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	495193	A. BUILDING _____ B. WING _____	C 02/24/2025

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 2/18/25 through 2/21/25 and 2/24/25. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five complaints were investigated during the survey: VA00062944 - Substantiated with a deficiency VA00062705- Substantiated with a deficiency VA00060998 - Substantiated with deficiencies VA00062707 - Unsubstantiated for lack of sufficient evidence VA00062617 - Substantiated with deficiencies The census in this 120-certified-bed facility was 113 at the time of the survey. The survey sample consisted of 12 resident reviews.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or	F 552		3/21/25

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

Electronically Signed | 03/18/2025

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F 552	Continued From page 1 professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility failed to ensure that one Resident (Resident #7), in a survey sample of 12 residents was informed, in advance, of the care to be provided and their rights upon admission. The findings include: For Resident #7, the facility staff failed to ensure that resident was informed, in advance, of the care to be provided and their rights upon admission and provide admission contract and rights on admission. Resident #7 was admitted to the facility on 09/03/2024, and discharged on 10/14/2024, with diagnoses of, but not limited, Type 2 diabetes, kidney transplant status, end stage renal disease, pulmonary hypertension, nutritional anemia, and multiple fractures of ribs. The most recent MDS (minimum data set) was an admission assessment with an (ARD) assessment reference date of 09/03/2024 was reviewed and revealed Resident #7's (BIMS) Brief Interview for Mental Status was coded a score of 15 out a possible 15 indicating no cognitive impairment. A review of Resident #7 admission packet and contracts was reviewed and revealed that Resident#7 was admitted on 09/03/2024, but that	F 552	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F552 Right to be informed/Make Treatment Decisions 1. Resident #7 no longer resides in the facility. 2. Current residents in the facility have the potential to be affected. The admission staff will audit current residents admitted past 30 days to verify admission contract are signed timely. Findings will be corrected. 3. The Administrator educated the admissions team regarding the admission process for resident rights on admission agreements to be reviewed with resident and/or responsible party with signature to validate understanding of the admissions agreement to the admission process in timely manner when admitted. 4. The director of admissions or designee will audit new admits weekly x 4 then monthly x 2 to verify the admission agreement was signed timely when admitted. Findings will be corrected.	

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F 552	Continued From page 2 admission process was not explained for forms signed and provided to the resident until 09/05/2024 On 02/18/2025 at 1:30 p.m., an interview was conducted with the Director of Nursing (DON) who was asked what and when admissions documents, contract and rights forms are provided to the residents and or the resident representative. The DON stated that the admission packet is discussed, and forms signed on admission, and if the admission is afterhours with 24 hours. medications are expected to be administered by licensed staff as ordered by the physician the ordered dose and time. A review of the document entitled "Admission Policy" was reviewed and revealed that "The Admission Director will ensure all proper documents are completed copied and filed appropriately whenever a patient applies for admission or er- admission." On 02/24/2025 during the end of day meeting, the Administrator and Director of Nursing was made aware of the concerns. No further information was provided.	F 552	Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis 5. Date of compliance: 3/21/2025	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		3/21/25

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F 584	Continued From page 3 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interviews the facility staff failed to provide a comfortable, and homelike environment for 1 of 12 residents (Resident #5), in the survey sample. The findings included:	F 584	F584 Safe/Clean/Comfortable/Homelike Environment 1. Resident #5 baseboard was replaced on 2/18/25 by the maintenance staff. 2. Current residents in the facility have	

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F 584	Continued From page 4 Resident #5 was originally admitted to the facility 2/11/2025. The current diagnoses included wedge compression fracture of third lumbar vertebra, type 2 diabetes mellitus without complications, major depressive disorder, and muscle weakness. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/17/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #5's cognitive abilities for daily decision making were moderately impaired. On 2/18/25 during an observation tour for room #48, it was observed that the cove base was missing around the entire perimeter of the room as well as the perimeter of the bathroom. It was also observed that cold air was coming out of the open areas and the cold air was flowing out into room #48. On 2/18/25 at 3:30 PM an interview was conducted with Resident #5. Resident #5 stated, "I'm 93 years old and I don't understand why they would put me in a room like this." Resident #5 also stated, "they did not finish the construction of this room, and I can feel the cold air coming in from the open areas." On 2/18/25 at 4:40 PM an interview was conducted with the Maintenance Director. The Maintenance Director stated that room #48 was being renovated and the work has not been completed. The Maintenance Director also stated that room #48 has been in its current state for about a month. The Maintenance Director	F 584	the potential to be affected. An audit by the maintenance director or designee was conducted to identify other baseboards in resident rooms that require repair/replacement. Findings will be repaired or replaced. 3. The Administrator educated the maintenance staff, social service and admissions team regarding homelike environment with repair of baseboards and/or renovations in resident□s rooms include preventative maintenance per schedule of resident□s room, plan and preparation to repair or replace identified areas. Based on the extent of repairs and/or renovations, the social service or admissions team will inform the residents/RP regarding room transfer as indicated if the residents cannot remain in the room during the repair or renovation process. 4. The Maintenance Director or designee will audit 5 resident rooms weekly x 4 then monthly x 2 to assess need for baseboard repairs or replacement. Findings will be repaired or replaced. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exist and sustained the review will be conducted on a random basis 5. Date of compliance: 3/21/2025	

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further stated that the room is not appropriate for a resident to be in due to its present condition.

On 2/18/25 at 4:50 PM an interview was conducted with the Regional Maintenance Director. The Regional Maintenance Director stated that the Corporate Maintenance Team has been working on the rooms and the reason that room #48 is not completed is due to the cove base being sent to another facility instead of this facility.

On 2/18/25 at 5:25 PM an interview was conducted with the Administrator. When asked about room #48 looking the way it does, the Administrator stated, "it's a Corporate Maintenance Team issue, I have nothing else to say about that."

On 2/19/25 at 9:50 AM an interview was conducted with the Administrator. The Administrator stated that when Resident #5 was admitted into Room #48, this room was the only room to put the resident in. The Administrator also stated that the Admissions Department put the resident in this room due to not having anywhere else to put the resident. When asked if room #48 was appropriate for Resident #5 to be in due to its condition, the Administrator further stated, "I'm not going to answer that question."

On 2/24/25 at approximately 4:37 p.m., a final interview was conducted with the Administrator, Director of Nursing, Assistant Administrator, Regional Vice President of Operations, and Regional Director of Clinical Services. An opportunity was offered to the facility's staff to present additional information. The Administrator stated, "these issues were fixed, and I do not

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F 584	Continued From page 6 agree with this." The Regional Vice President of Operations stated, "the issues were fixed the same day."	F 584		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on staff interviews, family interview and clinical record review, the facility's staff failed to remove/discontinue a Midline Intravenous Catheter before discharging a resident home therefore increasing the chance of complications, including infections, bleeding, and or dislodgement for 1 of 12 residents in the survey sample, Resident #12, a closed record sample. The findings included: Resident #12 was originally admitted to the facility 11/08/24 and discharged on 12/05/24 after an acute care hospital stay. The current diagnoses included: OTHER BACTERIAL INFECTIONS OF UNSPECIFIED SITE, FRACTURE OF UNSPECIFIED PART OF NECK OF RIGHT FEMUR, SUBSEQUENT ENCOUNTER FORCLOSED FRACTURE WITH ROUTINE HEALING. The admission, Minimum Data Set (MDS)	F 624	F 624 Preparation for Safe/Orderly Transfer/Dschrg 1. Resident #12 no longer resides in the facility. 2. Current residents in the center have the potential to be affected. The DON or designee will audit current residents with PICC/midline line have discontinued orders. Findings will be corrected. 3. The Staff Development Coordinator or designee will educate licensed nurses on the process for residents with PICC/midline IV catheters have physician orders to discontinue after usage is completed and/or prior to discharge unless resident is ordered to discharge with PICC/midline. 4. The Unit Manager or designee will complete audits weekly x 4 then monthly x 2 to verify residents with PICC/midline IV catheters has ordered to discontinue and verified removed to prevent potential	3/21/25

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F 624	Continued From page 7 assessment with an assessment reference date (ARD) of 11/14/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 3 out of a possible 15. This indicated Resident #12 cognitive abilities for daily decision making were severely impaired. In section"GG"(Functional Abilities Goals) the resident was coded as requiring Partial/Moderate assistance with eating, requiring Substantial/maximal assistance with oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, personal hygiene, roll left and right, walking 150 feet and dependent with putting on taking off footwear. The Care Plan dated 11/08/24 indicated that Resident #12 is at risk for pressure ulcers. The Goals: The resident will not have a skin impairment thru the review period. The interventions are to assess resident for risk of skin breakdown, Keep skin clean and dry as possible. The Medication Administration Record (MAR) read: Dextrose-NaCl Solution 5-0.45 % (Dextrose-Sodium Chloride) Use 80 ml/hr intravenously every shift for Hydration for 2 Days until finished 2 L is infused 11/22/24. A review of the November 2024 MAR show that Day, Evening and Night Shift IV fluids were administered. Dextrose-Sodium Chloride Intravenous Solution 5-0.45 % (Dextrose w/ Sodium Chloride) Use 2 liter intravenously every 24 hours for Hypernatremia Infuse 2 liters at 80cc/hour. Dated 11/20/2024.	F 624	complications. Findings will be corrected. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis. 5. Date of compliance: 3/21/2025	

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A review of the November 2024 MAR show that IV fluids were administered on 11/21/24, 11/22/24 and 11/23/24 per doctor's order. Place midline for hydration therapy one time only for Hydration.

A health status note dated 11/20/24 at 9:46 PM., read: IV started in the R forearm/wrist area 22 gauge on first attempt.pt tolerated with minimal discomfort. IV fluids started D51/2NS at 80 cc's per hour. Per orders.

A review of a Health Status note dated 11/22/2024 at 2:09 PM., read: "Patient alert and responsive. Patient has double lumen midline in right upper extremity. Patient has D5 1/2 NS running through midline,80cc/hr until 2 L infused. Patient received 240cc during this shift,tolerated well. Responsible Party (RP) contacted and notified of new orders and verbalized understanding."

A review of the skilled daily documentation note dated 11/30/2024 at 3:48 PM., read that Resident #12 had a Midline Intravenous (IV) access for hydration.

A review of the skilled daily documentation dated 12/03/24 read: That the resident does not have IV access.

IV Timeline:
11/20/24 8:20 AM., IV access present. Clysis started for hydration.
11/22/2024 10:25 AM., Place midline for hydration therapy one time only for Hydration.
11/20/24 9:46 PM., Health Status note. IV fluids started.
11/22/2024 9:53 PM., midline providing extra

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hydration from d50.45 saline at 80 ml/hr x 2 bags. no pain or distress noted this shift.
11/23/24 9:16 PM., Clysis discontinued. IV fluids started. Midline Access present.
11/23/24 at 10:41 PM., No midline. D50.45 iv had concluded in the previous shift.
11/23/24 1:45 AM., Midline access present. Health status note read: double lumen midline in rightupper extremity with no sign/symptomsof infection. On D5 1/2 N patent andinfusing through midline, 80cc/hr until 2 AM., Patient alert and responsive.No labored breathing nor distress noted.Patient on continuous oxygen 2 L viaNC. Noted double lumen midline in rightupper extremity with no sign/symptomsof infection. On D5 1/2 N patent andinfusing through midline, 80cc/hr until 2.
11/24/24 12:15 PM., Dextrose-NaCl Solution 5-0.45 %. Use 80 ml/hr intravenously every shift for Hydration for 2 Days until finished 2 L is infused 2L has been infused, order complete.
11/24/2024 11:16 PM., No Midline access present.
11/25/2024 11:55 PM.,No Midline access present.
11/27/2024 11:20 PM., No Midline access present.
11/26/2024 8:44 PM., No Midline acces present.
11/28/2024 1:39 PM., Midline IV access present.
11/29/2024 2:08 PM., Midline IV access present.
11/29/2024 10:59 PM No IV access present.
11/30/2024 3:48 PM., Midline IV access present.
12/1/2024 4:22 PM., No IV access present.
12/02/24 1:52 PM., Midline IV access present.
12/03/24 12/03/24 read: Does the resident have any Intravenous access=No
12/04/24 11:15 PM., Skilled Note- IV Therapy, IV access present: No

According to the timeline listed above the resident

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would have occassional IV access due to hydration concerns.

According to the review there was no indication that during discharge that an IV Midline catheter was ever discontinued from Resident #12.

A review of the discharge summary dated 12/5/2024 at 9:00 AM., Read: Resident discharging home with son. Resident was ordered a hospital bed, wheelchair, and oxygen. Resident was sent home with medications. Son will provide transportation. Resident will have home health (OT, PT, skilled nursing)through Center Well home health.

A review of the medical records and discharge summary did not reveal that a Midline IV was discontinued by staff before resident was discharged home.

On 2/21/25 at approximately 1:05 PM., an interview was conducted with Certified Nursing Assistant (CNA) #1. CNA #1 said an IV would be seen hooked up on her side of the bed, but on her day of discharge, she dressed but didn't notice an IV.

On 2/21/25 at approximately 2:10 PM., an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 said that Resident #12 did have a Midline IV in her arm but she wasn't there when the resident was discharged from the facility.

On 2/21/25 at approximately 4:45 PM., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON said that the resident's daughter in law called saying we

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had left the IV in the resident's arm. The ADON said that they would initially use a contracted outside service to put the Midline IV's in and that a Registered Nurse has to discontinue the Midline IV's in the facility. The ADON also said that transportation was initially called to pick up the resident but her son called and said he would pick her up instead which caused an abrupt discharge.

On 2/21/25 at approximately 5:25 PM., an interview was conducted with LPN #2. LPN #2 said that she didn't know that the resident had a midline IV in because "she wasn't my patient. I was helping another LPN with the discharge process." LPN #2 said that the LPN took care of Resident #12 but was no longer working at the facility. LPN #2 also mentioned that the ADON, Director of Nursing (DON) and a Registered Nurse (RN) were present in the facility, could have pulled it (IV), because LPNs are not allowed pull Midline IV's.

On 2/24/25 at approximately 2:30 PM., an interview was conducted with the Director of Nursing (DON). The DON said that the ADON reported to her that a family member called the facility saying that Resident #12 had been discharged with her IV still intact. She stated that they discussed the incident in clinical rounds the next day but didn't document anything because once a chart closes you shouldn't go back in. The DON also mentioned that complications such as infection and bleeding could happen from having a midline IV in.

On 2/24/25 at approximately 2:35 PM., an interview was conducted with the ADON concerning Resident #12. The ADON said that an

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F 624	Continued From page 12 RN should have discontinued the IV before discharge. On 2/24/25 at approximately 4:35 PM., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. Midline catheters should be selected based on the intended purpose and duration of use, known complications, and experience of individual catheter inserters. Midline catheters are a type of peripheral catheter, longer than short PIVs, and indicated for patients requiring therapy for more than five days but less than a few weeks (Gorski et al., 2021; Chopra et al., 2015). Generally, 8-25cm long, Midline catheters are inserted with ultrasound guidance into the larger diameter veins of the upper arm and tend to last longer than a PIV. The CDC states to use a Midline catheter or PICC instead of a short peripheral catheter if the duration of IV therapy will likely exceed six days (O'Grady et al., 2011). Midline catheters typically do not last without complications for more than a few weeks but can provide patients with a longer, more reliable access alternative to the short PIV (https://www.accessvascularinc.com/take-action/when-to-choose-piccs-vs-midlines-nancy-moureau).	F 624		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		3/21/25

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F 684	Continued From page 13 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to maintain the industry standards of diabetic management for one Resident (Resident #3) in a survey sample of 12 Residents. The findings included: For Resident #3, the facility staff failed to Assess and monitor the Resident, and update the plan of care for a morbidly obese immobile Diabetic Resident including removal of Diabetic medication management, removal of a therapeutic diet to decrease blood sugars, and removal of blood sugar checks, and resident weights. There was no assessment nor monitoring for a significant weight gain, while in the presence of worsening Respiratory illness, with continuous oxygen use, pneumonia, sleep apnea, and after hospitalization with an acute bout of congestive heart failure. Resident #3, was initially admitted to the facility on 12-13-23. Diagnoses included; diabetes mellitus, acute congestive heart failure, morbid obesity due to excess calories, sleep apnea with CPAP/BIPAP use, essential hypertension, and anxiety. The Resident was clinically complicated. Resident #3's most recent MDS (minimum data	F 684	F684 Quality of Care 1. Resident #3 had provider and dietitian discussed diabetic management and will honor resident rights to choose not to follow recommendations and/or physician orders and care plan revised/updated on 3/13/2025. 2. Current residents in the center have the potential to be affected. The DON or designee will audit current residents with diagnosis of diabetes to verify diabetic management including diet, weights, medication management, accu-checks, labs if applicable and resident rights are honored to choose not to follow recommendations and/or physician orders with care plan update/revised. Findings will be corrected. 3. The staff development coordinator or designee will educate licensed nurses and dietitian on the process for diabetic management and documentation includes diet, weights, medication management, accu-checks , labs if applicable, for assessing and monitoring with resident rights honored if chooses not to follow recommendations or physician orders with RP, provider and dietitian notified, care plan updated/revised. 4. The Unit Manager or designee will complete audits weekly x 4 then monthly x	

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F 684	Continued From page 14 set) with an ARD (assessment reference date) of 12-17-24 was coded as an annual assessment. Resident #3 was coded as a Brief interview for Mental Status score of 15 indicating no cognitive impairment, no short and long term memory deficits and required no assistance with making daily life decisions. The Resident was also coded as requiring extensive to total assistance of one to two staff members to perform most activities of daily living, due to immobility related to severe obesity from excess caloric intake. The Resident was coded as "did not refuse" treatment or care. Resident #3 was observed and interviewed on 2-19-25, and 2-24-25 during the lunch meal in his room. The Resident stated during those interviews "Look at this mess, (the lunch meal) they are trying to kill me.", and "I have to eat what they bring me, or I won't eat, and it's never what I ask for or what's on the ticket." The Resident also stated "They say you can get a salad, but every time I asked they say they are out of them.", and "Everything on that alternate list except salads is carbs, just go look at it." during the lunch meal both days. The Resident was asked if we could weigh him today, and his response was "Sure." The meal trays consisted of the following; On 2-19-25 - "Large Portion Regular Diet" - 2 dinner rolls, 4 large double battered and fried chicken chunks approximately 1 ounce each, 2 scoops (like and ice cream scoop) of mashed potatoes, 1 cup of green beans buttered, 1 bowl (1 cup) apple crisp desert, and 8 ounces of sweet tea to drink. The only items which were not sugary carbohydrates were the small chicken pieces inside the thick fried batter and the green beans, however, they were buttered.	F 684	2 to verify new residents or changes in resident diabetic management had processes were followed with supporting documentation, resident choices, care plan updated/revised. Findings will be corrected. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis. 5. Date of compliance: 3/21/2025	

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The tray ticket on this day was not observed to be followed, and specified a different meal than the Resident received, which was: - "Large Portion" "2 grilled cheese sandwiches on white bread, buttered green beans, buttered egg noodles, 1 peanut butter and jelly sandwich, apple crisp, and tea (all carbohydrate with the exception of the green beans).

On 2-24-25 - "Large Portion Regular Diet" - 2 Philly cheese steak sandwiches on submarine 6 inch sandwich rolls, sauteed peppers & onions, potato salad, 1 peanut butter and jelly sandwich, tea 8 ounces." The only items which were not sugary carbohydrates were the small pieces of beef and vegetables inside the 2 large 6 inch rolls.

The tray ticket on this day was observed to be followed, with only 2 changes. The 1 peanut butter and jelly sandwich was not on the tray, and a chocolate brownie was added to the tray as desert.

Immediately following the lunch meal the Dining Services Director was interviewed with the Corporate food services Director present. Both stated that "Large portion" meant anything on the plate was doubled, and "Double portion" would constitute everything on the entire tray would be doubled. They were asked for the menu and alternate menu, and it was supplied. The alternate menu consisted of carbohydrate dense foods, except for the 2 salad options listed.

They were asked if this (tray ticket) looked like a meal a morbidly obese Diabetic Resident should receive, they both stated "No".

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Physician orders were reviewed and revealed 3 diabetic medication orders for the Resident. Those follow below;

1. Farxiga 10 mg (milligrams) daily from 12-14-23 to 12-27-23 then discontinued.

* No order existed for Diabetic medication management in the clinical record from 12-27-23 to 3-9-24.

2. Jardiance 25 mg once daily from 3-09-24 to current.
3. Glimipiride 2 mg twice daily from 3-24-24 to current.

Further review of Resident #3's clinical record revealed the following;

Only 2 weights were documented in the clinical record. On admission on 12-13-23 Resident #3's weight was measured as 479.5 pounds. On 10-2-24 it was documented as 498 pounds (a 19 pound weight gain). The Resident had a history of a recent hospitalization with acute/resolved congestive heart failure, however, was not prescribed a diuretic.

Upon admission on 12-13-23 through 12-19-23 the Resident was prescribed a Heart healthy diet. This was discontinued on 12-19-23, and no other diet was specified in the physician orders until 1-8-24.

1-8-24 Regular diet. Discontinued on 3-12-24.

From admission to 3-12-24, Resident #3's blood sugars were measured daily to be consistently

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above 200 and at times above 300 up to 337.

On 3-7-24 the Resident received a diabetes laboratory blood test for hemaglobin A1C with a result of 10.0. The normal range is 4.0 to 6.0, and the Resident was very high revealing uncontrolled high blood sugar over time.

On 3-12-24 a physician's order for Diabetic diet was issued and continued through 9-24-24. No weight was assessed nor documented as being taken.

From 3-13-24 to 9-26-24 the Residents blood sugars began to normalize and by 4-13-24 it was consistently under 200 and between 84, and 185. By October of 2024, they were consistently within normal range with the following being documented; 10-9-24 - (104), 10-15-24 (87), 10-20-24 - (105).

On 6-27-24 the Resident received a diabetes laboratory blood test for hemaglobin A1C with a result of 6.8. The result had improved at the halfway point after the diet change.

On 7-17-24 the Resident was diagnosed with pneumonia, and given antibiotics, however, the Resident's blood sugar continued to improve.

On 9-26-24 A new physician's order was received for "Regular diet" to be begun again with no assessment nor justification.

On 11-1-24 (one month and 4 days later) the Resident's blood sugars were back up to 232 mg/dl.

On 11-29-24 a physician's order was given to

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discontinue blood sugar checks (finger stick blood sugar) FSBS. Which had been originally ordered and started on 2-13-24.

Registered Dietician (RD) notes were reviewed and follow below;

"Nutrition Assessments" were conducted 4 times for the Resident in 14 months after the initial assessment completed on 12-19-24. The initial assessment stated Resident history, and discontinue the "Heart Healthy diet" for a "Regular diet, add a multivitamin with minerals ordered 12-20-23, monitor weights and meal intake and follow up.

On 1-8-24, The Resident's diet was not changed and the interventions on admission were "Continued".

On 6-17-24 the Resident was changed to a "Diabetic diet" in the note and lists the admission weight of 479.5 on admission, as no other weights were obtained until 10-2-24, and to "Continue" the admission interventions.

9-16-24 a quarterly MDS assessment was completed, everything was continued and the note still stated as did the MDS the admission weight as no other weights were obtained.

On 9-26-24 the diet was changed back to regular, a month later the Resident's blood sugar was back up, and on 11-29-24 blood sugars were discontinued without any monitoring, assessed reason, nor care plan changes.

Finally on 12-17-24 the Resident's diet lists "Regular" again in the last RD note in the clinical

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record as of the time of survey and no reason is given, with no other changes.

On 2-24-25 an interview was conducted with the Registered Dietician (RD). She stated that "A liberalized diet is used if blood sugars are not high." She was asked if Resident #3 who had high blood sugars should be on a large portion regular diet. She stated she was unsure why he was placed on the diet , and why the diabetic diet was removed, however, "progress notes should reveal assessments and team meetings or care planning". No updates from admission were found. She stated that "large portion" was "less defined and more of a guess when preparing a Resident tray", whereas "double was self explanatory". She was informed that no assessments for diabetic management was found in the clinical record while reviewing the chronological history of this Resident's diabetic management care. She stated that decisions should always be based on data and outcomes.

Review of the care plan revealed that on 12-19-23 the initial admission base line care plan listed the 2 following focuses with the interventions related to dietary management and diabetic management;

1. Focus - Resident at risk of weight fluctuations, loss or malnutrition related to respiratory failure, CHF (congestive heart failure), severe morbid obesity due to excess calories, high BMI (body mass index) which measures the body fat based on height and weight (BMI equal to or greater than 30 = obesity) (The Resident's BMI was 61).

Interventions - RD consult as needed, record meal intake percentage, weights as ordered.

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F 684	Continued From page 20 2. Focus - Diabetes Mellitus - Resident is at risk for complications and blood glucose fluctuations related to diagnosis. Interventions - Administer medications as ordered, observe for signs and symptoms of hyper/hypoglycemia and notify MD as indicated, RD consult as needed. The only changes made to this initial care plan during the Resident's 14 month stay were the following 2 items; 1. Therapeutic diet as ordered (created 6-20-24) (resolved 1-22-25) 2. Resident consistently refusing to be weighed, added by the RD on 1-24-25. Offer the Resident to choose the day, time, frequency of weights in order to increase compliance and support desired autonomy. The MDS assessment stated that the Resident did not refuse care nor assessments, weights were not completed as ordered and not by facility policy. Medications were omitted for a period of 2.5 months while the Resident experienced dangerously high blood sugar readings, and there is no indication that the physician was ever made aware or intervened in any way. The therapeutic Diabetic diet was ordered on 3-12-24 and discontinued 9-24-24. The care plan was not updated to reflect the new therapeutic diet for 3 months, and not updated to indicate it had been discontinued until 4 months later. The purpose of a nursing care plan is to inform staff and drive patient care.	F 684		

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Review of Physician progress notes also do not indicate a reason for the diet change, nor do they illustrate monitoring of the history of the increasing blood sugars or resultant lower blood sugars when the diet was changed to a therapeutic "Diabetic Diet". Weights were not monitored, and Diabetic medication management was lacking from 12-27-24 to 3-9-24 (2.5 months) while receiving a "Regular Large Portion Diet".

Clinical records do not indicate any ongoing assessments for; Weight gain, discontinuance of diabetic medication management for 2.5 months, discontinuance of a successful therapeutic diet, and discontinuance of blood sugar monitoring. The data clearly showed successful interventions which were then discontinued. The diet was returned to a Regular large portion diet, and blood sugars began to rise again, which continued without any further assessment for 2 further months up until the time of survey.

LPN's (Licensed Practical Nurses) on both nursing units were interviewed by surveyors during the course of the survey, and asked if a Resident with Diabetes and high blood sugar checks should be consuming a large portion high carbohydrate diet, they unanimously stated "no". When asked why, each stated a different side effect; "Their blood sugars will go through the roof", "Their sugar will be high and could send them into ketoacidosis", "it could cause kidney failure and dialysis". All of their responses were correct, and could be a reasonable outcome.

Review of the facility's policy entitled "Weight Monitoring and Tracking" included:

"Procedure" #2. Patients will be weighed on

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F 684	Continued From page 22 admission/readmission and weekly time 4 weeks thereafter, or until the interdisciplinary team determines the weight is stable, then monthly thereafter. The Resident was not weighed monthly, and no progress notes indicate a reason until the RD placed in the care plan refusals by the Resident on 1-24-25. As the Resident was morbidly obese and weights would require large scales and multiple staff to complete, it appears weights were omitted for staff convenience. One star out of 5 stars was applied to the facility for staffing levels for the preceding year, by CMS (Centers for Medicare/Medicaid Services) in their payroll based journal staffing reports, CMS Compare. This indicated sub par staffing in the facility, and "excessively low weekend staffing" in the third and fourth quarters of 2024. On 2-24-25 at the end of day debrief the Administrator and corporate representatives were made aware of findings. No further information was provided.	F 684		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 725		3/21/25

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F 725	Continued From page 23 accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on Observations, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to schedule sufficient nursing staff to maintain the highest practicable well being of each resident. The findings included; During the course of the survey from 2-19-25 through 2-24-25 a complaint was investigated by the state agency. No date, nor date range was included for an allegation of insufficient nursing staff. The receipt of the complaint in the state agency occurred initially on 2-8-24. Residents placed in the survey sample were interviewed as well as nursing staff. They stated that staffing had been an issue at times over the past year, however, staffing had become more normalized within "the last few months".	F 725	F725 Sufficient Nursing Staff 1. The timeframe has passed to correct. 2. Current residents in the center have the potential to be affected. An audit by the administrator on the current resident census to verify the PPD is adequate to ensure staffing of licensed nurses and CNAs meet resident care needs. 3. The administrator will educate the staffing coordinator and nursing management (DON, ADON UM□s) on the process to ensure adequate staffing of licensed nurses and CNAs to meet resident care needs based on census and PPDs. Use of agency staff as needed to ensure adequate staffing to ensure sufficient staffing . 4. The administrator or designee will audit weekly x 4 then monthly x 2 to verify adequate staffing of licensed nurses and	

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HENRICO HEALTH & REHABILITATION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 24 Residents were observed to be dressed in clean clothing, no pervasive odors existed in the facility, and the general population of Residents were seen to be engaged in activities, therapies, and independent leisure activity outside on the front porch area, and in their own rooms. Residents clinical records were reviewed for Activities of daily living care (ADL's), medication administration, therapies, and dining activities. The care was ongoing and appeared at the time of survey to be sufficient currently. As worked staffing schedules and time clock punches were also reviewed and found to be sufficient currently. Since no exact dates can be ascertained, the previous year of CMS (Centers for Medicare/Medicaid Services) payroll base journal submissions, and CMS Compare reports were reviewed. This included "Fiscal year" 2024 quarter one through quarter 4. In those reports, one star out of 5 available stars was applied to the facility for staffing levels for the preceding year, by CMS in their payroll based journal staffing reports, and CMS Compare. This indicated sub par staffing in the facility for that time period, and "excessively low weekend staffing" in the third and fourth quarters of 2024. On 2-24-25 at the end of day debrief the Administrator and corporate representatives were made aware of findings. No further information was provided.	F 725	CNAs based on census and PPD was followed, findings will be addressed. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conducted on a random basis. 5. Date of compliance: 3/21/2025	