STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515169	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Center	1000 Lincoln Drive South Charleston, WV 25309

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 43340 Based on record review and staff interview, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN) form to two (2) of three (3) residents reviewed for the facility's beneficiary protection notification practice during an annual survey. This failure placed residents at risk of not being informed of their rights prior to the end of Medicare Part A covered services. Resident Identifiers: #28 and #19. Facility census: 129 Findings included: a) Beneficiary Notice Review On 04/10/24 at 2:22 PM, a review was completed regarding the beneficiary protection notification liability notices given for the following two (2) residents who remained at the facility following their last covered day of Medicare Part A services: - Resident #28 began Medicare Part A skilled services on 10/18/23. The last covered day of Part A service was 11/10/23. Notice of Medicare Non-Coverage (NOMNC) was signed and dated on 11/08/23. There was no evidence a SNF ABN form had been provided and signed. - Resident #19 began Medicare Part A skilled service on 02/20/24. The last covered day of Part A Service was 03/21/24. NOMNC was signed and dated on 03/19/24. There was no evidence a SNF ABN had been provided and signed. Review of Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice on Non-coverage (SNF ABN) Form CMS-10055 (2018) denoted Medicare requires Skilled Nursing Facilities to issue the SNF ABN to Medicare beneficiaries prior to providing care that Medicare usually covers, but may not pay for because the care is: - not medically reasonable and necessary; or - considered custodial. In an interview on 04/10/24 at approximately 2:33 PM, the Administrator acknowledged the facility failed to provide SNF ABN forms to Resident #28 and Resident #19 prior to their last covered day of Medicare Part A skilled services.

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

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

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(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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43340 Based on record review, resident interview, and staff interview, the facility failed to ensure that all alleged violations involving verbal abuse were reported to the appropriate state agencies. This was true for one (1) of five (5) residents reviewed under the abuse pathway in the Long-Term Care Survey Process. Resident identifier: 95. Facility census: 129. Findings included: a) Resident #95 Review of the facility grievance log, completed on 04/09/24 at 9:30 AM, found a grievance dated 01/15/24. Review of the grievance form revealed, Nurse informed resident that she had an odor and that she needed a shower in front of her friends. Actions taken to investigate the grievance were listed as, NHA (Nursing Home Administrator) and DON (Director of Nursing) addressed and interviewed those around and the CNA (Certified Nursing Assistant) that was around. Corrective action taken was to re-educate the nurse with an individual performance improvement plan (IPIP). The description of event on the IPIP was listed as, Resident had complaint that she was addressed in front of other residents in regards to smelling and needing a shower. As part of the re-education the facility's employee handbook Policy Group A #4 was referenced: Treating residents/patients in a disrespectful or unprofessional manner. The IPIP referenced, Re-education by DON (Director of Nursing) or designee in regard to appropriate bedside manner and resident rights. Explaining providing privacy for private conversations including need for shower/hygiene. During an interview on 04/15/24 at 12:03 PM, Resident #95 stated she recalled a time several months ago when Nurse #9 humiliated her in front of friends in the hallway by discussing her need to take a shower and her poor hygiene. Resident stated she knew that Resident #69 was present when the incident happened because she could remember Resident #69 saying, I don't believe she said that to you! Resident stated the nurse should have never approached her in public. She went on to say she reported the incident to the Administrator who addressed it to her satisfaction and that the nurse had apologized to her. Resident #69 was interviewed on 04/15/24 at 12:25 PM. Resident #69 reported she also remembered the incident when Nurse #9 spoke to Resident #95 in front of everyone. She stated, It was not nice for the nurse to talk to her like that. It was very derogatory. A bunch of us was sitting there. It was very embarrassing. We are adult human beings. We don't need to be treated like that. On 04/15/24 at 2:00 PM a record review was completed. Review of the facility's Abuse Prohibition Policy, with a revision date of 10/24/22, revealed the following definition for mental abuse, Mental abuse includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation. Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's state reportable log, completed on 04/15/24 at 3:03 PM, did not reflect the incident had been reported to the appropriate state agencies as alleged verbal abuse. During an interview on 04/16/24 at 10:47 AM, the Administrator confirmed the incident had not been identified as an allegation of verbal abuse and had not been reported to appropriate state agencies. The Administrator explained, She never used those words with me.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 49465 c) Resident 116 An observation on 04/08/24 at 1:18 PM, of Resident #116's lunch tray in front of her showed Resident #16 had not taken a bite of her food. During A record review on 04/08/24 at 3:00 PM, of Resident #116's medical record revealed the following weights: 04/5/24 8:39 AM, 80.6 P pounds (Lbs) with Mechanical Lift (ML) 03/27/24 4:18 PM, 80.8 Lbs with Wheelchair (WC) 03/20/24 5:37 PM, 82.4 Lbs with WC. 03/13/24 5:26 PM, 85.4 Lbs with WC. 03/6/24 9:06 PM, 84.4 Lbs with WC. 02/29/24 9:22 PM, 82.4 Lbs with WC. 02/19/24 3:44 PM, 84.4 Lbs with WC. 02/13/24 9:58 AM, 86.4 Lbs with WC. 01/18/24 8:29 AM, 90.0 Lbs with WC. 01/12/24 8:18 AM, 92.4 Lbs with WC. 01/3/24 9:24 AM, 94.8 Lbs with WC. 12/29/23 7:39 PM, 89.9 Lbs with ML. 12/21/23 10:49 PM, 92.4 Lbs with ML. 12/20/23 6:59 AM 92.4 Lbs Admission weight. The weights equaled a 12.5% weight loss in 3.5 months. Further record review showed that the last quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/27/24, section K, question K0300, is marked no for weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/15/24 at 12:37 PM the Clinical Reimbursement coordinator (CRC) #3 stated, I do not do that section, it is the Dietician. I agree, It does indicate no weight loss. I will get that fixed. During an interview on 04/15/24 at 1:18 PM the Registered Dietician (RD) stated, I was told not to do it that way if they have not been here 6 months. According to my people they told me not to mark it as weight loss if the resident had not been here the full 6 months, because we were having too much weight loss doing it that way. 45174 Based on medical record review and staff interview, the facility failed to accurately complete a Minimum Data Set (MDS) assessments for three (3) of 38 residents reviewed during the Long-Term Care Survey (LTCSP). Resident Identifiers: Resident #126, Resident #124 and Resident #116. Facility Census: 129. Findings Include: a) Resident #126 During a record review on 04/10/24 at 10:15 AM, Resident # 126's medical records revealed a discharged date on 02/20/24. Further record review revealed a general note dated 02/20/24 typed as written D/c (discharge) packet reviewed with resident. A Social Services (SS) note dated 02/20/24 Typed as written SS referred resident to(local) HH Home health)and ordered her a walker from (a medical supply company). A walker from the center was sent home with the resident and (a medical supply company) will deliver her new walker to her house. Further medical records review the MDS with an Assessment Reference Date (ARD) 02/20/24 Section A2105 titled Discharge Status: coded 04: Short Term General Hospital. During an interview on 04/10/24 at 2:57 PM, the Administrator acknowledged the MDS was coded incorrectly, the resident was discharged home. b) Resident #124 During a record review on 04/10/24 at 10:00 AM, Resident #124's medical record revealed a nurse note dated 01/14/24 Transfer to emergency room due to clinical acuity Further medical records review the MDS with an Assessment Reference Date (ARD) 01/14/24 Section A2105 titled Discharge Status: coded 01: Home/Community. During an interview on 04/10/24 at 1:08 PM Administrator acknowledged the MDS was coded incorrectly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/24 at 2:57 PM, the Administrator acknowledged the MDS was coded incorrectly and the resident was sent to the hospital not discharged home.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50552 Based on record review and staff interview, the facility failed to complete a new Pre-Admission Screening and Resident Review (PASARR) for residents with newly evident or a possible serious mental disorder. This was true for three (3) out of seven (7) residents reviewed under the category of PASARR, during the Long-Term Care Survey Process. Resident identifiers: #49, #44, and #81. Facility census: 129. Findings included: a) Resident #44 On 4/08/24 at 1:50 PM a review of Resident # 44 medical record revealed a Preadmission Screening and Resident Review form (PASRR) was completed on 08/01/19. A diagnosis of delusional disorder added on 04/21/20. It was noted Resident #44 was hospitalized on two (2) occasions. The facility failed to complete a new PASRR with the diagnosis of delusional disorder upon Resident # 44's readmission to the facility. A record review of Resident # 44's care plan revealed the facility failed to revise the interventions when a change occurred. On 4/10/24 at 11:01 AM and interview with the Social Worker Employee #154 was completed. Employee # 154 acknowledged Resident # 44 PASRR was incorrect and had not been completed prior to readmission to facility from hospitalization s with a diagnosis of delusional disorder and that the care plan had not been revised to reflect changes. 43340 Based on record review and staff interview, the facility failed to complete a new Pre-Admission Screening and Resident Review (PASARR) for residents with newly evident or a possible serious mental disorder. This was true for three (3) out of seven (7) residents reviewed under the category of PASARR, during the Long-Term Care Survey Process. Resident identifiers: #49, #44, and #81. Facility census: 129. Findings included: a) Resident #49 A record review, completed on 04/10/24 at 10:44 AM, revealed Resident #49 had been admitted to the facility on [DATE]. Review of resident's diagnoses revealed a Bipolar diagnosis with an effective/active date of 09/09/21. There was only one (1) PASARR, dated 11/20/2018, on file. Section III MI/MR Assessment Question #30 identified Schizophrenia and Major Depression. There was no evidence a new PASARR had been done when the Bipolar diagnosis was given. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 04/10/24 at 11:30 AM, Social Worker #154 reported there was not a new PASARR on file that addressed Resident #49's bipolar diagnosis. 49751 c) Resident #81 On 04/09/24 at 11:14 AM a record review of Resident #81's Preadmission Screening and Resident Review (PASARR) did not have Bipolar disorder or Post Traumatic Stress Disorder (PTSD) marked on the PASRR. Staff interview conducted on 04/09/24 at 12:00 PM with Administrator, who confirmed the PASARR did not have PTSD or Bipolar Disorder marked. On 04/09/24 at 12:22 PM Social Worker #154 states she is working on doing all new PASARR's for the facility. The facility failed to complete a new Pre-Admission Screening (PAS). Resident identifiers: #49, #44, #81 PS - RB a) 49 - RG b) 44 - TM c) 81 - BH Resident #81 PASARR Facility failed to ensure PASARR was completed after admission with scitzo diagnosis 04/10/24 10:16 AM MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED Medical Management 10/9/2021 BIPOLAR DISORDER, UNSPECIFIED Medical Management 10/9/2021 POST-TRAUMATIC STRESS DISORDER, UNSPECIFIED Medical Management 11/7/2023

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50552 Based on record review and staff interview the facility failed to revise the care plans for two (2) of 38 residents when their needs changed. Resident #71's care plan was not revised to reflect pain management. Additionally, the facility failed to include Resident #44's delusional disorder diagnosis in her care plan. Resident identifiers: #71 and #44. Facility census: 129. Findings included: a) Resident #44 On 4/08/24 at 1:50 PM a review of Resident #44's medical record noted a diagnosis of delusional disorder added on 04/21/20. A record review of Resident # 44's care plan revealed the facility failed to revise the interventions when a change occurred. On 4/10/24 at 11:01 AM an interview with the Social Worker #154 was completed. Social Worker #154 acknowledged Resident #44's PASRR was incorrect and had not been completed prior to readmission to facility from hospitalization s with a diagnosis of delusional disorder and that the care plan had not been revised to reflect changes. b) Resident #71 -On 4/08/24 at 12:32 PM an interview was conducted with Resident #71. Resident #71 stated, My back hurts sometimes, I take pain pills, sometimes it helps. -On 4/10/24 at 1:02 PM a follow up interview was conducted with Resident #71. Resident #71 stated, I have been having quite a bit of pain, I tell the certified nursing assistants (CNA'S), they tell me they have to tell someone else and leave, then the nurse never comes back Resident # 71 rated her pain 10/10 at the time of this interview. -On 4/10/24 at 1:10 PM a review of Resident #71's medical record revealed the care plan focus failed to include and address the resident's goals for pain relief, failed to address a diagnosis of cancer with a chest mass and lymph node involvement that was worsening and a recent code status change from full code to do not resuscitate with comfort measures, no tube feeding. The goal failed to include input from Resident #71 related to her goals for treatment, with the interventions having last been updated or revised on 06/01/22. Resident #71 had a recent change related to her pharmacological pain interventions on 04/10/24. A review of Resident #71's active physician's orders noted an order for Tylenol 350mg two (2) capsules by mouth two times a day for generalized pain. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 4/10/2024 at 1:20 PM the Clinical Operations Lead Registered Nurse (RN) #164 accompanied the surveyor and another surveyor to interview Resident #71 . When questioned by RN #164, Resident #71 stated that she was currently in pain, rating her pain a 9/10. RN#164 failed to ask Resident #71 what her goal for pain relief was, which was not addressed on the care plan. The surveyor asked the resident what her pain goal was. Resident #71 stated her pain goal was 0/10. RN #164 asked Resident #71 if she thought repositioning would help with her pain. Resident #71 responded, They have moved me all around this bed, nothing helps. RN#164 responded the nurse practitioner (NP) was in the building and she would have the NP come in and see her. - On 4/15/24 at 1:07 PM during an interview with the facility Clinical Reimbursement Coordinator (CRC) #3, the CRC acknowledged the care plan has not been updated or revised to reflect Resident #71's goals and recent changes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40595 Based on record review and staff interview the facility failed to ensure residents received treatemt and care in accordance with professional standards of pratcie, the comprehensive care plan and resident choices. Resident #49's medication was not available. Resident #33 did not receive insulin as ordree for elevated blood sugar. For Resident #125 the facility failed to ensure the residents wishes according to the Physician Orders for Scope of Treatment (POST) forms orders that were followed. The facility failed to ensure Resident #26's physician orders were followed for skin integrity and fracture stability. Advanced Directive orders did not match the POST for Resident #71 and Resident #44. Insulin administration was not documented for Resident #33. These failed practices had the potential to affect more than a limited number of residents. Resident identifiers: #125, #26, #71, #44, #49 and #33. Facility census: 129. Findings included: a) Resident #49 During medication pass observation on [DATE] at 8:53 AM, Licensed Practice Nurse (LPN) #105 could not locate Tizanidine HCl 2 mg tablet. LPN #105 stated, Oh yea that's right [Nurse Practitioner first name] told me I could hold it if it wasn't here from the pharmacy yet. Review of the Resident's Medication Administration Record (MAR) showed the Tizanidine HCl 2 mg Tablet medication was documented as a missed dose for three (3) consecutive days: [DATE], [DATE], and [DATE]. Record review showed an order for Tizanidine HCl Tablet 2 MG. Give 1 tablet by mouth one time a day for muscle spasms Vaseco 1mg (2 tabs) . Electronic Medication Administration Record Note dated [DATE] at 8:53 AM stated: Waiting on pharmacy holding Tizandine until arrival. NP notified. General Note dated [DATE] at 6:08 PM stated: Called pharmacy about resident's tizanidine. Pharmacy stated prescription can be sent out on tomorrow's run to facility on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronic Medication Administration Record Note[DATE] at 8:58 AM stated: Tizanidine HCl Tablet 2 MG Give 1 tablet by mouth one time a day for muscle spasms waiting on pharmacy. NP notified holding until arrival. Electronic Medication Administration Record Note dated [DATE] at 10:00 AM stated: TiZANidine HCl Tablet 2 MG Give 1 tablet by mouth one time a day for muscle spasms waiting on pharmacy. NP notified. On [DATE] at 3:47 PM during an interview with the Director of Nursing (DON) stated not having the medication available for administration was probably a pharmacy issue. The pharmacy was having staffing issues. The DON stated, I call them every day now and check on the orders., We used to get them from [local town] but now they come from [another location] two (2) hours away. We are working on it 43340 b) Resident #33 On [DATE] at 6:03 PM, a record review was completed. There was the following physician order, dated [DATE] at 11:30 AM: Insulin Lispro MUV 100 Unit/1 ML Vial Inject as per sliding scale: ,d+[DATE] = 1 Unit; ,d+[DATE] = 2 Units; ,d+[DATE] = 3 Units; ,d+[DATE] = 4 Units; ,d+[DATE] = 5 Units; ,d+[DATE] = 6 Units; ,d+[DATE] = 7 Units; ,d+[DATE] = 8 Units; ,d+[DATE] = 9 Units; ,d+[DATE] = 10 Units; ,d+[DATE] = 11 Units; ,d+[DATE] = 12 Units: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	,d+[DATE] = 13 Units; >400 Notify Provider The [DATE] Medication Administration Record (MAR) revealed Resident #33's blood sugar level was 435 on [DATE] at 5:00 PM. Documentation on the MAR did not reflect that insulin had been administered. Coding on the MAR was NN. The chart code for NN was listed as No/See Nurse Note. During an interview on [DATE] at 9:45 AM, the interim DON acknowledged the MAR did not reflect that any medication had been given. 45174 Based on observations, record review and staff interview, the facility failed to provide care/treatment services in accordance with professional standards of practice. For Resident #125 the facility failed to ensure the residents wishes according to the Physician Orders for Scope of Treatment (POST) forms orders that were followed. The facility failed to ensure Resident #26's physician orders were followed for skin integrity and fracture stability. Advanced Directive orders did not match the POST for Resident #71 and Resident #44. The facility failure to ensure medication was available for administration for Resident #49. Insulin administration was not documented for Resident #33. These failed practices had the potential to affect more than a limited number of Residents. Resident identifiers: Resident #125, Resident #26, Resident #71, Resident #44, Resident #49 and Resident #33. Facility Census: 129. Findings Include: a) Resident #125 During a record review on [DATE] at 2:58 PM, Resident # 125's medical record revealed an admitted [DATE] and the Resident expired on [DATE]. Resident #125's POST form dated and signed by Resident #125 on [DATE]. Section A titled: Cardiopulmonary Resuscitation Orders was coded CPR. Section E titled: Signature was not coded for authorization of changes. Further record review revealed a Physician Determination of Capacity dated [DATE] coded has capacity by the physician. Further record review revealed a Nurse Practitioner Encounter Note Date [DATE] typed as written DNR. COMFORT INTERVENTIONS - HD ONLY AS TOLERATED/NO BLOODWORK. NO IVF. NO TF. - Other Directive (Current and Verified) [DATE] The 2021 POST form guidance titled, Using the POST Form: Guidance for Health Care Professionals, 2021 edition, available on-line, stated The authorization section, when selected by the patient, authorizes the patient ' s Medical Power of Attorney representative to update the patient's POST form (by completing a new form) in accordance with the patient's expressed wishes and health care status in the event the patient becomes incapacitated. This box can only be authorized by the patient whilst they have decision-making capacity. This section is optional. (continued on next page)

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	515169	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Center	1000 Lincoln Drive South Charleston, WV 25309

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:55 PM, the Administrator acknowledged the POST should not have been changed at the end of life. b) Resident #26 During a record review on [DATE] at 1:32 PM, Resident #26's medical record revealed a physician order dated [DATE] Prevalon Boots to the BLE(bilateral lower extremities), licensed nurse to remove and assess skin integrity every day and night. Further record review revealed a Physician order dated [DATE] TLSO (Thoracic-Lumbar-Sacral Orthosis) brace to be worn while OOB (out of bed) Observations of Resident #26's Prevalon Boots and/or TLSO brace made throughout the LTCSP were as follows: -[DATE] at 2:01 PM, Resident sitting in a geri chair in the lounge not wearing boots or back brace. -[DATE] at 11:15 AM, Resident sitting a geri chair in the lounge area not wearing boots or back brace -[DATE] at 11:42 AM, Resident sitting a geri chair in the dining area not wearing boots or back brace -[DATE] at 1:20 PM, Resident sitting a geri chair in the lounge area not wearing boots or back brace -[DATE] at 9:20 PM, Resident was lying in bed not wearing boots. -[DATE] at 12:00 PM,Resident sitting a geri chair in the lounge area not wearing boots or back brace. During an interview on [DATE] at 3:14 PM, Clinical Operation Lead (COL) #164 was informed of the Resident #26 not wearing the Prevalon boots and/or the TLSO brace. On [DATE] at 3:17 PM, the COL #164 accompanied this Surveyor to Interview Licensed Practical Nurse (LPN) #127 LPN #127 was asked by the COL #164 clarify the orders: is the TLSO brace when she is out of bed and the Prevalon Boots when she is in bed? LPN stated The Boots day and night and the TLSO when out of bed. This surveyor and the COL #164 went Resident #26's room where she was lying in bed. Resident #26 was not wearing the Prevalon Boots. The COL #164 and LPN #127 searched Resident #26's room The Prevalon Boots and the TLSO brace. The COL #164 found one (1) of the Prevalon boots hidden in the bottom of the closet. The COL #164 found the TLSO brace behind the residents' clothing in the closet. LPN stated (Resident #26 name) had them on yesterday (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An immediate interview the COL #164 acknowledged the physician orders were not being followed. The facility failed to provide care/treatment services in accordance with professional standards of practice. PS- TB a) #125 - TB POST form b) #26 - TB Did not follow physician's order c) #71 - TM 2 Advanced Directive Orders did not match POST form d) #44 - TM Advanced Directive Order did not match POST form e) #49 - BC Facility did not have medication for three (3) consecutive days. f) #33 - RG Did not document insulin was administered on MARS when BS was above 400 Resident #26 Position, Mobility [DATE] 2:01 Pm No boots Prevalon BOOTS TO BLE LICENSED NURSE TO REMOVE AND ASSESS SKIN INTEGRITY every day and night shift Other Active [DATE] 19:00 [DATE] TLSO brace to be worn while OOB. No directions specified for order. Other Active [DATE] PUT IN ORdERS (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] at 2:01 no boots or back brace in gerichair. lounge [DATE] at 11:15Am no boots or back barace gerichair lounge [DATE] at 11:42 no boots or back brace in dining room [DATE] at 1:20PM no boots or back brace in gerichair lounge [DATE] at 9:20PM no boots or brace in bed [DATE] at 12:00 PM no boots or brace in gerichari lounge area. [DATE] at 3:14 Pm [NAME] was informed of the no boots and back brace [DATE] at 3:17 PM [NAME] Brewer was interviewed by the Coroprate RN and this surveyor, Bacj Brace is when she is oob and the boots while she is in beds. DUring a room visit with the Resident # 26 revealed no boots or brace had on. Coroprate nurse and [NAME] searched room for the brace and the boots. The corprtate RN found one boot hid in the bottom of the closet. the back brace was hid behind the resdients clothing in the closet. Breweer stated she had it yesterday. [NAME] acknowledge the physiin orders were not being followed. Resident #125 Death Based on record review and staff interview, the facility failed to provide care/treatment services in accordance with professional standards of practice. For Resident #125 the facility failed to ensure the residents wishes according the Physician Orders for Scope of Treatment (POST) forms orders were followed. The facility failed to ensure Resident #26 physician orders were followed for the Prevalon Boots and Thoracic- Lumbar-Sacral Orthosis (TLSO) brace. These failed practices had the potential to affect more than a limited number of Residents. Resident identifiers: Resident #125. Facility Census: 129. Findings Include: a) Resident #125 During a record review on [DATE] at 2:58 PM Resident # 125's medical record revealed admitted [DATE] and expiration on [DATE]. Resident #125's POST form dated and signed by the resident on [DATE]. Section A titled: Cardiopulmonary Resuscitation Orders was coded CPR. Section E titled: Signture was not coded for authorization of changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further record review revealed a Physician Determination of Capacity dated [DATE] has capacity by the physician. Further record review revealed a Nurse Practitioner Encounter Note Date [DATE] read as typed DNR. COMFORT INTERVENTIONS - HD ONLY AS TOLERATED/NO BLOODWORK. NO IVF. NO TF. - Other Directive (Current and Verified) [DATE] The 2021 POST form guidance titled, Using the POST Form: Guidance for Health Care Professionals, 2021 edition, available on-line, stated The authorization section, when selected by the patient, authorizes the patients Medical Power of Attorney representative to update the patients POST form (by completing a new form) in accordance with the patients expressed wishes and health care status in the event the patient becomes incapacitated. This box can only be authorized by the patient whilst they have decision-making capacity. This section is optional. [DATE] at 3:55 PM [NAME] acknowledge the POSt should not have been changed 50552 f) Resident #44 -On [DATE] at 1:54 PM a review of Resident # 44's medical record found a active physician's order for cardiopulmonary resuscitation (CPR), full code, full interventions with intravenous fluids (IVF) for two (2) weeks, no tube feeding (TF). The Physician's Order for Scope of Treatment (POST) form indicating Resident # 44 was to receive CPR, IVF without a stop date and a feeding tube long term. On [DATE] at 2:50 PM an interview with the facility Administrator was completed. The Administrator acknowledged the physicians order should have been discontinued with a new order entered for CPR, IVF and a feeding tube as needed to match the current POST form. g) Resident #71 On [DATE] at 2:16 PM, a review of Resident #71's medical record found two (2) active physician orders for advance directives which were conflicting: -Advanced Care Planning-Goals of Care: Refer to state form CPR (cardiopulmonary resuscitation) Full interventions IVF (intravenous fluids) no TF (tube feeding). Dated [DATE] -DO NOT RESUSCITATE (DNR) Comfort interventions, No feeding tube. Dated [DATE] Further review of Resident #71's medical record on [DATE] at 2:26 PM noted the care plan indicated Resident #71 was a full code with full interventions, intravenous fluids and no tube feeding. At 02:50 PM on [DATE] the Administrator acknowledged the correct active physician order was for Do Not Resuscitate, and that the previous order should have been discontinued and the care plan updated to reflect the do not resuscitate correct active physician order.

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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. 40595 Based on observation, and staff facility failed to ensure the environment was free of accident hazards. Resident #41's medication was left unattended in Resident room. A treatment cart and mediation cart were found unlocked and unattended. This failed practice was a random opportunity for discovery and had the potential affect more than a limited number of residents. Resident identifier: #41. Facility census: 129. Findings included: a) Resident #41 On 04/08/24 at 1:11 PM, Surveyor observed a Spiriva inhaler on Resident #41's over the bed table. Resident #41 stated, The nurse left it here this morning. It's probably not supposed to be here, they usually take it with them. Charge Nurse Supervisor Registered Nurse (RN) #9 answered call light and verified the medication in the room belonged to Resident #41 and removed it. RN #9 stated, I wasn't the one the one passed medications this morning and left it here, but I'll take it and put it up. RN #9 verified the Resident did not have an order for the inhaler to be left at bedside. Record review showed an order for Spiriva Handi-Haler Inhalation Capsule 18 MCG (Tiotropium Bromide Monohydrate). 1 puff inhale orally one time a day for COPD. Resident had capacity as of 04/16/22. 43340 b) Unlocked Medication Cart On 04/15/24 at 11:15 AM, Surveyor observed the medication cart on the 300 Hall was unlocked and unattended. Surveyor remained with the unlocked cart until LPN #28 appeared. LPN #28 confirmed the cart was unlocked and stated, I'm sorry. I've had a problem with it locking. Then locked the med cart in front of Surveyor. The Administrator noted on 04/15/24 at 11:20 AM, He is one of our newer nurses. We will re-educate him promptly. 49751 c) Treatment Cart On 04/09/24 at 9:30 PM surveyor observed treatment cart by South Nurses Station unlocked. Surveyor remaint by treatment cart till Licensed Practical Nurse (LPN) #106 came and locked it. At 9:34 PM on 04/09/24 LPN #106 stated oh sorry about that and locked the treatment cart.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 49751 Based on record review and staff, the facility failed to effectively evaluate pain level and effectiveness for pain medication given for two (2) of five (5) residents reviewed for pain. This failed practice had the potential to affect more than a limited number of residents. Facility census: 129 Resident identifiers: #71 and #81. Findings included: a) Resident #81 Record review on 04/15/24 at 03:12 PM revealed Licensed Practical Nurse (LPN) #28 signed out an oxycodone 5-325 tablet at 9:56AM on the controlled medication utilization record. The medication was documented on the Resident's Medication Administration Record (MAR) as administered. Further record review on 04/15/24 at 03:20 PM revealed no documentation showing the effectiveness of the pain medication that was signed out at 9:56 AM given was completed by LPN #29 On 04/15/24 at 3:20PM Clinical Operation Lead (COL) #164 confirmed effectiveness of the pain medication given was not completed by LPN #28. 50552

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49751 Based on staff interview and record review, the facility failed to ensure monthly Medication Regimen Reviews (MRR) were being reviewed/signed by the attending physician. This was true for one (1) of five (5) residents reviewed in the unnecessary medication review pathway during the Long-Term Care Survey Process. Facility Census: 129. Resident identifier: #6 Findings included: a) Resident #6 On 04/15/24 at 11:59 AM, a record review revealed the pharmacist had completed a monthly medication regimen review for Resident #6 on 12/26/23 with the following recommendation, Please reassess the existing A1C goal, and if appropriate, initiate Januvia 25 mg PO (by mouth) daily. Close monitoring (e.g., glucose) should accompany any change in diabetic therapy and guide further adjustments. Treatment intensification is recommended for those individuals not meeting therapy goals, to avoid the consequences of prolonged hyperglycemia. There was no evidence the physician had reviewed and acted on the recommendation. The attending physician did not sign the MRR for 12/26/24. During a staff interview on 04/15/24 at 12:01 PM, the Clinical Operation Lead #164 confirmed the MRR was not signed by the doctor for the MRR done on 12/26/23.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. 49465 Based on resident interview, staff interview, and record review the facility failed to obtain routine and/or emergency dental services for Resident #75. This failed practice was found true for (1) one of (4) four residents during the Long-Term Care Survey Process. Resident identifier #75. Facility Census 129. Findings Include: a) Resident #75 During an interview on 04/08/24 at 2:00 PM, Resident # 75 indicated to the surveyor that she had a loose tooth. A record review on 04/10/24 at 2:08 PM revealed that Resident # 75 has an active order dated 02/07/24 for a dental referral for loose cap to upper front tooth Further record review showed no referral to the dentist had been made. During an interview on 04/10/24 at 9:30 AM, the Interim Director of Nursing (IDON) stated, I'm not going to lie to you, there is not a dental referral in (Resident #75 name's) chart. I will get her an appointment made.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40595 Based on observation, and staff interview the facility failed to maintain appropriate infection control procedures during medication pass for Resident #49. This failed practice was a random opportunity for discovery and had the potential to affect a limited number of residents. Resident identifier: #49. Facility census: 129 Findings included: a) During medication pass observation, on 04/10/24 at 8:54 AM, Licensed Practice Nurse (LPN) #105 removed the following pills from blister pack with ungloved hand and touched the medication with bare fingers. LPN #105 had been opening medication cart doors and touching over the counter pill bottles with her bare hands prior to removing the pills from blister pack and placing them into a plastic medicine cup to be administered to Resident #49: Gabapentin 100 mg (milligram) capsule Lisinopril 2.5 mg tablet Oyster Shell 500/200 mg tablet On 04/10/24 at 10:01 AM the administrator was informed of the infection control issue observed by surveyor. The Administrator stated, This surprises me, she [LPN #105] told me med pass went well. So she gave dirty pills? That just common-sense stuff, they know not to handle the pills with soiled bare hands.