STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515186	A. Building B. Wing	08/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluestone Health and Rehabilitation	1600 Bland Street Bluefield, WV 24701

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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 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. 06308 Based on medical record reviews and staff interviews, the facility failed to notify a physician and a resident representative regarding changes in resident's condition. These were random opportunities for discovery and this was true fore Resident #43 and #6. Resident identifiers: #43 and #6 Facility census: 39. Findings included: a) Resident #43 A review of the medical record for Resident #43 on 08/30/21, had a progress note dated 08/09/21 at 1:02 PM regarding the behaviors the resident was exhibiting. The resident representative had been contacted, but there was no indication the physician had been notified of the altered mental status. In an interview with the Nursing Home Administrator (NHA) on 08/30/21 at 10:45 AM, she verified the physician was not notified of a change in condition regarding the behaviors the resident had exhibited. b) Resident #6 An interview with Director of Nursing (DON) #40 at 9:40 a.m. revealed Resident #6 had a fall on 8/2/21. The staff notified the attending physician, but did not contact the emergency/responsible party for the resident to notify them of the fall in the resident's room. Additionally, the DON was not able to show evidence of any notification of the incident from the nursing notes or on the event report. A note indicted this staff will pass along to incoming shift to notify emergency contact. However, the medical record was void of any evidence to indicate this was completed. 31498

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

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

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 31498 Based on medical record review, and staff interview, the facility failed to allow a resident to return to the facility after a hospital discharge. The was true for one (1) of three (3) residents reviewed for the area of hospitalization s during the Long Term Care Survey Process (LTCSP). Resident identifier: #7 Facility census: 39. Findings included: a) Resident #7 On 05/05/21, Resident #7 was discharged to the hospital due to pulling out his hemodialysis catheter. The case management staff at the hospital reported they contacted, Licensed Practical Nurse (LPN) #61 at the facility on 05/06/21 at 4:30 PM to explain Resident #7 would be ready to return after his hemodialysis session was completed. The facility LPN #61 reported they would not re-admit him after 6:00 PM, so both agreed the resident would return to the facility on the morning of 05/07/21. On 05/07/21 at 10:30 AM, the case management representative at the hospital was informed the facility was not going to re-admit the resident due to not having enough staff and beds. A review of the nursing schedule for 05/07/21 had the facility census at 38 with two (2) Registered Nurses (RN), two (2) Licensed Practical Nurses (LPN), and five (5) Nursing Assistants (NA) for the day shift-6 AM to 2 PM. In an interview with the Director of Nursing (DON) on 08/31/21 at 9:45 AM, she verified there was enough staff and beds available to re-admit Resident #7 on 05/07/21.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 39043 Based on record review and staff interview, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment was completed when required. This failed practice had the potential to affect one (1) of 20 sampled residents reviewed during the long-term care survey process. Resident Identifier: #10. Facility census: 39. Findings included: a) Resident #10 Review of Resident #10's medical records showed the resident had begun receiving hospice services on 03/14/21. Further review of the medical records showed hospice services were discontinued for Resident #10 on 06/25/21. No significant change MDS assessment was found in the resident's electronic health record after hospice services were discontinued. On 08/24/21 at 10:30 AM, the MDS Assessment Coordinator Registered Nurse confirmed Resident #10 did not have a significant change MDS assessment completed when hospice services were discontinued.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31498 Based on medical record reviews and staff interviews the facility failed to timely submit Minimum Data Sets (MDS) for tracking, a discharge tracking MDS for Resident #7 and a death in the facility MDS for Resident #1. This was true for two (2) of 20 sampled residents reviewed during the Long Term Care Survey Process. Resident identifiers: #7 and #1 Facility census: 39 Findings included: a) Resident #7 A medical record review on [DATE] for Resident #7 revealed an MDS had not been submitted timely when Resident #7 was discharged to an acute care hospital on [DATE]. In an interview with the MDS Coordinator on [DATE] at 9:45 AM, she verified there was no MDS completed when Resident #7 was discharged to the hospital on [DATE]. b) Resident #1 Review of Resident #1's medical records showed the resident had expired on [DATE]. No death in the facility tracking MDS assessment was located in the resident's electronic health record. On [DATE] at 11:14 AM, the MDS Assessment Coordinator Registered Nurse confirmed a death in the facility tracking MDS assessment had not been completed after the resident's death. No further information was provided through the completion of the survey. 39043

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Honor each resident's preferences, choices, values and beliefs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31520 Based on observation, medical record reviews and staff interviews, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for all residents residing on third (3rd) floor. Failure to deploy licensed nurses (RN's and/or LPN's) to provide initial and ongoing assessments of the clinical needs of the residents including any acute changes in condition, such as cardiac/respiratory failure, choking, hemorrhaging, poor glycemic control, onset of delirium, behavioral emergencies, or falls resulting in head injuries or fractures, and failure to deploy staff to provide ongoing monitoring and supervision of staff to assure the implementation of the care plan as written. This deficient practice put the 6 out of 9 residents on third (3rd) floor at risk for serious injury, serious harm, serious impairment, or death. Resident identifiers: #13, #15, #31, #23, #2 and #8. Facility Census: 39. The state agency determined these failures placed Residents #13, #15, #31, #23, #2 and #8. in an immediate jeopardy situation due to the lack of deployment of adequate license nurses (RN's and/or LPN's) to assess and treat any acute changes in condition, such as cardiac/respiratory failure, choking, hemorrhaging, poor glycemic control, onset of delirium, behavioral emergencies, or falls resulting in head injuries or fractures. The state agency notified the Nursing Home Administrator of the immediate jeopardy at 7:27 PM on [DATE]. The facility submitted an abatement plan of correction (APOC) at 8:27 PM on [DATE]. The state agency requested changes and an additional APOC was submitted at 8:53 PM on [DATE]. At 8:58 PM on [DATE], the APOC was accepted by the state agency. The state agency verified the APOC was implemented, and the immediate jeopardy was abated at [DATE] at 9:41 PM. Once the immediate jeopardy was abated, deficient practices remained, and the scope and severity were decreased from a K to an E. Date/time IJ was called at 7:27 PM on [DATE]. Date IJ started on [DATE]. Date Abatement POC approved at 8:53 PM on [DATE]. Date/time IJ was abated at 9:41 PM on [DATE] The plan of correction stated as follows: --The facility failed to deploy staff to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for all residents residing on third (3rd) floor. --Social Worker (SW) to contact residents and their families to inform of room moves to occur tonight. --Residents on third floor will be moved to the first floor immediately. --RN will be staffed on the 3rd floor until all residents are moved. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bluestone Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Bland Street Bluefield, WV 24701	

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--No residents will be placed on 3rd floor unless facility has adequate staffing. Findings included: a) Review of the Licensed nurse staffing schedule Review of the assignment sheet for [DATE] found the building has three (3) floors: First floor had nineteen (19) residents; second floor had eleven (11) residents, and third floor had nine (9) residents. First floor had a licensed nurse full time; the second and third floor had one (1) nurse who is responsible for all care and services provided to both second and third floors. A review of the licensed nurse, nursing schedule provided by the facility from [DATE] to [DATE] found the following: 1. Review of the nurse schedule for [DATE] to [DATE] from 6:00 AM to 6:00 PM On the following days the facility had 2 nurses scheduled to work all three (3) floors from 6:00 AM to 6:00 PM: [DATE], and [DATE]. On [DATE] the facility scheduled 2 nurses to work all three floors from 6:00 AM to 6:00 PM. A third nurse was scheduled to work from 2:00 PM to 10:00 PM. On the following days the facility had one (1) nurse scheduled to work all three (3) floors from 6:00 AM to 6:00 PM: [DATE], [DATE], and [DATE]. Between [DATE] through [DATE], there were 38 days out of 41 days were the facility only had 2 licensed nurses working to cover residents living on 3 floors of the nursing facility from 6:00 AM to 6:00 PM. In addition, the other 3 days in the review period only had 1 licensed nurse scheduled to work all 3 floors from 6:00 AM to 6:00 PM. No more than one Nurse Aide was present on the 3rd floor during the survey. 2. Review of the nurse schedule for [DATE] to [DATE] from 6:00 PM to 6:00 AM On the following days the facility had 2 nurses scheduled to work all three (3) floors from 6:00 PM to 6:00 AM: [DATE], and [DATE]. On [DATE] the facility scheduled 2 nurses to work all three floors from 6:00 AM to 6:00 PM. A third nurse was scheduled to work from 2:00 PM to 10:00 PM. On the following days the facility had one (1) nurse scheduled to work all three (3) floors from 6:00 PM to 6:00 AM: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The nursing schedule for the 3rd floor provided by the facility reflected no nurses were scheduled to work from 6:00 PM to 6:00 AM on [DATE]. Between [DATE] through [DATE], there were 39 days out of 41 days were the facility only had 2, 1 or no licensed nurses working to cover residents living on 3 floors of the nursing facility from 6:00 PM to 6:00 AM. A nursing schedule for the remaining days in [DATE] was requested but never provided; however, observations proved similar staffing patterns continued through [DATE]. An interview with the nursing home administrator on [DATE] at 7:27 PM confirmed residents were moved to the third floor on [DATE]. As of [DATE] the facility had residents residing on all three (3) floors of the facility. Surveyors could not ascertain the actual staffing levels for the 3rd floor as the facility could not produce assignment sheets or the entire schedule. During the interview with the administrator, she was unable to answer the question about the schedule. No more than one Nurse Aide was present on the 3rd floor during the survey. b) Emergency Crash Cart Observation on [DATE] at 9:30 AM of the emergency cart (crash cart) used for choking and emergency first aid as well as CPR was unable to be opened; no license nurse (RN/LPN) was on the floor to verify the contents of the cart. (A crash cart is used to provide treatment for patients in cardiac arrest until EMS arrives and contains an emergency kit for chocking and bleeding). The emergency crash cart was located on the 3rd floor next to the nurse's station. Observations on third floor on [DATE] from 11:15 AM to 11:50 AM revealed no licensed nurse (RN and/or LPN) was present for 35 minutes. From 11:53 AM to 12:05 PM there was no licensed nurse (RN/LPN) was on the third floor for 12 minutes. At 12:30 PM the nurse left the third floor via the elevator. At 12:25 PM on [DATE], it was determined the crash cart was unable to be accessed due to the lack of knowledge by staff on how to open the cart. LPN #90 did not know how to unlock the emergency crash cart. This was confirmed by the Director of Nursing (DON) on [DATE] at 1:20 PM. The observed timeline for getting the emergency crash cart open on [DATE] found: --11:50 am LPN #90 came to the floor and surveyor asked her to unlock the emergency crash cart. She was unable to open the cart and stated, I think the keys to this cart is downstairs on second floor. --11:53 am LPN #90 left the floor to get keys. --12:05 pm LPN #90 returned to floor and met with Hospice personnel evaluating Resident #13 for about 5 minutes and at 12:10 pm attempted to get in the crash cart to no avail. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--12:10 pm LPN called on the phone to have the DON to come and assist her in opening the emergency crash cart. --12:22 pm NA #83 stated she thought there was a button to push or slide on the drawers. At this time LPN #90 and the surveyor were able to open the drawers. --From 11:15 am till 12:22 pm the facility was unable to access the emergency cart. The crash (emergency) cart supplies are PPE, gloves, gown, face masks, non-rebreather mask, nasal cannula, venti-masks. First aid- alcohol swabs, abdominal pads, band aids, Coban wrap, normal saline, gauze, bodily fluid spill kit, Sani-cloths, bio-hazard bags, and red biohazard bags, Ambu- bag and suction machine and tubing. This is the only source of supplies located on third floor. Six (6) of nine (9) residents on the 3rd floor are Full Code Residents #2, #23, #13, #15, #8 and #31. If an emergency arises and no licensed nurses are on the floor, nurse aides must go to the nurses' room to call for assistance. The licensed nurse must reach the floor by elevator or two flights of stairs. This failure created an immediate jeopardy situation for all residents on the 3rd floor, and also for those who may require treatment from the crash cart. c) Resident #8 Review of the care plan revealed the following problems Resident #8 was care planned for: --Full code status --One occurrence of behavior of touching another female resident in private areas --History of verbally abusive/aggressive behavior, including cursing towards others. --Resident will curse and yell at another resident that wanders by his room or if they go into his room by mistake --Resident feels he must fight for his life and is unable to be redirected at times. --Resident has had behaviors becoming physically aggressive, including punching EMT staff. --Resident has actual behavior problem: Resident has exhibited sexually inappropriate such as trying to grab and touch female staff and one instance of this behavior towards another resident. --Potential for injury falls related to general weakness and declining gait. --Inability to maintain health state independently related to muscle weakness and chronic fatigue. --Bathing requires the assistance of 1 person, he likes to do his own daily care, and prefers showers 3 days a week. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--Resident requires the assistance of 1 person for dressing. --Resident is continent of bladder/bowel, uses bathroom, uses bathroom/urinal independently. Review of the current quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] gave the following information: --BIMS (Brief Interview for Mental Status) of 15 which indicated cognitively intact. --Independent for all activities of daily living (ADL) except for walking in corridor which did not occur during the quarter. --Required set up assistance for dressing, eating, and personal hygiene. --Required supervision of one for bathing. Observation of Resident #8 in hallway on first floor in his wheelchair on [DATE] at 1:00 PM found him yelling at Resident #14, who has been noted to wander in the hallways throughout the survey. The staff redirected Resident #8 away from Resident #14 and told Resident #8 that Resident #14 was permitted in the hallway. Resident #8 was moved from first floor to third floor on [DATE], to room [ROOM NUMBER] after having an episode of inappropriate touching of Resident #16 on [DATE]. Resident #8 was to be on every fifteen (15) minute checks after the inappropriate touching of Resident #16. Multiple observations on [DATE] at 9:35 AM, [DATE] at 11:15 AM to 12:30 PM, [DATE] at 2:20 PM found Resident #8 was mobile and freely moving about the third floor without any staff supervision. The facility failed to provide evidence Resident #8 was being checked every 15 minutes. Due to the facility's failure to provide adequate nursing staffing on the third floor, this placed Resident #8 and other residents in his environment at immediate jeopardy due to: --Resident #8 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. --Resident #8 was potentially a risk to other residents due to his history of sexually inappropriate behavior and the one recent incident of being sexually inappropriate with another resident. --Resident #8 had physically aggressive behaviors that have resulted in him punching an EMS worker. --Resident #8 is care planned for fall risk due to general weakness and declining gait. If the resident were to fall, the lack of nursing would delay identification of the fall and the need for immediate medical assistance. -Resident #8 has wandering behavior and is on 15 minute checks. There was no evidence in the documentation or in observations that these checks were occurring. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d) Resident #2 Review of the care plan included the following problems: --The resident had actual/history of/potential for behavior(s): refusing to take medications at times. --She can become frustrated and yell at staff. --She frequently states she wants to leave facility. --Resident is forgetful and will at times ask for a different meal to eat and when brought to her, she will state that she never asked for that. --She will keep food containers and food items that are on her tray such as milk, syrup containers, etc. ----- Behaviors maybe related to dementia/other diagnoses/issues. --Actual behavior problem was wandering related to dementia with mental behavioral disorders. --Inability to maintain health state independently related to personal history of other mental and behavioral disorders with a history of convulsions --Potential for injury falls related to dementia with general weakness and history of convulsions. Also, will throw self in floor. --Potential for seizure activity. Diagnosis of convulsions. --Resident not to have knives on meal trays. Review of the most recent Quarterly MDS with ARD [DATE] gave the following information: --BIMS score of 11 which indicated the resident is moderately cognitively impaired. --Independent for all ADLs except locomotion off unit occurred only once or twice and required limited assistance of one person for personal hygiene. --For bathing required supervision. --Occasionally incontinent of urine and bowel. Due to the facility's failure to provide adequate nursing staffing on the third floor, this place Resident #2 at immediate jeopardy due to: --Resident #2 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 3:41 PM, the DON verified Resident #13's oxygen concentrator was set on three (3) liters per minute and she confirmed the oxygen order was for two (2) liters per minute. Review of the care plan for Resident #13 found the following problems: --Resident has behaviors that include screaming, cursing, or throwing items during activities, often occurs when resident doesn't win a game or contest; also, episodes of throwing items in hall or at staff if she becomes angry or upset. --Impaired expressive or receptive communication related to a diagnosis of intellectual disability and dementia. --Resident may miss part of message. Resident at times misinterprets other resident's communication and behaviors which causes resident to act out verbally along with becoming physically threatening. --Resident is on anti-psychotic medication for behaviors. History of gradual dose reduction failures due to behaviors starting again or increasing. --Resident has a BIMS score of 11 score which indicated the Resident is moderately cognitively impaired --Resident requires extensive assist of one person with bathing, dressing, bed mobility, transfers, and toileting. Due to the facility's failure to provide adequate nursing staffing on the third floor, this place Resident #13 at immediate jeopardy due to: --Resident #13 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. h) Resident #31 Review of the care plan for Resident #31 included the following problems: --Inability to maintain health state independently related to weakness and history of CVA. --Resident has a potential for injury falls related to muscle weakness, difficulty walking requires one assist. --Resident noted to have a fall on [DATE], slid from bed while attempting to transfer. Resident had been educated on calling for assistance for transfers. Resident moved closer to nursing station. Review of the comprehensive MDS with an ARD of [DATE] found the following: --Resident #31 had a BIMS score of 6 which indicated severe cognitive impairment --Required extensive assistance with one-person physical assist for dressing, toilet use, and personal hygiene. (continued on next page)

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	515186	A. Building B. Wing	08/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluestone Health and Rehabilitation	1600 Bland Street Bluefield, WV 24701

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--Required limited assistance with one-person physical assistance for bed mobility and transfer. --Resident is always continent. Due to the facility's failure to provide adequate nursing staffing on the third floor, this place Resident #31 at immediate jeopardy due to: --Resident #31 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. --Resident #31 was at risk and care planned for falls. As a result he was moved closer to the nurses station, however, the lack of nursing did not increase his level of safety from falling. If the resident were to fall, the lack of nursing would delay identification of the fall and the need for immediate medical assistance. i) Resident #23 Review of the care plan found the following problems: --The resident had a history of and currently exhibited verbally abusive behavior when staff ask her about getting a shower or getting out of bed. --She stated that she wants staff to die, called them names, stated they were demons which is related to a psychotic disorder with hallucinations. --The resident's behaviors occur at least once a week, especially when she is asked if she wants to get a shower or if she is asked to get out of bed. --Resident has a history of stating she wanted to harm herself with a soda can. Resident has stated she wanted to harm herself because she wanted to leave the facility. --Inability of maintain health state independently related to decreased mobility. --History of falls prior to admission related to muscle weakness and debility. Review of the recent quarterly MDS with an ARD of [DATE] gave the following information: --Resident has a BIMS score of 15 which indicated the resident was cognitively intact. --Required extensive assistance with one-person physical assist for bed mobility, dressing, and personal hygiene. --Required extensive assistance with two or more persons physical assist for transfer and toilet use. --Required total dependence with assistance of one person for locomotion on unit. --Required physical assistance of one person for bathing. (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--Frequently incontinent of urine and stool. Due to the facility's failure to provide adequate nursing staffing on the third floor, this place Resident #23 at immediate jeopardy due to: --Resident #23 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. --Resident #23 had a history of making suicidal ideations and wandering. She was care planned for not having knives on meal trays and to make sure she did not keep items from her food tray. --Resident #23 had a history of falls due to decreased muscle weakness and debility. If the resident were to fall, the lack of nursing would delay identification of the fall and the need for immediate medical assistance.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 31498 31520 39043 Based on record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice. The facility failed to follow physician's orders for fingerstick blood glucose monitoring and insulin coverage. This failed practice had the potential to affect four (4) of six (6) residents receiving insulin medications. Resident identifiers: #10, #22, #29, #5. Facility census: 39. The state agency determined these failures placed Residents #10, #22, #29, #5 in an immediate jeopardy situation due to potential complications from hyperglycemia or hypoglycemia resulting from failure to follow the physician's orders. The state agency notified the Nursing Home Administrator of the immediate jeopardy at 6:08 PM on 08/24/21. The facility submitted an abatement plan of correction (APOC) at 7:35 PM on 08/24/21. The state agency requested changes and an additional APOC was submitted at 7:52 PM on 08/24/21. At 8:50 PM on 08/24/21, the APOC was accepted by the state agency. The state agency verified the APOC was implemented, and the immediate jeopardy was abated at 08/30/21 at 2:00 PM. Once the immediate jeopardy was abated, deficient practices remained, and the scope and severity were decreased from a K to an E. Date/time IJ was called at 6:08PM on 08/24/21. Date IJ started on 07/17/21. Date Abatement POC approved at 8:50 PM on 08/24/21. Date/time IJ was abated at 2:00 PM on 08/30/21 The plan of correction stated as follows, the facility's failure to follow the physician's orders for diabetic management. --The Quality Assurance Registered Nurse (QA RN) will review all diabetic orders and all finger sticks for accuracy. This will be completed 8/24/21. --Education on diabetic management and following physician ordered parameters prior to administering insulin to be provided to all licensed nurses by 8/27/20 by QA RN or designee. --QA RN or designee will review all finger sticks and insulin administrations for accuracy daily x 30 days, then weekly thereafter. --Practitioner will review medications and finger sticks on 8/25/2021 then monthly thereafter for all residents receiving insulin. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A deficient practice remained when the facility failed to follow physician's orders for laboratory testing for one (1) of five (5) residents reviewed for the care area of unnecessary medications. The facility also failed to follow medication orders. This was a random opportunity for discovery that had the potential to affect one (1) of 20 residents reviewed during the long-term care survey process. Additionally, the facility failed to obtain a discharge order from the physician for one (1) of three (3) residents reviewed for the care area of hospitalization . Resident identifiers: #42, #15, #43. Facility census: 39. Findings included: a) Resident #10 Review of Resident #10's physician's orders revealed an order written on 07/22/21 for Humalog Insulin, 5 units subcutaneously before meals, hold if the fingerstick blood sugar was less than 140. Resident #10's Medication Administration Record (MAR) from 07/26/21 to present was reviewed. On the following dates and times, Resident #10's MAR documented the resident's fingerstick was less than 140, and insulin was administered despite the parameter to hold: --08/02/21 at 7:00 AM, for fingerstick blood glucose of 110 --08/04/21 at 11:00 AM, for fingerstick blood glucose of 121 --08/09/21 at 7:00 AM, for fingerstick blood glucose of 124 --08/13/21 at 5:00 PM, for fingerstick blood glucose of 122 --08/14/21 at 5:00 PM, for fingerstick blood glucose of 137 --08/15/21 at 5:00 PM, for fingerstick blood glucose of 130 --08/13/21 at 5:00 PM, for fingerstick blood glucose of 108 On 08/10/21 at 11:00 AM, Resident #10's insulin was held for fingerstick blood glucose of 148, despite the parameters to give. On 08/24/21 at 10:01 AM, the above findings were reviewed with the Director of Nursing (DON). The DON had no additional information regarding the matter. The failure to follow the physician parameters for holding or giving insulin placed this resident at immediate jeopardy for hyperglycemia and hypoglycemia events. The immediate risk of low blood sugar (hypoglycemia) can lead to severe confusion and disorientation, seizures, loss of consciousness, coma, even death. The immediate risk of hyperglycemia (high blood sugar) can cause long-term complications, including problems in the extremities (hands and feet), bone and joint problems, nerve damage, blindness, kidney failure, and cardiovascular disease. b) Resident #22 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #22's physician's orders revealed the following insulin orders: --Novolog Insulin, 5 units subcutaneously at 7:00 AM (with no parameters), ordered 7/14/21 --Novolog Insulin, 8 units subcutaneously at 11:00 AM and 5:00 PM, hold for fingerstick blood glucose less than 140, ordered 07/14/21 --Lantus Insulin, 20 units subcutaneously at bedtime (with no parameters), ordered 03/10/21 Resident #22's MAR from 07/26/21 to present was reviewed. At 7:00 AM on the following dates, Resident #22's insulin was held despite no parameters to do so. --07/27/21 for fingerstick blood glucose of 104 --07/29/21 for fingerstick blood glucose of 103 --07/30/21 for fingerstick blood glucose of 125 --07/31/21 for fingerstick blood glucose of 73 --08/01/21 for fingerstick blood glucose of 86 --08/06/21 for fingerstick blood glucose of 62 --08/07/21 for fingerstick blood glucose of 115 --08/08/21 for fingerstick blood glucose of 98 --08/12/21 for fingerstick blood glucose of 92 --08/13/21 for b fingerstick blood glucose of 106 --08/14/21 for fingerstick blood glucose of 98 --08/15/21 for fingerstick blood glucose of 88 --08/18/21 for fingerstick blood glucose of 101 --08/19/21 for fingerstick blood glucose of 72 --08/20/21 for fingerstick blood glucose of 113 --08/22/21 for fingerstick blood glucose of 102 On the following dates and times, Resident #22's MAR documented the resident's fingerstick was less than 140, and insulin was administered despite the parameter to hold: --07/28/21 at 5:00 PM, for fingerstick blood glucose of 126 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--08/20/21 at 5:00 PM, for fingerstick blood glucose at 117 On 08/24/21 at 2:53 PM, the above findings were reviewed with the DON. The DON confirmed Resident #22 did not have an order to hold the 7:00 AM insulin dose for blood glucose level less than 140. The DON also confirmed Resident #22 received insulin the other two (2) times when the resident's blood glucose was less than 140. The failure to follow the physician parameters for holding or giving insulin placed this resident at immediate jeopardy for hyperglycemia and hypoglycemia events. The immediate risk of low blood sugar (hypoglycemia) can lead to severe confusion and disorientation, seizures, loss of consciousness, coma, even death. The immediate risk of hyperglycemia (high blood sugar) can cause long-term complications, including problems in the extremities (hands and feet), bone and joint problems, nerve damage, blindness, kidney failure, and cardiovascular disease. c) Resident # 29 Resident #29 was admitted on [DATE] with an order for Basaglar KwikPen (insulin) U-100 insulin to administer: 10 units; subcutaneous. Hold if blood sugar is less than 110. On the following dates and times, Resident # 29's MAR documented the resident's fingerstick was less than 110, and insulin was administered despite the parameter to hold: On 07/17/2021 at 4:15 PM, the blood sugar was 83 and Resident # 29 received 10 units of Basaglar (insulin) and should have been held. On 07/24/2021 at 5:25 PM, Resident # 29 was given Basaglar (insulin) 10 units when her blood sugar was 103 and should have been held. On 08/23/2021 at 6:30 PM Resident # 29 was given Basaglar (insulin) 10 units when her blood sugar was 109 and should have been held. Resident #29's blood sugars were not obtained on the following days: 07/21/21, 07/25/21, 07/26/21, 07/27/21, 07/28/21, 07/29/21, 07/30/21, 07/31/21, 08/01/21. The resident received Basaglar 10 units on every occasion mentioned above even through the blood sugars were not obtained. During an interview on 08/24/2021 at 6:30 PM, the Director of Nursing (DON) confirmed the staff failed to follow the physicians' orders to check the blood sugar before administering the insulin and to hold if below 110. She stated, she has no idea why it was not done. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The failure to follow the physician parameters for holding or giving insulin placed this resident at immediate jeopardy for hyperglycemia and hypoglycemia events. The immediate risk of low blood sugar (hypoglycemia) can lead to severe confusion and disorientation, seizures, loss of consciousness, coma, even death. The immediate risk of hyperglycemia (high blood sugar) can cause long-term complications, including problems in the extremities (hands and feet), bone and joint problems, nerve damage, blindness, kidney failure, and cardiovascular disease. d) Resident #5 Review of Resident #5's medical record found a physician order written on 05/26/21 for Insulin lispro solution- administer 10 units subcutaneous three times a day before meals at 7:00 am, 11:00 am and 5:00 PM for treatment of diabetes mellitus. An additional order was written on 05/26/21 for Lantus 30 units subcutaneous at 7:00 am daily. No order for fingersticks was found. Review of the August 2021, Medication Administration Record (MAR) for Resident #5 found the licensed nurses were obtaining a fingerstick at 7:00 am, 11:00 am and 5:00 PM without an order. On the following dates and times the Lispro 10 units was held on three (3) occasions without an order and no physician notification: 08/05/21 at 5pm- fingerstick was 68 08/06/21 at 5 PM - fingerstick was 76 08/14/21 at 5 PM- fingerstick was 84 On 08/24/21 at 3:30 PM, the above findings were reviewed with the DON. The DON confirmed Resident #5 did not have an order to obtain fingersticks and he did not have an order to hold the Lispro on 08/05/21, 08/06/21 and 08/14/21. The failure to follow the physician parameters for holding or giving insulin placed this resident at immediate jeopardy for hyperglycemia and hypoglycemia events. The immediate risk of low blood sugar (hypoglycemia) can lead to severe confusion and disorientation, seizures, loss of consciousness, coma, even death. The immediate risk of hyperglycemia (high blood sugar) can cause long-term complications, including problems in the extremities (hands and feet), bone and joint problems, nerve damage, blindness, kidney failure, and cardiovascular disease. e) Resident #42 Review of Resident #42's medical records revealed an order for laboratory tests, albumin and Keppra levels, to be performed on 08/02/21. Abnormal albumin levels may indicate kidney or liver problems or malnutrition. Keppra is a medication given for seizures, and levels are monitored to ensure a therapeutic, but not toxic, medication level has been obtained. Resident #42's electronic health record (EHR) contained no results for albumin and Keppra levels performed on 08/02/21. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/25/21 at 1:06 PM, the Director of Nursing (DON) confirmed laboratory testing for albumin and Keppra levels had not been performed on 08/02/21 as ordered by the physician. No further information was provided through the completion of the survey. f) Resident #15 Review of Resident #15s electronic medical records found an order for Morphine Extended-Release (ER) 15 milligrams (mg) twice daily for pain. Further review found handwritten prescriptions dated 04/14/21 through 08/01/21, by Resident #15's attending physician for Morphine Extended-Release (ER) 15 milligrams (mg) three times daily. Dispense #90 tablets. An interview with the Director of Nursing on 08/30/21 at 1:30 PM, verified the handwritten prescription by Resident #15's attending physician were for Morphine three times a day although the electronic medical records was for twice daily. She confirmed the electronic medical record was inaccurate. g) Resident #43 A medical record review on 08/30/21 for Resident #43, revealed no order had been obtained to discharge the resident to a local hospital for treatment on 08/09/21 at 1:02 PM. Resident #43 had exhibited behaviors, which the staff was unable to manage so he was transferred to a emergency room for evaluation. In an interview with the Nursing Home Administrator (NHA) on 08/30/21 at 3:10 PM, she reported she was unable to locate the order to transfer Resident #43 to the local hospital for treatment on 08/09/21. 39571

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39043 Based on record review and staff interview, the facility failed to perform a post-fall root cause analysis to deter future falls. This failed practice had the potential to affect one (1) of five (5) residents reviewed for the care area of falls. Resident identifier: #18. Facility census: 39. Findings included: a) Resident #18 Review of Resident #18's medical records revealed the resident experienced a fall on 06/26/21. The nursing progress note written on 06/26/2021 at 1:40 PM stated, Resident had a fall at 1:20 pm and got a 2.5 in [inch] skin tear on her left forearm. No other injuries reported, vital signs all within normal limits. BP [blood pressure] 105/65, hr [heart rate] 99, o2 [oxygen saturation] 98 tp [temperature] 97.6, resp [respirations] 20 and no pain. FNP [family nurse practitioner] [name redacted] ordered site to be dressed with non adherant [sic] dressing and wrapped if needed. No neuro [neurological] checks needed since resident did not hit her head at all. Emergency contact telephoned at this time to let them know. Resident's son was agreeable with treatment ordered. An event report was initiated at 06/28/21 at 12:43 PM. The event report contained the description, Resident to have fall and received skin tear to left forearm. Neurochecks not initiated related to resident not hitting head. The event report also stated, Falls require a Root Cause Analysis to determine How, Why, When and Where a fall occurred. Descriptive information is required of what occurred at the time of the fall to complete this process and develop a Plan of Care to deter future falls and prevent injury. This section was not completed on the event report, and included the following items: - Date/time of fall - History of falls in the last three months - If the fall was witnessed and by whom - Location of fall - If the resident reported being hungry, in pain, bored, or needing to go to the bathroom - What the resident was doing just prior to the fall - If appropriate footwear was on and in good condition or need of repair - If adaptive equipment was in use at the time of the fall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- If equipment was alarming at the time of the fall - Resident's usual ambulatory status - Mental status prior to the fall - Other possible contributing factors, such as dehydration, fever, recent change in activities of daily living abilities, medications, poor lighting, recent room move, acute illness, impaired gait and weakness, muscular weakness, impaired vision, poor safety awareness, improper use of assistive device, obstacles or tripping hazards, chronic medical conditions, postural hypotension, clutter. During an interview on 08/30/21 at 2:16 PM, the Director of Nursing (DON) stated she had initiated the event report on 06/28/21 because the nurse had not done so at the time of the fall. She agreed there was no documentation of the circumstances surrounding the fall and no documentation of a post-fall root cause analysis. No further information was provided through the completion of the survey.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31520 Based on observation, medical record reviews and staff interviews, the facility failed to deploy staff to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for all residents residing on third (3rd) floor. Failure to deploy licensed nurses (RN's and/or LPN's) to provide initial and ongoing assessments of the clinical needs of the residents including any acute changes in condition, such as cardiac/respiratory failure, choking, hemorrhaging, poor glycemic control, onset of delirium, behavioral emergencies, or falls resulting in head injuries or fractures, and failure to deploy staff to provide ongoing monitoring and supervision of staff to assure the implementation of the care plan as written. This deficient practice put the 6 out of 9 residents on third (3rd) floor at risk for serious injury, serious harm, serious impairment, or death. Resident identifiers: #13, #15, #31, #23, #2 and #8. Facility Census: 39. The state agency determined these failures placed Residents #13, #15, #31, #23, #2 and #8. in an immediate jeopardy situation due to the lack of deployment of adequate license nurses (RN's and/or LPN's) to assess and treat any acute changes in condition, such as cardiac/respiratory failure, choking, hemorrhaging, poor glycemic control, onset of delirium, behavioral emergencies, or falls resulting in head injuries or fractures. The state agency notified the Nursing Home Administrator of the immediate jeopardy at 7:27 PM on [DATE]. The facility submitted an abatement plan of correction (APOC) at 8:27 PM on [DATE]. The state agency requested changes and an additional APOC was submitted at 8:53 PM on [DATE]. At 8:58 PM on [DATE], the APOC was accepted by the state agency. The state agency verified the APOC was implemented, and the immediate jeopardy was abated at [DATE] at 9:41 PM. Once the immediate jeopardy was abated, deficient practices remained, and the scope and severity were decreased from a K to an E. Date/time IJ was called at 7:27 PM on [DATE]. Date IJ started on [DATE]. Date Abatement POC approved at 8:53 PM on [DATE]. Date/time IJ was abated at 9:41 PM on [DATE]. The plan of correction stated as follows: --The facility failed to deploy staff to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care for all residents residing on third (3rd) floor. --Social Worker (SW) to contact residents and their families to inform of room moves to occur tonight. --Residents on third floor will be moved to the first floor immediately. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Bluestone Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 1600 Bland Street Bluefield, WV 24701	

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--RN will be staffed on the 3rd floor until all residents are moved. --No residents will be placed on 3rd floor unless facility has adequate staffing. Findings included: a) Review of the Licensed nurse staffing schedule Review of the assignment sheet for [DATE] found the building has three (3) floors: First floor had nineteen (19) residents; second floor had eleven (11) residents, and third floor had nine (9) residents. First floor had a licensed nurse full time; the second and third floor had one (1) nurse who is responsible for all care and services provided to both second and third floors. A review of the licensed nurse, nursing schedule provided by the facility from [DATE] to [DATE] found the following: 1. Review of the nurse schedule for [DATE] to [DATE] from 6:00 AM to 6:00 PM On the following days the facility had 2 nurses scheduled to work all three (3) floors from 6:00 AM to 6:00 PM: [DATE], and [DATE]. On [DATE] the facility scheduled 2 nurses to work all three floors from 6:00 AM to 6:00 PM. A third nurse was scheduled to work from 2:00 PM to 10:00 PM. On the following days the facility had one (1) nurse scheduled to work all three (3) floors from 6:00 AM to 6:00 PM: [DATE], [DATE], and [DATE]. Between [DATE] through [DATE], there were 38 days out of 41 days were the facility only had 2 licensed nurses working to cover residents living on 3 floors of the nursing facility from 6:00 AM to 6:00 PM. In addition, the other 3 days in the review period only had 1 licensed nurse scheduled to work all 3 floors from 6:00 AM to 6:00 PM. No more than one Nurse Aide was present on the 3rd floor during the survey. 2. Review of the nurse schedule for [DATE] to [DATE] from 6:00 PM to 6:00 AM On the following days the facility had 2 nurses scheduled to work all three (3) floors from 6:00 PM to 6:00 AM: [DATE], and [DATE]. On [DATE] the facility scheduled 2 nurses to work all three floors from 6:00 AM to 6:00 PM. A third nurse was scheduled to work from 2:00 PM to 10:00 PM. (continued on next page)

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Bluestone Health and Rehabilitation	1600 Bland Street Bluefield, WV 24701

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On the following days the facility had one (1) nurse scheduled to work all three (3) floors from 6:00 PM to 6:00 AM: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. The nursing schedule for the 3rd floor provided by the facility reflected no nurses were scheduled to work from 6:00 PM to 6:00 AM on [DATE]. Between [DATE] through [DATE], there were 39 days out of 41 days were the facility only had 2, 1 or no licensed nurses working to cover residents living on 3 floors of the nursing facility from 6:00 PM to 6:00 AM. A nursing schedule for the remaining days in [DATE] was requested but never provided; however, observations proved similar staffing patterns continued through [DATE]. An interview with the nursing home administrator on [DATE] at 7:27 PM confirmed residents were moved to the third floor on [DATE]. As of [DATE] the facility had residents residing on all three (3) floors of the facility. Surveyors could not ascertain the actual staffing levels for the 3rd floor as the facility could not produce assignment sheets or the entire schedule. During the interview with the administrator, she was unable to answer the question about the schedule. No more than one Nurse Aide was present on the 3rd floor during the survey. b) Emergency Crash Cart Observation on [DATE] at 9:30 AM of the emergency cart (crash cart) used for choking and emergency first aid as well as CPR was unable to be opened; no license nurse (RN/LPN) was on the floor to verify the contents of the cart. (A crash cart is used to provide treatment for patients in cardiac arrest until EMS arrives and contains an emergency kit for chocking and bleeding). The emergency crash cart was located on the 3rd floor next to the nurse's station. Observations on third floor on [DATE] from 11:15 AM to 11:50 AM revealed no licensed nurse (RN and/or LPN) was present for 35 minutes. From 11:53 AM to 12:05 PM there was no licensed nurse (RN/LPN) was on the third floor for 12 minutes. At 12:30 PM the nurse left the third floor via the elevator. At 12:25 PM on [DATE], it was determined the crash cart was unable to be accessed due to the lack of knowledge by staff on how to open the cart. LPN #90 did not know how to unlock the emergency crash cart. This was confirmed by the Director of Nursing (DON) on [DATE] at 1:20 PM. The observed timeline for getting the emergency crash cart open on [DATE] found: --11:50 am LPN #90 came to the floor and surveyor asked her to unlock the emergency crash cart. She was unable to open the cart and stated, I think the keys to this cart is downstairs on second floor. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--11:53 am LPN #90 left the floor to get keys. --12:05 pm LPN #90 returned to floor and met with Hospice personnel evaluating Resident #13 for about 5 minutes and at 12:10 pm attempted to get in the crash cart to no avail. --12:10 pm LPN called on the phone to have the DON to come and assist her in opening the emergency crash cart. --12:22 pm NA #83 stated she thought there was a button to push or slide on the drawers. At this time LPN #90 and the surveyor were able to open the drawers. --From 11:15 am till 12:22 pm the facility was unable to access the emergency cart. The crash (emergency) cart supplies are PPE, gloves, gown, face masks, non-rebreather mask, nasal cannula, venti-masks. First aid- alcohol swabs, abdominal pads, band aids, Coban wrap, normal saline, gauze, bodily fluid spill kit, Sani-cloths, bio-hazard bags, and red biohazard bags, Ambu- bag and suction machine and tubing. This is the only source of supplies located on third floor. Six (6) of nine (9) residents on the 3rd floor are Full Code Residents #2, #23, #13, #15, #8 and #31. If an emergency arises and no licensed nurses are on the floor, nurse aides must go to the nurses' room to call for assistance. The licensed nurse must reach the floor by elevator or two flights of stairs. This failure created an immediate jeopardy situation for all residents on the 3rd floor, and also for those who may require treatment from the crash cart. c) Resident #8 Review of the care plan revealed the following problems Resident #8 was care planned for: --Full code status --One occurrence of behavior of touching another female resident in private areas --History of verbally abusive/aggressive behavior, including cursing towards others. --Resident will curse and yell at another resident that wanders by his room or if they go into his room by mistake --Resident feels he must fight for his life and is unable to be redirected at times. --Resident has had behaviors becoming physically aggressive, including punching EMT staff. --Resident has actual behavior problem: Resident has exhibited sexually inappropriate such as trying to grab and touch female staff and one instance of this behavior towards another resident. --Potential for injury falls related to general weakness and declining gait. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--Inability to maintain health state independently related to muscle weakness and chronic fatigue. --Bathing requires the assistance of 1 person, he likes to do his own daily care, and prefers showers 3 days a week. --Resident requires the assistance of 1 person for dressing. --Resident is continent of bladder/bowel, uses bathroom, uses bathroom/urinal independently. Review of the current quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] gave the following information: --BIMS (Brief Interview for Mental Status) of 15 which indicated cognitively intact. --Independent for all activities of daily living (ADL) except for walking in corridor which did not occur during the quarter. --Required set up assistance for dressing, eating, and personal hygiene. --Required supervision of one for bathing. Observation of Resident #8 in hallway on first floor in his wheelchair on [DATE] at 1:00 PM found him yelling at Resident #14, who has been noted to wander in the hallways throughout the survey. The staff redirected Resident #8 away from Resident #14 and told Resident #8 that Resident #14 was permitted in the hallway. Resident #8 was moved from first floor to third floor on [DATE], to room [ROOM NUMBER] after having an episode of inappropriate touching of Resident #16 on [DATE]. Resident #8 was to be on every fifteen (15) minute checks after the inappropriate touching of Resident #16. Multiple observations on [DATE] at 9:35 AM, [DATE] at 11:15 AM to 12:30 PM, [DATE] at 2:20 PM found Resident #8 was mobile and freely moving about the third floor without any staff supervision. The facility failed to provide evidence Resident #8 was being checked every 15 minutes. Due to the facility's failure to provide adequate nursing staffing on the third floor, this placed Resident #8 and other residents in his environment at immediate jeopardy due to: --Resident #8 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. --Resident #8 was potentially a risk to other residents due to his history of sexually inappropriate behavior and the one recent incident of being sexually inappropriate with another resident. --Resident #8 had physically aggressive behaviors that have resulted in him punching an EMS worker. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--Resident #8 is care planned for fall risk due to general weakness and declining gait. If the resident were to fall, the lack of nursing would delay identification of the fall and the need for immediate medical assistance. -Resident #8 has wandering behavior and is on 15 minute checks. There was no evidence in the documentation or in observations that these checks were occurring. d) Resident #2 Review of the care plan included the following problems: --The resident had actual/history of/potential for behavior(s): refusing to take medications at times. --She can become frustrated and yell at staff. --She frequently states she wants to leave facility. --Resident is forgetful and will at times ask for a different meal to eat and when brought to her, she will state that she never asked for that. --She will keep food containers and food items that are on her tray such as milk, syrup containers, etc. ----- Behaviors maybe related to dementia/other diagnoses/issues. --Actual behavior problem was wandering related to dementia with mental behavioral disorders. --Inability to maintain health state independently related to personal history of other mental and behavioral disorders with a history of convulsions --Potential for injury falls related to dementia with general weakness and history of convulsions. Also, will throw self in floor. --Potential for seizure activity. Diagnosis of convulsions. --Resident not to have knives on meal trays. Review of the most recent Quarterly MDS with ARD [DATE] gave the following information: --BIMS score of 11 which indicated the resident is moderately cognitively impaired. --Independent for all ADLs except locomotion off unit occurred only once or twice and required limited assistance of one person for personal hygiene. --For bathing required supervision. --Occasionally incontinent of urine and bowel. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Due to the facility's failure to provide adequate nursing staffing on the third floor, this place Resident #2 at immediate jeopardy due to: --Resident #2 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. --Resident #2 was also care planned for fall risk and history. If the resident were to fall, the lack of nursing would delay identification of the fall and the need for immediate medical assistance. Her history of convulsions also placed her at a higher risk of falling. e) Resident #15 Review of the care plan included the following problems: --Inability to maintain health state independently related to multiple sclerosis and hemiplegia. --At risk for falls related to hemiplegia and cerebrovascular accident (CVA). --At risk for skin integrity alterations related to bilateral food drop, hemiplegia to left non dominant side with decreased mobility. Review of a comprehensive MDS with an ARD of [DATE] gave the following information: --BIMS score of 6 which indicated the resident was severely cognitively impaired. --Required extensive assistance for bed mobility, transfer, dressing, toilet use, and personal hygiene. --Required two (2) person physical assist for bed mobility. Required physical help of one person in part of bathing activity. --Occasionally incontinent of urine and frequently incontinent of bowel. --Experienced one (1) fall with no injury in the last 3 months. Due to the facility's failure to provide adequate nursing staffing on the third floor, this place Resident #15 at immediate jeopardy due to: --Resident #15 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. --Resident #15 was also care planned for fall risk and history. If the resident were to fall, the lack of nursing would delay identification of the fall and the need for immediate medical assistance. g) Resident #13 On [DATE] at 2:20 PM, Resident #13 was observed lying in bed with a nasal cannula (an oxygen delivery device). (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #13's oxygen concentrator was observed on [DATE] at 2:20 PM to be running at a rate of three (3) liters per minute. There was no licensed nurse available to verify the oxygen flow rate. Employee #83, a Nurse Aide (NA), verified the oxygen was running at 3 liters per minute. A review of Resident #13's physician's orders revealed an order with a start date of [DATE] directing to provide oxygen at two (2) liters per minute. On [DATE] at 3:41 PM, the DON verified Resident #13's oxygen concentrator was set on three (3) liters per minute and she confirmed the oxygen order was for two (2) liters per minute. Review of the care plan for Resident #13 found the following problems: --Resident has behaviors that include screaming, cursing, or throwing items during activities, often occurs when resident doesn't win a game or contest; also, episodes of throwing items in hall or at staff if she becomes angry or upset. --Impaired expressive or receptive communication related to a diagnosis of intellectual disability and dementia. --Resident may miss part of message. Resident at times misinterprets other resident's communication and behaviors which causes resident to act out verbally along with becoming physically threatening. --Resident is on anti-psychotic medication for behaviors. History of gradual dose reduction failures due to behaviors starting again or increasing. --Resident has a BIMS score of 11 score which indicated the Resident is moderately cognitively impaired --Resident requires extensive assist of one person with bathing, dressing, bed mobility, transfers, and toileting. Due to the facility's failure to provide adequate nursing staffing on the third floor, this place Resident #13 at immediate jeopardy due to: --Resident #13 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. h) Resident #31 Review of the care plan for Resident #31 included the following problems: --Inability to maintain health state independently related to weakness and history of CVA. --Resident has a potential for injury falls related to muscle weakness, difficulty walking requires one assist. --Resident noted to have a fall on [DATE], slid from bed while attempting to transfer. Resident had been educated on calling for assistance for transfers. Resident moved closer to nursing station. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the comprehensive MDS with an ARD of [DATE] found the following: --Resident #31 had a BIMS score of 6 which indicated severe cognitive impairment --Required extensive assistance with one-person physical assist for dressing, toilet use, and personal hygiene. --Required limited assistance with one-person physical assistance for bed mobility and transfer. --Resident is always continent. Due to the facility's failure to provide adequate nursing staffing on the third floor, this place Resident #31 at immediate jeopardy due to: --Resident #31 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. --Resident #31 was at risk and care planned for falls. As a result he was moved closer to the nurses station, however, the lack of nursing did not increase his level of safety from falling. If the resident were to fall, the lack of nursing would delay identification of the fall and the need for immediate medical assistance. i) Resident #23 Review of the care plan found the following problems: --The resident had a history of and currently exhibited verbally abusive behavior when staff ask her about getting a shower or getting out of bed. --She stated that she wants staff to die, called them names, stated they were demons which is related to a psychotic disorder with hallucinations. --The resident's behaviors occur at least once a week, especially when she is asked if she wants to get a shower or if she is asked to get out of bed. --Resident has a history of stating she wanted to harm herself with a soda can. Resident has stated she wanted to harm herself because she wanted to leave the facility. --Inability of maintain health state independently related to decreased mobility. --History of falls prior to admission related to muscle weakness and debility. Review of the recent quarterly MDS with an ARD of [DATE] gave the following information: --Resident has a BIMS score of 15 which indicated the resident was cognitively intact. --Required extensive assistance with one-person physical assist for bed mobility, dressing, and personal hygiene. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	--Required extensive assistance with two or more persons physical assist for transfer and toilet use. --Required total dependence with assistance of one person for locomotion on unit. --Required physical assistance of one person for bathing. --Frequently incontinent of urine and stool. Due to the facility's failure to provide adequate nursing staffing on the third floor, this place Resident #23 at immediate jeopardy due to: --Resident #23 was has a full code status, and not having sufficient nursing staff available to call the code and immediately start CPR. --Resident #23 had a history of making suicidal ideations and wandering. She was care planned for not having knives on meal trays and to make sure she did not keep items from her food tray. --Resident #23 had a history of falls due to decreased muscle weakness and debility. If the resident were to fall, the lack of nursing would delay identification of the fall and the need for immediate medical assistance.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review and staff interview, the facility failed to ensure nursing staff had the appropriate competencies and skills sets to provide nursing services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This failed practice had the potential to affect four (4) of six (6) residents receiving insulin medications. Resident identifiers: #10, #22, #29, #5. Facility census: 39. Findings included: a) Resident #10 Review of Resident #10's physician's orders revealed an order written on 07/22/21 for Humalog Insulin, 5 units subcutaneously before meals, hold if the fingerstick blood sugar was less than 140. Resident #10's Medication Administration Record (MAR) from 07/26/21 to present was reviewed. On the following dates and times, Resident #10's MAR documented the resident's fingerstick was less than 140, and insulin was administered despite the parameter to hold: --08/02/21 at 7:00 AM, for fingerstick blood glucose of 110 --08/04/21 at 11:00 AM, for fingerstick blood glucose of 121 --08/09/21 at 7:00 AM, for fingerstick blood glucose of 124 --08/13/21 at 5:00 PM, for fingerstick blood glucose of 122 --08/14/21 at 5:00 PM, for fingerstick blood glucose of 137 --08/15/21 at 5:00 PM, for fingerstick blood glucose of 130 --08/13/21 at 5:00 PM, for fingerstick blood glucose of 108 On 08/10/21 at 11:00 AM, Resident #10's insulin was held for fingerstick blood glucose of 148, despite the parameters to give. On 08/24/21 at 10:01 AM, the above findings were reviewed with the Director of Nursing (DON). The DON had no additional information regarding the matter. b) Resident #22 Review of Resident #22's physician's orders revealed the following insulin orders: --Novolog Insulin, 5 units subcutaneously at 7:00 AM (with no parameters), ordered 7/14/21 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Novolog Insulin, 8 units subcutaneously at 11:00 AM and 5:00 PM, hold for fingerstick blood glucose less than 140, ordered 07/14/21 --Lantus Insulin, 20 units subcutaneously at bedtime (with no parameters), ordered 03/10/21 Resident #22's MAR from 07/26/21 to present was reviewed. At 7:00 AM on the following dates, Resident #22's insulin was held despite no parameters to do so. --07/27/21 for fingerstick blood glucose of 104 --07/29/21 for fingerstick blood glucose of 103 --07/30/21 for fingerstick blood glucose of 125 --07/31/21 for fingerstick blood glucose of 73 --08/01/21 for fingerstick blood glucose of 86 --08/06/21 for fingerstick blood glucose of 62 --08/07/21 for fingerstick blood glucose of 115 --08/08/21 for fingerstick blood glucose of 98 --08/12/21 for fingerstick blood glucose of 92 --08/13/21 for b fingerstick blood glucose of 106 --08/14/21 for fingerstick blood glucose of 98 --08/15/21 for fingerstick blood glucose of 88 --08/18/21 for fingerstick blood glucose of 101 --08/19/21 for fingerstick blood glucose of 72 --08/20/21 for fingerstick blood glucose of 113 --08/22/21 for fingerstick blood glucose of 102 On the following dates and times, Resident #22's MAR documented the resident's fingerstick was less than 140, and insulin was administered despite the parameter to hold: --07/28/21 at 5:00 PM, for fingerstick blood glucose of 126 --08/20/21 at 5:00 PM, for fingerstick blood glucose at 117 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/24/21 at 2:53 PM, the above findings were reviewed with the DON. The DON confirmed Resident #22 did not have an order to hold the 7:00 AM insulin dose for blood glucose level less than 140. The DON also confirmed Resident #22 received insulin the other two (2) times when the resident's blood glucose was less than 140. c) Resident # 29 Resident #29 was admitted on [DATE] with an order for Basaglar KwikPen (insulin) U-100 insulin to administer: 10 units; subcutaneous. Hold if blood sugar is less than 110. On the following dates and times, Resident # 29's MAR documented the resident's fingerstick was less than 110, and insulin was administered despite the parameter to hold: On 07/17/2021 at 4:15 PM, the blood sugar was 83 and Resident # 29 received 10 units of Basaglar (insulin) and should have been held. On 07/24/2021 at 5:25 PM, Resident # 29 was given Basaglar (insulin) 10 units when her blood sugar was 103 and should have been held. On 08/23/2021 at 6:30 PM Resident # 29 was given Basaglar (insulin) 10 units when her blood sugar was 109 and should have been held. Resident #29's blood sugars were not obtained on the following days: --07/21/21 --07/25/21 --07/26/21 --07/27/21 --07/28/21 --07/29/21 --07/30/21 --07/31/21, --08/01/21. The resident received Basaglar 10 units on every occasion mentioned above even through the blood sugars were not obtained. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/24/2021 at 6:30 PM, the Director of Nursing (DON) confirmed the staff failed to follow the physicians' orders to check the blood sugar before administering the insulin and to hold if below 110. She stated, she has no idea why it was not done. d) Resident #5 Review of Resident #5's medical record found a physician order written on 05/26/21 for Insulin lispro solution- administer 10 units subcutaneous three times a day before meals at 7:00 am, 11:00 am and 5:00 PM for treatment of diabetes mellitus. An additional order was written on 05/26/21 for Lantus 30 units subcutaneous at 7:00 am daily. No order for fingersticks was found. Review of the August 2021, Medication Administration Record (MAR) for Resident #5 found the licensed nurses were obtaining a fingerstick at 7:00 am, 11:00 am and 5:00 PM without an order. On the following dates and times the Lispro 10 units was held on three (3) occasions without an order and no physician notification: 08/05/21 at 5pm- fingerstick was 68 08/06/21 at 5 PM - fingerstick was 76 08/14/21 at 5 PM- fingerstick was 84 On 08/24/21 at 3:30 PM, the above findings were reviewed with the DON. The DON confirmed Resident #5 did not have an order to obtain fingersticks and he did not have an order to hold the Lispro on 08/05/21, 08/06/21 and 08/14/21.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31520 Based on record review, observation and staff interviews, the facility failed to ensure all controlled substances were stored in a separately locked, permanently affixed compartment on the medication cart. The facility failed to timely identify and remove (from current medication supply) medications for disposition, control and accountability of medication awaiting final disposition consistent with standards of practice. Additionally, the facility failed to have a system to account for controlled medications' receipt and disposition in sufficient detail to enable an accurate reconciliation. The facility failed to conduct any reconciliations of controlled substances in the last year. This system includes, but is not limited to: a record of receipt of all controlled medications with sufficient detail to allow reconciliation, records of personnel access, usage, and disposition of all controlled medications with sufficient detail to allow reconciliation (e.g., the MAR, proof-of-use sheets, or declining inventory sheets), including destruction, wastage, return to the pharmacy/manufacturer, or disposal, and periodic reconciliation of records of receipt, disposition, usage, and inventory for all controlled medications to identify loss or potential diversion of controlled medications so as to minimize the time between the actual loss or potential diversion and the time of detection and follow-up to determine the extent of loss. On [DATE] at 9:30 am, the nurse #90, had pre-poured Residents #4, #35, #5 and #15's narcotic prior to coming to 3rd floor to administer the medications. Therefore, the controlled medications were not stored in a separately locked, permanently affixed compartment on the medication cart. The facility failed to have an accurate accounting on receipt, administered and final disposition of control narcotics to determine if a loss and/or diversion of narcotics, which was identified during a narcotic count on second (2nd) floor. For Residents #11. #18 and #40, the facility failed to timely identify and remove (from current medication supply) medications for disposition, control and accountability of medication awaiting final disposition consistent with standards of practice. Resident identifiers: #15, #4, #35, #5, #11, #18 and #40. Facility census: 39. Findings include: a) Pre-poured narcotics for second (2nd) floor: Observation on [DATE] at 9:30 am, found Employee #90 a licensed practical nurse (LPN) had pre-poured, Residents #4, #35, #5 and #15's controlled substances prior to coming to 3rd floor to administer the medications: Resident #4- Tramadol 50 mg and Ativan 0.5 mg Resident #35 Neurontin 400 mg Resident #5 Ativan 0.5 mg and Neurontin 300 mg (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident # 15 Morphine sulfate Extended Release (ER) 15 mg and Neurontin 300 mg An interview with LPN #90, at 9:31 am on [DATE], found she had pre-poured the controlled substances in unlabeled medication cups for third (3rd) floor residents prior to coming from the second (2nd) floor. (Because the cups were not labeled, the nurse relied on her memory to identify which resident the medications belonged to.) She said she does it to save time due to controlled substances being on a separate medication cart, which she brought with her from the 2nd floor. At 10:45 am on [DATE], when informed of the LPN prepouring controlled substances for Residents #4, #35, #5 and #15 and placeing the medications in paper medication cups on top of medication cart; the Director of Nursing (DON) agreed this was not an acceptable nursing practice and that controlled substances should not be removed from the locked controlled substance drawer of the medication cart until the time of administration. b) Controlled medications count on second floor During an observation of the second floor on [DATE] at 6:30 AM, Licensed Practical Nurse (LPN) # 55 and LPN # 84 were observed counting the controlled medications for shift change. LPN #55 told LPN # 84 the card count should be 84 (card counting is counting the number of cards containing controlled medications and each card has a count sheet used to log out any controlled drug being removed), however LPN # 84 only counted 82 cards and she counted them four (4) times. LPN # 55 was counting the log sheets while LPN # 84 was counting the cards. LPN # 55 was asked which cards were missing. LPN # 55 said she did not know but would let the Director of Nursing (DON) know. LPN # 55 was asked if the card count was correct at the beginning of her shift, she said yes it was correct at that time. LPN # 55 worked the 6 PM to 6 AM shift. On [DATE] at 10:03 AM, DON was asked about the missing cards of the controlled medications. The DON said, there was not any missing cards, I took two out of the medications out of the medication cart yesterday. She was then asked, why was the count on [DATE] at 6:00 PM, correct yesterday? The DON said she was not told by LPN # 55 her count was short two cards yesterday. The DON was asked about the process of accounting for the controlled medications. She said yesterday on [DATE] the nurses were in the process of removing the discontinued and expired controlled medications from the medication carts, when you surveyors showed up and we got distracted. She went on to say that she forgot to subtract the two cards of morphine that was removed. The DON said the controlled medications come from the pharmacy with a log sheet. The log sheets are kept in the binder notebook and when a medication card is empty the nurse throws the card away and removes the log sheet from the binder. Then the card is recorded on the Master Controlled Substance Sheet Log where it is subtracted from the total. The DON said she does not know why LPN # 55 and LPN # 61 did not identify the wrong count on [DATE] at 6:00 PM. She was asked about the Morphine that was removed from the second-floor medication cart on Monday [DATE], and where was the morphine stored after removal on [DATE]? The DON stated in her locked desk drawer. c) Resident #30 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the expired or discontinued controlled medications, Resident # 30 had three (3) cards of Ativan 0.5 mg for a total of 78 pills. A review of the physician's orders revealed this medication was discontinued on [DATE]. During a brief interview on [DATE] at 1:12 PM, DON stated she does not have a place to store controlled drugs before the pharmacist can come to destroy them. 39043 d) Resident #11 On [DATE] at 11:35 AM, inspection of the first-floor medication cart was made. Licensed Practical Nurse (LPN) #84 was in attendance. A medication card containing clonazepam 0.5 mg, 4 tablets, for Resident #11 was noted to be in the narcotic drawer of the medication cart. Clonazepam is a controlled substance that must be kept in a locked drawer in the medication cart. Controlled substances no longer prescribed to residents must be removed and destroyed to prevent loss or diversion of the substance. Review of Resident #11's physician's orders showed the resident's clonazepam was discontinued on [DATE]. During an interview on [DATE] on 11:39 AM, the DON was informed the medication cart contained controlled substances for Resident #11 that had been discontinued on [DATE]. The DON was informed that retaining controlled substances discontinued by the physician increased the risk for loss and diversion. The DON stated the pharmacist does not come for medication destruction every month, and had last performed medication destruction at the facility in June, 2021. She stated she was going to begin removing discontinued controlled substances from the medication cart and locking them in a safe in her office until the pharmacist comes for medication destruction. No further information was provided through the completion of the survey. e) Resident #18 On [DATE] at 11:35 AM, inspection of the first-floor medication cart was made. Licensed Practical Nurse (LPN) #84 was in attendance. Four (4) medication cards containing alprazolam, 0.5 mg, for Resident #18 were noted to be in the narcotic drawer of the medication cart. The four (4) medication cards contained 139 and one half tablets. Alprazolam is a controlled substance that must be kept in a locked drawer in the medication cart. Controlled substances no longer being used by residents must be removed and destroyed to prevent loss or diversion of the substance. Review of Resident #18's physician's orders showed the resident's alprazolam was discontinued on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] on 11:39 AM, the DON was informed the medication cart contained controlled substances for Resident #18 that had been discontinued on [DATE]. The DON was informed that retaining controlled substances discontinued by the physician increased the risk for loss and diversion. The DON stated the pharmacist does not come for medication destruction every month, and had last performed medication destruction at the facility in June, 2021. She stated she was going to begin removing discontinued controlled substances from the medication cart and locking them in a safe in her office until the pharmacist comes for medication destruction. No further information was provided through the completion of the survey. f) Resident #40 On [DATE] at 11:35 AM, inspection of the first-floor medication cart was made. Licensed Practical Nurse (LPN) #84 was in attendance. Six (6) medication cards containing lorazepam, 0.5 mg, for Resident #40 were noted to be in the narcotic drawer of the medication cart. The six (6) medication cards contained 151 tablets. Review of Resident #40's physician's orders showed the resident was prescribed lorazepam, 0.5 mg, every six (6) hours. Resident #40 had expired on [DATE]. Lorazepam is a controlled substance that must be kept in a locked drawer in the medication cart. Having a large number of controlled substances available can contribute to loss or diversion of the substance. During an interview on [DATE] at 11:39 AM, the DON was asked about the large number of lorazepam tablets available for Resident #40. The DON stated the pharmacist had delivered more lorazepam tablets when Resident #40 had returned to the facility from a hospital stay, even though the facility already had lorazepam tablets for the resident. No further information was provided through the completion of the survey. 39571 g) Consultant pharmacist interview On [DATE] at 10:38 AM the Consultant Pharmacist (CP) was asked when the last date she was at this facility to destroy controlled medications. She said it has not been a regular routine time to destroy medications at this facility, due the many changes in management. She said she was at the facility on [DATE], [DATE], and [DATE]. CP said she has asked multiple times if the facility needed to destroy any medications, and when she was turned down many times, she stopped asking because she did not want to seem pushy or pestering them. The CP stated, she does not know why the facility did not keep a record of what medications were destroyed, however, she keeps records for her job. The CP was asked why the discontinued Ativan for Resident # 30 was not destroyed on [DATE]. CP said she only destroys the medications the facility gives her to destroy. The CP was asked about the large number of controlled medications being sent to the facility before the residents need more medications. The CP said she will look into it; she was not aware of this being a problem.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31520 Based on observation and staff interview, the facility failed to establish a system to ensure medications were stored and labeled according to professional standards to ensure medication safety. This failed practice was true for two (2) out of four (4) insulin's stored on the second floor, two of two tubersol vials, on the first floor, and Pre-poured narcotics not stored in a double lock system. These failed practices were random opportunities for discovery. These failed practices had the potential to affect more than a limited number of residents that currently reside at the facility. Residents Identifiers: Resident # 28, and # 5. Facility census 39. Finding included: a) Medication cart and medication storage room on the second floor On [DATE] at 8:28 AM, Licensed Practical Nurse (LPN) #90 was witness to the following: No date on the insulin pen Basaglar, to indicate when the insulin pen was initially opened. This insulin pen belongs to Resident # 29. Observation of the medication storage room refrigerator found an insulin vial inside of a plastic medication bottle. There was no date on the vial to indicate the initial date of access. This medication belonged to Resident #5. Also in the refrigerator was a box of Tubersol (used to test a person for tuberculous) with an open date of [DATE]. (Under the date on the box containing the vial was written, Do not use after 30 days.) LPN # 90 agreed the medication had expired. b) First-floor Medication Room On [DATE] at 11:00 AM, observation of the first floor medication room with LPN #84 found the following: In the medication room refrigerator, an opened multi-dose vial of tuberculin purified protein derivative was found not dated when first accessed. Tuberculin purified protein derivative is given by injection to aid in the diagnosis of tuberculosis. The vial was delivered from the pharmacy on [DATE]. The vial had a label which stated to discard the vial within 30 days of opening. LPN #84 agreed the facility would not know when to discard the vial because it had not been dated when opened. During further inspection, the following items were found in the cabinet area under the sink: A suction machine, tubing, and canister; pipettes for laboratory specimen collection; laboratory specimen bags; and a urine collection jug. LPN #84 was informed equipment could not be stored in the cabinet area under the sink. This area is not considered a clean area due to possible leaks from the sink pipes. LPN #84 stated the cabinet should have been locked to prevent usage. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inspection of cabinets and shelving in the medication room found the following expired items: - Sureprep individual skin wipes, with expiration date of April, 2021 - E-Z sterile lubricant jelly, with expiration date of December, 2019 - [NAME] soap towelettes, with expiration date of April, 2021 LPN #84 confirmed the items were expired and stated they would be removed from the medication room. No further information was provided through the completion of the survey. c) Pre-poured narcotics for second (2nd) floor: Observation on [DATE] at 9:30 am, Employee #90 an LPN had pre-poured, Residents #4, #35, #5 and #15's narcotic prior to coming to 3rd floor to administer the medications: Resident #4- Tramadol 50 mg and Ativan 0.5 mg Resident #35 Neurontin 400 mg Resident #5 Ativan 0.5 mg and Neurontin 300 mg Resident # 15 Morphine sulfate Extended Release (ER) 15 mg and Neurontin 300 mg Interview with LPN #90, at 9:31 am on [DATE], found she had pre-poured the narcotics for third (3rd) floor prior to coming from second (2nd) floor. She said she does it to save time due to the narcotics are on a separate medication cart, which she brought with her from 2nd floor. At 10:45 am on [DATE], when informed of the LPN prepouring narcotics for Residents #4, #35, #5 and #15 and placing the medications in paper medication cups on top of medication cart. The Director of Nursing (DON) agreed this was not acceptable nursing practice and that controlled substances should not be removed from the narcotic drawer until time of administration of the medications. 39043 39571

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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. 31520 39043 Based on observation and staff interview, the facility failed to store food in accordance with professional standards for food service safety. The food refrigerators in the medication storage rooms on the first floor and third floor had dried liquids on the shelves. Additionally, soft drink bottles were stored under the sink in the first-floor medication storage room. These failed practices had the potential to affect any residents receiving nutrition from these areas. Facility census: 39. Findings included: a) First-floor Medication Room On 08/24/21 at 11:00 AM, inspection of the first-floor medication storage room was made. Licensed Practical Nurse (LPN) #84 was in attendance. The medication room had a refrigerator containing food and drink for residents. The bottom shelf of this refrigerator was noted to have dried dark brown and light brown substances. LPN #84 stated she would ensure the refrigerator was cleaned. On further inspection, bottles of Sprite were found in the cabinet area under the sink. LPN #84 was informed food and drink could not be stored in the cabinet area under the sink. This area is not considered a clean area due to possible leaks from the sink pipes. LPN #84 stated the cabinet should have been locked to prevent usage. No further information was provided through the completion of the survey. b) Third Floor Medication Room On 08/24/21 at 1230 PM, inspection of the third-floor medication refrigerator was made. Licensed Practical Nurse (LPN) #90 was in attendance. The refrigerator contained food and drink for residents. The bottom shelf of this refrigerator was noted to have dried dark brown and light brown substances. LPN #90 acknowledged it was dirty and housekeeping was called to floor to clean it. Additionally, the refrigerator did not have a temperature log. The Director of Nursing was informed of the findings on 08/24/21 at 2:00 pm. No further information was provided prior to exit.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 31498 Based on random observations, Resident Refrigerators Policy and staff interview the facility failed to maintain resident's private refrigerators. During random observations, it was discovered 19 resident's private refrigerators were not being cleaned and daily temps were not being recorded. Room identifiers: #103, #104, #105, #106, #107, #111, #115, #124 and #126, #203, #204, #205, #206, #207, #208, #211, #301, and #302. Facility census: 39. Findings included: a) Resident private refrigerators Random observations for resident's refrigerators on 08/23/21, revealed housekeeping staff had failed to clean refrigerators weekly and record daily temperatures on the Refrigerator Temperature Log for resident's private refrigerators. - Room (Rm): 103 missing temperatures from 08/22/21 and 08/23/21. -Rm: 104 missing temperatures from 08/22/21 and 08/23/21. -Rm: 105 missing temperatures from 08/22/21 and 08/23/21. -Rm: 106 no scheduled cleaning completed on 08/20/21 and missing temperatures from 08/19 to 08/23/21. -Rm: 107 no scheduled cleaning completed on 08/20/21 and missing temperatures from 08/20 to 08/23/21. -Rm: 111 no scheduled cleaning completed on 08/20/21 and missing temperatures from 08/20 to 08/23/21. -Rm: 115 no scheduled cleaning completed on 08/20/21 and missing temperatures from 08/19 to 08/23/21. -Rm: 124 missing temperatures from 08/21 to 08/23/21. -Rm: 126 no scheduled cleaning completed on 08/20/21 and missing temperatures from 08/15 to 08/23/21. -Rm: 203 no scheduled cleaning completed on 08/06/21, 08/13/21, and 08/20/21 and no temperatures recorded from 08/01/21 to 08/23/21 -Rm: 204 no Refrigerator Temperature Log. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Rm: 205 no scheduled cleaning completed on 08/06/21, 08/13/21, and 08/20/21 and no temperatures recorded from 08/01/21 to 08/23/21. -Rm: 206 no scheduled cleaning completed on 08/06/21 and 08/20/21 and no temperatures recorded for 08/01/21 to 08/12/21 and 08/18/21 to 08/23/21. -Rm: 207 no scheduled cleaning completed on 08/06/21, 08/13/21, and 08/20/21 and no temperatures recorded from 08/03/21 to 08/07/21 and 08/10/21 to 08/22/21. -Rm: 208 no scheduled cleaning completed on 08/06/21, 08/13/21, and 08/20/21 and no temperatures recorded from 08/01/21 to 08/23/21. -Rm: 211 no scheduled cleaning completed on 08/20/21 and no recorded temperatures from 08/10/21 to 08/12/21 and 08/14/21 to 08/22/21. -Rm: 301 no Refrigerator Temperature Log and no thermometer. -Rm: 302 no Refrigerator Temperature Log and 2 thermometers both with different temperatures. A review of the Resident Refrigerators Policy on 08/25/21 includes guidelines for Housekeeping staff to record refrigerator temperatures daily and clean refrigerators weekly. This is to be recorded on a Refrigerator Temperature Log. In an interview with the Housekeeping Supervisor on 08/24/21 at 2:00 PM, verified the Housekeeping staff had not cleaned resident's private refrigerators weekly and there were several days refrigerator temperatures had not been recorded.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Deficiency Text Not Available

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31498 Based on record review and staff interview the facility failed to maintain medical records on each resident which were complete and accurately documented. This was a random opportunity for discovery for Reisdent #95, #96 and #24. Resident identifiers: Resident # 95, # 96 and # 24. Facility census 39. Findings included: a) Resident # 95 During a review of medical records, it was noted on the facility form, Census History (a list of expired Residents) it reported Resident # 95 expired on [DATE] at 8:35 AM. The nursing note states Resident # 95 was found without vital signs at 6:30 AM and transferred to the local funeral home at 8:27 AM. According to this documentation Resident # 95 was sent to the funeral home eight (8) minutes before they expired. During a brief interview on [DATE] at 10:06 AM, this was shown to Social Worker # 23. She had no response. b) Resident # 96 A review of medical records revealed Resident # 96 was found without vital signs on [DATE] at 12:56 am, and left for the funeral home at 3:53 am. On the facility form Census History it reported Reisdent #96 expired on [DATE] at 3:55 AM. According to this documentation the resident was sent to the funeral home 2 minutes before she expired. During a brief interview on [DATE] at 10:06 AM, this was shown to Social Worker # 23. She had no response. c) Resident #24 A medical record review on [DATE], revealed Resident #24 had an unwitnessed fall on [DATE]. This unwitnessed fall required neurological checks to be completed for a specified time following the fall, which was to be recorded on a Neurological Flow Sheet. In an interview with the Director of Nursing (DON) on [DATE] at 11:30 AM, she reported she was unable to locate the Neurological Flow Sheet for the unwitnessed fall on [DATE] for Resident #24. 39571

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	515186	A. Building B. Wing	08/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bluestone Health and Rehabilitation	1600 Bland Street Bluefield, WV 24701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 31520 39571 Based on observation, staff interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This failed practice was found in the care areas of: respiratory care for Resident # 29, more than a year without an annual review of the infection control policy, failure to provide appropriate infection surveillance for Resident # 22, Laundry room contamination of clean items, and contamination of medications during medication administration. These failed practice were random opportunities for discovery and had the potential to affect more than a limited number of residents residing at the facility. Facility census 39. Findings included: a) Resident # 29 During an interview and observation on 08/23/21 at 11:42 AM, a C-pap mask was laying on the top of the bed without being in a bag. Resident # 29 was asked how often it was cleaned. She stated it has not been cleaned since she has been here. A review of the medical records the physicians' orders are as follows: -C-Pap mask to be cleaned with mild soap and warm water and allowed to air dry QAM after removal. Special Instructions: document completions and refusals, once A Day -Cleanse C-Pap tubing [from machine into mask] with mild soap and warm water; rinse well and allow to air dry Q Sunday Special Instructions: Document completion or refusals On 08/24/21 at 8:10 AM, Licensed Practical Nurse (LPN) #90 was in room passing medication when Resident # 29 was asked how often has her C-Pap been cleaned. Resident # 29 stated it has not been cleaned while she has been here. LPN # 90 was asked how often it is supposed to be cleaned. LPN # 90 stated once a week. LPN # 90 was asked to look at the order and stated she will clean the C-pap today. LPN # 90 agreed there was not a bag in the room for storage of the C-pap mask. During a phone interview with LPN# 61 she was asked if she cleaned the C-pap mask on 08/23/2021. She stated she normally cleans the mask while Resident # 29 is taking her morning medications around 8 AM, she went on to say she then places it in a clear bag with blue writing on it and leaves it on her table. She was told that yesterday and today there was not a clear bag in the room anywhere in the room. LPN # 61 stated she washes the mask in the sink and uses the hand soap on the wall. b) Resident # 22 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of medical records it was noted Resident # 22 was to be in Contact isolation due to having Shingles on 08/16/2021. The isolation ended on 8/20/2021 after the blisters scabbed over and the resident was no long contagious. During an interview on 8/24/2021 at 1:48 PM, Infection Preventionist # 24 confirmed she failed to document on the tracking and trending log about Resident # 22 being in contact isolation on the dates of 08/16/2021 to 8/20/2021. c) Laundry Room During an interview and tour of the laundry room on 08/25/2021 at 12:33 PM, Housekeeping # 45 was asked about the items on top of the washing machine. The items were two (2) pairs of shoes, an abdominal band, and a wheelchair seat cover. Housekeeping # 45 said, the items mentioned above were air drying. He stated that he did not know he should not air-dry clean items in the soiled laundry room, however it makes sense. Housekeeper # 45 said the items would be washed and dried in the dryer room. d) Annual review of the Infection control Policy During an interview on 08/25/21 at 1:02 PM, Infection Preventionist # 24 stated the infection control policy was last reviewed on 1/21/2020. IP # 24 stated, it appears we are late about reviewing the policy. No additional information was provided. e) Resident #13 Observation of medication administration on 08/24/21 at 9:30 am, found Licensed Practical Nurse (LPN) #90 preparing Resident #13's morning medication. LPN #90, removed each pill out of bubble/blister packets into her bare hands and then placed the pills in a medication cup. She then proceeded to administer the medication to Resident #13. During an interview with LPN #90 on 08/24/21 at 9:40 am, she verified she is to pop the medication from the blister packets into a clean medication cup, and she should not touch any medication with her bare hands. The Director of Nursing (DON) was informed of the above-mentioned occurrence, and she confirmed the medication should not be touch by your bare hands on 08/24/21 at 11:00 AM.

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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. 06308 Based on observation and staff interview, the facility failed to ensure resident equipment was in a safe operating condition. The ice machine in the dining room was leaking and water was running onto the floor. This failed practice has the potential to affect more than a limited number of residents who are served ice from this unit. Census: 39 Finding included: a) During conversation with the environmental services supervisor (ESS, #47 at 8:13 a.m. on 08/24/21 it was verified the ice machine in the dining room was leaking water onto the floor. ESS #47 proceeded to see the floor was wet and moved the unit to be in better position to drain as it should. He then got rags and cleaned the spill. Also it was noted the outside of the unit had a large amount of lime deposit and rust, which was also confirmed with ESS #47.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. 39571 Based on observation and staff interview, the facility failed ensure handrails in the corridors were firmly secured to the walls. This failed practice was a random opportunity for discovery and had the potential to affect all residents residing on the second (2nd) floor of the facility. Facility census 39. Findings included: During a tour on 08/23/21 at 10:30 AM, Licensed Practical Nurse # 61, was asked to witness the loose handrails in the hallway on the second floor. She agreed they were loose and said she would let the maintenance man know. On 08/25/2021 at 7:38 AM, Registered Nurse # 4 was in the hall on the second floor and was shown there were still loose handrails. RN # 4 stated the maintenance people fixed the handrails yesterday. She agreed there was some railings still loose. During an interview on 08/30/2021 at 12:10 PM, Environmental supervisor stated, he had to go to the store to get anchors to hold the rails tight to the wall, but he did get all of them fixed today.