STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51A013	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnie Hamilton Health Care	186 Hospital Drive Grantsville, WV 26147

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 50801 The facility failed to have the Ombudsman information posted for wheel chair residents to easily read. This was a random observation. Facility census: Findings included: On 06/25/24 at 11: 14 AM found the Board of Notice for Resident's Rights and Ombudsman information was located to high for residents to be able to see and read. An interview with Nurse Aide/ Activity Director (NA/AD) #27 confirmed the Board of Notice was hung to high for residents in wheel chairs to be able to see and/or read. In an interview on 06/26/24 at 10:23 AM with the Director of Nursing (DON) stated that she understood the Board of Notice was hanging to high for residents to be able to see.

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 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. 50552 Based on record review and staff interview, the facility failed to ensure a resident was not neglected. The facility failed to provide services to a resident that was necessary to avoid physical harm. This was true for 1 (one) of 1 (one) resident's reviewed during the Long Term Survey Process. Resident #8 had an area on her breast that had not been identifeid by the facility. The resident suffered actual physical harm. The facility had not identified this as an area that needed assessed despite showering and dressing the resident daily. The area on the resident's breast was biopsied by a determatorly group and diagnosed as melanoma. Facility census: 24. Resident identifier: #8. Findings included: a) Resident #8 A medical record review for Resident #8 revealed Resident #8 and Resident #8's MPOA had attended a dermatology appointment on 03/21/24. The appointment was for skin irritations on Resident #8's face. During the appointment, Resident #8 questioned if the Dermatologist should look at the spot on her breast. This resulted in a biopsy being performed on her left breast with a diagnosis of melanoma. On 03/25/24 Resident #8's daughter spoke with the facility DOQA (Directof of Quality Assurance) stating, she was upset that no one mentioned the place on Resident #8's breast to her. The daughter stated that Resident #8 got a bath every other day. Resident #8 did not wear a bra and staff dressed her. Resident #8's daughter further stated, the spot was clearly visible and should have been reported and treated. The daughter did not understand why nobody reported this. An investigation was initiated by the facility. On 05/02/24, Resident #8 underwent surgery for a radical resection, wide local excision of melanoma, left breast, as per the Operative Report related to a diagnosis of Melanoma pathologic T3a lesion. A review of the physician's documentation noted that no documentation was made related to the area on Resident #8's left breast prior to the appointment on 03/21/24. The weekly summaries performed by the facility nursing staff were reviewed and revealed no documentation related to the area on Resident #8's left breast. On 06/25/24 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON). During the interview, the DON acknowledged that during the investigation a few staff stated they had noticed the area and reported it. However, no notification was made to the physician for follow up. The DON further acknowledged, the area on Resident #8's left breast had not been identified as an area of concern requiring follow up during the weekly summaries made by the facility nursing staff, which included the resident's skin condition. The facility had put the following plan in place after this issue was brought to their attention by the resident's daughter/power of attorney. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	1. Once the area of concern was brought to our attention by the Power of Attorney (POA) after dermatologist appointment on 03/21/24, we scheduled the first available appointment with surgeon for 05/02/25. Transport was provided by the POA at her preference. Staff provided all preoperative care for resident. 2. Baseline skin assessments were performed on all residents on or before 04/19/24. Suspicious areas of concern were reported to the physician and follow up care provided. 3. All staff were educated on reporting of changes in resident condition and documentation of changes on 03/26/24. Annual education will be provided to all staff concerning Abuse and Neglect. Licensed Practical Nurse (LPN) skin assessment competencies will be completed by 06/27/24. Baseline skin assessments will be completed on all new admissions and weekly thereafter. 4. Weekly skin assessments will be monitored weekly for 4 (four) weeks by the DON and results will be reported during the next Quality Assurance/ Integrated Quality Management meeting (IQM). DON will review skin assessments quarterly thereafter to ensure this deficient practice does not occur. 5. Completion date: 06/27/24. During an additional interview, conducted on 06/25/24 at 4:15 PM, the DON acknowledged that this incident has not been discussed or reviewed in the facility Quality Assurance and Performance Improvement (QAPI) and that no audits have been performed to ensure the weekly skin assessments are being performed and that she had not checked the skin assessments to ensure other residents had skin issues that may need addressed as stated in the letter dated 04/01/24 to Resident #8 ' s daughter.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review and staff interview the facility failed to develop and implement written policies and procedures to prohibit and prevent neglect and for these written policies to include the following components. This practice had the potentail to affect more than an isolated number of residents. Facility census: 24. Resident identifier: #8. Findings include: a) Resident #8 On 06/24/24 at approximately 1:15 PM, a review was completed of a facility complant regading Resident #8. The complaint included a letter received from the Director of Quality Assurance (DOQA) dated 04/01/24. The letter read as follows: This letter is a follow up to your concern received on March 25, 2024, in which you expressed concern about an area found on your mother's breast during a recent dermatology visit. As a result of your concern, a thorough review has been performed. The following is a summary of our findings: 1) Staff failed to appropriately recognize and document the area that is on your mother's breast that was discovered during a recent dermatology visit and; 2) While most staff were unaware of any unusual skin issue on the breast, a few mentioned a mole or age spot, but reported that it had not changed any in the past few days or weeks and a couple mentioned having noticed the area, and reporting it, but not recalling to whom or when it was reported. In an attempt to ensure that this occurrence does not happen again with your mother or any other resident of our Long Term Care Unit, the following actions are being taken: 1) All staff will receive re-education on what needs to be reported as changes in resident's skin condition; 2) All Licensed Practical Nurses (LPN'S) will receive re-education on how to properly perform and document skin assessments and report findings as needed. 3) Skin assessments are to be performed and documented on each resident as a baseline. 4) Baseline skin assessments are to be performed on all new admissions with weekly skin assessments completed thereafter. [NAME] Health System is truly sorry that this has happened, as we are here to provide our residents with the best care possible and have their best interests at heart. This letter was signed by the DOQA. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The complaint and above referenced letter was in regards to a dermatology appointment Resident #8 and Resident #8's MPOA had attended on 03/21/24. The appointment was for skin irritations on Resident #8's face. During the appointment, Resident #8 questioned if the Dermatologist should look at the spot on her breast, resulting in a biopsy being performed on her left breast with a diagnosis of melanoma being given. On 03/25/24 Resident #8's MPOA then spoke with the facility DOQA stating, she was upset that no one mentioned the place on Resident #8's breast to her. Resident #8 gets a bath every other day, that Resident #8 did not even wear a bra and staff dresses her. Resident #08's MPOA further stated, The spot is clearly visible and should have been reported and treated. I do not understand why nobody reported this. An investigation was initiated by the facility. On 05/02/24, Resident #8 underwent surgery for a radical resection, wide local excision of melanoma, left breast, as per the Operative Report related to a diagnosis of Melanoma pathologic T 3 a lesion. On 06/24/24 at approximately 4:00 PM during a review of Resident #8's medical record, the physician's documentation was reviewed. It was noted that no documentation was made related to the area on Resident #8's left breast. At this time the Weekly Summary's performed by the facility nursing staff were reviewed revealing no documentation related to the area on Resident #08's left breast. On 06/25/24 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON). During the interview, the DON acknowledged that while during the investigation a few staff stated they had noticed the area and reported it, no notification was made to the physician for follow up. The DON further acknowledged, the area on Resident #8's left breast had not been identified as an area of concern requiring follow up during the Weekly Summary's made by the facility nursing staff, which included the resident's skin condition. A review of the facility abuse/neglect policy revleaed: It is the policy of [NAME] Health System (MHHS) that all allegations of abuse, neglect, misappropriation of property, exploitation, injuries of unknown origin and reasonable suspicions of crime be appropriately reported and investigated within the federal and state guidelines. On 06/25/24 at 2:00 PM the DON acknowledged that by not reporting this allegation of neglect, the facility policy had not been implemented in this case.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review, policy review and staff interview, the facility failed to ensure all alleged violations of neglect are reported to the appropriate state agencies. This was true for 1 (one) of 1 (one) resident's reviewed during the Long Term Survey Process. Facility census: 24. Resident identifier: Resident #8 Findings included: a) Resident #8 On 06/24/24 at approximately 1:15 PM, a review was completed of a facility complaint made the Medical Power of Attorney (MPOA) of Resident #08. The MPOA included, with the complaint, a letter she had received from the Director of Quality Assurance (DOQA) dated 04/01/24. The letter read as follows: This letter is a follow up to your concern received on March 25, 2024, in which you expressed concern about an area found on your mother's breast during a recent dermatology visit. As a result of your concern, a thorough review has been performed. The following is a summary of our findings: 1) Staff failed to appropriately recognize and document the area that is on your mother's breast that was discovered during a recent dermatology visit and; 2) While most staff were unaware of any unusual skin issue on the breast, a few mentioned a mole or age spot, but reported that it had not changed any in the past few days or weeks and a couple mentioned having noticed the area, and reporting it, but not recalling to whom or when it was reported. In an attempt to ensure that this occurrence does not happen again with your mother or any other resident of our Long Term Care Unit, the following actions are being taken: 1) All staff will receive re-education on what needs to be reported as changes in resident's skin condition; 2) All Licensed Practical Nurses (LPN'S) will receive re-education on how to properly perform and document skin assessments and report findings as needed. 3) Skin assessments are to be performed and documented on each resident as a baseline. 4) Baseline skin assessments are to be performed on all new admissions with weekly skin assessments completed thereafter. [NAME] Health System is truly sorry that this has happened, as we are here to provide our residents with the best care possible and have their best interests at heart. This letter was signed by the DOQA. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The complaint and above referenced letter was in regards to a dermatology appointment Resident #08 and Resident #08's MPOA had attended on 03/21/24. The appointment was for skin irritations on Resident #08's face. During the appointment, Resident #08 questioned if the Dermatologist should look at the spot on her breast, resulting in a biopsy being performed on her left breast with a diagnosis of melanoma being given. On 03/25/24 Resident #8's daughter then spoke with the facility DOQA stating, she was upset that no one mentioned the place on Resident #08's breast to her. Resident #8 gets a bath every other day, that Resident #8 doesn't even wear a bra and staff dresses her. Resident #8's daughter further stated, The spot is clearly visible and should have been reported and treated. I do not understand why nobody reported this. An investigation was initiated by the facility. On 05/02/24, Resident #8 underwent surgery for a radical resection, wide local excision of melanoma, left breast, as per the Operative Report related to a diagnosis of Melanoma pathologic T3a lesion. On 06/24/24 at approximately 4:00 PM during a review of Resident #08's medical record, the physician's documentation was reviewed. It was noted that no documentation was made related to the area on Resident #08's left breast. At this time the Weekly Summary's performed by the facility nursing staff were reviewed revealing no documentation related to the area on Resident #8's left breast. On 06/25/24 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON). During the interview, the DON acknowledged that while during the investigation a few staff stated they had noticed the area and reported it, no notification was made to the physician for follow up. The DON further acknowledged, the area on Resident #8's left breast had not been identified as an area of concern requiring follow up during the Weekly Summary's made by the facility nursing staff, which included the resident's skin condition. During an additional interview, conducted on 06/25/24 at 4:15 PM, the DON acknowledged that this incident should have been reported to the appropriate state agencies. The DON further acknowledged this incident has not been discussed or reviewed in the facility Quality Assurance/ Integrated Quality Management meeting (IQM). and that no audits have been performed to ensure the weekly skin assessments are being performed as stated in the letter dated 04/01/24 to Resident #08's daughter. On 06/25/24 at 2:00 PM during an interview with the Director of Nursing (DON), the policy and procedure entitled, Abuse and Incidents resulting in serious bodily injury, reporting and investigating was reviewed with the DON. The following text was noted from this policy: It is the policy of [NAME] Health System (MHHS) that all allegations of abuse, neglect, misappropriation of property, exploitation, injuries of unknown origin and reasonable suspicions of crime be appropriately reported and investigated within the federal and state guidelines. At that time, the DON acknowledged that by not reporting this allegation of neglect, the facility policy had not been implemented in this case.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review, staff interview and observation the facility to ensure that each resident who experienced a significant change in status was comprehensively assessed using the Center for Medicare and Medicaid Services (CMS) specified Resident Assessment Instrument (RAI) process. Resident #11 experienced a significant weight loss while receiving enteral feedings and developed two (2) pressure ulcers. This was true for 1 (one) of 24 residents reviewed for the Long Term Survey Process. Resident identifier: #11. Facility census: 24. Findings included: a) Resident #11 Resident #11 was admitted on [DATE]. Diagnoses included Diabetes Mellitus, Dementia, Depression, Schizophrenia and lung disease. A Brief Interview of Mental Status (BIMS) could not be performed as the resident was rarely understood or answer. 1. Pressure Ulcers On 06/25/24 at approximately 12:00 PM, a review of Resident #11's medical record was performed. During the review, Resident #11 was noted to have a care plan with a start date of 01/31/24 revealing the following: Problem: Resident is at high risk for skin breakdown with skin risk assessment 12 with this review, incontinent of bowel and bladder and is dependent on staff for activities of daily living (ADL's). Goal: Resident will develop no impaired skin x 3 (three) months. Approach: 1) Assist bars to bed to assist with turning and repositioning. Start date: 01/31/24 2) Do skin assessments weekly. Start date: 01/31/24 3) Do skin risk assessment at least quarterly. Start date: 01/31/24 4) Monitor skin for redness or skin breakdown. Start date: 01/31/24 5) Prompt incontinence care using moisture barrier cream as a preventative measure. Start date: 01/31/24 A review of Resident #11's Weekly Nursing Summaries noted that for the week of 04/28/24 - 05/04/24, Resident #11's skin condition was documented as dry/fragile, skin tears, bruises and cut above left eye. This Weekly Summary was noted to be signed as completed on 05/05/24. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	For the week of 05/08/24 - 05/11/24 the Weekly Nursing Summary noted Resident #11's skin condition as coccyx breaking down-red, pressure ulcer to outside left ball of foot, dark red. This Weekly Summary was signed as completed on 05/12/24. For the week of 05/12/24 - 05/18/24 the Weekly Nursing Summary noted Resident #11's skin condition as pressure injuries noted and was signed as completed 05/20/24. A review of the physician's progress notes revealed no documentation related to any skin issues for Resident #11. Further review of the physician's orders noted the following treatment orders were written for the developed pressure areas: On 05/20/24 at 12:45 PM: 1) Skin prep to ball of left foot 3 times daily DX: Stage 1 (one) decub For 14 days then reassess 2) Skin prep to left heel 3 (three) times daily DX: Stage 1 (one) decub For 14 days then reassess 3) Chamosyn to coccyx 3 (three) times daily DX: Stage 2 (two) decub For 14 days then reassess On 05/28/24 at 10:10 PM: Air mattress to bed 2. Weight loss A review of Resident #11's physician's orders revealed that on 04/21/23 an order was written to start Resident #11 on Prosource 30 ml daily, the diagnosis given at that time was decline in meal intake. Following the above order it was noted that on 04/24/24 a physician's order was written for Resident #11 to have an appointment with area hospital name for percutaneus endoscopic gastrostomy (PEG) placement, with an order for Resident #11 to receive Glucerna 1.5 200 ml via gravity feed 4 (four) times daily with 75 mls of water before and after via PEG. A review of the Registered Dietician recommendations and Nutrition Notes revealed that on 05/08/24, a recommendation to discontinue Prosource was made to which the physician agreed to. It was also noted that the Nutrition Notes revealed the following documentation: 05/22/24: Resident wt. 102.8 lbs decrease of 0.7 lbs (.67%) x 1 (one) month. Decrease of 2.2 lbs (2.09%) x 3 (three) months. Decrease 10.4 lbs (9.18%) x 6 (six) months. Resident is fed via gastrostomy (G-tube) Glucerna 1.5 200 mls four times daily 75 ml water flushes before and after each feeding. This provides resident with 800 mls formula, 1200 kcal's, 66 gm protein, 608 ml free flushes, 600 ml flush total of 1208 ml. This note was signed by Employee #73. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/21/24: Resident with intolerance issues noted with eternal feed, flushes and/or Prosource. Current enterable feed meets estimated nutritional needs to help promote wound healing. She lost a significant amount of weight over the last 6 (six) months with weight (wt.) remaining between 100-105 lbs. No nutritional recommendations at this time. This note was signed by Employee #74. On 06/03/24 at 4:00 PM: Prosource 30 ml daily via PEG tube During a review of the form Vital Signs and Weight Record, the following weights were noted: 10/26/24: 113.2 loss of 2.4 lbs November: missed weight 12/01/23: 113.5 gain 0.3 lbs 01/03/24:106.6 lbs loss 6.9 lbs 02/03/24: 105 lbs loss 1.6 lbs 03/03/24: 105 lbs no loss 04/02/24: 103.5 lbs loss 1.5 lbs 4/21/24: PEG placement 05/3/24: 102.8 lbs loss 0.7 lbs 06/07/24: 100 lbs loss 2.8 lbs On 6/26/24 at 11:23 AM an interview was conducted with the Director of Nursing (DON). The DON acknowledged Resident #11 had experienced a significant change which would require Resident #11 to be comprehensively assessed using the CMS specified Resident Assessment Instrument (RAI) process. The DON stated there was no significant change completed on the Minimum Data Set (MDS) because the pressure ulcers were not something I thought would be ongoing since the pressure was healing after Resident #11 was started back on the Prosource.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49751 Based on record review and staff interview, the facility failed to ensure and new Preadmission Screening and Resident Review (PASARR) was not completed for a resident having a new medical diagnosis for major depressive disorder. This was found for one (1) of one (1) resident reviewed. Resident identifier: #8. Facility Census: 24. Findings included: a) Resident #8 On 06/26/24 at 1:15 PM on 06/24/24 at 3:48 PM a record review revealed resident was admitted [DATE] with a correct PASARR. On 08/07/17 Resident #8 received a diagnosis of major depressive disorder, recurrent severe with psychotic symptoms. A new PASARR was created after diagnosis of major depressive disorder, recurrent, severe with psychotic symptoms was added. The Director of Nursing (DON) confirmed on 06/26/24 at 1:25 PM a new PASARR was not completed after the resident received a diagnosis of major depressive disorder, recurrent, severe with psychotic symptoms and the care plan was not updated.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review and staff interview, the facility failed to ensure each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. This was true for 1 (one) of 12 residents reviewed during the Long Term Care Survey process. Facility census: 24. Resident identifier: Resident #11. Findings include: a) Resident #11 On 06/25/24 at approximately 12:00 PM, a review of Resident #11's medical record was performed. During the review of the Weekly Nursing Summaries, week of 05/08/24-05/11/24, the Weekly Nursing Summary noted Resident #11's skin condition as coccyx breaking down-red, pressure ulcer to outside left ball of foot, dark red. Resident #11 was noted to a care plan with a start date of 01/31/24 revealing the following: Problem: Resident is at high risk for skin breakdown with skin risk assessment 12 with this review, incontinent of bowel and bladder and is dependent on staff for activities of daily living (ADL's). Goal: Resident will develop no impaired skin x 3 (three) months. Approach: 1) Assist bars to bed to assist with turning and repositioning. Start date: 01/31/24 2) Do skin assessments weekly. Start date: 01/31/24 3) Do skin risk assessment at least quarterly. Start date: 01/31/24 4) Monitor skin for redness or skin breakdown. Start date: 01/31/24 5) Prompt incontinence care using moisture barrier cream as a preventative measure. Start date: 01/31/24 It was noted at this time that Resident #11's skin care plan had not been further reviewed or revised. A review of Resident #11's physician's orders revealed that on 04/21/23 an order was written to start Resident #11 on Prosource 30 milliliters (ml) daily, the diagnosis (DX) given at that time was decline in meal intake. Following the above order it was noted that on 04/24/24 a physician's order was written for Resident #11 to have an appointment with [NAME] Area Medical Center (CAMC) for percutaneus endoscopic gastrostomy (PEG) placement, with an order for Resident #11 to receive Glucerna 1.5 200 ml via gravity feed 4 (four) times daily with 75 ml's of water before and after via PEG. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51A013	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnie Hamilton Health Care	186 Hospital Drive Grantsville, WV 26147

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #11's Weekly Nursing Summaries noted that for the week of 04/28/24-05/04/24, Resident #11's skin condition was documented as dry/fragile, skin tears, bruises and cut above left eye. This Weekly Summary was noted to be signed as completed on 05/05/24. For the week of 05/08/24-05/11/24 the Weekly Nursing Summary noted Resident #11's skin condition as coccyx breaking down-red, pressure ulcer to outside left ball of foot, dark red. This Weekly Summary was signed as completed on 05/12/24. For the week of 05/12/24-5/18/24 the Weekly Nursing Summary noted Resident #11's skin condition as pressure injuries noted and was signed as completed 05/20/24. A review of the registered dietician recommendations and Nutrition Notes revealed that on 05/08/24, a recommendation to discontinue Prosource was made to which the physician agreed to. It was also noted that the Nutrition Notes revealed the following documentation: 05/22/24: Resident wt. 102.8 lbs decrease of 0.7 lbs (.67%) x 1 (one) month. Decrease of 2.2 lbs (2.09%) x 3 (three) months. Decrease 10.4 lbs (9.18%) x 6 (six) months. Resident is fed via gastrostomy (G-tube) Glucerna 1.5 200 ml's four times daily 75 ml water flushes before and after each feeding. This provides resident with 800 ml's formula, 1200 kcal's, 66 gm protein, 608 ml free flushes, 600 ml flush total of 1208 ml. This note was signed by Employee #73. 06/21/24: Resident with intolerance issues noted with eternal feed, flushes and/or Prosource. Current enterable feed meets estimated nutritional needs to help promote wound healing. She lost a significant amount of weight over the last 6 (six) months with weight (wt.) remaining between 100-105 lbs. No nutritional recommendations at this time. This note was signed by Employee #74. Further review of the physician's orders noted the following treatment orders were written for the developed pressure areas: On 05/20/24 at 12:45 PM: 1) Skin prep to ball of left foot 3 times daily DX: Stage 1 (one) decub For 14 days then reassess 2) Skin prep to left heel 3 (three) times daily DX: Stage 1 (one) decub For 14 days then reassess 3) Chamosyn to coccyx 3 (three) times daily DX: Stage 2 (two) decub For 14 days then reassess On 05/28/24 at 10:10 PM: Air mattress to bed On 06/03/24 at 04:00 PM: Prosource 30 ml daily via PEG tube (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 11:23 AM an interview was conducted with the Director of Nursing (DON). The DON acknowledged Resident #11's care plan did not reflect a person centered comprehensive approach and that the care plan had not been reviewed/revised to reflect the above noted interventions related to Resident #11's developed areas of pressure.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on record review and staff interview the facility failed to create/revise a care plan for Resident #8 with a new diagnosis of depression which was severe with psychotic symptoms. Resident #11 had newly developed pressure areas. The care plan was not updated to identify the approaches and intervention being used for the healing of those pressure areas. Facility Census: 24. Resident identifiers: #8 and #11 Findings include a) Resident #8 06/26/24 01:15 PM 06/24/24 03:48 PM record review revealed resident was admitted [DATE] with a correct PASARR, and on 08/07/17 Resident #8 received a diagnosis of major depressive disorder , recurrent, sever with psychotic symptoms. on 8/03/17 06/26/24 01:16 PM no new PASARR was created after diagnosis of major depressive disorder , recurrent, severe with psychotic symptoms. On 8/03/17 and was not addressed in the care plan 06/26/24 01:25 PM Director of nursing confirmed the care plan was not updated to address the major depressive disorder. b) Resident #11 On 06/25/24 at approximately 12:00 PM, a review of Resident #11's medical record was performed. During the review of the Weekly Nursing Summaries, week of 05/08/24-05/11/24, the Weekly Nursing Summary noted Resident #11's skin condition as coccyx breaking down-red, pressure ulcer to outside left ball of foot, dark red. Resident #11 was noted to a care plan with a start date of 01/31/24 revealing the following: The resident was at high risk for skin breakdown with skin risk assessment. The resident was incontinent of bowel and bladder and dependent upon staff for activities of daily living (ADLs). A goal was developed for the resident to have no impaired skin in three (3) months. Resident will develop no impaired skin x 3 (three) months. The approach to achieve the goal was listed on the care plan as: 1) Assist bars to bed to assist with turning and repositioning. Start date: 01/31/24 2) Do skin assessments weekly. Start date: 01/31/24 3) Do skin risk assessment at least quarterly. Start date: 01/31/24 4) Monitor skin for redness or skin breakdown. Start date: 01/31/24 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Prompt incontinence care using moisture barrier cream as a preventative measure. Start date: 01/31/24 It was noted at this time that Resident #11's skin care plan had not been further reviewed or revised. A review of Resident #11's physician's orders revealed that on 04/21/23 an order was written to start Resident #11 on Prosource 30 ml daily, the diagnosis (DX) given at that time was decline in meal intake. Following the above order, it was noted that on 04/24/24 a physician's order was written for Resident #11 to have an appointment with (name of local medical center) for percutaneous endoscopic gastrostomy (PEG) placement, with an order for Resident #11 to receive Glucerna 1.5 200 ml via gravity feed 4 (four) times daily with 75 mls (milliliters) of water before and after via PEG. Further review of Resident #11's Weekly Nursing Summaries noted that for the week of 04/28/24-05/04/24, Resident #11's skin condition was documented as dry/fragile, skin tears, bruises and cut above left eye. This Weekly Summary was noted to be signed as completed on 05/05/24. For the week of 05/08/24-05/11/24 the Weekly Nursing Summary noted Resident #11's skin condition as coccyx breaking down-red, pressure ulcer to outside left ball of foot, dark red. This Weekly Summary was signed as completed on 05/12/24. For the week of 05/12/24-5/18/24 the Weekly Nursing Summary noted Resident #11's skin condition as pressure injuries noted and was signed as completed 05/20/24. A review of the registered dietician recommendations and Nutrition Notes revealed that on 05/08/24, a recommendation to discontinue Prosource was made to which the physician agreed to. It was also noted that the Nutrition Notes revealed the following documentation 05/22/24 and 06/21/24. Resident wt. 102.8 lbs. decrease of 0.7 lbs. (.67%) x 1 (one) month. Decrease of 2.2 lbs (2.09%) x 3 (three) months. Decrease 10.4 lbs. (9.18%) x 6 (six) months. Resident is fed via gastrostomy (G-tube) Glucerna 1.5 200 mls four times daily 75 ml water flushes before and after each feeding. This provides resident with 800mls formula, 1200 kcal's, 66 gm protein, 608 ml free flushes, 600 ml flush total of 1208 ml. This note was signed by Employee #73. 06/21/24: Resident with intolerance issues noted with eternal feed, flushes and/or Prosource. Current enteral feed meets estimated nutritional needs to help promote wound healing. She lost a significant amount of weight over the last 6 (six) months with weight (wt.) remaining between 100-105 lbs. No nutritional recommendations at this time. This note was signed by Employee #74. Further review of the physician's orders noted the following treatment orders were written for the developed pressure areas: On 05/20/24 at 12:45 PM: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) Skin prep to ball of left foot 3 times daily DX: Stage 1 (one) decub For 14 days then reassess 2) Skin prep to left heel 3 (three) times daily DX: Stage 1 (one) decub For 14 days then reassess 3) Chamosyn to coccyx 3 (three) times daily DX: Stage 2 (two) decub For 14 days then reassess On 05/28/24 at 10:10 PM: Air mattress to bed On 06/03/24 at 04:00 PM: Prosource 30 ml daily via PEG tube On 6/26/24 at 11:23 AM an interview was conducted with the Director of Nursing (DON). The DON acknowledged Resident #11's care plan did not reflect a person-centered comprehensive approach and that the care plan had not been reviewed/revised to reflect the above noted interventions related to Resident #11's developed areas of pressure. 49751 50552

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 50552 Based on record review and staff interview, the facility failed to provide services to a resident that was necessary to avoid physical harm. This was true for 1 (one) of 1 (one) resident's reviewed during the Long Term Survey Process. Resident #8 had an area on her breast that had not been identifeid by the facility. The resident suffered actual physical harm. The area on the resident's breast was biopsied by a determatorly group and diagnosed as melanoma. Facility census: 24. Resident identifier: #8. Findings included: a) Resident #8 A medical record review for Resident #8 revealed Resident #8 and Resident #8's MPOA had attended a dermatology appointment on 03/21/24. The appointment was for skin irritations on Resident #8's face. During the appointment, Resident #8 questioned if the Dermatologist should look at the spot on her breast. This resulted in a biopsy being performed on her left breast with a diagnosis of melanoma. On 03/25/24 Resident #8's daughter spoke with the facility DOQA (Directof of Quality Assurance) stating, she was upset that no one mentioned the place on Resident #8's breast to her. The daughter stated that Resident #8 got a bath every other day. Resident #8 did not wear a bra and staff dressed her. Resident #8's daughter further stated, the spot was clearly visible and should have been reported and treated. The daughter did not understand why nobody reported this. An investigation was initiated by the facility. On 05/02/24, Resident #8 underwent surgery for a radical resection, wide local excision of melanoma, left breast, as per the Operative Report related to a diagnosis of Melanoma pathologic T3a lesion. A review of the physician's documentation noted that no documentation was made related to the area on Resident #8's left breast prior to the appointment on 03/21/24. The weekly summaries performed by the facility nursing staff were reviewed and revealed no documentation related to the area on Resident #8's left breast. On 06/25/24 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON). During the interview, the DON acknowledged that during the investigation a few staff stated they had noticed the area and reported it. However, no notification was made to the physician for follow up. The DON further acknowledged, the area on Resident #08's left breast had not been identified as an area of concern requiring follow up during the weekly summaries made by the facility nursing staff, which included the resident's skin condition. T he facility had put the following plan in place after this issue was brought to their attention by the resident's daughter/power of attorney. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	1. Once the area of concern was brought to our attention by the Power of Attorney (POA) after dermatologist appointment on 03/21/24, we scheduled the first available appointment with surgeon for 05/02/25. Transport was provided by the POA at her preference. Staff provided all preoperative care for resident. 2. Baseline skin assessments were performed on all residents on or before 04/19/24. Suspicious areas of concern were reported to the physician and follow up care provided. 3. All staff were educated on reporting of changes in resident condition and documentation of changes on 03/26/24. Annual education will be provided to all staff concerning Abuse and Neglect. Licensed Practical Nurse (LPN) skin assessment competencies will be completed by 06/27/24. Baseline skin assessments will be completed on all new admissions and weekly thereafter. 4. Weekly skin assessments will be monitored weekly for 4 (four) weeks by the DON and results will be reported during the next Quality Assurance/ Integrated Quality Management meeting (IQM). DON will review skin assessments quarterly thereafter to ensure this deficient practice does not occur. 5. Completion date: 06/27/24.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review and staff interview the facility failed prevent the development of pressure ulcers/injuries (PU/PI's) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to promote the prevention of pressure ulcer/injury development and promote the healing of existing pressure ulcers/injuries. The physician elected This was true for 1 (one) of 2 (two) residents reviewed for the Long Term Survey Process. Facility census: 24. Resident identifier: #11. Findings include: a) Resident #11 During the review, Resident #11's record a care plan was noted with a start date of 01/31/24. The care plan revealed the resident was at high risk for skin breakdown. The reisdent was incontinent of bowel and bladder and was dependent upon staff for activities of dialy living. The care plan goal was that the resident would not develop impaired skin for the next three (3) months. The appraoches to acheive this goal and resolve this probelm were as follows: 1) Assist bars to bed to assist with turning and repositioning. Start date: 01/31/24 2) Do skin assessments weekly. Start date: 01/31/24 3) Do skin risk assessment at least quarterly. Start date: 01/31/24 4) Monitor skin for redness or skin breakdown. Start date: 01/31/24 5) Prompt incontinence care using moisture barrier cream as a preventative measure. Start date: 01/31/24 A review of Resident #11's physician's orders revealed on 04/21/23 an order was written to start Resident #11 on Prosource 30 ml (militer) daily. The diagnosis given at that time was decline in meal intake. Following the above order it was noted that on 04/24/24 a physician's order was written for Resident #11 to have an appointment with [NAME] Area Medical Center (CAMC) for percutaneus endoscopic gastrostomy (PEG) placement, with an order for Resident #11 to receive Glucerna 1.5 200 ml via gravity feed 4 (four) times daily with 75 mls of water before and after via PEG. A review of Resident #11's Weekly Nursing Summaries noted that for the week of 04/28/24-05/04/24, Resident #11's skin condition was documented as dry/fragile, skin tears, bruises and cut above left eye. This Weekly Summary was noted to be signed as completed on 05/05/24. (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	For the week of 05/08/24-05/11/24 the Weekly Nursing Summary noted Resident #11's skin condition as coccyx breaking down-red, pressure ulcer to outside left ball of foot, dark red. This Weekly Summary was signed as completed on 05/12/24. For the week of 05/12/24-5/18/24 the Weekly Nursing Summary noted Resident #11's skin condition as pressure injuries noted and was signed as completed 05/20/24. . Further review of the physician's orders noted the following treatment orders were written for the developed pressure areas: On 05/20/24 at 12:45 PM 1) Skin prep to ball of left foot 3 times daily DX: Stage 1 (one) decub for 14 days then reassess 2) Skin prep to left heel 3 (three) times daily DX: Stage 1 (one) decub for 14 days then reassess 3) Chamosyn to coccyx 3 (three) times daily DX: Stage 2 (two) decub for 14 days then reassess On 05/28/24 at 10:10 PM Air mattress to bed A review of the registered dietician recommendations and Nutrition Notes revealed that on 05/08/24, a recommendation to discontinue Prosource was made to which the physician agreed to. It was also noted that the Nutrition Notes revealed the following documentation: 05/22/24 Resident wt. 102.8 lbs decrease of 0.7 lbs (.67%) x 1 (one) month. Decrease of 2.2 lbs (2.09%) x 3 (three) months. Decrease 10.4 lbs (9.18%) x 6 (six) months. Resident is fed via gastrostomy (G-tube) Glucerna 1.5 200 mls four times daily 75 ml (mililiter) water flushes before and after each feeding. This provides resident with 800 mls formula, 1200 kcal's, 66 gm (gram) protein, 608 ml free flushes, 600 ml flush total of 1208 ml. This note was signed by Employee #73. 06/21/24 Resident with intolerance issues noted with eternal feed, flushes and/or Prosource. Current enteral feed meets estimated nutritional needs to help promote wound healing. She lost a significant amount of weight over the last 6 (six) months with weight (wt.) remaining between 100-105 lbs. No nutritional recommendations at this time. This note was signed by Employee #74. Further review of the physician's orders noted the following treatment orders were written for the developed pressure areas: On 05/28/24 at 10:10 PM there was a physician's order for an air mattress to the bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 06/03/24 at 4:00 PM there was a physician's order for Prosource 30 ml daily via PEG tube During a review of the form Vital Signs and Weight Record, the following weights were noted: 10/26/24: 113.2 loss of 2.4 lbs November: missed weight 12/01/23: 113.5 gain 0.3 lbs (pounds) 01/03/24:106.6 lbs loss 6.9 lbs 02/03/24: 105 lbs loss 1.6 lbs 03/03/24: 105 lbs no loss 04/02/24: 103.5 lbs loss 1.5 lbs 4/21/24: PEG placement 05/3/24: 102.8 lbs loss 0.7 lbs 06/07/24: 100 lbs loss 2.8 lbs On 6/26/24 at 11:23 AM an interview was conducted with the DON who stated the doctor had mentioned that discontinuing the Prosource may have been what caused the pressure ulcer and Resident #11's 4.7% weight loss. The DON acknowledged that no protein, albumin levels or prealbumin levels were obtained to ensure Resident #11 was receiving enough protein to maintain healthy skin. In addition the DON acknowledged there had been no root cause analysis completed for Resident #11's developed pressure areas and that it had not been taken to the facility Quality Assurance/ Integrated Quality Management meeting (IQM).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50552 Based on staff interviews and observation the facility failed to maintain a medication error rate less than 5 %. Med error rate 7.41%. This was true for 2 (two) of 5 (five) residents observed during the Long-Term Survey Process. Facility census: 24. Resident identifiers: Resident #7, Resident #15. Findings include: a) Resident #07 On 06/26/24 at 06/26/24 11:06 AM, this Surveyor observed LPN #51 administer a percutaneous endoscopic gastrostomy (PEG) tube feeding. The physician's order was as follows: Administer Jevity 1.5 237 ml via PEG tube, gravity feed four times daily with 110 milliliters (ml) water flushes before and after each feeding. This provides the resident with 948 ml formula, 1420 kilocalorie's (kcal's) (27kcals/kilograms (kg)), 60g protein (1.2 grams (g)/kg), 720 ml free fluids, 880 ml flush for total of 1600 ml. LPN #51 was noted to aspirate the PEG tube to check for correct placement. After LPN #51 was noted to administer the following: (1) 7 ounces (oz) cup water (1) bottle of Jevity 1.5 8 oz (237 ml) (1) 7 oz cup water After completing feeding, this Surveyor questioned the ml of water administered. LPN #51 stated the cup is 7 oz (ounces). This Surveyor then asked LPN #51 to review order for water flushes. LPN #51 acknowledged that in 1 (one) 7 oz cup there is 210 ml's (milliliters) of water. LPN #51 acknowledged she administered 420 ml's of water instead of the ordered 220 ml's. b) Resident #15 On 06/26/24 at 09:50 AM, this Surveyor observed LPN #51 obtain blood sugar via glucometer. The order for insulin administration was as follow: Blood sugars before meals and at bedtime with sliding scale using Novolin R Insulin subcutaneously (SUB-Q) as follows: 200-250= 2 units 251-300= 4 units 301-350= 6 units (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	351-400= 8 units Greater than 400 call Physician Diagnosis (DX): Diabetes Mellitus (DM) The blood sugar was timed to be obtained at 11:30 AM on the Medication Administration Record (MAR). The reading at the time the blood sugar was obtained was 286 . LPN #51 then drew up 4 (four) units of Novolin R and administered it to Resident #15. Once LPN #51 had completed administering insulin to Resident #15, LPN #52 acknowledged the insulin was administered outside of the 1 (one) hour window.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50552 Based on staff interview and observation the facility failed to ensure safe and secure storage (including limited access, and mechanisms to minimize loss or diversion) of all medication. This was a random opportunity for discovery. Facility census: 24. Findings include: a) Facility On 06/26/24 at 07:45 AM, this Surveyor conducted an medication administration with Licensed Practical Nurse (LPN) #51. At the beginning of the medication administration, this Surveyor observed the medication refrigerator and noted the Schedule II-V drugs requiring refrigeration not stored in a box permanently affixed to medication refrigerator. During an interview conducted with the Director of Nursing (DON) on 06/26/24 at approximately 08:20 AM, the DON acknowledged the Schedule II-V drugs requiring refrigeration were not stored in a box permanently affixed to medication refrigerator. The DON stated, We tried to fix it, I don't know how to do it without damaging the refrigerator.

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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. 49751 Based on observation and staff interview, the facility failed to ensure pans were being stored properly. A random opportunity for discovery found wet pans stacked together. This failed practice had the potential to affect more than a minimum number of residents residing in the facility. Facility Census: 24. Findings included: a) During an observation in the kitchen on 06/24/24 at approximately 1:00 PM, Dietary Manager #9 pulled three (3) pans that were stored after being washed and sanitized. The pans appeared to be wet and were not dried before being stored. During an interview on 06/24/24 at approximately 1:05 PM Dietary Manager #9 confirmed the pans should have been dried before being stored let me get these re-washed and educate my staff on ensuring pans are dried before stacking them and storing them.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on facility record and staff interview, the facility failed to implement adverse event monitoring, and failed to implement performance improvement program activities that focus on quality of care. This was discovered during the long term care survey process and had the potential to affect all of the residents. Census 24. Findings included: a) Resident #8 - Adverse Event Monitoring 06/24/24 at approximately 1:15 PM a review was completed of a facility complaint. During the interview process of this complaint, the Medical Power of Attorney (MPOA) of Resident #8 was interviewed and the following letter was provided that the MPOA had received from the Director of Quality Assurance (DOQA) dated 04/01/24. The letter read as follows: This letter is a follow up to your concern received on March 25, 2024, in which you expressed concern about an area found on your mother ' s breast during a recent dermatology visit. As a result of your concern, a thorough review has been performed. The following is a summary of our findings: 1) Staff failed to appropriately recognize and document the area that is on your mother's breast that was discovered during a recent dermatology visit and; 2) While most staff were unaware of any unusual skin issue on the breast, a few mentioned a mole or age spot, but reported that it had not changed any in the past few days or weeks and a couple mentioned having noticed the area, and reporting it, but not recalling to whom or when it was reported. In an attempt to ensure that this occurrence does not happen again with your mother or any other resident of our Long Term Care Unit, the following actions are being taken: 1) All staff will receive re-education on what needs to be reported as changes in resident ' s skin condition; 2) All Licensed Practical Nurses (LPNS) will receive re-education on how to properly perform and document skin assessments and report findings as needed. 3) Skin assessments are to be performed and documented on each resident as a baseline. 4) Baseline skin assessments are to be performed on all new admissions with weekly skin assessments completed thereafter. [NAME] Health System is truly sorry that this has happened, as we are here to provide our residents with the best care possible and have their best interests at heart. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a medical record review on 06/25/24 at approximately 11:30 AM , it was identified that on 05/02/24, Resident #8 underwent surgery for a radical resection, wide local excision of melanoma, left breast, as per the Operative Report related to a diagnosis of Melanoma pathologic T3a lesion. On 06/25/24 at approximately 2:00 PM, during an interview with the Director of Nursing (DON), the DON acknowledged that this incident was not reported to the appropriate state officials. On 06/26/24 at approximately 12:44 PM, during an interview with the DON and the Director of Quality Assurance (DOQA), the DOQA acknowledged the letter referenced above and that the DOQA had prepared this letter for the MPOA. The DOQA stated when the MPOA's complaint was received by the facility that a facility investigation was completed and they had identified the referenced areas in the letter that could be improved so they put the actions outlined in the letter in place to help prevent it from happening again. The DON and DOQA stated they did not present this incident to their Quality Assurance/ Integrated Quality Management meeting as they felt they had addressed the issue with the process they had completed. The DON and DOQA further acknowledged that the quality assurance process was designed to implement adverse event monitoring in which the data can be analyzed and the information can be used to develop further activities to prevent the adverse events from occurring again. The DON and DOQA stated they did not monitor the actions so they were not able analyze the data to ensure the actions were successful to avoid any further adverse events. DOQA stated she felt they had failed to thoroughly utilize the quality assurance performance improvement processes to its fullest potential to ensure the residents quality of care. b) Weekend Registered Nurse (RN) - Performance Improvement Program During a facility record review on 06/25/24 at approximately 09:15 AM it was identified that the facility was approved for F731 Registered Nurse (RN) seven (7) days a week with a specification that was indicated for the long term care unit for weekend RN coverage. This approval was dated 08/08/23 and is valid until 08/07/24. During an interview with the Human Resources (HR) #72, on 06/26/24 at 10:15 AM, she stated that she was new in her position but would provide any information she could to identify any incentives that was put in place for Registered Nurses (RN's) that work at the adjacent [NAME] hospital to pick up weekend shifts on the long term care unit. She further stated she would provide a list of indeed ads that were placed and any other effort they may have utilized to recruit for the RN position since the waiver was approved on 08/08/23. Staff #72 did not provide any further information or documentation of the recruiting efforts being put forth to fill the weekend RN position. On 06/26/24 04:09 PM the DON stated she had spoken with the Chief Executive Officer (CEO) and there were no other advertising done for recruitment for the weekend RN position other than what was posted on indeed.com. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the DON and Chief Operating Officer (COO) on 06/26/24 at approximately 05:30 PM the COO provided a facility printed document that listed the indeed.com ads that had been run for an RN in the long term care facility. The document indicated that the Registered Nurse job posting that was placed with Indeed.com was completed initially on 08/21/23 with 1 total applicant noted; it was placed again on 10/30/24 with 0 applicants noted and placed again on 04/22/24 with 0 applicants noted. The COO was not aware of how long the job posting ran for. The DON and the COO were not aware if this RN posting was specifically listed for the weekend RN position. No further efforts were made by HR #72, the DON or the COO to provide recruitment activity for the weekend Registered Nurse position. During an interview with the DON on 06/27/24 at approximately 12:44 PM, she stated that she had just hired a Minimum Data Set (MDS) Coordinator RN and that she had recruited this applicant herself for this position as she felt the priority for the facility was the MDS Coordinator position. The DON further stated that the DON is currently filling the role of the MDS RN and needs to have less duties as the DON as she believes this would help improve the quality of care that the residents are receiving. A further review with the DON of the duties of an MDS RN being the responsibility for completing Minimum Data Sets in a timely manner and other administrative duties versus the RN weekend managers responsibility being to provide direct care utilizing nursing processes as well as to administer medications and treatments as ordered by the physician. When asked if the RN weekend manager duties would provide more hands on care and if the overall quality of care of the residents should be the priority, the DON stated she agreed that the overall quality of care should be the priority. During the interview with the DON on 06/27/24 at approximately 1:30 PM, the DON stated there was not a Performance Improvement Report, Analysis and Plan for Improvement- Plan Do Check Act (PDCA) put in place for the recruitment of a weekend Registered Nurse. The PDCA that was put in place on 09/01/23 identified the facility had received the waiver for RN coverage on the weekends. This plan outlined the DON was to monitor for decline in quality of care or increase in hospitalization . Starting on 08/08/23 the DON said she started monitoring the re-hospitalization s to determine if there was a decline in the quality of care as she felt if someone was re-hospitalized it may be due to a decline in the quality of care they were receiving. The DON was asked if she monitored quality of care areas that did not require re-hospitalization , such as urinary tract infections (UTI's), pressure ulcers, pneumonia, increase in falls, and declines in nutrition. The DON stated she did not monitor these areas, she only focused on the re-hospitalization . The DON agreed that the data collected from monitoring the quality of care areas would have provided more data to analyze to determine if there had been any quality of care concerns that do not require re-hospitalization . (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DON further stated she did not report monthly as required by the PDCA plan. The DON stated she felt she didn't need to discuss the information because she worked the unit and she knew there were no quality of care concerns. She further stated that the PDCA plan was discontinued on 02/06/24 as the PDCA was put in place for a six (6) month period of monitoring due to the weekend RN position being vacant. The DON acknowledged the weekend RN position remains vacant and this has the potential to affect the health outcomes and overall quality of care for all of the residents.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 49650 The facility failed to maintain a quality assessment and assurance committee. This was discovered during the review of the facilities Quality Assurance Assessment committee during the Long Term Care survey Process. The Medical Director/designee and the Administrator did not attend the meetings. has the potential to affect all of the residents. Identifiers: Medical Director, Administrator. Facility Census: 24 Findings included: a) Medical Director/designee On 06/26/24 at 10:45 AM during an interview with the DON regarding the attending signatures for the Quality Assurance Meetings, the DON stated the Chief Nurse Officer (CNO) was the medical director designee. The DON also stated that the CNO served as the Infection Control Nurse for the long term care and attends the meeting as the Infection Control nurse in addition to the Medical Director designee. During the review of the CMS guidelines, that states the Medical Directors designee must not be another required member. The DON and that the Infection Control Nurse are required members. The CNO would not be able to complete the dual role as the Medical Directors Designee and the Infection Control Nurse. The DON stated they were not aware of this information and acknowledged that the attendance was not in compliance with the requirements outlined. b) Administrator On 06/26/24 at 10:50 AM during a review with the DON regarding the attending signatures for the Quality Assurance Meetings, the DON stated that that the Social Worker/System Practice Administrator and the Executive assistant attends in place of the required Chief Executive Officer/Administrator. A further review of the the CMS guidelines revealed that the facility's administrator, owner, board member, or other individual in a leadership role who has knowledge of facility systems and the authority to change those systems need to be in attendance. The DON stated neither the SW/SPA nor the EA have the authority to change the facility systems without authorization from the CEO/Administrator who does not attend the meetings. The DON acknowledged that this attendance is not in compliance with the requirements outlined.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50552 Based on observation and staff interview the facility failed to ensure safe cleaning and disinfection of resident care equipment (glucometers). The glucometers were shared among residents according to the manufacturers recommendations. The glucometer was used on 11 of 24 residents on the unit. Facility census: 24. Findings include: a) Facility On 06/26/24 at approximately 10:00 AM, a medication administration observation was made with Licensed Practical Nurse (LPN) #51. At that time, LPN #51 performed a blood glucose test on Resident #15 using a glucometer that shared among facility residents. After completion LPN #15 was noted to take a packet from the medication cart, take the towelette from the packet and wipe off the glucometer with it and immediately started to place it back in the charging station. At that time, this Surveyor asked LPN #15 what product she was using on the glucometer. LPN #15 responded she was using an alcohol pad. This Surveyor questioned LPN #15 related to dwell time of the alcohol pad to which she responded that she was unsure. On 06/26/24 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON). At that time the DON acknowledged she was aware facility staff were using alcohol pads to clean the glucometer. A copy of the facility policy and procedure was requested related to the cleaning of the glucometer. Policy and Procedure entitled, Cleaning of non-critical, reusable resident care equipment was provided. The policy and procedure read as follows: Page 2 Procedure: C. Cleaning and maintenance processes will follow manufacturer's recommendations. During an interview with the DON on 06/26/24 at approximately 3:00 PM, a copy of the manufacturer's instructions for use was requested and obtained. The manufacturer's instructions for use listed Clorox Germicidal Wipes and Super Sani-Cloth Germicidal Disposable Wipes as the acceptable products for cleaning and disinfecting. A note in the manufacturers instructions stated: Always use Clorox Germicidal Wipes (EPA* reg. no. 67619-12) or Super Sani-Cloth Germicidal Disposable Wipes (EPA* reg. no. 9480-4) to clean and disinfect the meter. Do not use any other cleaning or disinfecting solution. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an addition interview conducted with the DON on 06/26/24 at approximately 3:50 PM, the DON acknowledged the facility had not been following the Policy and Procedure for cleaning and disinfecting reusable resident care equipment.