STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51E124	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakin Hospital	11522 Ohio River Road West Columbia, WV 25287

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 49465 Based on observation, family interview, and staff interviews the facility failed to allow family members to visit with residents in the residents room. This failed practice was found true for (1) one of (2) two residents reviewed for dignity during the Long-Term Care Survey Process. Resident identifier: #40. Facility census: 61. Findings Include: a) Resident #40 During a phone interview on 03/04/25 at 11:53 AM, the Medical Power of Attorney (MPOA) for Resident #40 stated, They told me that I am not allowed to go to her room, we only get to visit in the lobby. I think that is a bunch of (b***sh*t.) The State Agency (SA) asked MPOA, How long has it been since you were allowed in Resident #40's room? The MPOA stated, I come every other day and it has been like this since Covid started. An observation on 03/04/25 at 11:04 AM, revealed the MPOA and Resident #40 sitting in the lobby visiting. During an interview on 03/04/25 at 11:14 AM, Licensed Practical Nurse (LPN) #72 stated, It all started a while back when we had sickness, and then we noticed that we have residents who yell and scream and sometimes become confrontational with visitors so we decided to just let them visit in the lobby and sometimes we will do the library. SA then asked, Are residents ever allowed to have a visitor in their room? LPN #72 stated, Well if they are at the end of life or if they are sick and cannot get up we make arrangements. During an interview on 04/04/25 at 11:26 AM, Licensed Social Worker (LSW) #95 stated, Families visit in the conference room and in the lobby. Every now and then we will let them come to the dining room that we are not using. We have not been letting families visit in the rooms since Covid started. We do that for infection control purposes, even if we are not in an outbreak.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 31826 Based on a resident council meeting, observation, and staff interview, the facility failed to ensure each resident had access to and was able to file an anonymous grievance and/or concern with the facility. This was discovered during the resident council meeting and has the potential to affect more than a limited number of residents currently residing in the facility. Facility Census: 61. Findings Include: a) A resident council meeting was held on 03/04/25 at 2:30 PM. During this meeting the residents agreed they did not know how or where the forms were located to file a grievance. They were asked if they were able to file a grievance at the facility anonymously and they did not know. Review of the facility grievance log found they had not had a grievance or complaint filed since 07/18/24. Review of the facility's policy titled Grievance which did not contain an effective date found the resident has a right to file a grievance anonymously. During an interview with Social Worker (SW) #11 on 03/10/25 at 2:47 PM, she was asked were the grievance forms were located. She stated they are behind the nurse's station and in my office. When asked if the residents would have access to those places without asking the staff for the form, she stated well it is posted on the bulletin board back there. She was asked to show the surveyor where the forms were posted. Upon observation of the bulletin board, it was noted the board was an informational board which had the facility's required postings. She had one (1) single form which was in a sheet protector hanging on the board. She was asked why there was only one (1) form there and she stated, Well I have not replenished them in a while. A board with the same information was later observed on the other side of the facility. This board also contained a grievance form in a page protector sleeve. This board contained all the facility's required postings as did the board SW #11 had shown the surveyor earlier. This board, however, was covered with a sheet of plastic which would have prevented a resident from retrieving the grievance and concern form. Later in the day the Nursing Home Administrator was asked to observe the boards. She was asked if she thought the residents would know that grievance form was for them to take. She stated, No. She agreed it looked like the form was there for informational purposes to show what form was used to file a grievance.

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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 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. 31826 45173 Based on record review and staff interview, the facility failed to ensure residents of the facility were free from abuse and neglect. For Residents #2 and #56, the facility failed to ensure they were free from sexual abuse, committed by Resident #214. For Residents #33, #50, #38, #43, #216, #51, #215, #46, #6, #35, and #17, the facility failed to ensure these residents were free of neglect related to medication administration. For Resident #33, the facility failed to ensure this resident was free from abuse due to misappropriation of medications. For Resident #1, the facility failed to transfer the resident in the correct manner, resulting in neglect. For Resident #20, the facility failed to ensure this resident was free from neglect by failing to ensure the seatbelt was fastened while being transferred in the van. This was true for 16 of 16 residents reviewed for abuse and neglect during the survey process. Resident identifiers: #2, #56, #33, #50, #38, #43, #216, #51, #215, #46, #6, #35, #17, #33, #1, #20. Facility census: 61. The State Agency (SA) determined psychosocial harm was caused to Residents #2 and #56 when Resident #214 sexually assaulted both residents. For Resident #2, the facility returned Resident #2 to the same room with Resident #214, following the incident, and failed to provide documentation that supervision occurred to prevent the issue from happening again. For Resident #56, the facility failed to maintain proper supervision on Resident #214, following an incident of sexual assault on Resident #2, allowing him to sexually assault Resident #56, who has a diagnosis of Post Traumatic Stress Disorder (PTSD) from being raped in prison, and failing to provide documentation showing supervision was held on Resident #214, despite Residents #56 and #214 being roommates. The reasonable person standard was applied to determine the psychosocial harm niether Resident #56 and #2 were not able to verbalize how this affected them due to cognitive impairment. A reasonable person is likely to suffer feelings including but not limited to anger, fear, depression, hopelessness, dispair, and frequent crying spells. Findings include: a) Resident #2 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During review of a facility reported incident (FRI) on 03/04/25, it was discovered Resident #214 had sexually abused Resident #2 on 12/19/24. According to the facility investigation, on 12/19/24, Nurse Aide (NA) #65 noticed Resident #214 with his hand on the groin of Resident #2, under a blanket, while residents were waiting to see the podiatrist in the dining room. NA #65 told Resident #214 to get your hands off of him. At this point, NA #65 stated the resident then pulled his hand out and just looked at me with no response and no emotion. NA #65 stated she pulled Resident #2 away from Resident #214 and informed the unit manager of the incident. Resident #214 remained in the dining room, unsupervised, at this point. Resident #2 was then taken back into the dining room, with Resident #214, while another staff member observed them. Resident #214 was placed on line of sight (LOS) observation while out of bed, and fifteen minute checks. No documentation on LOS observation was provided. Fifteen minute check documentation provided by the facility revealed no one signed off on observing Resident #214. The fifteen minute checks list Resident #214 in bed and room from 12:00 AM on 12/19/224 until 11:45 AM, with the exception of 9:15 AM when the resident was documented as being located at shower. All of these have been signed off by an employee. 12:00 PM to 12:45 PM list the resident's location as bed. 1:00 PM to 1:30 PM lists the location of the resident as podiatry. 1:45 PM to 11:45 PM lists the resident's location as bed. No observation from 12:00 PM to 11:45 PM on 12/19/24 has been signed off on by an employee of the facility, with the initials section left blank. The facility stated the following in their five (5) day follow up investigation report for the incident on 12/19/24: (Resident #214's name) is a new resident who was placed in (facility name) from (correctional facility) because he had no other options. He is a registered sex offender and will remain on 1-1 (one on one observation) as long as necessary. However, there were no orders entered, nor as any documentation provided to support the resident was on one (1) on one (1) observation during this time. In fact, in an interview with the Director of Nursing (DON) on 3/4/25, at approximately 12:55 PM, it was confirmed there were only orders present for Resident #214 to be placed on LOS observation and 15 minute checks, not 1 on 1, following this incident. Resident #2 is nonverbal and a Brief Interview for Mental Status (BIMS) score was unable to be obtained due to the residents diagnoses, which are listed as follows: Spastic quadriplegia; dextrocardia; congenital cranial anomaly; microcephaly; seizure disorder; hyperthyroidism; multinodular goiter; GERD; profound intellectual disabilities. Due to the residents condition, the reasonable person standard was applied, in which it is assumed Resident #2 did not want to be sexually assaulted by Resident #214 and did not wish to be placed back in the same room with his abuser immediately following the incident. b) Resident #56 (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

During review of the FRI involving Resident #214, it was noted a second incident occurred on 12/22/24 at approximately 8:30 AM, this time involving Resident #56. Despite Resident #214 being placed on LOS observation, 15 minute checks and, according to the 5 day follow up, 1 on 1 observation, he was found to have his hand on the groin area of Resident #56. According to the initial report from the facility, (Resident #214's name) moved over to (Resident #56's name) while he was asleep in his wheelchair. He fondled (Resident #56's name) when staff turned their head. The facility stated the following on the 5 day follow up report: (Resident #214's name) was on line of sight when not in bed. He moved his wheelchair close to another resident who was sleeping in his chair in the dayroom. Staff turned their head to check on another resident and when they turned around he was fondling the other resident over top his pants. They were immediately separated and a skin assessment was completed on (Resident #56's name).

A review of Resident #56's medical record indicates he has a diagnosis of Post Traumatic Stress Disorder (PTSD) due to being raped in prison. There was no mention in the resident's care plan about the incident occurring on 12/22/24. Further review of Resident #56's medical record include psych notes, one dated 01/23/25, in which the resident states I'm not safe here. Another psych note dated 02/06/25, the resident states he is being raped and killed. The psych note states the resident's anxiety is rather high.

At approximately 12:49 PM on 03/04/25, an interview was conducted with the facility Social Worker (SW), who is in charge of admissions and investigations. The SW stated He was, we did not feel, stable. He was throwing feces and had other issues. When asked about how the incident occurred on 12/22/24, the SW stated, Staff turned their backs on him. He did it because staff turned their backs and stopped watching him. The SW stated the police were called and during their interview with Resident #214, he stated he had been looking at the facility for cameras and did not notice any, and once he did not see cameras, he decided he was going to abuse someone.

Following this incident, Resident #214 was placed on 1 on 1 observation and an order was obtained at 11:36 AM to send the resident to the hospital. The resident left for the hospital at approximately 12:00 PM on 12/22/24. Resident #214 and #56 resided in the same room. From the time of the incident at approximately 8:30 AM, until the time Resident #214 left for the hospital at approximately 12:00 PM, there is no documentation to support any observations taking place to verify the whereabouts of Resident #214. The 15-minute check forms end on 12/21/24, despite the resident not having an order to discontinue them. At approximately 4:00 PM on 3/4/25, one (1) on one (1) documentation was requested from the facility, showing Resident #214 was observed. The DON confirmed they do not do such documentation. The DON also acknowledged the absence of 15-minute check documentation for 12/22/24, the date of this incident.

Under the Corrective action taken portion of the 5 day follow up, the facility states the following: (Resident #214's name) was on line of sight when not in bed. He has now been sent to (hospital) for a mental hygiene. (Facility) will not be taking him back due to being unable to protect our residents from (Resident #214's name). He fondled another resident on 12/19/24 which was reported.

Staff interviews and Abuse Policy

During an interview with Confidential Employee #1 on 3/4/25, they stated We didn't want to take him (Resident #214) but we weren't given a choice. We were told we had to take him. We tried to not take him.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	At approximately 1:00 PM on 3/4/25 an interview was conducted with the DON regarding the incidents. The DON stated the resident was denied at first, but the hospital sent more documentation that resulted in the resident being accepted to the facility. The DON stated the documentation supplied identified the resident needing assistance with ADLS, such as help with transferring, so the facility decided to accept him at this point. The DON stated during the second incident, the staff were further up the hallway when it occurred and they couldn't get to him before he assaulted Resident #56. Resident #214 was not placed on 1 on 1 observation (despite the 5 day follow up to the initial incident stating he would be, in order to keep others safe) until after the second incident, on 12/22/24, and was only placed on line of sight observation because The thought was if we can see him, we can intervene. The DON acknowledged staff were not able to keep an eye on Resident #214 and broke the line of sight, due to having to care for another resident, allowing him to abuse Resident #56. At approximately 1:25 PM on 03/04/25, an interview was conducted with Registered Nurse (RN) #5 regarding Resident #214. RN #5 was asked how well the resident was able to ambulate in his wheelchair, to which she responded He was agile like a cat, and that surprised me because we were told he needed a lot of assistance and had trouble getting around. I was in his room when he first got here and was waiting on a lift to come so we could get him up, and he just moved himself from his bed to his chair by himself. I was scared because I thought I was going to get in trouble when he did that. But he was a lot more agile than we thought and were told. During a review of the facility's resident to resident abuse policy, Section IV, titled procedure, Section C, states: If the patient is deemed dangerous, they will be placed on an observation level (which will be determined by the Care Team or nursing supervisor on weekends/holidays) until all referrals have been completed. Referrals will also be made to the staff Psychologist, Psychiatrist, and Medical Doctor for evaluation. The observation levels are as such: 1. 1:1 Strict One staff accompanies the patient at all times This one stuff must keep the patient within arms length at all times Document staff observations and patient activities every hour 2. 1:1 Line of Sight/Constant Awareness One staff assigned to keep patient in view at all times Document staff observations and patient activities every hour 3. Fifteen (15) minute checks At a minimum check every 15 minutes around the clock The patient will participate in all unit activities, being observed every 15 minutes by the assigned staff Documentation of staff at least every 15 minutes (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	4. Routine Observation Patient will participate in all unit and facility activities, being observed by assigned staff as normal The facility failed to have a person assigned to Resident #214, as stated in the aforementioned policy and, failed to keep documentation as required. During an interview with the DON at approximately 11:15 AM on 03/12/25, it was confirmed the facility did not follow the policy stated above, failing to take appropriate actions to keep residents safe from further incidents of abuse by another resident. The DON stated there is typically one staff member assigned to the resident, however, that staff member still helps assist with other residents as well, which would require them to leave their assigned resident they are observing. The DON stated if a Nurse Aide is not available to observe the assigned resident, they should ask the Unit Manager to observe them. If the unit manager is not available, they should ask a Nurse Aide from another unit to come down and observe their resident while they help, potentially pulling a staff member from another unit. c) Resident #33 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration and neurological (neuro) checks on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed: --Cranberry Capsule --Aricept --Memantine --Remeron --Seroquel The following neuro checks were missed: --07/13/24 8:00 PM --07/14/24 12:01 AM --07/14/24 4:00 AM On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility. (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

d) Resident #33

On 03/03/24 at 3:00 PM, a review of an FRI was completed. The review found on 11/15/24 at 12:00 PM, Registered Nurse (RN) #26 and RN #3 were both in the medication room, which is verified by facility video. RN #3 was complaining about being sick to her stomach. RN #26 was told by RN #3 which resident had Zofran available. RN #26 looked at the resident's medication and none was available. Then, RN #3 told RN #26 that was the wrong resident and then proceeded to tell RN #26 another resident, who had Zofran available. RN #26 got the medication card and popped the pill out. The pill was dropped and RN #3 proceeded to pick the pill up from the floor, obtained some water and took the pill. Both RN #3 and RN #26 were suspended throughout the investigation. RN #3 signed a consent for a drug testing. The drug testing was found to be negative of any substances.

On 03/04/25 at 12:50 PM, the DON was interviewed regarding this incident. The DON stated, both of the RNs are still working here, both were given education and discipline, and both were suspended for three (3) days without pay. Therefore, the incident was substantiated for misappropriation of resident property by the facility.

e) Resident #50

On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed:

--Klonopin

--Lithium

--Melatonin

--Zyprexa

--Trileptal

--Miralax

On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility.

f) Resident #51

On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late:

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F 0600 Level of Harm - Actual harm Residents Affected - Few	--Neurontin--2 hours and 10 minutes --Hydrocodone-Acetaminophen 5/325mg--2 hours and 10 minutes --Buspar--2 hours and 10 minutes --Robaxin--2 hours and 10 minutes --Metoprolol Tartrate--2 hours and 10 minutes --Wellbutrin XL--2 hours and 10 minutes On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility. g) Resident #62 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed: --Acetaminophen --Zyprexa --Miralax --Depakote On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility. h) Resident #46 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed: --Eliquis --Vitamin C (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	--Depakote --Metoprolol Succinate --Zyprexa --Miralax --Hiprex On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility. i) Resident #216 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late: --Levsin--2 hours and 17 minutes late --Senna--2 hours and 17 minutes late --Claritin--3 hours and 18 minutes late On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility. j) Resident #38 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed: --Acetaminophen/Codeine 30mg --Vitamin C --Bisacodyl suppository --Klonopin (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	--Lamictal --Lithium --Risperdal --Symbicort inhaler On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility. k) Resident #43 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late: --Zyprexa--3 hours and 19 minutes --Coreg--2 hours and 20 minutes --Klonopin--2 hours and 21 minutes --Buspar--2 hours and 21 minutes --Latanoprost eye drops--2 hours and 22 minutes On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility. l) Resident #6 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late: --Neurontin--2 hours and 8 minutes On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	m) Resident #35 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late: --Hydrocodone/Acetaminophen 7.5/325mg--1 hour and 19 minutes --Trazodone--1 hour and 20 minutes --Fibercon--1 hour and 20 minutes --Buspar--2 hours and 22 minutes On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration and neurological (neuro) checks on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed: --Cranberry Capsule --Aricept --Memantine --Remeron --Seroquel The following neuro checks were missed: --07/13/24 8:00 PM --07/14/24 12:01 AM --07/14/24 4:00 AM On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility. n) Resident #17 (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 0600 Level of Harm - Actual harm Residents Affected - Few	On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late: --Clozaril--2 hours and 58 minutes --Depakote 1 hour and 58 minutes --Coreg--1 hour and 58 minutes --Keppra--1 hour and 59 minutes --Tramadol--1 hour and 59 minutes On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration and neurological (neuro) checks on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed: --Cranberry Capsule --Aricept --Memantine --Remeron --Seroquel The following neuro checks were missed: --07/13/24 8:00 PM --07/14/24 12:01 AM --07/14/24 4:00 AM On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the incident did happen and LPN #134 was terminated for not completing her nursing duties. LPN #134 was found to be vaping and talking on her telephone in the medication room for multiple hours. Therefore, the incident was substantiated for neglect by the facility. n) Resident #1 (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 0600 Level of Harm - Actual harm Residents Affected - Few	On 03/04/25 at 9:20 PM Nurse Aide (NA) #107 was observed transferring Resident #1 from his recliner in the hallway to his wheelchair. NA #107 completed the transfer by himself and had the assistance of no other staff members. No devices were used for this transfer. The resident was wearing no skid sock during this transfer. On 03/04/25 at 9:29 PM, NA #107 was again observed transferring Resident #1 from his wheelchair to his recliner in the hallway. NA #107 again completed this transfer by himself with no assistance from any other staff member. At the time of this transfer Resident #1 was barefooted. No Devices were used for this transfer. At 9:32 PM a review of Resident #1's fall prevention care plan was completed. This review found the resident was to be assisted with two (2) staff members with all transfers. The care plan also indicated the resident was to be encouraged to wear special orthotic shoes for safer transfers and prevention of falls. Another focus statement on Resident #1's care plan read as follows, (First Name of Resident #1) requires 2 person assist with bed mobility, with transferring, and ambulation due to severe intellectual disabilities, cerebral palsey . At 9:35 PM on 03/04/25, NA #107 was asked to identify how he would know the transfer status of a resident he stated, We look at the kardex. Charge Nurse (CN) #12 was asked to review Resident #1's Kardex and to inform the surveyor how Resident #1 was to be transferred. She confirmed at 9:38 PM on 03/04/25 the resident was to be transferred with the assistance of two (2) staff members. She showed the surveyor this information on the Kardex. The kardex was located in the hallway and was accessible to NA #107. An interview with NA #107 at 9:40 PM confirmed he transferred the resident by himself. He reviewed the Kardex and stated, I did it wrong because I did it by myself. The surveyor then reviewed the Kardex for Resident #1. The kardex read as follows related to transfers: Transfer Dependent 2 assist Limited brief type transfer device to be used. Further review of the care plan comments found the following, 02/17/25 fall slid to floor during transfer from recliner to w/c (wheelchair) no injury interventions in place. A review of the ADL flow sheets on the morning of 03/10/25 for Resident #1, for the date of 02/17/25 confirmed the staff who was transferring the resident during this transfer documented the resident was transferred via extensive assist with the help of one (1) staff member. Further review of the ADL flow sheets for the remainder of February, 25 found for every night shift transfer the NA's were documenting Resident #1 was transferred via extensive assist with the assistance of one (1) staff member. This indicated a systemic failure in the transfers of Resident #1 which should have been identified and address by the facility prior to the IJ situation. However this was not identified by the facility staff prior to the surveyor alerting the Nursing Home Administrator of the ADL flow sheet documentation on 03/10/25 at 11:00 am. No reeducation of staff was completed nor was this aide reported for neglect prior to the IJ situation on 03/04/25. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	NA #107 and NA #81 both neglected Resident #1 by not transferring him in a manner which met his needs as it was reflected in his plan of care. The resident is at risk for injury as a result of their neglectful behavior. o) Resident #20 On 03/10/25 at 10:19 AM, a review of the facility's reportable of an unusual occurrence found the following, Resident #20 was taken to an appointment on 04/04/24 the resident was being transported to an appointment and refused to wear his seat belt and the resident slid out of the seat when they went around a sharp curve. An interview with the NHA on 03/10/25 confirmed they did some education that if they refuse to wear the seatbelt that they should not go on the transport. The NHA was unable to provide evidence this training was completed. She was unable to find the sign in sheets. The NHA provided the surveyor with the facility incident report related to this incident. A review of the incident found that NA #94 and NA #93 were the staff which went on the transport with Resident #20 on this date. NA #94 was driving and NA #93 was in the back of the van with Resident #20. The incident report contained the following under the heading Comments: Resident was in the van going to his Dr.'s appointment. Resident refused to put seat belt on. While going around a sharp turn resident slid off his seat and into the floor. Resident stated, Get me back in my seat. The comments under the heading findings found the following, Resident was not secured by seatbelt during transport, thus slid to floor during sharp turn. Resident was sitting in van seat during transport. The actions taken by the facility were listed as, Had resident sit in his w/c (wheelchair) on return back. Resident is to be secured by seatbelt during all transportation. The NHA was asked if any statements were obtained from staff related to this incident. The NHA confirmed in the afternoon of 03/11/25 that no statements were obtained. She provided a list of all staff who assist resident with van transfers. The following staff from the list provided were interviewed beginning at 1:30 PM on 03/11/25: Activity Director, Recreation Specialist (RS) #48 and RS #1, all indicated if a resident refuses to wear their seatbelt they should not be transported. RS #48 and RS #1 stated they would report it to the Activity Director and the resident would not be allowed to go on the trip. All three (3) agreed it has always been this way. The activity director has worked at the facility since 1989, RS #48 has worked at the facility since 1999. RS # has worked at the facility since 2022. NA #31 who works in the special needs program at the facility indicated if a resident was to refuse to wear their seatbelt, she would not take them on the transport. She indicated the vehicle cannot move until the resident is secured. She stated it has always been this way and not something that had recently came about. She has been an employee of the facility since 2017. Office Assistant #64 stated, If they refuse to wear their seatbelt then they can not go on a transport. OA #64 was then asked if this was a change since the incident or has it always been this way and she stated, I have been doing transports for a little over two (2) years and it has always been that way. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The NHA was again interviewed at 1:45 PM on 03/11/25 and was made aware of the above interviews. She stated, Well that tells me they knew better. When asked if NA #94 and NA #93 were reported for neglect for not ensuring Resident #20 was wearing a seatbelt she stated they were not. She was asked to provide any training to the staff who go on transports prior to transporting. Later in the afternoon she stated, They only receive training on the state vehicle use policy. A review of the state vehicle use policy found the following, .Seat Belts must be worn at all times On the morning of 03/12/25 the two (2) staff accompanying Resident #20 on this trip was interviewed. NA #93 confirmed she was in the back of the van with Resident #20. She stated she had assumed the other staff member has fastened his seat belt and she did not check it prior to leaving. She stated, I didn't know he was unbuckled until he slid out of the seat. She indicated

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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. 31826 Based on record review, policy review, observation and staff interview the facility failed to implement their abuse and neglect policy by failing to report all allegations of abuse and/or neglect to the appropriate state agencies. For resident #2 and #56 the facility failed to identify a resident with a history of sexually predatory behavior and put into place interventions to prevent the sexual abuse of other residents. This was true for five (5) of 16 residents reviewed for the care area of abuse during the long termcare survey process. Resident Identifiers: #1, #20,#12, #2, and #56. Facility Census: 61. Findings Include: a) Policy review A review of the facility's policy titled Abuse, Neglect, Exploitation, and Misappropriation reporting and investigating with a policy accepting date of 03/2023 found the following pertaining to the reporting of alleged allegations: .Reporting Allegations to the Administrator and Authorities If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. . Immediately is defined as: Within two hours of an allegation involving abuse or results in serious bodily injury . b) Resident #1 On 03/04/25 at 9:20 PM Nurse Aide (NA) #107 was observed transferring Resident #1 from his recliner in the hallway to his wheelchair. NA #107 completed the transfer by himself and had the assistance of no other staff members. No devices were used for this transfer. The resident was wearing no skid sock during this transfer. On 03/04/25 at 9:29 PM, NA #107 was again observed transferring Resident #1 from his wheelchair to his recliner in the hallway. NA #107 again completed this transfer by himself with no assistance from any other staff member. At the time of this transfer Resident #1 was barefooted. No Devices were used for this transfer. At 9:32 PM a review of Resident #1's fall prevention care plan was completed. This review found the resident was to be assisted with two (2) staff members with all transfers. The care plan also indicated the resident was to be encouraged to wear special orthotic shoes for safer transfers and prevention of falls. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another focus statement on Resident #1's care plan read as follows, (First Name of Resident #1) requires 2 person assist with bed mobility, with transferring, and ambulation due to severe intellectual disabilities, cerebral palsey . At 9:35 PM on 03/04/25, NA #107 was asked to identify how he would know the transfer status of a resident he stated, We look at the kardex. Charge Nurse (CN) #12 was asked to review Resident #1's Kardex and to inform the surveyor how Resident #1 was to be transferred. She confirmed at 9:38 PM on 03/04/25 the resident was to be transferred with the assistance of two (2) staff members. She showed the surveyor this information on the Kardex. The kardex was located in the hallway and was accessible to NA #107. An interview with NA #107 at 9:40 PM confirmed he transferred the resident by himself. He reviewed the Kardex and stated, I did it wrong because I did it by myself. An interview with the NHA on 03/05/25 at 5:19 PM was asked if NA #107 had been reported to the appropriate state agencies for neglect. She stated, It should have been let me check. At 5:26 PM on 03/05/25 the NHA stated, It had not been reported but she is reporting it now. c) Resident #12 On 03/04/25 at 1:14 PM a review of the resident council minutes found Resident #12 stated, someone gave him a shot in the middle of the night. This form was signed by the activities representative and the Nursing Home administrator. A review of the resident's record indicated he had a BIMS of 15 which indicated he is cognitively intact. At 1:10 pm on 03/04/25 an interview with the Social Worker found this had not been reported to any state agencies. She stated, I did not report this because they did not show it to me. At 3:57 PM on 03/04/25 an interview with the Nursing Home Administrator confirmed this allegation was not reported and should have been. d) Resident #20 On 03/10/25 at 10:19 AM, a review of the facility's reportable of an unusual occurrence found the following, Resident #20 was taken to an appointment on 04/04/24 the resident was being transported to an appointment and refused to wear his seat belt and the resident slid out of the seat when they went around a sharp curve. The NHA provided the surveyor with the facility incident report related to this incident. A review of the incident report found that NA #94 and NA #93 were the staff which went on the transport with Resident #20 on this date. NA #94 was driving and NA #93 was in the back of the van with Resident #20. (continued on next page)

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The incident report contained the following under the heading Comments: Resident was in the van going to his Dr.'s appointment. Resident refused to put seat belt on. While going around a sharp turn resident slid off his seat and into the floor. Resident stated, Get me back in my seat.

The comments under the heading findings found the following, Resident was not secured by seatbelt during transport, thus slid to floor during sharp turn. Resident was sitting in van seat during transport. The actions taken by the facility were listed as, Had resident sit in his w/c (wheelchair) on return back. Resident is to be secured by seatbelt during all transportation.

The NHA was asked if any statements were obtained from staff related to this incident. The NHA confirmed in the afternoon of 03/11/25 that no statements were obtained. She provided a list of all staff who assist resident with van transfers. The following staff from the list provided were interviewed beginning at 1:30 PM on 03/11/25:

Activity Director, Recreation Specialist (RS) #48 and RS #1, all indicated if a resident refuses to wear their seatbelt they should not be transported. RS #48 and RS #1 stated they would report it to the Activity Director and the resident would not be allowed to go on the trip. All three (3) agreed it has always been this way. The activity director has worked at the facility since 1989, RS #48 has worked at the facility since 1999. RS # has worked at the facility since 2022.

NA #31 who works in the special needs program at the facility indicated if a resident was to refuse to wear their seatbelt she would not take them on the transport. She indicated the vehicle can not move until the resident is secured. She stated it has always been this way and not something that had recently came about. She has been an employee of the facility since 2017.

Office Assistant #64 stated, If they refuse to wear their seatbelt then they can not go on a transport. OA #64 was then asked if this was a change since and incident or has it always been this way and she stated, I have been doing transports for a little over two (2) years and it has always been that way.

The NHA was again interviewed at 1:45 PM on 03/11/25 and was made aware of the above interviews. She stated, Well that tells me they knew better. When asked if NA #94 and NA #93 were reported for neglect for not ensuring Resident #20 was wearing a seatbelt she stated they were not. She was asked to provide any training the staff who go on transports receive prior to transporting. Later in the afternoon she stated, They only receive training on the state vehicle use policy.

A review of the state vehicle use policy found the following, .Seat Belts must be worn at all times

On the morning of 03/12/25 the two (2) staff accompanying Resident #20 on this trip was interviewed. NA #93 confirmed she was in the back of the van with Resident #20. She stated she had assumed the other staff member had fastened his seat belt and she did not check it prior to leaving. She stated, I didn't know he was unbuckled until he slid out of the seat. She indicated if she had known he was not secured she would not have left on the transport until he was secured. She stated, On the way back I ensured he was buckled myself.

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

NA #94 was out of the facility on another transport however she did call into the facility to speak with this surveyor. During the telephone interview, NA #94 stated, It was awhile ago and she didn't remember all the details. When asked who usually takes care of strapping in the residents she indicated it is usually the person who loads them into the vehicle. She was unable to recall if that was her or NA #93. She stated, But (Name of Resident #20) unbuckles himself all the time. Another unidentified staff member could be heard in the background saying, He has done that to me before. NA #94 stated When he does that we have to pull over and get him buckled back up. NA #94 stated, He has always done that he don't like the seat belt. When asked if she had known the resident was not buckled what she would have done she stated, We would not have left with him.

e) Resident #2

During review of a facility reported incident (FRI) on 3/4/25, it was discovered Resident #214 had sexually abused Resident #2 on 12/19/24. According to the facility investigation, on 12/19/24, Nurse Aide (NA) #65 noticed Resident #214 with his hand on the groin of Resident #2, under a blanket, while residents were waiting to see the podiatrist in the dining room. NA #65 told Resident #214 to get your hands off of him. At this point, NA #65 stated the resident then pulled his hand out and just looked at me with no response and no emotion. NA #65 stated she pulled Resident #2 away from Resident #214 and informed the unit manager of the incident. Resident #214 remained in the dining room, unsupervised, at this point. Resident #2 was then taken back into the dining room, with Resident #214, while another staff member observed them. Resident #214 was placed on line of sight (LOS) observation while out of bed, and fifteen minute checks. No documentation on LOS observation was provided. Fifteen minute check documentation provided by the facility revealed no one signed off on observing Resident #214. The fifteen minute checks list Resident #214 in bed and room from 12:00 AM on 12/19/24 until 11:45 AM, with the exception of 9:15 AM when the resident was documented as being located at shower. All of these have been signed off by an employee. 12:00 PM to 12:45 PM list the residents location as bed. 1:00 PM to 1:30 PM lists the location of the resident as podiatry. 1:45 PM to 11:45 PM lists the resident's location as bed. No observation from 12:00 PM to 11:45 PM on 12/19/24 has been signed off on by an employee of the facility, with the initials section left blank.

The facility stated the following in their five (5) day follow up investigation report for the incident on 12/19/24: (Resident #214's name) is a new resident who was placed in (facility name) from (correctional facility) because he had no other options. He is a registered sex offender and will remain on 1-1 (one on one observation) as long as necessary. However, there were no orders entered, nor as any documentation provided to support the resident was on one (1) on one (1) observation during this time. In fact, in an interview with the Director of Nursing (DON) on 03/04/25, at approximately 12:55 PM, it was confirmed there were only orders present for Resident #214 to be placed on LOS observation and 15 minute checks, not 1 on 1, following this incident.

Resident #2 is nonverbal and a Brief Interview for Mental Status (BIMS) score was unable to be obtained due to the residents diagnoses, which are listed as follows: Spastic quadriplegia; dextrocardia; congenital cranial anomaly; microcephaly; seizure disorder;hyperthyroidism; multinodular goiter; GERD; profound intellectual disabilities. Due to the residents condition, the reasonable person standard was applied, in which it is assumed Resident #2 did not want to be sexually assaulted by Resident #214 and did not wish to be placed back in the same room with his abuser immediately following the incident.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's resident to resident abuse policy, Section IV, titled procedure, Section C, states: If the patient is deemed dangerous they will be placed on an observation level (which will be determined by the Care Team or nursing supervisor on weekends/holidays) until all referrals have been completed. Referrals will also be made to the staff Psychologist, Psychiatrist, and Medical Doctor for evaluation. The observation levels are as such: 1. 1:1 Strict One staff accompanies the patient at all times This one stuff must keep the patient within arms length at all times Document staff observations and patient activities every hour 2. 1:1 Line of Sight/Constant Awareness One staff assigned to keep patient in view at all times Document staff observations and patient activities every hour 3. Fifteen (15) minute checks At a minimum check every 15 minutes around the clock The patient will participate in all unit activities, being observed every 15 minutes by the assigned staff Documentation of staff at least every 15 minutes 4. Routine Observation Patient will participate in all unit and facility activities, being observed by assigned staff as normal The facility failed to have a person assigned to Resident #214, as stated in the aforementioned policy and, failed to keep documentation as required. During an interview with the DON at approximately 11:15 AM on 3/12/25, it was confirmed the facility did not follow the policy stated above, failing to take appropriate actions to keep residents safe from further incidents of abuse by another resident. The DON stated there is typically one staff member assigned to the resident, however, that staff member still helps assist with other residents as well, which would require them to leave their assigned resident they are observing. The DON stated if a Nurse Aide is not available to observe the assigned resident, they should ask the Unit Manager to observe them. If the unit manager is not available, they should ask a Nurse Aide from another unit to come down and observe their resident while they help, potentially pulling a staff member from another unit. E) Resident #56 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Lakin Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 11522 Ohio River Road West Columbia, WV 25287	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of the FRI involving Resident #214, it was noted a second incident occurred on 12/22/24 at approximately 8:30 AM, this time involving Resident #56. Despite Resident #214 being placed on LOS observation, 15 minute checks and, according to the 5 day follow up, 1 on 1 observation, he was found to have his hand on the groin area of Resident #56. According to the initial report from the facility, (Resident #214's name) moved over to (Resident #56's name) while he was asleep in his wheelchair. He fondled (Resident #56's name) when staff turned their head. The facility stated the following on the 5 day follow up report: (Resident #214's name) was on line of sight when not in bed. He moved his wheelchair close to another resident who was sleeping in his chair in the dayroom. Staff turned their head to check on another resident and when they turned around he was fondling the other resident over top his pants. They were immediately separated and a skin assessment was completed on (Resident #56's name). A review of Resident #56's medical record indicates he has a diagnosis of Post Traumatic Stress Disorder (PTSD) due to being raped in prison. There was no mention in the resident's care plan about the incident occurring on 12/22/24. Further review of Resident #56's medical record include psych notes, one dated 1/23/25, in which the resident states I'm not safe here. Another psych note dated 2/6/25, the resident states he is being raped and killed. The psych note states the resident's anxiety is rather high. At approximately 12:49 PM on 03/04/25, an interview was conducted with the facility Social Worker (SW), who is in charge of admissions and investigations. The SW stated He was, we did not feel, stable. He was throwing feces and had other issues. When asked about how the incident occurred on 12/22/24, the SW stated, Staff turned their back on him. He did it because staff turned their back and stopped watching him. The SW stated the police were called and during their interview with Resident #214, he stated he had been looking at the facility for cameras and did not notice any, and once he did not see cameras, he decided he was going to abuse someone. Following this incident, Resident #214 was placed on 1 on 1 observation and an order was obtained at 11:36 AM to send the resident to the hospital. The resident left for the hospital at approximately 12:00 PM on 12/22/24. Resident #214 and #56 resided in the same room. From the time of the incident at approximately 8:30 AM, until the time Resident #214 left for the hospital at approximately 12:00 PM, there is no documentation to support any observations taking place to verify the whereabouts of Resident #214. The 15 minute check forms end on 12/21/25, despite the resident not having an order to discontinue them. At approximately 4:00 PM on 3/4/25, one (1) on one (1) documentation was requested from the facility, showing Resident #214 was observed. The DON confirmed they do not do such documentation. The DON also acknowledged the absence of 15 minute check documentation for 12/22/24, the date of this incident. Under the Corrective action taken portion of the 5 day follow up, the facility states the following: (Resident #214's name) was on line of sight when not in bed. He has now been sent to (hospital) for a mental hygiene. (Facility) will not be taking him back due to being unable to protect our residents from (Resident #214's name). He fondled another resident on 12/19/24 which was reported. During a review of the facility's resident to resident abuse policy, Section IV, titled procedure, Section C, states: If the patient is deemed dangerous they will be placed on an observation level (which will be determined by the Care Team or nursing supervisor on weekends/holidays) until all referrals have been completed. Referrals will also be made to the staff Psychologist, Psychiatrist, and Medical Doctor for evaluation. The observation levels are as such: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. 1:1 Strict One staff accompanies the patient at all times This one stuff must keep the patient within arms length at all times Document staff observations and patient activities every hour 2. 1:1 Line of Sight/Constant Awareness One staff assigned to keep patient in view at all times Document staff observations and patient activities every hour 3. Fifteen (15) minute checks At a minimum check every 15 minutes around the clock The patient will participate in all unit activities, being observed every 15 minutes by the assigned staff Documentation of staff at least every 15 minutes 4. Routine Observation Patient will participate in all unit and facility activities, being observed by assigned staff as normal The facility failed to have a person assigned to Resident #214, as stated in the aforementioned policy and, failed to keep documentation as required. During an interview with the DON at approximately 11:15 AM on 3/12/25, it was confirmed the facility did not follow the policy stated above, failing to take appropriate actions to keep residents safe from further incidents of abuse by another resident. The DON stated there is typically one staff member assigned to the resident, however, that staff member still helps assist with other residents as well, which would require them to leave their assigned resident they are observing. The DON stated if a Nurse Aide is not available to observe the assigned resident, they should ask the Unit Manager to observe them. If the unit manager is not available, they should ask a Nurse Aide from another unit to come down and observe their resident while they help, potentially pulling a staff member from another unit. 49467 D) Resident #2 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of a facility reported incident (FRI) on 3/4/25, it was discovered Resident #214 had sexually abused Resident #2 on 12/19/24. According to the facility investigation, on 12/19/24, Nurse Aide (NA) #65 noticed Resident #214 with his hand on the groin of Resident #2, under a blanket, while residents were waiting to see the podiatrist in the dining room. NA #65 told Resident #214 to get your hands off of him. At this point, NA #65 stated the resident then pulled his hand out and just looked at me with no response and no emotion. NA #65 stated she pulled Resident #2 away from Resident #214 and informed the unit manager of the incident. Resident #214 remained in the dining room, unsupervised, at this point. Resident #2 was then taken back into the dining room, with Resident #214, while another staff member observed them. Resident #214 was placed on line of sight (LOS) observation while out of bed, and fifteen minute checks. No documentation on LOS observation was provided. Fifteen minute check documentation provided by the facility revealed no one signed off on observing Resident #214. The fifteen minute checks list Resident #214 in bed and room from 12:00 AM on 12/19/24 until 11:45 AM, with the exception of 9:15 AM when the resident was documented as being located at shower. All of these have been signed off by an employee. 12:00 PM to 12:45 PM list the residents location as bed. 1:00 PM to 1:30 PM lists the location of the resident as podiatry. 1:45 PM to 11:45 PM lists the resident's location as bed. No observation from 12:00 PM to 11:45 PM on 12/19/24 has been signed off on by an employee of the facility, with the initials section left blank. The facility stated the following in their five (5) day follow up investigation report for the incident on 12/19/24: (Resident #214's name) is a new resident who was placed in (facility name) from (correctional facility) because he had no other options. He is a registered sex offender and will remain on 1-1 (one on one observation) as long as necessary. However, there were no orders entered, nor as any documentation provided to support the resident was on one (1) on one (1) observation during this time. In fact, in an interview with the Director of Nursing (DON) on 3/4/25, at approximately 12:55 PM, it was confirmed there were only orders present for Resident #214 to be placed on LOS observation and 15 minute checks, not 1 on 1, following this incident. Resident #2 is nonverbal and a Brief Interview for Mental Status (BIMS) score was unable to be obtained due to the residents diagnoses, which are listed as follows: Spastic quadriplegia; dextrocardia; congenital cranial anomaly; microcephaly; seizure disorder;hyperthyroidism; multinodular goiter; GERD; profound intellectual disabilities. Due to the residents condition, the reasonable person standard was applied, in which it is assumed Resident #2 did not want to be sexually assaulted by Resident #214 and did not wish to be placed back in the same room with his abuser immediately following the incident. During a review of the facility's resident to resident abuse policy, Section IV, titled procedure, Section C, states: If the patient is deemed dangerous they will be placed on an observation level (which will be determined by the Care Team or nursing supervisor on weekends/holidays) until all referrals have been completed. Referrals will also be made to the staff Psychologist, Psychiatrist, and Medical Doctor for evaluation. The observation levels are as such: 1. 1:1 Strict One staff accompanies the patient at all times This one stuff must keep the patient within arms length at all times Document staff observations and patient activities every hour (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. 1:1 Line of Sight/Constant Awareness One staff assigned to keep patient in view at all times Document staff observations and patient activities every hour 3. Fifteen (15) minute checks At a minimum check every 15 minutes around the clock The patient will participate in all unit activities, being observed every 15 minutes by the assigned staff Documentation of staff at least every 15 minutes 4. Routine Observation Patient will participate in all unit and facility activities, being observed by assigned staff as normal The facility failed to have a person assigned to Resident #214, as stated in the aforementioned policy and, failed to keep documentation as required. During an interview with the DON at approximately 11:15 AM on 3/12/25, it was confirmed the facility did not follow the policy stated above, failing to take appropriate actions to keep residents safe from further incidents of abuse by another resident. The DON stated there is typically one staff member assigned to the resident, however, that staff member still helps assist with other residents as well, which would require them to leave their assigned resident they are observing. The DON stated if a Nurse Aide is not available to observe the assigned resident, they should ask the Unit Manager to observe them. If the unit manager is not available, they should ask a Nurse Aide from another unit to come down and observe their resident while they help, potentially pulling a staff member from another unit. E) Resident #56 During review of the FRI involving Resident #214, it was noted a second incident occurred on 12/22/24 at approximately 8:30 AM, this time involving Resident #56. Despite Resident #214 being placed on LOS observation, 15 minute checks and, according to the 5 day follow up, 1 on 1 observation, he was found to have his hand on the groin area of Resident #56. According to the initial report from the facility, (Resident #214's name) moved over to (Resident #56's name) while he was asleep in his wheelchair. He fondled (Resident #56's name) when staff turned their head. The facility stated the following on the 5 day follow up report: (Resident #214's name) was on line of sight when not in bed. He moved his wheelchair close to another resident who was sleeping in his chair in the dayroom. Staff turned their head to check on another resident and when they turned around he was fondling the other resident over top his pants. They were immediately separated and a skin assessment was completed on (Resident #56's name). (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #56's medical record indicates he has a diagnosis of Post Traumatic Stress Disorder (PTSD) due to being raped in prison. There was no mention in the resident's care plan about the incident occurring on 12/22/24. Further review of Resident #56's medical record include psych notes, one dated 1/23/25, in which the resident states I'm not safe here. Another psych note dated 2/6/25, the resident states he is being raped and killed. The psych note states the resident's anxiety is rather high. At approximately 12:49 PM on 3/4/25, an interview was conducted with the facility Social Worker (SW), who is in charge of admissions and investigations. The SW stated He was, we did not feel, stable. He was throwing feces and had other issues. When asked about how the incident occurred on 12/22/24, the SW stated, Staff turned their back on him. He did it because staff turned their back and stopped watching him. The SW stated the police were called and during their interview with Resident #214, he stated he had been looking at the facility for cameras and did not notice any, and once he did not see cameras, he decided he was going to abuse someone. Following this incident, Resident #214 was placed on 1 on 1 observation and an order was obtained at 11:36 AM to send the resident to the hospital. The resident left for the hospital at approximately 12:00 PM on 12/22/24. Resident #214 and #56 resided in the same room. From the time of the incident at approximately 8:30 AM, until the time Resident #214 left for the hospital at approximately 12:00 PM, there is no documentation to support any observations taking place to verify the whereabouts of Resident #214. The 15 minute check forms end on 12/21/25, despite the resident not having an order to discontinue them. At approximately 4:00 PM on 3/4/25, one (1) on one (1) documentation was requested from the facility, showing Resident #214 was observed. The DON confirmed they do not do such documentation. The DON also acknowledged the absence of 15 minute check documentation for 12/22/24, the date of this incident. Under the Corrective action taken portion of the 5 day follow up, the facility states the following: (Resident #214's name) was on line of sight when not in bed. He has now been sent to (hospital) for a mental hygiene. (Facility) will not be taking him back due to being unable to protect our residents from (Resident #214's name). He fondled another resident on 12/19/24 which was reported. During a review of the facility's resident to resident abuse policy, Section IV, titled procedure, Section C, states: If the patient is deemed dangerous they will be placed on an observation level (which will be determined by the Care Team or nursing supervisor on weekends/holidays) until all referrals have been completed. Referrals will also be made to the staff Psychologist, Psychiatrist, and Medical Doctor for evaluation. The observation levels are as such: 1. 1:1 Strict One staff accompanies the patient at all times This one stuff must keep the patient within arm's length at all times Document staff observations and patient activities every hour 2. 1:1 Line of Sight/Constant Awareness One staff assigned to keep patient in view at all times (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Document staff observations and patient activities every hour 3. Fifteen (15) minute checks At a minimum check every 15 minutes around the clock The patient will participate in all unit activities, being observed every 15 minutes by the assigned staff Documentation of staff at least every 15 minutes 4. Routine Observation Patient will participate in all unit and facility activities, being observed by assigned staff as normal The facility failed to have a person assigned to Resident #214, as stated in the aforementioned policy and, failed to keep documentation as required. During an interview with the DON at approximately 11:15 AM on 3/12/25, it was confirmed the facility did not follow the policy stated above, failing to take appropriate actions to keep residents safe from further incidents of abuse by another resident. The DON stated there is typically one staff member assigned to the resident, however, that staff member still helps assist with other residents as well, which would require them to leave their assigned resident they are observing. The DON stated if a Nurse Aide is not available to observe the assigned resident, they should ask the Unit Manager to observe them. If the unit manager is not available, they should ask a Nurse Aide from another unit to come down and observe their resident while they help, potentially pulling a staff member from another unit.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31826 Based on record review and staff interview the facility failed to ensure all allegations of abuse and or neglect were reported to all state agencies as required. This was true for three (3) of 16 residents reviewed for the care area of abuse during the long term care survey process. Resident Identifiers: #1, #12, and #20. Facility Census: 61. Findings Include: a) Resident #1 On 03/04/25 at 9:20 PM Nurse Aide (NA) #107 was observed transferring Resident #1 from his recliner in the hallway to his wheelchair. NA #107 completed the transfer by himself and had the assistance of no other staff members. No devices were used for this transfer. The resident was wearing no skid sock during this transfer. On 03/04/25 at 9:29 PM, NA #107 was again observed transferring Resident #1 from his wheelchair to his recliner in the hallway. NA #107 again completed this transfer by himself with no assistance from any other staff member. At the time of this transfer Resident #1 was barefooted. No Devices were used for this transfer. At 9:32 PM a review of Resident #1's fall prevention care plan was completed. This review found the resident was to be assisted with two (2) staff members with all transfers. The care plan also indicated the resident was to be encouraged to wear special orthotic shoes for safer transfers and prevention of falls. Another focus statement on Resident #1's care plan read as follows, (First Name of Resident #1) requires 2 person assist with bed mobility, with transferring, and ambulation due to severe intellectual disabilities, cerebral palsy . At 9:35 PM on 03/04/25, NA #107 was asked to identify how he would know the transfer status of a resident he stated, We look at the kardex. Charge Nurse (CN) #12 was asked to review Resident #1's Kardex and to inform the surveyor how Resident #1 was to be transferred. She confirmed at 9:38 PM on 03/04/25 the resident was to be transferred with the assistance of two (2) staff members. She showed the surveyor this information on the Kardex. The kardex was located in the hallway and was accessible to NA #107. An interview with NA #107 at 9:40 PM confirmed he transferred the resident by himself. He reviewed the Kardex and stated, I did it wrong because I did it by myself. An interview with the NHA on 03/05/25 at 5:19 PM was asked if NA #107 had been reported to the appropriate state agencies for neglect. She stated, It should have been let me check. At 5:26 PM on 03/05/25 the NHA stated, It had not been reported but she is reporting it now. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b) Resident #12 On 03/04/25 at 1:14 PM a review of the resident council minutes found Resident #12 stated, someone gave him a shot in the middle of the night. This form was signed by the activities representative and the Nursing Home administrator. A review of the resident's record indicated he had a BIMS of 15 which indicated he is cognitively intact. At 1:10 pm on 03/04/25 an interview with the Social Worker found this had not been reported to any state agencies. She stated, I did not report this because they did not show it to me. At 3:57 PM on 03/04/25 an interview with the Nursing Home Administrator confirmed this allegation was not reported and should have been. c) Resident #20 On 03/10/25 at 10:19 AM, a review of the facility's reportable of an unusual occurrence found the following, Resident #20 was taken to an appointment on 04/04/24 the resident was being transported to an appointment and refused to wear his seat belt and the resident slid out of the seat when they went around a sharp curve. The NHA provided the surveyor with the facility incident report related to this incident. A review of the incident report found that NA #94 and NA #93 were the staff which went on the transport with Resident #20 on this date. NA #94 was driving and NA #93 was in the back of the van with Resident #20. The incident report contained the following under the heading Comments: Resident was in the van going to his Dr.'s appointment. Resident refused to put seat belt on. While going around a sharp turn resident slid off his seat and into the floor. Resident stated, Get me back in my seat. The comments under the heading findings found the following, Resident was not secured by seatbelt during transport, thus slid to floor during sharp turn. Resident was sitting in van seat during transport. The actions taken by the facility were listed as, Had resident sit in his w/c (wheel chair) on return back. Resident is to be secured by seatbelt during all transportation. The NHA was asked if any statements were obtained from staff related to this incident. The NHA confirmed in the afternoon of 03/11/25 that no statements were obtained. She provided a list of all staff who assist resident with van transfers. The following staff from the list provided were interviewed beginning at 1:30 PM on 03/11/25: Activity Director, Recreation Specialist (RS) #48 and RS #1, all indicated if a resident refuses to wear there seatbelt they should not be transported. RS #48 and RS #1 stated they would report it tot he Activity Director and the resident would not be allowed to go on the trip. They all three (3) agreed it has always been this way. The activity director has worked at the facility since 1989, RS #48 has worked at the facility since 1999. RS # has worked at the facility since 2022. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NA #31 who works in the special needs program at the facility indicated if a resident was to refuse to wear their seatbelt she would not take them on the transport. She indicated the vehicle can not move until the resident is secured. She stated it has always been this way and not something that had recently came about She has been an employee of the facility since 2017. Office Assistant #64 stated, If they refuse to wear their seatbelt then they can not go on a transport. OA #64 was then asked if this was a change since and incident or has it always been this way and she stated,I have been doing transports for a little over two (2) years and it has always been that way. The NHA was again interviewed at 1:45 PM on 03/11/25 and was made aware of the above interviews. She stated, Well that tells me they knew better. When asked if NA #94 and NA #93 were reported for neglect for not ensuring Resident #20 was wearing a seatbelt she stated they were not. She was asked to provide any training the staff who go on transports receive prior to transporting. Later in the afternoon she stated, They only receive training on the state vehicle use policy. A review of the state vehicle use policy found the following, .Seat Belts must be worn at all times On the morning of 03/12/25 the two (2) staff accompanying Resident #20 on this trip was interviewed. NA #93 confirmed she was in the back of the van with Resident #20. She stated she had assumed the other staff member had fastened his seat belt and she did not check it prior to leaving. She stated, I didn't know he was unbuckled until he slid out of the seat. She indicated if she had known he was not secured she would not have left on the transport until he was secured. She stated, On way back I ensured he was buckled myself. NA #94 was out of the facility on another transport however she did call into the facility to speak with this surveyor. During the telephone interview, NA #94 stated, It was awhile ago and she didn't remember all the details. When asked who usually takes care of strapping in the residents she indicated it is usually the person who loads them into the vehicle. She was unable to recall if that was her or NA #93. She stated, But (Name of Resident #20) unbuckles himself all the time. Another unidentified staff member could be heard in the background saying, He has done that to me before. NA #94 stated When he does that we have to pull over and get him buckled back up. NA #94 stated, He has always done that he don't like the seat belt. When asked if she had known the resident was not buckled what she would have done she stated, We would not have left with him.

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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. 49465 Based on record review, and staff interview, the facility failed to ensure they referred one (1) of three (3) residents reviewed for Preadmission Screening and Resident Review (PASARR) for a Level II PASARR evaluation and determination after the resident had a newly evident mental disorder. Resident identifier #15. Resident census: 61. Findings include: a) Resident #15 A record review on 03/10/25 at 9:49 AM, revealed, Resident #15 had a diagnosis which included the following: Intellectual disabilities, Intellectual developmental disorder; diagnosis from 2015 Post Traumatic Stress Syndrome (PTSD); diagnosis from 2015 Recurrent Major Depression; diagnosis from 2023 Psychotic disorder, Schizophrenia spectrum; diagnosis from 2024 Further record review revealed, Resident #15's last PASARR was completed on 03/14/17 and did not indicate the Recurrent Major Depression or the Psychotic disorder, Schizophrenia spectrum. During an interview, on 03/10/25 at 10:38 AM, the Director of Social Services (DSS) #11 stated, Yes, a new pass should have been completed. Let me check on that. During an interview on 03/10/25 at 11:33 AM, DSS #11 stated, I found that we did a new Pass on her in 2023, but I was unaware of the new diagnosis in 2024 of Schizophrenia, so it was not done.

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NAME OF PROVIDER OR SUPPLIER: Lakin Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE: 11522 Ohio River Road West Columbia, WV 25287	

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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 45173 Based on record review and staff interview, the facility failed to ensure Pre-Admission screening (PAS) included all psychiatric diagnoses for Resident #50. This is true for one (1) of one (1) resident reviewed during the initial screening process of the survey. Resident #50. Facility Census: 61. Findings Include: a) Resident #50 On 03/03/25 at 3:28 PM, a record review was completed. The review found the PAS was not available on the electronic medical record (EMR). On 03/10/25 at 2:31 PM, the PAS dated 02/15/22 was reviewed. There was no documentation found for the diagnoses of anxiety disorder, unspecified; depressed mood, unspecified; PTSD; and hallucinations. On 03/10/25 at 2:48 PM, the Director of Social Services #11 was interviewed. The Director of Social Services stated, we received this from (Name of an acute psychiatric facility). The Director of Social Services #11 did confirm the diagnoses were not included on the PAS.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31826 Based on record review and staff interviews, the facility failed to develop and implement a comprehensive person-centered care plan for resident #54 by not providing a goal in the care plan. Resident #20 for accident hazards, and Resident #49 for comfort care process. This was found true for three (3) of 34 residents care plans reviewed during the long term care survey process. Resident Identifier: #54, #20, and #49. Facility Census: 61. Findings include: a) Resident #54 On 03/03/25 at 03:16 PM a record review of Resident # 54's care plan revealed the following; Strength/Problem D-100 - Resident receives a Level 7 Regular, Level 0 thin liquids diet and has no apparent dietary problems Rev. #4 (No Goal) Interventions DIET AS ORDERED. Level 7 Regular, Level 0 thin liquids diet, coffee and chocolate milk with meals, food in bowls 10, 2, has Sunday snack staff assist with meals/fed by staff health shakes with lunch and dinner. Rev. #4 Honor specific food preferences: No Rice No Hot Cereal No Eggs Rev. #4 (continued on next page)

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Monitor weight as ordered: monthly

Rev. #4

Record % intakes. Rev. #4

Provide three balanced meals plus

HS snack daily requested PB&J

sandwiches for HS snacks. is also

receiving 10 am and 2pm snacks

Rev. #4

On 03/04/25 at 4:02 PM, an interview with the Nursing Home Administrator confirmed there was no goal in place on the care plan.

b) Resident #20

On 03/10/25 at 10:19 AM, a review of the facility's reportable of an unusual occurrence found the following, Resident #20 was taken to an appointment on 04/04/24 the resident was being transported to an appointment and refused to wear his seat belt and the resident slid out of the seat when they went around a sharp curve.

The NHA provided the surveyor with the facility incident report related to this incident. A review of the incident found that NA #94 and NA #93 were the staff which went on the transport with Resident #20 on this date. NA #94 was driving and NA #93 was in the back of the van with Resident #20.

On the morning of 03/12/25 the two (2) staff accompanying Resident #20 on this trip was interviewed. NA #93 confirmed she was in the back of the van with Resident #20. She stated she had assumed the other staff member has fastened his seat belt and she did not check it prior to leaving. She stated, I didn't know he was unbuckled until he slid out of the seat. She indicated if she had known he was not secured she would not have left on the transport until he was secured. She stated, On way back I ensured he was buckled myself.

NA #94 was out of the facility on another transport however she did call into the facility to speak with this surveyor. During the telephone interview, NA #94 stated, It was awhile ago and she didn't remember all the details. When asked who usually takes care of strapping in the residents she indicated it is usually the person who loads them into the vehicle. She was unable to recall if that was her or NA #93. She stated, But (Name of Resident #20) unbuckles himself all the time. Another unidentified staff member could be heard in the background saying, He has done that to me before. NA #94 stated When he does that we have to pull over and get him buckled back up. NA #94 stated, He has always done that he don't like the seat belt. When asked if she had known the resident was not buckled what she would have done she stated, We would not have left with him.

(continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #20's care plan found no indication of the behavior unbuckling his seatbelt during transport. There was no special instructions given to staff so they could be more vigilant and observant during the transport of this resident. In an interview with the NHA on the morning of 03/12/25 she was made aware the care plan was void of any information related to Resident #20's behavior of unbuckling his seat belt in the van. She was asked if she wanted to review the care plan at this time and declined . No further information was provided prior to the end of the survey. C) Resident #49 During a review of Resident #49 ' s record on 03/03/25 at approximately 3:00 PM, it was noted the resident had a 7.22% weight loss since his last weight obtained on 02/02/25, with the most recent weight being on 03/01/25. During an interview with the resident ' s Power of Attorney (POA), he stated the facility had not notified him of the weight loss. During an interview with the Administrator on 03/11/25 at 11:20 AM, the Administrator stated Resident #49 had a status of Do Not resuscitate (DNR) Comfort Care. The administrator presented the policy for CC at the facility. The policy, titled Comfort Care Procedure, Section IV, titled Procedure, Page two (2), states: The following interventions WILL NOT BE PROVIDED to the resident who has an order for Comfort Care: No vital signs No weights No blood sugars No blood draws No x-rays, EKGs No out of facility services The administrator also states the facility would not notify family members in the result of a significant weight loss, due to the fact the resident would not be weighed under the comfort care policy. Review of Resident #49 's care plan and orders, reveal both were updated on 10/23/23 for Comfort Care. Further review of the resident's vital signs and weights indicate the facility has been performing vitals, both daily and weekly, and weights monthly, despite the resident having an order, and being care planned, for comfort care, meaning these things should be discontinued. These vitals and weights have continued from 10/23/23, the day the resident was made DNR Comfort Care, until present day. At approximately 11:20 AM on 03/12/25, the Director of Nursing (DON) confirmed Resident #49 was placed on comfort care and has not stopped receiving weights and vitals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49467 49751

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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 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. 49465 Based on record reviews and staff interviews the facility failed to revise care plans related to activities. This was found true for four (4) of 34 care plans reviewed during the long-term care survey process. Resident identifiers: #21, #46, #32, and #15. Facility census:61. Findings include: a)Resident #21 Record review on 03/10/25 revealed the following activity care plan: Problem/Strength: ~(Resident #21's first name) does not participate in most activities, per choice is self directed to his room Goal: ~(Resident #21's first name here) will participate in activities of choice 2 x (two times) per week through next review and remain self-directed. Interventions Included: ~(Resident #21's first name here) may be involved in facility friend to friend program ~(Resident #21's first name here) enjoys watching TV in his room ~(Resident #21's first name here)enjoys conversation with staff ~(Resident #21's first name here) spending time outdoors when weather permits ~(Resident #21's first name here) may attend special needs as scheduled Further record review of resident daily participation record revealed Resident # 21 is documented on having received one on one Activities. During an interview on 03/10/25 at 3:14 PM with the Activity Director (AD) she stated, He gets one (1) on one (1) and sensory stimulations because he is with dependent residents on the unit. I will update the care plan now. B) Resident #32 A review of Resident #3's record review 03/10/25 revealed the following activity care plan: (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Problem/Strength: ~(Resident #32's first name) does not participate in most activities, does need assistance at times Goals: ~(Resident #32's first name here) will continue participation through next review period. Interventions included: ~(Resident #32's first name here) may participate in canteen cart as funds allow. ~Staff will assist with pet therapy when available. ~(Resident #32's first name here)may be involved in facility friend to friend program ~(Resident #32's first name here) may attend special needs for class time and also for meal training as ordered. ~(Resident #32's first name here) enjoys parties and special events Further record review of the resident daily participation record revealed Resident # 32 is documented on having received one on one Activities and sensory stimulation. During an interview on 03/10/25 at 3:26 PM the AD confirmed the care plan did need updated and stated, I will update the care plan now. c) Resident #46 A record review of Resident #46's care plan on 03/10/25 revealed the following activity care plan: Problem/Strength ~(Resident #46's first name) attends some group activities but at times prefers to stay in bed or on her unit. Goal: ~(Resident #46's first name here) will participate in activities of choice two(2) times a week through next review. Interventions included: ~(Resident #46's first name here) may participate in canteen cart as funds allow. ~Staff will provide encouragement. ~(Resident #46's first name here)may be involved in facility friend to friend program (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~(Resident #46's first name here) may attend special needs as scheduled ~(Resident #46's first name here) enjoys outdoors when wheather permits. Further record review of the resident's daily participation record revealed Resident # 46 is documented on having received one on one Activities and sensory stimulation. During an interview on 03/10/25 at 3:40 PM the AD confirmed the care plan did need updated and stated, I will update the care plan now, Thank you for bringing these care plans to my attention, i plan to go over all residents care plans. d) Resident #15 A record review on 03/10/25 at 1:06 PM revealed an Activity care plan for Resident #15 that read as follows: Focus: (Resident #15 name) participates in most group activities, does need assistance at times. (Resident #15 name) is also self-directed to the unit or room. Goal: (Resident #15 name) will maintain participation in activities through next review and remain self-directed. Interventions: (Resident #15 name) enjoys attending arts/crafts, bingo, facility parties, special events and religious services. (Resident #15 name) enjoys participating in off group activities as scheduled (Resident #15 name) may attend special needs for meals training as ordered (Resident #15 name) may be involved in facility friend to friend program (Resident #15 name) may participate in Canteen cart as funds allow The last update on the above care plan was 07/09/24. A review on 03/10/25 at 1:40 PM, of Resident #15's nursing progress notes from 02/02/25 to present, revealed the resident had 32 behavior related notes. None of the notes indicate any activity intervention for the behaviors. Further review of Resident #15's care plan for behaviors reads as follows: Focus: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Resident #15 name) has anxiety, depression and a history of Post Traumatic Stress Syndrome (PTSD). Personal historical information suggests abused by her stepfather and generally neglected during her childhood. Has a history of the following behaviors while at (Name of Facility), outburst of anger, history of cursing, screaming, yelling, crying, agitation, attention seeking, verbal and physical aggression. Goal: Inappropriate behaviors will be decreased to 1 time per week through the next review period Activity related Interventions include: * Involve (Resident #15 name) in activities daily * Redirect (Resident #15 name) to activity of choice when feeling depressed/upset, aggressive. Some activities (Resident #15 name) prefers are coloring, drawing, listening to music, snacks and drinks, and enjoys one on one attention. * In room activities for social stimulation if (Resident #15 name) cannot attend activities, redirect to coloring pages, drawing pictures or TV on the unit may be successful. The last activity related interventions on the above care plan were completed on 07/23/24. During an interview on 03/10/24 at 2:05 PM, The Activity Director (AD) stated, (Resident #15 name) has been here for a while. We have done different things with her to see what she likes. She has gone downhill in the last year. She cannot do her own bingo card or anything anymore. The AD further confirm Resident #15 has had a big change and that her activity care plan had not been updated since 07/09/24. 49751

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49465 Based on observation, record review, resident interview, and staff interview the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental and psychosocial well-being of each resident. This failed practice was found true for four (4) of six (6)residents reviewed for activities during the Long-Term Care Survey Process. Resident identifiers #15, #21, #46, and #32. Facility census 61. Findings include: a) Resident #15 An initial observation on 03/03/25 at 12:46 PM, revealed Resident #15 sitting in a recliner outside of her room turned sideways asleep. Further observation at 2:00 PM, found Resident #15 in the recliner in the same position. An observation on 03/04/25 at 10:30 AM, found the resident in her recliner, patting her chair arm. Further observation at 3:15 PM, revealed Resident #15 sitting in her recliner. The unit television (TV) was playing, but the TV was (4) four doors down across the hall from Resident #15's recliner position. Further observation on 03/04/25 at 9:30 PM, revealed Resident #15 in her recliner outside of her room asleep. An observation on 03/10/25 at 11:30 PM, found Resident #15 sitting in her recliner patting her armchair. A record review on 03/10/25 at 1:06 PM, of Resident #15's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/28/24, Section F indicates that it is somewhat important for the resident to have books, newspaper and magazine, listen to music, do things with groups of people, go outside when the weather is nice, and participate in religious services or practices. Section F also indicates that it is very important for the resident to do her favorite activities. Further record review of Resident #15's Activity care plan read as follows: Focus: (Resident #15 name) participates in most group activities, does need assistance at times. (Resident #15 name) is also self-directed to the unit or room. Goal: (Resident #15 name) will maintain participation in activities through next review and remain self-directed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions: (Resident #15 name) enjoys attending arts/crafts, bingo, facility parties, special events and religious services. (Resident #15 name) enjoys participating in off group activities as scheduled (Resident #15 name) may attend special needs for meals training as ordered (Resident #15 name) may be involved in facility friend to friend program (Resident #15 name) may participate in Canteen cart as funds allow The last update on the above care plan was 07/09/24. A review on 03/10/25 at 1:40 PM, of Resident #15's nursing progress notes from 02/02/25 to present, revealed the resident had 32 behavior related notes. None of the notes indicate any activity intervention for the behaviors. Further review of Resident #15's care plan for behaviors reads as follows: Focus: (Resident #15 name) has anxiety, depression and a history of Post Traumatic Stress Syndrome (PTSD). Personal historical information suggests abused by her stepfather and generally neglected during her childhood. Has a history of the following behaviors while at [NAME], outburst of anger, history of cursing, screaming , yelling, crying , agitation, attention seeking ,verbal and physical aggression. Goal: Inappropriate behaviors will be decreased to 1 time per week through the next review period Activity related Interventions include: * Involve (Resident #15 name) in activities daily * Redirect (Resident #15 name) to activity of choice when feeling depressed/upset, aggressive. Some activities (Resident #15 name) prefers are coloring, drawing, listening to music, snacks and drinks, and enjoys one on one attention. * In room activities for social stimulation if (Resident #15 name) cannot attend activities, redirect to coloring pages, drawing pictures or TV on the unit may be successful. The last activity related interventions on the above care plan were completed on 07/23/24. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/10/24 at 2:05 PM, The Activity Director (AD) stated, (Resident #15 name) has been here for a while. We have done different things with her to see what she likes. She has gone downhill in the last year. She cannot do her own bingo card or anything anymore. The AD further confirmed that Resident #15 has had a big change and that her activity care plan had not been updated since 07/09/24. b)Resident #21 Record review on 03/10/25 revealed the following activity care plan: Problem/Strength: ~(Resident #21's first name) does not participate in most activities, per choice is self-directed to his room Goals: ~(Resident #21's first name here) will participate in activities of choice 2x (two times) per week through next review and remain self-directed. Interventions: ~(Resident #21's first name here) may be involved in facility friend to friend program ~(Resident #21's first name here) enjoys watching TV in his room ~(Resident #21's first name here)enjoys conversation with staff ~(Resident #21's first name here) spending time outdoors when weather permits ~(Resident #21's first name here) may attend special needs as scheduled Further record review of resident daily participation record revealed Resident #21 is documented as having received one on one Activities. On 03/10/25 at 3:14 PM during an interview with the Activity Director (AD) she stated, He gets one (1) on one (1) and sensory stimulations because he is with dependent residents on the unit. I will update the care plan now. c) Resident #32 A review of Resident #32's medical record on 03/10/25 revealed the following activity care plan; Problem/Strength: ~(Resident #32's first name) does not participate in most activities, does need assistance at times Goals: (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	~(Resident #32's first name here) will continue participation through next review period. Interventions: ~(Resident #32's first name here) may participate in canteen cart as funds allow. ~Staff will assist with pet therapy when available. ~(Resident #32's first name here)may be involved in facility friend to friend program ~(Resident #32's first name here) may attend special needs for class time and also for meal training as ordered. ~(Resident #32's first name here) enjoys parties and special events Further record review of the resident's daily participation record revealed Resident # 32 is documented as having received one on one activities and sensory stimulation. During an interview on 03/10/25 at 3:26 PM the AD confirmed the care plan did need updated and stated I will update the care plan now. d) Resident #46 A reiview of Resident #46's medical record on 03/10/25 revealed the following activity care plan: Problem/Strength: ~(Resident #46's first name) attends some group activities but at times prefers to stay in bed or on her unit. Goal: ~(Resident #46's first name here) will participate in activities of choice two(2) times a week through the next review. Interventions: ~(Resident #46's first name here) may participate in the canteen cart as funds allow. ~Staff will provide encouragement. ~(Resident #46's first name here)may be involved in facility friend to friend program ~(Resident #46's first name here) may attend special needs as scheduled ~(Resident #46's first name here) enjoys the outdoors when weather permits. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further record review of the resident's daily participation record revealed Resident # 46 is documented as having received one on one Activities and sensory stimulation. During an interview on 03/10/25 at 3:40 PM, the AD confirmed the care plan did need to be updated and stated, I will update the care plan now, Thank you for bringing these care plans to my attention, I plan to go over all residents care plans. 49751

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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. 45173 Based on record review and staff interview, the facility failed to follow physician's orders relating to medication administration for Resident #33, #50, #51, #62, #46, #216, #38 #6, #35, #17 and #43 as well as 15-minute observations and weekly skin assessments, and comfort care as well as documentation of an allegation of neglect for Resident #11. This is true for 13 of 34 residents reviewed during the survey process. Resident identifiers: #33, #50, #51, #62, #46, #216, #38, #6, #35, #17, #43, #49, and #11. Facility census: 61. Findings Include: a) Resident #33 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration and neurological (neuro) checks on the A wing. Also, 15-minute observation checks on 06/23/24 and 06/24/24 which was ordered by the physician on 04/26/24 and weekly skin assessments which were ordered by the physician on 07/19/23. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed: --Cranberry Capsule --Aricept --Memantine --Remeron --Seroquel The following neuro checks were missed: --07/13/24 8:00 PM --07/14/24 12:01 AM --07/14/24 4:00 AM The following 15 minute observation checks were missed: --06/23/24 7:45 PM --06/23/24 8:15 PM --06/23/24 8:45 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--06/23/24 9:15 PM --06/23/24 9:45 PM --06/23/24 10:15 PM --06/23/24 10:45 PM --06/23/24 11:15 PM --06/23/24 11:45 PM --06/24/24 12:15 AM --06/24/24 12:45 AM --06/24/24 1:15 AM --06/24/24 1:45 AM --06/24/24 2:15 AM --06/24/24 2:45 AM --06/24/24 3:15 AM --06/24/24 3:45 AM --06/24/24 4:15 AM --06/24/24 4:45 AM --06/24/24 5:15 AM --06/24/24 5:45 AM --06/24/24 6:15 AM --06/24/24 6:45 AM The following weekly skin assessments were not completed: --09/07/24 --12/05/24 --12/26/24 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/25 at approximately 2:00 PM, the Director of Nursing (DON) confirmed the medications, neuro checks, 15 minute observations, and weekly skin assessments were missed. b) Resident #50 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed: --Klonopin --Lithium --Melatonin --Zyprexa --Trileptal --Miralax On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the the medications were missed. c) Resident #51 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late: --Neurontin--2 hours and 10 minutes --Hydrocodone-Acetaminophen 5/325mg--2 hours and 10 minutes --Buspar--2 hours and 10 minutes --Robaxin--2 hours and 10 minutes --Metoprolol Tartrate--2 hours and 10 minutes --Wellbutrin XL--2 hours and 10 minutes On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the medications were late. d) Resident #62 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed: --Acetaminophen --Zyprexa --Miralax --Depakote On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the medications were missed. e) Resident #46 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed: --Eliquis --Vitamin C --Depakote --Metoprolol Succinate --Zyprexa --Miralax --Hiprex On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the medications were missed. f) Resident #216 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late: --Levsin--2 hours and 17 minutes late (continued on next page)

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

--Senna--2 hours and 17 minutes late

--Claritin--3 hours and 18 minutes late

On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the medication was late.

g) Resident #38

On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were missed:

--Acetaminophen/Codeine 30mg

--Vitamin C

--Bisacodyl suppository

--Klonopin

--Lamictal

--Lithium

--Risperdal

--Symbicort inhaler

On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the medication was missed.

h) Resident #43

On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late:

--Zyprexa--3 hours and 19 minutes

--Coreg--2 hours and 20 minutes

--Klonopin--2 hours and 21 minutes

--Buspar--2 hours and 21 minutes

(continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Latanoprost eye drops--2 hours and 22 minutes On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the medication was late. i) Resident #6 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late: --Neurontin--2 hours and 8 minutes On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the medication was late. j) Resident #35 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late: --Hydrocodone/Acetaminophen 7.5/325mg--1 hour and 19 minutes --Trazodone--1 hour and 20 minutes --Fibercon--1 hour and 20 minutes --Buspar--2 hours and 22 minutes On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the medication was late. k) Resident #17 On 03/03/25 at 2:32 PM, a review of a facility-reported incident (FRI) dated 07/17/24 found Licensed Practical Nurse (LPN) #134 did not follow physician's orders regarding medication administration on the A wing. The following medications were ordered for 07/13/24 at 9:00 PM. The following medications were late: --Clozaril--2 hours and 58 minutes --Depakote 1 hour and 58 minutes --Coreg--1 hour and 58 minutes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Keppra--1 hour and 59 minutes --Tramadol--1 hour and 59 minutes On 03/04/25 at approximately 11:00 AM, the Director of Nursing (DON) confirmed the medication was late. L) Resident #49 During a review of Resident #49 ' s record on 03/03/25 at approximately 3:00 PM, it was noted the resident had a 7.22% weight loss since his last weight obtained on 02/02/25, with the most recent weight being on 03/01/25. During an interview with the resident ' s Power of Attorney (POA), he stated the facility had not notified him of the weight loss. During an interview with the Administrator on 03/11/25 at 11:20 AM, the Administrator stated Resident #49 had a status of Do Not Resuscitate (DNR) Comfort Care. The administrator presented the policy for CC at the facility. The policy, titled Comfort Care Procedure, Section IV, titled Procedure, Page two (2), states: The following interventions WILL NOT BE PROVIDED to the resident who has an order for Comfort Care: No vital signs No weights No blood sugars No blood draws No x-rays, EKGs No out of facility services The administrator also states the facility would not notify family members in the result of a significant weight loss, due to the fact the resident would not be weighed under the comfort care policy. Review of Resident #49 ' s care plan and orders, reveal both were updated on 10/23/23 for Comfort Care. Further review of the resident's vital signs and weights indicate the facility has been performing vitals, both daily and weekly, and weights monthly, despite the resident having an order, and being care planned, for comfort care, meaning these things should be discontinued. These vitals and weights have continued from 10/23/23, the day the resident was made DNR Comfort Care, until present day. At approximately 11:20 AM on 03/12/25, the Director of Nursing (DON) confirmed Resident #49 was placed on comfort care and has not stopped receiving weights and vitals. m) Resident #11 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facilities reportables on 03/10/25 at 2:56 PM, revealed a reportable for Resident #11 from 02/26/25 with a (5) five-day follow-up summary that reads as follows Unit nurse for A east on 02/26/25 went to change a resident dressing that was scheduled to be changed every (3) three days. The dressing in place of two different skin tears on that date was dated 02/16/25. Upon review of the treatment sheet Licensed Practical Nurse (LPN) #29 had initialed the dressing and treatment as being completed on both 02/19/25 and 02/22/25. The nurse completed the treatment, MD notified and no worsening of the skin tear wounds were noted. LPN #29 was suspended pending investigation for neglect and falsification of documentation. Based on interviews and documentation of her co-workers and herself, she was assigned to the hallway of A east which had a census total of 12 residents: she did not perform the treatments as they were ordered and as she initialed on the treatment sheet documentation. She stated at one point in the investigation that she asked other nurses to do the treatment on one of the dates but the other nurse statement said this was not the case. She stated that on the 22nd, she had left the facility and then returned, had already initialed the treatment book and just forgot to do the dressing. According to her time and attendance punches, she did not leave and return on the 22nd, but was there for the duration of her shift. She did leave and return on the 23rd, and then left early for that shift and was absent on the 24th for her scheduled shift. Based on interviews, record reviews, the allegation of neglect was substantiated per facility investigation as well as falsification of documentation. She received education and disciplinary action and has returned to work. A record review on 03/10/25 at 3:16 PM, revealed that Resident #11 had no nursing notes or skin assessments related to the incident. During an interview on 03/10/25 at 3:19 PM, the Director of Nursing (DON) confirmed that she did not see anything in the chart relating to the incident. The DON then stated, That is strange, let me look into it and get back to you. Further interview, on 3/10/25 at 3:40 PM, The DON stated, I talked to the nurses, and they just said because there was not change and it did not require any interventions we changed the dressing and documented in with a check mark in the Treatment record 49465 49467

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31826 Based on observation, record review, and staff interview the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. Nurse Aide (NA) #107 was observed transferring Resident #1 by himself on two (2) occasions. Resident #1 was identified as a resident who required the assistance of two (2) staff when transferring. NA #107 had the resident Kardex available to him which identified the correct way to transfer Resident #1, but he failed to look at the Kardex and transfer the resident in a correct manner. The State Agency (SA) identified this failure placed Resident #1 in an immediate jeopardy (IJ) situation. The facility was notified of the IJ on 03/04/25 at 11:23 PM. The final plan of correction (POC) was accepted by the SA on 03/05/25 at 4:21 PM. After the implementation of the POC was confirmed with observations of transfers, education record review, and staff interviews the IJ was abated on 03/06/25 at 10:15 AM. After the IJ was abated a deficient practice remained and the scope and severity was reduced from a J to an E. A deficient practice remained for Resident #20 related to unsafe transports in the facility van, Resident #33 and #54 related to elopements and for Resident #7 related to smoking assessment completion. Resident Identifiers: #1, #20, #33, #54, and #7. Facility Census: 61. Findings include: a) Resident #1 On 03/04/25 at 9:20 PM Nurse Aide (NA) #107 was observed transferring Resident #1 from his recliner in the hallway to his wheelchair. NA #107 completed the transfer by himself and had the assistance of no other staff members. No devices were used for this transfer. The resident was wearing non-skid socks during this transfer. On 03/04/25 at 9:29 PM, NA #107 was again observed transferring Resident #1 from his wheelchair to his recliner in the hallway. NA #107 again completed this transfer by himself with no assistance from any other staff member. At the time of this transfer Resident #1 was barefooted. No Devices were used for this transfer. At 9:32 PM a review of Resident #1's fall prevention care plan was completed. This review found the resident was to be assisted with two (2) staff members with all transfers. The care plan also indicated the resident was to be encouraged to wear special orthotic shoes for safer transfers and prevention of falls. Another focus statement on Resident #1's care plan read as follows, (First Name of Resident #1) requires 2 person assist with bed mobility, with transferring, and ambulation due to severe intellectual disabilities, cerebral palsy . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At 9:35 PM on 03/04/25, NA #107 was asked to identify how he would know the transfer status of a resident he stated, We look at the Kardex. Charge Nurse (CN) #12 was asked to review Resident #1's Kardex and to inform the surveyor how Resident #1 was to be transferred. She confirmed at 9:38 PM on 03/04/25 the resident was to be transferred with the assistance of two (2) staff members. She showed the surveyor this information on the Kardex. The Kardex was located in the hallway and was accessible to NA #107. An interview with NA #107 at 9:40 PM confirmed he transferred the resident by himself. He reviewed the Kardex and stated, I did it wrong because I did it by myself. The surveyor then reviewed the Kardex for Resident #1. The Kardex read as follows related to transfers: Transfer Dependent 2 assist Limited brief type transfer device to be used. In an interview at approximately 10:30 PM CN #12 confirmed a brief type of transfer device was a sling used to aid in transfers. NA #107 did not use the brief type of transfer device when performing the observed transfers. NA #124 and NA #113, both stated, I do not know what a brief type transfer device is. When NA# 117 was asked what a brief type transfer device was he described a mechanical lift not knowing for sure what it was. Further review of the care plan comments found the following, 02/17/25 fall slid to floor during transfer from recliner to w/c (wheelchair) no injury interventions in place. A review of the ADL flow sheets on the morning of 03/10/25 for Resident #1, for the date of 02/17/25 confirmed the staff who was transferring the resident during this transfer documented the resident was transferred via extensive assistance with the help of one (1) staff member. Further review of the ADL flow sheets for the remainder of February 2025 found for every night shift transfer the NAs were documenting Resident #1 was transferred via extensive assistance with the assistance of one (1) staff member. This indicated a systemic failure in the transfers of Resident #1 which should have been identified and addressed by the facility prior to the IJ situation. However, this was not identified by the facility staff prior to the surveyor alerting the Nursing Home Administrator of the ADL flow sheet documentation on 03/10/25 at 11:00 am. No reeducation of staff was completed nor was this aide reported for neglect prior to the IJ situation on 03/04/25. The facility's accepted Plan of Correction read as follows: F689 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Resident #1 care plan and Kardex was reviewed on 3/05/25 with resulting update to hold orthopedic shoes due to pedal edema. Staff #107 and charge nurse #12 was in-serviced on 03/04/25 with Resident #1 current transfer orders and where to locate all resident transfer orders on the Kardex's. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. a. All residents have the potential to be affected. All other transfer orders and Kardex's were reviewed by DON and ensured that they were in place for each resident. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. a. All direct care staff working on 3/05/25 will be in-serviced on transfer orders and the Kardex system by 03/05/25. All other direct care staff will be in-serviced before their next scheduled shift. All Kardexes and transfer orders for all residents will be reviewed by the DON/designee by 03/05/25 to ensure the measures are appropriate and in place. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. a. Random checks on all shifts will be conducted by the DON/designee on 3 random residents to ensure that the appropriate measures are in place per the care plan and Kardex. The DON/designee will review all transfer orders for all residents and ensure accuracy. The audit and review of transfer orders will be completed at least daily 5 days per week for 2 weeks, then twice weekly for 2 weeks, then weekly for 4 weeks, then monthly for 3 months, then quarterly for 6 months with any corrective action immediately upon discovery. The QAPI nurse will report the findings of the audit to the DON/designee and to the QAPI team quarterly for review and follow-up. b) Resident #20 On 03/10/25 at 10:19 AM, a review of the facility's reportable of an unusual occurrence found the following, Resident #20 was taken to an appointment on 04/04/24 the resident was being transported to an appointment and refused to wear his seat belt and the resident slid out of the seat when they went around a sharp curve. An interview with the NHA on 03/10/25 confirmed they did some education that if they refuse to wear the seatbelt that they should not go on the transport. The NHA was unable to provide evidence that this training was completed. She was unable to find the sign in sheets. The NHA provided the surveyor with the facility incident report related to this incident. A review of the incident found that NA #94 and NA #93 were the staff which went on the transport with Resident #20 on this date. NA #94 was driving, and NA #93 was in the back of the van with Resident #20. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The incident report contained the following under the heading Comments: Resident was in the van going to his Dr.'s appointment. Resident refused to put seat belt on. While going around a sharp turn resident slid off his seat and into the floor. Resident stated, Get me back in my seat. The comments under the heading findings found the following, Resident was not secured by seatbelt during transport, thus slid to floor during sharp turn. Resident was sitting in van seat during transport. The actions taken by the facility were listed as, Had resident sit in his w/c (wheelchair) on return back. Resident is to be secured by seatbelt during all transportation. The NHA was asked if any statements were obtained from staff related to this incident. The NHA confirmed in the afternoon of 03/11/25 that no statements were obtained. She provided a list of all staff who assist residents with van transfers. The following staff from the list provided were interviewed beginning at 1:30 PM on 03/11/25: Activity Director, Recreation Specialist (RS) #48 and RS #1, all indicated if a resident refused to wear their seatbelt they should not be transported. RS #48 and RS #1 stated they would report it to the Activity Director and the resident would not be allowed to go on the trip. All three (3) agreed it had always been this way. The activity director had worked at the facility since 1989, RS #48 has worked at the facility since 1999. RS # has worked at the facility since 2022. NA #31 who worked in the special needs program at the facility, indicated if a resident was to refuse to wear their seatbelt, she would not take them on the transport. She indicated the vehicle cannot move until the resident is secured. She stated it had always been this way and not something that had recently came about She had been an employee of the facility since 2017. Office Assistant #64 stated, If they refuse to wear their seatbelt then they cannot go on a transport. OA #64 was then asked if this was a change since the incident or had it always been this way and she stated, I have been doing transports for a little over two (2) years and it has always been that way. The NHA was again interviewed at 1:45 PM on 03/11/25 and was made aware of the above interviews. She stated, Well that tells me they knew better. When asked if NA #94 and NA #93 were reported for neglect for not ensuring Resident #20 was wearing a seatbelt she stated they were not. She was asked to provide any training the staff who go on transports receive prior to transporting. Later in the afternoon she stated, They only receive training on the state vehicle use policy. A review of the state vehicle use policy found the following, .Seat Belts must be worn at all times On the morning of 03/12/25 the two (2) staff accompanying Resident #20 on this trip were interviewed. NA #93 confirmed she was in the back of the van with Resident #20. She stated she had assumed the other staff member had fastened his seat belt and she did not check it prior to leaving. She stated, I didn't know he was unbuckled until he slid out of the seat. She indicated if she had known he was not secured she would not have left on the transport until he was secured. She stated, On the way back I ensured he was buckled myself. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	NA #94 was out of the facility on another transport however she did call into the facility to speak with this surveyor. During the telephone interview, NA #94 stated, It was a while ago and she didn't remember all the details. When asked who usually took care of strapping in the residents she indicated it is usually the person who loads them into the vehicle. She was unable to recall if that was her or NA #93. She stated, But (Name of Resident #20) unbuckles himself all the time. Another unidentified staff member could be heard in the background saying, He has done that to me before. NA #94 stated When he does that we have to pull over and get him buckled back up. NA #94 stated, He has always done that as he doesn't like the seat belt. When asked if she had known the resident was not buckled what she would have done she stated, We would not have left with him. A review of Resident #20's care plan found no indication of the behavior unbuckling his seatbelt during transport. There were no special instructions given to staff so they could be more vigilant and observant during the transport of this resident. 45173 c) Resident #33 On 03/11/25 at 9:00 AM, a review of a facility-reported incident (FRI) dated 06/23/25 at 8:45 PM was reviewed. The review found the resident eloped from the facility for 11 minutes. The time frame was verified per facility video. The resident was noted with wandering behaviors and was an elopement risk, which was care planned. The resident slid the metal slide which was placed on the B hall day room doors. Then, the resident went to the fire door, opened the door and was found on the sidewalk outside the exit door. The resident was on 15-minute observation checks and a wanderguard was in place. The B Hall wing was empty at this time. The exit door alarm cannot be heard from the nurses' station of the occupied units. The actions taken to prevent an additional occurrence was place a stop sign on the B hall day room doors, maintain metal slide in place and add loud vibration (screech) alarm to the B hall day room doors. An interview was held with the Director of Social Services #11 on 03/11/25 at 9:33 AM. The Director of Social Services #11 stated, there weren't any witnesses .it was the B wing day room through the exit door .she held the door open for 15 seconds and got out the exit door. On 03/11/25 at 9:45 AM, a tour of the B wing was completed with the Administrator, the Assistant Director of Nursing (ADON) #62, and Maintenance Worker #14. The entry door to the B wing day room was observed with a metal slide at the bottom of the doors and a screech alarm was on the handles of the door. An interview with ADON #62 was held. The ADON stated, At the time of the incident, the metal slide was in place; however, the resident moved it out of place. The screech alarm was put in place after the incident .all exit doors have a wander guard alarm in place. d) Resident #54 Upon further review, on 03/11/25 at 10:30 AM, an additional elopement for Resident #54 was found. The elopement took place on 06/02/24 at 7:53 PM. The review found the resident had slid the metal slide bar to open the unoccupied B wing and opened the fire door and was found on the sidewalk outside the fire door. The exit door alarm cannot be heard from the nurses' station of the occupied units. The actions taken to prevent an additional occurrence at this time was an obtained physician's order to start one-on-one observations while awake and 15-minute checks while sleeping. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with ADON #62 was held on 03/11/25 at 11:00 AM. ADON #62 confirmed the incident with Resident #33 had taken place 21 days after the incident with Resident #54. No action was put in place to add an additional alarm to the B wing day room doors after the incident with Resident #54 on 06/02/24. e) Resident #7 Resident #7 was identified as a resident that smoked cigarettes. During a review of Resident #7's record, on 03/05/25, it was noted the most current smoking assessment completed was dated 07/18/23. At approximately 3:00 PM on 03/05/25, an interview was conducted with the Social Worker (SW) regarding smoking assessments. The SW indicated she was responsible for completing the assessments. The SW was asked how often the facility completes smoking assessments to which she stated, We only do them if an issue arises with a resident. If they develop an issue holding the cigarette, or smoking safely, then we would do a new one. At approximately 10:00 AM on 03/06/25, the SW presented a copy of the facility's policy on smoking assessments. The policy titled Safe Smoking Assessment, Section IV, titled Procedure, states the following: All residents who smoke or use tobacco will have an Assessment for Supervised Smoking completed annually by the Social Worker/Designee. The SW confirmed at this time, the assessment dated for 07/18/23 was the most recent assessment completed. The SW confirmed the resident should have had another assessment in 2024. At approximately 11:15 AM on 03/12/25, the Director of Nursing (DON) acknowledged the missing assessment. 49467

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49467 Based on record review and staff interview, the facility failed to deploy sufficient staff to meet the needs of the residents residing at the facility. This has the potential to affect all residents residing in the facility. Resident identifiers: 2, 56, 214, 31. Facility census: 61. Findings include: A) Residents #2, 56, 214 During review of Facility Reported Incidents (FRIs) involving Residents #2, 56, and 214, it was noted the facility had Resident #214 on line of sight (LOS) observation, 15 minute checks, and one (1) on one (1) observation during his stay at the facility due to aggressive sexual behavior towards other residents. These incidents took place between 12/19/24 and 12/22/24. Following the incident on 12/19/24, in which Resident #214 sexually assaulted Resident #2, Resident #214 was placed on LOS observation. However, on 12/22/24, another incident took place, in which Resident #214 assaulted Resident #214. The facility's investigation stated the following to be the cause of the incident: (Resident #214's name) was on line of sight when not in bed. He moved his wheelchair close to another resident who was sleeping in his chair in the dayroom. Staff turned their head to check on another resident and when they turned around he was fondling the other resident over top his pants. During a review of the facility's resident to resident abuse policy, Section IV, titled procedure, Section C, states: If the patient is deemed dangerous they will be placed on an observation level (which will be determined by the Care Team or nursing supervisor on weekends/holidays) until all referrals have been completed. Referrals will also be made to the staff Psychologist, Psychiatrist, and Medical Doctor for evaluation. The observation levels are as such: 1. 1:1 Strict One staff accompanies the patient at all times This one staff must keep the patient within arms length at all times Document staff observations and patient activities every hour 2. 1:1 Line of Sight/Constant Awareness One staff assigned to keep patient in view at all times Document staff observations and patient activities every hour 3. Fifteen (15) minute checks (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At a minimum check every 15 minutes around the clock The patient will participate in all unit activities, being observed every 15 minutes by the assigned staff Documentation of staff at least every 15 minutes 4. Routine Observation Patient will participate in all unit and facility activities, being observed by assigned staff as normal The facility failed to have a person assigned to Resident #214, as stated in the aforementioned policy and, failed to keep documentation as required. During an interview with the DON at approximately 11:15 AM on 03/12/25, it was confirmed the facility did not follow the policy stated above, failing to take appropriate actions to keep residents safe from further incidents of abuse by another resident. The DON stated there is typically one staff member assigned to the resident, however, that staff member still helps assist with other residents as well, which would require them to leave their assigned resident they are observing. The DON stated if a Nurse Aide is not available to observe the assigned resident, they should ask the Unit Manager to observe them. If the unit manager is not available, they should ask a Nurse Aide from another unit to come down and observe their resident while they help, potentially pulling a staff member from another unit. Based on documentation supplied by the facility, between the dates of 12/19/24 and 12/22/24, the facility had 19 residents, counting Resident #214, on 15 minute checks, and two (2) residents, counting Resident #214, on LOS observation. Based on staffing numbers supplied by the facility they had the following staff available for those days: 12/19/24- Seven (7) Nurse Aides (NA) on day shift Five (5) Nurses on day shift 5 NAs on night shift Three (3) nurses on night shift 12/22/24- Eight (8) NAs on day shift 5 Nurses on day shift 5 NAs on night shift 3 Nurses on night shift (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on these numbers, and the number of residents on 15 minute checks and LOS observations at the time, the facility did not meet the required amount of staff, based on their policy, to sufficiently supervise residents that needed supervision, and to care for residents in the facility. B) Resident 31 During the review of a FRI regarding a fall suffered by Resident #31, it was discovered the resident was not supposed to be left in the bathroom by himself due to being a high fall risk. On the evening of 6/18/24, Nurse Supervisor (NS) #36, according to the investigation, went into the bathroom when she noticed the resident urinating in the bathroom stall. NS #36 then returned to the med cart, leaving Resident #31 in the bathroom alone. NS #36 returned to the med cart in Five (5) to 10 minutes, at which time Resident #31 stated he had fallen and managed to pick himself up from the floor. Due to a call in, Licensed Practical Nurse (LPN) #72 stated she was asked to stay and work as a Nurse Aide on C Hall after her full shift on A Hall, during the day. LPN #72 stated she requested to step outside of the building to roll her car windows up, at which time, this left only NS #36 on the floor to pass medications and supervise residents who required it. At this time, due to insufficient staff, Resident #31 suffered an unwitnessed fall in the bathroom, due to being left alone, against physician orders. C) Staffing numbers During review of facility staffing documentation on 3/12/25, it was noted the facility failed to have sufficient staff to meet resident needs on the following days: 06/18/24 - Date of incident involving Resident #31 Five (5) NAs on day shift Four (4) Nurses on day shift Six (6) NAs on night shift Three (3) Nurses on night shift 12/19/24- Date of incident involving Resident #2 and #214 Seven (7) Nurse Aides (NA) on day shift Six (6) Nurses on day shift Five (5) NAs on night shift Three (3) nurses on night shift 12/22/24- Date of incident involving Resident #56 and #214 Eight (8) NAs on day shift (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Five (5) Nurses on day shift Five (5) NAs on night shift Three (3) Nurses on night shift 01/17/25 Eight (8) NAs on day shift Three (3) Nurses on day shift Six (6) NAs on night shift Three (3) Nurses on night shift 01/18/25 Eight (8) NAs on day shift Four (4) Nurses on day shift Six (6) NAs on night shift Four (4) Nurses on night shift 03/04/25 Six (6) NAs on day shift Five (5) Nurses on day shift Five (5) NAs on night shift Three (3) Nurses on night shift The facility HPPD Report gives the following target information for staffing levels: Day Shift - one (1) Registered Nurse (RN); four (4) LPNs; 10 NAs. Night Shift - one (1) RN; two (2) LPNs; eight (8) NAs Daily Total - three (3) RNs; six (6) LPNs; 18 NAs At approximately 12:00 PM on 03/12/25, the Administrator acknowledged the staffing levels for the aforementioned days. The Administrator acknowledged the target staffing numbers on the HPPD reports and stated the numbers were old and not correct but had not been updated.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49465 Based on observation, staff interview and resident interview the facility failed to notify residents of changes on the menu. This failed practice was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Resident identifier #57. Facility census 61. Findings Include: a) Resident #57 During the initial interview on 03/04/25 at 9:23 AM, Resident #57 stated, The food sucks, It's the same old stuff. Like today is soup and sandwich but they don't tell us what the soup or the sandwich is. I am not sure if I like it or not, so I ordered grilled cheese and tomato soup. They change the menu all the time and don't tell us what the change is. How do we know if we like it if we don't know what it is? During an interview on 03/10/25 at 11:45 AM, The Dietary Manager (DM) stated, Where we have a lot with the flu, we decided to do chicken noodle soup today and a sandwich. I made our dietician aware. The State Agency (SA) asked, Were the residents aware of the change? The DM stated, No, but we just thought they would like it since we have a flu outbreak. An observation on 03/10/25 at 12:00 PM, revealed a menu hanging on all (4) four units that read as follows: Lunch Menu: Chicken Fajitas, peppers and onions, refried beans, chips and salsa, and pineapples. On 03/10/25 at 11:41 AM Administrator states yes, it should have been changed, but it was a last minute decision where a lot is sick and we decided be best to serve soup for lunch. Confirming residents were not notified ahead of the change being made. 49751

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 49751 Based on observation, record review and staff interviews the facility failed to ensure Residents #1, #2, and#14, had the proper consistency thickened liquids. This was a random opportunity of discovery and had the potential to cause harm such as choking, aspiration or death. Resident identifier: #1, #2, and #14. Facility Census: 61. The State Agency (SA) determined this to be an Immediate Jeopardy situation. Findings include: a) Resident #1 -Record Review A review of Resident #1's medical record revealed the resident had a history of dysphasia and aspiration pneumonia, further record review of the care plan found a focus statement related to the history of dysphasia and aspiration pneumonia. Interventions for this focus statement included, per speech therapy; puree/pudding thinned consistency and pudding thick liquids diet. The care plan also contained the following focus statement, (First name of Resident #1) requires an altered texture diet due to Chewing and swallowing abilities related to being edentulous and having esophageal strictures. He is at a high risk for aspiration received at level 4 puree diet, level 4 extremely thick low fat diet. The goal read as follows: Residents will safely consume meals and snacks daily within the next review period. The interventions included: Diet Level 4 pureed, low fat PTL Level 4 extremely thick consistency. Further record review of Resident #1's orders found the following order Level four (4) extremely thick, level four (4) pure. -Observation/Staff Interview On 03/04/25 at 9:44 PM an observation in Resident #1's room found a water pitcher with ice water in it and it was not thickened. At this time Licensed Practical Nurse (LPN) #115 stated no this is not thickened. b) Resident #2 -Record Review A record review of Resident #2 revealed resident has an order for thickened liquids: (continued on next page)

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Order- Lactose free Level three (3) moderately thick Level four (4) puree diet Resident #2 has the following listed as focuses on his care plan: Problem: Potential for aspiration and pneumonia as evidenced by history of coughing and choking during meals. Problem: (Resident #2's name) receives an altered texture diet and thickened liquids r/t (related to) chewing and swallowing abilities are impaired. Intervention: Will receive diet as ordered: Pureed, honey-thick liquids; double desserts. Gravy w/ meds; lactose free. No dairy products. Double portions all meals. 10 am 2 PM HS snacks and Sunday snacks fed by staff; Disciplines: All. -Observation and Staff interview Thin liquids were observed at the resident's bedside at 10:10 PM on 03/04/25. During an interview on 03/04/25 at 10:13 PM, Unit Charge Nurse (UCN) #12 stated, We were always told to pass ice, but they never drink it. SA then asked UCN #12 if he had access to the water pitcher at any time? UCN #12 stated, Yes and then confirmed that the water was not thickened as ordered. c) Resident #14 -Record Review A record review on 03/04/25 at 10:00 PM, revealed a diet order for Resident #14 that read as follows: Level 2 mildly thick liquids, Level 4 puree diet. Further record review on 03/04/25 at 10:45 PM, revealed a care plan for Resident #14 that read as follows: {Focus: (Resident #14 name) requires an altered texture diet due to difficulty chewing/swallowing. Goals: (Resident #14 name) will safely consume meals and snacks as evidenced by being able to properly chew and swallow foods for next review period. Interventions: Diet as ordered: Puree, nectar thick liquids, swallowing precautions. 10,2 PM house snack and Sunday snack. Maroon spoon to control bite size gravy/sauce/broth on meats swallowing precautions assist as needed to slow down frequently while eating. (continued on next page)

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Monitor for signs and symptoms of aspiration: Increase in cough, choking, change in lung sounds, wheezing etc. Notify MD. -Observation and Staff Interview An observation on 03/04/25 at 10:13 PM revealed Resident #14 lying in bed. His bedside table had a water pitcher on it with thin liquids. During an interview on 03/04/25 at 10:13 PM, Unit Charge Nurse (UCN) #12 stated, We were always told to pass ice, but they never drink it. SA then asked UCN #12 if he had access to the water pitcher at any time? UCN #12 stated, Yes and then confirmed that the water was not thickened as ordered. The Immediate Jeopardy was called on 03/04/25 at 11:53 PM. A plan of correction wasaccepted at 03/05/25 at 2:09 AM. The IJ was abated on 03/06/25 at 10:15 AM. -Plan of Correction as written by facility; 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; a. Residents #1, #2, and #14 have had the water pitchers removed from their room on 3/05/25. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; a. All residents have the potential to be affected. The Nurse Supervisor made rounds on 3/05/25 and checked all residents who require a thickened liquid and removed the water pitchers from their rooms. For residents on a thickened liquid diet, staff will ensure that those residents receive water, consistent with their diet orders, at least every two hours and on nightly rounds as ordered. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; a. All direct care staff will be in-serviced by the DON/designee on F807 regulation and will complete a sign in sheet and post test to demonstrate understanding by 3/15/25. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; (continued on next page)

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F 0807 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. An audit will be completed by the Quality Assurance and Performance Improvement (QAPI) Nurse/designee to ensure that all residents who have a thickened liquid diet do not have water pitchers in their rooms. The audit will be completed at least daily 5 days per week for 2 weeks, then twice weekly for 2 weeks, then weekly for 4 weeks, then monthly for 03 months, then quarterly for 6 months with any corrective action immediately upon discovery. The QAPI nurse will report findings of the audit to the DON/designee and to the QAPI team quarterly for review and follow-up.

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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.

45173

Based on observation, record review, and staff interview, the facility failed to maintain infection control standards during incontinence care for Resident #1, who was on enhanced barrier precautions, by not wearing the appropriate PPE, by throwing soiled clothing, linens and a brief on the floor of the shower room, and continuing to wear soiled gloves throughout the unit after the incontinence care was provided for Resident #1; and, storing clean linen in the shower room, and did not maintain contact/droplet precautions during an influenza outbreak. Resident identifier: #1.

Facility Census: 61.

Findings Include:

a) Resident #1

On 03/04/25 at 9:20 PM, Resident #1 was observed sitting in a recliner with visible signs of urinary signs of urinary incontinence on Resident #1's pants. The resident was transferred from recliner to the wheelchair. The resident is on enhanced-barrier precautions due to a history of Methicillin-Resistant Staphlococcus Aureus (MRSA). Nurse Aide (NA) #107 did not don personal protective equipment (PPE) while transferring or providing incontinence care to Resident #1. The resident was taken to the shower room in a wheelchair. The resident was stood up in front of his wheelchair and the resident's hands were placed on the grab bar by NA #107. NA #107 removed the saturated pants, hipsters and soiled brief and placed the soiled items directly on the shower room floor. NA #107 then began to clean the resident with wet wash cloths and soap, which were placed on the floor of the shower room with the other soiled items. NA #107 completed the incontinence care and redressed the resident while wearing soiled gloves. NA #107 then proceeded to return the resident to a recliner in the hallway. During transport, NA #107 continued to wear soiled gloves and obtained a clean incontinence pad, which NA #107 then placed in the recliner. NA #107 returned to the shower room still wearing the soiled gloves. The NA #107 was asked, do you use something to contain the soiled brief, linen and clothing in? on 03/04/25 at 9:38 PM. NA #107 said no, we just put it in the bins, one for soiled facility linens, and one for resident's personal clothing. NA #107 was, also, asked about the use of PPE as well as continuing to wear soiled gloves during the dressing of the resident, transferring the resident and obtaining clean linen. NA #107 stated, oh my bad .I forgot to grab the PPE and remove my gloves.

At this same time while in the shower room, observations of clean linen stacked on a bed side commode in the shower room as well as a resident's personal clothing and unused briefs were lying on the shower bed.

On 03/04/25 at 9:45 PM, Charge Nurse #12 was interviewed regarding the infection control breaches. The Charge nurse was asked, is the resident (#1) on any type of precautions? The Charge nurse stated, no, he isn't .that's for someone else. At this time, Charge Nurse #12 nodded her head in agreement that there had been infection control breaches. NA #107 returned to the shower room and began gathering the soiled linen and the resident's clothing and placed them into a bins in the hallway.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Lakin Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 11522 Ohio River Road West Columbia, WV 25287	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/04/25 at 11:15 PM, the Administrator was notified. The Administrator confirmed the nurse aide should have worn PPE during the transfer and the incontinence care. The Administrator, also, confirmed the nurse aide should not be wearing soiled gloves throughout the unit, and soiled linens and personal clothing as well as a soiled brief should not be placed on the shower room floor. b) Enhanced-barrier precautions Enhanced-barrier precautions were in place for Resident #1. The signage was placed on his door which stated, wear gloves and a gown for the following: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care. (Typed as written.) c) Clean linen storage On 03/05/25 at 3:48 PM, clean linen was observed in the shower room on the B East unit. NA #133 confirmed the clean linen should not be stored in the shower room. NA #133 then removed the linen from the shower room and placed it in the dirty linen cart. On 03/05/25 at 4:35 PM, the Administrator was notified. The Administrator confirmed the clean linen should not be stored in the shower room. d) Influenza Outbreak On 03/10/25 at 12:36 PM, Accounting Specialist #38 was standing at the A North Unit with the door open giving the residents money. The A North unit was under contact/droplet precautions due to an influenza outbreak. On 03/10/25 at 12:43 PM, the Accounting Specialist #38 stepped inside the unit door without wearing PPE and kept the door open for approximately nine (9) minutes. Multiple residents were noted at the door without wearing masks. On 03/10/25 at 12:48 PM, the Accounting Specialist #38 was interviewed regarding the contact/droplet precautions. The Accounting Specialist #38 stated, I shouldn't have kept the door open to the hallway and I should have put on PPE .I want to keep everyone safe. On 03/10/25 at 12:50 PM, the Administrator was notified. The Administrator confirmed the door to the unit should have remained closed and the Accounting Specialist should have donned PPE upon entering the unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 51E124	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49467 Based on record review and staff interview, the facility failed to complete required yearly education for two (2) Nurse Aides (NAs) at the facility. This has the potential to affect more than a limited number of residents residing in the facility. Facility census: 61. Findings include: During review of facility staffing on o3/12/25, yearly staff educations were reviewed. During review, it was discovered that the educations for NAs #21 and #107 had been photocopied and not completed by the staff themselves. The post tests were copied, with the answers already filled in and all the staff members were required to do was write their name at the top, along with the date. During an interview with the Nurse Educator (NE) on 3/12/25 at approximately 11:30 AM, the NE stated she was aware of instances where staff members would make copies of the educations and fill in their names at the top, to avoid having to do the post tests, as they were already filled out, although she stated she had never personally seen anyone do them. The NE then picked up some of the post tests and ran her finger across the answers, as if she was trying to smear ink, and stated Yes, those are copies. During an interview with the Administrator at approximately 12:00 PM on 3/12/25, she confirmed the educations were photo copies, as well, and not completed by the staff themselves.