STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035139	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Show Low	2401 East Hunt Street Show Low, AZ 85901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 Based on observations, clinical record review, resident and staff interviews, and review of facility policy, the facility failed to ensure one resident (#145) was assessed to be safe for medication self-administration. The deficient practice could result in resident not taking or able to take the medication needed for treatment. The census was 48. Findings include: Resident #145 was admitted on [DATE] with diagnoses of clostridium difficile, enterocolitis, end stage renal disease (ESRD), ankylosing spondylitis, and atherosclerotic heart disease. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8 indicating the resident had moderate cognitive impairment. A physician order dated August 6, 2024 for Sevelamer Carbonate (phosphate binder) 800 mg milligram) three times a day for ESRD with meals. There was no evidence found in the clinical record that self-administration was determined as clinically appropriate for resident #145. There was no evidence that the resident was assessed for self-administration. A medication observation was conducted on August 5, 2024 at 11:19 a.m. There was a white pill in a medicine cup on the bedside table of a resident #145 that was left unattended. The resident stated the pill was his phosphorus binder that was taken prior to lunch; and that, he self-administers this medication on a daily basis. An interview was conducted with resident #145 on August 5, 2024 at 11:42 a.m. The resident stated the name of the pill that was in the cup was hard to pronounce so he calls it his dialysis meal pill. Resident #145 said that the nurse usually keeps his dialysis meal pill on his bedside table, so he can remember to take it. He said that the registered nurse (RN/Staff #2) was the one who left white pill next to his breakfast tray this morning. Further, the resident stated that he self-administers his medication three times a day, all the time because all the nurses allow it; and, he would just reach over and takes the pill when it's time. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with a Registered Nurse (RN/Staff #2) conducted on August 5, 2024 at 11:47 a.m., the RN stated that when administering medications, nurses follow the 7 rights: right person, right medication, right dose, right time, right route, right reason, and right documentation. The RN also stated that when giving resident medications, the policy was to wait at bedside until all medications were taken by the resident; and that, no medications were to be left at bedside due to the risks such as leaving the medication for someone else to take. Further, the RN said that there was no reason for medication to be left at bedside and it was against facility policy to leave medications unattended. The RN said that if a medication was found at the bedside, it was to be removed and reported to the Director of Nursing (DON). An interview with a licensed practical nurse (LPN/Staff #13) was conducted on August 6, 2024 at 8:07 a.m. The LPN stated that when giving medication, it was a policy to stay by the bedside until all medications were administered; and, if any medication was found by the bedside, it was to be collected and turned in to the DON. During an interview with the Director of Nursing (DON/staff #105) conducted on August 6, 2024, the DON stated that there was absolutely no reason for any medication to be placed at the bedside-unless they have an order to do otherwise. The DON said that there were too many risks involved, such as someone else taking the medication, and that practice was against facility policy. Further, the DON stated there was no self-administration determination found in the clinical record for Resident #145. A facility policy on Self-Administration with an effective date of January 1, 2024 included that residents have the right to self-administer medications if the interdisciplinary team (IDT) determined that it is clinically appropriate and safe for the resident to do so. If it is deemed safe and appropriate for the resident to self-administer medications, this is documented in the medical record, and the care plan. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the responsible party or proper disposal.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 Based on clinical record review, resident and staff interviews and review of facility policies and procedures, the facility failed to ensure two residents (#24 and #37) received notification prior to the room change. The deficient practice could result in resident's preferences not honored. Census was 48. Findings include: -Resident #24 was readmitted to the facility on [DATE] with diagnoses of alcoholic hepatic failure, unspecified dementia with other behavioral disturbance, epilepsy, anxiety disorder and abnormalities of gait and mobility. The census list revealed that the resident had a room change on June 22, 2023 and December 4, 2023. The clinical record revealed no evidence that the resident was notified of a room change on June 22, 2023. The Room and/or Roommate Change Notice dated December 4, 2023 revealed that the notice was to inform the resident in advance of a room change and the reason for the room change was due to other residents' welfare effective December 4, 2023. However, the documentation did not include any further explanation of this reason. The notice signed by a staff member and dated December 4, 2023. However, the documentation did not include any resident signature. The clinical record revealed no evidence that the resident was given advance notice regarding the room change on December 4, 2023. The Room And/or Roommate Change Notice dated February 9, 2024 revealed that the notice was to inform the resident in advance of a room change with effective date of February 9, 2024. However, the section on the reason for the discharge was left blank. It also included that the notice was provided to the resident. It also included that the notice was signed by a staff; but, was not signed by the resident or the resident's representative. The clinical record revealed no evidence that the resident was given advance notice regarding the room change on February 9, 2024. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident had intact cognition. The census list revealed that the resident had room change on August 1, 2024. However, the clinical record revealed no evidence that a written notice regarding the roommate or room change was provided to the resident prior to August 1, 2024. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on August 8, 2024 at 7:55 a.m. with resident #24 who stated that she did not recall signing a room change/roommate change form or being informed of a room or roommate change. -Resident #37 was admitted on [DATE] with diagnoses of transient cerebral ischemic attack, right sided hemiplegia and hemiparesis following cerebral infarction and muscle weakness. The admission Minimum Data Set assessment dated [DATE] revealed a BIMS score of 15 indicating the resident was cognitively intact. Review of the census list revealed the resident had a room change and became on August 1, 2024 and became the roommate of resident #24. However, the clinical record revealed no evidence that the resident was given an advance notice regarding the room change on August 1, 2024. In an interview with resident #37 conducted on August 8, 2024 at 7:45 a.m. resident #37 stated that she refused the room change was refused, did not like the change and admitted to throwing a fit regarding the change. The resident further stated that she was very upset and unhappy that day of the room change, and was still upset about the room change. Further, resident #37 stated that she did not receive or sign any written notice regarding the room change. Resident #37 stated the staff came to see her when she was still in her previous room, informed her of the move and then was to new room soon after on the same day. During an interview with the administrator (staff #49) and the director of nursing (DON/staff #105) conducted on August 8, 2024 at approximately 11:45 a.m., both the administrator and DON stated that room assignments were influenced by factors such as resident preference and/or behavioral issues. The DON stated that residents were to be given written and advance notice about room or roommate changes. The DON stated that residents #37 and 24 did not a written Room and/or Roommate notice for the room or roommate change on August 1, 2024. Further, the DON stated that the room And/or Roommate Change Notice dated February 9, 2024 for resident #24 documentation was incomplete. The facility policy on Resident Rights-Room Change/ Roommate Assignment with an effective date of January 1, 2024 included that prior to changing a room or roommate assignment, residents are given advance written notice of such change. Advance written notice of a roommate change includes why the change is being made.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50887 Based on clinical record review, staff interviews, and policy review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) assessments Level I screening was completed as required for one sampled resident (#4). The deficient practice could result in resident not receiving specialized services needed. Findings include: Resident (#4) was admitted on [DATE] with diagnoses of major depressive disorder, unspecified mood (affective) disorder, bipolar disorder, post-traumatic stress disorder, and anxiety disorder. A review of the Level 1 PASRR screening dated November 8, 2022 revealed that the resident's admission met the criteria for 30-day convalescent care. The care plan dated November 9, 2022 included that the resident used antidepressant and anxiety medications related to depression and anxiety disorder. Intervention included to give antidepressant and anti-anxiety medications as ordered by the physician. The clinical record revealed that the resident remained at the facility for longer than 30-days from admission. Review of the care plan dated July 20, 2023 revealed resident used anti-psychotic medications related to bipolar disorder; and that, medications were administered to treat behaviors of hallucinations and agitation. Intervention included to administer medications as ordered. The clinical record revealed resident had the new diagnoses on the following dates: -Post-traumatic disorder on July 19, 2023; -Bipolar disorder current episode depressed severe with psychotic features on July 19, 2023; -Mood (affective) disorder on October 19, 2023; and, -Major Depressive disorder on March 21, 2024. The physician progress note dated June 2, 2024 included that the resident's mood had been stable and resident continued to receive psychiatric treatment. Assessment included recurrent major depression. The encounter follow-up note dated June 13, 2024 revealed the resident was alert and oriented x 3 and had a calm mood. Diagnosis included recurrent major depressive disorder, in partial remission. Plan was to continue oral antidepressant daily. The quarterly Minimum Data Set (MDS) assessment dated [DATE] included a brief interview for mental status (BIMS) score of 15 indicating the resident had intact cognition. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The encounter follow-up note dated July 23, 2024 included tat the resident was alert and oriented x3 and had a calm mood. Diagnosis included anxiety. Despite documentation of new mental disorder/illness diagnoses and documentation that resident remained longer than 30-days, there was no evidence found that a PASSR Level I screening was completed for the resident after November 8, 2022. An interview and review of the clinical record was conducted on August 6, 2024 at 11:39 a.m. with a social worker (staff #12) who stated that the last PASRR Level I screening completed for resident #4 was on November 8, 2022. In an interview conducted with the Director of Nursing (DON/staff #105) on August 6, 2024 at 12:07 p.m., the DON stated that the last PASSR evaluation complete for resident (#4) was on November 8, 2022. The DON (staff #105) also stated that there should have been another one completed because resident (#4) passed the 30-day stay; and that, the resident not having another PASSR screening after 30-day stay did not meet the facility expectations. In another interview with the DON (staff #105) conducted on August 8, 2024 at 10:47 a.m., the DON stated that specialized services could have been recommended for resident (#4); and without the PASRR being completed, the resident could not have received appropriate services for her diagnoses. Review of the facility policy on Pre-Admission Screening and Resident Review (PASRR), revealed the facility would verify that a Level 1 PASSR screening had been conducted; and that, if the resident was positive for potential mental illness or intellectual disability, a Level II PASSR referral must be submitted. It was the responsibility of the facility to make referrals for a Level II PASSR, or ensure the referral was made by the case manager. The policy also included that a request for Level II evaluation is not required for individuals requiring admission to the nursing facility for a convalescent period (not to exceed 30 consecutive days). If it is later determined that the admission will last longer than 30 consecutive days, a new PASRR Level I Screening must be completed as soon as possible or within 40 calendar days of the admitted to the nursing facility.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 Based on clinical record review, interviews, and policy review, the facility failed to ensure one resident (#41) and/or representative participated and involved in the development of the care plan and in making decisions of his care. The deficient practice could result in residents needs not being met. Census was 48. Findings include: Resident #41 was admitted on [DATE] with diagnoses of chronic kidney disease stage 3, adult failure to thrive, tremor, chronic pain, depression and abnormalities of gait and mobility. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 6 which indicated the resident had severe cognitive impairment. The baseline care plan signed by resident #41 and dated July 15, 2024 revealed the resident and/or representative consented to receive care. The goal was for that resident/representative will participate in planning my care and treatment according to the resident's goals and preferences. Interventions included for resident/representative will be informed of the type of care to be provided and risks and benefis of proposed treatments; and, thre resident/representative will participate in IDT (interdisciplinary team) care conference meetings. The care conference note dated July 2024 included that resident comprehensive care conference was conducted on July 23, 2024; and, was attended by resident relations, activities and dietary staff. The IDT (interdisciplinary team) care plan conference note dated August 7, 2024 revealed the IDT met with resident and his representative to discuss care plan and provide estimated length of stay. The resident/representative were listed as attendees. Per the documentation, the resident and representative were informed of the managed care plan, processes on concurrent review and NOMNC (Notice of Medicare Non-Coverage) issuance. However, this was struck out on August 7, 2024 at 5:02 pm because of incomplete documentation. Another IDT Care Plan Conference note dated August 7, 2024 at 5:03 p.m., revealed that on July 23, 2024, IDT met with the resident and his representative to discuss care plan and provide an estimated length of stay; and that, the resident/representative were informed of the managed care plan and processes on concurrent review. Per the documentation, the resident/representative were attendees to this care plan conference. Despite documentation that resident/resident representative (RR) attended the care paln conferences, during the interview with resident #41 and RR was conducted on August 5, 2024 at approximately 1:00 p.m., the resident and RR reported concerns about being at facility for over three weeks, and no provider or staff member has met with them about care planning. The RR stated that she was frustrated because she made several attempts to contact the resident relations manager (staff #12) over the past three weeks; and, had left numerous messages for staff #12. However, the representative said that staff #12 was unavailable and the RR did not receive any response at all. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In another interview with the resident and RR conducted on August 6, 2024 at 12:30 p.m., both the resident and RR reported displeasure about not knowing what's going on. The resident stated that the he signed something regarding an IDT care conference held on July 15, 2024; but, he was not aware that he was supposed to be present his care conference. The resident stated that he never attended a group meeting with staff to discuss his care, and did not know that such a group even existed. He said that did not recall meeting in a conference room, or having a group of people by his bedside discussing his care; and that, he was dissatisfied dissatisfaction with the attending primary care provider who knew nothing about him and made decisions about his care; and, never spoke with him about his care. The resident further stated that the attending primary care provider came in his room, introduced himself, and then left the room and mentioned nothing about course of action. The RR denied attending the care conferences for the resident in July 2024. An interview was conducted on August 7, 2024 at 12:00 p.m. with the RR who was waiting in hallway to talk to the resident relations manager (staff #)12 about care resident #41 was supposed to receive. The RR stated that she did not have an appointment; and that, although she was frustrated, she was willing to keep showing up, and wait as long as needed to meet with someone about the resident's care. An interview with Director of Nursing (DON/staff #105) was conducted on August 7, 2024 at approximately 12:35 p.m. The DON stated that the resident/representative were invited to care conferences which were typically held in conference room of facility. The DON stated that care conferences can also be held at bedside; and that, the meeting was dependent on resident preference. Further, the DON said that meetings were held for resident eligibility and updates; and, residents were encouraged to join. In an interview with the resident relations manager (staff #12) conducted on August 7, 2024 12:40 p.m., staff #12 said that she had beenin the position since October of 2023; and that, her responsibilities included addressing grievances, holding care conferences, clinical and concurrent reviews, and order equipment. She stated that care conferences were conducted by the bedside within 72 hours of admission; and that, documentation of this meeting was no longer necessary because the resident's needs were being addressed. Staff #12 said that care conference meetings were usually attended by her, the resident, DON, dietary director and activities director. Regarding resident #41, she stated that the notation in the care conference note dated August 7, 2024 was an error and she will correct the entry in the system. Staff #12 said that the correct date for the care conference was July 23, 2024; and that, this meeting was held in the office with the activities director (staff #29). Further, staff #12 stated that the RR was in attendance via the telephone; and, notice of non-coverage, and private pay policy were discussed during this meeting. During an interview with the DON conducted on August 8, 2024 at approximately 2:00 p.m., the DON stated that care conferences were to be documented in the clinical record; so, the resident relations manager (staff #12) was misinformed. Reviewof the facility policy on Care Plans-Comprehensive with revision date of [DATE], revealed that the care plan should reflect the resident's expressed wishes regarding care and treatment goals. In the event a resident refuse to participate in the development of care plan, refusals are to be documented appropriately in clinical record.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50862 Based on observations, clinical records review, staff interviews, and review of facility documentation, policies and procedures, the facility failed to ensure adequate supervision when smoking was provided for one resident (#25). The deficient practice could result in resident having potential for accidents related to smoking. Findings include: -Resident #25 was admitted on [DATE] with diagnoses of cerebral infarction, monoplegia of upper limb following other nontraumatic intracranial hemorrhage affecting left dominant side, aphasia, adjustment disorder with mixed anxiety, and depressed mood. The care plan dated revised on January 11, 2024 revealed the resident wished to smoke, was designated as having impaired safety awareness, and needed supervision. The goal was that the resident will smoke safely at designated areas at scheduled times. Interventions included that the resident may utilize device to promote safe smoking practices, demonstrate safe technique for putting out matches or lighter and disposing of ash, will ask for smoking materials, and was oriented to smoking procedures and areas. The smoking evaluation dated April 9, 2024 included that the resident had cognitive loss, dexterity problem and needed supervision. Per the documentation, the resident can light his own cigarette and needed the facility to store his lighter and cigarette The care plan revised on April 9, 2024 revealed the resident had a behavioral problem related to refusing medications and may try to smoke and hide cigarettes in her room. Interventions included to anticipate and meet her needs and intervene as necessary to protect the rights and safety of others. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident had short-term and long-term memory problems, had a moderately impaired cognitive skill for daily decision making, and required cues/supervision. During an observation conducted on August 5, 2024 at 11:37 a.m., resident (#25) was in her room sitting in a wheelchair and had her lighter. The resident stated that she keeps her own cigarettes and lighter in her room; and that, she does not wear a smoking apron and does not require or have supervision when she was out smoking During a smoking observation on August 6, 2024 at 3:53 p.m. resident #25 was at the designated smoking location with other 2 female residents; and, resident #25 was not wearing a smoking apron. There was no staff member present at the designated smoking area with the residents. An interview with the three residents including resident #25 was conducted during the observation. All three residents stated that they were assessed for smoking by staff; and, they were permitted to keep their personal smoking paraphernalia such as cigarettes and lighters in their rooms. Further, the three residents including resident #25 stated that they were not required to wear smoking and were not required to be supervised when smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on August 7, 2024 at 3:54 p.m. with Certified Nursing Assistant (CNA/staff #56) who stated that residents who were independent can smoke and can keep their cigarettes in their room; but, not their lighters. The CNA stated that the lighters were to be kept at the front desk and the resident had to ask for their lighter when going out to smoke. The CNA stated that the facility no longer had a posted smoking schedule. She stated that she receives resident care information from the nurse; and that, all of the residents in her assigned section were independent smokers. Regarding resident #25, she stated that resident #25 was in her assigned care section; and, that facility management was aware that resident #25 had cigarettes and lighters in her room. The CNA further stated that the resident was not willing to give her lighter and cigarettes to staff. An observation was conducted on August 7, 2024 at 4:04 p.m. resident #25 came out of her room with cigarettes and a lighter on her lap and self-propelled herself in her wheelchair passing the staff at the front desk and a nurse at the nursing cart. The resident then proceeded into the dining room and self-exited alone through the dining room door leading into the courtyard to the facility's designated smoking area. The resident retrieved a cigarette from her lap, placed and lit the cigarette in her mouth. At 4:19 p.m., resident #25 lit up another. There was no staff present in the designated smoking area with resident #25 until 4:28 p. m. when a staff member came to designated smoking area and assisted resident #25 back inside the facility. In an interview with nurse (staff #13) conducted on August 7, 2024 at 4:22 p.m., the nurse stated there was a smoking assessment completed upon resident's admission; but, she does not know if there was a follow-up assessment. She stated that residents were not supposed to have lighters with them; and that, the lighters were normally kept at the front desk. The nurse said that the residents were required to ask the receptionist for their lighter. She said that there was a smoking schedule posted in the past; but now, the residents can go out any time to the designated smoking area since they were all independent. A review of the clinical record was conducted by the nurse during the interview and the nurse stated that the smoking assessment for resident #25 was completed by MDS Coordinator (staff #51) on April 9, 2024. The nurse said that the assessment included that resident #25 was a smoker, needed supervision when smoking, and had to ask staff for smoking materials. The nurse said that the facility had to store the resident's lighter and cigarettes. Further, the nurse said that she had not seen resident #25 with a lighter; and that, she was not aware of the resident's care plan or smoker assessment. The nurse further stated without supervision resident (#25) could be a risk for catching on fire or burning herself. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on August 8, 2024 at 7:40 a.m. with the MDS Coordinator (staff #51) who stated that the floor nurse completes the smoking risk assessment upon admission of the resident; but, if the floor nurse does not complete this assessment, she completes the smoking risk assessment and she would then initiate a smoking care plan. She states she updates the smoking assessment and smoking care plans quarterly and if there was a significant change in condition. The MDS coordinator stated the residents who were not independent were not permitted to have unsupervised smoking, the residents must be in view of staff while smoking, and the resident's smoking paraphernalia such as their lighters were kept at the front desk. The MDS coordinator stated that independent residents were allowed to keep their lighters in their rooms. A review of the clinical record was conducted by the MDS coordinator during the interview and she stated that the resident's most recent smoking assessment indicated that resident #25 required supervision with smoking and the resident's lighter was stored either at the nurse station or at the front desk. The MDS coordinator said that the resident's most recent smoking risk assessment was correct. The MDS coordinator stated that she updates a list of resident smokers who were to be supervised to be kept at the front desk. Regarding resident #25, the MDS coordinator stated that resident #25 should be supervised while smoking for safety issues due to the risk of resident dropping cigarette in lap or improperly disposing of hot cigarette butts. During an interview with acting Director of Nursing (staff #105) conducted on August 8, 2024 8:15 a.m., the acting DON stated that upon admission, a new resident is asked whether they are a smoker or not. The acting DON said that the nurse or the MDS coordinator then completes the assessment and, care plan findings; and, would reassess the resident quarterly, or sooner if a significant change was identified. The acting DON also said that all the residents at the facility who smoke facility smokers had been identified as independent. The acting DON also said that if they had a resident that required supervision, the facility have set smoking schedule, the smoking activity of the residents were to be supervised by staff rotation in the designated resident smoking area of the patio, and, the resident's lighters would be kept at the front desk. The acting DON stated that there were no residents at the facility who required supervised smoking, so the residents were permitted to keep their own smoking supplies in their rooms. Further, the acting DON stated that management was responsible for the implementation of the smoking policy; and that, the expectation was for staff to follow the facility smoking policy and procedures. During the interview, a review of the clinical record was conducted with the acting DON who stated that the most recent smoking assessment for resident #25 was on April 9, 2024; and that resident (#25) needed supervision with smoking activities and was not to have cigarettes or a lighter kept in her room. The acting DON stated that the smoker care plan for this resident (#25) was not followed/implemented by staff. A revision of smoking evaluation was completed by the acting DON and dated August 8, 2024. The evaluation included that resident #25 no longer needed supervision when smoking and the resident does need the facility to store lighter and cigarettes. The care plan was revised on August 8, 2024 to include that the resident wished to smoke, was designated as a safe smoker, and was independent. Review of the facility policy on Resident Safety: Smoking Policy revealed that resident's ability to smoke safely is re-evaluated quarterly. Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51103 Based on record review, resident and staff interviews, and review of policies and procedure, the facility failed to ensure PICC (peripherally inserted central catheter) line dressing change was administered as ordered by the physician for one resident (#496). The deficient practice could result in complications such as infection. The census was 48. Findings include: Resident #496 was admitted to the facility on [DATE] with diagnoses of left knee staphylococcal arthritis, immunodeficiency, systemic lupus erythematosus, and muscle weakness. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. It also included that the resident was coded as having medically complex conditions and had full code-Cardiopulmonary Resuscitation (CPR) status. A physician order dated [DATE] included for Ceftriaxone Sodium (antibiotic) injection solution reconstituted 1 GM (Gram), use 1 gram IV (intravenously) every 24 hours for MRSA [methicillin-resistant Staphylococcus aureus (bacteria)] related to left knee staphylococcal arthritis until [DATE]. The active physician order summary revealed the following medications with order start date of [DATE]: -Change peripherally inserted central catheter (PICC) line dressing every 7 days and as needed using sterile technique. (order start date: [DATE]); -Change PICC line tubing every 24 hours for intermittent flow every day shift; -Flush PICC line with 10 ml (milliliters) of NS (normal saline) every shift and as needed and pre/post medication; -Monitor PICC line insertion site every shift for signs and symptoms of infection, redness, warmth, swelling and drainage every shift; and, -Discontinue IV/PICC line after completion of IV antibiotics and provider approval dated [DATE]. A physician order dated [DATE] included enhanced barrier precautions due to the IV and PICC line. The orders for the PICC line and IV Ceftriaxone were transcribed onto the Treatment Administration Record (TAR) for July and [DATE]. Review of the TAR from [DATE] through [DATE] revealed that PICC line dressing/tubing changes, flushing and monitoring were administered as ordered by the physician. Further review of the TAR revealed that PICC line dressing change was documented as administered on [DATE] and [DATE]. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, during an observation of a PICC line dressing change conducted on [DATE] at 7:10 a.m., the PICC line dressing was not initialed and did not have a date and time it was last changed. The PICC line was on the right upper arm of resident #496; and, both clamps above injection caps were unclamped. The white perforated adhesive surrounding the transparent film had a significant amount of grayish areas. An interview with resident #496 was conducted immediately following the observation. The resident stated that the PICC line was placed on him because he had a left knee staph (bacteria) infection. The resident stated that he tries not to get the dressing dirty because it was hardly changed; and that, the dressing was last changed at the facility close to time of his admission. Resident#496 said that he does not know how often the PICC line dressing should be changed; but, the dressing was not changed this week. He stated that the dressing became dirtier each day, but he figured that it was okay since the nurses always used it. In an interview with a licensed practical nurse (LPN/staff #13) conducted on [DATE] at 7:35 a.m., the LPN stated that the facility policy was to change PICC line dressing at least once a week or if soiled; and, the site was to be checked every shift for signs and symptoms of infection. The LPN said that checking of the PICC line site was to ensure dressing was intact, clean, and dry. Regarding resident #496, the LPN stated that PICC line is necessary for resident antibiotic therapy due to knee infection. During the interview, a review of the clinical record was conducted by the LPN who stated that the documentation in the TAR showed that dressing observations were checked off each shift which meant no issues were observed. An observation the resident's PICC line dressing was conducted with the LPN who stated the resident's PICC line dressing was dirty and needed to be replaced. The LPN also stated that she could not to see or locate date/initials/time on when the dressing was last changed per their policy. During an interview with the director of nursing (DON/staff #105) conducted on [DATE] at 7:50 a.m., the DON stated that PICC line care included the use of aseptic technique, frequency of PICC line care, and what staff were to monitor each shift which includes looking for redness, swelling, drainage, and overall integrity of dressing. The DON stated that staff were to replace the PICC line dressing if it appears loose or soiled per policy. A review of the clinical record was conducted by the DON during the interview. The DON stated that there was a physician order for dressing changes and monitoring; and, documentation in the MAR and TAR for resident #496 showed completion of site checks each shift. An observation the resident's PICC line dressing was conducted with the DON who assessed the resident's dressing and stated that the dressing was soiled and needed changing immediately. The DON also stated that she was unable to locate date, time, and initials on when the dressing was last changed; and, this practice was not according to their policy. The facility policy on Intravenous Therapy: Central Venous Catheter Care and Dressing Changes with an effective date [DATE], included that to perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened, or visibly soiled). Inspection of the skin and dressing included drainage as a complication sign. Sterile dressing procedure stated dressing should be labeled with initials, date and time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50887 Based on clinical record review, staff interviews, and facility policy and procedure, the facility failed to ensure blood pressure medications were administered following physician ordered parameters for one sampled resident (#4). The deficient practice could result in elevated blood pressure and possible stroke for the resident. Findings include: Resident (#4) was admitted on [DATE] with diagnoses of hypotension, major depressive disorder, bipolar disorder, and post-traumatic stress disorder. Review of the care plan dated March 22, 2024 included the resident had hypertension related to lifestyle. Interventions included to obtain blood pressure readings as ordered, to take blood pressure readings under the same conditions each time. For example, resident was sitting, use right arm. A physician order dated March 29, revealed an order for Midodrine hydrochloride (anti-orthostatic hypotensive) tablet 5 mg (milligrams), give one tablet by mouth every 8 hours for low blood pressure, hold for SBP (systolic blood pressure) greater than 130. This order was transcribed onto the Medication Administration Record (MAR) for June 2024 and July 2024. Review of the MAR for June 2024 and July 2024 revealed that Midodrine was administered outside of ordered physician parameters on the following dates: -June 6, 2024 with a systolic blood pressure of 131; -June 7, 2024 with a systolic blood pressure of 131; -June 30, 2024 with a systolic blood pressure of 139; and, -July 3, 2024 with a systolic blood pressure of 138. The quarterly Minimum Data Set (MDS) assessment dated [DATE] included a brief interview for mental status (BIMS) score of 15 indicating the resident had intact cognition. Review of the clinical record revealed no documentation of the reason why Midodrine was administered outside of physician ordered SBP parameters; and that, the physician was notified. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on August 7, 2024 at 9:50 a.m. with a Licensed Practical Nurse (LPN/Staff #13) who stated medication administration included staff reviewing the physician order; and, if there were parameters for blood pressure (BP), the resident's BP would be assessed prior to medication administration. She stated that if the resident's BP was within the physician ordered parameters the medication would be administered to the resident. She also stated that if the BP was outside of the physician ordered parameters, the medication would not be administered. During the interview, a review of the clinical record was conducted with the LPN who stated that Midodrine was administered to the resident outside the physician ordered parameters on June 6, June 7, and June 30, 2024. The LPN further stated that this did not follow the physician orders and could result in elevated blood pressure and possibly stroke. An interview with the Director of Nursing (DON/Staff #105) was conducted on August 8, 2024 at 10:47 a.m. The DON stated that her expectation was for the nurse to follow the physician order when administering medications; and that, a medication would not be administered outside of physician ordered parameters. She further stated if the medication was administered outside the physician ordered parameters, the expectation was that the provider would be notified. During the interview, a review of the clinical record was conducted by the DON who stated that the MAR for June and July 2024 showed that Midodrine had been administered outside of physician ordered parameters on June 6, June 7, June 30, and July 03, 2024. Further, the DON (staff #105) also stated that this did not meet the facility expectations and the resident could be at risk for elevated blood pressure, discomfort, and headache. The facility policy on Medications: Administering Oral Medications included to verify that there is a physician's medication order, and perform any pre-administration assessments prior to administering medications.

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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. 51103 Based on observation, staff interview, and policy review, the facility failed to ensure that medications were dated when opened; and, failed to ensure expired medications were discarded and not readily available for resident use. The deficient practice could result in medication errors, reduced drug effectiveness and adverse reactions. The facility census was 48. Findings include: A medication observation was conducted on August 5, 2024 at 11:19 a.m. There was a white pill in a medicine cup on the bedside table of a resident #145 that was left unattended. The resident stated the pill was his phosphorus binder that was taken prior to lunch; and that, he self-administers this medication on a daily basis. An observation of medication cart #1 was conducted with registered nurse (RN/staff #48) on August 6, 2024 at 7:05 a.m. There were opened bottles of Vitamin C and Vitamin B12 with no open dates. There was also an opened aspirin bottle with no open date and had expiration date of July 2024. The RN stated that she was not familiar with the facility's policy on non-dated opened medication bottles. She said that the correct procedure was to date bottle upon opening; and that, the nurses were responsible for checking for expired medication on medication carts. During an interview with licensed practical nurse (LPN/staff #13) conducted on August 6, 2024 at 8:02 a.m., the LPN stated that once a medication bottle is opened, the bottle had to be labeled with the open date. The LPN said that she was not sure as to how long opened medication bottle was kept after opening; and that, the nurses were responsible for checking for expired medication on medication carts. During an observation conducted on August 6, 2024 7:00 a.m. through 8:30 a.m., a bag of intravenous (IV) Ceftriaxone (antibiotic) 1gram (gr) /100 milliliters (ml) was found on top of medication cart #2. The licensed practical nurse (LPN/staff #13) left the medication cart unattended from 7:37 a.m. through 7:45 a.m. with the bag of IV Ceftriaxone on top of the medication cart. On August 6, 2024 at 8:11 a.m. an interview was conducted with LPN/staff #13 who stated that an unattended IV medication on top of the medication cart was allowed as long as the resident's name was not visible. The LPN admitted to leaving the IV medication unattended, with the patient name visible on several occasions. The LPN also stated that leaving oral medications unattended on top of the medication cart it would not meet the facility policy and the risk for doing so could include another resident taking the medication. An observation of medication cart #2 conducted with licensed practical nurse (LPN/staff #13) on August 6, 2024 at 8:35 a.m. The medication cart #2 contained the following opened medication bottles with no open date: -Magnesium Oxide 400 milligram(mg); (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Geri-Kit 8.6 mg; -Gentle-Lax 5 mg; -Calcium Citrate 250 mg; -Acid Reducer 20 mg; and, -Omeprazole 20 mg; The medication cart also contained the following opened and expired bottles: -Cetirizine 10 mg with expiration date of _____; and, -Iron tablets 65 mg with expiration date of June 23, 2024. An observation of medication storage room was conducted on August 6, 2024 approximately 3:10 p. m. There were 3 bottles of expired Nutricia Pro-Stat, Wild Cherry Punch with expiration date of March 22, 2024. An opened bottle of 8-Hour Arthritis Pain Relief had no open date. During an interview with the Director of Nursing (DON/Staff #105) conducted on August 6, 2024 at 4:30 p.m., the DON stated that new multi dose bottles should be dated on the bottle immediately upon opening, and the expiration date checked. The said that she was not sure about the 28-day time limit in policy; but, the facility follows the manufacturer guidelines for expiration dates. The DON stated that medication was bought in from the pharmacy and locked inside medication cart until time for it to be administered; and that, it was against the policy to leave IV medication unattended on top of a medication cart, regardless of whether identification label was visible or not. Further, the DON stated that it was acceptable to leave medication unattended, whether on top of cart, or by resident bedside; and that, expired medications should be removed and discarded immediately. The facility policy on Medication Labeling and Storage revealed that medications and biologicals are stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The facility policy on Discarding Medications, effective January 1, 2024 stated that medication that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substance.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50887 Based on clinical record reviews, interviews, and policy review the facility failed to ensure recommended follow up dental appointments were scheduled for 1 of 14 sampled residents (#8). The deficient practice could result in delayed dental services and risk of infection for resident. Findings include: Resident (#8) was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus without complications, personal history of traumatic brain injury, and unspecified dementia. The care plan dated November 14, 2022 included that the resident had oral/dental health problems. Intervention included to coordinate arrangements for dental care, transportation, as needed/as ordered. The late entry monthly nursing summary dated August 5, 2023 included that the resident was oriented x 3. Oral/dental assessment included resident had broken natural teeth and likely had cavity. Review of the dental consultation report dated August 16, 2023 revealed that teeth #3, #4, and #5 were untreatable due to decay and were extracted. The consultation report also recommended that the resident should return for additional extractions. The alert charting note dated August 16, 2023 included that the resident went to a dental appointment and had 3 teeth extracted. Per the documentation, the recommendation was for the resident to return for more extractions. On the lower left corner of the report was a handwritten initial of a registered nurse that it was noted and dated August 16, 2023. Despite documentation of the dental consult recommendation, there was no evidence found that scheduled follow up appointments for resident (#8) was made after August 16, 2023. The encounter note dated May 25, 2024 included that the resident was alert and oriented x 0 The physician progress note dated June 2, 2024 included the resident had poor dentition noted. The monthly nursing summary dated June 28, 2024 revealed the resident was oriented x 2. oral/dental assessment included that the resident had likely cavity and had no difficulty with chewing or swallowing. An interview was conducted on August 6, 2024 at 11:25 a.m. with a registered nurse (RN/staff #48) who stated that if the progress note showed there was a need for a follow up dental appointment, the expectation was for staff to verify if the follow up was completed. During the interview, a review of the clinical record was conducted with the RN (Staff #48) who stated that the recommendation for a follow up dental appointment on August 16, 2023 was passed along to the night shift nurse; however, there was no evidence found in the clinical record that the follow-up dental appointment was done or completed. The RN further stated that there was no evidence that a dental appointment had been scheduled after August 16, 2023. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on August 7, 2024 at 8:22 a.m. with the transportation manager (Staff #115) who stated that the process of scheduling follow-up appointments for skilled nursing residents included receiving the appointment card from the transportation drivers; and, she would then put the next appointment into a scheduling system. In another interview with the transportation manager conducted on August 7, 2024 at 10:31 a.m., the transportation manager stated that there were no follow up dental appointments scheduled for resident (#8) after August 16, 2023. Further, the transportation manager said that this did not meet facility expectations and that the resident would be at risk for infection. During an interview with the Director of Nursing (DON/staff #105) conducted on August 8, 2024 at 10:47 a.m. , the DON stated that the process for scheduling follow up appointments included for the appointment card given to the transportation manager (staff #115) who would then schedule the appointment. The DON (staff #105) also stated that the transportation manager (staff #115) also reviews physician orders for any appointments and would schedule them. A review of the clinical record was conducted by the DON who stated that the electronic health record revealed no documentation of any follow up appointments scheduled for resident (#8) after August 16, 2023. Further, the DON (staff #105) stated that this did not meet facility standards and the resident would be at risk for discomfort, dental caries, and infection. Review of the facility's policy on Dental Services revealed that the facility would provide routine and emergency dental services through contracts or referrals to a local, community, or resident's personal dentist. The facility also had a contract with a dentist that comes to the facility on a monthly basis. The policy also indicated that nursing services are responsible for notifying social services of a resident's need for dental services. Social services personnel would be responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50862 Based on observations, staff interview, and review of policy and procedures, the facility failed to discard food/liquid items by their use-by-dates, failed to ensure that food items were appropriately refrigerated, and failed to ensure appropriate hand hygiene during food preparation and during the serving line. The census was 48, sample was 12. Findings include: An observation of the unit norishment refrigerator/freezer was conducted on [DATE] at 9:33 a.m. revealed an unlabeled container that contained a purple colored liquid substance had an expiration date of [DATE]. Another observation was conducted on [DATE] at 11:32 a.m. The cook (staff #5) placed a gloved hand into a salad bag removing the salad mix from the bag, then placing it on the plate. With the same gloved hand, the cook then reached out into his shirt pocket, removed a marker and dated the salad bag, opened the refrigerator door, placed the resealed salad bag into refrigerator, then removed a bag of boiled eggs and a bag of tomatoes from the refrigerator. The cook then proceeded to slice the boiled eggs and tomatoes on a cutting board without changing his gloves and placed the sliced boiled eggs and tomatoes on salad plate and then handed the completed salad plate to dietary aide (staff #47). At this point, the cook removed his gloves and donned new gloves without washing his hands. The cook opened the refrigerator with the new donned gloved hands, removed the cottage cheese from the refrigerator, grabbed a plate and placed the plate on the same cutting board used to slice eggs and tomatoes. The cook then opened the cottage cheese container, scooped cottage cheese onto the plate, closed lid of the cottage cheese, and returned the cottage cheese container to the refrigerator wearing the same pair of gloves. An interview was [DATE] at 1:16 p.m.p.m. with the kitchen manager (staff #6) and dietary manager (staff #100). The kitchen manager stated that the unlabeled container of purple liquid was grape cool-aid and it had an expiration date of [DATE]. Further, the kitchen manager stated that the container should have been removed. Both the kitchen manager (staff #6) and dietary manager (staff #100) stated that the risk of the using food/liquid items after expiration date could make residents sick. During the breakfast observation conducted on [DATE] at 7:12 a.m., the serving line cook (#57) removed her gloves, did not wash hands and proceeded to adjusting clean stacks of hot plates and the stacks of hot plate covers without her bare hands. She then donned gloves on without washing her hands and adjusted sink faucet spout and then sliced bananas on cutting board using the same gloved hands. Without changing her gloves, she then scooped the food from the hot tray, placed the food onto the individual hot plates, removed the sliced bananas from the cutting board one hand-full at a time and placed the sliced bananas directly onto each individual plate during serving. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the kitchen manager (staff #6) and dietary manager (staff #100) was conducted [DATE] at 10:21 a.m. The kitchen manager stated that the expectation was for staff to use gloves for hand protection and to keep food safe; and that, staff were to wash their hands between gloves changes. The kitchen manager also said that staff wear gloves at all times when touching the food; and, before staff enters the refrigerator, they were expected to remove their gloves, and then donn new set of gloves before touching food. The dietary manager (staff #100) stated that gloves should always be used when staff was touching ready to serve food. Both staff stated that staff not washing hands, not performing hand hygiene and changing gloves in between food handling were not acceptable and did not meet the facility expectations. The kitchen manager stated that the risk of improper hand hygiene could result in resident's becoming sick from cross contamination. Review of the facility policy on dietary Services: Refrigerators and Freezers revealed that the facility will ensure safe refrigerator maintenance, temperatures, and will observe food expiration guidelines. All food shall be appropriately dated to ensure proper rotation by expiration dates. Use-by-dates will be completed with expiration dates on all prepared food in refrigerators. Supervisor will be responsible for ensuring food items in pantry, refrigerators are not expired or past perish dates. The facility policy on Food Storage and Date Marking included that food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination. Date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed or discarded will be visible on the Time and Temperature Control for Safety (TCS) that is not for immediate use. All foods will be checked to assure that foods will be consumed by their use by dates, or frozen, or discarded, at the end of the day. The facility policy on General Food Preparation and Handling, revealed that TCS foods that stand four or more hours at room temperature must be discarded. Staff will handle utensils, cups, glasses, and dishes in such a way as to avoid touching surfaces that food or drink will come in contact with. Tongs or other serving utensils will be used to serve breads or other items to avoid bare hand contact with food.