STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51E109	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jackie Withrow Hospital	105 South Eisenhower Drive Beckley, WV 25801

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 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. 49467 Based on observation, record review, and staff interview, the facility failed to ensure each resident was treated with dignity and respect. Resident #48 visibly soiled for an extended period of time in the little dining room on the third floor. This was a random opportunity for discovery. Resident identifier: #48. Facility census: 51. Findings included: a) Resident #48 At approximately 9:15 AM on 08/13/24, this surveyor entered the dining room on unit 3-C of the facility, where Resident #48 was parked in the geri chair. Resident #48 was noted to be in the geri chair, with the lap tray down, and his pants visibly soiled/wet in the groin area. At approximately 9:21 AM, Resident #48 attempted to stand up from the geri chair but was unable to due to the lap tray. At this time, Resident #48's right leg began to bounce up and down, anxiously. The resident attempted to stand again, unsuccessfully, at which time his right leg began to bounce up and down at a faster pace. Resident #48 attempted to stand a third time and was unsuccessful, at which time his leg bounced up and down faster. At this time, Resident #48 attempted to stand up from the geri chair a fourth time, again, unsuccessfully. At this time, the resident's right leg was bouncing, furiously, up and down, along with his left hand. The resident seemed visibly agitated and anxious at this time. The resident eventually calmed down after approximately five (5) minutes and fell asleep in his chair. At approximately 9:37 AM, Nurse Aide (NA) #8 entered the dining room and began speaking with another resident who was falling asleep in his wheelchair. NA #8 asked the resident if he wanted to go back to his room to go to sleep, at which time she took the resident back to his room. NA #8 did not interact with Resident #48, nor check on him for proper positioning of himself or the lap tray, nor did she notice he was visibly soiled. NA #8 entered the dining room again at approximately 9:40 AM and removed a clothing protector from breakfast from a female resident, then removed the resident from the dining room. NA #8 did not interact with Resident #48 at this time, nor did she notice he was visibly soiled. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 9:46 AM, NA #8 escorted a new resident into the dining room and placed them at the table to the direct right of Resident #48. At this time, there was no interaction with Resident #48 to check positioning of him, the lap tray, or to notice he was visibly soiled. At approximately 9:47 AM, NA #57 entered the dining room with another new resident, placed the resident at the table next to Resident #48. NA #57 did not notice Resident #48 was soiled, nor did they check for proper positioning of the resident or lap tray. At approximately 9:49 AM, Recreation Specialist (RS) #69, entered the dining room to escort residents to an activity taking place at the time. As RS #69 approached Resident #48, she stated Oh, he's wet, at which point, she backed away from Resident #48, gathered other residents, and left the dining room. RS #69 did not ask Resident #48 if he needed assistance, nor did she check to see if the lap tray, or Resident #48, was properly positioned. At approximately 9:51 AM, NA #8 entered the dining room again. NA #8 walked over to a resident sitting beside Resident #48, spoke with resident, turned around, used the hand sanitizer dispenser, and left the dining room. NA #8 did not check on Resident #48, despite him being visibly soiled, for proper positioning of him or the lap tray. At approximately 10:06 AM, Resident #48 attempted to stand up from the geri chair, however, he was unsuccessful due to the lap tray. At this time, the resident started bouncing his legs up and down, anxiously. The resident attempted to reposition himself in the geri chair at this time. Resident's legs now are bouncing faster and harder. Resident #48 attempted to stand out of the chair one more time, unsuccessfully. At this time, the resident's legs were bouncing faster. At approximately 10:15 AM, NA #57 entered the dining room and asked two other residents if they wanted to go to the social and listen to some music. The residents stated they did, at which time, she escorted them past Resident #48, out the door and to the activity room. NA #57 did not check on Resident #48 during this trip to the dining room, leaving him still, visibly soiled, and the positioning of him and the lap tray in question. At this time, Resident #48 remained the only resident in the dining room. At approximately 10:21 AM, NA #8 and NA #57 entered the dining room. NA #8 stated He's wet. NAs began to escort resident out of the dining room, at which point, this surveyor asked them if RS #69 had come to inform them Resident #48 was soiled after she left the dining room at approximately 9:49 AM. Both NAs stated no. At approximately 10:45 AM on 08/13/2024, the Administrator of the facility was notified of Resident #48 being visibly soiled at approximately 9:15 AM, RS #69 entering the dining room and stating Oh, he's wet and leaving, without alerting staff, resulting in Resident #48 not being changed until approximately 10:21 AM. The administrator asked how long the resident was sitting in the dining room soiled. This surveyor stated, From about 9:15 AM until about 10:21 AM when the aides came to get him. However, he was already wet, so he may have been wet for a longer period of time. At this time, the administrator stated the facility would report and investigate the claim of neglect. The facility completed its investigation and substantiated the allegation of neglect due to RS #69 stating she forgot to notify anyone of Resident #48's needs.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49650 Based on observation and staff interview the facility failed to ensure the residents were provided a safe, clean, comfortable and homelike environment. A wall was in poor repair in a residents room. This was a random opportunity for discovery during the long term care survey process. Identifier: Room C 316. Facility census: 51. Findings included: a) Room C 316 During a tour of the facility, Room C 316 was observed to have an area on the wall under the air conditioner which was approximately two (2) feet by two (2) feet in size which was not covered by paint and exposed the white wall plaster underneath. This area was extremely rough in texture and some of the wall plaster was missing. On 08/13/24 at 12:53 PM, during an interview with Certified Nursing Assistant #8, she agreed the wall area was not a pleasant homelike environment and stated she would let maintenance know. During an interview with the Director of Nursing (DON) on 08/13/24 at 1:03 PM the DON stated she would also make maintenance aware of the wall condition.

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F 0600 Level of Harm - Minimal harm or potential for 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. 49467 Based on observation, record review, and staff interview, the facility failed to ensure each resident was free from abuse and neglect by leaving Resident #48 visibly soiled for an extended period of time. This was a random opportunity for discovery. Resident identifier: 48. Facility census: 51. Findings included: a) Resident #48 At approximately 9:15 AM on 08/13/24, this surveyor entered the dining room on unit 3-C of the facility, where Resident #48 was parked in a geri chair. Resident #48 was noted to be in the geri chair, with the lap tray down, and his pants visibly soiled/wet in the groin area. At approximately 9:21 AM, Resident #48 attempted to stand up from the geri chair but was unable to due to the lap tray. At this time, Resident #48's right leg began to bounce up and down, anxiously. The resident attempted to stand again, unsuccessfully, at which time his right leg began to bounce up and down at a faster pace. Resident #48 attempted to stand a third time and was unsuccessful, at which time his leg bounced up and down faster. At this time, Resident #48 attempted to stand up from the geri chair a fourth time, again, unsuccessfully. At this time, the resident's right leg was bouncing, furiously, up and down, along with his left hand. The resident seemed visibly agitated and anxious at this time. The resident eventually calmed down after approximately five (5) minutes and fell asleep in his chair. At approximately 9:37 AM, Nurse Aide (NA) #8 entered the dining room and began speaking with another resident who was falling asleep in his wheelchair. NA #8 asked the resident if he wanted to go back to his room to go to sleep, at which time she took the resident back to his room. NA #8 did not interact with Resident #48, nor check on him for proper positioning of himself or the lap tray, nor did she notice he was visibly soiled. NA #8 entered the dining room again at approximately 9:40 AM and removed a clothing protector from breakfast from a female resident, then removed the resident from the dining room. NA #8 did not interact with Resident #48 at this time, nor did she notice he was visibly soiled. At approximately 9:46 AM, NA #8 escorted a new resident into the dining room and placed them at the table to the direct right of Resident #48. At this time, there was no interaction with Resident #48 to check positioning of him, the lap tray, or to notice he was visibly soiled. At approximately 9:47 AM, NA #57 entered the dining room with another new resident, placed the resident at the table next to Resident #48. NA #57 did not notice Resident #48 was soiled, nor did they check for proper positioning of the resident or lap tray. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 9:49 AM, Recreation Specialist (RS) #69, entered the dining room to escort residents to an activity taking place at the time. As RS #69 approached Resident #48, she stated Oh, he's wet, at which point, she backed away from Resident #48, gathered other residents, and left the dining room. RS #69 did not ask Resident #48 if he needed assistance, nor did she check to see if the lap tray, or Resident #48, was properly positioned. At approximately 9:51 AM, NA #8 entered the dining room again. NA #8 walked over to a resident sitting beside Resident #48, spoke with resident, turned around, used the hand sanitizer dispenser, and left the dining room. NA #8 did not check on Resident #48, despite him being visibly soiled, for proper positioning of him or the lap tray. At approximately 10:06 AM, Resident #48 attempted to stand up from the geri chair, however, he was unsuccessful due to the lap tray. At this time, the resident started bouncing his legs up and down, anxiously. The resident attempted to reposition himself in the geri chair at this time. Resident's legs now are bouncing faster and harder. Resident #48 attempted to stand out of the chair one more time, unsuccessfully. At this time, the resident's legs were bouncing faster. At approximately 10:15 AM, NA #57 entered the dining room and asked two other residents if they wanted to go to the social and listen to some music. The residents stated they did, at which time, she escorted them past Resident #48, out the door and to the activity room. NA #57 did not check on Resident #48 during this trip to the dining room, leaving him still, visibly soiled, and the positioning of him and the lap tray in question. At this time, Resident #48 remained the only resident in the dining room. At approximately 10:21 AM, NA #8 and NA #57 entered the dining room. NA #8 stated He's wet. NAs began to escort resident out of the dining room, at which point, this surveyor asked them if RS #69 had come to inform them Resident #48 was soiled after she left the dining room at approximately 9:49 AM. Both NAs stated no. At approximately 10:45 AM on 08/13/24, the Administrator of the facility was notified of Resident #48 being visibly soiled at approximately 9:15 AM, RS #69 entering the dining room and stating Oh, he's wet and leaving, without alerting staff, resulting in Resident #48 not being changed until approximately 10:21 AM. The administrator asked how long the resident was sitting in the dining room soiled. This surveyor stated, From about 9:15 AM until about 10:21 AM when the aides came to get him. However, he was already wet, so he may have been way for a longer period of time. At this time, the administrator stated the facility would report and investigate the claim of neglect. The facility completed its investigation and substantiated the allegation of neglect due to RS #69 stating she forgot to notify anyone of Resident #48's needs.

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on observation, record review, and staff interview, the facility failed to ensure each resident was free from physical restraints. Resident #48 was physically restrained by the facility, causing psychosocial harm. This was true for one (1) of one (1) residents reviewed for physical restraints during the long term care survey process. Resident identifier: #48. Facility census: 51. Findings included: a) Resident #48 At approximately 12:00 PM on 08/12/24, during review of the resident matrix (resident census and conditions of residents) provided by the facility, it was determined the facility had Resident #48 marked as being in physical restraints. Upon review of Resident #48's record, it was determined the resident was in a geri chair with a hard lap tray across it, preventing the resident from standing. The order for the restraint reads as follows: When OOB (Out of Bed): GERICHAIR BILAT HIPSTERS & LAP TRAY FOR SAFETY. CHECK RES (Resident) Q30 MIN (Every 30 minutes) FOR PROPER POSITIONING OF RES & LAP TRAY Q2 HOURS & PRN FOR EXERCISE, REST, TOILETING & HYGIENE NEEDS. At approximately 1:30 PM on 08/12/24, an interview was conducted with Licensed Practical Nurse (LPN) #103 regarding the geri chair and lap tray for Resident #48. LPN #103, regarding the lap tray, stated, I've been here since he first got here. When he got here he would walk around all the time, but he had some falls so they put him in the chair and put the tray on it so he couldn't get up and walk. LPN #103 was asked if Resident #48 was able to release the lap tray from the chair on command, in the event of an emergency, to which she stated No, he can't release it. But he can probably yell out if he needs help (Multiple attempts were made to communicate with Resident #48 during the survey process, however, Resident #48 never spoke, nor yelled during the survey). At this time, Resident #48 was observed trying to stand up out of the geri chair, but was unable to due to the lap tray. Resident #48's right leg started to bounce up and down, anxiously, when he was unsuccessful in standing. Seconds later, Resident #48 attempted to stand again, which was unsuccessful. After a second unsuccessful attempt at standing up, Resident #48's right leg bounced up and down harder, and at a faster pace. This continued for approximately 30 seconds and Resident #48 fell asleep in the chair. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	During further record review at approximately 3:00 PM on 08/12/24, it was noted the facility entered the following note, completed by the Director of Nursing (DON) into Resident #48's record on 7/30/24: Assessment completed regarding continuing the need for lap tray. After assessing resident we will continue to utilize the lap tray due to increase in fall risk in the past. Resident did have a decline in health in [DATE] and the lap tray was discontinued on 12/6/23. The resident began walking again without assistance and having increased falls. It was decided we would re-order a soft lap buddy on 1/4/24. Resident still continued to walk and have increased falls. The lap tray was re-ordered on 1/8/24. Resident has had the following orders in the past due to increased falls. Low bed, removing mattress from the low bed with another mat beside (as resident tends to get out of bed and crawl on the floors,) helmet, hipsters, soft lap buddy. Nothing has been successful. The order will continue for the lap tray and to release q2h prn for periods of rest, activies [sic], hygeine [sic], brief changes, or to lay down in bed. MPOA is aware of the lap [NAME] [sic] and in agreement for continued use. The Pre-restraint assessment completed by the facility, attached to the progress note, revealed the facility did not assess Resident #48 for the use of a wheelchair, walker, chair alarm, cane, or many other forms of restraint alternatives, before putting him into a geri chair with a lap tray, as evidenced by the section titled Restraint Alternatives on the assessment. The options given are low bed, wheelchair, cushion, chair alarm, wedges, non-slip grip socks, walker, pillow, cane, other. Marked with an X in the section are low bed, non-slip grip socks, and other. The final section of the pre-restraint assessment titled Results have the following options: None, chemical restraint, physical restraint. The box reading None is marked with an X while chemical restraint and physical restraint are not marked. A call was placed to the wife of Resident #48, who is the Medical Power of Attorney (MPOA), to determine whether she was aware of the use of the lap tray, due to the note stating the MPOA was aware of the lap buddy, and not the lap tray, however, the call was not successful. Despite the note dated 7/30/24 stating the resident required the geri chair and lap tray as a restraint for safety due to increased falls, a preliminary viewing of the incident report provided by the facility, from December 2023, through August 2024, the resident had five (5) incidents from 12/15/23 through 7/16/24, one of which was a result of a shower chair breaking as the resident was on the way to be bathed. Of the remaining four, it was unclear which ones, if any, the resident was ambulating before falling, as all the incidents were noted as unwitnessed. At approximately 9:15 AM on 08/13/24, this surveyor entered the dining room on unit 3-C of the facility, where Resident #48 was parked in the geri chair. Resident #48 was noted to be in the geri chair, with the lap tray down, and his pants were visibly soiled/wet in the groin area. At approximately 9:21 AM, Resident #48 attempted to stand up from the geri chair but was unable to due to the lap tray. At this time, Resident #48's right leg began to bounce up and down, anxiously. The resident attempted to stand again, unsuccessfully, at which time his right leg began to bounce up and down at a faster pace. Resident #48 attempted to stand a third time and was unsuccessful, at which time his leg bounced up and down faster. At this time, Resident #48 attempted to stand up from the geri chair a fourth time, again, unsuccessfully. At this time, the resident's right leg was bouncing, furiously, up and down, along with his left hand. The resident seemed visibly agitated and anxious at this time. The resident eventually calmed down after approximately five (5) minutes and fell asleep in his chair. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	At approximately 9:37 AM, Nurse Aide (NA) #8 entered the dining room and began speaking with another resident was falling asleep in his wheelchair. NA #8 asked the resident if he wanted to go back to his room to go to sleep, at which time she took the resident back to his room. NA #8 did not interact with Resident #48, nor check on him for proper positioning of himself or the lap tray, nor did she notice he was visibly soiled. NA #8 entered the dining room again at approximately 9:40 AM and removed a clothing protector from breakfast from a female resident, then removed the resident from the dining room. NA #8 did not interact with Resident #48 at this time, nor did she notice he was visibly soiled. At approximately 9:46 AM, NA #8 escorted a new resident into the dining room and placed them at the table to the direct right of Resident #48. At this time, there was no interaction with Resident #48 to check positioning of him, the lap tray, or to notice he was visibly soiled. At approximately 9:47 AM, NA #57 entered the dining room with another new resident, placed the at the table next to Resident #48. NA #57 did not notice Resident #48 was soiled, nor did they check for proper positioning of the resident or lap tray. At approximately 9:49 AM, Recreation Specialist (RS) #69, entered the dining room to escort residents to an activity taking place at the time. As RS #69 approached Resident #48, she stated Oh, he's wet, at which point, she backed away from Resident #48, gathered other residents, and left the dining room. RS #69 did not ask Resident #48 if he needed assistance, nor did she check to see if the lap tray, or Resident #48, was properly positioned. At approximately 9:51 AM, NA #8 entered the dining room again. NA #8 walked over to a resident sitting beside Resident #48, spoke with resident, turned around, used the hand sanitizer dispenser, and left the dining room. NA #8 did not check on Resident #48, despite him being visibly soiled, for proper positioning of him or the lap tray. At approximately 10:06 AM, Resident #48 attempted to stand up from the geri chair, however, he was unsuccessful due to the lap tray. At this time, the resident started bouncing his legs up and down, anxiously. The resident attempted to reposition himself in the geri chair at this time. Resident's legs now are bouncing faster and harder. Resident #48 attempted to stand out of the chair one more time, unsuccessfully. At this time, the resident's legs were bouncing faster. At approximately 10:15 AM, NA #57 entered the dining room and asked two other residents if they wanted to go to the social and listen to some music. The residents stated they did, at which time, she escorted them past Resident #48, out the door and to the activity room. NA #57 did not check on Resident #48 during this trip to the dining room, leaving him still, visibly soiled, and the positioning of him and the lap tray in question. At this time, Resident #48 remained the only resident in the dining room. At approximately 10:21 AM, NA #8 and NA #57 entered the dining room. NA #8 stated He's wet. NAs began to escort resident out of the dining room, at which point, this surveyor asked them if RS #69 had come to inform them Resident #48 was soiled after she left the dining room at approximately 9:49 AM. Both NAs stated no. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	At approximately 10:30 AM, NA #8 and #57 were observed brining Resident #48 out into the hallway from his room, standing him up out of the chair, and assisting him with walking approximately 15 to 20 feet before sitting him back in the chair. Resident #48 was observed in the chair the rest of the day. Review of the facility's policy on physical restraints states the opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed. Resident #48 was exercised for approximately 30 to 40 seconds. At approximately 10:45 AM on 08/13/24, the Administrator of the facility was notified of Resident #48 being visibly soiled at approximately 9:15 AM, RS #69 entering the dining room and stating Oh, he's wet and leaving, without alerting staff, resulting in Resident #48 not being changed until approximately 10:21 AM. The administrator asked how long the resident was sitting in the dining room soiled. This surveyor stated, From about 9:15 AM until about 10:21 AM when the aides came to get him. However, he was already wet, so he may have been way for a longer period of time. At this time, the administrator stated the facility would report and investigate the claim of neglect. The facility completed its investigation and substantiated the allegation of neglect due to RS #69 stating she forgot to notify anyone of Resident #48's needs. At approximately 10:00 AM on 08/14/24, Resident #48 was observed attempting to stand up from his geri chair. The attempt was unsuccessful and the resident began to bounce his left leg up and down at a fast pace. The resident seemed anxious and agitated. At approximately 10:02 AM, Resident #48 attempted to rise out of the geri chair for a second time. Unsuccessful, the resident started to bounce his leg at a faster pace. The resident seemed more agitated and anxious. At approximately 10:04 AM, Resident #48 attempted, again, to stand from the geri chair. The resident was unsuccessful and seemed to become more agitated and anxious, bouncing his leg up and down ferociously. The resident eventually stopped trying to get up and began to stare off. A reasonable person standard was applied to this situation because Resident #48 is not able to verbalize how not being able to stand was making him feel. However, he was showing outward signs of agitation as evidenced by his leg bouncing up and down and it becoming faster after each attempt to stand up. A reasonable person would feel agitation and frustration if restrained and not able to stand and walk freely Further record review revealed Resident #48 has orders for a weighted blanket while in bed and a concave mattress, due to increased falls from bed. At approximately 12:00 PM on 08/14/24, an interview was conducted with the DON, in which she was asked to supply incident reports pertaining to the falls suffered by Resident #48 and how they led to him being physically restrained in the geri chair. The DON stated the resident had a number of falls and the facility was concerned about his safety. The DON was asked if the facility ever considered less restrictive measures before they restrained Resident #48 in the geri chair, such as a wheelchair. The DON stated We didn't believe a wheelchair was appropriate for him, so no, I don't believe we did evaluate him for one, but I would have to check to make sure. The DON stated she did not believe the resident could propel a wheelchair now, stating He probably could have before, but not now. Review of the Minimum Data Set (MDS) Assessments For Resident #48 revealed the following: (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 0604 Level of Harm - Actual harm Residents Affected - Few	For the MDS dated [DATE], Section G0300 reveals the resident was Steady at all times while walking. The resident was independently walking distances of ten (10) feet on uneven surfaces and with picking up objects. The MDS showed the resident required partial to moderate assistance, or supervision for Activities of Daily Living (ADLs) The MDS also revealed the resident received no restorative services at this time. The MDS indicated the resident exhibited wandering behaviors every day. After the initial order for the physical restraint on 06/16/24, the MDS dated [DATE] revealed the resident remained independent with the same tasks as in the MDS in May 2023. The MDS states the resident exhibits wandering behaviors daily. In a significant change MDS, dated [DATE], the resident was not noted to have any impairment of lower or upper extremity. However, walking was no longer attempted, due to a medical or safety concern, and the resident was now totally dependent for all ADLs. The resident still, according to the MDS, exhibited wandering behavior daily. Each MDS was submitted following the significant change in August 2023, up to and including the annual MDS dated [DATE], now shows the resident completely dependent for all ADLs, walking not being attempted due to a medical or safety concerning, and exhibiting wandering behavior daily, despite being restrained in the geri chair with a lap tray. At approximately 1:00 PM on 08/14/24, an interview was conducted the the MDS Coordinator and the DON. The MDS coordinator was asked about the resident exhibiting wandering behavior daily if he was in the chair. The MDS Coordinator stated When they release him from the chair he will stand up and walk. He will stand up and walk if he isn't watched. The DON was asked if the resident was able to walk if he would be able to propel a wheelchair on his own, despite her saying she did not feel he could in an earlier interview. The DON stated Some days he can walk and some days he can't. We thought he would slide out of a wheelchair if we put him in one. The DON and MDS Coordinator both stated Resident #48 was able to ambulate independently up until the point of being ordered the geri chair with the lap tray. The DON confirmed at this time the facility did not assess Resident #48 for a wheelchair due to them believing he would slide out of it. Review of the Treatment Administration Record (TAR) for Resident #48 reveals the following order: When OOB (Out of Bed): GERICHAIR BILAT HIPSTERS & LAP TRAY FOR SAFETY. CHECK RES (Resident) Q30 MIN (Every 30 minutes) FOR PROPER POSITIONING OF RES & LAP TRAY Q2 HOURS & PRN FOR EXERCISE, REST, TOILETING & HYGIENE NEEDS. Upon review of the TAR for May, June, July, and August 2024, there are no initials or signatures on the TAR to indicate the resident was ever released from the restraint every two hours. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	At approximately 2:19 PM on 08/14/24, the DON stated the facility did not have a signed consent from Resident #48's MPOA for the use of the restraint. The DON was asked about the progress note dated 7/30/24, in which it states the MPOA is aware of the use of the lap buddy and agrees with its usage, and if the MPOA knows of the lap buddy or the more restrictive lap tray. The DON states the MPOA is aware of the lap tray but is unable to provide any documentation to support. The DON states the MPOA is hard to get a hold of by phone and has never visited the resident since he came to the facility, and is unable to provide any proof of consent, other than the note stating the MPOA is aware. The DON was then asked about the TAR, and being unable to verify the resident was released from the restraints as ordered. The DON stated That is just on there as an FYI, no one signs off on it. There are nurses notes stating he was released from the restraints. When asked how the facility verifies the resident was released from the restraints every two hours, since no one signs off on the TAR, the DON stated I don't guess I really have a way, other than the nurses notes are in there. At this time, the DON and this surveyor reviewed the nurses notes in the system from May through August 2024. This review revealed no notes mentioning the resident was released from the restraints every two hours as required. When asked if she would confirm there were no signatures or nursing notes to indicate the resident was removed from the restraints, the DON stated I confirm there's nothing there but I don't agree with it. The DON supplied the incident reports pertaining to falls for Resident #48 from April of 2023 through August 2024. Upon review of an incident report dated 07/10/24, it was noted a bruise was observed by NA #8 while changing the resident. The bruise was noted to be on the left leg of the resident and to be the same height and size as the armrest on the geri chair. The incident reports revealed the following: 04/19/23- Presumed fall. Resident lying in floor with table overturned. 04/27/23- Resident lying on bathroom/shower floor resting his head on his hands. No injuries or redness. Resident stated he didn't fall. 04/30/23- Resident ambulating in hallway, and fell on his left arm and slid down wall to floor. Brief noted around resident's knees. Brief fell to resident's knees, may have contributed to fall. 05/06/23- Resident fell on left shoulder and hip while turning in front of a door. 06/13/23- Resident observed in floor of dining room with another resident's wheelchair flipped forward. 06/15/23- Resident found by NA, head pointing downward in the floor. Legs and feet pointing upward draped across dining room chair. Lap tray was ordered on 06/16/23. The DON stated in the interview the resident used to be in the military and would crawl underneath his roommates bed, thinking he was working on it, and that's how staff would sometimes find him. The exact number of falls of the resident falling while ambulating compared to the resident rolling out of bed are unknown.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50551 Based on record review and staff interview, the facility failed to properly investigate an allegation of injury of unknown origin. This was a discovered during an investigation of a facility reported incident. Resident identifier: #55. Facility census: 51. Findings include: a) Resident #55 On [DATE] 8:24 AM, a review of care plan revealed the following: -Resident exhibits behaviors of refusing showers, treatments and/or medications. Her guardian has reported this is a lifelong issue. Resident will also make false accusations against staff. Resident has stated on several occasions staff pull her up by her arms and upon further investigation will identify someone has not worked in the facility for a long period of time. Effective [DATE] -Resident is at risk for cognitive loss, alteration in thought process related to diagnosis of Affective Psychosis, Mild Cognitive Disorder, Dementia, Bipolar Disorder and recurrent depression. Effective [DATE] -Resident's community history involves surviving a rape, house fire and breast cancer. -Resident has unclear speech due to history of cerebrovascular accident (resident can nod yes or no, board or pen and paper for communication). Effective [DATE] -Resident has persistent episodes of anger manifested by not getting what she wants. Resident will pinch, slap, punch, bite, pull other's hair, make false accusations, refusing care and scratch employees and residents. Effective [DATE]. -Potential for increasing confusion secondary to dementia and schizophrenia. Effective [DATE] -Needs to be kept comfortable. Has no cardiopulmonary resuscitation (CPR) request. Do not resuscitate (DNR)/Comfort measures. No labs, no weights, no intubation, no tube feeding, no dialysis, no antibiotics, no intravenous (iv) fluid, no feeding tube. May use oxygen via non-rebreather as needed for comfort. May use suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital unless comfort needs can not be met in the facility. Effective [DATE]. - Resident is comfort care. Effective [DATE]. On [DATE] at 9:03 AM, a review of resident's diagnosis list at time of death: -Vascular Dementia without behavioral disturbance -Essential hypertension (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Type 1 (one) diabetes mellitus without complications -Hyperlipidemia, unspecified -Schizoaffective disorder, unspecified -Bipolar Disorder, unspecified -Major depressive Disorder, recurrent, unspecified -Cerebral Infarction, unspecified -Malignant neoplasm of endometrium -Chronic Obstruction Pulmonary Disease, unspecified -Atherosclerotic Heart Disease of Native coronary artery without angina pectoris -Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity -Gastro-esophageal reflux disease with esophagitis -Personal History of other diseases of the digestive system On [DATE] at 10:00 AM, a review of incident reported for Resident #55 dated for [DATE] revealed the resident was found with an injury of unknown origin. Resident is nonverbal and communicated with nods, pointing, and a dry erase boards. Resident also has a history of making false allegations against staff. On the date of the incident, staff inquired as to how she obtained the bruise on her arm and resident nodded yes when asked if it was caused by staff trying to pull her up. Interviews were conducted with (three) 3 staff who were on shift during time who denied witnessing anyone, or they themselves, had pulled resident's arm. Resident's orders were to be lifted using a lift. She could not name or describe the alleged perpetrator. The investigation contained no statements from other residents and no body audits of other residents residing on the same hall as Resident #55. On [DATE] at 11:45 AM, an Interview with the Social Services Director #63 who reported the facilities normal process for investigating an allegation of abuse would be to interview staff involved or on shift as well as all residents and complete body audits on those who could not be interviewed. She stated no other resident's aside from the alleged victim was interviewed and only three (3) staff members. Social Services Director #63 stated, she was unsure as to why she did not interview any other residents or complete body audits for this investigation.

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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 45171 Based on record review and staff interview the facility failed to ensure the admission Preadmission Screening and Resident Review (PASSR) contained all pertinent diagnoses. This was true for one (1) of seven (7) PASSRs' reviewed during the long term care survey process. Resident Identifier: #42 Facility Census: #51 Findings Include: a) Resident #42 On 08/13/24 at 8:23 AM record review shows Resident #42 has the following medical diagnosis: Schizophrenia 12/10/19 Dementia 12/10/19 Intellectual disabilities 08/28/23 The PASSR provided by the Director of Social Work #63, which was dated 10/22/19 did not contain a dementia diagnosis. The following diagnoses were on the PASSR: mental disorders delusions Schizophrenic disorder Schizophrenia Unspecified neurocognitive disorder unspecified symptoms and signs involving cognitive functions and awareness This was confirmed with the Director of Social Work on 08/23/24 at 3:30 PM, who agreed that the dementia diagnosis should have been on the PASSR dated 10/22/19.

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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. 49467 Based on resident interview, staff interview and observation, the facility failed to update and implement a person-centered comprehensive care plan to meet the resident preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. Resident identifiers: Resident #26 and Resident #48. Facility Census: 51. Findings include: a) Resident #26 On 08/12/24 at 10:18 AM, an observation and interview was conducted with Resident #26 which revealed Resident #26 had whiskers on his face, hair was unkempt and clothing was stained. In addition, this Surveyor smelled a strong odor. Upon entering the room, Resident #26 stated I need a hair cut, shave and I shit. I need a shower too. On 08/13/24 at 11:25 AM, a record review for Resident #26 was conducted revealing a shower schedule for every Wednesday and Saturday, evening shift. In addition, Resident #26 is noted to be an assist of 1 (one) person for bathing. Upon reviewing the Nurse Assistant (NA) documentation for the month of July 2024, multiple refusals by Resident #26 were noted to be documented, the following dates are as follows: 1. 07/03/24 2. 07/17/24 3. 07/24/24 4. 07/31/24 At this time, Resident #26's care plan was reviewed, revealing no care plan or interventions for refusal of care. On 08/14/24 at 1:20 PM, a review of the policy and procedure entitled, Requesting, Refusing and/or Discontinuing Care or Treatment was conducted, which states that if a resident refuses care, it will be documented in the resident's record and appropriate changes will be made to the resident's care plan. An interview was conducted with the Director of Nursing (DON) at 1:30 PM, in which the DON acknowledged Resident #26 was not care planned for refusal of care. B) Resident #48 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon review of Resident #48's record, it was determined the resident was in a geri chair with a hard lap tray across it, preventing the resident from standing. The resident has an intervention on his care plan which reads as follows: When OOB (Out of Bed): GERICHAIR BILAT HIPSTERS & LAP TRAY FOR SAFETY. CHECK RES (Resident) Q30 MIN (Every 30 minutes) FOR PROPER POSITIONING OF RES & LAP TRAY Q2 HOURS & PRN FOR EXERCISE, REST, TOILETING & HYGIENE NEEDS. At approximately 9:15 AM on 08/13/24, this surveyor entered the dining room on unit 3-C of the facility, where Resident #48 was parked in the geri chair. Resident #48 was noted to be in the geri chair, with the lap tray down, and his pants visibly soiled in the groin area. At approximately 9:21 AM, Resident #48 attempted to stand up from the geri chair but was unable to due to the lap tray. At this time, Resident #48's right leg began to bounce up and down, anxiously. The resident attempted to stand again, unsuccessfully, at which time his right leg began to bounce up and down at a faster pace. Resident #48 attempted to stand a third time and was unsuccessful, at which time his leg bounced up and down faster. At this time, Resident #48 attempted to stand up from the geri chair a fourth time, again, unsuccessfully. At this time, the resident's right leg was bouncing, furiously, up and down, along with his left hand. The resident seemed visibly agitated and anxious at this time. The resident eventually calmed down after approximately five (5) minutes and fell asleep in his chair. At approximately 9:37AM Nurse Aide (NA) #8 entered the dining room and began speaking with another resident which was falling asleep in his wheelchair. NA #8 asked the resident if he wanted to go back to his room to go to sleep, at which time she took the resident back to his room. NA #8 did not interact with Resident #48, nor check on him for proper positioning of himself or the lap tray, nor did she notice he was visibly soiled. NA #8 entered the dining room again at approximately 9:40 AM and removed a clothing protector from breakfast from a female resident, then removed the resident from the dining room. NA #8 did not interact with Resident #48 at this time, nor did she notice he was visibly soiled. At approximately 9:46 AM, NA #8 escorted a new resident into the dining room and placed them at the table to the direct right of Resident #48. At this time, there was no interaction with Resident #48 to check positioning of him, the lap tray, or to notice that he was visibly soiled. At approximately 9:47 AM, NA #57 entered the dining room with another new resident, placed them at the table next to Resident #48. NA #57 did not notice Resident #48 was soiled, nor did they check for proper positioning of the resident or lap tray. At approximately 9:49 AM, Recreation Specialist (RS) #69, entered the dining room to escort residents to an activity taking place at the time. As RS #69 approached Resident #48, she stated Oh, he's wet, at which point, she backed away from Resident #48, gathered other residents, and left the dining room. RS #69 did not ask Resident #48 if he needed assistance, nor did she check to see if the lap tray, or Resident #48, was properly positioned. At approximately 9:51 AM, NA #8 entered the dining room again. NA #8 walked over to a resident sitting beside Resident #48, spoke with that resident, turned around, used the hand sanitizer dispenser, and left the dining room. NA #8 did not check on Resident #48, despite him being visibly soiled, for proper positioning of him or the lap tray. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 10:06 AM, Resident #48 attempted to stand up from the geri chair, however, he was unsuccessful due to the lap tray. At this time, the resident started bouncing his legs up and down, anxiously. The resident attempted to reposition himself in the geri chair at this time. Resident's legs now are bouncing faster and harder and the resident looks uncomfortable, by the look on his face. Resident #48 attempted to stand out of the chair one more time, unsuccessfully. At this time, the resident's legs were bouncing faster. At approximately 10:15 AM, NA #57 entered the dining room and asked two other residents if they wanted to go to the social and listen to some music. The residents stated they did, at which time, she escorted them past Resident #48, out the door and to the activity room. NA #57 did not check on Resident #48 during this trip to the dining room, leaving him still, visibly soiled, and the positioning of him and the lap tray in question. At this time, Resident #48 remained the only resident in the dining room. At approximately 10:21 AM, NA #8 and NA #57 entered the dining room. NA #8 stated He's wet. NAs began to escort resident out of the dining room, at which point, this surveyor asked them if RS #69 had come to inform them Resident #48 was soiled after she left the dining room at approximately 9:49 AM. Both NAs stated no. At approximately 10:45 AM on 08/13/2024, the Administrator of the facility was notified of Resident #48 being visibly soiled at approximately 9:15 AM, RS #69 entering the dining room and stating Oh, he's wet and leaving, without alerting staff, resulting in Resident #48 not being changed until approximately 10:21 AM. The administrator asked how long the resident was sitting in the dining room soiled. This surveyor stated, From about 9:15 until about 10:21 when the aides came to get him. However, he was already wet, so he may have been that way for a longer period of time. The Administrator was notified that staff did not check on the resident or lap tray, per his care plan during this timeframe. At this time, the administrator stated the facility would report and investigate the claim of neglect. The facility completed its investigation and substantiated the allegation of neglect due to RS #69 stating she forgot to notify anyone of Resident #48's needs. 50552

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49467 Based on record review and staff interview, the facility failed to ensure a resident did not have an Activities of Daily Living (ADL) decline unless unavoidable, due to Resident #48 being physically restrained in a geri chair with a lap tray. This was true for one (1) of one (1) residents reviewed for ADL decline during the survey process. Resident identifier: 48. Facility census: 51. Findings include: A) Resident #48 At approximately 12:00 PM on 08/12/24, during review of the resident matrix (resident census and conditions of residents) provided by the facility, it was determined the facility had Resident #48 marked as being in physical restraints. Upon review of Resident #48's record, it was determined the resident was in a geri chair with a hard lap tray across it, preventing the resident from standing. The order for the restraint reads as follows: When OOB (Out of Bed): GERICHAIR BILAT HIPSTERS & LAP TRAY FOR SAFETY. CHECK RES (Resident) Q30 MIN (Every 30 minutes) FOR PROPER POSITIONING OF RES & LAP TRAY Q2 HOURS & PRN FOR EXERCISE, REST, TOILETING & HYGIENE NEEDS. At approximately 1:30 PM on 08/12/24, an interview was conducted with Licensed Practical Nurse (LPN) #103 regarding the geri chair and lap tray for Resident #48. LPN #103, regarding the lap tray, stated, I've been here since he first got here. When he got here he would walk around all the time, but he had some falls so they put him in the chair and put the tray on it so he couldn't get up and walk. LPN #103 was asked if Resident #48 was able to release the lap tray from the chair on command, in the event of an emergency, to which she stated No, he can't release it. But he can probably yell out if he needs help. At approximately 12:00 PM on 08/14/24, an interview was conducted with the DON, in which she was asked to supply incident reports pertaining to the falls suffered by Resident #48 and how they led to him being physically restrained in the geri chair. The DON stated the resident had a number of falls and the facility was concerned about his safety. The DON was asked if the facility ever considered less restrictive measures before they restrained Resident #48 in the geri chair, such as a wheelchair. The DON stated We didn't believe a wheelchair was appropriate for him, so no, I don't believe we did evaluate him for one, but I would have to check to make sure. The DON stated she did not believe the resident could propel a wheelchair now, stating He probably could have before, but not now. Review of the Minimum Data Set (MDS) Assessments For Resident #48 revealed the following: For the MDS dated [DATE], Section G0300 reveals the resident was Steady at all times while walking. The resident was independently walking distances of ten (10) feet on uneven surfaces and with picking up objects. The MDS showed the resident required partial to moderate assistance, or supervision for Activities of Daily Living (ADLs) The MDS also revealed the resident received no restorative services at this time. The MDS indicated the resident exhibited wandering behaviors every day. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After the initial order for the physical restraint on 06/16/24, the MDS dated [DATE] revealed the resident remained independent with the same tasks as in the MDS in May 2023. The MDS states the resident exhibits wandering behaviors daily. In a significant change MDS, dated [DATE], the resident was not noted to have any impairment of lower or upper extremity. However, walking was no longer attempted, due to a medical or safety concern, and the resident was now totally dependent for all ADLs. The resident still, according to the MDS, exhibited wandering behavior daily. Each MDS which was submitted following the significant change in August 2023, up to and including the annual MDS dated [DATE], now shows the resident completely dependent for all ADLs, walking not being attempted due to a medical or safety concerning, and exhibiting wandering behavior daily, despite being restrained in the geri chair with a lap tray. At approximately 1:00 PM on 08/14/24, an interview was conducted the the MDS Coordinator and the DON. The MDS coordinator was asked about the resident exhibiting wandering behavior daily if he was in the chair. The MDS Coordinator stated When they release him from the chair he will stand up and walk. He will stand up and walk if he isn't watched. The DON was asked if the resident was able to walk if he would be able to propel a wheelchair on his own, despite her saying she did not feel he could in an earlier interview. The DON stated Some days he can walk and some days he can't. We thought he would slide out of a wheelchair if we put him in one. The DON and MDS Coordinator both stated Resident #48 was able to ambulate independently up until the point of being ordered the geri chair with the lap tray. The DON confirmed at this time the facility did not assess Resident #48 for a wheelchair due to them believing he would slide out of it.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49467 Based on observation and staff interview, the facility failed to provide Actiity of Daily Living (ADL) care for dependent residents, by leaving Resident #48 soiled for an extended period of time. This was a random opportunity for discovery. Resident identifier: 48. Facility census: 51. Findings include: A) Resident #48 At approximately 9:15 AM on 08/13/2024, this surveyor entered the dining room on unit 3-C of the facility, where Resident #48 was parked in the geri chair. Resident #48 was noted to be in the geri chair, with the lap tray down, and his pants visibly soiled in the groin area. At approximately 9:21 AM, Resident #48 attempted to stand up from the geri chair but was unable to due to the lap tray. At this time, Resident #48 ' s right leg began to bounce up and down, anxiously. The resident attempted to stand again, unsuccessfully, at which time his right leg began to bounce up and down at a faster pace. Resident #48 attempted to stand a third time and was unsuccessful, at which time his leg bounced up and down faster. At this time, Resident #48 attempted to stand up from the geri chair a fourth time, again, unsuccessfully. At this time, the resident ' s right leg was bouncing, furiously, up and down, along with his left hand. The resident seemed visibly agitated and anxious at this time. The resident eventually calmed down after approximately five (5) minutes and fell asleep in his chair. At approximately 9:37 Nurse Aide (NA) #8 entered the dining room and began speaking with another resident that was falling asleep in his wheelchair. NA #8 asked the resident if he wanted to go back to his room to go to sleep, at which time she took the resident back to his room. NA #8 did not interact with Resident #48, nor check on him for proper positioning of himself or the lap tray, nor did she notice he was visibly soiled. NA #8 entered the dining room again at approximately 9:40 AM and removed a clothing protector from breakfast from a female resident, then removed the resident from the dining room. NA #8 did not interact with Resident #48 at this time, nor did she notice he was visibly soiled. At approximately 9:46 AM, NA #8 escorted a new resident into the dining room and placed them at the table to the direct right of Resident #48. At this time, there was no interaction with Resident #48 to check positioning of him, the lap tray, or to notice that he was visibly soiled. At approximately 9:47 AM, NA #57 entered the dining room with another new resident, placed the at the table next to Resident #48. NA #57 did not notice Resident #48 was soiled, nor did they check for proper positioning of the resident or lap tray. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 9:49 AM, Recreation Specialist (RS) #69, entered the dining room to escort residents to an activity taking place at the time. As RS #69 approached Resident #48, she stated Oh, he ' s wet, at which point, she backed away from Resident #48, gathered other residents, and left the dining room. RS #69 did not ask Resident #48 if he needed assistance, nor did she check to see if the lap tray, or Resident #48, was properly positioned. At approximately 9:51 AM, NA #8 entered the dining room again. NA #8 walked over to a resident sitting beside Resident #48, spoke with that resident, turned around, used the hand sanitizer dispenser, and left the dining room. NA #8 did not check on Resident #48, despite him being visibly soiled, for proper positioning of him or the lap tray. At approximately 10:06 AM, Resident #48 attempted to stand up from the geri chair, however, he was unsuccessful due to the lap tray. At this time, the resident started bouncing his legs up and down, anxiously. The resident attempted to reposition himself in the geri chair at this time. Resident ' s legs now are bouncing faster and harder and the resident looks uncomfortable, by the look on his face. Resident #48 attempted to stand out of the chair one more time, unsuccessfully. At this time, the resident ' s legs were bouncing faster. At approximately 10:15 AM, NA #57 entered the dining room and asked two other residents if they wanted to go to the social and listen to some music. The residents stated they did, at which time, she escorted them past Resident #48, out the door and to the activity room. NA #57 did not check on Resident #48 during this trip to the dining room, leaving him still, visibly soiled, and the positioning of him and the lap tray in question. At this time, Resident #48 remained the only resident in the dining room. At approximately 10:21 AM, NA #8 and NA #57 entered the dining room. NA #8 stated He ' s wet. NAs began to escort resident out of the dining room, at which point, this surveyor asked them if RS #69 had come to inform them Resident #48 was soiled after she left the dining room at approximately 9:49 AM. Both NAs stated no. At approximately 10:45 AM on 08/13/2024, the Administrator of the facility was notified of Resident #48 being visibly soiled at approximately 9:15 AM, RS #69 entering the dining room and stating Oh, he ' s wet and leaving, without alerting staff, resulting in Resident #48 not being changed until approximately 10:21 AM. The administrator asked how long the resident was sitting in the dining room soiled. This surveyor stated, From about 9:15 until about 10:21 when the aides came to get him. However, he was already wet, so he may have been that way for a longer period of time. At this time, the administrator stated the facility would report and investigate the claim of neglect. The facility completed its investigation and substantiated the allegation of neglect due to RS #69 stating she forgot to notify anyone of Resident #48 ' s needs.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45171 Based on record review and staff interview the facility failed to ensure residents did not receive a second purified protein derivative test (PPD) when it was not warranted. This is true for five (5) of eight (8) residents reviewed for immunizations during the survey. Resident Identifiers: #1, #4, #10, #26 and #31 Facility Census: #51 This will be cited as past non compliance because the facility identified what had happened and took immediate steps to correct the failure to ensure it does not reoccur. All components of the plan of correction were completed prior to this survey beginning. Findings Include: a) Resident #1 On 08/13/24 record review shows Resident #1 received a purified protein derivative test (PPD) 04/09/24. The PPD skin test is a method used to diagnose silent (latent) tuberculosis (TB) infection. According to the facility reported incident, after receiving this test, Nurse Manager (NM) #58 discovered that the resident had already received a PPD on 03/05/24. On 08/14/24 at 2:50 PM during an interview with NM #58 she stated the administering documentation is usually put in the CareVue charting system the facility uses. She had checked for documentation and it was not present. She then checked in a box that is a to do box where she would have had any previous immunizations that needed to be input in the CareVue system, There were none present for this resident. She continued to put the order in the system for the PPD to be administered to the resident. The following day she found documentation that the resident had indeed received a PPD on 03/05/24. She immediately called the physician and the pharmacist. The pharmacist informed her the resident would not be harmed by this. He also instructed her it could read as a false positive and not to read the results which involves watching the forearm where it was administered for a red swelling spot. The physician gave orders to watch for a localized rash. The resident was observed for 72 hours with no adverse reaction. All responsible parties were notified. The facility performed a house wide audit of all immunizations for system documentation. They provided education to all nursing staff. They have changed their process as to ensure this does not occur again. Rather than place documentation in a box, the nurse staff hand delivers the documentation to the Registered Nurse to enter into the system, as the Licensed Practical Nurse staff can not document under immunizations in the system. This was confirmed on 08/14/24 at 4:00 PM with the Director of Nursing. b) Resident #4 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/24 record review shows Resident #4 received a purified protein derivative test (PPD) 04/09/24. The PPD skin test is a method used to diagnose silent (latent) tuberculosis (TB) infection. According to the facility reported incident, after receiving this test, Nurse Manager (NM) #58 discovered that the resident had already received a PPD on 03/05/24. On 08/14/24 at 2:50 PM during an interview with NM #58 she stated the administering documentation is usually put in the CareVue charting system the facility uses. She had checked for documentation and it was not present. She then checked in a box that is a to do box where she would have had any previous immunizations that needed to be input in the CareVue system, There were none present for this resident. She continued to put the order in the system for the PPD to be administered to the resident. The following day she found documentation that the resident had indeed received a PPD on 03/05/24. She immediately called the physician and the pharmacist. The pharmacist informed her the resident would not be harmed by this. He also instructed her it could read as a false positive and not to read the results which involves watching the forearm where it was administered for a red swelling spot. The physician gave orders to watch for a localized rash. The resident was observed for 72 hours with no adverse reaction. All responsible parties were notified. The facility performed a house wide audit of all immunizations for system documentation. They provided education to all nursing staff. They have changed their process as to ensure this does not occur again. Rather than place documentation in a box, the nurse staff hand delivers the documentation to the Registered Nurse to enter into the system, as the Licensed Practical Nurse staff can not document under immunizations in the system. This was confirmed on 08/14/25 at 4:00 PM with the Director of Nursing. c) Resident #10 On 08/13/24 record review shows Resident #10 received a purified protein derivative test (PPD) 04/09/24. The PPD skin test is a method used to diagnose silent (latent) tuberculosis (TB) infection. According to the facility reported incident, after receiving this test, Nurse Manager (NM) #58 discovered that the resident had already received a PPD on 03/05/24. On 08/14/24 at 2:50 PM during an interview with NM #58 she stated the administering documentation is usually put in the CareVue charting system the facility uses. She had checked for documentation and it was not present. She then checked in a box that is a to do box where she would have had any previous immunizations that needed to be input in the CareVue system, There were none present for this resident. She continued to put the order in the system for the PPD to be administered to the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The following day she found documentation that the resident had indeed received a PPD on 03/05/24. She immediately called the physician and the pharmacist. The pharmacist informed her the resident would not be harmed by this. He also instructed her it could read as a false positive and not to read the results which involves watching the forearm where it was administered for a red swelling spot. The physician gave orders to watch for a localized rash. The resident was observed for 72 hours with no adverse reaction. All responsible parties were notified. The facility performed a house wide audit of all immunizations for system documentation. They provided education to all nursing staff. They have changed their process as to ensure this does not occur again. Rather than place documentation in a box, the nurse staff hand delivers the documentation to the Registered Nurse to enter into the system, as the Licensed Practical Nurse staff can not document under immunizations in the system. This was confirmed on 08/14/25 at 4:00 PM with the Director of Nursing. d) Resident #26 On 08/13/24 record review shows Resident #26 received a purified protein derivative test (PPD) 04/09/24. The PPD skin test is a method used to diagnose silent (latent) tuberculosis (TB) infection. According to the facility reported incident, after receiving this test, Nurse Manager (NM) #58 discovered that the resident had already received a PPD on 03/05/24. On 08/14/24 at 2:50 PM during an interview with NM #58 she stated the administering documentation is usually put in the CareVue charting system the facility uses. She had checked for documentation and it was not present. She then checked in a box that is a to do box where she would have had any previous immunizations that needed to be input in the CareVue system, There were none present for this resident. She continued to put the order in the system for the PPD to be administered to the resident. The following day she found documentation that the resident had indeed received a PPD on 03/05/24. She immediately called the physician and the pharmacist. The pharmacist informed her the resident would not be harmed by this. He also instructed her it could read as a false positive and not to read the results which involves watching the forearm where it was administered for a red swelling spot. The physician gave orders to watch for a localized rash. The resident was observed for 72 hours with no adverse reaction. All responsible parties were notified. The facility performed a house wide audit of all immunizations for system documentation. They provided education to all nursing staff. They have changed their process as to ensure this does not occur again. Rather than place documentation in a box, the nurse staff hand delivers the documentation to the Registered Nurse to enter into the system, as the Licensed Practical Nurse staff can not document under immunizations in the system. This was confirmed on 08/14/25 at 4:00 PM with the Director of Nursing. e) Resident #31 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/13/24 record review shows Resident #31 received a purified protein derivative test (PPD) 04/09/24. The PPD skin test is a method used to diagnose silent (latent) tuberculosis (TB) infection. According to the facility reported incident, after receiving this test, Nurse Manager (NM) #58 discovered that the resident had already received a PPD on 03/05/24. On 08/14/24 at 2:50 PM during an interview with NM #58 she stated the administering documentation is usually put in the CareVue charting system the facility uses. She had checked for documentation and it was not present. She then checked in a box that is a to do box where she would have had any previous immunizations that needed to be input in the CareVue system, There were none present for this resident. She continued to put the order in the system for the PPD to be administered to the resident. The following day she found documentation that the resident had indeed received a PPD on 03/05/24. She immediately called the physician and the pharmacist. The pharmacist informed her the resident would not be harmed by this. He also instructed her it could read as a false positive and not to read the results which involves watching the forearm where it was administered for a red swelling spot. The physician gave orders to watch for a localized rash. The resident was observed for 72 hours with no adverse reaction. All responsible parties were notified. The facility performed a house wide audit of all immunizations for system documentation. They provided education to all nursing staff. They have changed their process as to ensure this does not occur again. Rather than place documentation in a box, the nurse staff hand delivers the documentation to the Registered Nurse to enter into the system, as the Licensed Practical Nurse staff can not document under immunizations in the system. This was confirmed on 08/14/25 at 4:00 PM with the Director of Nursing.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49650 Based on observation and staff interview, the facility failed to ensure the food was stored in accordance with professional standards for food service safety. This was identified during the long term care survey and had the potential to affect more than a limited number of residents. Identifiers: Walk-in refrigerator, Refrigerator #1, Walk-in freezer. Facility census: 51. Findings Included: a) Walk-in refrigerator During a tour of the kitchen on [DATE] at 10:37 AM the walk-in refrigerator the following food storage issues were identified: * [NAME] peppers that had began to rot and the outside was watery and softened with white mold. * Watermelon that had began to rot and the outside was watery and softened. * Tomato's that had began to rot and the outside was watery and softened with white mold. * Busted egg in open carton. * Lettuce opened but not dated that had began to rot and the lettuce was watery and softened with a brownish color. * Butter that was not dated. * Open pack of cheese not dated. * Blue pack of raisins not dated. During an interview with the Hospital Supportive Services Supervisor (HSSS) on [DATE] at approximately 10:41 AM she agreed, the items appeared to be rotten and molding. The HSSS disposed of these items at this time. The HSSS also agreed that the items not dated should have been dated and disposed of these items also. b) Reach in refrigerator. During a tour of the kitchen on [DATE] at approximately 10:43 AM the following food storage issues were identified in the walk-in refrigerator: * Parmesan cheese dated [DATE] - [DATE]. * Jell-O not dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* One (1) bag of sliced ham [DATE] - [DATE]. * Two (2) bags of sliced ham [DATE] - [DATE] * Two (2) packs of opened cheese not dated During an interview with the Hospital Supportive Services Supervisor (HSSS) on [DATE] at approximately 10:51 AM she agreed that the items dated for [DATE]- [DATE] and the items dated [DATE]/24 - [DATE] had expired and should have already been discarded. The HSSS did dispose of the items at this time. The HSSS also agreed that the items not dated should have been dated and disposed of these items also. c) Walk in freezer. During a tour of the kitchen on [DATE] at approximately 10:53 AM the walk-in freezer contained the following food storage issues: * Three (3) cod fillets five (5) pound boxes not dated. During an interview with the Hospital Supportive Services Supervisor (HSSS) on [DATE] at approximately 10:59 AM she agreed that the items not dated should have been dated. The HSSS disposed of the items at this time.

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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. 45171 Based on observation and staff interview the facility failed to maintain an effective infection control program to prevent spread of disease and infections by not properly identifying Enhanced Barrier Precaution (EBP) isolation rooms. This was a random opportunity of discovery. Resident Identifiers: #26, #45 and #307. Facility Census: #51 Findings Included: a) Resident #26 On 08/13/24 at 11:15 AM observation found Enhanced Barrier Precaution (EBP) isolation personal protective equipment (PPE) (provided in caddies on the door) on resident room doors that had no identifying isolation sign. The Infection Prevention Nurse #34 provided a list of residents that are in EBP. The list provided identified eighteen (18) residents that should be in EBP. While comparing the list to the room doors, it was found that three (3) of the rooms were not in compliance with the facility policy which states Signs are to be posted on the door outside the resident room indicating the type of precautions and PPE required . and . PPE is available outside the resident rooms . This information is necessary for staff know what PPE is required during care so as to not spread germs throughout the facility. Resident #26 (room B331A) is required to be in EBP due to Methicillin-resistant Staphylococcus Aureus (MRSA). There was no identifying isolation sign nor was there any personal protective equipment available outside the room. On 08/23/24 at 12:05 PM this was confirmed with the Infection Control Nurse #34 who agreed the appropriate signs nor the PPE were available as required. b) Resident #45 On 08/13/24 at 11:15 AM observation found EBP isolation PPE (provided in caddies on the door) on resident room doors that had no identifying isolation sign. The Infection Prevention Nurse #34 provided a list of residents that are in EBP. The list provided identified eighteen (18) residents that should be in EBP. While comparing the list to the room doors, it was found that three (3) of the rooms were not in compliance with the facility policy which states Signs are to be posted on the door outside the resident room indicating the type of precautions and PPE required . and . PPE is available outside the resident rooms . This information is necessary for staff know what PPE is required during care so as to now spread germs throughout the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #45 (room C304A) is required to be in EBP due to Methicillin-resistant Staphylococcus Aureus (MRSA). There was no identifying isolation sign on the door to the room. On 08/23/24 at 12:05 PM this was confirmed with the Infection Control Nurse #34 who agreed the appropriate sign was not posted as required. c) Resident #307 On 08/13/24 at 11:15 AM observation found EBP isolation PPE (provided in caddies on the door) on resident room doors that had no identifying isolation sign. The Infection Prevention Nurse #34 provided a list of residents that are in EBP. The list provided identified eighteen (18) residents that should be in EBP. While comparing the list to the room doors, it was found that three (3) of the rooms were not in compliance with the facility policy which states Signs are to be posted on the door outside the resident room indicating the type of precautions and PPE required . and . PPE is available outside the resident rooms . This information is necessary for staff know what PPE is required during care so as to now spread germs throughout the facility. Resident #307 (room B326A) is required to be in EBP due to Vancomycin-resistant Enterococcus (VRE). There was an inappropriate identifying sign on the door stating the resident was in contact isolation while it should read as EBP. On 08/23/24 at 12:05 PM this was confirmed with the Infection Control Nurse #34 who agreed the appropriate sign were not posted as required.