STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	51E148	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopemont Hospital	150 Hopemont Drive Terra Alta, WV 26764

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49465 Based on staff interviews and observation the facility failed to provide a dignified dining service. This failed practice was found true for (1) one random resident observed during the lunch dining in the Long-Term Care Survey Process. Resident identifier #44. Facility Census 49. Findings Include: a) Resident #44 During an observation on 05/29/24 at 12:15 PM, Resident #44 was sitting at a table with (3) three other residents. The other (3) three residents got their lunch tray at 12:15PM. (9) nine other residents at different tables were served before Resident #44 received her lunch tray at 12:25 PM. Further observation showed that (1) one of the residents seated at the table with Resident #44 was finished eating when Resident # 44 got her lunch tray. During an interview, on 05/29/24 at 12:25 PM, with Nurse aide (NA) #87 she stated, We are supposed to pass them out in order, but they don't come out in order. We must find them. We have not come to [Resident # 44 name} tray yet.

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: 51E148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. 50552 Based on resident observation, record review and staff interview, the facility failed to ensure the resident and or representative was informed in advance by the physician, other practitioner or health professional of the risks and benefits of proposed care, of treatment alternatives or treatment options and to choose the alternative option preferred. This was true for 1 (one) of 18 residents reviewed in the Long-Term Care Survey Process. Resident identifier: #36. Facility census: 49. Findings include: a) Resident #36 On 05/28/24 at 12:30 AM, a review of Resident #36's medical record was conducted. A fall care plan was noted with interventions stating, Encourage resident to wear hipsters at all times for safety. and Encourage resident to wear soft helmet while ambulating for safety. On 05/28/24 at 01:07 PM an observation of Resident #36 was conducted. Resident #36 was noted to be in bed, no hipsters were noted to be on Resident #36 and no helmet was noted to be present. On 5/29/24 at 11:25 AM an interview with Employee #72 was conducted. Employee #72 stated, He refuses to wear the hipsters. Further review of Resident #36's medical record on 5/29/24 at 08:00 PM was conducted. Resident #36's capacity form, fall care plan and the Interdisciplinary Team recommended interventions. It was then noted that several of the Interdisciplinary Team recommended interventions were continue educating on fall interventions and encourage resident to use them, as he always refuses. The documented dates for this intervention included the following: 04/04/24, 04/17/24, 04/19/24, 04/23/24 and 05/19/24. Review of Resident #36's capacity form indicated that Resident #36 had been examined and found to be mentally incapable of granting informed consent or to have the capacity to consent to treatment and that Resident #36's brother had been named as Health Care Surrogate. On 5/30/24 at approx. 9:00 AM an interview with Employee #73 was conducted. Employee #73 stated, He refuses to wear his helmet and hipsters. They are in his closet. Further review of Resident #36's medical record on 5/29/24 at 08:00 PM noted a behavior care plan with an intervention stating, Nurse may disguise medication in his food in the attempt to make sure he takes it due to sexual behaviors. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/30/24 at approximately 9:30 AM, an interview was conducted with the Director of Nursing (DON). This Surveyor reviewed, with the DON, the behavior and fall care plan including the interventions. This Surveyor then asked the DON if Resident #36 had the right to refuse treatment or if education related to the risks of refusing treatment was provided to Resident #36 or his MPOA. The DON stated, You are contradicting what you said yesterday about him not being able to be educated if you are saying he can refuse his medications. His MPOA says we can disguise it in his food and so does the doctor. This Surveyor then requested a copy of the facility resident rights and a copy of education provided to Resident #36 or his MPOA related to risks of refusal of his medications, helmet, and hipsters. This Surveyor also requested the DON provide education that was provided to Resident #36 or his MPOA related to alternative options of his refusal of medication, helmet, and hipsters. On 5/30/24 at approximately 11:30 AM a copy of Policy and Procedure entitled, Resident Rights Guidelines for all Nursing Procedures was provided to this Surveyor which stated, Prior to having direct care responsibilities, staff must have appropriate in-service training on resident rights, including, Resident right of refusal (medications and treatments). The DON did not provide further documentation related to the request for education provided to Resident #36 or his MPOA related to the risks of refusing medication, helmet and hipsters or alternative options related to the refusal of his medications, helmet, or hipsters.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 50795 Based on staff interview and facility documentation, the facility failed to provide reasonable accommodation in regard to activities of daily living (ADLs). This was true for one (1) of eighteen (18) residents reviewed under the ADL pathway. Resident identifier: #43. Facility Census: 49 Findings included: a) Gas Leak Resulting in No Hot Water Facility staff had reported signs of a gas leak on 05/26/24. The gas company technician had noted a positive test for gas in the kitchen area, and, as a precaution, recommended turning off the gas supply to the facility. As a result, no hot water had been available for the residents since 05/26/24. a) Resident #43 During staff interviews on 05/30/24 at 11:03 AM, with Nurse Aide (NA) #29, Registered Nurse (RN) #83 and Licensed Practical Nurse (LPN) #73, stated the bath wipes used for bed baths were to be warmed for 20 seconds in a microwave before being used on residents. However, staff were unable to warm the bath wipes because the microwave ovens had been removed due to safety concerns. This resulted in residents being wiped down with cold bath wipes. NA #39 stated that residents who had capacity were refusing the bed baths. During a review of Bath/Shower Temperature Logs at the nursing station on 05/30/24 at 11:17 AM, RN #83 and LPN #73 showed a shower being completed for Resident #43 on the evening of 05/26/24. During an interview with Resident #43 on 05/30/24 at 11:47 AM, the resident, in the presence of NA #10, stated that he did not take cold showers. Submission of a request for Bath/Shower Temperature Logs completed on 05/30/24 at 11:17 AM. These logs revealed no completed sheets. Upon interview with the Director of Nursing (DON) - on 05/30/24 at 12:47 PM, DON stated there were no log sheets available because no showers were offered due to the non-availability of hot water. Record review of Health Services Worker (HSW) intervention logs produced by the DON revealed documentation of a shower for Resident #43 on 05/26/24. The HSW Interventions logs required entries specifying which type of bath was offered to the resident. (W) for whirlpool, (S) for shower, and (BB) for bed bath. The MDS Coordinator provided the logs for Resident #43. The logs had a single letter entered for each day. When questioned about what the letters denoted, the MDS Coordinator stated that she would ask the DON. She returned, and stated the DON had informed her they were the initials of the staff person performing the bath. When questioned further as to why there was only one letter, and why there was no information to identify who the initials belonged to, the MDS coordinator stated that she didn't have any further information.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49465 50552 Based on observation, staff interview, and resident interview the facility failed to provide a homelike environment by not allowing Resident # 29 access to his personal belongings by his own freewill. Resident #33's room had personal health information taped on the bed and had cosmetic imperfections that could pose a safety hazzard in the bathroom. This failed practice was found true for two (2) of two (2) residents reviewed for environment during the Long-Term Care Survey Process. Resident identifiers: #29, #33. Facility Census: 49. Findings Include: a) Resident # 29 During the initial interview on 05/28/24 at 1:46 PM, Resident # 29 stated, I want stuff out of my closet, and I can't get to it because there is a lock on it. When surveyor asked if he had a key to it Resident #29 stated, No, the nurse or NA has it and I have to have them come and unlock. It takes them a long time. A record review on 05/28/24 at 2:00 PM revealed that Resident # 29 has a Brief Interview of Mental Status (BIMS) score of 14. During an interview, on 05/28/24 at 3:30 PM, the Administrator stated, I'm sure there is a reason that the locks are on the closets, someone was probably getting into his closet, or something. It should be care planned. A record review on 05/28/24 at 4:00PM, revealed Resident #29 does not have a care plan to have his closet pad locked. There is also no nurses' notes in the medical record to indicate why his closet would be pad locked. During an interview, on 05/28/24 at 4:50 PM, the Administrator stated, I know why his closet is locked, I feel like he was defecating in it. When the surveyor asked if there were notes to attest to that. The administrator said, I don't know. 05/29/24 10:00 AM Observation of resident rooms revealed locks are off closet. 05/29/24 10:15 AM Resident stated, Hey I was able to get in my closet today. b) Resident #33 05/28/24 12:55 PM an observation revealed tape noted to bed on foam around head/foot board (says the foam is to protect my head). In the bathroom towel rack was observed off the wall, hardware present. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/30/24 02:55 PM during a staff interview the staff member said, Oh God. The staff member confirmed the hardware on wall posed safety hazard and said a request would be sent to maintenance to fix it.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 50551 Based on resident council meeting interviews, observation and staff interview the facility failed to ensure residents were able to submit grievances anonymously. This had the potential to affect more than an isolated number of residents. Facility census: 49. Findings included: a) 05/28/24 12:30 PM, Observed a sign in the front lobby stating there were grievance forms available at the front desk. 05/29/24 10:45 AM, During resident council meeting, Resident #24 stated in order to file a grievance residents and family must ask for a form at the front desk. She stated that staff will assist residents in filing out the paper. Resident #24 stated there was no place to get the forms anonymously or to submit them anonymously. 05/29/24 11:12 AM during an interview with Social Worker (SW) #9 the SW explained that the process of completing a grievance was to ask a staff member for a form and that she or other staff would assist in completing the form if asked. She stated there was no place to get a form anonymously and/or submit it anonymously.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 50552 Based on record review and staff interview, in response to allegations of abuse, the facility failed to have evidence that all alleged violations are thoroughly investigated. This was true for 1 (one) of 7 (seven) residents reviewed in the Long Term Care Survey Process. Resident identifier: Resident #25. Facility census: 49. Findings include: Resident #25 On 05/29/24 at 09:00 PM, a review of Facility Reported Incident (FRI) dated 05/16/24, was conducted. It was reported on 05/16/24 that on 05/15/24 at 10:00 PM, while facility staff was providing care to Resident #25, a 10cm x 5cm bruise, right upper thigh was noted and that it was estimated to be approximately 2-3 days old. A review of the facility ' s investigation noted that statements were obtained from 12 from staff members. However upon reviewing the statements obtained it was noted that 7 (seven) of the 12 statements were from employees not working on the unit at the time of the occurrence. At that time this Surveyor requested a copy of the schedule from the date and time of the occurrence. It was then noted that statements were not obtained from 3 (three) staff members working the date of the incident on the hallway of Resident #25. Further review of the schedules 4 (four) days prior to the date of the occurrence, also reveals statements were not obtained from the staff working on the hallway of Resident #25. On 05/30/24 at approximately 12:00 PM, a review of the facility policy entitled, Abuse, Neglect, Reporting/Investigation was reviewed and was noted to state the following: Investigation: The Resident Advocate/Grievance Official shall have access to all records and employees. The Resident Advocate/Grievance Official will gather all facts, conduct interviews of all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Failure to do so will result in disciplinary action and/or reporting to the employees licensing entity. 5. There will be a complete and thorough documentation of the investigation. On 05/30/24 at 12:55 PM, an interview was conducted with the facility Social Worker who acknowledged the above referenced policy, and that she failed to interview 8 (eight) employees who could have had knowledge of the occurrence. The facility Social Worker also acknowledged at that time she had not performed a thorough investigation.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review and staff interview, the facility failed to ensure a complete and accurate Preadmission Screening and Resident Review (PASRR) and failed to complete a new PASRR when a PASRR expired. This deficient practice had the potential to affect two (2) of two (2) residents reviewed for the care area of PASRR. Resident identifiers: #27 and #41. Facility census: 49. Findings included: a) Resident #27 Review of Resident 27's medical records showed the resident was admitted on [DATE]. The resident had a diagnosis of unspecified psychosis not due to a substance or known physiological condition at the time of admission to the facility. Resident #27 had been transferred from another long-term care facility who documented that the resident had a diagnosis of psychosis. Further review of Resident #27's medical records showed a PASSR completed [DATE]. The PASSR did not indicate the resident had a diagnosis of psychotic disorder. On [DATE] at 2:00 PM, Social Worker #65 confirmed Resident #27's admission PASSR was incorrect and did not indicate the resident had a diagnosis of psychosis. No further information was provided through the completion of the survey process. Facility failed to ensure a complete an accurate admission PASSAR, and an expired PASSAR TN-PS 2 of 2 residents looked at for PASSAR a) Resident # 27 TN B) Resident # 41 CR Resident #27 PASARR [DATE] 04:39 PM unable to find PASSAR in file PASSAR dated [DATE] did indicate psychotic disorder - when was diagnosed ? had diagnoses from transferring LTC [DATE] of unspecified psychosis not due to a substance or known physiological condition SW #65 confirmed admission MDS was incorrect; psychosis was not identified (continued on next page)

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49465 Facility failed to ensure a complete an accurate admission PASSAR, and an expired PASSAR TN-PS 2 of 2 residents looked at for PASSAR a) Resident # 27 TN B) Resident # 41 CR Resident #41 PASARR F-645 Facility failed to ensure residents PASSAR was accurate and correct. Resident # 41 [DATE] 03:25 PM Interview with Director of Social Services, We are in the process of trying to get her out of the facility per her family. They want her in the [NAME] area near them, but nooone has accepted her yet. Do you think I should do a new one.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49465 Based on record review, resident observation and staff interview the facility failed to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs.This was true for 3 (three) of 18 residents reviewed during the Long Term Care Survey Process. Resident identifiers: Resident #36, Resident #25 and Resident #45. Facility census: 49. Findings Include: Resident #36 On 05/28/24 at 12:30 AM, a review of Resident #36 ' s medical record was conducted. A fall care plan was noted with interventions stating, Encourage resident to wear hipsters at all times for safety. and Encourage resident to wear soft helmet while ambulating for safety. On 05/28/24 at 01:07 PM an observation of Resident #36 was conducted. Resident #36 was noted to be in bed, no hipsters were noted to be on Resident #36 and no helmet was noted to be present. A further review of Resident #36 ' s medical record was conducted on 05/28/24 at approximately 01:25 PM, which noted Resident #36 had 19 documented falls from 01/01/24 through 05/26/24. The falls were as follows: 01/15/24, 01/22/24, 01/28/24, 02/13/24, 03/6/24, 03/0/247, 03/11/24, 03/14/24, 03/23/24, 04/01/24, 04/08/24, 04/09/24, 04/17/24, 04/19/24, 04/23/24, 05/19/24, 05/20/24, 05/21/24 and 05/26/24. It was also noted during this review that after a fall on 04/01/24 at 08:15 PM, Resident #36 was sent to the emergency room due to sustaining a laceration to the left elbow that was documented to be deeper than first appeared. Then on 05/16/24, Resident #36 was sent to the hospital related to this laceration of the left elbow. During a review of Resident #36 ' s hospital record it was noted Resident #36 was diagnosed with septic left olecranon bursitis after a failed outpatient antibiotic series. On 05/29/24 at 11:20 AM a copy of the facility fall policy was requested from the Director of Nursing (DON). On 05/29/24 at 11:25 AM an interview with Employee #72 was conducted. Employee #72 states He refuses to wear the hipsters. On 05/29/24 at approximately 12:30 PM, a review of the provided facility policy titled, Falls Risk Assessment and Management Program was conducted and noted the following text: A multi-disciplinary team will meet monthly to review the resident ' s identified as being high risk for falls, to evaluate the interventions in place and to modify the Resident ' s Care Plan as needed. At these meetings, individual falls and/or residents are discussed and analyzed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Possible intrinsic and extrinsic factors *Evaluation of present interventions in place *Current or newly prescribed medications *Further preventative measures and interventions *Additional equipment/supply needs Therapy or Restorative Nursing evaluations/treatment - for decline in function, adaptive needs, seating assessment, etc. Special attention is paid to residents with any repeat occurrences. Following the Fall Management meeting, the DON, ADON and Unit Managers or charge nurse will implement individual changes recommended by the team; modify the resident ' s fall risk assessment plan of care and mini-in-service staff on the units of changes/updates. A copy of any Interdisciplinary Team notes, related to Resident #36 ' s falls that have occurred during the year of 2024 were requested. 5/29/24 at 01:30 PM the Interdisciplinary Team notes were provided. The months provided were from 03/21/24 through 05/21/24. This Surveyor then requested a copy of Resident #36 ' s capacity form from the DON. Further review of Resident #36 ' s medical record on 5/29/24 at 08:00 PM was conducted. Resident #36 ' s capacity form, fall care plan and the Interdisciplinary Team recommended interventions. It was then noted that several of the Interdisciplinary Team recommended interventions were continue educating on fall interventions and encourage resident to use them, as he always refuses. These dates this intervention was documented included the following: 04/04/24, 04/17/24, 04/19/24, 04/23/24 and 05/19/24. Review of Resident #36 ' s capacity for indicated that Resident #36 had been examined and found to be mentally incapable of granting informed consent or to have the capacity to consent to treatment and that Resident #36 ' s brother had been named as Health Care Surrogate. On 5/30/24 at approximately 09:00 AM an interview with Employee #73 was conducted. Employee #73 states, He refuses to wear his helmet and hipsters. They are in his closet. On 5/30/24 at approximately 09:33 AM, an interview was conducted with the Director of Nursing (DON). This Surveyor reviewed, with the DON, Resident #36 ' s fall care plan.The DON acknowledged that from 12/19/23 until 04/02/24 Resident #36 ' s fall care plan had not been revised or updated with Interdisciplinary Team intervention recommendations then states, I don ' t know why it wasn ' t updated with new interventions after each fall. Resident #25 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/28/24 at 02:49 PM an observation of Resident #25 was made. Resident #25 was noted to be at the end of A Hall at the exit door attempting to open it when the alarm sounded. Resident #25 was then approached by a member of the facility staff. who was coming out of another resident room, easily redirected Resident #25. At this time, Resident #25, was observed to have a wander guard to his right ankle, was seated in a back wheelchair with a chair alarm attached to it. On 05/29/24 at 07:50 AM a review of Resident #25 medical record was performed. It was noted that in Resident #25 ' s behavior care plan focus that Resident #25 had a history of wandering and attempting to enter unsupervised areas. An intervention in this care plan was as follows: 15 minute checks for safety was entered. This Surveyor then asked the Director of Nursing (DON) for documentation of the care planned 15 minute checks. On 5/29/24 at approx 12:30 PM a record review of the facility 15 minute check worksheet for Resident #25 noted that multiple areas of documentation were missing. On 5/29/24 at 01:15 PM an interview with the DON was conducted. The DON acknowledged the missing documentation should be present. c) Resident #45 During a record review on 05/28/24 at 3:47 PM, of Resident #45 ' s fall care plan created on 12/08/23 reads as follows: Focus: {Effective date of 03/21/24} FALL- (Resident #45 name) has the risk for injury related to falls, fragile skin, balance issues, and poor safety awareness secondary to impaired cognition from a number of factors that include : aging process, side effects from psychotropic medications, behavior issues, and Alzheimer ' s disease. Goals: {Effective date of 02/28/24} - Areas of impaired skin will show no signs or symptoms of infection and resolve within 30 days. (Resident #45 name) will not have a significant injury from falls within the next 90 days. Interventions: -Provide assistance with transfer, ambulation and locomotion as needed. -Ensure that the call bell is within reach at all times. -Provide a safe, clutter free environment. -Ensure resident wears appropriate, well-fitting footwear to minimize the risk of slipping -Pad alarm to bed and wheelchair at all times for safety. -May use a wheelchair as needed due to weakness and unsteady gait. -15 minute checks for resident safety. (continued on next page)

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	51E148	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hopemont Hospital	150 Hopemont Drive Terra Alta, WV 26764

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1:1 at all times due to resident safety. -Encourage periods of rest. -When staff witness (Resident #45 name) is sitting on the floor, stay with her and offer a chair to sit on. -Hipsters on at all times. Further record review of Resident #45 ' s orders showed that 1:1 at all times had been discontinued on 03/08/24. During an interview on 05/29/24 at 11:13 AM, The Director of Nursing (DON) stated, The one to one ' s were discontinued in March. I don't know why it is still on her care plan, it should not be. That care plan is a social worker care plan and I guess she did not take it out. 50552

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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. 50795 Based on record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice which would allow the residents to achieve their highest practicable physical, mental, and psychosocial well-being. This was true for two (2) out of four (4) residents reviewed for restorative nursing services. Resident identifiers: #5 and #37. Facility census: 49. Findings included: a) Resident #5 Record review on 05/30/24 at 11:51 AM, revealed that Resident #5's physician had prescribed Range of Motion (ROM)/stretching protocol global 1 (one) time daily, up to 5 (five) times a week for contracture management on 12/15/21. During an interview on 05/30/24 at 10:46 AM, Physical Therapist (PT) #15 and PT # 22 , and also confirmed by record review, revealed the resident received twelve (12) treatments out of a prescribed twenty-five (25) treatments, during the period 04/01/24 to 04/31/24. b) Resident #37 Record review for Resident #37 revealed that his physician had prescribed Moist Heat to L LE (Left Lower Extremity) and low back 1x/daily for up to 5x a week for 20 minutes or less per treatment for pain management. Treatment record review, and interview with PT #15 and PT #22 revealed that application of the moist heat pad required a nurse to be in attendance. Treatments were frequently canceled because the nurse was busy and unable to come to physical therapy. Treatment record review for Resident #5 revealed that resident received five (5) moist heat treatments out of the prescribed twenty-three (23) treatments, during the period 05/01/24 to 05/30/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50552 Based on record review, staff interview and resident observation the facility failed to provide supervision, implementation, monitoring and modifying of interventions to prevent avoidable accidents. This was true for 2 (two) of 7 (seven) residents reviewed during the Long-Term Care Survey Process. Resident identifiers: Resident #36 and Resident #25. Facility census: 49. Findings include: a) Resident #36 On 05/28/24 at 12:30 PM, a review of Resident #36 ' s medical record was conducted. A fall care plan was noted with interventions stating, Encourage resident to wear hipsters at all times for safety. Encourage resident to wear soft helmet while ambulating for safety. On 05/28/24 at 1:07 PM an observation of Resident #36 was conducted. Resident #36 was noted to be in bed, no hipsters were noted to be on Resident #36 and no helmet was noted to be present. A further review of Resident #36's medical record was conducted on 05/28/24 at approximately 1:25 PM, which noted Resident #36 had 19 documented falls from 01/01/24 through 05/26/24. The falls occurred on: 01/15/24, 01/22/24, 01/28/24, 02/13/24, 03/6/24, 03/0/247, 03/11/24, 03/14/24, 03/23/24, 04/01/24, 04/08/24, 04/09/24, 04/17/24, 04/19/24, 04/23/24, 05/19/24, 05/20/24, 05/21/24 and 05/26/24. It was also noted during this review that after a fall on 04/01/24 at 8:15 PM, Resident #36 was sent to the emergency room due to sustaining a laceration to the left elbow that was documented to be deeper than first appeared. Then on 05/16/24, Resident #36 was sent to the hospital related to this laceration of the left elbow. During a review of Resident #36 ' s hospital record it was noted Resident #36 was diagnosed with septic left olecranon bursitis after a failed outpatient antibiotic series. On 05/29/24 at 11:20 AM a copy of the facility fall policy was requested from the Director of Nursing (DON). On 05/29/24 at 11:25 AM an interview with Employee #72 was conducted. Employee #72 stated, He refuses to wear the hipsters. On 05/29/24 at approximately 12:30 PM, a review of the provided facility policy titled, Falls Risk Assessment and Management Program was conducted and noted the following text: A multi-disciplinary team will meet monthly to review the resident's identified as being high risk for falls, to evaluate the interventions in place and to modify the Resident's Care Plan as needed. At these meetings, individual falls and/or residents are discussed and analyzed *Possible intrinsic and extrinsic factors (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Evaluation of present interventions in place *Current or newly prescribed medications *Further preventative measures and interventions *Additional equipment/supply needs Therapy or Restorative Nursing evaluations/treatment - for decline in function, adaptive needs, seating assessment, etc. Special attention is paid to residents with any repeat occurrences. Following the Fall Management meeting, the DON, ADON and Unit Managers or charge nurse will implement individual changes recommended by the team; modify the resident's fall risk assessment plan of care and mini-in-service staff on the units of changes/updates. A copy of any Interdisciplinary Team notes, related to Resident #36's falls that have occurred during the year of 2024 were requested. On 05/29/24 at 01:30 PM the Interdisciplinary Team notes were provided. The months provided were from 03/21/24 through 05/21/24. This Surveyor then requested a copy of Resident #36's capacity form from the DON. Further review of Resident #36 ' s medical record on 5/29/24 at 08:00 PM was conducted. Resident #36 ' s capacity form, fall care plan and the Interdisciplinary Team recommended interventions. It was then noted that several of the Interdisciplinary Team recommended interventions were continue educating on fall interventions and encourage resident to use them, as he always refuses. The dates this intervention was documented included the following: 04/04/24, 04/17/24, 04/19/24, 04/23/24 and 05/19/24. Review of Resident #36 ' s capacity for indicated that Resident #36 had been examined and found to be mentally incapable of granting informed consent or to have the capacity to consent to treatment and that Resident #36 ' s brother had been named as Health Care Surrogate. On 05/30/24 at approximately 9:00 AM an interview with Employee #73 was conducted. Employee #73 stated, He refuses to wear his helmet and hipsters. They are in his closet. On 05/30/24 at approximately 9:33 AM, an interview was conducted with the Director of Nursing (DON). This Surveyor reviewed, with the DON, Resident #36's fall care plan. The DON acknowledged that from 12/19/23 until 04/02/24 Resident #36's fall care plan had not been revised or updated with Interdisciplinary Team intervention recommendations then states, I don't know why it wasn't updated with new interventions after each fall. Resident #25 On 05/28/24 at 2:49 PM an observation of Resident #25 was made. Resident #25 was noted to be at the end of A Hall at the exit door attempting to open it when the alarm sounded. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #25 was then approached by a member of the facility staff who was coming out of another resident room. This staff member easily redirected Resident #25. At this time, Resident #25, was observed to have a wander guard to his right ankle. The resident was seated in a back wheelchair with a chair alarm attached to it. On 05/29/24 at 07:50 AM a review of Resident #25's medical record was performed. It was noted that in Resident #25's behavior care plan focus that Resident #25 had a history of wandering and attempting to enter unsupervised areas. An intervention in this care plan was 15-minute checks for safety. This Surveyor asked the Director of Nursing (DON) for documentation of the care planned 15-minute checks. It was also noted that in a separate social work care plan focus that Resident #25 was on a one to one as he wandered into rooms of others and was an elopement risk. On 5/29/24 at 12:30 PM a record review of the facility 15-minute check worksheet for Resident #25 noted that multiple areas of documentation were missing. On 5/29/24 at 01:15 PM, an interview with the DON was conducted. The DON acknowledged the missing documentation should be present. On 5/30/34 at 11:18 AM, an interview with the Assistant Director of Nursing (ADON) was conducted. The ADON acknowledged that the care plan was incorrect and should have been updated.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49650 Based on facility record review and staff interview the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. This was true for two (2) of five (5) days identified during the long-term care survey process. This had the ability to affect all the residents. Facility census: 49. Findings included: a) 05/28/23 On 05/29/24 at approximately 11:00 AM during a review of the facilities payroll transaction report of all direct care hours for 05/28/23, no direct care Registered Nurse (RN) hours were identified for 05/28/23. On 05/29/24 at approximately 11:05 AM during a further review of the facility Nursing Staff Information Sheet (also known as the Nursing Staffing Posting form), the total number of Registered Nurse staff for 05/28/23 was handwritten in at one (1) and the total number of hours for the Registered Nurse Staff hours was also handwritten in at eight (8). During an interview with the Director of Nursing (DON) on 05/29/24 at approximately 12:15 PM, he stated he had found an agency Timesheet for Agency RN #95 and that he had hours marked for 05/28/23. The DON was asked to provide documentation of the facility or the agency payroll documentation to identify the hours marked and that they had actually been worked. No further information was provided by the DON. b) 07/05/23 On 05/29/24 at approximately 11:00 AM during a review of the facilities payroll transaction report of all direct care hours for 07/05/23 revealed no direct care Registered Nurse (RN) hours were identified for 07/05/23. On 05/29/24 at approximately 11:05 AM during a further review of the facility Nursing Staff Information Sheet (also known as the Nursing Staffing Posting form), the total number of Registered Nurse staff for 07/05/23 was handwritten in at zero (0) and the total number of hours for the Registered Nurse Staff hours was also handwritten in at zero (0). During an interview with the Director of Nursing (DON) on 05/29/24 at approximately 12:15 PM, he stated they had numerous Registered Nurses (RN) with administrative duties in the facility that day and that he did not have to have an RN on duty. During a review of the RN requirements in accordance with the Payroll Based Journal for direct care and administrative duties, the DON said he would have to read that information for himself. The information was then provided for the DON electronically on the computer screen and the DON stated he would have to check into who else was in the building at this time. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DON acknowledged that no RN's were listed on the Nursing Staff Information for 07/05/24 and that there were no RNs with non-administrative duties payroll time captured in the facility transaction report for direct care hours on 07/05/24. No further information was provided by the DON.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 49650 Based on facility record review and staff interview the facility failed to provide the accurate data on the nurse staffing information form. The daily census was not accurate for 4 of 5 daily of the nurse staffing information forms reviewed during the long-term care process. This issue had the ability to affect more than a limited number of residents. Census: 49. Findings included: The facilities available and occupied beds report review on 05/29/24 at 11:00 AM revealed the following: a) 05/28/23 On 05/28/23 the daily census was identified to be 46 and the staffing posting form was a handwritten census of 49. b) 07/05/23 On 07/05/23 the daily census was identified to be 47 and the staffing posting form was a handwritten census of 48. c) 01/01/24 On 01/01/24 the daily census was identified to be 43 and the staffing posting form was a handwritten census of 44. d) 05/27/24 On 05/27/24 the daily census was identified to be 49 and the staffing posting form was a handwritten census of 50. During an interview with the Director of Nursing (DON) on 05/29/24 at approximately 12:20 PM, he acknowledged that the forms were not accurate and stated that he could not explain why the census was not accurately documented on the nursing staffing information form. No further information was provided.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review and staff interview, the facility failed to ensure behavior monitoring and medication side effect monitoring was documented for a resident receiving psychotropic meds. This deficient practice affected one (1) of five (5) residents reviewed for the care area of unnecessary medications. Resident identifier: #12. Facility census: 49. Resident identifier: a) Resident #12 Review of the facility's policy titled Behavioral Assessment, Intervention, and Monitoring with no implementation date specified, stated the following: - If a resident was being treated for altered behavior and mood, the Interdisciplinary Team (IDT) would document any improvements or worsening in the resident's behavior, mood, and function. - The IDT would monitor for side-effects related to psychoactive medications. Review of Resident #12's medical records showed the resident had been admitted to the facility on [DATE]. Resident #12 had diagnoses of anxiety, depression, and mood disorder. The resident was prescribed the psychotropic medications Buspar (buspirone) for anxiety, Zoloft (sertraline) for depression, and Seroquel (quetiapine) for mood disorder. The resident had a physician order written on 05/09/24 to monitor for side effects of medication during administration and every shift. Further review of Resident #12's medical records did not show any monitoring of the resident's symptoms of anxiety, depression, or mood disorder. Furthermore, review of Resident #12's medical records did not show any monitoring of medication side-effects for the resident. The Director of Nursing (DON) and Minimum Data Set (MDS) Nurse #4 were interviewed on 05/30/24 at 11:20 AM. MDS Nurse #4 stated residents taking psychotropic medications (medications that affect the mind, emotions, and behavior) have their behaviors and side-effects monitored every shift on a handwritten documentation sheet. The DON stated Resident #12 had no behaviors or side-effects but confirmed this had not been documented on a behavior monitoring sheet. No further information was provided through the completion of the survey.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 49650 Based on facility record review and staff interview the facility failed to conduct and document a complete facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. The facility did not assess the physical environment, equipment, services, and other physical plant considerations that are necessary to care for the resident population. This was a random opportunity for discovery during the long-term care survey. Census: 49. Findings included: a) Gas leak On 05/29/24 at approximately 11:30 AM during a review of the facility assessment revealed on Page 14 under number 3.12 to provide your facility-based and community-based risk assessment, utilizing an all-hazards approach (an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and natural disasters). It was further identified on Page 24 of the facility assessment that the following were the identified facility risks and or community risks/disasters listed that have the potential to affect the facility: 1. Fire 2. High wind/ tornado 3. Flood 4. Pandemic communicable diseases such as influenza, Ebola 5. Workplace security issue such as bomb threat, terrorism, active shooter 6. Loss of electrical power or water service 7. Hazardous material release 8. Loss of facility computer system 9. Severe Weather 10. Missing/ eloped resident. During an interview with the Administrator on 05/30/24 at approximately 11:36 AM the Administrator explained the recent events of the gas services loss due to a gas leak and the potential evacuation of the residents and staff that the facility had faced. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Administrator agreed that the facility assessment, when completed correctly, should identify the individual facility vulnerabilities to enable the facility to thoroughly assess the needs of its resident population and the required resources to provide the care and services the residents need. The Administrator further agreed that the facility failed to complete the facility-based risk assessment, utilizing an all-hazards approach with the main source of hot water for residents bathing being the gas service and the ability to prepare the residents meals being solely dependent on the gas service. The Administrator further commented since he has experienced this gas leak with an initial threat of a potential explosion and the possible need for an emergency evacuation of the residents and staff. And with the ongoing complete loss of their gas services which is affecting the means of providing the residents their baths and preparing their meals, it would be a definite vulnerability of the facility that was not identified in the facility assessment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50795 Based on staff interview and facility documentation, the facility failed to provide accurate and complete medical records in regard to activities of daily living (ADLs). This was true for one (1) of eighteen (18) residents reviewed under the ADL pathway. Resident identifier: #43. Facility Census: 49 Findings included: a) Gas Leak Resulting in No Hot Water Facility staff had reported signs of a gas leak on 05/26/24. The gas company technician had noted a positive test for gas in the kitchen area, and, as a precaution, recommended turning off the gas supply to the facility. As a result, no hot water had been available for the residents since 05/26/24. a) Resident #43 During a review of Bath/Shower Temperature Logs at the nursing station on 05/30/24 at 11:17 AM, RN #83 and LPN #73 showed a shower being completed for Resident #43 on the evening of 05/26/24. Submission of a request for Bath/Shower Temperature Logs completed on 05/30/24 at 11:17 AM. These logs revealed no completed sheets. Upon interview with the Director of Nursing (DON) - on 05/30/24 at 12:47 PM, DON stated there were no log sheets available because no showers were offered due to the non-availability of hot water. Record review of Health Services Worker (HSW) intervention logs produced by the DON revealed documentation of a shower for Resident #43 on 05/26/24. The HSW Interventions logs required entries specifying which type of bath was offered to the resident. (W) for whirlpool, (S) for shower, and (BB) for bed bath. The MDS Coordinator provided the logs for Resident #43. The logs had a single letter entered for each day. When questioned about what the letters denoted, the MDS Coordinator stated that she would ask the DON. She returned, and stated the DON had informed her they were the initials of the staff person performing the bath. When questioned further as to why there was only one letter, and why there was no information to identify who the initials belonged to, the MDS coordinator stated that she didn't have any further information.

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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	Provide and implement an infection prevention and control program. 49465 Based on observation and staff interview the facility failed to provide hand washing to residents on B hall before their lunch meal. Resident #33 had a pool noodle type piped foam taped around the head and foot board of the bed. This foam could not be effectively cleaned. These practices were random opportunities for discovery during the Long-Term Care Survey Process. Facility Census: 49. Findings included: a) B-hall An observation on 05/29/24 at 12:35 PM, revealed (7) seven lunch trays were passed on B hall with no hand hygiene provided. During an interview on 05/29/24 at 12:35 PM, with Nurse Aide (NA) #29 she stated, I'll be honest, we normally don't do it on the hallway. We do in the dining room but not on the hallway During an interview on 05/29/24 at 1:30 PM, with The Director of Nursing (DON) he confirmed that handwashing should be completed with residents before they receive their tray. 49650 b) Resident #33 05/29/24 at 1:38 PM during a tour of resident room the black pipe foam that resembled a pool noodle was seen to be tapped with black tape along the headboard and the foot board of the bed. Some of the tape was coming lose and the foam was tearing apart in several areas. Licensed Practical Nurse (LPN) #50 stated the cleaning and disinfecting of the foam was not the nursing responsibility and that the housekeepers clean it. During an interview on 05/29/24 at 1:39 PM with Housekeeper #41 the housekeeper stated she would spray her disinfectant to the top surface and let is set on the pipe foam for about 30 seconds and then wipe it down. During an interview at on 05/29/24 1:41 PM with the DON and Material Data Set RN #05, the DON acknowledged the foam was torn in areas and the foam material was not able to be fully disinfectant. He stated it should had been changed out.