STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515186	A. Building B. Wing	04/30/2026

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based upon record review, staff interviews, resident interview, and observation, the facility failed to maintain a resident environment as free from accident hazards as possible. This was true for three (3) of the three residents reviewed during the long term care survey process. The facility's failure to thoroughly review circumstances and change the processes for deliveries to residents created a risk of serious harm related to residents ordering over-the-counter medications known to be abused as well as THC gummies and offering them to other residents. Resident identifiers: #27, #54, #57 #5 and #42. Facility census: 57. Findings included: a) During an Interview with an anonymous resident the following was reported: On 4/03/26, two female residents purchased cannabis gummies and had them delivered via Door Dash. The anonymous resident reported that the two female residents offered her a gummy, which she refused. She went on to report both female residents were sent out to the hospital after one of the residents was noticeably impaired. These residents were later identified as Resident #5 and #42. Record review completed on 04/21/26 of the facilities reportable and grievance logs revealed no investigation was completed for Resident #5 and Resident #42 regarding changes in condition due to cannabis gummies being brought into the facility and offered to other residents. The surveyor reviewed a change in condition dated 04/03/26 stating Resident #5 was sent to the local ER for further evaluation and a toxicology screen. The signs and symptoms the resident was displaying included altered mental status and suspicion of substance abuse. Resting pulse was noted as greater than 100 at 105 also. A review of a nursing progress note dated 04/03/26 at 2:00 PM labeled as a late entry revealed the following: Resident was educated on facility policies regarding not being allowed to have OTC medications or CBD products in the room; the resident voiced understanding and agreement. A nursing note dated 04/03/26 at 1:10 PM stated CNA approached this nurse and informed me that Resident #42 had informed her that this resident had given her two gummies and that she consumed one and it tasted bad, so she threw the other one away in her trash can. CNA removed the gummy from Resident #42's trash can and gave it to this nurse. A square red gummy with sugar coating was observed. I then went to speak with this resident, and she was observed lying on her bed with eyes reddened and voiced CO 'feeling tired'. VS then obtained; 108/84, 98.1, 16, 105, 95% off RA. I asked resident what type of gummy she consumed and she stated, 'pot gummies' and pointed towards a wooden box on her bedside table. I asked resident if I could look in the box and she stated, 'yes go ahead'. I opened the wooden box and observed several loose squared red gummies with sugar coating on them, three vape pens, one suspected CBD vape pen, a bottle of Benadryl, and several Imodium tablets in store foil packaging. Resident then informed this nurse that she purchased the gummies and (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	CBD vape pen from door dash. I then asked resident if I could remove the items and she consented. Administrator, DON, and physician was notified. The wooden box with all belongings was released to administrator. New orders received per FNP to send resident out to local ER for further evaluation due to suspicion of substance abuse and obtain a toxicology screen. Resident made aware and in agreement with new order. 1:20 PM- (name of emergency medical transport) notified for transport 1:25 PM- Report called to (name of hospital) ER nurse 1:45 PM- (name of local emergency medical transport) on site x2 attendees to transport resident to local ER. All transfer paperwork was sent with resident. Resident #42 was on the following medications and possible side effects taking medications with Cannabis gummies Prozac (Fluoxetine) 40 MG: Major interaction. Prozac can increase THC levels, causing increased drowsiness, worsening depression, cognitive impairment, or mania. Buspar (Buspirone) 7.5 MG: Potential for serotonin syndrome (confusion, muscle twitching, rapid heart rate) when combined with other serotonergic agents and cannabis. Keppra (Levetiracetam) 750 MG: Increased risk of drowsiness, dizziness, confusion, and difficulty concentrating. Prazosin 1 MG: Potential for increased dizziness or fainting due to additive blood-pressure-lowering effects. A note dated 04/03/26 at 2:27 PM stated, LPN #69 came and notified me that two residents (#42 and #5) consumed unknown substance like gummies. I immediately went to assess this resident while the LPN #29 was notifying the DON, administrator, and Dr. Resident #42 eyes were very red and stated she feels paranoid. Vitals 115/76, 108, 18, 97.9, 92% RA. Resident told this Nurse that she received Two Gummies from (resident #5). She stated the Gummies tasted bad, so she threw the gummy in the trash. The CNA #58, took the Gummy out of the trash and took it to the nurse station. Resident #42 also told this nurse that another resident (#15), knew about the Gummies. This Nurse went and spoke to Resident #15 and the resident stated that Resident #5 came into her room and told her that she has Gummies and THC pens. Resident #5 told Resident #14 that she was going to give resident #42 two gummies. Resident #15 also stated that Resident #5 wrote a letter to a worker, Restorative aide #46 letters and she still had the letter on her bed, and I can have the letter if I want it. Nurse went to the room and got the letter and gave it to the administrator. Nurse did not read the letter. LPN #24 and LPN #69 were on our way to check on (resident #5) when we noticed a man from Door Dash knocking on the door. The man gave the nurse the bag and exited the facility quickly. It was a pack of cigarettes with a receipt with two CBD purchases on the receipt. The facility administration (administrator and director of nursing) had no evidence that a thorough investigation into this matter had been completed. Because only a limited action was taken following the incident on 04/03/26 the facility administration was presented with an Immediate Jeopardy template on 04/21/26 at 6:00 PM. The failure to identify a situation where residents were susceptible to drug abuse from other residents created an immediate jeopardy situation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 04/21/26 at approximately 8:45 PM, the facility presented the following Plan of Correction: 1. Corrective Action for Residents Affected Resident #5 and Resident #42 were immediately assessed on 04/03/2026 for any adverse effects related to ingestion of suspected cannabis gummies. Nursing assessments, vital signs monitoring, and physician notifications were completed. Residents were transferred to the hospital as indicated and monitored upon return with no ongoing adverse effects identified. Anonymous Resident #1 was interviewed and confirmed no ingestion occurred. The resident remained safe with no identified concerns. The facility immediately initiated an abuse investigation on 04/21/2026 and reported the allegation in accordance with regulatory guidelines. The facility ensured that all required notifications were completed. 2. Identification of Other Residents with Potential to be Affected On 04/21/2026, the facility started conducting a comprehensive room-to-room audit of all residents, that either they or their responsible party consent too, to identify the presence of non- prescribed medications, suspected cannabis and/or CBD products, or unauthorized substances. The facility is attempting to interview all residents regarding knowledge of any residents sharing or giving each other over-the-counter medications or other non-prescribed substances or anyone offering non-prescribed substances to them or ingesting any non-prescribed or over-the-counter medications or substances. The facility has started and is conducting interviews with all staff regarding knowledge of residents sharing or giving over-the-counter medications, or health or pharmaceutical products; noticed any situations where staff or resident may have exchanged non-prescription products outside of the standard process; and any challenges or concerns seen related to residents accessing or using non-prescription products safely. All residents are being assessed for signs and symptoms of impairment or changes in condition. A retrospective review of incident reports, 24-hour reports, and grievance logs is being completed for the previous 30 days to ensure no additional unreported or uninvestigated incidents existed in violation of F600, F609, and F610 requirements. 3. Systemic Changes to Prevent Recurrence The facility implemented the following systemic changes to address compliance with F600, F609, and F610: External deliveries by DoorDash will be inspected by staff upon delivery, in accordance with Federal Regulation 557, Respect, Dignity/Right to have Personal Property and follow guidelines on how to search residents' deliveries with consent. Residents will be re-educated on the facility's expectations regarding safety, including the prohibition of non-prescribed medications and substances within the facility, and the importance of not sharing or accepting medications or items from other residents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All staff will be re-educated on 04/21/2026 or prior to their next scheduled shift on the following: Abuse prevention and resident-to-resident abuse (F600) Mandatory reporting requirements, including timelines and immediate reporting expectations (F609) Investigation requirements, including documentation, interviews, and follow-through (F610) Identification of impairment and prohibition of non-prescribed medications and substances New hires will receive this education during orientation, and ongoing education will be reinforced through monthly in-services and QAPI review. 4. Monitoring to Ensure Compliance The facility implemented the following monitoring systems: The Administrator and/or designee will audit all reportable events and grievances daily for two (2) weeks, then weekly for four (4) weeks, and monthly thereafter to ensure compliance with F609 reporting requirements. The Director of Nursing (DON) or designee will audit all abuse investigations weekly for four (4) weeks, then monthly for two (2) months to ensure investigations are completed timely and thoroughly in accordance with F610 requirements. The facility will conduct weekly audits of delivery logs and contraband checks for four (4) weeks, then monthly for two (2) months. Findings will be reviewed through the QAPI program, and corrective actions will be implemented as needed to ensure sustained compliance. c) The State Agency accepted the Plan of Correction on 04/21/26 at 9:07 PM. d) Education and Post Tests Staff Interviews Have you ever observed residents sharing or giving each other over-the-counter medications, or health or pharmaceutical products? Have you you noticed any situations where staff or residents may have exchanged non-prescription products outside of the standard process? Are there any challenges or concerns you've seen related to residents accessing or using non-prescription products safely? Recognizing Substance Use in Long-Term Care Quick Reference For Clinical Staff Why It Matters- Substance use in older adults is often under- recognized, Signs may mimic dementia, delirium or depression, Early recognition improves safety and outcomes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Common Substances in Long Term Care- Alcohol, Prescription medications (opioids, benzodiazepines, sleep aides), Over- the-counter misuse (sleep/cough products). General Warning Signs- Falls, unsteady gait, slurred speech, New or worsening confusion or memory changes, Mood swings, agitation, withdrawal, Decline in ADL's or therapy participation. Substance-Specific Clues- Alcohol: odor, flushed face, tremors, unexplained injuries. Opioids: excessive drowsiness, pinpoint pupils, slow breathing. Benzodiazepines/Sedative: confusion, falls, daytime sleepiness. Higher-Risk Residents- Chronic pain or anxiety/depression, Cognitive impairment, History of substance use, Polypharmacy or recent life transitions. What Staff Should Do- Observe and compare to baseline, Document objectively and factually, Report concerns through proper channels. Escalate Immediately If- Unresponsiveness or respiratory depression, Suspected overdose, Sudden severe confusion or repeated unexplained falls. Remember- Substance use is a medical issue, not a moral one. Use dignity, respect and teamwork. DoorDash Delivery Protocol To help ensure the safety and well-being of all residents, the facility will no longer allow DoorDash services to deliver items directly to residents. All deliveries must be received by facility staff before being given to the resident. Facility staff will inspect these deliveries with resident consent. Facility staff will respect the resident tights to refuse inspection. This process helps us confirm that items are appropriate, safe, and in compliance. Residents are encouraged to plan accordingly and understand that this protocol is in place to protect their health and maintain a safe living environment for everyone. Medication Safety For your safety, residents are not permitted to share prescribed medications, non-prescribed (over-the-counter) medications, or other substances with others. Medications are ordered specifically for each individual and may be harmful if taken by someone for whom they were not intended. Residents should also not accept medication or other substances if it is offered by another resident, even if it seems harmless. If you feel unwell or believe you need medication, please notify staff so they can assist you appropriately and safely. The IJ was abated on 04/22/26 at 4:28 PM. b) Resident #27 Resident #27 has capacity to make own medical decisions. Progress notes from the resident's medical record documented the following: 02/18/2026 12:40*Nursing NoteNote Text: The Administrator, with the DON [Director of Nursing] and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	UM [Unit Manager] present, spoke with resident regarding staff reports that they had witnessed her having a vape in her room that she refused to allow the nurse to secure per policy. She initially denied having a vape at all and then she admitted to having had one that was now empty. Administrator asked where she got the vape and resident stated, I'm not going to tell you where I got it. She then stated she threw it away. The Administrator attempted to clarify when and where it was discarded. She said today, in the trash barrels in the hallway. She would not elaborate on the time she discarded the vape. UM went immediately to attempt to locate the discarded vape without success. Resident was educated verbally by the Administrator on the dangers of using a vape in a room with an oxygen concentrator present and turned on and further educated her on the smoking policy to include that all smoking paraphernalia must be turned into the nurses to be stored until scheduled smoke times, and finally that vaping is not permitted inside the facility. Resident voiced understanding and agreed to follow the policy. 02/18/2026 12:21*Communication with ResidentNote Text: This NHA knocked on resident's door and asked to enter. This NHA was accompanied by the DON. This NHA entered the resident's room to address concerns regarding the presence of a vape device and/or smoking paraphernalia within the resident's room. The resident admitted to having a vape device in her possession and keeping the vape in her room.The resident had previously been educated by this NHA on 12/26/25 regarding the facility smoking policy, which states that all smoking paraphernalia must be stored in a secure location accessible to staff. Residents are not permitted to keep smoking paraphernalia on their person or within their room. Smoking items may only be utilized during designated smoking times, under staff supervision, and in theapproved smoking area. At that time, the resident verbalized understanding of the policy.During this encounter, the resident was re-educated on the facility smoking policy and the associated safety risks of vaping or smoking within the facility. Additional education was provided regarding the significant fire and safety hazards related to vaping or smoking in proximity to oxygen equipment. The resident currently has an oxygen concentrator in her room and prefers to leave the concentrator running continuously, even when not actively in use, per her preference.The resident verbalized understanding of the education provided. The resident declined to disclose how the vape device was obtained and refused this NHA's request to inspect drawers or personal storage areas to verify removal of the device from the room. The resident was unable to clearly state where or how the vape device had been disposed of prior to this NHA's discussion with resident. 02/18/2026 11:49*Behavior NotePlease describe the behavior demonstrated:: Knocked on resident's door for medication pass. Resident didn't answer. This nurse poked her head in the door and observed resident resting in her bed with eyes closed and audible snoring observed with a vape in her hand. Resident asked if she would give this nurse vape. Resident stated No and tucked vape into clear plastic tote bag.How often did this behavior occur/last: 1xDescribe any interventions attempted:: Attempted to educate resident on smoking and vaping policy. Resident continued to refuse to give this nurse vape. DON and Administrator notified.Effectiveness of Interventions:: The resident's care plan with an initiationdate of 09/08/25 included that they smoked cigarettes. The resident had the following physician orders: -Oxygen Therapy: Oxygen 3 liters via Nasal Cannula continuously. May be removed for transports, shower, and activities of interest.every shiftOther Active 3/29/2026 A quarterly smoking assessment was last conducted on 03/10/26, and was not marked for vaping. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to the Medical University of South Carolina, vaping while using supplemental oxygen is extremely dangerous and can cause severe fires, explosions, facial burns, and death. Oxygen supports combustion, making even small sparks from a vape's heating element, or a battery failure, ignite the enriched oxygen atmosphere, clothing, or the nasal cannula instantly. During the period of the survey, it was still not known whether the resident had vape pens in her possession, and resident refused a room search. This possible serious fire hazard was reviewed with RN Consultant #87 on 04/29/2026 at 12:22 PM. RN Consultant indicated she would be taking care of this immediately. b) Resident #54 An observation on 04/14/26 at 1:00 PM, Resident #54 was observed lying in his bed with the right fall mat leaned along the wall behind the headboard. Record review completed on 04/14/26 showed the care plan had an intervention stating Fall matts to bilateral sides of bed while resident is in the bed During an interview with LPN #65 on 04/14/26 at 1:05 PM who confirmed floor matt was not in place and statedI'll get that down now they just laid Resident #54 down c) Resident #57 During a check for fall prevention measures on 04/23/26 at 9:15AM, Resident #57 was observed lying in his bed with the bed not in the low position. A review of the care plan for Resident #57 includes the following: RISK FOR FALLS: the resident is at riskfor falls related to: muscle weakness,cognitive impairment, incontinence,psychoactive medication use, recenthospitalizations, visual impairment; historyof traumatic brain injury and multiple CVAswith deficits. Bed in lowest positionDate Initiated: 12/05/2025 It was confirmed in an interview with Registered Nurse Consultant #86 that Resident #57's bed was not in lowest position with resident in the bed at 04/23/26 at 9:21 AM.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on resident interview and record review the facility failed to protect two (2) residents from neglect by failing to provide care timely incontinence care Resident #1 and failing to provide the correct texture of food for Resident #3. Resident identiifers: #1, and #3. Resident #1 sustained actual physical harm from this action. Facility Census 57. Findings Included: Findings include: a) Resident #1 A policy titled Abuse includes a definition for neglect that reads: neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. During the initial interview with Resident #1 on 04/20/26 at 1:55 PM, he stated he had been left overnight without having his brief changed and had been experiencing diarrhea. Resident #1 stated he requested to be changed. Resident #1 stated that when they did change his brief the next morning, the bowel movement had to be picked off and his bottom all the way to the front was sore. In an interview with Nurse Aide (NA) #25 via telephone at 12:50 PM on 04/21/26, she stated she changed Resident #1 on Saturday, 04/18/26 before she left for the day. She stated she went back on Sunday, 04/19/26 to assist his aide and Resident #1 stated he had not been changed since CNA #25 did it the day before. Resident #1 stated he had asked the night shift aides to change him, but they came in, changed his roommate and left. NA #25 states Resident #1 was raw and his skin was bad! CNA #25 stated she reported the issue to Licensed Practical Nurse (LPN) #69 immediately. In an interview with CNA #58 via telephone on 04/21/26 at 1:25PM. She stated she went in to change a wet and soiled brief on Sunday morning. Resident #1 stated he had not been changed all night. He stated he had asked the aides that came in to change his roommate, but the aide said they would come back. However the aide left and did not return. CNA #58 states his skin was pretty bad and raw and red. CNA #58 stated she showed LPN #69 immediately, who then notified Registered Nurse (RN) #63. An order written on 04/19/26 reads as follows: Wound Care: Cleanse excoriation to sacrum and scrotum with soap and water, allow to dry then apply barrier cream Shift until resolvedevery shift for wound healing. The active date/time on the order was 04/19/26 at 6:00 PM. The last skin assessments in the Electronic Medical Record (EMR) are from 04/08/26 and 04/15/26 which show no skin issues to the sacrum or scrotum. A record review of the reportables and grievances does not include this situation. In an interview with Administrator on 04/22/26 at approximately 12:00PM, she confirmed that this situation would be neglect if it is accurate. b) Resident #3 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the progress notes dated 04/26/26 for Resident #3 reads: Resident was given grilled cheese on dinner tray. Her diet order is for mechanical soft. Resident ate some of the grilled cheese before the Nurse Aide (NA) noticed and she coughed a few times and then was fine. NA took the tray and got her another one that she could eat without problem. Lumina contacted and spoke with [the provider] and she ordered to document situation and if there were any further coughing or congestion episodes to call back. The diet orders for Resident #2 include mechanical soft texture (a diet that consists of foods that are moist, soft-textured and easily formed into a bolus). The Diet and Nutrition Care Manual for a mechanical soft diet lists grilled sandwiches as foods to avoid. An interview with nurse consultant #87 on 04/29/26 at 1:30PM confirmed this incident occurred according to the documentation and was not reported.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record reviews and staff interviews the facility failed to develop and implement a person centered comprehensive care plan regarding activities for residents #37,#29,#25,#8,#1,#2, and accidents hazards for resident #54,#57 and Positioning and mobility for residents #7 and #18. These failed practices had the potential to affect more than a minimal number of residents residing in the Long Term Care Facility. Resident Identifier: #37,#29,#25,#8,#1,#2,#57 #7 and #18 Facility census: 57 Findings Included: a) Resident #37 Record review completed on 04/23/26 revealed the following Activities-Resident Preferences Evaluation Section A Daily Preferences Question nine (9) Daily preferences note Resident stated he likes to play cards and checkers. Resident enjoys taking showers in the evening. Section B Activity Preferences question two (2)a Preferred music genre(s): Early listening, Ethnic/Heritage, Jazz, Modern/Current. Further record review of Resident37's Care Plan revealed to not be person centered no mentioning of preferences such as Cards, checkers or types of music the resident prefers to listen to are in the residents plan of care. During an interview on 04/27/26 at approximately 3:00 PM with the Activity Director while Registered Nurse Coordinator # 87 present. the activity director confirmed care plans were not person centered and set individualized goals. b) Resident #29 Record review completed on 04/23/26 revealed the following; Activities-Resident Preferences Evaluation review revealed the following: Resident #29 enjoyed judge shows, criminal discovery shows, Martyr Mystery, and criminal documentaries. Resident enjoys going on outings with her son. Section B Activity Preferences question two (2)a Preferred music genre(s): Rock and country. Question nine(9) Activity Preference Note: Resident prefers not to participate in group activities at this time. Resident enjoys participating in one-on-one activities with activity staff and self-directed activities. Section B Activity Preferences question two (2)a Preferred music genre(s): Rock and county. Further review of Resident #29's care plan revealed no mention of one-on-one activities, preferred TV shows, or the type of music resident #29 enjoyed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview, on 04/27/26 at approximately 3:00 PM, with the Activity Director while Registered Nurse Coordinator # 87 present the Activity Director confirmed that care plans were not person centered and lacked individualized goals. c) Resident #25 Record review completed on 04/23/26 revealed the following; Activities-Resident Preferences Evaluation~ Section A Daily Preferences Question nine (9) Daily preferences note: Resident prefers to rest throughout the day. Residents enjoy social visits Resident enjoys going on outings with her son. ~ Section B Activity Preferences question two (2)a Preferred music genre(s): Rock and county.Question nine(9) Activity Preference Note: Resident prefers not to participate in group activities at this time. Resident enjoys participating in one-on-one activities with activity staff and self directed activities. is all marked as preferences Further record review of resident #25's care plan showed no preferences for one on one activities by staff, TV shows or type of music Resident #25 prefers. During an interview on 04/27/26 at approximately 3:00 PM with the Activity Director while Registered Nurse Coordinator # 87 present. The activity director confirmed care plans were not person centered and set individualized goals. d) Resident #8 Activities. Record review completed on 04/23/26 revealed the following; Activities-Resident Preferences Evaluation~ Section A Daily Preferences Question nine (9) Daily preferences note: Resident prefer to stay in bed and not participate in Out of Room (OOR) or group activities at this time. Residents go out Monday, Wednesday, and Friday for dialysis. Resident enjoys talking on her cell phone to family and friends. ~ Section B Activity Preferences question two (2)a Preferred music genre(s): inspirational/Religious, Jazz, Modern/Current.Question nine(9) Activity Preference Note: Resident does not participate in OOR activities at this time. Resident actively participates in self directed activities of interests is all marked as preferences Further record review of Resident #8's care plan shows no preferences for music. During an interview on 04/27/26 at approximately 3:00 PM with the Activity Director while Registered Nurse Coordinator # 87 present. the activity director confirmed care plans were not person centered and set individualized goals. e) Resident #1 Record review completed on 04/23/26 revealed the following; Activities-Resident Preferences Evaluation~ Section A Daily Preferences Question nine (9) Daily preferences note: Residents prefer to stay in bed and sleep most days. Other times when Resident #1 is up, he enjoys sitting in the hallways talking with other residents and staff that goes by. ~ Section B Activity Preferences question two (2)a Prefered music genre(s): Country and Modern/Current.Question nine(9) Activity Preference Note: Resident participates in self directed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	activities of interests, Resident prefers not to participate in group activities at this time. Residents at times will allow a one on one activity of his choice. Further review of Resident #1's care plan revealed personal specific goals to be set for the one on one visits. During an interview on 04/27/26 at approximately 3:00 PM with the Activity Director while Registered Nurse Coordinator # 87 present. The activity director confirmed care plans were not person centered and set individualized goals. f) Resident # 54 Accidents During a check for fall prevention measures on 04/14/26 at 1:00 PM, Resident #57 was observed lying in his bed with the right fall mat leaned along the wall behind the headboard. Record review completed on 04/14/26 showed the care plan had an intervention stating Fall matts to bilateral sides of bed while resident is in the bed During an interview with LPN #65 on 04/14/26 at 1:05 PM who confirmed floor matt was not in place and statedI'll get that down now they just laid Resident #54 down

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review, observation, and staff interview, the facility failed to post accurate nurse staffing data in a prominent location viewable by staff and visitors. This was found to be true for 22 days of 23 days of staffing reviewed during the long term care survey process. Facility census: 57.Findings included: a) The surveyor attempted to find the daily nursing staffing data sheet upon entrance to the facility on [DATE], and could not find it. Upon asking where it was posted, the Director of Nursing took me to the nurse's station where the posting was located on the wall near the nurses station. The surveyor requested nursing staffing data sheets and time punch detail sheets for staff for the following days:-04/25/26-04/19/26-04/18/26-03/29/26-03/28/26-02/15/26-02/14/26-12/27/25-12/26/25-12/24/25-11/29/2[illegible] review of the posted nurse staffing sheets found the following inaccuracies:-Inaccurate dates were posted nurse staffing sheets on the following dates:10/5/25 actual date, 10/5/26 was date listed on the posting04/18/26 actual date, 4/18/25 was date listed on posting04/19/26 actual date, 04/19/25 was date listed on posting During an observation on 04/28/26 at 12:02 AM, the staffing numbers for the night shift on the daily nurse staffing sheet documented two (2) Licensed Practical Nurses (LPN), three (3) Nurse Aides (NA) and zero (0) Registered Nurses (RN) working. A visual count confirmed one (1) LPN, 0 RN, and 2 NA. Nurse Aide #5 was sleeping on duty upon arrival to the facility. Nurse Aide #10 was in the breakroom with a makeshift office set up using a table, laptop, battery charger, and large rolling briefcase. Later, the surveyor learned one NA was sitting 1:1 with a resident, leaving two NAs to cover the 56 other residents in the facility. During an interview with LPN #36, when asked about another LPN working per the posted daily nurse staffing sheet, he replied the other LPN is pregnant and called in sick. When asked if this would cause some work to not be completed, he responded that if he worked hard, they would get it all done. During an interview with the Regional Director of Operations (RDO) on 04/28/26 at 12:35 AM, the surveyor reviewed the staffing sheet discrepancy, and the findings: one NA was sleeping, and the other was conducting business on his laptop. Other inaccuracies found were:-04/25/26 Unable to discern actual number of NAs working on day and evening shifts, as changes were made on top of writing-04/19/26 Total hours worked were wrong on staffing sheet, 165.5 were posted, versus 156.8 actual hours worked.-04/18/26 Total hours worked were wrong on staffing sheet. 150.5 was posted, versus168.08 actual hours worked.-03/29/26 Total hours worked were wrong on staffing sheet. 159 was posted, versus167.6 actual hours worked.-03/28/26 Total hours worked were wrong on staffing sheet. 142.5 was posted, versus150.33 actual hours worked.-02/14/26 Total hours worked were wrong on staffing sheet. 127.5 was posted, versus 124.66 actual hours worked.-12/27/25 Total hours worked were wrong on staffing sheet. 162 was posted, versus 180.36 actual hours worked.-12/26/25 Total hours worked were wrong on staffing sheet. 155.5 was posted versus168.8 actual hours worked.-12/24/25 Total hours worked were wrong on staffing sheet. 181.5 was posted, versus 191.98 actual hours worked.-11/29/25 Total hours worked were wrong on staffing sheet. 146.75 was posted, versus 157.2 actual hours worked.-11/28/25 Total hours worked were wrong on staffing sheet. 158.75 was posted, versus 170.2 actual hours worked.-11/27/25 Corrections made on top of actual hours and number of staff, so it is not clear which numbers are correct.-11/01/25 Total hours worked were wrong on staffing sheet. 151 was total based on staffing sheet, actual actuals were 164.25.-10/31/25 Total hours worked were posted as 155.62. Adding the hours on the nurse staffing sheet, you get 147.5. Using time detail report, total hours worked were actually 167.33.-10/30/25 It is unclear as to the number of Nurse Aides working on 1st shift. Total hours worked were 143 versus actual hours worked being 178.98.-10/11/25 Total hours worked were wrong on staffing sheet. 129 hours was posted, versus 160.31 actual hours worked.-10/10/25 Total hours worked were wrong on staffing sheet. 158 hours was posted, versus 175.05 actual hours worked.-10/09/25 Total hours worked were wrong on (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staffing sheet. 158.75 was posted, versus 205.97 actual hours worked.-10/08/25 Total hours worked were wrong on staffing sheet. 158.25 was posted, versus 176.71 actual hours worked.-10/07/25 Total hours worked were wrong on staffing sheet. 146 was posted versus 160.62 actual hours worked.-10/06/25 Total hours worked were wrong on staffing sheet. 135 was posted versus 144.69 actual hours worked.-10/05/25 Actual number of NAs working on 1st shift is posted as three (3,) when according to punch detail report there were four (4). Total hours worked were wrong on staffing sheet. 154,5 was posted versus 168.12 actual hours worked. Samples of the descrepancies were reviewed with RN Consultant on 04/28/26 mid afternoon.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interviews, staff interviews, observations, the facility administration failed to effectively operate the facility in a manner that ensured residents attained or maintained their highest practicable physical, mental, and psychosocial well-being. The facility failed to provide administrative oversight to ensure adequate staffing, resident protection systems, abuse/neglect reporting and investigation, and a person-centered activity program were implemented and monitored. These systemic failures resulted in repeat deficient practices and had the potential to affect all residents residing in the facility. Facility census: 57.Findings include:Review of staffing schedules, punch detail reports, and Hours Per Patient Day (HPPD) calculations revealed the facility failed to maintain minimum staffing levels on 2 of 23 reviewed days.On 04/25/26, the HPPD was calculated at 1.99 using posted staffing data and 2.59 using punch detail sheets.On 02/14/26, the HPPD was calculated at 2.19 using staffing data sheets and 2.14 using punch detail sheets, below the minimum required 2.25 HPPD.Review of the CASPER report revealed the facility triggered for low weekend staffing during Quarter 1 of 2026.During an interview on 04/20/26 at 1:55 PM, Resident #1 stated he had been left overnight in a soiled brief while experiencing diarrhea despite requesting assistance from staff. Resident #1 stated when staff changed him the following morning, his bottom was sore all the way up to the front.During a telephone interview on 04/21/26 at 12:50 PM, CNA #25 stated she had changed Resident #1 on 04/18/26 prior to leaving work and returned the following day to assist another aide. CNA #25 stated Resident #1 reported he had not been changed overnight despite requesting assistance from night shift aides. CNA #25 stated Resident #1 was raw and his skin was bad.During an interview on 04/21/26 at 1:25 PM, CNA #58 stated Resident #1 reported staff changed his roommate during the night but did not return to change him. CNA #58 stated the resident's skin was pretty bad and raw and red.Review of the medical record revealed a wound care order dated 04/19/26 for excoriation to the sacrum and scrotum; however, no skin assessment had been completed prior to the order. Previous skin assessments dated 04/08/26 and 04/15/26 documented no skin issues.These findings demonstrated that the facility failed to provide adequate administrative oversight, which meant sufficient staffing and monitoring systems were not in place to prevent neglect and ensure resident care needs were met.Facility policy titled Abuse defined neglect as failure of the facility or its staff to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy further required allegations involving abuse, neglect, exploitation, or mistreatment to be reported timely to the administrator and appropriate state agencies.Review of facility reportable and grievance logs revealed no investigation was initiated regarding Resident #1 being left overnight in a soiled brief resulting in excoriation and skin breakdown.During an interview on 04/22/26 at approximately 12:00 PM, the Administrator confirmed the incident involving Resident #1 was not reported to the state agency.Further review revealed the facility also failed to report a crime involving cannabis gummies brought into the facility and offered to other residents to the state agency, and failed to thoroughly investigate reasonable suspicion of that crime.During an interview, Anonymous Resident #1 reported that on 04/03/26 two residents purchased cannabis gummies through DoorDash and offered them to other residents. The resident reported both residents were later sent to the hospital after one became noticeably impaired.Review of facility reportable and grievance logs revealed no investigation had been completed for Resident #5 and Resident #42 regarding changes in condition related to cannabis gummies being brought into the facility and offered to residents.Review of nursing documentation dated 04/03/26 revealed Resident #5 exhibited altered mental status, reddened eyes, lethargy, and an elevated pulse of 105 after consuming a pot gummy. Documentation revealed staff discovered additional gummies and vape pens in the resident's room, and the resident required transfer to the emergency department for evaluation and toxicology screening.These findings demonstrated that facility administration failed to ensure (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	systems were in place for reporting, investigating, and responding to allegations of neglect, abuse, and significant changes in resident condition.Based on resident interviews, Resident Council review, observations, record review, and staff interviews, the facility failed to provide an ongoing activity program that met the interests and psychosocial needs of residents.During the Resident Council meeting on 04/14/26, residents voiced concerns regarding repetitive and non-age-appropriate activities, lack of evening activities, and limited meaningful engagement. Residents reported activities primarily consisted of bingo, cartoons, coloring, and children's games.Record review of activity calendars from January through April 2026 revealed repetitive programming including cartoons, [NAME] Says, Hungry Hippos, poster making, and Connect Four. The calendars also included a daily smoking break labeled Puff Masters and Pioneers as a scheduled activity.Review further revealed minimal evening programming after 3:00 PM and no structured sensory programming for low-functioning residents.Observation on 04/21/26 at 7:00 PM and again at 8:00 PM revealed residents sitting in hallways and the television room without staff interaction or organized activities.During an interview on 04/27/26, the Activity Director stated there was no specific list of residents requiring sensory stimulation programming and stated room visits were conducted during one-on-one visits.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to maintain a complete accurate medical record for resident #54 regarding Nothing by Mouth (NPO) Resident #63's skin assessments, Resident#18's NPO orders, and Resident #63's POST form. These were random opportunities of discovery during the Long-Term care survey process and has the potential to affect more than a minimal number of residents residing in the facility. Resident identifier: #54, #63, #18 Facility census: 57 a) Resident #54 Record review of orders completed on 04/13/26 revealed the following intervention in the care plan may give all medications and liquids via gastrostomy tube r/t resident is NPO Further record review revealed the following orders; Lorazepam oral concentrate 2 MG/ML Give .25 ML by mouth three times a day Neomycin sulfate oral tablet 500 MG give two tablets by mouth two times a day During an interview with LPN #65 when asked about giving medications to Resident #54 by mouth she stated No he gets all of his medicine by g-tube and confirmed the order was not correct and stated I will call and get those clarified now.' b) Resident #18 Resident has orders for nil per os (NPO) diet, texture and consistency, meaning nothing by mouth. During a record review on 04/23/26, there is an order for Neurontin: give one (1) capsule by mouth three (3) times a day and an order for Zanaflex: give two (2) [milligrams] mg by mouth four (4) times a day. In an interview with LPN #69 at 4:10PM on 04/27/26, she stated she has not given Resident #18 anything by mouth throughout this month. She stated the documentation that she signed showing Resident #18 received medication by mouth on the Medication Administration Record (MAR) was incorrect. In an interview with Director of Nursing on 04/28/26 at 1:30PM, it was confirmed that Resident #18 is to have nothing by mouth and she had two (2) medications ordered by mouth and documentation that it was being administered by mouth. c) Resident #2 During an interview with Resident #2 on 04/23/26 at 9:10AM, he stated he had not been out of bed for about two (2) months, since his back surgery. In an interview with Nurse Aide (CNA) #4 at 11:30AM on 04/23/26, she stated Resident #2 has not been up since his surgery. She stated that using the Hoyer lift hurts his knee, and although they attempted to convince him to get up, he refused. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview with Registered Nurse Unit Manager (RNUM) #63 at 11:30AM on 04/23/26 she stated Resident #2 has not been up since his surgery that she has witnessed. A review of Chair/Bed-to-Chair Transfer tasks for Resident #2 notes that Resident #2 required substantial/maximum assist or was dependent with transfers on the following dates: -04/01/26 -04/02/26 -04/08/26 -04/09/26 -04/10/26 -04/11/26 -04/12/26 -04/15/26 -04/15/26 -04/20/26 A review of sit to stand tasks for Resident #2 notes that he required substantial/maximum assist or was dependent with these transfers on the following dates: -04/02/26 -04/10/26 -04/16/26 -04/20/26 A review of toilet transfer tasks notes that Resident #2 was dependent with toilet transfers on the following dates: -04/07/26 -04/10/26 -04/11/26 -04/16/26 -04/20/26 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the task labeled wheel 50 feet with two turns, show that Resident #2 was dependent and using a manual wheelchair on the following dates: -04/01/26 -04/02/26 -04/08/26 -04/09/26 -04/10/26 -04/11/26 -04/15/26 -04/16/26 -04/20/26 The five (5) day Minimum Data Set (MDS) dated [DATE] for Resident #2 has sit to stand and toilet transfers labeled as inapplicable, and chair/bed-to-chair transfers labeled as not attempted due to medical conditions or safety concerns. The question regarding the use of a wheelchair is marked no. An interview with Director of Nursing on 04/28/26 at 1:30PM confirmed incorrect documentation regarding Resident #2's transfers.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon record review and staff interview, the facility failed to notify the ombudsman and resident/resident representative of the resident's transfer and provide information on the bed hold notification. This was found to be true for two (2) of two (2) residents reviewed during the long term care survey process. Resident identifiers: #62, #27. Facility census: 57. Findings included: a) Resident #62 Resident #62 was admitted to the facility on [DATE]. Resident was transferred to (name of local Hospital) on 03/10/26 after being found unresponsive. The resident did not have capacity to make their own medical decisions. The progress notes from the resident's medical record pertaining to this day included the following: 3/10/2026 04:40*Nursing NoteNote Text: Resident had anormal v/s [vital signs] and lethargic, right arm swollen, legs and feet swollen called NP [Nurse Practitioner] [first and last name of Nurse Practitioner] stated to send her to the [name of acute care facility] ER [Emergency Room]ambulance is here to transfer her outto the ER 3/10/2026 09:18*Nursing NoteNote Text: Called [name of acute care facility] for update. Spoke with [first name of staff] in ER. Stated, Resident will be admitted to ICU at [name of acute care facility] when bed comes available with Dx [diagnosis] of UTI [Urinary Tract Infection], Septic Shock, Respiratory Failure, bil plueral effusion and lung mass. MPOA [Medical Power of Attorney] aware. 3/11/2026 06:51 Orders - Administration NoteNote Text: Resident admitted to [acute care facility] A review of the documentation for the acute transfer found that the facility representative signed the bed hold notice, however, there was no documentation to support the verbal notification, such as a second signature or verification that the bed hold notice had been mailed to the resident's representative for signature. Additionally, the bed hold notice included the bed hold policy as well as a list of resources available for contacting if the resident was dissatisfied with their transfer/discharge. The surveyor requested verification that the Long Term Care Ombudsman was notified of the transfer. The facility could not produce this documentation. b) Resident #27 Resident #27 has the capacity to make their own medical decisions. The resident's medical record documents the resident was transferred to an acute care facility on 12/28/25, returning to the long-term care facility on 01/05/26. The progress notes in the medical record on the transfer date included the following: 12/28/2025 13:29*Nursing NoteNote Text: LPN came to this nurse and stated resident had slurred speech and was lethargic. Upon assessment, resident noted to be laying in the bed and unable to keep eyes open. Upper extremities noted to be twitching intermittently. Skin noted to be pallor. B/P [Blood Pressure] 58/47. Unable to obtain pulse and O2 D/T [due to] resident being uncooperative. Resident able to awake long enough to respond Yes to going out to the ER after this nurse asked if she would go. Resident very disoriented. [Name of EMS] attendees X 2 arrived via stretcher for transport to [name of acute care facility]. All appropriate paperwork sent with attendees. Report called in to [name of acute care facility] ER. Physician, UM [unit manager], and DON notified. A review of the acute transfer form and paperwork provided by the facility found the ombudsman was not notified of the transfer. The transfer paperwork and findings for both residents were reviewed with the Director of Nursing (DON) at 04/23/2026 9:54 AM. She acknowledged it. This was also reviewed with the NHA (Nursing Home Administrator) on 04/23/26 at 10:58 AM.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interview, the facility failed to update the Pre-admission Screening and Resident Review (PASARR) when a diagnoses of Post Traumatic Stress Disorder (PTSD), was added for Resident #5. This was true for one (1) of four (4) residents reviewed for PASARR. Resident identifier: #5. Facility census: 57. Findings included: Findings included: a) Resident #5 On 04/27/26 at 2:46 PM a review of the medical record found that a PASARR had been completed on 11/17/26 for Resident #5. Resident #5 was transferred from another facility on 11/17/26. A diagnosis of PTSD was added on 11/21/26. This PASARR was not updated to reflect the PTSD diagnosis. The Registered Nurse (RN) #85 confirmed this on 04/28/26 at approximately 10:45 AM.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, Resident Council review, record review, observations, and staff interviews, the facility failed to provide an ongoing, person-centered activity program that met the interests and needs of the resident population, including providing age-appropriate activities, evening programming, and individualized/sensory activities for low-functioning residents.This deficient practice had the potential to affect all residents residing in the facility by failing to promote psychosocial well-being, meaningful engagement, and quality of life. Resident identifier; #48,#19,#25,#8,#1,#2,#3,#37,#45,#23 Facility Census; 57 Findings include:a) Resident Council Concerns and Resident InterviewsDuring an initial interview on 04/20/26 at 12:50 PM, Resident #2 stated the activity staff hardly ever come into his room for activities.During the Resident Council meeting held on 04/14/26 at 11:00 AM, Residents #48, #19, #23, #3, #37, and #45 voiced concerns regarding the facility's activity program. Residents expressed a desire for more age-appropriate programming, stating that current activities primarily consist of bingo with candy prizes, cartoons, and coloring. While some residents reported enjoying crafts, they indicated a preference for more adult-oriented group activities, including music and interactive programming.Resident #37 stated, The activities here are elementary, and further reported there are no consistent evening activities, with only occasional movie nights offered. Resident #25 stated, Yeah, we get offered coloring and cartoons, and indicated that requests for evening activities had been discussed in prior Resident Council meetings a month or two ago, with no implementation noted. b) Activity Programming ReviewRecord review completed on 04/27/26 of the facility's activity calendars from January 2026 through April 2026 revealed repetitive activities that were not age-appropriate for the adult resident population. Examples include:January: Connect Four, poster making, cartoons, Hungry HipposFebruary: Cartoons, [NAME] Says, Connect FourMarch: Cartoons, [NAME] Says, Connect FourAdditionally, the calendar included a daily scheduled activity titled Puff Masters and Pioneers from 1:00 PM to 1:30 PM, which was identified as a facility-designated smoking break rather than a structured activity.Review further revealed limited activity offerings after 3:00 PM, typically consisting of only one (1) to two (2) activities, such as an evening movie or a group session titled Singing with [NAME].A request was made for a list of residents requiring sensory stimulation programming for low-functioning residents. The Activity Director (AD) stated, I don't have a particular list of residents who require sensory stimulation activities; we just do room visits when we complete one-on-ones. No additional documentation or structured sensory programming was provided for review.Review of resident care plans indicated they were not consistently person-centered or reflective of individual preferences and needs as identified in the comprehensive assessments. c) ObservationObservation conducted on 04/21/26 at 7:00 PM revealed residents seated in the hallway and television room without staff interaction or structured activities.Continued observation at 8:00 PM on the same date showed residents remained in the television room without engagement or staff-led programming.Observations indicated that no organized activities were provided after 4:00 PM unless self-directed by residents. d) Staff InterviewsOn 04/14/26 at 4:00 PM, residents were observed sitting in the hallway doorway and television room. Licensed Practical Nurse (LPN) #65 was asked whether evening activities were offered and stated, Not that I am aware of. Some residents watch TV; however, I am normally only here until 6:00 PM.During an interview on 04/27/26 at approximately 3:00 PM, the Activity Director (AD) stated, I base my activities on what they want through Resident Council. When asked specifically about evening activities, the AD stated, We talk about it in Resident Council; they are fine with it.

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	515186	A. Building B. Wing	04/30/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, staff interview, staff postings review and resident interview the facility failed to ensurse sufficient nursing staff across all shifts and units to meet the needs of depdendent residents. Resident identifiers: #1. Facility census: 57. a) Findings included:During the resident council meeting on 04/22/25, the residents voiced concerns of call lights are answered sometimes after 1-3 hours. Residents stated that staff would say they would be right back, but they never returned or came back hours later claiming they had been outside smoking with a resident. -04/20/26 Resident #8 stated, Sometimes it takes a while to get help.-04/20/26 at 12:39 PM, Resident #2 stated, Night shift takes forever to answer a call light.-04/20/26 at 1:43 PM, Resident #25 stated, It takes an hour to answer the call light. I have to go to the bathroom a lot because of my meds.-04/21/26 at 10:33 AM, Resident #27 stated, I frequently wait 45 minutes or more to get changed. At the 4:00 PM smoke break, all the Nurse Aides and one nurse accompany the residents outdoors to smoke, leaving one nurse to cover the entire floor. After 5:00 PM, they won't even bother to answer call lights, you are forced to wait until day shift comes on. If you need to be changed during meal tray pass, they will tell you to wait until they are through with passing trays.-04/20/26 at 9:36 PM, Resident #5 stated, They need more help. A record review of the following days was completed. This involved using the posted daily nurse staffing sheet along with the detail punch time sheets for each staff member to match the posted daily nurse staffing sheet, and calculating the Hours Per Patient Day (HPPD). -On 04/25/26, the HPPD was calculated at 1.99 using posted staffing data and 2.59 using punch detail sheets.On 02/14/26, the HPPD was calculated at 2.19 using staffing data sheets and 2.14 using punch detail sheets, below the minimum required 2.25 HPPD. These findings were reviewed with RN Consultant #87 on 04/29/26 late afternoon. b) Resident #1 A policy titled Abuse includes a definition for neglect that reads: neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. During the initial interview with Resident #1 on 04/20/26 at 1:55 PM, he stated he had been left overnight without having his brief changed and had been experiencing diarrhea. Resident #1 stated he requested to be changed. Resident #1 stated that when they did change his brief the next morning, the bowel movement had to be picked off and his bottom all the way to the front was sore. In an interview with Nurse Aide (NA) #25 via telephone at 12:50 PM on 04/21/26, she stated she changed Resident #1 on Saturday, 04/18/26 before she left for the day. She stated she went back on Sunday, 04/19/26 to assist his aide and Resident #1 stated he had not been changed since CNA #25 did it the day before. Resident #1 stated he had asked the night shift aides to change him, but they came in, changed his roommate and left. NA #25 states Resident #1 was raw and his skin was bad! CNA #25 stated she reported the issue to Licensed Practical Nurse (LPN) #69 immediately. In an interview with CNA #58 via telephone on 04/21/26 at 1:25PM. She stated she went in to change a wet and soiled brief on Sunday morning. Resident #1 stated he had not been changed all night. He stated he had asked the aides that came in to change his roommate, but the aide said they would come back. However the aide left and did not return. CNA #58 states his skin was pretty bad and raw and red. CNA #58 stated she showed LPN #69 immediately, who then notified Registered Nurse (RN) #63.An order written on 04/19/26 reads as follows: Wound Care: Cleanse excoriation to sacrum and scrotum with soap and water, allow to dry then apply barrier cream Shift until resolvedevery shift for wound healing. The active date/time on the order was 04/19/26 at 6:00 PM.The last skin assessments in the Electronic Medical Record (EMR) are from 04/08/26 and 04/15/26 which show no skin issues to the sacrum or scrotum.A record review of the reportables and grievances does not include this situation.In an interview with Administrator on 04/22/26 at approximately 12:00PM, she confirmed that this situation would be neglect if it is accurate.c) During an observation on 04/28/26 at 12:02 AM, the staffing numbers for the night shift on the daily nurse (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staffing sheet documented two (2) Licensed Practical Nurses (LPN), three (3) Nurse Aides (NA) and zero (0) Registered Nurses (RN) working. A visual count confirmed one (1) LPN, 0 RN, and 2 NA. Nurse Aide #5 was sleeping on duty upon arrival to the facility. Nurse Aide #10 was in the breakroom with a makeshift office set up using a table, laptop, battery charger, and large rolling briefcase. Later, the surveyor learned one NA was sitting 1:1 with a resident, leaving two NAs to cover the 56 other residents in the facility. During an interview with LPN #36, when asked about another LPN working per the posted daily nurse staffing sheet, he replied the other LPN is pregnant and called in sick. When asked if this would cause some work to not be completed, he responded that if he worked hard, they would get it all done. During an interview with the Regional Director of Operations (RDO) on 04/28/26 at 12:35 AM, the surveyor reviewed the staffing sheet discrepancy, and the findings: one NA was sleeping, and the other was conducting business on his laptop. Review of the CASPER report also revealed the facility triggered for low weekend staffing during Quarter 1 of 2026.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and resident and staff interviews, the facility failed to provide meals that were palatable and attractive. This had the potential to affect all residents receiving nutrition from the kitchen. Resident identifiers: #2, #35 and #27. Census: 57Findings include: a) Resident #2 During initial interviews on 04/20/26 at 12:55PM, Resident #2 stated that the food is terrible. b) Resident #35 On 04/21/26 1:47 PM Resident #35 stated the food is sometimes cold and it does not taste good A sample tray with hamburger and french fries was brought to state surveyors on 04/28/26. The hamburger was not apealing to they eye, the French Fries were mushy and pale, the hamburger lacked seasoning and left a tasted not desired after eating, On 04/28/26 at 1:00 PM Registered Nurse Consultant #87 confirmed the meal looked unappetizing. c) Resident # 27 During initial interviews on 04/21/26 at 10:35 AM, Resident #27 stated, The food is terrible. It is so bad, that I order all of my food in. This should not have to be the way it is, since I already pay once for it.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on record review and staff interviews, the facility failed to ensure Resident #3 received food in the form to meet her needs. This was a random opportunity for discovery during the Long-Term Care Survey Process. Census: 57 Resident identifier: #3Findings include: a) Resident #3 A review of the progress notes dated 04/26/26 for Resident #3 reads, Resident was given grilled cheese on dinner tray. Her diet order is for mechanical soft. Resident ate some of the grilled cheese before the [Certified Nurse Aid] CNA noticed and she coughed a few times and then was fine. CNA took the tray and got her another one that she could eat without problem. Lumina contacted and spoke with [the provider] and she ordered to document situation and if there were any further coughing or congestion episodes to call back. The diet orders for Resident #2 include mechanical soft texture (this diet consists of foods that are moist, soft-textured and easily formed into a bolus).The Diet and Nutrition Care Manual for a mechanical soft diet lists grilled sandwiches as foods to avoid. An interview with Registered Nurse Consultant #87 on 04/29/26 at 1:30PM confirmed Resident #3 is ordered a mechanical soft diet and that a grilled cheese sandwich is not on that diet.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interview the facility failed to ensure pans were dry before stacking rusulting in Wet nesting a dangerous practice of stacking or storing washed, wet items (like bowls, plates, or pots) together before they are fully dry. This trapped moisture creates a dark, low-air environment that allows bacteria to grow rapidly this failed practice had the potential to affect more than a minimal number of residents residing in the long termcare facility. Facility censuse:57During the initial tour of the kitchen on 04/20/26 with the Dietary Manager, two (2) metal pans and one clear plastic serving container was observed on the shelf stacked and wet. The Dietary Manager pulled them and stated, I'll take care of these now. On 04/21/26 at 10:00 AM during a follow-up kitchen tour, another metal pan was observed wet on the shelf. The Dietary Manager confirmed the pan was wet and removed it.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations and staff interview the facility failed to ensure call light was within reach of Resident #54. This was a random opportunity for discovery. Resident identifier: #54 Facility census: 57Findings Include: a) Resident #54On 04/22/26 at 2:10 PM the surveyor observed Resident #54 in a geri chair beside his bed. The call light was hanging off the back of the headboard, out of reach.During an interview on 04/22/26 2:30 PM with Nurse Aide (NA) #30 this surveyor asked where his call light was, NA#30 stated, We normally hook it to his shirt but he can point and tell us what he needs,it should be within reach to get our attention. An interview with the Director of Nursing (DON) on 4/23/26 at approximately 11:00 AM confirmed that the call light should be within resident's reach.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on record review, staff and resident interview, the facility failed to ensure a resident's right to receive written notice, including reason for change, before resident's room or roommate is changed. Resident identifiers: #45, and #25. Facility census: 57. Findings included: a) Resident #45 On 04/20/26 at 1:59 PM, Resident #45 reported she was not notified that her room was being moved until the facility came to move her room on 03/05/26 and was never notified in writing. On 04/23/26 at approximately 12:30 PM, during an interview, the Social Worker reported she notified Resident #45 verbally prior to changing her room that she would be moving that day to another room because this room was needed for isolation on 03/05/26. She reported she did not notify Roommate #25 that she was getting a roommate and did not notify either party in writing. Review of document titled Hill Valley Healthcare Room Change/Roommate Assignment revealed the following: Specific Procedures/Guidance2. Prior to changing a room or roommate assignment all parties involved in the change/assignment (e.g., residents and their representatives will be given advance notice of such change.)3. Advance notice of a roommate change will include why the change is being made and any information that will assist the roommate in becoming acquainted with his or her new roommate. b) Resident #25During an interview with Resident #25 on 04/20/26 at 1:30 PM the resident reported that she was not notified she was getting a roommate. She was unaware until her new roommate was moved into her room. On 04/23/26 at approximately 12:30 PM, during an interview, the Social Worker reported that she verbally notified Resident #45 verbally prior to changing her room. She explained that the room change was necessary for an isolation on 03/05/26. She reported she did not notify Roommate #25 that she was getting a roommate and did not notify either party in writing. Review of document titled Hill Valley Healthcare Room Change/Roommate Assignment revealed the following: Specific Procedures/Guidance2. Prior to changing a room or roommate assignment all parties involved in the change/assignment (e.g., residents and their representatives will be given advance notice of such change.)3. Advance notice of a roommate change will include why the change is being made and any information that will assist the roommate in becoming acquainted with his or her new roommate.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, resident interview and staff interview, the facility failed to allow a resident and/or their responsible party to exercise his or her right to file an anonymous grievance for facility and follow grievance policy on a grievance completed for another resident. Resident identifier: #22. Facility census: 57. a) Resident Council Resident Council meeting was held on 04/21/2026 at 11:00 AM with a group of 11 (eleven) residents who reported they had no method to anonymously file a grievance. Residents reported they did not want to report complaints for fear of retaliation. They felt concerns brought up in the resident council were not taken seriously. An interview with the Social Worker on 04/21/26 at 6:39 PM revealed there was no method for an anonymous grievance. She reported residents and family members had to ask a nurse or department head for a grievance form.Review of the Facility policy titled Grievances/Complaints states that residents and their representatives have the right to file grievances, either orally or in writing, with facility staff or the agency designated to hear grievances (e.g., the State Ombudsman). The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on resident interview and record review the facility failed to report a resident allegation of neglect involving not having a brief changed and an instance where a resident was given the wrong consistency of food. The facility also failed to report the reasonable suspicion of a crime where a resident brought in THC gummies and distributed them to other residents. Resident identifiers: #3 and #1. Facility census: 57. Findings Included: a) Resident #1 A policy titled, Abuse includes a definition for neglect that reads, neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.The policy also reads, the organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than [two] 2 hours after allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. During the initial interview with Resident #1 on 04/20/26 at 1:55 PM, he stated staff left him overnight without changing his brief and that he had been experiencing diarrhea. Resident #1 states he requested to be changed. Resident #1 stated that when they did change his brief the next morning, his bottom was sore all the way up to the front. In a telephone interview with Nurse Aide (NA) #25 at 12:50PM on 04/21/26, she stated she changed Resident #1 on Saturday, 04/18/26 before she left for the day. She stated she returned on Sunday, 04/19/26 to assist his aide. Resident #1 stated he had not been changed since CNA #25 did it the day before. Resident #1 stated he had asked the night shift aides to change him, but they came in, changed his roommate and left. CNA #25 states Resident #1 was raw and his skin was bad! NA #25 stated she reported the issue to Licensed Practical Nurse (LPN) #69 immediately. In an interview with CNA #58 via telephone on 04/21/26 at 1:25PM, she stated she went in to change a wet and soiled brief on Sunday morning. Resident #1 stated he had not been changed all night. He stated he asked the aides who came in to change his roommate, but they said they would come back. However, the aides left and did not return. CNA #58 states his skin was pretty bad and raw and red. CNA #58 stated she showed LPN #69 immediately, who then notified Registered Nurse (RN) #63. An order written on 04/19/26 reads as follows: Wound Care: Cleanse excoriation to sacrum and scrotum with soap and water, allow to dry then apply barrier cream. Continue until resolved every shift for wound healing. This order was dated 04/19/26 at 6:00 PM. The last skin assessments in the Electronic Medical Record (EMR) are from 04/08/26 and 04/15/26 which show no skin issues to the sacrum or scrotum.A record review of the reportables and grievances did not include this situation.In an interview with the Administrator on 04/22/26 at approximately 12:00 PM, she confirmed that this situation was not reported to the state office.b) Resident #3 A review of the progress notes dated 04/26/26 for Resident #3 reads: Resident was given grilled cheese on dinner tray. Her diet order is for mechanical soft. Resident ate some of the grilled cheese before the Nurse Aide (NA) noticed and she coughed a few times and then was fine. NA took the tray and got her another one that she could eat without problem. Lumina contacted and spoke with [the provider] and she ordered to document situation and if there were any further coughing or congestion episodes to call back. The diet orders for Resident #2 include mechanical soft texture (a diet that consists of foods that are moist, soft-textured and easily formed into a bolus). The Diet and Nutrition Care Manual for a mechanical soft diet lists grilled sandwiches as foods to avoid. An interview with nurse consultant #87 on 04/29/26 at 1:30PM confirmed this incident occurred according to the documentation and was not (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported. c) During an Interview with an anonymous resident the following was reported: On 4/03/26, two female residents purchased cannabis gummies and had them delivered via Door Dash. The anonymous resident reported that the two female residents offered her a gummy, which she refused. She went on to report both female residents were sent out to the hospital after one of the residents was noticeably impaired. These residents were later identified as Resident #5 and #42. Record review completed on 04/21/26 of the facilities reportable and grievance logs revealed no investigation was completed for Resident #5 and Resident #42 regarding changes in condition due to cannabis gummies being brought into the facility and offered to other residents. The surveyor reviewed a change in condition dated 04/03/26 stating Resident #5 was sent to the local ER for further evaluation and a toxicology screen. The signs and symptoms the resident was displaying included altered mental status and suspicion of substance abuse. Resting pulse was noted as greater than 100 at 105 also. A review of a nursing progress note dated 04/03/26 at 2:00 PM labeled as a late entry revealed the following: Resident was educated on facility policies regarding not being allowed to have OTC medications or CBD products in the room; the resident voiced understanding and agreement.A nursing note dated 04/03/26 at 1:10 PM stated CNA approached this nurse and informed me that Resident #42 had informed her that this resident had given her two gummies and that she consumed one and it tasted bad, so she threw the other one away in her trash can. CNA removed the gummy from Resident #42's trash can and gave it to this nurse. A square red gummy with sugar coating was observed. I then went to speak with this resident, and she was observed lying on her bed with eyes reddened and voiced CO 'feeling tired'. VS then obtained; 108/84, 98.1, 16, 105, 95% off RA. I asked resident what type of gummy she consumed and she stated, 'pot gummies' and pointed towards a wooden box on her bedside table. I asked resident if I could look in the box and she stated, 'yes go ahead'. I opened the wooden box and observed several loose squared red gummies with sugar coating on them, three vape pens, one suspected CBD vape pen, a bottle of Benadryl, and several Imodium tablets in store foil packaging. Resident then informed this nurse that she purchased the gummies and CBD vape pen from door dash. I then asked resident if I could remove the items and she consented. Administrator, DON, and physician was notified. The wooden box with all belongings was released to administrator. New orders received per FNP to send resident out to local ER for further evaluation due to suspicion of substance abuse and obtain a toxicology screen. Resident made aware and in agreement with new order.1:20 PM- (name of emergency medical transport) notified for transport1:25 PM- Report called to (name of hospital) ER nurse1:45 PM- (name of local emergency medical transport) on site x2 attendees to transport resident to local ER. All transfer paperwork was sent with resident.Resident #42 was on the following medications and possible side effects taking medications with Cannabis gummiesProzac (Fluoxetine) 40 MG: Major interaction. Prozac can increase THC levels, causing increased drowsiness, worsening depression, cognitive impairment, or mania.Buspar (Buspirone) 7.5 MG: Potential for serotonin syndrome (confusion, muscle twitching, rapid heart rate) when combined with other serotonergic agents and cannabis.Keppra (Levetiracetam) 750 MG: Increased risk of drowsiness, dizziness, confusion, and difficulty concentrating.Prazosin 1 MG: Potential for increased dizziness or fainting due to additive blood-pressure-lowering effects.A note dated 04/03/26 at 2:27 PM stated, LPN #69 came and notified me that two residents (#42 and #5) consumed unknown substance like gummies. I immediately went to assess this resident while the LPN #29 was notifying the DON, administrator, and Dr. Resident #42 eyes were very red and stated she feels paranoid. Vitals 115/76, 108, 18, 97.9, 92% RA. Resident told this Nurse that she received Two Gummies from (resident #5). She stated the Gummies tasted bad, so she threw the gummy in the trash. The CNA #58, took the Gummy out of the trash and took it to the nurse station. Resident #42 also told this nurse that another resident (#15), knew about the Gummies. This Nurse went and spoke to Resident #15 and the resident stated that Resident #5 came into her room and told her that she has Gummies and THC pens. Resident #5 told Resident #14 that she was going to give resident #42 two gummies. Resident #15 also stated that Resident #5 wrote a letter to a worker, Restorative aide #46 letters and she still had (continued on next page)

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	515186	A. Building B. Wing	04/30/2026

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the letter on her bed, and I can have the letter if I want it. Nurse went to the room and got the letter and gave it to the administrator. Nurse did not read the letter. LPN #24 and LPN #69 were on our way to check on (resident #5) when we noticed a man from Door Dash knocking on the door. The man gave the nurse the bag and exited the facility quickly. It was a pack of cigarettes with a receipt with two CBD purchases on the receipt. The facility administration (administrator and director of nursing) had no evidence that this reasonable suspicion of a crime had been reported to the state survey agency or that a thorough investigation into this matter had been completed. d) Resident #22An interview with Resident #22's daughter was conducted on 04/28/26 at 10:00 AM. The daughter reported she arrived at the facility on 04/07/26 at 6:50 AM, and followed a nurse aide to her room who reported the resident was vomiting throughout the night. When they entered the room, the daughter noticed the resident was wearing the same brief she had on when the daughter left the previous evening, which she had dated for 5:00 PM. Daughter reported the brief was soaked, her mother's health had declined and she asked the nurse to send her to the hospital. She also expressed recent dissatisfaction with care regarding sheet changes and incontinence care, stating she had several conversations with the Director of Nursing. She also reported filing a grievance on this date stating she told staff during the care plan meeting, as well as the Director of Nursing, that her mother had not been changed since the previous day. On 04/28/26 at approximately 4:00 PM, an interview was conducted with the Director of Nursing (DON) and Registered Nurse Consultant #8. They reported that the incident was not classified as abuse/neglect because the facility did not consider the brief to be wet. They would have only changed it if it was wet and would have only reported the incident if they found it to be abuse/neglect. DON did speak with the daughter on 04/07/26; however, the facility could not find any paperwork, grievances, or resolutions for the allegations reported.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on resident interview and record review the facility failed to identify and thoroughly investigate allegations of neglect which included two (2) residents not receiving timely incontinence care and a resident receiving the incorrect texture of food. Resident identifiers: #1, #3 and #22. Facility Census 57. Findings Included: Findings include: a) Resident #1 A policy titled, Abuse includes a definition for neglect that reads: Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. This policy also states, Designated staff will immediately review and investigate all allegations or observations of abuse. The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within [five] 5 working days of the incident. During the initial interview with Resident #1 on 04/20/26 at 1:55 PM, he stated staff left him overnight without changing his brief and that he had been experiencing diarrhea. Resident #1 states he requested to be changed. Resident #1 states when they did change his brief the next morning, his bottom was sore all the up to the front. In an interview with Certified Nurse Aide (CNA) #25 via telephone at 12:50PM on 04/21/26, she stated she changed Resident #1 on Saturday, 04/18/26 before she left for the day. States she went back on Sunday, 04/19/26 to assist his aide and Resident #1 stated he had not been changed since CNA #25 did it the day before. Resident #1 stated he had asked the night shift aides to change him, but they came in, changed his roommate and left. CNA #25 states Resident #1 was raw and his skin was bad! CNA #25 stated she reported the issue to Licensed Practical Nurse (LPN) #69 immediately. In an interview with CNA #58 via telephone on 04/21/26 at 1:25PM. She stated she went in to change a wet and soiled brief on Sunday morning. Resident #1 stated he had not been changed all night. He stated he asked the aides that came in to change his roommate, but they said they would come back. However, the aides left and did not return. CNA #58 states his skin was pretty bad and raw and red. CNA #58 stated she showed LPN #69 immediately, who then notified Registered Nurse (RN) #63. An order written on 04/19/26 at 6:00 PM reads as follows: Wound Care: Cleanse excoriation to the sacrum and scrotum with soap and water, allow to dry then apply barrier cream every shift until resolved for wound healing. The last skin assessments in the Electronic Medical Record (EMR) are on 04/08/26 and 04/15/26 which show no skin issues to sacrum or scrotum. A record review of the reportables and grievances do not include this situation. In an interview with the Administrator on 04/22/26 at approximately 12:00 PM, she confirmed that this situation was not reported or thoroughly investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Resident #22 An interview with Resident #22's daughter was conducted on 04/28/26 at 10:00 AM. The daughter reported she arrived at the facility on 04/07/26 at 6:50 AM, and followed a nurse aide to her room who reported the resident was vomiting throughout the night. When they entered the room, the daughter noticed the resident was wearing the same brief she had on when the daughter left the previous evening, which she had dated for 5:00 PM. Daughter reported the brief was soaked, her mother's health had declined and she asked the nurse to send her to the hospital. She also expressed recent dissatisfaction with care regarding sheet changes and incontinence care, stating she had several conversations with the Director of Nursing. She also reported filing a grievance on this date stating she told staff during the care plan meeting, as well as the Director of Nursing, that her mother had not been changed since the previous day. On 04/28/26 at approximately 4:00 PM, an interview was conducted with the Director of Nursing (DON) and Registered Nurse Consultant #8. They reported that the incident was not classified as abuse/neglect because the facility did not consider the brief to be wet. They would have only changed it if it was wet and would have only reported the incident if they found it to be abuse/neglect. DON did speak with the daughter on 04/07/26; however, the facility could not find any paperwork, grievances, or resolutions for the allegations reported. c) Resident #3 A review of the progress notes dated 04/26/26 for Resident #3 reads: Resident was given grilled cheese on dinner tray. Her diet order is for mechanical soft. Resident ate some of the grilled cheese before the Nurse Aide (NA) noticed and she coughed a few times and then was fine. NA took the tray and got her another one that she could eat without problem. Lumina contacted and spoke with [the provider] and she ordered to document situation and if there were any further coughing or congestion episodes to call back. The diet orders for Resident #2 include mechanical soft texture (a diet that consists of foods that are moist, soft-textured and easily formed into a bolus). The Diet and Nutrition Care Manual for a mechanical soft diet lists grilled sandwiches as foods to avoid. An interview with nurse consultant #87 on 04/29/26 at 1:30PM confirmed this incident occurred according to the documentation and was not reported.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review and staff interview, the facility failed to recognize standards of practice that address the identified limitations in ability to perform activities of daily living (ADL) to ensure Resident #57 received assistance with meals. This was true for one (1) of four (4) sampled for nutrition during the Long-Term Care Survey Process. Census: 57 Resident identifier: #57Findings include: a) Resident #57 The surveyor watched the lunch service on 04/22/26. Resident #57 was served his tray at 12:02 PM. Resident was observed falling asleep periodically during this meal. He finished his meal at 1:27 PM, and staff picked up the tray after he ate 51-75% of the meal. Staff provided no cueing during this time nor offered to reheat his meal. In an interview with Occupational Therapy Assistant (OTA) #20 on 04/23/26 at approximately 3:30 PM, she stated she had dinner with Resident #57 on 04/22/26. She stated she spent 30 minutes in the room and provided cueing for Resident #57 to finish approximately 50% of his meal. In an interview with CNA #4 on 04/28/26 at 11:51 AM, she stated Resident #57 takes a long time to finish his meals. She stated aides must leave his tray after picking up the rest of the trays because he eats so slowly. A review of Resident #57's weights shows he weighed 176 pounds on 02/02/26. On 04/06/26, Resident #57 weighed 170 pounds. This calculates to a 3.41% weight loss in three (3) months. On 12/04/25, Resident #57 weighed 185 pounds. This calculates to an 8.82% weight loss over five (5) months. A risk review note dated 04/01/26 shows a five (5) percent weight loss over 30 days. The interventions are to provide the diet as ordered, a Registered Dietician (RD) consult as needed, record meal percentage intake, and record weights as ordered. The orders for Resident #57 include giving one four (4) ounce serving of fortified pudding in the afternoon. The care plan for Resident #57 includes providing set up only for meals. It was confirmed in an interview with Director of Nursing (DON) at 1:25 PM on 04/28/26 that Resident #57 does not receive any assistance with his meals and that he has experienced weight loss.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review and staff interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards. This failure occurred because orders and a care plan directed applying a splint to the wrong hand for Resident #18. The facility also failed to notify the medical provider when a resident's blood sugar was over 400. Resident identifiers: #18 and #27. Facility census: 57.Findings included: a) Resident #18 During initial interviews on 04/20/26 at 2:20 PM, observeration noted that Resident #18's right hand was tightly fisted and lacked a splinting device. A record review of Resident #18's orders revealed orders to apply and remove a splint to the left hand as tolerated every night shift for mobility. Resident #18 has a diagnosis of a right hand contracture listed in the medical record. The care plan for Resident #18, revised on 03/09/26, reads: left hand splinting as ordered. During an interview with Occupational Therapist (OT) #62 on 04/22/26 at 1:27 PM, she confirmed the splinting order should be for the right hand. An interview with the Director of Nursing on 04/28/26 at 1:25 PM confirmed that the orders and the care plan are written to place a splint on Resident #18's functional hand rather than her contracted hand. b) Resident #27 During a record review, an order for Resident #27's Humalog Kwikpen dated 02/09/26 included, hold for [blood sugar] BS less than 100 and call provider for [blood sugar] BS over 400. A review of the Medication Administration Record for March and April of 2026 showed the following dates with blood sugar over 400:03/02/2603/03/2603/06/2603/11/2603/12/2603/16/2603/17/2603/30/2603/31/2604/03/26The facility could not provide proof of contacting the provider when blood sugars were over 400.Registered Nurse Consultant #87 confirmed at 12:05 PM on 04/29/26 that according to documentation the provider was not notified on the above dates when blood sugar was over 400.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, record review and staff interviews, the facility failed to provide appropriate equipment to maintain mobility with the maximum practicable independence regarding Resident #2's bed rails. This was true for one (1) of three (3) residents sampled for activities of daily living during the Long-Term Care Survey Process. Census: 57 Resident identifier: #2Findings include: A policy titled, Bed Rail Risk and Safety reads: any resident being considered for using a bed with bed rail(s) is evaluated by the facility's interdisciplinary team to determine whether the resident's functional status and bed mobility is improved through the use of bed rail(s), to identify any bed rail that might constitute physical restraint, and to identify individual characteristics that may increase the risk of entrapment by bed rails or mattress. During an interview with Resident #2 on 04/23/26, he stated someone came in and took one of his bed rails which he used to roll on to his side for the aides to clean him up. A review of the Minimum Data Set (MDS) dated [DATE] shows resident requires substantial/max assist to roll to the left and right.A review of the Siderail Consent forms show resident had both handrails on 01/19/25 and 01/27/26, but was changed to one (1) bed rail on 04/16/26.The MDS dated [DATE] also showed that Resident #2 required substantial/max assist with rolling to the left and right.In an interview with Director of Rehab at 11:05AM on 04/27/26, he stated he had performed the most recent bed rail assessment and decided to use only one bed rail because of the risk of entrapment as Resident #2 now requires max assist for rolling.In an interview with Certified Nurse Aide (CNA) # 25 at 1:15PM on 04/27/26, she stated that Resident #2 used the left bed rail during the care process.In an interview with CNA # 4 at 1:15PM, she stated Resident #2 used the left bed rail to help roll and had no issues with it, but that she has not been involved in his care since the bed rail is no longer there.In an interview with CNA #44 at 2:45PM on 04/27/26, she stated that she has provided care for Resident #2 since not having the left bed rail and it makes everything much more difficult. She states he had no issue rolling to the left with the bed rail and since the left side of the bed is against the wall, he now has to roll to the right and she has to reach over him to provide care.In an interview with Director of Nursing (DON) at 1:25PM on 04/28/26, she confirmed Resident #2 has had bed rails on both sides of the bed until 04/16/26 when one was removed with no documentation as to why the left bed rail was removed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, and staff interviews, the facility failed to ensure Resident #48 and Resident #57 received adequate hydration. This was true for two (2) of four (4) residents sampled for hydration during the Long-Term Care Survey Process. Resident identifiers: #48, #57. Census: 57. a) Resident #48 A policy titled, Resident Hydration and Prevention of Dehydration states that nursing staff will provide and encourage intake of bedside, snack, and meal fluids, on a daily and routine basis as part of daily care. During the initial tour of the facility on 04/20/26 at approximately 1:00 PM, it was noted that Resident #48 did not have water at his bedside while in bed. Resident #48 stated that if he needed water, he had to ask for it. He also stated he needed a lot of water because he had undergone a kidney transplant. Again on 04/23/26 at 9:15 AM, it was observed that Resident #48 was in bed without water available at his bedside. Registered Nurse Consultant #86 confirmed that Resident #48 did not have water within reach at 9:21 AM on 04/23/26. During a record review, an ambulatory clinical summary dated 04/02/26 included provider instructions that read: stay active and stay hydrated, drink at least [two liters] 2L of water daily. b) Resident #57 A policy titled, Resident Hydration and Prevention of Dehydration states that nursing staff will provide and encourage intake of bedside, snack, and meal fluids, on a daily and routine basis as part of daily care. During the initial interview on 04/20/26 at approximately 1:15 PM, it was noted that Resident #57 did not have water at his bedside while in bed. On 04/23/26 at 9:15 AM, it was observed that Resident #57 was in bed with his empty water pitcher on his bedside table and out of reach. Registered Nurse Consultant #86 confirmed that Resident #57 did not have water within reach at 9:21 AM on 04/23/26. A record review of Resident #57's care plan includes the following: encourage adequate nutrition and hydration.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and staff interview the facility failed to maintain proper infection prevention by leaving Resident #54's tube feeding syringe open to the elements, this was a random opportunity of discovery during the long term care survey process. Resident Identifier: #54. Facility Census: 57 Findings include;a) Resident #54On 04/20/26 at 1:30 PM observed resident tube feeding syringe was laying out exposed and not covered/bagged and left open to the elements Further observation on 04/20/26 at 2:20 PM showed the tube feeding syringe continued to be exposed to the elements. During an interview with Licensed Practical Nurse (LPN) #65, the LPN stated, I was just in there; I will throw it away, get a new one and date it. This confirmed the tube feeding syringe was not covered.