p> <p>Resident #1 filed a grievance dated 11/20/24 the resident indicated the pancakes were cold, not enough sausage, and the pancake was so hard she could not cut it.</p> <p>b) Resident Interviews</p> <p>On 01/07/25 at 11:38 AM, Resident #26 stated his food was often cold when served to him.</p> <p>On 01/07/25 at 2:26 PM, Resident #7 stated her food, especially soup, was often cold when served to her.</p> <p>During and interview with Resident #13 on 01/07/25 at 12:22 PM, the resident stated the food looks bad and it is cold all the time and the meat is tough.</p> <p>c) Food temperature Measurement</p> <p>On 01/08/25 at 12:08 PM the Dietary manager obtained the temperature of the meal items served during the noon time meal. The temperatures were obtained when the final resident received their meal tray. The following temperatures were obtained:</p> <p>--Chicken Strip: 101.1 degrees Fahrenheit</p> <p>-- [NAME] Slaw: 54.3 degrees Fahrenheit.</p> <p>(continued on next page)</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Dietary Manager stated she was going to take the temperature of the other chicken strip. She obtained the temperature the surveyor noted the temperature was 100 degrees F. The dietary manager in an interview later in the day on 01/08/25 stated she thought the temperature of the second chicken tender was 131 degrees. The surveyor and the Dietary manager was unable to agree on the temperature of the second tender however we did agree on the temperature of the first tender which as 101.1 degrees F.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>49467</p> <p>Based on record review, observation, and resident and staff interview, the facility failed to accommodate Resident #36's food preferences by serving her eggs. This was a random opportunity for discovery. Resident identifier: #36. Facility census: 58.</p> <p>Findings included:</p> <p>a) Resident #36</p> <p>At approximately 2:15 PM on 01/07/25, during an interview with Resident #36, she stated They send me eggs every morning and I can't eat them because I'm allergic to them. The resident reiterated she did not like eggs.</p> <p>At approximately 2:00 PM on 01/08/25, during review of Resident #36's dietary profile dated 12/27/2024, it was noted, under the food allergy section of the assessment, the resident was allergic to eggs.</p> <p>At approximately 8:00 AM on 01/09/25, during observation of the breakfast tray pass, Resident #36 was served a breakfast casserole.</p> <p>At approximately 8:05 AM on 01/09/25, the Dietary Manager (DM) confirmed the breakfast casserole contained eggs.</p> <p>At approximately 8:15 AM the Director of Nursing (DON) confirmed the resident had received breakfast casserole.</p> <p>At approximately 12:00 PM on 01/09/25, the DM provided the survey team with the recipe for the breakfast casserole. The recipe confirms the presence of eggs in the casserole.</p> <p>The facility was able to provide documentation in support of Resident #36 not having an allergy to eggs, however, it was noted the resident voiced her dislike of eggs and did not wish to receive them on her tray.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31826</p> <p>Based on observation and and staff interview, the facility failed to ensure food was stored and an served in a safe and sanitary manner. There were multiple items in the walk-in cooler that was either out of date or not dated to indicate when they had been opened. Additionally two (2) vents in the kitchen ceiling had a collection of dust around the vents on the ceiling. The vent on the HVAC unit in the kitchen had a collection of dust on the outer metal grate covering the filter. The filter itself was also completely covered in dust. This failed practice had the potential to affect all residents currently receiving nutrition from the facility's kitchen. Facility Census: 58.</p> <p>Findings Included:</p> <p>a) Walk in cooler:</p> <p>An initial tour of the kitchen with the Dietary Manager (DM) on 01/07/25 beginning at 10:47 AM found the following food storage issues in the walk in cooler:</p> <ul style="list-style-type: none"> <li>- 37 individual cups of assorted yogurt which all had a manufactures stamped expiration date of 01/06/25.</li> <li>- A prepackaged container of fruit salad that had an open date of 12/17/24 and a manufactured stamped expiration date of 12/28/24.</li> <li>-- One (1) five (5) pound (LB) bag of shredded cheddar cheese that had a discard date of 01/05/25.</li> <li>- One 46 ounce (oz) container of [NAME] apple sauce which was opened and partially used did not have an open date.</li> <li>- One (1) five (5) LB container of scramble egg mix which was opened and not dated.</li> <li>-- Two (2) five (5) LB bags of mozzarella cheese one was nearly empty and both were opened and not dated. The DM confirmed all findings at the time of discovery and discarded all items.</li> </ul> <p>b) Cleanliness</p> <p>Additional observation of the kitchen with the DM on 01/08/25 at approximately 12:15 PM with the DM found a collection of dust around two (2) ceiling vents. The vents themselves were not dusty however the ceiling surrounding the vents was covered in dust. One (1) of the vents was directly over the steam table. Also the the metal grate covering the filter on the HVAC (Heating, Ventilation and air conditioning) unit was covered in dust. The filter under the metal grate was also covered in dust. When asked who was responsible for cleaning identified areas the DM stated it was the responsibility of maintenance.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 12:17 PM on 01/08/25 Maintenance Assistant #55 confirmed the metal grate on the HVAC system needed cleaned. She was asked how often the filter on the system needed to be replaced, she indicated that it should be done monthly. She said, It should be dated for the day it was last changed. She removed the filter and confirmed there was not a date on the filter and confirmed it needed to be changed.</p> <p>The DM confirmed the areas on the ceiling around the vents also needed to be cleaned.</p>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>49465</p> <p>Based on record review and staff interview, the facility failed to complete an accurate facility assessment related to the overall acuity of care needed for its population. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents during the Long-Term Care Extended Survey Process. Facility census 58.</p> <p>Findings Included:</p> <p>a) Facility Assessment (FA)</p> <p>A review on 01/14/24 at 11:30 AM of the Facility Assessment revealed the facility reviewed their FA on 10/24/24. Under over all acuity of residents the following calculations were determined:</p> <p>Assistance with Activities of Daily Living (ADL's) 20 %</p> <p>Mobility impairments 0%</p> <p>incontinence impairments 0%</p> <p>cognitive or behavioral impairment 18.18 %</p> <p>specialized care ( dialysis, vents, wound care) 0 %</p> <p>Other NA</p> <p>During an interview, on 01/14/25 at 2:00 PM, the Administrator stated, I missed a section evidently. I will fix it. He confirmed that he did not feel the overall acuity section out correctly. The Administrator later confirmed that the facility assessment was incorrect.</p> <p>A review on 01/14/24 at 2:20 PM of the tool titled {Simple Long Term Care (LTC) Diagnosis}, that the facility used to determine acuity of care from 10/2023 to 10/2024 indicated the following:</p> <p>Diseases of the musculoskeletal system and connective tissue: 64.9%</p> <p>Factors influencing health status and contact with health services: 53.2%</p> <p>Diseases of the Genitourinary system: 51.4%</p> <p>Diseases of the skin and subcutaneous tissue: 26.1%</p> <p>A review on 01/14/24 at 2:30 PM of the Policy titled, Facility Assessment, Under (3) three, C, reads as follows:</p> <p>(continued on next page)</p>

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>c. Factors that affect the overall acuity of the residents, such as number and percentages of residents with:</p> <ul style="list-style-type: none"> <li>i. Need for assistance with ADL s</li> <li>ii. Mobility impairments</li> <li>iii. Incontinence (bowel or bladder)</li> <li>iv. Cognitive, substance use disorder, trauma or behavioral healthcare needs/ impairments</li> <li>v. Conditions or diseases that require specialized care (dialysis, ventilators, wound care).</li> </ul>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>31826</p> <p>39043</p> <p>Based on record review and staff interview, the facility failed to ensure complete and accurate medical records for two (4) of 21 residents in the long-term care survey sample. Resident #49 had an incomplete Physician Orders for Scope of Treatment (POST) form. Resident #6 had an inaccurate medication order and care plan. Resident identifiers: #49, and #6. Facility census: 58.</p> <p>Findings included:</p> <p>a) Resident #49</p> <p>Review of Resident #49's medical records showed a [NAME] Virginia Physician Orders for Scope of Treatment (POST) form completed on 05/24/24. The portion of the POST form regarding medically assisted nutrition was blank. This section contained the following four (4) options:</p> <ul style="list-style-type: none"> <li>- Provide feeding through new or existing surgically-placed tubes.</li> <li>- Time-limited trial of ____ days but no surgically-placed tubes.</li> <li>- No artificial means of nutrition desired.</li> <li>- Discussed but no decision made (provide standard of care).</li> </ul> <p>On 01/08/25 at 12:06 PM, the Director of Nursing (DON) stated medically assisted nutrition was discussed with the resident representative who was unable to make a decision regarding the matter at the time. The DON acknowledged the option Discussed but no decision made (provide standard of care) should have been chosen.</p> <p>Additionally, telephone consent was obtained from the resident's representative on 05/24/24, with two (2) staff members signing to verify the consent.</p> <p>According to the manual titled Using the POST Form Guidance for Healthcare Professionals, available on-line, If the incapacitated patient's MPOA representative or health care surrogate is unavailable at the time of form completion, this section can be signed by two witnesses for verbal confirmation of agreement from the patient's MPOA representative or health care surrogate. The form should be signed at the earliest available opportunity.</p> <p>On 01/15/25 at 12:05 PM, the DON confirmed Resident #49's POST form had not been signed by the resident's representative after verbal consent was obtained.</p> <p>No further information was provided through the completion of the survey process.</p> <p>b) Resident #6</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Bluestone Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1600 Bland Street Bluefield, WV 24701	
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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #6's medical records showed an order written on 01/03/25 for Seroquel (quetiapine fumarate) 25 mg at bedtime for dementia with psychosis related to unspecified psychosis not due to a substance or known physical condition.</p> <p>Review of Resident #6's comprehensive care plan showed the following focus initiated on 12/06/24, The resident has risk for complications related to cognitive impairment secondary to dementia, secondary to memory impairment.</p> <p>Review of Resident #6's diagnoses list did not show a diagnosis of dementia. The resident did have a diagnosis of unspecified psychosis not due to a substance or known physical condition. The nurses progress notes documented hallucinations and delusions.</p> <p>The resident's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 01/01/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment.</p> <p>On 01/09/25 at 12:18 PM, the Director of Nursing (DON) stated Resident #6 did not have a diagnosis of dementia. She stated the resident was receiving Seroquel due to psychosis and acknowledged the diagnosis of dementia was incorrect in the order. She also acknowledged the care plan incorrectly stated the resident had a diagnosis of dementia.</p> <p>No further information was provided through the completion of the survey process.</p> <p>51554</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39043</p> <p>49467</p> <p>Based on observation and staff interview, the facility failed to follow proper infection control practices, by dropping cartons of milk on the floor and placing them back in the cart with clean cartons, by sending uncovered cups full of coffee out onto the floor from the kitchen, and by failing to ensure enhanced barrier precautions were followed and posted for Residents #20 and 58. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents. Resident identifiers: 20, 58. Facility census: 58.</p> <p>Findings included:</p> <p>a) Milk cartons</p> <p>At approximately 11:53 AM on 01/07/25 Nurse Aide (NA) #58 was observed, during lunch tray pass, dropping two cartons of milk on the floor. NA #58 picked up the two cartons and placed them back in the cart with the clean milk cartons. NA #58 acknowledged dropping the milk cartons on the floor and returning them to the cart with the clean milk cartons and stated I don't know why I did that, I just wasn't thinking.</p> <p>b) Coffee cups</p> <p>At approximately 11:59 AM on 01/07/25, during lunch tray pass, a tray of approximately 12 cups of coffee was observed on the drink cart, full of coffee, uncovered, with no lids. NA #48 confirmed the cups were sent from the kitchen, filled with coffee, uncovered, with no lids. NA #48 most of the time they are sent out with lids on them but I guess they must have forgotten to put them on today.</p> <p>c) Resident #20</p> <p>Resident #20 had Enhanced Barrier Precautions (EBP) signage in her room over her bed. On 01/14/25 at 9:21 AM, Licensed Practical Nurse (LPN) #33 donned gloves but not a gown and entered the resident's room to perform a skin check focused to bony prominences. The resident stated she had been having diarrhea. When LPN #33 undid the resident's brief, the resident did have dark soft stool in her brief.</p> <p>LPN #33 was asked why the resident was on EBP. She stated she did not know because she usually worked in the other hallway.</p> <p>The resident had an order written on 09/25/24 for infection precautions - EBP R/T [related to] impaired skin integrity. The resident's progress notes showed the resident had three (3) previous stage II pressure ulcers to her buttocks and coccyx. The last one healed 11/12/24.</p> <p>On 01/14/25 at 11:25 AM, the Director of Nursing (DON) acknowledged a gown should have been worn for skin inspections for residents with Enhanced Barrier signage.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d) Resident #58</p> <p>Resident #58 had Enhanced Barrier Precautions (EBP) signage in her room over her bed. On 01/14/25 at 9:21 AM, Licensed Practical Nurse (LPN) #33 donned gloves but not a gown and entered the resident's room to perform a skin check focused to bony prominences. LPN #33 stated she did not know why the resident was on EBP. In addition to inspecting the resident's bony prominences, LPN #33 had interacted with the resident's bed covers by straightening out the resident's bed covers.</p> <p>Review of the resident's orders showed no orders for Enhanced Barrier Precautions.</p> <p>On 01/14/25 at 11:25 AM, the Director of Nursing (DON) acknowledged a gown should have been worn for skin inspections for residents with Enhanced Barrier signage.</p> <p>e) Policy review</p> <p>The facility's policy titled Enhanced Barrier Precautions (EBP) Policy with original date 03/24/24 stated EBP should be utilized during the following activities:</p> <ul style="list-style-type: none"> <li>- Dressing</li> <li>- Bathing/showering</li> <li>- Transferring</li> <li>- Providing hygiene</li> <li>- Changing linens</li> <li>- Changing briefs or assisting with toileting</li> <li>- Device care or use</li> <li>- Wound care</li> </ul> <p>The facility's Enhanced Barrier Precautions signage stated providers and staff must wear gloves and a gown for the following high-contact resident care activities:</p> <ul style="list-style-type: none"> <li>- Dressing</li> <li>- Bathing/showering</li> <li>- Transferring</li> <li>- Changing linens</li> <li>- Providing hygiene</li> <li>- Changing briefs or assisting with toileting</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Device care or use</p> <p>- Wound care</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043</b></p> <p>Based on record review and staff interview, the facility failed to administer pneumococcal vaccines in accordance with Centers for Disease Control (CDC) guidelines. This deficient practice had the potential to affect more than a limited number of residents. Resident identifiers: #6 and #17. Facility census: 58. Findings included:</p> <p>a) Resident # 6</p> <p>Review of Resident #6's medical records showed the resident signed a consent to have a PPSV23 vaccination administered on 12/06/24. The consent stated PCV20 may be used if PPSV23 was not available. The consent stated, The CDC recommends one pneumococcal vaccine PPSV23 for adults [AGE] years of age or older. If you are 65 or older and have not had a pneumonia vaccine, or received PCV13, PCV15 or PCV20 at least 1 year ago or PPSV23 at least 5 years ago (when under 65), you should receive one dose of PPSV23. On 12/11/24, Resident #6 received vaccination with PPSV23.</p> <p>b) Resident #17</p> <p>Review of Resident #17's medical records showed the resident's representative signed a consent to have a PPSV23 vaccination administered on 12/12/24. The consent stated PCV20 may be used if PPSV23 was not available. The consent stated, The CDC recommends one pneumococcal vaccine PPSV23 for adults [AGE] years of age or older. If you are 65 or older and have not had a pneumonia vaccine, or received PCV13, PCV15 or PCV20 at least 1 year ago or PPSV23 at least 5 years ago (when under 65), you should receive one dose of PPSV23. On 01/04/25, Resident #6 received vaccination with PPSV23.</p> <p>c) Policy Review</p> <p>The resident's policy titled Pneumococcal Vaccine, with no implementation or revision date given, stated residents would be offered the pneumococcal vaccination upon initial admission to the nursing home in accordance with the guidelines set forth by the Center for Disease Control (CDC) and/or the Advisory Committee on Immunization Practices (ACIP). The ACIP is a committee within the CDC.</p> <p>According to the CDC's guidance regarding pneumococcal vaccine timing for adults dated October 2024, available online, adults [AGE] years or older who have not received prior pneumococcal vaccines should be offered one of the following:</p> <ul style="list-style-type: none"> <li>- Pneumococcal 20-valent Conjugate Vaccine (PCV20)</li> <li>- Pneumococcal 20-valent Conjugate Vaccine (PCV21)</li> <li>- Pneumococcal 20-valent Conjugate Vaccine 15 (PCV15) followed by pneumococcal polysaccharide vaccine 23 (PPSC23) after a year</li> </ul> <p>d) Interview</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/15/25 at 10:00 AM, the Director of Nursing (DON) confirmed unvaccinated residents were offered PPSV23 vaccination and PCV20 was only used when PPSV23 vaccination was unavailable. The DON stated the facility was unaware that CDC guidelines for pneumococcal vaccinations had changed and no longer recommended PPSV23 vaccination for unvaccinated residents.</p>