STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495230	A. Building B. Wing	10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29123 Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to assess one of eighteen (18) residents for self-adminstration of medications, Resident #31. Resident #31 was observed with an albuterol inhaler at her bedside for self administration as needed. Resident #31 had not been assessed by the interdisciplinary team to ensure safe usage of the inhaler. Findings were: Resident #31 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: Fibromyalgia, depression, respiratory disorder, and chronic ischemic heart disease. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 08/19/2021, assessed Resident #31 as cognitively intact with a summary score of 15. On 10/05/2021 at approximately 8:00 a.m., Resident #31 was observed sitting on her bed. She was wearing oxygen via a nasal cannula at 3 liters per minute. Resident #31 was interviewed about life at the facility and was asked about her oxygen. She stated, I got pneumonia a while back. I didn't wear it before then. Now I get short of breath when I take it off and to walk to the bathroom. My oxygen sats drop .sometimes I wheeze, that's why I have this. Resident #31 held up an albuterol inhaler that was laying on her bed. She stated, The doctor told me to keep it here at my bedside so that's where it is .I use it when I am short of breath or wheezing. Resident #31 was asked how often she used her inhaler. She stated, Whenever I need it .he [her doctor] said I can use it every four hours if I need to. Sometimes it's four hours, sometimes it's longer, sometimes if I'm wheezing I might use it a little before the four hours is up. Resident #31 was asked if she had to get one of the staff to come and help her with the inhaler when she used it or watch her use it. She stated, No, I do it myself, I don't need anybody to help me. She was asked if she had used an inhaler at home or prior to having pneumonia. She stated, No, I never had any problems breathing until then. The clinical record was reviewed at approximately 11:00 a.m. The physician order sheet contained the following order dated 06/09/2021: VENTOLIN [albuterol] HFA DOSE COUNTER 200 INH 90MCG 2 puff inhale orally every 4 hours as needed for Shortness of breath. May keep at bedside per MD. There was no assessment by the interdisciplinary team for safe self administration of the inhaler observed in the clinical record. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an end of the day meeting on 10/05/2021 at approximately 5:30 p.m., with the DON (director of nursing) and the corporate nurse consultant the above information was discussed. The DON was asked what was expected to be in place if a resident was keeping medication at her bedside for self administration. She stated, There should be an assessment, a doctor's order, and it should be on the care plan .it should be in the clinical record. The DON stated she would look to see what she could find. On 10/06/2021 at approximately 9:00 a.m., the DON provided information regarding Resident #31. She stated, She did not have an assessment, we did one this morning. A copy of the facility policy for self administration of medications was requested and received. Per the facility policy, Self-Administration of Medication at Bedside: .Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions Complete Self-administration of Medications Evaluation. The Interdisciplinary Team will review the evaluation and will document .approval granted must be checked yes or no . No further information was received prior to the exit conference on 10/06/2021.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview and clinical record review, the facility staff failed to ensure a safe, operational bed for one of eighteen residents in the survey sample, Resident #11. Resident #11 was in a bed with no functional controls to raise the head, foot or height of the bed. The findings include: Resident #11 was admitted to the facility on [DATE] with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated [DATE] assessed Resident #11 with severely impaired cognitive skills. On 10/5/21 at 11:48 a.m., accompanied by a hospice registered nurse (RN #1), Resident #11 was observed in bed. The head of the bed was raised approximately 30 degrees. RN#1 repositioned the resident for a dressing change and stated the resident's bed did not work. RN #1 stated the bed controls were broken and she was unable to move the resident's bed up/down or raise/lower the head of the bed. RN #1 stated she reported the broken bed to maintenance last Thursday (9/30/21) and the bed had not been fixed. RN #1 stated, They could have called me. We would have gotten a bed. RN #1 stated she was unable to reposition the bed when turning the resident and she was concerned the bed height was not as low as possible. RN #1 stated the resident was a fall risk and had experienced previous falls from the bed. RN #1 demonstrated that the remote did not work. RN #1 stated she was also concerned about the inability to raise the head of the bed for meals and/or resident comfort. On 10/5/21 at 3:40 p.m., the certified nurses' aide (CNA #1) that routinely cared for Resident #11 was interviewed about the bed controls. CNA #1 stated there was a short in the wiring to the bed remote. CNA #1 picked up the remote and there was tape around the wiring near the handset. CNA #1 stated he was aware the bed controls were not working but he did not know how long the bed had been out of service. CNA #1 stated he could move the wiring around and sometimes get the bed to move. On 10/5/21 at 3:43 p.m., the maintenance director (other staff #1) was interviewed about Resident #11's bed. The maintenance director stated the controls on the bed did not work. The maintenance director stated Resident #11's bed was one of several that were donated to the facility and he was unable to get repair parts for the bed or the controls. The maintenance director stated he was told about the broken bed last Friday (10/1/21) and he thought hospice was going to replace the bed. The maintenance director stated he currently had no extra or replacement beds in the facility. Resident #11's plan of care (revised 8/31/21) listed the resident required the extensive assistance of one to two people for bed mobility, transfers and activities of daily living including dressing and incontinence care and was at risk for falls. This finding was reviewed with the director of nursing and regional director of clinical services on 10/5/21 at 5:35 p.m.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40027 Based on observation, staff interview, clinical record review and facility document review the facility staff failed to implement their abuse prevention policies regarding promptly reporting an injury of unknown origin to the state agency for 1 for 18 in the survey sample, Resident #48; and failed to follow their pre-employment screening policies for 13 out of 25 employees reviewed. Resident #48 was found with a medium size gash to the back of his head of unknown origin requiring 5 staples. This injury of unknown origin was not reported to the state survey agency or other local agencies as required by the facility's policy for abuse reporting/investigation. The findings include: Resident #48 was admitted to the facility on [DATE] with diagnoses that included infarction, hemiplegia and hemiparesis affecting right dominant side, muscle weakness, dementia with behavioral disturbance, hyperlipidemia, anxiety, hypertension, depression, dysphasia and psychosis. The most recent minimum data set (MDS) dated [DATE] was a quarterly assessment and assessed Resident #48 as severely cognitively impaired for daily decision making with a score of 3 out of 15. Under Section G Functional Status the MDS assessed Resident #48 as requiring limited assistance with one person physical assistance for transfers, ambulation, eating and locomotion; extensive assistance with one person physical assistance for toileting, bed mobility, personal hygiene, and bathing. Under Section J1900. - Falls, the MDS assessed Resident #48 has having one fall with injury since the previous assessment. Resident #48's clinical record was reviewed on 10/05/2021. Observed within the progress notes was the following: 9/25/2021 09:00 Writer was alerted by CNA (certified nursing assistant) that resident had blood on his pillow. Upon assessment a medium size gash was noted to the back of his head. Resident stated 'I did not fall, the door hit me.' [Medical Director] notified and orders were given to send resident to [Hospital] for sutures and evaluation. Resident had no change in LOC (lost of consciousness) . [Ambulance Service] transported resident via stretcher. Facesheet, med orders, bed hold, and care plan all sent with resident. 09/25/2021 19:25 (7:25 p.m.) Resident arrived back to facility around 1530 (3:30 p.m.) via non emergency ambulance on stretcher. He has 5 staples to the laceration on the back of his head. PRN (as needed) Tylenol given due to c/o pain. MD and ADON (assistant director of nursing) aware of his arrival. Staples to be removed in 5 days per MD. resident took evening meds w/o (without) complications. Will continue to monitor. Observed in the clinical record was a Change in Condition (SBAR) form dated 09/25/2021 that documented the same information noted in the 9/25/2021 9:00 a.m. progress note and docmented notification to Resident #48's guardian. On 10/05/2021 at 5:34 p.m. during a meeting with the director of nursing (DON) and corporate consultant the above information was discussed. The DON was asked if the information was reported to the State Agency and for the investigation. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/06/2021 at 9:36 a.m., the assistant director of nursing (RN #2) was interviewed regarding the incident. RN #2 was asked if there was an initial investigation and if the fall was reported to the state agency. RN #2 stated, no, I had worked a double shift and had just got home when the licensed practical nurse (LPN) called and notified me of the incident. When I returned to work I didn't complete investigation or notify the State Agency. I know that's not a valid reason not to complete the investigation. The LPN stated she had notified the MD (medical director) and completed the SBAR (change of condition) form and sent [Resident #48] to the ER (emergency room) per MD orders. RN #2 was asked if it was ever determined how Resident #48 sustained the injury. RN #2 stated, no, [Resident #48] is constantly moving. We have to monitor him because he attempts to walk and/or transfer himself alone and he is a fall risk. During my shift he had a good day and didn't have any falls or any incidents. On 10/06/2021 at 10:25 a.m. the director of nursing (DON) was interviewed regarding the injury sustained by Resident #48. The DON stated, no the incident was not reported to the State Agency. I am in the process of reporting it today. The investigation wasn't completed either. I started that on yesterday and will give you a copy of the witness statements. The DON was asked why incident was not reported and why the investigation was not completed. The DON stated, I apologize I was not here and it got overlooked. As soon as it was brought to my attention I started the process . The DON was asked if she was able to determine what caused the injury of unknown origin. The DON stated, no unfortunately not. [Resident #48] is active and moves around a lot. I can't really say what happened to him. The DON was asked if she and/or the administrator were notified of the incident. The DON stated no, I was out of work on sick leave due to shoulder surgery and unfortunately the administrator went out on sick leave for COVID. I feel like my staff did what they were supposed to regarding assessing the resident and reporting it the ADON and MD, who gave orders to send the resident to the ER. However, the ADON failed to complete the additional steps to notify the state agency and start and complete the investigation. The DON was asked to provide the facility's abuse policy. A review of the facility policy titled Abuse, Neglect, Exploitation & Misappropriation (Rev. 11/28/2017) documented the following: 7. Reporting/Response - Any employee contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hors after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials with the State law. In the absence of the Executive Director, the Director of Nursing is the designated abuse coordinator. Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting as required by law . Review of Report: Report all results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken The Abuse Coordinator of The Company will refer any or all incidents and reports of resident abuse to the appropriate state agencies . (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/05/2021 at 2:50 p.m., the above information was discussed during a meeting with the DON and Corporate consultant. The DON provided copies of the facility reported incident (FRI) dated 10/6/2021 sent to the state agency and the witness statements. The LPN and the CNA who provided care for Resident #48 on 09/25/2021 were not available for interview during the survey. No other information was provided to the survey team prior to exit on 10/06/2021 at 5:15 p.m. 21875 2. On 10/6/21 at 10:30 a.m., twenty-five employee records were reviewed for compliance with the facility's pre-employment screening protocols. Ten out of the 25 records reviewed were incomplete with missing sworn statements, reference checks and a criminal background check. Three employees worked from five to twenty months in the facility before criminal background checks were obtained. The thirteen employee records with missing pre-employment screening information included the following listed by hire date. 8/14/19 - no sworn statement, no reference checks 9/27/19 - no criminal background check until 6/3/21 4/03/20 - no reference checks 8/31/20 - no criminal background check until 6/2/21 10/1/20 - no criminal background check performed, no reference checks 12/10/20 - no reference checks 12/15/20 - no sworn statement 1/14/21 - no criminal background check until 6/2/21 5/25/21 - no sworn statement, no reference checks 8/31/21 - no reference checks 9/21/21 - no sworn statement 9/28/21 - (two employees) - no reference checks (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/6/21 at 11:50 a.m., the human resources (HR) coordinator (other staff #6) was interviewed about the missing pre-employment screening information for the identified thirteen employees. The HR coordinator stated she had worked at the facility since April 2021 and had recognized a problem with incomplete pre-employment screening. The HR coordinator stated several of the criminal background checks were late because she had them done when she recognized they were missing. The HR coordinator stated that sometimes there was a delay because staff had not signed permission forms for the background check. The HR coordinator stated she obtained reference checks by telephone for the most recent hires (August 2021, September 2021) but she was unable to find where she documented the calls/references. When asked about the licensed practical nurse hired 10/1/20 that had no criminal background or reference checks, the HR coordinator stated this nurse currently worked prn (as needed). The HR coordinator stated this nurse had not returned the consent for the criminal background check. The HR coordinator stated this employee worked in the facility occasionally since 10/1/20 with the most recent days worked as 9/22/21 and 9/24/21. The facility's abuse prevention policy (N-1265 revised 11/28/17) documented the following concerning employee screening, Persons applying for employment with the center will be screened for a history of abuse, neglect, exploitation of resident property. This includes but not limited to: Employment history . Criminal Background check .Abuse check with appropriate licensing board and registries, prior to hire . Licensure or Registration verification prior to hire .Information from former employers . This finding was reviewed with the director of nursing and regional director of clinical services on 10/6/21 at 2:50 p.m.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40027 Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure an injury of unknown origin was reported to the State Survey Agency and adult protective services for 1 of 18 in the survey sample, Resident #48. Resident #48 was found with a medium size gash to the back of his head of unknown origin requiring 5 staples. The findings include: Resident #48 was admitted to the facility on [DATE] with diagnoses that included infarction, hemiplegia and hemiparesis affecting right dominant side, muscle weakness, dementia with behavioral disturbance, hyperlipidemia, anxiety, hypertension, depression, dysphasia and psychosis. The most recent minimum data set (MDS) dated [DATE] was a quarterly assessment and assessed Resident #48 as severely cognitively impaired for daily decision making with a score of 3 out of 15. Under Section G Functional Status the MDS assessed Resident #48 has requiring limited assistance with one person physical assistance for transfers, ambulation, eating and locomotion; extensive assistance with one person physical assistance for toileting, bed mobility, personal hygiene, and bathing. Under Section J1900. - Falls, the MDS assessed Resident #48 has having one fall with injury since the previous assessment. Resident #48's clinical record was reviewed on 10/05/2021. Observed within the progress notes was the following: 9/25/2021 09:00 Writer was alerted by CNA (certified nursing assistant) that resident had blood on his pillow. Upon assessment a medium size gash was noted to the back of his head. Resident stated I did not fall, the door hit me. [Medical Director] notified and orders were given to send resident to [Hospital] for sutures and evaluation. Resident had no change in LOC (lost of consciousness) . [Ambulance Service] transported resident via stretcher. Facesheet, med orders, bed hold, and care plan all sent with resident. 09/25/2021 19:25 (7:25 p.m.) Resident arrived back to facility around 1530 (3:30 p.m.) via non emergency ambulance on stretcher. He has 5 staples to the laceration on the back of his head. PRN (as needed) Tylenol given due to c/o (complaints of) pain. MD and ADON (assistant director of nursing) aware of his arrival. Staples to be removed in 5 days per MD. resident took evening meds w/o (without) complications. Will continue to monitor. Observed in the clinical record was a Change in Condition (SBAR) form dated 09/25/2021 that documented the same information noted in the 9/25/2021 9:00 a.m. progress note and docmented notification to Resident #48's guardian. On 10/05/2021 at 5:34 p.m. during a meeting with the director of nursing (DON) and corporate consultant the above information was discussed. The DON was asked if the information was reported to the state agency and for the investigation. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/06/2021 at 9:36 a.m., the assistant director of nursing (RN #2) was interviewed regarding the incident. RN #2 was asked if there was an initial investigation and if the fall was reported to the state agency. RN #2 stated, no, I had worked a double shift and had just got home when the licensed practical nurse (LPN) called and notified me of the incident. When I returned to work I didn't complete investigation or notify the state agency. I know that's not a valid reason not to complete the investigation. The LPN stated she had notified the MD (medical director) and completed the SBAR (change of condition) form and sent [Resident #48] to the ER (emergency room) per MD orders. RN #2 was asked if it was ever determined how Resident #48 sustained the injury. RN #2 stated, no, [Resident #48] is constantly moving. We have to monitor him because he attempts to walk and/or transfer himself alone and he is a fall risk. During my shift he had a good day and didn't have any falls or any incidents. On 10/06/2021 at 10:25 a.m. the director of nursing (DON) was interviewed regarding the injury sustained by Resident #48. The DON stated, no the incident was not reported to the state agency. I am in the process of reporting it today. The DON was asked why incident was not reported. The DON stated, I apologize I was not here and it got overlooked. As soon as it was brought to my attention I started the process . The DON was asked if she and/or the administrator were notified of the incident. The DON stated no, I was out of work on sick leave due to shoulder surgery and unfortunately the administrator went out on sick leave for COVID. I feel like my staff did what they were supposed to regarding assessing the resident and reporting it the ADON and MD, who gave orders to send the resident to the ER. However, the ADON failed to complete the additional steps to notify the state agency and start and complete the investigation. The DON was asked to provide the facility's abuse policy. A review of the facility policy titled Abuse, Neglect, Exploitation & Misappropriation (Rev. 11/28/2017) documented the following: 7. Reporting/Response - Any employee contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hors after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials with the State law. In the absence of the Executive Director, the Director of Nursing is the designated abuse coordinator. Once an allegation of abuse is reported, the Executive Director, as the abuse coordinator, is responsible for ensuring that reporting is completed timely and appropriately to appropriate officials in accordance with Federal and State regulations, including notification of Law Enforcement if a reasonable suspicion of crime has occurred. Facility staff should be aware of and comply with their individual requirements and responsibilities for reporting as required by law . Review of Report: Report all results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken The Abuse Coordinator of The Company will refer any or all incidents and reports of resident abuse to the appropriate state agencies . On 10/05/2021 at 2:50 p.m., the above information was discussed during a meeting with the DON and Corporate consultant. The DON provided copies of the facility reported incident (FRI) dated 10/6/2021 sent to the state agency and the witness statements. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No other information was provided to the survey team prior to exit on 10/06/2021 at 5:15 p.m.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29123 Based on clinical record review and staff interview the facility staff failed to accurately completed a PASARR (Preadmission screening) for one of eighteen residents in the survey sample, Resident #46. Findings were: Resident #46 was admitted to the facility on [DATE]. His diagnoses included but were not limited to: Schizophrenia, dementia with behavioral disturbance, alcohol abuse, chronic viral hepatitis, and post traumatic stress syndrome. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/09/2021. Resident #46 was assessed as cognitively intact with a summary score of 15. Resident #46's clinical record was reviewed on 10/05/2021 at approximately 3:00 p.m. There was no PASARR observed in the clinical record. During an end of the day meeting on 10/05/2021 at approximately 5:30 p.m., with the DON (director of nursing) and the corporate nurse consultant, the above information was discussed. The DON stated that she would locate the PASARR. The copy of a PASARR dated 11/26/2018 was presented on 10/06/2021 at approximately 8:00 a.m. The PASARR did not list any mental disorder diagnoses for Resident #46. Resident #46's medical record documented multiple mental illness diagnoses including but not limited to: Schizophrenia, bipolar disorder, major depressive disorder, and post traumatic stress syndrome. The PASARR was shown to the DON on 10/06/2021 at approximately 9:00 a.m., and she was asked who had completed the document. She observed the signature and stated, I'm not sure who that was. It was pointed out to her that the information on the document was not reflective of the diagnoses listed on Resident #46's clinical record. She stated, I will have to look into that. No further information was received prior to the exit conference on 10/06/2021.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29123 Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to develop a comprehensive care plan for four of eighteen residents in the survey sample, Resident #31, #38, #46, and #11. Resident #31 was not care planned for self-administration of an albuterol inhaler; Resident #38 was not care planned for smoking; Resident #46 was not care planned for dental issues; and Resident #11 was not care planned with interventions for an existing pressure ulcer. Findings were: 1. Resident #31 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: Fibromyalgia, depression, respiratory disorder, and chronic ischemic heart disease. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 08/19/2021, assessed Resident #31 as cognitively intact with a summary score of 15. On 10/05/2021 at approximately 8:00 a.m., Resident #31 was observed sitting on her bed. She was wearing oxygen via a nasal cannula at 3 liters per minute. Resident #31 was interviewed about life at the facility and was asked about her oxygen. She stated, I got pneumonia a while back. I didn't wear it before then. Now I get short of breath when I take it off and to walk to the bathroom. My oxygen sats drop .sometimes I wheeze, that's why I have this. Resident #31 held up an albuterol inhaler that was laying on her bed. She stated, The doctor told me to keep it here at my bedside so that's where it is .I use it when I am short of breath or wheezing. Resident #31 was asked how often she used her inhaler. She stated, Whenever I need it .he [her doctor] said I can use it every four hours if I need to. Sometimes it's four hours, sometimes it's longer, sometimes if I'm wheezing I might use it a little before the four hours is up. Resident #31 was asked if she had to get one of the staff to come and help her with the inhaler when she used it or watch her use it. She stated, No, I do it myself, I don't need anybody to help me. She was asked if she had used an inhaler at home or prior to having pneumonia. She stated, No, I never had any problems breathing until then. The clinical record was reviewed at approximately 11:00 a.m. Her care plan did not contain any interventions or references to the self-administration of albuterol. During an end of the day meeting on 10/05/2021 at approximately 5:30 p.m., with the DON (director of nursing) and the corporate nurse consultant the above information was discussed. The DON was asked what was expected to be in place if a resident was keeping medication at her bedside for self administration. She stated, There should be an assessment, a doctor's order, and it should be on the care plan .it should be in the clinical record. The DON stated she would look to see what she could find. On 10/06/2021 at approximately 9:00 a.m., the DON provided information regarding Resident #31. She stated, She did not have anything on her care plan regarding self administration of the inhaler. A copy of the facility policy for self administration of medications was requested and received. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the facility policy, Self-Administration of Medication at Bedside: .Criteria must be met to determine if a resident is both mentally and physically capable of self-administering medication and to keep accurate documentation of these actions Complete the Care Plan for approved self-administered drugs. Self-administration of meds is reviewed by the Care Plan Team with each quarterly review, and when any change in status is noted. No further information was received prior to the exit conference on 10/06/2021. 2. Resident #38 was admitted to the facility on [DATE] and readmitted on [DATE]. His diagnoses included but were not limited to: Diabetes Mellitus, peripheral vascular disease, hypertension, and chronic obstructive pulmonary disease. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/02/2021. Resident #38 was assessed as cognitively intact with a summary score of 15. During the entrance conference to the facility on [DATE] at approximately 6:15 p.m., a list of smokers was requested. Resident #38 was on the list. On 10/05/2021, Resident #38 was observed outside during the morning smoke break at approximately 11:15 a.m. smoking a cigarette. Resident #38's clinical record was reviewed at approximately 1:00 p.m. There were no interventions on the care plan regarding smoking. During an end of the day meeting on 10/05/2021 at approximately 5:30 p.m., with the DON (director of nursing) and the corporate nurse consultant the above information was discussed. The DON was asked what was expected to be in place if a resident was a smoker. She stated, There should be an assessment done quarterly, and it should be on the care plan .it should be in the clinical record. The DON stated she would look to see what she could find. A copy of the facility's smoking policy was requested. On 10/06/2021 at approximately 9:00 a.m., the DON stated, He [Resident # 38] did not have a smoking care plan. We did it today. The facility policy regarding smoking was received and contained the following: During designated smoking times staff will be assigned to assist or supervise residents whose care plans indicate assistance or supervision is required while smoking. No further information was obtained prior to the exit conference on 10/06/2021. 3. Resident #46 was admitted to the facility on [DATE]. His diagnoses included but were not limited to: Schizophrenia, dementia with behavioral disturbance, alcohol abuse, chronic viral hepatitis, and post traumatic stress syndrome. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/09/2021. Resident #46 was assessed as cognitively intact with a summary score of 15. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record was reviewed on 10/05/2021 at approximately 3:00 p.m. Review of the progress note section contained the following information: 09/27/2021 07:14 [a.m.] Resident c/o [complains of] left lower gum/mouth pain. Resident teeth are decayed. Tylenol 650 mg given for c/o pain. MD notified RP [responsible party] aware. 09/27/2021 07:58 [a.m.] MD called with order for Amoxicillin tid [three times per day] X [times] 7 day[s] and arrange for dental consult. The care plan was reviewed. There were no interventions or problem areas listed for dental care or his tooth infection. At approximately 3:45 p.m., Resident #46 was interviewed. He was asked about his tooth infection. He stated, Yeah, they gave me something for it. It was really hurting. He was asked if he had an appointment to see the dentist. He stated, I'm not sure if I have one yet or not. During an end of the day meeting on 10/05/2021 at approximately 5:30 p.m., with the DON (director of nursing) and the corporate nurse consultant the above information was discussed. The DON was asked if Resident #46's care plan should contain information about his tooth decay and pending appointment. She stated, Yes, it should be on there. I will look for it. On 10/06/2021 at approximately 9:00 a.m., the corporate nurse presented a care plan for dental interventions for Resident #46. She stated, We just created this, he didn't have one. She was asked who was supposed to be doing care plans in the facility. She stated, MDS normally does them but she is out. Nursing does them too .nursing should have care planned his dental problems when he went on the antibiotics. No further information was obtained prior to the exit conference on 10/06/2021. 21875 4. Resident #11 was admitted to the facility on [DATE] with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated [DATE] assessed Resident #11 with severely impaired cognitive skills. Resident #11's clinical record documented the resident had ongoing treatment for a pressure ulcer on her right gluteal fold requiring daily dressing changes and wound care. On 10/5/21 at 11:48 a.m., registered nurse (RN) #1 was observed performing a dressing change to Resident #11's gluteal pressure ulcer. The ulcer was irregular shaped and approximately one inch in length and .5 inches wide. The wound depth was superficial and the wound bed was pink/red. Resident #11's plan of care (revised 8/31/21) included no interventions regarding the resident's gluteal pressure ulcer. The care plan listed the resident had a pressure ulcer on the right gluteal fold with goals that included no progression or infection of the wound. The care plan documented no interventions for care or treatment of the wound. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/6/21 at 4:45 p.m., the director of nursing (DON) was interviewed about Resident #11's care plan. The DON stated treatments were in place and the resident had an air mattress for prevention of further ulcers. The DON stated the care plan had been started but not completed. This finding was reviewed with the DON and regional director of clinical services on 10/5/21 at 5:35 p.m.

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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** 40027 Based on observation, staff interview, and clincial record review, the facility staff failed to review and revise a comprehensive care plan for 1 of 18 in the survey sample, Resident #48. Resident #48's care plan was not revised for falls, including an injury of unknown origin. The findings include: Resident #48 was admitted to the facility on [DATE] with diagnoses that included infarction, hemiplegia and hemiparesis affecting right dominant side, muscle weakness, dementia with behavioral disturbance, hyperlipidemia, anxiety, hypertension, depression, dysphasia and psychosis. The most recent minimum data set (MDS) dated [DATE] was a quarterly assessment and assessed Resident #48 as severely cognitively impaired for daily decision making with a score of 3 out of 15. Under Section G Functional Status the MDS assessed Resident #48 has requiring limited assistance with one person physical assistance for transfers, ambulation, eating and locomotion; extensive assistance with one person physical assistance for toileting, bed mobility, personal hygiene, and bathing. Under Section J1900. - Falls, the MDS assessed Resident #48 has having one fall with injury since the previous assessment. Resident #48's clinical record was reviewed on 10/05/2021. Observed within the progress notes was the following: 8/21/2021 18:14 (6:14 p.m.) . Resident s/p (status post) fall day 1 of 3. No pain or distress noted from fall. Resident up in w/c (wheelchair) during shift, at times attempting to walk behind w/c). Resident redirect and assisted back into w/c for safety purposes. No bruising or open areas related to fall noted at this time. 8/23/21 11:25 Fall Meeting Note: Resident observed sitting on the floor by the bedside unable to let staff know what happened due to cognition. Increase in behaviors and unable to be redirected. New intervention Frequent monitoring to ensure safety. MD/RP aware. 8/23/21 12:02 he also had a fall later in afternoon, found on floor up against his drawers. No injuries, no c/o (complaints of) pain, ROM (range of motion) intact. new intervention: Ensure appropriate footwear. MD/RP (responsible party) aware of 2nd fall. 9/13/2021 15:39 (3:39 p.m.) . Resident noted sitting on floor in room. Assisted back into bed. No c/o pain or distress. No skin issues noted. Resident placed on Q (every) 15 min checks, encouraged to use call bell for assistance. Message left for guardian ad litem. MD (medical director) and DON (director of nursing) aware. 9/25/2021 09:00 . Writer was alerted by CNA (certified nursing assistant) that resident had blood on his pillow. Upon assessment a medium size gash was noted to the back of his head. Resident stated I did not fall, the door hit me. [Medical Director] notified and orders were given to send resident to [Hospital] for sutures and evaluation. Resident had no change in LOC (lost of consciousness) . [Ambulance Service] transported resident via stretcher. Facesheet, med orders, bed hold, and care plan all sent with resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/25/2021 19:25 (7:25 p.m.) . Resident arrived back to facility around 1530 (3:30 p.m.) via non emergency ambulance on stretcher. He has 5 staples to the laceration on the back of his head. PRN (as needed) Tylenol given due to c/o pain. MD and ADON (assistant director of nursing) aware of his arrival. Staples to be removed in 5 days per MD. resident took evening meds w/o complications. Will continue to monitor. The clinical record included fall evaluations completed on 8/21/21 and 9/13/2021, both which assessed Resident #48 has a high risk for falls. The 8/21/2021 fall evaluation assessed a score of 65, with interventions of non-skid foot wear and ensuring the call bell was in reach. The 9/13/2021 fall evaluation assessed a score of 80 with an intervention of 15 minute checks. A review of Resident #48's care plans did not include the falls from 08/21/21 and 9/13/21, or the injury of unknown origin on 9/25/21. The care plan did not include the intervention of 15 minute checks. On 10/05/2021 at 5:34 p.m., the above information was discussed during a meeting with the director of nursing (DON) and corporate consultant. The DON was asked who was responsible for updating the care plans. The DON stated the MDS (minimum data set) coordinator nurse was responsible for updating care plans, however she was out sick at this time. The DON was asked how often was Resident #48 monitored. The DON stated, it can vary every 15, every 30 minutes, it just all depends on the particular resident. The DON stated she would review the record and follow-up. On 10/06/2021 at 8:51 a.m., the DON was interviewed regarding the care plans not being updated. The DON stated the MDS coordinator should have updated the care plans. No other information was provided to the survey team prior to exit on 10/06/2021 at 5:15 a.m.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40027 Based on observation, staff interview, and clinical record review, the facility staff failed to ensure care in accordance with the resident's plan of care for 1 of 18 in the survey sample, Resident #27. Resident #27 was not weighed per facility standing orders, and to ensure that she was maintaining weight as directed in her care plan. The findings include: Resident #27 was admitted to the facility on [DATE] with diagnoses that included hypertension, anemia, paraplegia, mild-protein-calorie malnutrition, adult failure to thrive, gastro-esophageal reflux disease (GERD), depression, and dementia with behavioral disturbance. The most recent minimum data set (MDS) dated [DATE] was the annual/comprehensive assessment and assessed Resident #27 has having long and short term memory problems with continuous inattention and behaviors including delusions, rejection of care and behaviors towards others. Resident #27's clinical record was reviewed on 10/05/2021. The weights section of the clinical record documented the last recorded weight as 1/4/2021 129.0 pounds and was entered by the director of nursing (DON). Resident #27's care plan documented, [Resident #27] has nutritional problem or potential nutritional problem r/t (related to) HTN (hypertension), dementia, anemia, history of UTIs (urinary tract infection). Goal: [Resident #27] will maintain adequate nutritional status as evidenced by maintaining weight, no s/sx (signs/symptoms) of malnutrition. (Revision Date: 8/12/2021). Interventions: observe/document report PRN any s/sx of refusing to eat, appears concerned during meals . The care plan documented Resident #27 having behaviors including rejection of care including refusing showers, pocketing medications and spitting them out and yelling and hitting at staff. Neither the care plan nor the clinical record documented Resident #27 refusing to have weights done. On 10/05/2021 at 5:34 p.m. during a meeting with the director of nursing (DON) and corporate consultant the above information was discussed. The DON was asked how often were weights obtained on residents. The DON stated weights were obtained monthly by standing order unless otherwise ordered by the physician more frequently. The DON stated Resident #27 often refused having her weights obtained. The DON was advised there was no refusals documented in the clinical record or on the care plan. The DON stated she would follow-up with additional information. On 10/06/2021 at 8:30 a.m., the DON provided a copy of the Annual Nutritional Evaluation completed on 08/20/2021 by the dietitian. Observed on the evaluation under the weights section was the most recent weight 01/04/2021 129.0 pounds. The evaluation documented the weight history in monthly increments of 1 month, 3 months and 6 months as unknown and documented no weights since 1/4/21 due to resident refusal (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON stated, I checked and you were right there was no documentation on the care plan or clinical record about her refusing weights. Her meal intake documents she has been consistent between 76-100% of each meal. The dietitian and doctor are now aware and we will get an order to d/c (discontinue) the weights due to her refusals. The DON was asked if there was a concern about weight loss. The DON stated, I would think not since her meal intake has been consistent. This should have been done months ago and there should have been some documentation about her refusals. No additional information was provided to the survey team prior to exit on 10/06/2021 at 5:15 p.m.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to perform a pressure ulcer dressing change in a manner to prevent infection for one of eighteen residents in the survey sample, Resident #11. A nurse failed to perform hand hygiene and gloves changes during a dressing change to Resident #11's pressure ulcer. The findings include: Resident #11 was admitted to the facility on [DATE] with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated [DATE] assessed Resident #11 with severely impaired cognitive skills. Resident #11's clinical record documented physician orders dated 9/14/21 with instructions to cleanse the wound, pat dry, apply Santyl ointment and alginate foam dressing daily for treatment of the right gluteal fold pressure ulcer. On 10/5/21 at 11:48 a.m., hospice registered nurse (RN) #1 was observed performing a dressing change to Resident #11's right gluteal fold pressure ulcer. RN #1 entered the room with supplies and without prior hand hygiene, put on clean gloves. RN #1 positioned supplies on the over-bed table, pulled down bed covers and assisted the resident to position on her left side in bed. RN #1 removed the soiled dressing and without removing gloves or performing hand hygiene, proceeded to cleanse the wound with cleanser/gauze. After patting the wound dry with gauze, RN #1 applied Santyl ointment to the wound bed with a cotton-tipped applicator. RN #1 placed the new dressing on the bed, wrote the date and her initials on the dressing and then applied the dressing over the wound. Without removing gloves or performing hand hygiene, RN #1 repositioned the resident in bed and pulled covers over the resident. RN #1 discarded used supplies, removed gloves and then washed her hands prior to exiting the room. On 10/5/21 at 12:00 p.m., RN #1 was asked about glove changes and hand hygiene after removing the soiled dressing. RN #1 stated, We don't do that. On 10/6/21 at 9:03 a.m., the director of nursing (DON) was interviewed about the observed dressing change for Resident #11's pressure ulcer. The DON stated hand hygiene was supposed to be performed prior to any dressing change and glove changes with additional hand hygiene after removing a dirty dressing. The DON stated hand sanitizer was acceptable as long as hands were not visibly dirty. The DON stated the hospice nurses were expected to follow the facility's infection control protocols during dressing changes. The DON stated, They [hospice] should abide by our standards. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Hand Hygiene (revised 2/5/21) documented, The CDC [Centers for Disease Control and Prevention] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e., alcohol-based sanitizer including foam or gel) .Purpose: To reduce the spread of germs in the healthcare setting . This policy documented that hand hygiene should be performed, .before initiating a clean procedure .Before and after patient care .After contact with blood, body fluids, or excretions, mucous membranes, non-intact skin, or wound dressings . When hands are moved from a contaminated-body site to a clean body site during patient care .After glove removal . The [NAME] Manual of Nursing Practice 11th edition on page 843 documents concerning infection prevention, Hand hygiene is the single most recommended measure to reduce the risks of transmitting microorganisms .Hand hygiene should be performed between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles; before donning and after removing gloves is vital for infection control. It may be necessary to clean hands between tasks on the same patient to prevent cross-contamination of different body sites . (1) This finding was reviewed with the DON and regional director of clinical services on 10/5/21 at 5:35 p.m. (1) Nettina, [NAME] M. [NAME] Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/[NAME] & [NAME], 2019.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40027 Based on observation, staff interview, and clinical record review, the facility staff failed to provide adequate supervision and/or services to prevent accidents for 2 of 18 residents in the survey sample, Resident #48 and Resident #11. Resident #48 was not provided adequate monitoring/supervision, sustained an injury of unknown origin on his head that required 5 staples, resulting in harm. Resident #11 was not provided fall mats as required in her care plan. The findings include: 1. Resident #48 was admitted to the facility on [DATE] with diagnoses that included infarction, hemiplegia and hemiparesis affecting right dominant side, muscle weakness, dementia with behavioral disturbance, hyperlipidemia, anxiety, hypertension, depression, dysphasia and psychosis. The most recent minimum data set (MDS) dated [DATE] was a quarterly assessment and assessed Resident #48 as severely cognitively impaired for daily decision making with a score of 3 out of 15. Under Section G Functional Status the MDS assessed Resident #48 as requiring limited assistance with one person physical assistance for transfers, ambulation, eating and locomotion; extensive assistance with one person physical assistance for toileting, bed mobility, personal hygiene, and bathing. Under Section J1900. - Falls, the MDS assessed Resident #48 has having one fall with injury since the previous assessment. Resident #48's clinical record was reviewed on 10/05/2021. Observed within the progress notes was the following: 9/25/2021 09:00 Writer was alerted by CNA (certified nursing assistant) that resident had blood on his pillow. Upon assessment a medium size gash was noted to the back of his head. Resident stated I did not fall, the door hit me. [Medical Director] notified and orders were given to send resident to [Hospital] for sutures and evaluation. Resident had no change in LOC (level of consciousness) . [Ambulance Service] transported resident via stretcher. Facesheet, med orders, bed hold, and care plan all sent with resident. 09/25/2021 19:25 (7:25 p.m.) Resident arrived back to facility around 1530 (3:30 p.m.) via non emergency ambulance on stretcher. He has 5 staples to the laceration on the back of his head. PRN (as needed) Tylenol given due to c/o (complaints of) pain. MD and ADON (assistant director of nursing) aware of his arrival. Staples to be removed in 5 days per MD. resident took evening meds w/o (without) complications. Will continue to monitor. Observed in the clinical record was a Change in Condition form dated 09/25/2021 that documented the same information noted in the 9/25/2021 9:00 a.m. progress note, and documented notification to Resident #48's guardian. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the order summary documented the following orders: Wound Healing every shift for infection for 5 Days Clean the wound with wound cleanser, pat dry and apply bacitracin each shift for 5 days. Order Date: 09/25/2021. Start Date: 09/25/2021. End Date: 09/30/2021 Remove staples to back of head for wound healing 10/01/2021. Order Date: 09/25/2021. Start Date: 10/01/2021. End Date: 10/01/2021 . Resident #48's care plan documented the following: [Resident #48] is at risk for falls r/t (related to) Gait/balance problems, Incontinence, recent CVA, history of falls, Poor communication/comprehension. Date Initiated/Revision Date: 08/04/2020. Goal: Minimize risk of minor injury. Date Initiated 8/4/2020. Revision Date: 08/16/2020. Interventions: Anticipate and Meet [Resident #48] needs. Be sure [Resident #48] call light is within reach and encourage him to use it for assistance as needed. Bed in low position. Ensure that [Resident #48] is wearing appropriate footwear/non-skid socks when ambulating or mobilizing in w/c (wheelchair). Pt (physical therapy) evaluate and treat as ordered or PRN (as needed). A review of the IDT (interdisciplinary team) Fall Team Meeting Notes documented the following: 08/23/2021 12:02. he also had a fall later in afternoon, found on floor up against his drawers. No injuries, no c/o pain, ROM (range of motion) intact. new intervention: Ensure appropriate footwear. MD/RP aware of 2nd fall. 8/23/2021 11:25. IDT Fall Meeting Note: Resident observed sitting on the floor by the bedside unable to let staff know what happened due to cognition. Increase in behaviors and unable to be redirected. New intervention Frequent monitoring to ensure safety. MD/RP aware. Resident #48's care plan was not updated to include the intervention of frequent monitoring to ensure safety from the 8/23/2021 IDT meeting. The clinical record only included resident safety check sheets dated 08/21/2021 through 8/24/2021. A fall risk assessment dated [DATE] assessed Resident #48 as a high risk for falls with a score of 80. The assessment documented Resident #48 with a history of falls, having a weak gait, and overestimating/forgetting his limitations. The assessment documented call bell within reach and Q15 (every 15) minutes check as previous interventions that worked. On 10/05/2021 at 9:15 a.m., Resident #48 was observed self-propelling on the unit near the nurses station in a wheelchair. Resident #48 was observed speaking loud and fast in a foreign language and hitting the nurses station counter, pulling at his pants and attempting to stand up from the wheelchair. Various staff were observed asking the resident what was wrong and to speak in English. Resident #48 was overheard saying, English, Hell no. Staff members redirected Resident #48 and he was taken to his room. On 10/05/2021 at 5:34 p.m. during a meeting with the director of nursing (DON) and corporate consultant the above information was discussed. The DON was asked if the information was reported to the State Agency and for the investigation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/06/2021 at 9:36 a.m., the assistant director of nursing (registered nurse - RN #2) was interviewed regarding the incident. RN #2 was asked if it was ever determined how Resident #48 sustained the injury. RN #2 stated, No, [Resident #48] is constantly moving. We have to monitor him frequently because he attempts to walk and/or transfer himself alone and he is a fall risk. During my shift he had a good day and didn't have any falls or any incidents. RN #2 was asked if the LPN (licensed practical nurse) and CNA who provided care to Resident #48 on 09/25/2021 were available for interview. RN #2 stated, The CNA is scheduled off today and the LPN will come into work at 3 p.m. today. I can see if I can reach them by phone and follow-up with you. On 10/06/2021 at 10:25 a.m. the director of nursing (DON) was interviewed regarding the injury sustained by Resident #48. The DON stated, No the incident was not reported to the State Agency. I am in the process of reporting it today. The investigation wasn't completed either. I started that on yesterday and will give you a copy of the witness statements. The DON was asked why the incident was not reported and why the investigation was not completed. The DON stated, I apologize I was not here and it got overlooked. As soon as it was brought to my attention I started the process . The DON was asked if she was able to determine what caused the injury of unknown origin. The DON stated, no unfortunately not. [Resident #48] is active and moves around a lot. I can't really say what happened to him. There should be resident safety check sheets uploaded in the clinical record. The DON was advised the clinical record only included resident safety check sheets dated 08/21/2021 through 8/24/2021. On 10/06/2021 at approximately 11:45 a.m., the DON was asked to contact the LPN and CNA who provided care to Resident #48 on 09/25/21 for an interview. The DON stated the LPN wasn't feeling well and had called out for her shift and the CNA was already scheduled off; however, she would try to reach them for a phone interview. On 10/06/2021 at 2:50 p.m., the above information was discussed during a meeting with the DON and Corporate consultant. The DON provided copies of the facility reported incident (FRI) dated 10/6/2021 sent to the State Agency and the witness statements. The DON was asked what was considered frequent checks since the clinical record documented frequent checks as an intervention for Resident #48. The DON stated, depending on the resident it can vary between every 15 minutes, 30 minutes, up to an hour. The corporate consultant stated, at least every 2 hours. A review of the resident safety sheets provided were dated for 09/26/2021 through 10/05/2021. There were no sheets provided for 9/24/2021 or 9/25/2021. The sheets included 15 minute interval slots for first, second and third shift. The following dates were not completed for each 15 minute slot for the entire first and second shift: 9/26/21, 9/27/21, and 10/2/21; 10/3/21 was not completed for the entire first shift. There was no documentation in the progress notes, safety sheets, or elsewhere in the clinical record evidencing that the staff had monitored or supervised Resident #48 prior to finding him with the injury to his head on 9/25/2021. A review of the witness statement from the CNA who provided care on 09/25/21 documented the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On the morning of 9/25/21 I went into check on [Resident #48] and he was in his bed sleeping. I noticed blood on his pillow. I then looked at his head and he had a gash in the back of his head. I told the nurse immediately and they proceeded to care for him. A review of the witness statement from the LPN who provided care on 09/25/21 documented the following: I was alerted by the CNA that resident had blood on his pillow. Upon inspection a medium sized gash was noted to back of head, blood on pillow. Resident stated he did not fall & that the door went boom. Writer inspected both the bathroom door & outside room door & found no blood or any other indication that resident was injured by door. Bedroom floor, sink, & bed post were all inspected & also yielded no evidence of blood. Writer contacted ADON & MD, pressure applied to site & resident sent out to [ER]. The LPN and CNA who provided care on 09/25/2021 and wrote the witness statements were not available for interview during the survey. The above findings were discussed during a meeting on 10/06/2021 at 4:38 p.m. with the DON and corporate consultant. The staff were advised of the concerns of harm related to lack of supervision for Resident #48 who was identified as a fall risk and sustained an injury of unknown origin. The DON was asked if the facility had any additional information to present regarding the incident. The DON stated, No I think we have presented all that we have at this time. No other information was presented to the survey time prior to exit on 10/06/2021 at 5:15 p.m. 21875 2. Resident #11 was admitted to the facility on [DATE] with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated [DATE] assessed Resident #11 with severely impaired cognitive skills. Resident #11 was observed in bed on 10/5/21 at 10:50 a.m., 12:00 p.m. and 3:30 p.m. with no protective floor mats on either side of her bed. Resident #11's clinical record documented the resident had experienced previous falls from the bed. A nursing note dated 3/31/21 documented, Found on floor at foot of bed. Resident was on her bottom .Skin tear was observed on her right elbow following fall . A nursing note dated 5/26/21 documented, Writer heard residents roommate calling for help. When writer got to room resident had rolled out of bed on to the floor. Resident was on her stomach. The bed was in lowest position when resident rolled out .redness on residents face and under her left arm near armpit area . (Sic) Resident #11's plan of care (revised 8/31/21) listed the resident was at risk of falls and had experienced actual falls due to dementia and incontinence. Interventions to minimize falls included, .Mat to bilateral sides of bed . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/5/21 at 3:38 p.m., accompanied by certified nurses' aide (CNA) #1 that routinely cared for Resident #11, the resident was observed in bed with no mats in the floor. CNA #1 was interviewed at this time about mats. CNA #1 stated he was not aware the resident required floor mats. CNA #1 stated the resident had a history of falls but had not fallen in awhile. CNA #1 stated he did not recall any recent use of mats with Resident #11. Resident #11 was observed in bed on 10/6/21 at 8:11 a.m. without use of protective floor mats. On 10/6/21 at 8:14 a.m., the registered nurse (RN #2) working on Resident #11's unit was interviewed about the floor mats. RN #2 stated he was not sure about the mats. RN #2 stated the resident had mats in place at one time but he did not know if they were still required. On 10/6/21 at 10:37 a.m., RN #2 stated he checked Resident #11's care plan and the floor mats were supposed to be in place for fall/injury prevention. RN #2 stated, It is care planned. She [Resident #11] should have them [mats]. This finding was reviewed with the director of nursing and regional director of clinical services on 10/6/21 at 2:50 p.m.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, facility document review and clinical record review, the facility staff failed follow infection control practices with placement of urinary catheter bag for one of eighteen residents in the survey sample, Resident #11. Resident #11's catheter bag was observed in the floor beside the resident's bed. The findings include: Resident #11 was admitted to the facility on [DATE] with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated [DATE] assessed Resident #11 with severely impaired cognitive skills.On 10/5/21 at 8:50 a.m., Resident #11 was observed in bed. The resident's urinary catheter bag was in the floor beside the bed on the window side of the room. On 10/5/21 at 10:51 a.m., Resident #11's urine collection bag was again observed in the floor beside the bed. On 10/5/21 at 11:48 a.m., accompanied by hospice registered nurse (RN #1), Resident #11's urinary catheter bag was observed clipped to the bottom sheet on the resident's bed. RN #1 was interviewed at this time about the catheter bag previously in the floor. RN #1 stated she found the bag in the floor when she came in to assess the resident. RN #1 stated she did not find a hook or place to hang the bag so she clipped it to the bottom sheet to get it off the floor. On 10/6/21 at 9:08 a.m., the director of nursing (DON) was interviewed about the catheter bag in the floor. The DON stated the urine collection bag was not supposed to be in the floor and was supposed to be in a privacy bag hanging from the bed rail. On 10/6/21 at 9:36 a.m., the licensed practical nurse (LPN #1) routinely caring for Resident #11 was interviewed about the catheter bag. LPN #1 stated the catheter bag was supposed to be hanging from the bed rail and not in the floor. LPN #1 stated she was not aware of an issue with hanging the bag and she had seen the bag hanging from the bed on previous days. The facility's policy titled Catheter Care, Urinary (revised 9/5/17) documented steps for cleansing/care of the catheter tubing that included, .Remove catheter securement device while maintain connection with drainage tube .Wash perineal area .Rinse well and dry .Clean Catheter tubing with soap and water .Rinse well . Reattach catheter securement device .Return equipment to proper place . These findings were reviewed with the DON and regional director of clinical services on 10/6/21 at 2:50 p.m.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21875 Based on observation, facility document review and staff interview, the facility staff failed to store food in a sanitary manner in the main kitchen. The findings include: On 10/4/21 at 6:25 p.m., accompanied by the dietary manager (other staff #2) the kitchen and food storage areas were inspected. Stored in the dry storage room were the following: one carton of Thick and Easy dairy beverage - opened and not dated; one 46-ounce carton of nectar thick orange juice - opened and not dated; two 46-ounce cartons of thickened apple juice - opened and not dated. The seals on these beverage were punctured and the product partially used from the cartons. These beverages were not refrigerated but were stored in the dry storage room along with unopened cartons of thickened beverages and juices. The manufacturer's label on each of these cartons stated to Refrigerate after opening. On 10/4/21 at 6:30 p.m., the dietary manager was interviewed about the opened, unrefrigerated dairy/juice beverages. The dietary manager stated the opened beverages should have been dated when opened and stored in the refrigerator. The dietary manager stated he did not know why the opened beverages were returned to the dry storage room. The dietary manager stated, I've got a couple of new people. The Food Storage and Retention Guide (reference FDA Food Code 2013) provided by the dietary manager documented supplements and thickened beverages should be stored per manufacturer's guidelines. This finding was reviewed with the director of nursing and regional director of clinical services on 10/5/21 at 5:35 p.m.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29123 Based on staff interview, clinical record review and facility documentation review, the facility staff failed to administer the COVID vaccine in a timely manner to one of 18 residents, Resident #27. Resident #27's Responsible Party consented to administration of the COVID vaccine on 06/04/2021, the vaccine was not given until 09/30/2021. Findings were: Resident #27 was admitted to the facility on [DATE] with the following diagnoses, including but not limited to: hypertension, paraplegia, mild-protein-calorie malnutrition, adult failure to thrive, gastro-esophageal reflux disease (GERD), depression, and dementia with behavioral disturbance. The most recent minimum data set (MDS) with an ARD (assessment reference date) of 08/09/2021 was an annual assessment. Resident #27 was assessed as has having long and short term memory problems with continuous inattention and behaviors including delusions, rejection of care and behaviors towards others. Resident #27's clinical record was reviewed on 10/06/2021 at approximately 10:30 a.m. Observed in the progress note section was the following entry: 06/04/2021 12:01 [p.m.] Spoke with residents RP [responsible party] .regarding the covid 19 vaccine. Risks and benefits education discussed at this time. Consent received to provide either [NAME] or Moderna vaccine. There was no further documentation in the clinical record regarding administration of the vaccine. The MARS (medication administration records) for June, July, August, September, and October were reviewed. There were no entries regarding the administration of the COVID 19 vaccine. The DON was interviewed at approximately 11:30 a.m. regarding whether or not Resident #27 had received the COVID vaccine per her RP's request. The DON stated that she would check with the ADON (assistant director of nursing) and see what she could find. At 11:55 a.m., an interview was conducted with the DON and the ADON. The ADON stated that the resident had refused the vaccine in June when he attempted to give it to her and again in July. He stated, I actually gave it to her last week. The DON and the ADON were told that there was no documentation in the clinical record on the MAR or in the progress notes that the vaccine had been administered. The ADON stated, I have that in my binder. At approximately 2:45 p.m., the ADON presented a handwritten verbal order from the physician for the COVID 19 vaccine: 9/30/2021 @1920 [7:20 p.m.] Administer 1st dose of Pfizer Covid Vaccine 0.3 ml-IM today Pfizer Lot: (lot number) Exp [expires]: 11/30/2021 RBTO [read back telephone order] (followed by the physician and ADON's name). The order was not signed by the physician nor was the order noted indicating the vaccine had been administered as ordered. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON also presented a COVID-19 VACCINE INFORMATION AND CONSENT FORM dated 09/30/2021 and signed by the resident. The Question Have you ever received a dose of COVID -19 vaccine? was marked as No. Underneath that answer the above mentioned vaccine lot number and expiration date were written in. The ADON was asked why the vaccine was not given in June when the RP requested it. He stated, At that time the pharmacy preferred that we have ten vaccines to give before we requested it .the vial is multidose and that kept it from being wasted. He presented a COVID-19 Vaccine Order Form dated 06/23/2021 with Resident # 27's name and nine other names on it. We got the vaccine then, but she refused to take it. He was asked where that was documented. He stated, That wasn't a choice on the form .she refused again in August. He presented a Vaccine Intake Form with Resident #27's name at the top was handwritten Refused 8-11-21. The ADON was asked if there was a consent form that the resident or RP had signed indicating that the vaccine had been refused in August. He stated, We didn't have that choice on the form at the time. The clinical record was again reviewed for evidence that the vaccine had been offered/refused/given. No documentation was observed. The facility policy, COVID-19 Vaccine was obtained and reviewed. Per the facility policy: Documenting COVID -19 Vaccine-Review consent with the staff, resident/resident representative .obtain signature indicating accept of declination .documentation includes, but is not limited to: whether the resident/representative consented or declined vaccine. If consented and administered: Vaccine manufacturers name, dose, location, lot number and expiration date, date of administration, resident monitoring for 72 hours. If declined .reason for declination: Contradiction, refusal, previously obtained outside the center . A meeting was held on 10/06/2021 at 3:10 p.m., with the DON and corporate nurse consultant. The DON was asked about the handwritten order. She stated, That is just the order, it should be noted that it was done and it is not .the order should also be in (name of electronic record), not on paper. She was asked if the electronic system had been down on the day the order was taken. She stated, No, and it should be on the MAR .after the injection we should be monitoring for signs and symptoms of reaction for 3 days, documenting where given the vaccine was given, the type, lot number, expiration date, all of the information. It should also be on the immunization screen in the system. She was told that the Immunization screen still said SARS-COV-2 (COVID-19) (Dose 1) Consent Refused. She stated, That should have been done when it was given .we don't have anything documenting why it wasn't done when requested by the RP or about when it was given. No further information was obtained prior to the exit conference on 10/06/2021.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, facility document review, staff interview and clinical record review, the facility staff failed to inspect a bed frame and mattress for possible entrapment risks for one of eighteen residents in the survey sample. Resident #11's bed, installed with a specialty air mattress for over 5 months, had not been inspected for entrapment risks. The facility's most recent bed inspections had no documented date of completion and did not include all facility beds in use. The findings include: Resident #11 was admitted to the facility on [DATE] with a re-admission on 4/10/21. Diagnoses for Resident #11 included Alzheimer's, hypertension, dementia with behaviors, protein-calorie malnutrition, history of small intestine infarction, dysphagia and urinary retention. The minimum data set (MDS) dated [DATE] assessed Resident #11 with severely impaired cognitive skills. Resident #11's clinical record documented a nursing note dated 4/28/21 stating, Outside vendor arrived at facility at 2130 [9:30 p.m.] to deliver new air mattress. Resident was transferred OOB [out of bed] by staff to wheelchair while new bed was set up .No issues noted with new mattress. On 10/5/21 at 11:48 a.m., Resident #11 was observed in bed with an air mattress in use. On 10/5/21 at 4:37 p.m., the maintenance director (other staff #1) was interviewed about the facility's bed inspection program for entrapment risks. The maintenance director stated he inspected mattresses periodically for cracks and holes and replaced mattress as needed. The maintenance director stated beds were inspected routinely for function, condition and operation and that all beds installed with side rails had inspections for entrapment risks. The inspection for Resident #11's bed with the installed air mattress was requested. On 10/6/21 at 8:23 a.m., the maintenance director stated he checked gaps/measurements for beds/mattresses installed with side rails. The maintenance director stated Resident #11's bed was not a standard bed but was one of several that had been donated to the facility. The maintenance director stated he had no inspections of Resident #11's bed and had not inspected the bed with the specialty air mattress installed for entrapment risks. The maintenance director stated several of the donated beds had been in the facility for months and he did not remember exactly when they were put in use with residents. The maintenance director stated, I haven't gotten to that bed yet. The maintenance director presented a completed bed inspection sheet with measurements for FDA zone 7 (gap between the head and/or footboard and the end of the mattress). The completed form was not dated and listed bed make, model, type, serial number and mattress type. Gap measurements for zone 7 were documented as 2 inches or less. The form did not indicate if the measurements were between the headboard or footboard and the mattress. The list did not include the two beds and/or mattresses in Resident #11's room (Resident #11 and her roommate). The maintenance director presented an inspection list for beds in the facility with side rails dated 2021 that documented measurements for FDA bed zones 1 to 6. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495230	A. Building B. Wing	10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakhurst Health & Rehabilitation	4238 James Madson Highway Fork Union, VA 23055

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no safety inspection performed on Resident #11's bed with a standard mattress and there had been no review for entrapment risks since the bed was installed with an air mattress on 4/28/21. There was no formal policy/protocol regarding bed/mattress inspections and documented bed reviews included undated checklists and did not identify and include several donated beds in use or the beds in Resident #11's room. These findings were reviewed with the director of nursing and regional director of clinical services on 10/6/21 at 2:45 p.m.