STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515189	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairmont Rehabilitation and Healthcare Center LLC	130 Kaufman Drive Fairmont, WV 26554

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on policy review, observation, staff interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and that each resident received adequate supervision and assistance to prevent accidents. The facility failed to provide a fire blanket, fire extinguisher, a metal can with a self-closing lid, and staff supervision when Resident #25 was observed smoking in the designated smoking area. Additionally, treatment carts were left unlocked and unattended on the 100 Hallway and the 300 Hallway. Resident Identifier: #25. Facility Census: 106.The facility's failure to follow their Smoking Policy by not providing a fire blanket, fire extinguisher, a metal can with a self-closing lid, and staff supervision when Resident #25 was observed outside smoking in the designated smoking area placed all smoking residents currently residing in the facility at risk for serious bodily harm and/or death. These failures were determined to place all smoking residents in an Immediate Jeopardy (IJ) situation. The facility was notified of the Immediate Jeopardy (IJ) at 7:38 PM on 07/30/25. The State Office approved the facility Plan of Correction (POC) at 9:25 AM on 07/31/25. After observation, staff interview, review of facility documentation, and record review determining the implementation of the POC, the IJ was abated at 9:25 PM on 07/31/25.The IJ started on 07/30/25 at 7:38 P:M and ended on07/31/25 at 9:25 AM.Findings included:a) Resident #25 On 07/30/25 at 11:35 AM, Resident #25 was observed outside with Resident #20 in the designated smoking area. Further observation revealed there was no fire blanket, fire extinguisher, or a metal container with a self-closing lid. A review of the facility's smoking Policy and Procedure, dated October 2017, on 07/30/25 at 12:15 PM, revealed:-The objective of the smoking policy was to promote safety for residents within the facility. It noted that facility staff would provide materials and assist each resident during the posted smoking times, in the designated area.-The policy stated residents may not keep any smoking materials in their room, or on their person.-Residents who smoke were to smoke with direct staff monitoring. It stated a staff member would be assigned to the smoking area during established smoking times for resident safety and supervision.-The assigned staff member was expected to carry a communication device to establish contact with the nursing staff in the event of an emergency-Employee expectations were to monitor residents in the smoking area; provide a fire blanket and fire extinguisher; empty ashtrays into metal containers with a self-closing cover containing sand to reduce risk of fire. Additional guidelines for staff were to monitor the smoking area, distribute cigarettes, conduct walking rounds to observe and intervene for safety issues, and to light cigarettes.During an interview with Resident #25 on 7/30/25 at 12:35 PM, he stated he kept his cigarettes and lighter in the top drawer of his bedside table. He stated that he kept them out on his table today and went out to smoke. He stated that Nurse Aide #53 knew he was going out to smoke today. He stated Resident #20 lit his cigarette for him.Review of Resident #25's smoking evaluation, 07/25/25 at 4:45 PM, noted resident was to be a supervised smoker.On 7/30/25 at 1:00 PM, during a separate interview with Resident #25, he stated his Quadriplegia diagnosis stemmed from an accident where he had fallen off a ladder and broke his neck. The resident reported he was working with therapy to address contractures / stiff hands because of the accident. The Life Safety Surveyor reported that Resident #25 had asked if he would (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	help pick up resident's water tumbler that had fallen in his lap because the resident was unable to pick it up by himself.During an interview on 07/30/25 at 11:50 AM, the Director of Nursing (DON) confirmed that Resident #25 had been in the designated smoking area. The DON also confirmed there was no fire blanket, fire extinguisher, or metal container with a self-closing lid in the resident smoking area at this time. She believed they had been ordered.The facility was notified of the Immediate Jeopardy (IJ) at 7:38 PM on 07/30/25. The State Office approved the facility Plan of Correction (POC) at 9:25 AM on 07/31/25. After observation, staff interview, review of facility documentation, and record review determining the implementation of the POC, the IJ was abated at 9:25 PM on 07/31/25.The Administrator, on 07/30/25 at 11:57 AM, confirmed that the facility had placed an order for a fire extinguisher and a metal container with a self-closing lid approximately two (2) weeks ago. The Administrator also stated that the facility did have fire blankets and acknowledged none had been placed in the designated smoking area for residents. Observation, on 7/30/25 at 3:41 PM, revealed the treatment cart in the 100 hall was left unlocked and unattended in the hall near the Nurses Desk. The surveyor was able to open the drawer without staff noticing. On 7/30/25 at 3:42 PM, LPN #77, acknowledged that he had left the treatment cart unlocked and unattended while he answered a phone call.On 7/3012025 in response to immediate Jeopardy citation F0689 the facility took the following immediate actions: -Ensured resident smoking area contained smoking blanket which was secured in designated area; a metal container with a self-closing lid was placed in area; and fire extinguisher provided-The facility acquired smoking items from smoking residents, and these items were placed in a secure container where these items will be kept when not in use inside locked med room.-The facility immediately initiated education on the smoking policy for residents to staff and residents. At[staff on shift of 7-30-25 were educated and atl incoming staff will be educated prior to starting next shift.-Facility established designated posted smoking times for the residents and an accompanying smoking assignment list of staff who will be providing supervision of residents who smoke with supervision or assistance.-Care plans have been updated for our smoking residents-Facility policy has been updated effective 7130/25 at 5:45 pm-All current smoking resident assessments were reviewed by DON to be accurate and true with no necessary changes from original assessmentObservation, on 7/30/25 at 3:41 PM, revealed the treatment cart in the 100 hall was left unlocked and unattended in the hall near the Nurses Desk. The surveyor was able to open the drawer without staff noticing. On 7/30/25 at 3:42 PM, LPN #77, acknowledged that he had left the treatment cart unlocked and unattended while he answered a phone call. 300 Hall Treatment CartOn 07/28/25 at 3:45 PM, An observation of an unlocked, unattended treatment cart on the 300 Hall. The cart was in a place easily accessible allowing access to medication / treatment supplies by residents, unauthorized persons, or visitors. On 07/28/25 at 4:02 PM, during an interview with the Registered Nurse (RN) #105 it was confirmed the treatment cart was unlocked. RN #105 verified that the treatment cart should not be unlocked when unattended. She closed and locked the treatment cart at this time.No further information was provided prior to the end of the survey on 08/04/25 at 4:30 PM.

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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 interview, record review and investigation, the facility's management, by their inaction, and decisions in administering the facility, contributed to the following deficient practice, namely a failure to train, educate, and verify the competency of the nursing staff to ensure that they could appropriately assess and care for the resident population residing in the facility. Resident Identifiers: Resident #7 and Resident #45. Facility Census: 106.Findings Include:During a review of the records for Resident #7 and Resident #45 on 07/28/25 at approximately 1:00 PM it was revealed that the nursing staff were assessing and documenting the presence and patency of a non-existent AV access, and in addition failing to correctly assess the resident's dialysis accesses for patency, and infection as prescribed by the physician.a) Resident #7During an interview with Resident #7 on 07/28/25 at approximately 3:14 PM, resident stated that she had been on dialysis since 2016. The resident went on to state that her dialysis access was a permacath. She further stated that she went to dialysis on Mondays, Wednesdays. and Fridays. She also stated that she had never had an AV fistula or graft.Record review on 07/28/25 at 10:00 AM revealed a physician's order dated 06/19/25 which statedDialysis: Site of AV shunt Check bruit and Thrill every shift!Record review and interview revealed that Resident #7 did NOT have an AV access shunt. Despite this fact, eight (8) nurses, the RN Unit Manager and the Director of Nursing (DON) signed off / documented over a period of approximately six (6) weeks that they had successfully assessed the residents shunt for patency. Ongoing record review on 07/30/25 at approximately 9:00 AM revealed that from 06/19/25 to 07/29/25 the following staff members had documented that they had assessed the resident's AV access, and had heard the bruit and felt the thrill over the access for bruit and thrill.During an interview with the Administrator and the Director of Nursing (DON) on 07/30/25 at approximately 11:00 AM. They were notified that the nursing staff were assessing and documenting that Resident #7 had a patent AV fistula/graft. The DON stated, As soon as you brought it up I knew that I had worked that unit and assessed that resident. Most times there is so much to be checked off that we automatically click the boxes.b) Resident #45During an interview on 07/30/25 at approximately at approximately 1:22 PM. Resident #45 had just returned to the facility after her dialysis treatment. Record review revealed that resident has a Brief Interview for Mental Status (BIMS) of 15 and is very cognizant of her care requirements and diet. She stated that her access had been revised at the hospital on [DATE] because she had some issues during dialysis. Resident displayed her right arm which had a large dressing over the lower area of her AV fistula. Upon being asked about the monitoring of her access, resident stated that the nursing staff checked her access sometimes!Record review revealed that Resident # 45 too had an order for monitoring of her AV access for bruit and thrill every shift.When Resident #45 was asked about the frequency of the assessments of her AV access, resident stated It was last checked a few weeks ago by that nurse (LPN) #77. Resident stated that no one had checked it since then. Resident #45 went on to state that the dialysis clinic had educated her about checking her access, and she stated that she usually checked it in the mornings.Record review revealed that the assessments were documented every shift by the nursing staff.A review of the facility assessment on 07/30/25 at approximately 9:00 AM revealed that it does not address any training for hemodialysis, or on the care and treatment of residents on dialysis.During an interview with the DON on 07/30/25 at 4:20 PM, the DON stated, We don't have any training! she further stated that she has been the DON since August of 2024, and she has not seen any dialysis training.The facility nursing staff's inability to accurately assess an AV access for patency creates a serious potential for harm to any dialysis patient in the facility. Assessing, and identifying a non-patent AV access allows for an immediate revision of the access, or the insertion of a temporary dialysis catheter to allow the residents to continue receiving their life saving dialysis treatments.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and observations the facility failed to provide residents a confidential way to file a written grievance. This findings had the potential to affect more than a limited number of residents. Facility census: 96. Findings included:a) Grievances On 07/30/25 at 1:40 PM during a Resident Council meeting it was revealed there was no confidential way to file a grievance without telling a staff member. On 07/30/25 at 2:15 PM an observation found no grievance forms readily available throughout the facility. The grievances forms were located at the front of the building behind closed non-handicap accessible double doors with a wander guard lock. During an interview, on 07/30/25 at 2:32 PM, the Administrator stated that the residents could get a form at the nurse's station by asking a staff member or at the front of the building behind the double doors. She also confirmed that most residents would need help getting through the doors to obtain the grievance forms.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and staff interview, the facility failed to report a five day follow up on allegations of abuse or neglect in a timely fashion to the appropriate state agencies. This was a random opportunities for discovery. Resident identifiers: #82. Facility census: 106.a) Resident #82 On 04/10/25, the facility shared an Initial Reporting of Allegations regarding alleged mental/verbal abuse to Resident #82 by Licensed Practical Nurse (LPN) #201 where she called resident an asshole. In an interview, 7/30/24 at 9:10 AM, the Administrator acknowledged the facility had failed to submit a five (5) day follow up to the appropriate state agencies. The administrator reported the facility's investigation into this incident, as well as any staff education, could not be found due to new ownership and files before 05/2025 were not available.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide dependent residents with the assistance needed for showers and personal hygiene. This was true for three (3) of four (4) residents sampled. Resident Identifiers: #24, #72 and #76. Facility Census: 106. Findings Includea) Resident #24During an interview on 07/29/2025 at 10:39 AM, Resident #76 stated that she was scheduled for showers on Tuesday and Friday. The resident explained that the availability of showers depended on staffing levels. She further stated that she was admitted on [DATE] and her first shower occurred on 07/15/25. Record review on 07/29/25 at approximately 10:45 AM revealed that Resident #24 had received a shower on 07/15/25 and 07/19/25. The record also revealed that Resident #24 refused showers on 07/22/25 and 07/25/25. Resident denies refusing showers. She stated, I'll take anything that I can get. b) Resident #72 During an interview with Resident #72 on 07/29/25 at approximately 12:06 PM, the resident stated that she was admitted on [DATE]. Resident #72 stated that she had received a bed bath on 07/14/25. Record review on 07/29/25 at 11:30 AM revealed that Resident #72 received the following:bed bath 07/14/25shower 07/16/25bed bath 07/23/25Resident #72 went on to state that she would be lucky if she could get two baths a week. c) Resident #76 On 07/29/25 at approximately 1:13 PM, Resident #76 stated that she was scheduled for two (2) showers a week. She said that she could request showers, but it depended on who was working. If the staff didn't feel like showering her, she would get a bed bath instead. Resident #76 denied refusing a shower or a bed bath. 07/29/25 2:00 PM record review revealed the following:Refused to shower at 8:45 PM on 07/01/25Shower at 8:44 PM on 07/04/25Shower at 8:33 PM on 07/08/25Bed bath at 9:34 PM on 07/11/25Refused a shower at 10:05 PM on 07/15/25Bed bath at 7:31 PM on 07/25/25. Records reveal that Resident #76 did not receive a bed bath or shower for a period of nine (9) days, between 07/15/25 and 07/25/25 During an interview with the Administrator on 07/30/25 at approximately 10:55 AM, the Administrator provided shower logs and stated that they were accurate. During an interview on 07/29/25 at approximately 3:45 PM, with Nursing Assistants (NAs) #34, #53, and #107, they stated that there were times when, in the evenings, it was difficult to get all the residents on the schedule.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview, and record review, the facility failed to ensure that the nursing staff were adequately educated and trained in the assessment and care of residents on dialysis. This failed practice had the potential to cause serious harm to any dialysis resident in the facility. The facility's failure to monitor and ensure that the nursing staff were accurately assessing resident's dialysis accesses, placed all residents on dialysis, currently residing in the facility at risk for serious bodily harm and/or death. These failures were determined to place all dialysis residents in an Immediate Jeopardy (IJ) situation. This was true for two (2) of two (2) residents sampled. Resident Identifiers: Resident #7 and Resident #45. Facility Census: 106. The facility was notified of the Immediate Jeopardy (IJ) at 11:47 AM 07/31/25. The State Office approved the facility's POC at 2:27 PM on 07/31/25. After observation, staff interview, review of facility documentation, and record review determining the implementation of the POC, the IJ was abated at 7:31 PM on 07/31/25. The IJ started on 06/19/25 at 6:00 PM and ended on 07/28/25 at 7:00 PM. The facility's approved abatement POC consisted of the following: 1. All dialysis patients were assessed with no identified concerns; Patient orders were corrected; MD notified and no new orders; All dialysis patients orders and labs were audited with no identified concerns. Resident's care plans were reviewed and updated. 2. Facility assessment was updated to include Hemodialysis Catheters-access and care of for licensed nursing staff. 3. Education was initiated immediately on 07/30/25 as part of facility ad hoc POC and continued into 07/31/25 for all licensed nursing staff. 4. Facility Hemodialysis Catheter policy was reviewed with no changes.5. Facility licensed nursing orientation was updated to include HD catheter care and access competency and education.6. DON or designee audits orders three times a week. DON or designee will observe nurse following doctor's orders correctly three times a week times 4 weeks. Then orders will be reviewed one time a week and observations will be completed once a week, times 8 weeks.7. Audit tools will be used and reviewed weekly with IDT team. DON or designee will perform hemodialysis training upon hire as part of orientation and annual competencies. Additional training will be provided by DON or designee as needed. All competencies' reviews will be turned in to NHA for compliance validation. Findings Include:a) Resident #7During an interview with Resident #7 on 07/28/25 at approximately 3:14 PM, resident stated that she had been on dialysis since 2016. The resident went on to state that her dialysis access was a permacath. She further stated that she went to dialysis on Mondays, Wednesdays. and Fridays. She also stated that she had never had an AV fistula or graft.Record review on 07/28/25 at 10:00 AM revealed a physician's order dated 06/19/25 which statedDialysis: Site of AV shunt Check bruit and Thrill every shift!Record review and interview revealed that Resident #7 did NOT have an AV access shunt. Despite this fact, eight (8) nurses, the RN Unit Manager and the Director of Nursing (DON) signed off / documented over a period of approximately six (6) weeks that they had successfully assessed the residents shunt for patency. Ongoing record review on 07/30/25 at approximately 9:00 AM revealed that from 06/19/25 to 07/29/25 the following staff members had documented that they had assessed the resident's AV access, and had heard the bruit and felt the thrill over the access for bruit and thrill:Director of Nursing (DON) on 06/26/25Registered Nurse (RN) supervisor #17 on 07/07/25, 07/16/25, and 07/21/25RN #101 on 06/23/25, 06/24/25, 06/27/25, 06/29/25, 07/02/25, 07/03/25, 07/07/25, 07/08/25, 07/11/25, 07/16/25, 07/21/25, 07/25/25, 07/26/25 and 07/26/25RN #121 on 07/05/25 and 07/20/25RN #55 on 07/25/25Licensed Practical Nurse (LPN) #77 on 06/27/25, 07/01/25, 07/02/25, 07/10/25, and 07/19/25.LPN #120 on 07/01/25LPN #32 on 06/19/25, 06/20/25, 06/24/25, 06/25/25, 06/28/25, 06/29/25, 06/30/25, 07/03/24, 07/04/25, 07/08/25, 07/09/25, 07/12/25, 07/13/25, 07/14/25, 07/17/25, 07/18/25, 07/22/25, 07/23/25, 07/26/25, and 07/27/25.LPN #87 on 06/20/25, 06/21/25, 06/22/25, 06/25/25, 06/26/25, 07/05/25, 07/06/25, (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/10/25, 07/14/25, 07/20/25, 07/23/25, 07/24/25 and 07/28/25.LPN #92 on 06/21/25. 06/22/25, 06/23/25, 07/06/25, 07/11/25, and 07/15/25.During interviews with the nursing staff and the unit manager, no one could remember which arm they had checked, and remained silent with a shocked look on their faces when it was addressed that resident did not have an AV access shunt that could be checked for bruit and thrill. During an interview with the Administrator and the Director of Nursing (DON) on 07/30/25 at approximately 11:00 AM. They were notified that the nursing staff were assessing and documenting that Resident #7 had a patent AV fistula/graft. The DON stated, As soon as you brought it up I knew that I had worked that unit and assessed that resident. Most times there is so much to be checked off that we automatically click the boxes.During another interview with RN #101 at 6:31 PM on 07/30/25. RN #101 stated that he had assessed resident's access for bruit and thrill. When asked which arm he had assessed, RN stated the right arm!Upon being notified that the resident did not have an AV access in either arm, RN appeared surprised and did not say anything more. b) Resident #45During an interview on 07/30/25 at approximately at approximately 1:22 PM. Resident #45 had just returned to the facility after her dialysis treatment. Record review revealed that resident has a Brief Interview for Mental Status (BIMS) of 15 and is very cognizant of her care requirements and diet. She stated that her access had been revised at the hospital on [DATE] because she had some issues during dialysis. Resident displayed her right arm which had a large dressing over the lower area of her AV fistula. Upon being asked about the monitoring of her access, resident stated that the nursing staff checked her access sometimes!Record review revealed that Resident # 45 too had an order for monitoring of her AV access for bruit and thrill every shift.When Resident #45 was asked about the frequency of the assessments of her AV access, resident stated It was last checked a few weeks ago by that nurse (LPN) #77. Resident stated that no one had checked it since then. Resident #45 went on to state that the dialysis clinic had educated her about checking her access, and she stated that she usually checked it in the mornings.Record review revealed that the assessments were documented every shift by the nursing staff.A review of the facility assessment on 07/30/25 at approximately 9:00 AM revealed that it does not address any training for hemodialysis, or on the care and treatment of residents on dialysis.During an interview with the DON on 07/30/25 at 4:20 PM, the DON stated, We don't have any training! she further stated that she has been the DON since August of 2024, and she has not seen any dialysis training.The facility nursing staff's inability to accurately assess an AV access for patency creates a serious potential for harm to any dialysis patient in the facility. Assessing, and identifying a non-patent AV access allows for an immediate revision of the access, or the insertion of a temporary dialysis catheter to allow the residents to continue receiving their life saving dialysis treatments.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on facility record review and staff interviews, the facility failed to complete Nurse Aides (NA) annual evaluations. This was true for two (5) of five (5) reviewed for staffing during the Long-Term Survey Process (LTCSP). Nurse Aide Identifiers: #70, #56, #10, #96, and #100. Facility census: 106. Findings included:a) A facility records review revealed, NA #70, NA #56, NA #10, NA #96 and NA#100 did not receive their 12-month evaluation. During an interview on 07/30/25 at 1:25 PM the Administrator confirmed there was no annual evaluations completed for NA #70, NA #56, NA #10, NA #96 and NA#100 . She stated that NA evaluations were something the facility needs to work on getting completed.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on record review and staff interview the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. This failed practice had the potential to affect all residents in the facility. Facility census: 106. In an interview with the Kitchen Manager #60, on 07/31/25 at 10:30AM, he stated his Food Handlers Certification had expired on 07/06/25 and stated he thought he had a 30 day grace period and that he andEmployee #19 were scheduled for a Food Handler's Course on 07/31/25. He also stated that he was a salaried worker and works at least 40 hours weekly. On 07/31/25 at 10:35AM, during a record review of kitchen staff certifications, it was verified that employees identified as #60 and #19 were working in the kitchen on expired Food Handlers Certifications. Both employees certifications expired on 07/06/25.A review of the employee kitchen schedule on 07/31/25 at 2:00PM verified that Employee #19 worked on July 7, 8, 11, 12, 13, 16, 22, 24, 25, 27, 29, and 30, 2025 after his certification had expired on 07/06/2025.

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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 observation, interview and policy review the facility failed to properly store food in accordance with professional standards. This is true for the Kitchen and Nourishment Room. This had the potential to affect all residents in the facility. Facility census 106.Findings included:a) On 07/28/25 at 11:27 AM, during Initial Brief Tour of Kitchen, with the Dietary Kitchen Manager #60 who acknowledged the following: -Walk In Cooler: 1 tray of sweet potato wedges and 1 tray of blended vegetables with no covering or labels and a package of celery left open to air with no labels or dates. -Reach In Cooler: 1 larger tray with salad cups and blue berry desert cups, and a small tray of pickle cups uncovered, unlabeled and undated.2 (two) wrapped sandwiches with unlabeled/undated. -Utensil drawers: all 4 utensil drawers were observed with all utensils scattered and not in the same direction. -Pots and Pans Lid Storage: It was observed that dirty pot lids were stored with clean lids on the storage rack. On 07/29/25 at 1:30 PM, during a Brief Tour of the 100 Hall Nourishment Room, with the Dietary Kitchen Manager #60 who acknowledged the following in the freezer:-1 box of frozen Banquet Pot Pie and 4 small tubs of ice not labeled or dated. On 07/30/25 at 1:00 PM a review facility policy, Food Storage: Cold Foods. Procedures stated All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review and staff interview, the facility failed to document the vaccination status of each staff member (i.e., immunized or not). This was a random opportunity for discovery. Facility census: 106.During an interview on 07/30/25 at approximately 3:50 PM, the Director of Nursing (DON) reported that the facility only had a total number of staff that received COVID vaccine. The facility did not have any documentation readily available that detailed which staff had received or had not received the COVID vaccine.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interview, the facility failed to ensure residents had a dignified existence. Urinary catheter bags were found uncovered.This failed practice was a random opportunity of discovery. Resident Identifier: #115. Facility Census: 106Findings included:a) Resident #115On 07/28/25 at 2:05PM, during a resident interview, it was observed that Resident # 23's catheter bag did not have a bag cover. The uncovered catheter bag was placed on the side but near the foot of the bed which could be seen by any passerby in the hallway. During an interview, on 07/28/25 at 12:10 PM, Licensed Practical Nurse (LPN) #54 acknowledged the catheter bag was not covered.

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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 observation, staff interview, and resident interview, the facility failed to provide reasonable accommodations of needs, by not ensuring Resident #90's call light was within her reach. This failed practice was a random opportunity for discovery.Resident identifier #90. Facility Census: 106.Findings include:a) Resident #90 During an interview with, Resident #90 on 07/30/25 at 12:13 PM, it was observed that Resident #90's call light was not within her reach. She stated she needed to get a nurse to lower the head of her bed and kept asking where her call light was. During an interview on 07/30/25 at 12:15 PM with the Nurse Aide (NA) #63, She acknowledged the call light was hanging on the bed frame behind the resident's mattress where the resident could not see it or reach it.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and interview, the facility failed to identify a newly evident diagnosis of Bipolar Disorder on the Preadmission Screening and Resident Review (PASARR). Resident Identifier: Resident identifier: #35. Facility Census:106. Findings Include:a) Resident #35 record review revealed an updated PASSAR dated 03/27/23, which did not identify any diagnosis of mental illness and stated, ?No Level II required.'The resident was diagnosed with bipolar disorder on 05/08/23. The facility failed to update the PASSAR and did not refer the resident for a Level II review, despite the newly evident disorder. During an interview with the Director of Social Services (DSS) #111 on 07/30/25 at 1:55 PM, she confirmed that she was aware that some PASSARs had not been updated. DSS #111 further stated that she was in the process of performing a whole-house review of PASSARs.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and staff interviews, the facility failed to ensure that the resident's Pre-admission Screening (PAS) reflected pre-admission diagnoses for one (1) of three (3) resident reviewed for the category of PASARR, during the long-term care survey. Resident identifier: #35. Census 106.Findinbs included: a) Resident #35 During record review on 07/30/25 at approximately 12:10 PM, it was noted that Resident #35's initial PASSAR dated 05/12/22 did not identify any mental illness and stated, No Level II required. However, a review of the resident's diagnoses revealed a diagnosis of Major Depressive Disorder dated 01/27/22. During an interview with the Director of Social Services (DSS) #111 on 07/30/25 at 1:55 PM, she confirmed that she was aware that some PASSARs had not been updated. DSS #111 further stated that she was in the process of performing a whole-house review of PASSARs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to create a comprehensive care plan that addressed the resident's diagnosis of Post Traumatic Stress Disorder (PTSD), failed to incorporate knowledge about PTSD into care plans, failed to identify trauma triggers, and failed to implement interventions and practices to address those triggers and prevent re-traumatization. This was true of two (2) of two (2) residents sampled. Resident Identifiers: #24, #72. Facility Census:106.Findings Include a) Resident #24 Record review 07/29/2025 9:30 AM revealed that Resident #24 has a diagnosis of Post Traumatic Stress Disorder (PTSD) dated 07/10/25. A review of the resident's care plan revealed that PTSD was not addressed. In addition, the care plan failed to identify trauma triggers and failed to implement interventions and practices to address those triggers and prevent re-traumatization. b) Resident #72 During a review of records for Resident #72 on 07/29/2025 10:52 AM, it was noted that the resident had been diagnosed with chronic PTSD on 07/08/25. Further record review revealed that the resident's Care Plan was not updated to address PTSD. The care plan failed to identify trauma triggers and failed to implement interventions and practices to address those triggers and prevent re-traumatization. During an interview with the Director of Social Services (DSS) #111 on 07/30/25 at 1:55 PM, she stated that she was working to update the care plans to reflect interventions to add

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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 interview, and record review, the facility failed to follow a physician's order to administer medications to meet the needs of the resident. This was true for two (2) of seven (7) residents sampled. In addition, the facility also failed to ensure that residents were weighed as per the physician's order. Resident Identifiers: #7, #45, and #103. Facility Census: 106. Findings Include: a) Resident #7 During an interview with Resident #7 on 07/28/25 at approximately 3:14 PM, the resident stated that she had been on dialysis since 2016. The resident went on to state that her dialysis access was a permacath. She further stated that she went to dialysis on Mondays, Wednesdays, and Fridays. Record review on 07/29/25 at 10:35 AM revealed a physician's order for: Sevelamer Carbonate Oral Tablet (Sevelamer Carbonate) Give 800 mg by mouth with meals every Tue, Thu, Sat, Sun for CKD (chronic kidney disease) Give 800 mg by mouth three times a day every Mon, Wed, Fri - give with meals b) Resident #45 During an interview on 07/30/25 at approximately at approximately 1:22 PM. Resident #45 had just returned to the facility after her dialysis treatment. Record review revealed that the resident has a Brief Interview for Mental Status (BIMS) of 15, and is very cognizant of her care requirements and diet. Resident stated that she goes for dialysis on Mondays, Wednesdays, and Fridays. Resident #45 has also been prescribed Sevelamer Carbonate Oral Tablet (Sevelamer Carbonate). Give 800 mg by mouth with meals. Resident #7 and Resident #45 leave the facility for their dialysis treatments at approximately 6:30 AM on Mondays, Wednesdays, and Fridays. Residents return to the facility at approximately 1:00 PM. Residents stated they receive their medications during med pass.A review of the Medication Administration Record (MAR) revealed that the facility documented the administration of Sevelamer Carbonate to the residents at 7:00 AM, 12:00 PM, and 5:00 PM every day, and not with their meals, as prescribed by their physician. During an interview with the Administrator and Director of Nursing on 07/30/25 at approximately 11:00 AM, the DON confirmed that she would check on the prescription. c) Resident #103 During an interview on 07/20/25 at approximately 8:15 AM, Employee #59 was asked if Resident #103 received monthly weights. The employee replied, Let me check here for you. Employee #59 found in the electronic medical record (EMR) an order for monthly weights. When asked to show the last documented weight for resident #103, Employee #59 stated, It looks like it was back in May. During an interview on 07/30/25 at approximately 8:40 AM, the facility Administrator acknowledged the finding.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and resident interview, the facility failed to follow currently recognized standards of care in providing assessments and care of a resident's dialysis access. This was true for two (2) of two (2) residents sampled. Resident Identifiers: Resident #7 and Resident #45. Facility Census:106.Findings Included:a) Resident #7Resident #7 had an order dated 06/19/25 by her physician stating, Dialysis: Site of AV shunt Check Bruit and Thrill every shift.During an interview with Resident #7 on 07/28/25 at approximately 3:14 PM, the resident stated that she had been on dialysis since 2016. The resident went on to state that her dialysis access was a permacath. She further stated that she went to dialysis on Mondays and Wednesdays and Fridays. She also stated that she had never had an Arteriovenous (AV) fistula or graft.Record review on 07/28/25 at approximately 3:30 PM revealed that Resident #7, did not have an AV access shunt. The record review supported the resident's comment that dialysis access was a Permacath. Despite this fact, eight (8) nurses, the RN Unit Manager and the Director of Nursing (DON) signed off / documented over a period of approximately six (6) weeks that they had successfully assessed residents shunt for patency.During interviews with the nursing staff and Unit Manager #17 on 07/29/25 at 12:33 PM, none of them could remember which arm they had assessed for a AV access. During an interview with the Administrator and the Director of Nursing (DON) on 07/29/25 at approximately 11:00 AM they were notified that the nursing staff were assessing and documenting that Resident #7 had a patent AV fistula/graft.The DON, she stated, As soon as you brought it up I knew that I had worked that unit and assessed that resident. The DON commented that most time there was so much to be checked off that they automatically click the boxes.During another interview with Registered Nurse (RN) #101 at 6:31 PM on 07/30/25 the RN stated that he had assessed resident's access for bruit and thrill. When asked which arm he had assessed, RN stated the right arm. Upon being notified that the resident did not have an AV access in either arm, RN appeared surprised and did not say anything more.Until surveyor intervention on 07/29/25 at 11:00 AM, there was no order for nursing staff to assess the resident's actual dialysis access, which was a permacath located on the right chest.b) Resident #45During an interview on 07/30/25 at approximately at approximately 1:22 PM Resident #45 had just returned to the facility after her dialysis treatment.Record review revealed that resident had a Brief Interview for Mental Status (BIMS) of 15 and was very cognizant of her care requirements and diet. During this interview she stated that her access had been revised at the hospital on [DATE] because she had some issues during dialysis. The resident displayed her right arm which had a large dressing over the lower area of her AV fistula. Upon being asked about the monitoring of her access, the resident stated that the nursing staff checked her access sometimesRecord review revealed that Resident # 45 too had an order for monitoring her AV access for bruit and thrill every shift.When Resident #45 was asked about the frequency of the assessments of her AV access, the resident stated, It was last checked a few weeks ago by that nurse (LPN) #77. Resident #45 stated that no one had checked it since then. Resident #45 went on to state that the dialysis clinic had educated her about checking her access, and she stated that she usually checked it in the mornings.Record review revealed conflicting information as it showed that the assessments to the AV access were documented every shift by the nursing staff.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on facility documentation and staff interview the facility failed to have required members sign in at the Quality Assessment and Assurance (QAA) meetings. This failed practice had the potential to affect all residents residing at the facility. Facility Census: 106. Record review of the facility's documentation of QAA Meeting Agenda and Minutes revealed no sign-in sheets for staff that attended the meeting quarterly. The facility provided copies of meeting signature pages that were copied, and the dates were changed per month. During an Interview 08/04/25, at 1:38 PM the Administrator verified the required members did not sing in for the quarterly QAA meetings. The Administrator said they just copied a page of signatures and changed the date.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, The facility failed to maintain all patient care equipment in safe operating condition.This failed practice was a random opportunity for discovery. Resident identifiers : #73 and #18 Facility Census: 106 On 07/28/25 at 3:10 PM, during a resident interview and facility walk through in room [ROOM NUMBER], it was observed that Resident #73 and #18's bathroom had a strong smell of urine with a puddle of water around the toilet base on the floor. On 07/30/25 at 10:29 AM during an interview with the Director of Nursing, and administrator in room [ROOM NUMBER], it was observed that a towel was wrapped around the base of the toilet, they acknowledged the toilet had a leak and caused a puddle of water on the bathroom floor.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and staff interview, the facility failed to provide a safe and sanitary environment for residents and staff. A portion of the wall in the laundry room had a black-like substance growing on it. This was a random opportunity for discovery. Facility census: 106.Findings included:a) Laundry Room WallAn observation in the small area behind the dryers, made on 07/30/25 at approximately 10:50 AM, revealed what appeared to be a black-like substance at the bottom of the wall facing the right side of the dryers. On 07/20/25 at approximately 11:52 AM, an interview with Employee #75 verified this finding. This finding was also acknowledged by the facility administrator on 07/30/25 at approximately 11:59 AM.