STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495340	A. Building B. Wing	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Newport News Nursing & Rehab	12997 Nettles Drive Newport News, VA 23602

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37828 Based on staff interviews, clinical record review and facility document review, the facility staff failed to notify the physician of two (2) missed doses of a scheduled medication Coreg (Carvedilol) 6.25 milligrams (mg) per physician's orders for 1 out of 38 residents (Resident #24) in the survey sample. The findings included: Resident #24 was admitted to the facility on [DATE]. Diagnoses included but are not limited to Congestive Heart Failure (CHF) and Coronary artery disease (CAD). Resident #24's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date of 06/16/22 coded Resident #24's Brief Interview for Mental Status (BIMS) scored a 13 out of a possible score of 15 indicating no cognitive impairment. The MDS coded Resident #24 requiring limited assistance of one with bed mobility, transfer, dressing, transfer, personal hygiene and bathing and supervision with limited assistance of one with eating for Activities of Daily Living (ADL) care. The care plan with a revision date of 02/03/21 identified Resident #24 has altered cardiovascular status related but not limited to Congestive Heart Failure (CHF) and Hypertension. The goal set for the resident by the staff was that the resident will be free from complications of cardiac problems. Resident #24 had a physician order dated 02/02/21, for Coreg tablet 6.25 mg. The order read to give one (1) tablet by mouth two times a day related to coronary artery disease. The medication was scheduled to be administered at 9:00 a.m., and 5:00 p.m. On 08/26/22 at approximately 4:20 p.m., a medication administration observation was made with Licensed Practical Nurse (LPN) #1. The LPN was unable to locate Resident #24's Coreg 6.25 mg inside the medication cart. The LPN stated she would order the missing medication from the pharmacy. The medication was not administered to Resident #24. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/29/22 at 04:22 PM, a medication observation was conducted with LPN #1. LPN #1 was unable to locate the medication Coreg 6.25 mg to administer to Resident #24 as written on the medication administration record (MAR) therefore, the medication wasn't administered. LPN #1 stated she could see the medication was ordered but it wasn't available on the medication cart and she would look further into the rationale later. A review of Resident #24's clinical record did not reveal the physician was informed the resident was not administered his Coreg 6.25 mg on 08/28/22 and 08/29/22 at 5:00 p.m. On 08/30/22 at approximately 5:16 p.m., a phone call was placed to License Practical Nurse (LPN) #1. The LPN was assigned to administer Resident #24 his Coreg 6.25 mg on 08/28/22 and 08/29/22 at 5:00 p.m. A message was left, the LPN never returned the call. The Administrator, Director of Nursing (DON) and Regional Director of Clinical Services was informed of the finding during a briefing on 08/31/22 at approximately 3:57 p.m. The DON stated the nurse should have notified the physician that Resident #24 did not receive his scheduled Coreg 6.25 mg on the two days mentioned above. The facility's policy titled Notification of Change in Condition - revised on 12/16/20. Policy: The center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. Definitions: -Congestive Heart Failure occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath. Certain heart conditions, such as narrowed arteries in the heart (coronary artery disease) or high blood pressure, gradually leave the heart too weak or stiff to fill and pump blood properly (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms). -Coronary artery disease is a common heart condition. The major blood vessels that supply the heart (coronary arteries) struggle to send enough blood, oxygen and nutrients to the heart muscle. Cholesterol deposits (plaques) in the heart arteries and inflammation are usually the cause of coronary artery disease. Signs and symptoms of coronary artery disease occur when the heart doesn't get enough oxygen-rich blood (https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/symptoms-causes). -Coreg is used to treat heart failure (condition in which the heart cannot pump enough blood to all parts of the body) and high blood pressure. It also is used to treat people who have had a heart attack. Carvedilol is often used in combination with other medications. Carvedilol is in a class of medications called beta-blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure (https://medlineplus.gov/ency/article/007365.htm).

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F 0585 Level of Harm - Potential for minimal harm Residents Affected - Many	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. 09546 Based on observations, policy and procedures review, complaint investigation, group, staff and resident, interviews, it was determined that the facility staff failed to ensure all residents in the facility had the right to file a grievance anonymously. The findings include: During observations on 08/28/22 at 5:15 P.M. on the Rosewood, Meadowland and Pinebrook unit bulletin boards and nursing stations, there was no posting on how to file a grievance. Observations in the facility lobby area as well at the social workers office did not reveal a posting on how to file a grievance. There was no information included on how to file an anonymous grievance. Further observations did not reveal a place that residents or visitors could deposit a grievance without giving it to the staff. During a group interview of cognitively intact residents as identified by the Activities Director (AD) on 08/29/22 at 10:00 a.m., Residents #43, #71, #66, #10, #47 and #84, they all stated that they did not know how to file a grievance anonymously. During an interview on 08/30/22 at 10:17 a.m., with the Social Service Director, he stated, grievance forms are kept in his office, residents and visitors can ask for a form and complete the form and turn it in to him. The Social Service Director was asked if there was a process in place that allowed for the resident or visitors to file an anonymous grievance. The Social Service Director stated there was not a posting or a drop box that informs a visitor or resident on how to file a grievance without asking a staff member for the form. During an interview on 08/30/22 at 1:47 p.m., the Administrator stated the Social Service Director is the facility grievance Official. The Administrator stated grievance forms are kept at each nursing station and behind the nursing station desk and visitors or residents can ask staff for a grievance form. The Administrator was asked if a resident or a visitor could file an anonymous grievance. The Administrator stated the resident or visitor would have to request a grievance form and return the form to the staff. A review of the facility's policy titled, Resident's Rights and Responsibilities dated 01/07 Grievances, did not include a procedure for a resident to file an anonymous grievance. COMPLAINT DEFICIENCY

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34306 Based on observation, clinical record review, and staff interviews, the facility staff failed to report to the Office of Licensure and Certification an injury of unknown origin which resulted in an edematous, black and blue right foot for 1 of 38 residents (Resident #26), in the survey sample. The findings included: Resident #26 was originally admitted to the facility 11/18/2014 and the resident had never been discharged from the facility. The current diagnoses included; dementia, a-fib, and high blood pressure. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/20/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #26's cognitive abilities for daily decision making were severely impaired. In section G (Physical functioning) the resident was coded as requiring total physical assistance of one person with toileting, extensive physical assistance of two plus persons with bed mobility and transfers, extensive physical assistance of one person with dressing and bathing, supervision with physical assistance of one person with eating and activity didn't occur with walking, locomotion, personal hygiene. Resident #26 was observed in his room during the initial tour on 8/28/22 at approximately 5:15 p.m., with a very edematous, black and blue right foot. The resident was unable to state what had occurred to his right foot. A nurse's notes dated 8/23/22 at 6:30 p.m., stated the resident's entire right foot was observed to be bruised and Resident #26 denied pain and discomfort the resident's responsible party was made aware. A review of the Nurse Practitioner (NP) 8/24/22 progress note revealed the NP diagnosed the resident with traumatic ecchymosis of the right foot and an x-ray of the right foot and ankle was ordered. An interview was conducted with the Director of Nursing (DON) on 8/30/22 at approximately 4:09 p.m., regarding the cause and an investigation documentation regarding Resident #26's edematous and bruised right foot. The DON stated she would get back to the surveyor regarding documentation related to the resident's right foot. On 8/31/22 at approximately 11:00 a.m., the DON stated she had spoken with the Administrator, NP and Registered Nurse (RN) #2. The NP and RN #2 didn't notify the Administrator about the resident's edematous and bruised right foot because they stated they weren't aware it was considered an injury of unknown origin which required the facility to self-report to authorities within prescribed timeframes and complete a thorough investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/31/22 at approximately 11:08 a.m., an interview was conducted with Certified Nursing Assistant (CNA) #1. CNA #1 stated Resident #26 was a long term resident and he is normally cooperative with care, often restless, and attempts to reposition himself. She stated the resident was currently with right foot bruising and edema and had a bandage on his left foot. CNA #1 stated she wasn't aware of what caused the problems to either of the resident's feet. On 8/31/22 at approximately 11:23 a.m., an interview was conducted with the NP. The NP stated she did do something regarding Resident #26's edematous and bruised right foot, she assessed the foot and ordered x-rays. On 8/31/22 at approximately 1:20 p.m., the Administrator provided a copy of the Facility Reported Incident (FRI) that was sent to the Office of Licensure and Certification on 8/31/22 regarding Resident #26's edematous and bruised right foot. The Administrator stated the two staff members had been educated and he was confident such an event would be reported for investigation going forward. On 9/1/22 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant. An opportunity was offered to the facility's staff to present additional information. They stated there was no additional information to report and no concerns were voiced.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34896 Based on medical record review, staff interviews and facility document review the facility staff failed to ensure a Baseline Care Plan was developed within 48 hours upon admission for 1 of 38 residents in the survey sample, Resident #91. The facility staff failed to ensure a Baseline Care Plan was developed within 48 hours for Resident #91 who was admitted on [DATE]. The findings included: Resident #91 was admitted to the facility on [DATE] with diagnoses to include but not limited to Subarachnoid Hemorrhage, Mild Cognitive Impairment and History of Falling. Resident #91's most recent Minimum Data Set was a 5 day with an Assessment Reference Date of 8/18/22. Resident #91's Brief Interview for Mental Status was coded as a 12 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. On 08/29/22 at 1:52 p.m. during an initial tour interview Resident #91 was asked if the facility had reviewed his baseline care plan. Resident #91 stated that he did not remember getting baseline care plan on admission. Resident #91's electronic medical record and hard chart medical record were reviewed for the completed Baseline Care Plan, however, it was not identified in either record. There was a blank baseline care plan document in Resident #91's hard chart medical record. On 8/29/22 2:06 p.m. the Director of Nursing (DON) was asked who was responsible for completing the Baseline Care Plans within 48 hours of admission. The DON stated that the admission nurse was responsible for doing the baseline care plan on admission. On 8/30/22 at 5:17 p.m. an interview was conducted with Licensed Practical Nurse (LPN) #3 regarding Resident #91's Baseline Care Plan. LPN #3 stated that she had been working at the facility for over a year and that she had never been told that the admitting nurse was responsible for doing the baseline care plan. On 8/31/22 at 11:10 a.m. an interview was conducted with the DON where the above information was shared. The DON stated that the baseline care plan should be started upon admission, completed within 48 hours and then reviewed with the resident at the journey home meeting. The facility policy titled Plans of Care last revised 9/25/17 was reviewed and is documented as follows: .Policy: An individualized person-centered plan of care will be established by the interdisciplinary team with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal requirements. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: .Develop and implement an Individualized Person-Centered baseline plan of care within 48 hours of admission that includes, but not limited to, goals based on the admission orders, physician orders, dietary orders, therapy services, social services, and any other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed. On 8/31/22 at 4:00 p.m. a pre-exit debriefing was held with the Administrator, Director of Nursing and the Regional Director of Clinical Services where the above information was shared. Prior to exit no further information was shared.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37828 Based on staff interview, clinical record review and facility documentation, the facility staff failed to develop a person-centered comprehensive care plan for 1 of 38 residents (Resident #36) in the survey sample. The findings included: Resident #36 was admitted to the facility on [DATE]. Diagnoses included but are not limited to Leiomyoma (cancer) of the uterus, End Stage Renal Dialysis (requiring dialysis), Cerebral Infarction and Atrial Fibrillation (A-FIB). The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 07/04/22 coded the resident on the Brief Interview for Mental Status (BIMS) 15 out of a possible score of 15 indicating no cognitive impairment. Resident #36 was coded total dependence of two with bathing and dressing, extensive assistance of two with bed mobility, transfer, toilet use and personal hygiene and supervision with limited assistance of one with eating for Activities of Daily Living (ADL) care. Review of Resident #36's care plan on 07/29/22 revealed only three areas were care planned: at risk for COVID-19 (nursing), actual impairment to skin integrity related to right buttock wound (nursing) and is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t Physical Limitations. She is capable of some independent leisure activities. She prefers to spend her time in her room watching TV and socializing on her personal cell phone (Community Life Aide). On 08/29/22 at approximately 10:08 a.m., an interview was conducted with the MDS Coordinator. She reviewed Resident #36's care plan and stated, a comprehensive care plan was never developed for Resident #36. She said a comprehensive care plan should have been completed no later than 07/21/22 but somehow it was missed. She proceeded to say that the care plan is used to inform the staff of the resident's current problems and to help minimize risk of complications related to the problems identified. The Administrator, Director of Nursing (DON) and Regional Director of Clinical Services was informed of the finding during a briefing on 08/31/22 at approximately 3:57 p.m. The facility did not present any further information about the findings. The facility's policy titled Plan of Care - revised on 09/25/17. Policy: An individualized person-centered plan of care will be established by the interdisciplinary (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. -Procedure: Develop a comprehensive plan of care for each resident that includes measurable objective and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on resident interview, staff interviews, clinical record review and facility documentation review the facility staff failed to invite 2 of 38 (Resident #60 and #40) residents in the survey sample to their person-centered care plan meeting. The findings included: 1.Resident #60 was originally admitted to the facility on [DATE] and readmitted [DATE] after an acute care hospital stay. The current diagnoses included: Type 2 Diabetes Mellitus without complications and chronic obstructive pulmonary disease with acute exacerbation. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/28/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 00 out of a possible 15. This indicated Resident #60 cognitive abilities for daily decision making were severely impaired. In sectionG(Physical functioning) the resident was coded as requiring limited assistance of one person with bed mobility, supervision set-up help only with dressing, independent with eating set-up only, extensive assistance of one person with toilet use and personal hygiene. Social Service Progress Note in the clinical read that a Care Plan meeting was held on 2/24/22 at approximately 11:55 AM. The writer attempted to reach out to Resident #60's guardian and left voice message. There was no evidence that Resident #60 attended the Care Plan Meeting. A review of Resident #60's clinical record reveal that no other Multidisciplinary Care Plan meetings were held since the meeting on 2/24/22. On 8/30/2022 at approximately 12:48 PM Resident #60 was asked if he had attended Care Plan Meetings. He said that no one had informed him about any meetings. On 08/31/22 at approximately 10:31 AM an interview was conducted with OSM (Other Staff Member/Social Services Worker) #3 concerning Care Plan Meetings. He said that several messages were left in the past for Resident #60's guardian to return his call but was unable to reach him. On 08/31/22 at approximately 11:30 AM a telephone interview was conducted with OSM #2 (Resident's legal guardian). He said the last meeting that he attended was over the telephone in May 2022. We don't get notifications when the Care Plan meetings are being held. Usually I'll inquire and they do the meeting. On 08/31/2022 at approximately 4:30 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The DON (Director of Nursing) stated, He should have gotten an invite. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37828 2. The facility staff failed to invite Resident #40 to participate in her person-centered care plan meeting. Resident #40 was admitted to the facility on [DATE]. Diagnoses for Resident #40 included but not limited to Adult failure to thrive and major depression. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 07/07/22 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. On 08/29/22 at approximately 11:03 a.m., an interview was conducted with Resident #40. She stated she has not been invited to attend a care plan meeting for a while now. She also stated a care plan invitation letter was never delivered. An interview was conducted with the MDS Coordinator on 08/30/22 at approximately 10:08 a.m. She stated she provides the SW with the care plan date but the SW will invite the resident to participate in their care plan meeting. On 08/30/22 at approximately 10:17 a.m., an interview was conducted with the SW. The SW reviewed the care plan invitation binder located in his office but was not able to locate an invitation letter or the signature page that the resident attended or declined to attend her care plan meeting. On the same day at 3:25 p.m., the SW stated he was not able to locate any documentation that Resident #40 actually had a care plan meeting for the month of July 2022. He stated the resident should have had a care plan meeting on 07/21/22 but unfortunately, there was no evidence that Resident #40 had a care plan meeting. The Administrator, Director of Nursing (DON) and Regional Director of Clinical Services was informed of the finding during a briefing on 08/31/22 at approximately 3:57 p.m. The facility did not present any further information about the findings. The facility's policy titled Care Plan Invitation revised on 09/25/17. Policy: The resident and/or the resident representative shall be invited to attend each of the Interdisciplinary Care Plan Conference for the specific resident. Procedure: 1. Deliver a Care Planning invitation to the resident 7-14 days prior to the date of the conference and place a copy of the invitation in the medical record. 4. Have all attendees to the Care Planning Conference, including resident and resident representative sign the Care Plan Conference Record to verify their attendance.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37828 Based on resident interview, staff interviews and clinical record review the facility staff failed to provide personal care to include showers for 2 of 38 residents (Resident #41 and #15) in the survey sample who was unable to independently carry out activities of daily living (ADL's). The findings included: 1. The facility staff failed to ensure Resident #41 received showers on a routine basis. Resident #41 was admitted to the facility on [DATE]. Diagnoses for Resident #41 included but not limited to obesity and Chronic Obstructive Pulmonary Disease (COPD). Resident #41's Minimum Data Set (MDS-an assessment protocol) a quarterly assessment with an Assessment Reference Date of 07/07/22 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. The MDS coded Resident #41 total dependent of one with bathing, extensive assistance of two with transfer, extensive assistance of one with toilet use, limited assistance of one with bed mobility and dressing, supervision with limited assistance of one with personal hygiene and supervision with eating for Activities of Daily Living (ADL) care. The MDS coded Resident #41 always incontinent of bowel and frequently incontinent of bladder. The comprehensive care plan with a revision date of 07/16/22 documented Resident #41 with ADL self-care performance deficit related to activity intolerance, fatigue, limited mobility and incontinence. The goal set for the resident by the staff is maintain current level of function in ADL care. Some of the interventions to manage goal is the resident requires extensive to total assist by one (1) staff with bathing/showering and provide sponge bath when a full bath or shower cannot be tolerated. An interview was conducted with Resident #41 on 08/29/22 at approximately 12:35 p.m. The resident stated she cannot recall the last time a shower was given. She proceeded to say showers are not given due to a shortage of Certified Nursing Assistant (CNA's). A review of Resident #41's shower schedule revealed showers to be given every Monday and Thursday (3-11) shift. A review of Resident 41's ADL Documentation Survey Report for July 2022 revealed showers were not provided on the following shower days: 07/11, 07/18, 07/21 and 07/25/22. A review of Resident 41's ADL Documentation Survey Report for August 2022 revealed showers were not provided on the following shower days: 08/03, 08/08, 08/11, 08/15, 08/18, 08/22, 08/25 and 08/29/22. An interview was conducted with CNA #3 on 08/30/22 at approximately 5:06 p.m. The CNA was assigned to provide a shower to Resident #41 on 07/11/22. The CNA stated the resident did not get her shower because there was a shortage of CNA's on that day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A phone interview was conducted with CNA #4 on 08/30/22 at approximately 5:08 p.m. The CNA was assigned to provide a shower to Resident #41 on 07/21/22. The CNA said she did not provide a shower to the resident on the day in question. She said it was unfortunate that when there is not enough CNAs or a shift is split with another CNA, showers are not provided. A phone call was placed to CNA #5 on 08/3022 at approximately 6:00 p.m. The CNA was assigned to give a shower to Resident #41 on 08/08/22 and 08/15/22. A message was left, the CNA never returned the call. The Administrator, Director of Nursing (DON) and Regional Director of Clinical Services was informed of the finding during a briefing on 08/31/22 at approximately 3:57 p.m. The Administrator stated staffing on the 3-11 shift is being pieced together by pulling staff from 7-3 and 11-7 to help fill in the gaps. He (administrator) stated the issues with showers not being provided on the 3-11 shift is most definitely due to short staffing of CNA's on the 3-11 shift. 34896 2. The facility staff failed to ensure Resident #15 who was unable to carry out activities of daily living was offered and received showers to maintain good personal hygiene. Resident #15 was admitted to the facility on [DATE] with diagnoses to include but not limited to Left Hemiparesis, Left Below the Knee Amputation and Morbid Obesity. Resident #15's most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 6/10/22. The Brief Interview for Mental Status (BIMS) was coded as a 15 out of a possible 15 for Resident #15, indicating she was cognitively intact and capable of daily decision making. Under Section G Functional Status Resident #15 was coded as being total dependent with one-person physical assist for bathing. Resident #15's facility shower schedule was reviewed and indicated her shower days to be Mondays and Thursdays on the 3-11 shift. Resident #15's Comprehensive Care Plan last revised 6/22/22 was reviewed. The Comprehensive Care Plan indicated the resident was at risk for ADL Self Care performance deficit related to left sided hemiparesis, weakness, left above the knee amputation, non-ambulatory and left hand contractures. Facility interventions put in place for Resident #15 included that the staff would provide one person assistance with bathing/showering as necessary. Resident #15's Bathing Documentation Survey Report for August 2022 was reviewed. The documentation indicated that the resident had only received bed baths by facility staff for the month of august. There was no documentation to show the resident was offered or given a shower in the month of august. On 8/28/22 at 4:10 p.m. Resident #15 was interviewed. Resident #15 stated that she had not been getting her showers because of short staffing and she really would like one. Resident #15 did state she was getting bed baths just not her showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/22 at 4:20 p.m. an interview was conducted with Certified Nursing Assistant (CNA) #6 regarding Resident #15's showers. CNA #6 stated, Showers are not getting done on 3-11 because of us being short staffed. We have been working short and we having been trying to do all we can for the residents. On 8/28/22 at 5:00 p.m. an interview was conducted with CNA #7 regarding Resident #15's showers. CNA #7 stated, I normally work 3-11 and showers are not getting done because of us being short staffed. On 8/31/22 at 2:40 p.m. an interview was conducted with CNA #8 regarding Resident #15's showers. CNA #8 stated, I work over to help 3-11 because we are short staffed. By the time you make rounds, help with meals, and get the residents in bed there is no time for showers. Most of the time you don't have the second person to help you get her up to take her to the shower. On 8/31/22 at 11:20 a.m. an interview was conducted with the Director of Nursing regarding Resident #15 not getting her showers. The Director of Nursing stated that she expects residents to be showered twice a week or more if they want. The Director of Nursing stated, Honestly, her showers probably were not done due to staffing. The facility policy titled Bathing/Showering last revised 9/1/17 was reviewed and is documented as follows: .Policy: assistance with showering and bathing will be provided at least twice a week and as needed to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and as needed cleansing. The resident's frequency and preferences for bathing will be reviewed at least quarterly during the care conference . On 8/31/22 at 4:00 p.m. a pre-exit debriefing was held with the Administrator, Director of Nursing and the Regional Director of Clinical Services where the above information was shared. Prior to exit no further information was shared. COMPLAINT DEFICIENCY

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34306 Based on observations, staff interviews, and clinical record review, the facility staff failed to develop and institute measures to prevent pressure ulcer development for an individual known to develop pressure ulcers to the left foot/ankle for 1 of 4 residents with pressure ulcers (Resident #26), in the survey. A. The facility staff failed to promote healing of deep tissue pressure ulcer to the left lateral plantar foot and to conduct a complete assessment, reassess and document the status of the pressure ulcer once the wound bed was exposed which resulted in deterioration as evidenced by eschar and drainage at various times, which constituted harm. B. The facility staff failed to promote healing of deep tissue pressure ulcer by not obtaining a treatment for the left great toe pressure ulcer and to conduct a complete assessment, reassess and document the status of the left great toe once the wound bed was exposed, which constituted harm. The findings included: Resident #26 was originally admitted to the facility 11/18/2014 and the resident had never been discharged from the facility. The current diagnoses included; dementia, a-fib, and high blood pressure. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/20/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #26's cognitive abilities for daily decision making were severely impaired. In section G (Physical functioning) the resident was coded as requiring total physical assistance of one person with toileting, extensive physical assistance of two plus persons with bed mobility and transfers, extensive physical assistance of one person with dressing and bathing, supervision with physical assistance of one person with eating and activity didn't occur with walking, locomotion, personal hygiene. A review of the facility's matrix revealed Resident #26 had facility acquired pressure ulcers and during the initial tour on 8/28/22 at approximately 5:15 p.m., Resident #26 was observed in his room with Kling wrap to the left lower extremity. The right foot as observed with an increased amount of edema (swelling), and black and blue discoloization. The resident was unable to state what had occurred to either extremity. Historical documentation from the resident's record revealed the resident had experienced repeated pressure ulcers and skin impairment to the left lower extremity including the left proximal foot 6/8/22, a DTI of the left pinky toe 6/2/22, the left outer ankle pressure ulcer 5/18/22, 4/26/2022 left ankle wound infection, 4/5/22 Skin tear to left ankle. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 8/30/22 at approximately 12:35 p.m., the resident was observed in bed reclined on a standard mattress with non-skid shoes to bilateral feet. He was lying on his left side and the left foot was positioned so the left 5the digit and ankle were making contact with the bed and the left great toe was up. On 8/31/22 at approximately 1:10 p.m., Resident #26 was observed in bed again lying on his left side with his left foot, the 5th digit and ankle down against the mattress and the great toe up. No positioning/ offloading devices such as wedges, or pillows heel floats were in use. On 8/31/22 at approximately 11:08 a.m., an interview was conducted with Certified Nursing Assistant (CNA) #1. CNA #1 stated Resident #26 was a long term resident and he is normally cooperative with care, often restless, and attempts to reposition himself. She stated the resident was currently with right foot bruising and swelling and had a bandage on his left foot. CNA #1 stated she had never used positioning devices with the resident. On 8/31/22 at approximately 11:17 a.m., an interview was conducted with Certified Nursing Assistant (CNA) #2. CNA #2 stated he normally gets the resident out of bed in the morning and his gown is usually off and the resident is only a brief and socks. CNA #2 stated the resident is usually lying on his side to face the window (his left side) and there are no positioning devices. CNA #2 also stated the resident had stopped walking when he returned to the unit in June and because of open areas to his foot he doesn't wear his brown dress shoes any longer. He also stated when the resident experiences discomfort related to his contracture he will become resistant. The following active pressure ulcer orders were on the current August 2022 physician order summary and were signed off on the MAR as provided by the licensed nursing staff: 7/8/22- Iodosorb Gel 0.9 % (Cadexomer Iodine) Apply to the bottom of the left foot wound topically, one time a day every Monday, Thursday, and Saturday for the left ankle wound. 8/12/22- Left plantar foot and left ankle wound. Cleanse with normal saline. Pat dry, apply Iodosorb to the wound bed, cover the wound with bordered gauze one time a day every Monday, Wednesday, Friday to the left plantar wound. A. left lateral plantar foot: At the time of the Pressure Ulcer Wound Round on 6/15/22 no weekly skin assessments had been completed since 4/20/22 and there were no nurse's notes or other documentation in the resident's record concerning the resident's left lateral plantar's foot deep tissue injury. It appeared the resident's left lateral plantar's foot pressure ulcer was identified when another pressure ulcer to the left foot was being assessed during wound rounds and left lateral plantar's foot pressure ulcer was first assessed during wound rounds with the wound care physician during Pressure Ulcer Wound Rounds on 6/15/22. The left lateral plantar's foot wound was identified as an unstageable deep tissue injury with intact skin, measuring 1.1 centimeters (cm) by 2.0 centimeters by 0 centimeters. The assessment further revealed the wound bed was without drainage or odor, the wound edges were firm and without redness, and the periwound skin area was intact. The treatment was to cleanse the wound with normal saline, pat dry, apply skin prep and off load, one time a day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The left lateral plantar's foot pressure ulcer was reassessed 6/22/22 during the Pressure Ulcer Wound Rounds. It remained classified as an unstageable deep tissue injury, measuring 1.0 cm by 2.0 centimeters by 0 centimeters. The assessment further revealed the wound bed was without drainage or odor, the wound edges were firm and without redness, and the periwound skin area was intact. The treatment was changed to cleanse with normal saline, pat dry and apply betadine wipes and offload one time a day. The left lateral plantar's foot pressure ulcer was reassessed 6/29/22 during the Pressure Ulcer Wound Rounds. It remained classified as an unstageable deep tissue injury, measuring 1.0 cm by 2.0 centimeters by 0 centimeters and the wound bed was identified with black eschar, no drainage or odor, the wound edges were firm, without redness, and the periwound was intact. The treatment remained the same. The wound was now with nonviable tissue, eschar. The left lateral plantar's foot pressure ulcer was reassessed 7/6/22 during the Pressure Ulcer Wound Rounds. It remained classified as an unstageable deep tissue injury, measuring 0.5 cm by 0.9 centimeters by 0 centimeters with a pink wound bed and without redness, drainage or odor. The periwound was intact. A treatment was to start 7/822 to cleanse with normal saline. Pat dry and apply Iodosorb and cover the wound with a dressing one time a day every Monday, Wednesday, and Friday. The wound bed was pink making it observable and the pressure ulcer should have been staged. The left lateral plantar's foot pressure ulcer was reassessed 7/13/22 during the Pressure Ulcer Wound Rounds. It remained classified as an unstageable deep tissue injury, measuring 0.5 cm by 0.8 centimeters by 0.1 centimeters and the wound bed was without drainage or odor but the wound bed's tissue type and color were not documented, the wound edges were firm and without edges and the periwound was intact. The treatment remained the same. The left lateral plantar's foot pressure ulcer was reassessed 7/20/22 during the Pressure Ulcer Wound Rounds. It remained classified as an unstageable deep tissue injury, measuring 0.5 cm by 1.5 centimeters by 0.1 centimeters. The wound bed tissue type and color were not documented but a small amount of clear serous drainage was documented, the wound edges remained firm and without redness and the periwound was intact. The treatment remained the same. The wound showed deterioration in the width and was now draining. The left lateral plantar's foot pressure ulcer was reassessed 7/27/22 during the Pressure Ulcer Wound Rounds. It remained classified as an unstageable deep tissue injury, measuring 0.5 cm by 1.0 centimeters by 0.1 centimeters. The wound bed tissue type and color were not documented but the wound was with a small amount of clear serous drainage, the wound edges remained firm and without redness and the periwound was intact. The treatment was changed to cleanse with normal saline, pat dry, apply silver alginate to wound and cover with a silicone foam dressing one time a day every Monday, Wednesday, Friday. The left lateral plantar's foot pressure ulcer was reassessed 8/3/22 during the Pressure Ulcer Wound Rounds. It remained classified as an unstageable deep tissue injury, measuring 0.5 cm by 1.0 centimeters by 0.1 centimeters. The wound bed tissue type and color were not documented but the wound continued with a small amount of clear serous drainage, the wound edges remained firm and without redness and the periwound was intact. The treatment was changed to cleanse with normal saline, pat dry, apply Iodosorb to the wound bed, and cover the wound with bordered gauze one time a day every Monday, Wednesday, and Friday. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The left lateral plantar's foot pressure ulcer was reassessed 8/10/22 during the Pressure Ulcer Wound Rounds. It remained classified as an unstageable deep tissue injury, measuring 1.0 cm by 2.0 centimeters by 0.1 centimeters. The wound bed tissue type and color were not documented, it was without drainage or odor, the wound edges were firm and without redness and the periwound was intact. An order was given to start on 8/12/22 read; cleanse with normal saline, pat dry, apply Iodosorb to the wound bed, and cover the wound with bordered gauze one time a day every Monday, Wednesday, and Friday. This wasn't a change in the wound order. The left lateral plantar's foot pressure ulcer was reassessed 8/17/22 during the Pressure Ulcer Wound Rounds. It remained classified as an unstageable deep tissue injury, measuring 0.5 cm by 1.5 centimeters by 0.1 centimeters. The wound bed tissue type and color were not documented, it was without drainage or odor, the periwound was intact, the edges were firm and without redness. The treatment remained the same. The left lateral plantar's foot pressure ulcer was reassessed 8/24/22 during the Pressure Ulcer Wound Rounds. It remained classified as an unstageable deep tissue injury, measuring 0.1 cm by 0.1 centimeters by 0.1 centimeters. The wound bed tissue type and color were not documented, it was without drainage or odor, the periwound was intact, the edges were firm and without redness. The treatment remained the same. On 8/30/22 at approximately 12:40 p.m., a wound care observation was conducted with Licensed Practical Nurse (LPN) #5. LPN #5 removed a dressing from Resident #26's left lateral plantar's foot pressure ulcer. The left lateral plantar's foot pressure ulcer pressure ulcer was opened, measuring approximately 0.4 cm by 0.4 cm by 0.2 cm and presented with a pale pink wound bed with no drainage, and no odor. The wound was surrounded by new skin from a previously opened area. LPN #5 cleaned the left lateral plantar's foot pressure ulcer with normal saline, applied Iodosorb Gel and a border dressing. The left lateral plantar's foot pressure ulcer was reassessed by the NP on 8/31/22 at approximately 1:10 p.m. , and determined to be opened and without the wound bed was observable to be staged. The NP assessment wasn't made available to the survey team prior to the conclusion of the survey. B. Left great toe: A review of the Pressure Ulcer Wound Rounds documentation revealed Resident #26 was assessed on 8/10/22 with an unstageable deep tissue injury of the left great toe, which measured 0.3 cm by 0.5 cm by 0.1 cm. The wound bed tissue type and color were not documented, it was without drainage or odor, the wound edges were firm and without redness and the periwound was intact. The 8/10/22 NP progress note stated the left lateral great toe was with granulation tissue. A pressure ulcer with granulation tissue should be staged. The Pressure Ulcer Wound Rounds documentation for 8/17/22 revealed the resident was with an unstageable deep tissue injury of the left great toe pressure ulcer increased in size measuring 0.5 cm by 0.5 cm by 0.1 cm. The wound bed tissue type and color were not documented, it was with a small amount of clear serous drainage but no odor, the wound edges were firm and without redness and the periwound was intact. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The NP's 8/24/22 progress note stated the resident had a pressure ulcer of the left lateral great toe with granulation tissue but without slough, eschar and signs of infection. The progress note further read the wound treatment was Iodosorb. There was no Pressure Ulcer Wound Rounds documentation for 8/24/22. This wound was documented as resolved on 8/24/22 by the Assistant Director of Nursing. A review of the August 2022 Physician's Order Summary (POS) failed to offer evidence there was a treatment order for the left great toe pressure ulcer. On 8/30/22 at approximately 12:40 p.m., a wound care observation was conducted with Licensed Practical Nurse (LPN) #5. LPN #5 removed a dressing from Resident #26's left lateral great toe. The left lateral great toe pressure ulcer had an open area approximately 0.2 cm by 0.2 cm by 0.1 cm, with a pink wound bed and presented with light yellow drainage. Immediately around the left lateral great toe pressure ulcer was fragile new skin and distally there was blanchable red skin. LPN #5 cleaned the left lateral great toe pressure ulcer with normal saline, applied Iodosorb Gel and a border dressing. The left lateral great toe pressure ulcer was reassessed by the NP on 8/31/22 and determined to be opened with drainage. The NP's assessment wasn't made available to the survey team and a wound care order for treatment of the left great toe were not written after the assessment to be carried out by the licensed nursing staff prior to conclusion of the survey. On 8/31/22 at approximately 11:23 a.m., an interview was conducted with the treating NP and the Wound Care Registered Nurse (RN). The NP stated she didn't change her documentation from deep tissue injury with intact skin because she was under the impression that once a pressure ulcer was classified it had to remain whatever it was identified as until it healed, not that if the wound bed became observable the staging should be changed. The NP also stated she was unaware there had been no treatment orders in place for the resident's left great toe and she thought the resident's left great toe was healed. Upon the NP's reassessment of the resident's left great toe on 8/31/22 at approximately 1:10 p.m., it was identified as opened and with drainage. The NP further stated she was aware the resident favored lying on his left side and the resident's pressure ulcer development was always to the left lower foot and ankle but she hadn't thought to develop a plan to protect the left foot in order to prevent additional pressures ulcers. The NP stated she had ordered nutritional support (Prostat and Juven) to aid in healing of the resident's pressure ulcers. The current care plan had a problem dated 4/22/22 which read; (name of the resident) has a potential for skin impairment related to smoking dry/fragile skin and use of psychotropic medication. The goal read; (name of the resident) potential for impaired skin integrity will be minimized through the review date. The interventions included; float heels as tolerated while in bed. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The current care plan had a problem dated 7/19/22 which read; resident has a deep tissue injury of the left pinky toe. The goal read; the resident's DTI will be healed by the review date. The interventions included; Treatment as ordered and monitor for effectiveness of treatment. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Wound consult as ordered. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Braden scale completed 6/2/22 revealed Resident #26 had a low risk for pressure ulcer development. It revealed the resident responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. Skin is occasionally moist, requiring an extra linen change approximately once a day. Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair. Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered. Moves in bed and in chair independently and has sufficient muscle strength to lift up. On 9/1/22 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no information was provided and no concerns were voiced. M0300: Current Number of Unhealed Pressure Ulcers/Injuries at Step 2: Identify Unstageable Pressure Ulcers 1. Visualization of the wound bed is necessary for accurate staging. 2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable. 3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg. 4. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable. 5. A pressure injury with intact skin that is a deep tissue injury (DTI) should not be coded as a Stage 1 pressure injury. It should be coded as unstageable. (CMS's RAI Version 3.0 Manual, Chapter 3 page M-8) COMPLAINT DEFICENCY

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on resident interview, staff interview, and clinical record review, the facility staff failed to assure 1 of 38 residents (Resident #14) was assisted to properly apply and seal the (continuous positive airway pressure (CPAP), and to ensure 1 of 38 residents (Resident #33)'s oxygen concentrator filter was clean and free of debris. The findings included: Resident #14 was originally admitted to the facility 4/4/22 for rehabilitation and the resident had never been discharged from the facility. The current diagnoses included; scarring related to coronary artery disease with previous bypass surgery, chronic pain syndrome secondary to chronic obstructive pulmonary disease, Long COVID-19, and obstructive sleep apnea, requiring CPAP. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/7/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #14's cognitive abilities for daily decision making were intact. In section G (Physical functioning) the resident was coded as requiring limited physical assistance of one person with transfers and toileting, supervision physical assistance of one person of one person with bed mobility and walking in the room, supervision with set-up help only with walking off the unit, locomotion, personal hygiene and bathing. On 8/29/22 at approximately 1:30 p.m., Resident #14 stated he applies his CPAP mask nightly but when he awakes during the night it is around his eyes and sometimes he attempts to reposition it or simply takes it off. He further stated he thought he was securely applying it but he couldn't be because the same thing happens each night. Resident #14 also stated the nurses have never assisted him to apply the mask or spoken to him about the importance of obtaining a good seal. A review of the Physician Order Summary revealed the resident had an order dated 4/18/22 which read Apply CPAP at bedtime. This order was signed off each night on the medication administration record by a nurse. On 8/31/22 at approximately 2:20 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #4. LPN #4 stated the resident applies and removes his own CPAP mask because she had observed him wearing it and the resident had not said anything to her about it not securely sealing and staying in place throughout the night. On 9/1/22 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no information was provided and no concerns were voiced. 34896 2. The facility staff failed to ensure Resident #33's oxygen concentrator filter was clean and free of debris. Resident #33 was admitted to the facility on [DATE] with diagnoses to include but not limited to Chronic Respiratory Failure and Dementia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #33's most recent Minimum Data Set was a quarterly with an Assessment Reference Date of 7/1/22. Resident #33's Brief Interview for Mental Status was coded as an 8 out of a possible 15, indicating the resident was moderately cognitively impaired but capable of some daily decision making. Under Section O Special Treatments, Procedures and Programs, Resident #33 was coded as receiving oxygen. Resident #33's Physician Orders were reviewed and indicated the resident was on Oxygen (O2) - Continuous at 2L (liters) via NC(nasal Cannula) dated 5/26/22. During the survey the following observations were made of Resident #33's oxygen concentrator filter: On 08/28/22 at 4:13 p.m., Resident's O2 concentrator filter on the back of the concentrator was coated with a large amount of thick gray dust and debris. On 08/29/22 at 10:14 a.m., Resident's O2 concentrator filter continues to be coated with large amount of thick gray dust and debris. On 08/30/22 at 1:15 p.m., Resident's O2 concentrator filter continues to be coated with large amount of thick gray dust and debris. On 08/31/22 at 9:00 a.m. Charge Nurse Licensed Practical Nurse (LPN) #4 and this surveyor went to Resident #33's room to inspected the 02 concentrator filter. LPN #4 was asked who is responsible in the facility for cleaning the filters. LPN #4 stated, I think they have someone that comes in and cleans the filters. The nurses don't do it, but it does look dirty. I will have to ask who cleans them. On 8/31/22 at 11:15 a.m. an interview was conducted with the Director of Nursing regarding Resident #33's dirty O2 concentrator filter. The Director of Nursing stated, It is clean now. The nurses are responsible for checking and cleaning the filters every Monday. The facility policy titled Departmental (Respiratory Therapy)-Prevention of Infection last revised 11/2011 was reviewed and is documented as follows: .Purpose: The purpose pf this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. .Infection Control Considerations Related to Oxygen Administration: 9. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. On 8/31/22 at 4:00 p.m. a pre-exit debriefing was held with the Administrator, Director of Nursing and the Regional Director of Clinical Services where the above information was shared. Prior to survey exit no further information was shared.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34306 Based on a resident interview, staff interviews, clinical record review, and review of facility documents, the facility staff failed to provide scheduled around the clock Morphine Sulfate for greater than 24 hours, resulting in constant chest pain with periods of a hammering chest pain which made breathing difficult and increased anxiousness for 1 of 38 residents (Resident #14), in the survey sample. The findings included: Resident #14 was originally admitted to the facility 4/4/22 for rehabilitation and the resident had never been discharged from the facility. The current diagnoses included; scarring related to coronary artery disease with previous bypass surgery, chronic pain syndrome secondary to chronic obstructive pulmonary disease, Long COVID-19, and obstructive sleep apnea, requiring (continuous positive airway pressure) CPAP. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/7/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #14's cognitive abilities for daily decision making were intact. In section G (Physical functioning) the resident was coded as requiring limited physical assistance of one person with transfers and toileting, supervision physical assistance of one person of one person with bed mobility and walking in the room, supervision with set-up help only with walking off the unit, locomotion, personal hygiene and bathing. During an interview with Resident #14 on 8/31/22 at approximately 1:30, p.m., the resident stated he thought he would have to go to the hospital overnight because of severe chest pain rating 7 out of 10 after receiving the scheduled Lyrica. He stated he experienced periods of constant chest pain, then there was periods of a hammering chest pain which made breathing difficult and increased anxiousness. The resident stated he didn't think to apply his CPAP when his breathing was compromised because he felt a transfer to the hospital was the only answer. The resident voiced these symptoms, in the past, had required transfer to the hospital to manage the pain until it was controlled. The resident stated he had been without the scheduled Morphine Sulfate since receiving the last dose on 8/29/22 at approximately 9:00 p.m., until 6:00 a.m., that morning, 8/31/22. Resident #14 stated the nurses said the Morphine Sulfate hadn't been delivered from the pharmacy. Resident #14 stated the same thing happened approximately 2 months ago but it didn't take as long for the medication to arrive to the facility. The resident stated the nurses don't understand when he has been without the Morphine Sulfate, when he does receive it doesn't control the pain again for at least a day or two. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted with Registered Nurse (RN) #2, on 9/1/22 at approximately 11:15 a.m. RN #2 stated on 8/31/22 when she accepted the assignment which included Resident #14 she wasn't informed the Morphine Sulfate wasn't available to the administered and hadn't been available since 8/29/22 at 9:00 p.m. RN #2 stated at approximately 1:00 p.m., when she began passing the 2:00 p.m., medications that she was unable to locate the ordered Morphine Sulfate for Resident #14 but, she saw Norco in the narcotic box for the resident therefore she explained her finding to the Nurse Practitioner (NP) and the NP gave her a onetime order for Norco. RN #2 stated there was no order on the current Physician's Order Summary for Norco yet she didn't realize it was a discontinued medication and should not have stored with the active medications. RN #2 additionally stated she made no other attempts to obtain the Morphine Sulfate and she didn't discuss not having the Morphine Sulfate available to administer with anyone after speaking with the NP, including the pharmacy staff. On 9/1/22 at approximately 2:40 p.m., an interview was conducted with the Director of Nursing (DON), regarding the Morphine Sulfate for Resident #14. The DON stated she wasn't aware there was a concern regarding the Morphine Sulfate until the surveyor asked for documents referencing the drug. The DON stated obtaining a onetime dose of Norco wasn't a substitute for not having the scheduled medication and it wasn't likely to control the Resident's pain. The DON stated she had no further information to present regarding the unavailable Morphine Sulfate. A review of the Physician Assistant - Certified (PA-C) progress note dated 8/15/22 stated the resident's pain didn't improve with use of the Norco therefore a rotation of Morphine Sulfate and an increase in Lyrica were instituted to achieve effective pain control. The August 2022 Physician's order summary revealed an order dated 7/6/22 for Morphine Sulfate Tablet 15 mg; Give 0.5 tablet by mouth every 8 hours for chest wall pain. A review of the medication administration record (MAR) revealed the resident receive the a 10:00 p.m., scheduled dose of Morphine Sulfate on 8/29/22 but on 8/30/22 the Morphine Sulfate wasn't administered at 6: 00 a.m., and 2:00 p.m., the documentation was coded 9, Other/See Nurse Notes, and scheduled dose of Morphine Sulfate wasn't administered at 10:00 p.m., the documentation was coded 11, Held Per Parameters. There were no information referencing parameters for this medication. A review of the nurse's progress note revealed no supporting documentation for the above codes (9, 11) and no assessments indicating the resident's status without administration of the scheduled doses of Morphine Sulfate. A review of the current care plan dated 8/2/22 had a problem which read; (name of the resident) has complaints of chest and neuropathic pain. The goal read; (name of the resident) will have well-controlled pain through review date, 9/11/2022. The interventions included; administer medication/treatment as ordered. Monitor/document side effects and effectiveness. Monitor vital signs during reported chest pain episode (at least q 5 min). On 9/1/22 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no information was provided and no concerns were voiced. Morphine sulfate is a strong analgesia used to relieve severe, acute pain or moderate to severe, chronic pain. (pubchem.ncbi.nlm.nih.gov/compound/16051935) (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Lyrica capsules, oral solution (liquid),and extended-release (long-acting) tablets are used to relieve neuropathic pain (pain from damaged nerves) that can occur in your arms, hands, fingers, legs,feet, or toes if you have diabetes and postherpetic neuralgia (PHN; theburning, stabbing pain or aches that may last for months or years after anattack of shingles) (https://medlineplus.gov/druginfo/meds/a605045.html)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34896 Based on observation, resident record review, staff interviews and facility document review the facility staff failed to ensure dialysis services to include ongoing communication with the dialysis center was in place for 1 of 38 residents in the survey sample, Resident #21. The facility staff failed to ensure dialysis services to include ongoing communication with the dialysis center was in place on Resident #21's dialysis days. The findings included: Resident #21 was admitted to the facility on [DATE] with the diagnoses to include but not limited to End Stage Renal Disease and Dependence on Dialysis. Resident #21 attends dialysis on Mondays, Wednesdays and Fridays. The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 6/17/22. Resident #21's Brief Interview for Mental Status (BIMS) was a 12 out of a possible 15 which indicates the resident is cognitively intact and capable of daily decision making. Under Section O Special Treatments, Procedures, and Programs Resident #21 was coded for Dialysis while a resident. Resident #21's most recent comprehensive care plan dated 7/16/22 was reviewed and indicated that the resident receives dialysis/hemodialysis related to renal failure on Mondays, Wednesdays and Fridays. On 8/30/22 at 10:20 a.m. Resident #21's Dialysis Communication Book was reviewed. Resident #21's Dialysis Communication Book revealed that for the months of May, June, and July 2022 there were 9 missing dialysis communication sheets. On 8/31/22 at 8:45 a.m. Licensed Practical Nurse (LPN) #4 was asked about the missing dialysis communication sheets for Resident #21. LPN #4 stated, I'm not sure where the missing ones are, sometime the dialysis doesn't send them back. The night shift prepares the sheets for the following dialysis day and they are sent each time he goes to dialysis. On 8/31/22 at 11:10 a.m. an interview was conducted with the Director of Nursing regarding her expectations for communication with the dialysis center in regards to residents receiving dialysis. The Director of Nursing stated, I expect that each time a resident goes out to dialysis their dialysis communication book with a communication sheet be send with them and returned after the treatment. The facility policy titled Coordination of Hemodialysis Services last revised 7/2/19 was reviewed and is documented as follows: .Policy: Residents requiring an outside ESRD (End Stage Renal Disease) facility will have services coordinated by the facility. There will be communication between the facility and the ESRD facility regarding the resident . .Procedure: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The Dialysis Communication form will be initiated by the facility for any resident going to an ERSD center for hemodialysis . On 8/31/22 at 4:00 p.m. a pre-exit debriefing was held with the Administrator, Director of Nursing and the Regional Director of Clinical Services where the above information was shared. Prior to exit no further information was shared.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34896 Based on staff interviews the facility staff failed to have on duty sufficient nursing staff to provide nursing services to include showers during the 3:00 p.m.-11:00 p.m. shift. The findings included: On 8/28/22 at 4:20 p.m. an interview was conducted with Certified Nursing Assistant (CNA) #6 regarding Resident showers. CNA #6 stated, Showers are not getting done on 3-11 because of us being short staffed. We have been working short and we having been trying to do all we can for the residents. On 8/28/22 at 5:00 p.m. an interview was conducted with CNA #7 regarding Resident showers. CNA #7 stated, I normally work 3-11 and showers are not getting done because of us being short staffed. On 8/31/22 at 2:40 p.m. an interview was conducted with CNA #8 regarding Resident showers. CNA #8 stated, I work over to help 3-11 because we are short staffed. By the time you make rounds, help with meals, and get the residents in bed there is no time for showers. An interview was conducted with Certified Nursing Assistant (CNA) #3 on 08/30/22 at approximately 5:06 p. m. The CNA stated when the facility is short staffed with CNA's, showers are not provided to the residents. A phone interview was conducted with CNA #4 on 08/30/22 at approximately 5:08 p.m. The CNA said she can only provide the necessary care and services to the residents' when we are under staff with CNA's. She said unfortunately, when we do not have enough CNA's or a shift is split with another CNA, showers are not provided. On 8/31/22 at 4:00 p.m. a pre-exit debriefing was held with the Administrator, Director of Nursing and the Regional Director of Clinical Services where the above information was shared. The team was asked if there are any staffing struggles in the facility and if so what was the facility doing. The Administrator stated, We have used agency staffing in the past but stopped in January of 2022. We stopped agency due to the staff not showing up, complaints we were receiving and the absurd cost to the facility. We recently added unit managers to the floor due to a lack of oversight. During this time we had to let go quite a bit of our 3-11 CNA staff and it left us depleted. We have been piecing together the 3-11 shift by pulling staff from 7-3 and 11-7 to help fill in the gaps and offering a very robust bonus program. Currently I think there is 8 open CNA positions on the 3-11 shift. The staff are used to working short but we do want to get more staff in the building. The issue with showers not being provided on the 3-11 shift is most definitely due to short staffing on 3-11. Prior to exit no further information was shared.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 34896 Based on observations, staff interviews, and facility document review the facility staff failed to ensure that the Nursing Staffing Information was posted daily potentially affecting all residents. The findings included: On 8/28/22 upon entrance the posted Daily Staffing Information document was observed in the front lobby and was dated 8/26/22. On 8/28/22 at 3:48 p.m. an interview was conducted with the Weekend Receptionist regarding the posted Daily Staffing Information dated 8/26/22. The Weekend Receptionist stated that she is the person responsible for updating and posting the Daily Staffing Information, however no one had left her any to post for 8/27/22 or 8/28/22. The Weekend Receptionist informed the supervisor that there been a recent change in the staff scheduler and that was the reason the staffing sheets were not available for 8/27/22 and 8/28/22. The Facility was unable to provide a policy for posting of the Daily Staffing Information when requested. On 8/31/22 at 11:17 a.m. an interview was conducted with the Director of Nursing regarding the missing Daily Staffing Information for 8/28/22. The Director of Nursing stated, I expect the Daily Staffing Information to be post daily and to be accurate. On 8/31/22 at 4:00 p.m. a pre-exit debriefing was held with the Administrator, Director of Nursing and the Regional Director of Clinical Services where the above information was shared. Prior to exit no further information was shared.

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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. 34306 Based on clinical record review, staff interview, and review of the facility's policy the facility staff failed to ensure a resident didn't receive an unnecessary psychotropic medication for 1 of 38 residents (Resident #26), in the survey sample. The facility's staff failed to ensure Resident #26 did not receive as needed Xanax for greater than 14 days without the physician and/or prescribing practitioner evaluating the resident for the appropriateness of continuous as needed use. The findings included: Resident #26 was originally admitted to the facility 11/18/2014 and the resident had never been discharged from the facility. The current diagnoses included; dementia, a-fib, and high blood pressure. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/20/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated Resident #26's cognitive abilities for daily decision making were severely impaired. In section G (Physical functioning) the resident was coded as requiring total physical assistance of one person with toileting, extensive physical assistance of two plus persons with bed mobility and transfers, extensive physical assistance of one person with dressing and bathing, supervision with physical assistance of one person with eating and activity didn't occur with walking, locomotion, personal hygiene. Xanax (Alprazolam) is one of the most widely prescribed benzodiazepines for the treatment of generalized anxiety disorder and panic disorder. Its clinical use has been a point of contention as most addiction specialists consider it to be highly addictive, given its unique psychodynamic properties which limit its clinical usefulness, whereas many primary care physicians continue to prescribe it for longer periods than recommended. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846112/) A physician's order dated 5/31/22 read; Xanax (Alprazolam) Tablet 0.25 milligrams (mg); Give 1 tablet by mouth every 12 hours as needed for anxiety. The 5/31/22, physician's order for Xanax had no stop use date or documentation the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the medication after the initial 14 days of use. The active care plan didn't address use of as needed Xanax. The medication administration record (MAR) revealed the medication Xanax was administered twice after the 14th day, 6/16/22, and 6/20/22. A review of the most recent Pharmacy consult report dated 8/22/22 didn't address the as needed use of the medication Xanax. On 9/1/22 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant. An opportunity was offered to the facility's staff to present additional information they stated there was no additional information to report and no concerns were voiced.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37828 Based on observation of medication pass and pour, staff interviews, clinical record review, and facility documentation, the facility staff failed to ensure they were free of medication error rate of 5 percent (%) or greater. During the medication observation, there were twenty-five (25) opportunities for error, two (2) medication errors were observed which resulted in a medication error rate of 8%. The resident involved in the medication error rate was Resident #24. The findings included: Resident #24 was admitted to the facility on [DATE]. Diagnoses included but are not limited to Congestive Heart Failure (CHF) and Coronary artery disease (CAD). Resident #24's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date of 06/16/22 coded Resident #24's Brief Interview for Mental Status (BIMS) scored a 13 out of a possible score of 15 indicating no cognitive impairment. On 08/26/22 at approximately 4:20 p.m., a medication pass and pour observation was conducted with Licensed Practical Nurse (LPN) #1. The LPN was unable to locate Resident #24's Coreg (Carvedilol) 6.25 milligrams (mg) inside the medication cart. The LPN stated she will order the missing medication from pharmacy. The medication was not administered to Resident #24. On 08/29/22 at 04:22 PM, a Medication pass and pour observation was conducted with LPN #1. LPN #1 was unable to locate the medication Coreg 6.25 mg to administer to Resident #24 as written on the medication administration record (MAR) therefore, the medication wasn't administered. LPN #1 stated she could see the medication was ordered but it wasn't available on the medication cart and she would look further into the rationale later. LPN #1 didn't state there were other options to obtain the medication. Resident #24 had a physician order dated 02/02/21, for Coreg tablet 6.25 mg. The order read to give one (1) tablet by mouth two times a day related to coronary artery disease. The medication was scheduled to be administered at 9:00 a.m., and 5:00 p.m. On 08/30/22 at approximately 11:28 a.m., Registered Nurse (RN) #2 checked the medication inventory list from the facility's Omnicell drug dispensing machine. The following medications were located in the Omnicell machine: Coreg 3.125 mg (6 tablets) and Coreg 6.25 mg (8 tablets). The RN stated all nurses' have access to the Omnicell machine. She stated the nurse(s) should have pulled the Coreg 6.25 mg from the Omnicell machine and administered the medication as ordered per physician. On 08/30/22 at approximately 5:16 p.m., a phone call was placed to License Practical Nurse (LPN) #1. The LPN was assigned to administer Resident #24 his Coreg 6.25 mg on 08/28/22 and 08/29/22 at 5:00 p.m. A message was left, the LPN never returned the call. The Administrator, Director of Nursing (DON) and Regional Director of Clinical Services was informed of the finding during a briefing on 08/31/22 at approximately 3:57 p.m. The DON stated the nurse's should have pulled the Coreg 6.25 mg from the Omnicell machine and administered the medication as ordered by the physician. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Administering Medication revised on 04/19. Policy statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 6. Medications errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional training. Definitions: -Congestive Heart Failure occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath. Certain heart conditions, such as narrowed arteries in the heart (coronary artery disease) or high blood pressure, gradually leave the heart too weak or stiff to fill and pump blood properly (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms). -Coronary artery disease is a common heart condition. The major blood vessels that supply the heart (coronary arteries) struggle to send enough blood, oxygen and nutrients to the heart muscle. Cholesterol deposits (plaques) in the heart arteries and inflammation are usually the cause of coronary artery disease. Signs and symptoms of coronary artery disease occur when the heart doesn't get enough oxygen-rich blood (https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/symptoms-causes).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37828 Based on staff interviews, clinical record review and facility documentation, the facility staff failed to administer two (2) doses of a significant medication Coreg (Carvedilol) 6.25 milligrams (mg) as ordered by the physician for 1 out of 38 residents (Resident #24) in the survey sample. The findings included: Resident #24 was admitted to the facility on [DATE]. Diagnoses included but are not limited to Congestive Heart Failure (CHF) and Coronary artery disease (CAD). Resident #24's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date of 06/16/22 coded Resident #24's Brief Interview for Mental Status (BIMS) scored a 13 out of a possible score of 15 indicating no cognitive impairment. The care plan with a revision date of 02/03/21 identified Resident #24 has altered cardiovascular status related but not limited to CHF and high blood pressure. The goal set for the resident by the staff was that the resident will be free from complications of cardiac problems. Resident #24 had a physician order dated 02/02/21, for Coreg tablet 6.25 mg. The order read to give one (1) tablet by mouth two times a day related to coronary artery disease. The medication was scheduled to be administered at 9:00 a.m., and 5:00 p.m. On 08/26/22 at approximately 4:20 p.m., a medication administration observation was made with Licensed Practical Nurse (LPN) #1. The LPN was unable to locate Resident #24's Coreg 6.25 mg inside the medication cart to administer the medication as ordered by the physician. The LPN stated she will order the missing medication from pharmacy. The medication was not administered to Resident #24. On 08/29/22 at 04:22 p.m., a medication administration observation was made with Licensed Practical Nurse (LPN) #1. LPN #1 was unable to locate the medication Coreg 6.25 mg to administer to Resident #24 as written on the medication administration record (MAR) therefore, the medication wasn't administered. LPN #1 stated she could see the medication was ordered but it wasn't available on the medication cart and she would look further into the rationale later. LPN #1 didn't state there were other options to obtain the medication. On 08/30/22 at approximately 5:16 p.m., a phone call was placed to License Practical Nurse (LPN) #1. The LPN was assigned to administer Resident #24 his Coreg 6.25 mg on 08/28/22 and 08/29/22 at 5:00 p.m. A message was left, the LPN never returned the call. The Administrator, Director of Nursing (DON) and Regional Director of Clinical Services was informed of the finding during a briefing on 08/31/22 at approximately 3:57 p.m. The DON was not able to provide evidence that the medication Coreg 6.25 mg was pulled from the Omnicell machine on the days two days mentioned above. She stated the nurse should have pulled the Coreg 6.25 mg from the Omnicell machine and administered the medication as ordered by the physician. The facility's policy titled Administering Medication revised on 04/19. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 6. Medications errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional training. Definitions: -Congestive Heart Failure occurs when the heart muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath. Certain heart conditions, such as narrowed arteries in the heart (coronary artery disease) or high blood pressure, gradually leave the heart too weak or stiff to fill and pump blood properly (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms). -Coronary artery disease is a common heart condition. The major blood vessels that supply the heart (coronary arteries) struggle to send enough blood, oxygen and nutrients to the heart muscle. Cholesterol deposits (plaques) in the heart arteries and inflammation are usually the cause of coronary artery disease. Signs and symptoms of coronary artery disease occur when the heart doesn't get enough oxygen-rich blood (https://www.mayoclinic.org/diseases-conditions/coronary-artery-disease/symptoms-causes). -Coreg is used to treat heart failure (condition in which the heart cannot pump enough blood to all parts of the body) and high blood pressure. It also is used to treat people who have had a heart attack. Carvedilol is often used in combination with other medications. Carvedilol is in a class of medications called beta-blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure (https://medlineplus.gov/ency/article/007365.htm).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37828 Based on observation and staff interviews, the facility staff failed to ensure insulin pens were labeled in accordance with currently accepted professional principles in 3 out of 5 medication carts. The findings included: On 08/31/22 at approximately 11:28 a.m., the medication cart on Meadowland Unit (cart 2) was inspected with Registered Nurse (RN) #2. Stored inside the medication cart was four (4) Lantus (insulin) pens open but without a date when open. A pharmacy sticker was observed on all the insulin pens to discard 28 days after opening. On 08/31/22 at approximately 11:34 a.m., the medication cart on Rosewood Unit (cart 1) was inspected with RN #2. Stored inside the medication cart was a Lantus (insulin) pen with an open date of 06/24/22. A pharmacy sticker was observed on the insulin pen to discard 28 days after opening. The RN stated the insulin pen should have been removed from the medication cart 28 days after being open on 06/24/22. Further inspection of the medication cart revealed an open Lantus pen but without an open date. The RN stated once the insulin pens were removed from the medication refrigerator and placed inside the medication cart, the insulin must provide an opened date. She stated, there is no way of knowing when the insulin pens were opened. She stated all the insulin pens will be removed from medication carts. The Administrator, Director of Nursing (DON) and Regional Director of Clinical Services was informed of the finding during a briefing on 08/31/22 at approximately 3:57 p.m. The DON stated once the Lantus insulin pen is removed from the refrigerator and open for use, the insulin pen is to be dated and discarded after 28 days. The facility's policy titled Administering Medications revised 04/19. Policy statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 12. The expiration /beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date open is recorded on the container. Definitions (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lantus (insulin glargine) is a man-made form of a hormone that is produced in the body. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. Insulin glargine is long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours. Storing opened (in use) Lantus: Store the injection pen at room temperature (do not refrigerate) and use within 28 days (www.drugs.com/lantus.html).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 09546 Based on observations, facility documentation, staff and resident interviews, the facility staff failed to ensure menus were followed. The findings included: During the dinner meal observation on 08/28/22 at 3:28 PM (kitchen tour) the dinner - meal included: spaghetti and meat sauce, squash, dinner rolls, and chocolate pudding with whip topping for deserts. Alternate menu included- vegetable soup, deep fried fish which was served during the lunch menu as (lemon pepper fish fillet), and mashed potatoes. Beverages included ice tea, and milk. The week -4 master menu indicated: Dinner- chicken tenders, creamy gravy, french fries, tossed salad with dressing, biscuit, vanilla ice cream, milk and tea of choice. Alternate menu included: hamburger steak with grilled onions, brown gravy, buttered noodles and whole kernel corn. During the lunch meal observation at 11:18 a.m. on 8/30/22 the meal consisted of chicken thighs, noodles, green beans, loaf of bread slices (2) chocolate pudding for desert. The alternate menu included meat loaf which was served during the Monday's lunch menu, mash potatoes and carrots. The week -4 master menu indicated: Lunch- marinated chicken thigh, parmesan noodles, sauteed green beans, dinner rolls, chocolate pudding, tea of choice. Alternate- meatballs with gravy, mashed potatoes, sugar snap peas. During an interview at 11:32 a.m. on 8/30/22 the Dietary Manager stated, she was aware of the issues of food availability and not following the menus. The Dietary Manager stated, I have put in a Performance improvement plan starting in September. 9/1/22-The Performance Improvement Project (PIP) Guide Indicated: Start - September - Key area for Improvement- Staff Education on Meal Accuracy and Production. Goal: Educate the staff on the importance of tray accuracy and serving sizes. Educate about how to find proper substitutes if item is out, and providing a well rounded meal if making a menu change. Making sure meal production is overall correct from start to finish. What is the root causes(s) for the problem? 1. Resident complaints about inaccurate tray items. 2. Over or under production of food items. Menu Policy revised 9/2017 indicated: Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. Procedures: 1. Menu cycles will be developed and tailored to the needs and requirements of the facility. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 09546 Based on observations, and staff interview the facility staff failed to store and serve food under sanitary conditions. The findings included: During the kitchen observations at 3:28 P.M. on 08/28/22 the ice machine was observed to be leaking water. Towels with brown stains were observed under the ice machine. An open package of Lance cheese crackers was observed on the counter under the micro wave oven. A hole was observed in the drain line of the three compartment sink. A large plastic pan measuring approximately 14 inches wide by 22 inches long was observed catching drained waste water. Ice build-up was observed on the kitchen floor leading from the walk-in freezer. Ice build-up was observed on the freezer door seals. Ice build-up was observed on the floor inside the freezer. The freezer door was observed to have a bend in the middle of the door seal. The base board at the hand washing sink was observed to have a four inch by six inch long hole with exposed plaster coming off. The wall at the two compartment sink was observed to have an estimated four feet long by four inch wide wall covering coming off. During an interview at 3:52 P.M. on 08/28/22 the Dietary Manager stated, I have been employed for about three weeks. I gave the Administrator a list of items that needed to be repaired and replaced.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, staff interview, clinical record review, and review of facility documents, the facility's staff failed to have a consistent ongoing Infection prevention and control program to include antibiotic use protocols and a system to monitor antibiotic use. The findings included: A review the Antibiotic Stewardship education book was conducted on 8/30/22 at approximately 11:20 AM., Months were reviewed from January 2022-July 2022. The following areas were missing or incomplete: March: Missing [NAME] criteria. June: Incomplete [NAME] criteria, no line listing. July: No [NAME] criteria. On 8/30/22 at approximately 11:20 AM an interview was conducted with RN (Registered Nurse) #3 concerning the Antibiotic Stewardship Program. She said the [NAME] Criteria told you what the infection is and whether it met the criteria for surveillance, and it showed trends in antibiotics. Moving forward, I will finish the [NAME] criteria and line listings every month. In March 2009, members of the Society for Healthcare Epidemiology of America ([NAME]) Long-Term Care Special Interest Group (LTCSIG) agreed that the surveillance definitions of infections in LTCFs should be updated in light of (1) a substantial increase in the body of evidence-based literature about infections in the elderly in LTCF settings, (2) the availability of improved diagnostics for infection surveillance, (3) the changing populations of patients who are cared for in nonhospital settings, and (4) the updated acute care hospital surveillance definitions of the CDC's National Healthcare Safety Network (NHSN). The process of updating the McGeer Criteria included an evidence-based structured review of the literature in addition to consensus opinions from industry leaders including infectious diseases physicians and epidemiologists, infection preventionists, geriatricians, and public health officials. https://www.jstor.org/stable/10.1086/667743#metadata_info_tab_contents On 08/31/2022 at approximately 4:30 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. 37828 2. The facility staff failed to ensure a process was in placed for the review of laboratory reports to determine if the antibiotic prescribed needs to be adjusted for Resident #36. Resident #36 was admitted to the facility on [DATE] with a current diagnoses of Urinary Tract Infection (UTI). The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 07/04/22 coded the resident on the Brief Interview for Mental Status (BIMS) 15 out of a possible score of 15 indicating no cognitive impairment. Resident #36 was coded total dependence of two with bathing and dressing, extensive assistance of two with bed mobility, transfer, toilet use and personal hygiene and supervision with limited assistance of one with eating for Activities of Daily Living (ADL) care. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #36's Medication Administration Record (MAR) for August 2022 revealed an order to start Macrobid (Nitrofurantoin) 100 mg by mouth twice a day x 5 days for UTI starting on 08/26/22. Further review of the MAR revealed the antibiotic was first administered on 08/26/22 at 5:00 p.m., and given through 08/31/22 at 9:00 a.m., indicating nine (9) doses were administered. A review of Resident #36's Urine Analysis (U&A) and Culture and Sensitivity (C&S) dated 08/27/22 revealed organism #1 greater than 100,000 (Citrobacter Freudii) and organism #2 greater than 100,000 (Proteus Mirabilis). Further review of the C&S report revealed the antibiotic (Macrobid) ordered on 08/26/22 to treat Resident #36's UTI was resistant to organism #2. The Director of Nursing (DON) was interviewed on 08/31/22 at approximately 11:18 a.m. She stated she did not realize the antibiotic (Macrobid) ordered on 08/26/22 to treat Resident #36's UTI was resistant to the organism growing until the morning of 8/31/22. She stated when the final lab report (C&S) was faxed to the facility on [DATE], the nurse should have reviewed the report and notified the on-call provider for a change in antibiotic treatment. A review of Resident #36's nurse's note dated 08/31/22 at 5:19 p.m., revealed the antibiotic (Macrobid) was discontinued and a new antibiotic was started for Keflex 500 mg four times a day x 10 days for UTI. The Administrator, Director of Nursing (DON) and Regional Director of Clinical Services was informed of the finding during a briefing on 08/31/22 at approximately 3:57 p.m. The facility did not present any further information about the findings. The facility's policy titled Antibiotic Stewardship revised on 12/2016. Policy statement: Antibiotics will be prescribed and administered to residents under the guidance of a facility's Antibiotic Stewardship Program. Policy Interpretation and Implementation 1. The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotic in our residents. 11. When a culture and sensitivity (C&S) is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued. Definitions: 1. Urinary Tract Infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney (http://www.cdc.gov/HAI/ca_uti/uti.html). 2. Urine Analysis (UA) is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder. This means it does not contain any bacteria or other organisms (such as fungi) but bacteria can enter the urethra and cause a UTI (http://www.webmd.com/a-to-z-guides/urine-culture). (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Culture and Sensitivity (C&S) is sample of urine is added to a substance that promotes the growth of germs. If no germs grow, the culture is negative. If germs grow, the culture is positive. The type of germ may be identified using a microscope or chemical tests. Sometimes other tests are done to find the right medicine for treating the infection. This is called sensitivity testing (http://www.webmd.com/a-to-z-guides/urine-culture). 4. Macrobid is used to treat urinary tract infections. Nitrofurantoin is in a class of medications called antibiotics. It works by killing bacteria that cause infection (https://medlineplus.gov/druginfo/meds). 5. Keflex is used to treat certain infections caused by bacteria such as pneumonia and other respiratory tract infections; and infections of the bone, skin, ears, genital and urinary tract (https://medlineplus.gov/druginfo/meds).

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 40711 Based on observation, staff interview, and review of facility documents, the facility's staff failed to have an Infection Preventionist to work on a part-time basis and failed to complete specialized training in infection prevention and control. The findings included: On 8/29/22 at approximately 10:45 AM., an interview was conducted with RN #3 (Infection Preventionist/IP). She stated, I only work here prn/as needed. I only do the Antibiotic Stewardship portion. On 8/30/22 at approximately 12:05 PM an interview was conducted with the IP concerning her Infection Preventionist Certification. She stated that she completed her certification a few years ago but is not able to retrieve her certificate at this time. On 08/31/22 at approximately 4:30 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.

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Newport News Nursing & Rehab	12997 Nettles Drive Newport News, VA 23602

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on staff interview, and clinical record review, the facility staff failed to provide documentation in the resident's clinical record of the influenza vaccine administration and or the pneumococcal vaccine or the refusal/declinations of vaccines for 2 of 38 residents (Resident #21 and Resident #74), in the survey sample. The findings included: 1.Resident #21 was originally admitted to the facility 08/13/2018 and readmitted on [DATE]. The current diagnoses included; DEPENDENCE ON RENAL DIALYSIS and TYPE 2 DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 06/17/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were moderately impaired. A review of Resident #21's clinical record revealed that he was offered the Influenza vaccine but declined on 10/23/2019. No recent declinations were found. A review of Resident #21's clinical record also revealed that he was offered the pneumococcal vaccine but declined on 11/11/2014. No recent declinations were found. 2. For Resident #74 the facility staff failed to update his immunization consents and or declinations. Resident #74 was originally admitted to the facility 05/28/2013 and readmitted on was discharged home 8/17/21. The current diagnoses included; CEREBRAL PALSY, UNSPECIFIED and TYPE 2 DIABETES MELLITUS WITHOUT. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 08/05/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #74's cognitive abilities for daily decision making were moderately impaired. A review of Resident #74's clinical record revealed that he was offered the Influenza vaccine but already received the vaccine during the current season outside of the facility on 10/09/18. Telephone consent was last dated on 4/19/19. No recent declinations were found. A review of Resident #74's clinical record revealed that he was offered the pneumococcal vaccine but declined on 4/19/19. No recent declinations were found. On 08/31/2022 at approximately 4:30 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The DON (Director of Nursing) was asked how often the facility should update consent forms or declinations for immunizations. She stated, We update them yearly.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report COVID19 data to residents and families. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to inform three Residents of a COVID-19 Positive case on 8/24/22 and failed to inform 1 Resident of his COVID-19 test results. (Resident #11, Resident #60 Resident #76), in the survey sample. The findings included: 1. For Resident #11 the facility staff failed to notify her of a COVID-19 positive notification on 8/24/22. Resident #11 was originally admitted to the facility on [DATE]. The resident has never been discharged from the facility. The current diagnoses included; FIBROMYALGIA and MUSCLE WEAKNESS (GENERALIZED). The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 06/02/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #11 cognitive abilities for daily decision making were intact. In sectionG(Physical functioning) the resident was coded as requiring supervision one person assist with bed mobility, eating and dressing, supervision set-up help with transfers, toilet use, personal hygiene and bathing. On 08/31/22 at approximately 2:28 PM., an interview was conducted with Resident #11 concerning the above issues. She stated that she wasn't notified of a positive COVID19 case on 8/24/22. A review of Resident #11's clinical record show no COVID-19 notification was given from 8/24/22 to 9/01/22. 2. For Resident #60 the facility staff failed to notify him or his legal guardian of a COVID-19 positive case on 8/24/22. Resident #60 was originally admitted to the facility on [DATE] and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS and CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE) EXACERBATION. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/28/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 00 out of a possible 15. This indicated Resident #60 cognitive abilities for daily decision making were severely impaired. In sectionG(Physical functioning) the resident was coded as requiring limited assistance of one person with bed mobility, supervision set-up help only with dressing, independent with eating set-up only, extensive assistance of one person with toilet use and personal hygiene. (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/30/22 at 12:50 an interview was conducted with Resident #60 concerning COVID19 notifications. He was asked if the staff had informed him of a COVID19 positive case the previous week (8/24/22). He stated, No. A review of Resident #60's clinical record from 8/24/22 to 9/01/22 was conducted and revealed that he nor his legal guardian were notified of a COVID19 positive case on 8/24/22. 08/31/22 11:30 AM a telephone interview was conducted with OSM (Other Staff Member/legal guardian) #2 concerning the above issue. He said that he does not receive notifications from the facility unless he inquires. 3. For Resident #76 the facility staff failed to notify him of a COVID-19 positive case on 8/24/22 and failed to inform him of his test results on 8/30/22. Resident #76 was originally admitted to the facility 08/02/2022. The resident has never been discharged from the facility. The current diagnoses included; ACUTE ON CHRONIC SYSTOLIC (CONGESTIVE) HEART FAILURE and UNSPECIFIED LACK OF COORDINATION. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 08/09/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #76 cognitive abilities for daily decision making were intact. In sectionG(Physical functioning) the resident was coded as requiring supervision set-up help only with bed mobility, transfers, eating and personal hygiene, limited assistance of one person with dressing, supervision of one person physical assistance with toilet use and total dependence with bathing. On 8/31/22 at approximately 2:12 PM., an interview was conducted with Resident #76 concerning the above issue. He said that he was tested for COVID19 on yesterday (8/30/22) but was not informed of the results. He stated, I assume, I'm negative, He was also asked if he was informed of a staff member testing positive for COVID-19 on 8/24/22. He said, no. A review of Resident #76's clinical record dated 8/24/22 through 9/01/22 reveal there was no communication given to him regarding a staff testing positive for COVID-19 or that he had been informed of his COVID-19 results on 8/30/22. On 08/31/22 at approximately 10:31 AM an interview was conducted with OSM (Other Staff Member/Social Services Worker) #3 concerning the COVID-19 testing. He said that he and the administrative team were responsible for informing the residents of the positive COVID-19 cases in the building. He also stated that he and another staff member were responsible for putting the note in PCC (Point Click Care) but he didn't have time to input the notes. On 09/1/22 at approximately 10:30 AM., a brief interview was conducted with OSM #3 concerning the above issue. He said that moving forward he would document the notifications in PCC. (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/31/2022 at approximately 4:30 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 09546 Based on observations and staff interview, the facility staff failed to maintain all mechanical equipment in safe operating condition. The findings included: During the kitchen observation at 3:28 P.M. on 8/28/22, the facility staff failed to ensure the following mechanical equipment in the kitchen was in safe operating condition: One of the steam table sections was not operating properly and was out of use. A Project Agreement proposal dated April 25, 2022 indicated: Walk in freezer has two defective defrost heaters. Inoperative defrost termination switch. Defective evaporator coil freezer. The freezer was observed to have ice on the walk in freezer floor as well as spillage out into the kitchen floor due to the above problems identified with the walk in freezer. The temperatures were within normal range. An inoperable kitchen equipment list provided by the dietary manager dated 08/10/22 indicated: Tray line bracket inoperable. Meat slicer inoperable. Two door stand-up refrigerator inoperable. During an interview on 08/28/22 at 3:40 P.M.,the dietary manager stated, she gave the Administrator a list of needed repairs. During an interview on 8/30/22 at 11:15 a.m., the Administrator stated the dietary manager made him aware of the needed repairs and is trying to get the needed repairs and equipment replacement items in his capital improvement budget.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, resident interview, staff interview, and review of facility documents, the facility staff failed to manage an effective pest control program for 1 of 38 residents (Resident #11), in the survey sample. The findings included: Resident #11 was originally admitted to the facility 11/15/2018. The resident has never been discharged from the facility. The current diagnoses included; FIBROMYALGIA and MUSCLE WEAKNESS (GENERALIZED). The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 06/02/2022 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #11 cognitive abilities for daily decision making were intact. In sectionG(Physical functioning) the resident was coded as requiring supervision one person assist with bed mobility, eating and dressing, supervision set-up help with transfers, toilet use, personal hygiene and bathing. On 08/30/22 at approximately 1:00 PM., during an interview with Resident #11 an observation was made in her bathroom; multiple roaches of all sizes were observed crawling on the bathroom floor and on the bathroom door. Resident #11 stated that she has informed the staff about having roaches in her bathroom. On 08/31/22 at approximately 9:26 AM an interview was conducted with OSM (Other Staff Member) #6 concerning Resident #11's room. He said that Residents will usually go to the nurses concerning roaches. The resident stated, They started seeing roaches earlier this year. On 08/31/22 at approximately 4:18 PM., staff and resident interviews were conducted throughout the facility and room observations were made. Staff and residents denied seeing rodents in the facility. They stated no pests were seen throughout the facility except for in Resident #11's room. A review of the pest control book for the Meadowland unit revealed the last pest sighting was on 3/10/2020. On 8/30/22 at approximately 6:00 PM., an interview was conducted with OSM #6 concerning pest control. He said they were last serviced on 8/15/22 and found roaches, ants and spiders doing the service. The service they received in May 2022 was for outside treatment only. He said that he personally sprayed Resident #11's room [ROOM NUMBER]/29/22 around 7:00 PM but didn't see any roaches and that he also sprayed Resident #11's room again on 8/30/22 and saw no pests. He also said that due to COVID-19 starting in 2020, service to the facility had stopped. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/31/2022 at approximately 4:30 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.