STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2024
NAME OF PROVIDER OR SUPPLIER: Pine Bluff Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 6810 South Hazel Street Pine Bluff, AR 71603	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 48390 Based on observation, interviews, record review, facility document review, facility policy preview, it was determined the facility failed to ensure residents were provided privacy during care provided for surgically created airway (tracheostomy/trach) care for 1 (Resident #13) of 1 sample mix resident; and to ensure collection bags for resident's indwelling catheters are kept in a privacy bag for 1 (Resident #216) of 1 sample mix residents. The findings are: 1. Review of Resident #13's Admission Record revealed the resident was admitted on [DATE] with a diagnoses of tracheostomy complication. Review of Resident #13's Physician Orders, dated 4/19/2024, noted suction tracheostomy (trach) as needed (PRN), every shift, trach care once a day on Thursday, change trach ties one time a day every Thursday, trach care every 24 hours (hrs.) and PRN clean trach site with 1/2 normal saline (NS) and 1/2 Peroxide then rinse with NS and apply dry dressing daily and PRN two times a day related to tracheostomy complications. Review of Resident #13's Care Plan dated 5/6/2024 noted the resident has impaired immunity related to tracheostomy in place. On 10/11/2024 at 2:44 PM, the Surveyor observed Licensed Practical Nurse (LPN) #11 perform tracheostomy care for Resident #13. During trach care LPN #13 re-secured inner cannula with tracheostomy ties and told the resident he would be right back he needed to get more gauze. LPN removed gloves and left the room at 2:58 PM. LPN #11 returned to the room at 3:00 PM with more gauze but did not shut the resident's door and proceeded with tracheotomy care. During an interview with LPN #11 on 10/11/2024 at 3:04 PM, confirmed when he exited Resident #13's room to get more gauze, he did not shut the resident's door when he returned and continued trach care. LPN #11 confirmed it is a resident privacy violation to perform care with the door open. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Assistant Director of Nursing (ADON) on 10/14/2024 at 3:07 PM, she confirmed that Resident #13's door should have been closed throughout trach care and that it is a dignity concern. 2. Resident #216 has a diagnosis of type 2 diabetes mellitus, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and disorder of prostate. During an observation on 10/07/24 at 2:45 PM, Resident #216's catheter collection bag was hanging on the side of the bed, visible from the door, and not in a privacy bag. During an interview on 10/07/24 at 3:00 PM Certified Nursing Assistant (CNA) #17 confirmed Resident #216's catheter collection bag should be in a privacy bag. During an observation on 10/10/24 at 10:50 AM, Resident #216's catheter bag was hanging on the side of the bed, visible from the door, the catheter collection bag was not in a privacy bag. A privacy bag was hanging on the Resident's walker close to the bed, but the catheter collection bag was not in the privacy bag. A review of Resident #216's Care Plan, initiated on 10/04/24, revealed the resident has an indwelling catheter. Intervention included catheter position which includes the catheter bag and tubing below the level of the bladder and away from entrance and door. During an interview on 10/14/24 at 5:00 PM, the Assistant Director of Nursing (ADON) confirmed a resident with a catheter should have a privacy bag. Facility provided a policy titled Resident Rights with a revision date of December 2016 noted Policy Statement Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; t. privacy and confidentiality.

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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. 48977 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure 1 (Resident #265) sampled resident was safe to self-administer medications. The findings include: A plan of care for Resident #265 (Revision on: 09/11/2024) revealed Resident #265 had impaired cognitive function/dementia or impaired thought processes related to history of suicidal ideation. Interventions included to administer medications as ordered, monitor, and document for side effects and effectiveness. On 10/07/24 at 11:14 AM, the Surveyor observed over the counter medications in Resident #265's bathroom. On 10/07/24 at 12:47 PM, the Surveyor observed over the counter medications in Resident #265's bathroom. On 10/08/24 at 9:03 AM, the Surveyor observed over the counter medications in Resident #265's bathroom. On 10/08/24 at 9:30 AM, the Nurse Consultant stated there were no residents on 400 hall (the hall on which Resident #265 resided) who self-administered medications. The Nurse Consultant stated Resident #265 did not have an order for the medications to be kept in the bathroom, and the resident should not have medication accessible. The Nurse Consultant stated Resident #265 had not been assessed to self-administer medications safely and doing so could have a negative impact on the resident. On 10/11/24 at 4:40 PM, the Administrator stated there were no residents residing in the facility assessed to self-administer their own medications, therefore medications should not be accessible to Resident #265 with supervision. The Administrator stated there could be a potential negative outcome from the resident having medications in their room or taking medications the facility was unaware of, such as another resident wandering in the resident's room and getting the medications, or the resident having an interaction with other medication the resident was taking. A policy titled Self-Administration of Medications noted Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.

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	045379	A. Building B. Wing	10/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 48977 Based on interviews and facility policy review, the facility failed to ensure residents received mail on Saturdays. The findings include: On 10/10/24 at 11:31 AM, during a meeting with the resident council members, the surveyor was informed mail is not delivered on Saturdays. On 10/10/24 at 11:35 AM, the Activity Director stated she delivers mail Monday through Friday, which are the days she works. On 10/14/24 at 4:40 PM, during an interview the Administration stated nobody delivers mail Saturdays. A policy titled Resident Rights noted residents in the facility have the right to send and receive mail promptly.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38200 48390 Based on record review, interview, facility document review, facility policy review, it was determined that the facility failed to ensure an incident of an injury of unknown source was reported to the Administrator within 2 hours of discovery, which resulted in a delay in initiating an investigation and protective measures, and in reporting to the Office of Long-Term Care (OLTC) and other agencies in accordance with state law for 2 (Resident #50 and #59) of 2 (Residents # 50, and #59) sample mix residents. The findings are: 1. Review of Resident #50's Progress Note revealed, an Incident Note dated 7/13/2024 at 6:11 PM noted the resident was found on floor with cut to forehead, referring to [hospital] for observation. Review of Resident #50's Progress Note revealed an Alert Note dated 7/14/2024 at 5:56 PM that noted [hospital] called regarding resident and stated that x-ray results from 7/13/2024 showed resident with fractured mandible bone and should be placed on soft foods diet and needs to follow up with Ears Nose and Throat (ENT). Review of Resident #50's Order Summary Report with an order date of 7/15/2024 noted regular diet, mechanical soft texture, regular/thin consistency, [hospital] called regarding resident and stated that x-ray results from 7-13-2024 showed resident with fractured mandible bone and should be placed on soft foods diet and needs to follow up with ENT. Review of Resident #50's Care Plan dated 7/15/2024 noted the resident had an actual fall on 7/13/24 with serious injury fractured jawbone related to (r/t) poor balance, for no apparent acute injury, determine and address causative factors of the fall. During an interview with Resident #50 on 10/10/24 at 10:38 AM, the Surveyor asked Resident #50 about an unwitnessed fall where they ended up with a fractured mandible and the resident stated they fell out of their chair trying to get into bed. During an interview with the Administrator on 10/10/24 at 11:49 AM, the Administrator confirmed she had no reportable completed for Resident #50's unwitnessed fall on 7/13/2024 that resulted in a major injury with a fracture to the resident's mandible. During an interview with the Nurse Consultant on 10/11/24 at 11:00 AM, he confirmed there was no Incident and Accident Report (I&A) for Resident #50 on 7/13/2024 after an unwitnessed fall that resulted in major injury. During an interview with the Administrator on 10/11/2024 at 11:03 AM, she confirmed no Incident and Accident report had been completed for Resident #50 on 7/13/2024 after an unwitnessed fall that resulted in a major injury. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #59's Admission Record showed Resident was admitted with a diagnosis of amputation of two or more toes, cognitive communication deficit, constipation, difficulty walking, muscle wasting, type 2 diabetes mellitus, malnutrition, dehydration, chronic ulcer of left heel and midfoot, dementia, and weakness, Review of a Progress Note dated 09/25/24 at 8:16 PM showed This nurse was called to resident's room resident has rolled out of bed onto fall mat face down and face was off mat hitting right side of face on floor resident able to move all extremities. He has blood all over right side of face and head resident cleaned up with wound cleaner approximately a 2 cm (centimeter) long and .3 wide abrasion across right eyebrow. Eyes reactive to light resident kept quenching his eyes c/o (complaining of) head hurting denies all other sites of pain. Doctor notified by message sending resident out to hospital for evaluation, no family to notify. Resident informed medical transport service contacted for transport. On 10/14/24 at 5:00 PM the Administrator (AD) was asked if she had any reportables for the month of September. The AD indicated she did not have any reportables. The AD was asked if she was aware of Resident #59 being sent to the hospital on 09/25/24 due to resident falling out of bed. The AD did not reply. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled Abuse Investigation and Reporting, with a revision date of July 2017, revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/ or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy Interpretation and Implementation Role of the Administrator: 1. If an accident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator will keep the resident, and his/her representative (sponsor) informed of the progress of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. 6. The Administrator will inform the resident and his/ her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/ her designee, to the following persons or agencies: a. The State licensing/ certification agency responsible for surveying/ licensing the facility; b. The local/ State Ombudsman; c. The Resident's Representative (Sponsor) or Record; d. Adult Protective Services (where state law provides jurisdiction in long term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse OR had resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. 3. Verbal/ written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone. 4. Notices will include, as appropriate: a. The name of the resident; b. The number of the room in which the resident resides, c. The type of abuse that was committed (i.e., verbal, physical, sexual, neglect, etc.); d. The date and time the alleged incident occurred, e. The name(s) of all persons involved in the alleged incident, and f. What immediate action was taken by the facility. 5. The Administrator, or his/ her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. Review of facility policy titled Accidents and Incidents- Investigating and Reporting with a revision date of July 2017 noted Policy Statement All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation 1. The Nurse Supervisor/ Charge Nurse and/ or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 5. The Nurse Supervisor/ Charge Nurse and/ or department director or supervisor shall complete a Report of Incident/ Accident form and submit the original to the Director or Nursing Services within 24 hours of the incident or accident. 6. The Director of Nursing shall ensure that the Administrator receives a copy of the Report of Incident/ Accident form for each occurrence.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 38200 Based on record review, interview, facility document review, and facility policy review, it was determined the facility failed to ensure an incident of an injury of unknown origin was immediately and thoroughly investigated, failed to ensure protective measures were consistently implemented and maintained for 2 (Resident #50, and #59) of 2 sample mix resident investigated. The findings are: Review of Resident #50's Progress Notes revealed an Incident Note dated 7/13/2024 at 6:11 PM that noted the resident was found on floor with cut to forehead, referring to [hospital] for observation. Review of Resident #50's Progress Note revealed an Alert Note dated 7/14/2024 at 5:56 PM that revealed [hospital] called regarding resident and stated that x-ray results from 7-13-2024 showed resident with fractured mandible bone and should be placed on soft foods diet and needs to follow up with Ears, Nose, and Throat (ENT.) Review of Resident #50's Order Summary Report revealed an order that indicated, regular diet, mechanical soft texture, Regular/Thin consistency Start Date 7/15/2024, [hospital] called regarding resident and stated that x-ray results from 7-13-2024 showed resident with fractured mandible bone and should be placed on soft foods diet and needs to follow up with ENT. every shift Start Date 7/14/2024. Review of Resident #50's Care Plan, dated 7/15/2024, noted Resident #50 has had an actual fall on 7/13/24 with serious injury (fractured mandible) related to (r/t) poor balance, for no apparent acute injury, determine and address causative factors of the fall. During an interview with Resident #50 on 10/10/24 at 10:38 AM, the Surveyor asked Resident #50 about an unwitnessed fall where they ended up with a fractured jawbone (mandible) and the resident stated they fell out of their chair trying to get into bed. During an interview with the Administrator on 10/10/24 at 11:49 AM, the Administrator confirmed she had no investigation completed for Resident #50's unwitnessed fall on 7/13/2024 that resulted in a major injury with a fracture to the resident's mandible. During an interview with the Nurse Consultant on 10/11/24 at 11:00 AM, he confirmed there was no I&A for Resident #50 on 7/13/2024 after an unwitnessed fall that resulted in major injury. During an interview with the Administrator on 10/11/2024 at 11:03 AM, she confirmed no I&A report had been completed for Resident #50 on 7/13/2024 after an unwitnessed fall that resulted in a major injury. Review of an Admission Record dated 09/10/2024 revealed Resident # 59 was admitted with the following diagnosis: two toes amputated, trouble communicating difficulty in walking, muscle wasting, type 2 diabetes mellitus, malnutrition, dehydration, high blood pressure chronic ulcer of left heel and midfoot, , dementia, and behavioral disturbance, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a Progress Note dated 09/25/24 at 8:16 PM showed This nurse was called to resident's room resident has rolled out of bed onto fall mat face down and face was off mat hitting right side of face on floor. Resident able to move all extremities. He has blood all over right side of face and head. Resident cleaned up with wound cleaner approximately a 2 cm (centimeters) long and .3 wide abrasion across right eyebrow and complains of head hurting. [Doctor] notified by message sending resident out the hospital for evaluation, no family to notify. Resident informed emergency transport service contacted for transport. On 10/14/24 at 5:00 PM, the Administrator (AD) was asked if she had any reportable for the month of September. The AD indicated she did not have any reportable. The AD was asked if she was aware of Resident #59 being sent to the hospital on 09/25/24 due to a fall, the AD did not reply. A facility policy titled Abuse Investigation and Reporting with a revision date of July 2017 read Policy Statement .All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/ or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy Interpretation and Implementation Role of the Administrator: 1. If an accident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. 6. The Administrator will inform the resident and his/ her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident. Role of Investigator: 1. The individual conducting the investigation will, as a minimum: a. Review the completed documentation forms; b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person(s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (if medically appropriate); f. Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; g. Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; h. Interview the resident's roommate, family members, and visitors; i. Interview other residents to whom the accused employee provides care or services; and j. Review all events leading up to the alleged incident. 3. The investigator will notify the ombudsman that an abuse investigation is being conducted. The ombudsman will be invited to participate in the review process. a. If the ombud declines the invitation to participate in the investigation, that information will be noted in the investigation record. The ombudsman will be notified of the results of the investigation as well as any corrective measures taken. A facility policy titled, Accidents and Incidents- Investigating and Reporting, with a revision date of July 2017, noted Policy Statement .All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation 1. The Nurse Supervisor/ Charge Nurse and/ or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 5. The Nurse Supervisor/ Charge Nurse and/ or department director or supervisor shall complete a Report of Incident/ Accident form and submit the original to the Director or Nursing Services within 24 hours of the incident or accident. 6. The Director of Nursing shall ensure that the Administrator receives a copy of the Report of Incident/ Accident form for each occurrence. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48390

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 37925 Based on record review and interview, the facility failed to notify the Ombudsman of a resident's transfer to the hospital for 1 (Resident #57) sampled resident reviewed for hospitalization . The findings are: On 10/09/2024 at 2:23 PM, Resident #57's Progress Notes were reviewed and indicated on 08/26/2024 at 2:14 AM, the resident was being sent to a local hospital due to a decrease level of consciousness (LOC) and resident's relative was notified. On 09/05/24 at 18:25 (6:25 PM) an admission summary note indicated the resident was received back from [local hospital]. Resident #57's Order Summary Report was reviewed and indicated the resident had a diagnosis of a type of disorder affecting a person's movements, ability to communicate, think, feel, and behave clearly (catatonic schizophrenia). Resident #57's admission Minimum Data Set, with an Assessment Reference Date of 08/21/2024, was reviewed and indicated the resident had a staff assessment for mental status score of 3, which indicated the resident was severely cognitively impaired and received antipsychotic medications since admission/entry or reentry. On 10/14/2024, the Assistant Director of Nursing (ADON) was asked to provide the Ombudsman's notification for Resident #57 and others who were transferred out of the facility in August and September 2024. On 10/14/2024 at 6:15 PM, the ADON stated, Social Services is responsible for this [Ombudsman notification], but it was not made clear to her that she was responsible for notifying the Ombudsman, so it was not done.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 48390 Based on interviews, record review, and facility policy review, it was determined the facility failed to complete timely quarterly assessments for 1 (Resident #215) of 1 sampled resident reviewed for resident assessments. Findings include: A review of the Minimum Data Set's (MDS) for Resident #215 shows an entry MDS was completed on 03/28/24, as the only one completed for resident. Resident #215 is lacking an Admission MDS and a Quarterly MDS. A review of an undated facility policy titled, MDS Error Correction did not address the timeliness of MDS's being completed. On 10/10/24 at 4:32 PM, the Administrator (AD) was asked when was the last time the facility had an MDS Coordinator. The AD indicated they had a Registered Nurse (RN) start July 8 and resign July 25. The AD then indicated another RN started on August 27th and worked 3 days and quit. The AD indicated they have a sister facility in Oklahoma and the Licensed Practical Nurse (LPN) MDS Coordinator has been helping complete the MDS's for the facility. The AD indicated they just contracted with an RN that would be doing the MDS's, the RN would not be coming into the facility but would do everything remotely. On 10/14/24 at 4:58 PM, the AD was asked when an admission MDS should be completed. The AD indicated within 3 to 5 days of admission. The AD was asked when a quarterly MDS should be completed. The AD indicated quarterly from date of admission. The AD was asked if Resident #215 should have had an admission MDS completed by this point in time, his admitted being 03/28/24. The AD indicated yes, and it must have been overlooked, because Resident #215 should have had an admission and a quarterly MDS by now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2024
NAME OF PROVIDER OR SUPPLIER: Pine Bluff Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 6810 South Hazel Street Pine Bluff, AR 71603	

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 48390 Based on facility document review and interview, it was determined the facility failed to electronically transmit encoded accurate and complete Minimum Data Set (MDS) assessments to the Centers for Medicare and Medicaid Services (CMS) within the required time frame of 14 days to provide accurate and up-to-date information for quality measures for 2 (Residents #215, #47) of 2 sampled residents whose MDS assessments were reviewed. The findings are: On [DATE] the following reviews were made in Resident #47's health record: a. Discharge return anticipated MDS date [DATE] that was exported but not accepted. b. Entry MDS dated [DATE] that was exported but not accepted. The discharge return not anticipated MDS dated [DATE] in progress. Resident #47 discharged from the facility on [DATE] to the hospital and expired at the hospital on [DATE]. Review of Resident #47's Progress Note dated [DATE] at 11:14 AM showed, the resident was transferred to the hospital Review of Resident #47's Progress Note dated [DATE] at 9:54 AM showed family called the facility to inform them that Resident #47 had expired at the hospital. During an interview with the Assistant Director of Nursing on [DATE] at 3:07 PM, she confirmed that facility has no MDS Coordinator, and that Resident #47 should have had a discharge return anticipated MDS completed since the resident was to return to the facility from the hospital on [DATE] when the resident was sent to and admitted to the hospital, and the assessment should have been completed and submitted within 14 days. She also confirmed the exported MDS assessments on [DATE] and [DATE] did not show they were accepted by CMS. Facility policy titled MDS Completion and Submission Timeframes with a revision date of [DATE] noted facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Policy Interpretation and Implementation 1. The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' Qua) Quality Improvement Evaluation System (QIES). Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. 3. Submission of MDS records to the QIES ASAP is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of fifteen (15) months form the date submitted. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility in-service titled Late MDS/ Care plans dated [DATE] noted please see attached POC (Plan of correction) for catching up all late MDS/ Care plans and for follow up. Review of Resident #215's Admission Record showed Resident was admitted to facility on [DATE] with a diagnosis of type 2 diabetes mellitus, high blood sugar, deficiency of vitamins, schizophrenia, acute pain due to trauma, chronic ulcer of skin, and break down of skin. A review of an undated facility policy titled, MDS Error Correction, did not address the timeliness of MDS being completed. On [DATE] at 4:32 PM, the Administrator (AD) was asked when was the last time the facility had an MDS Coordinator. The AD indicated they had a Registered Nurse (RN) start [DATE] and resign [DATE]. The AD then indicated they had another RN start on [DATE] and worked 3 days and quit. The AD indicated they have a sister facility in Oklahoma and the Licensed Practical Nurse (LPN) MDS Coordinator has been helping complete the MDS's for the facility. The AD indicated that they just contracted with an RN that would be doing the MDS's remotely, the RN would not be coming into the facility but would do everything remotely.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 38200 48977 Based on record review, interview, facility document review, facility policy review, it was determined that the facility failed to ensure physician's orders were followed for 1 (Resident #16) of 1 sample mix resident with a wound and orders for skin evaluations weekly; to accurately assess the quarterly Minimum Data Set (MDS) to reflect to accurate drug class for the medication Risperdal for 1 (Resident #8) or 1 sample mix residents. The findings are: Review of Resident #16's Order Summary Report dated 5/21/2024 noted a stage 3 wound to left big toe: Cleanse with wound cleanser, pat & dry, apply collagen matrix with silver to affected site, cover with dry dressing, complete nursing assessment/ body audit every week on 7 PM-7 AM shift. Review of Resident #16's Quarterly Minimum Data Set (MDS) with an Assessment Reference date of (ARD) of 08/26/2024 noted in Section M0150 the resident did not have an unhealed pressure ulcer/ injury. Section M1030 noted the resident did not have any venous or arterial ulcers. Review of Resident #16's Skin Only Evaluation dated 08/19/2024 revealed left great toe wound length 0.4 cm (centimeter), width 0.4 cm, 0.1 cm. Skin Only Evaluation dated 10/12/2024 revealed left great toe wound length 1.5 cm, width 1 cm, depth 0.2 cm. There are no other wound evaluations from 08/19/2024 through 10/12/2024. Skin Only Evaluations: 05/22/2024- Diabetic foot ulcer Length: 1 cm Width: 1 cm Depth: 0.1 cm 07/16/2024- Diabetic foot ulcer Length: 0.4 cm Width: 0.4 cm Depth 0.126 cm 07/23/2024- Diabetic foot ulcer Length: 0.3 cm (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Width: 0.3 cm Depth: none recorded 07/24/2024- Other skin issue No measurements- documented left greater toe area already being treated. 07/25/20240 Diabetic foot ulcer Length: 0.3 Width: 0.3 Depth: not recorded 07/31/2024 Skin. Does Resident have current skin issues? No 08/06/2024- Diabetic foot ulcer Length: 0.4 cm Width: 0.4 cm Depth: 0.1 cm 08/12/2024 Skin. Does Resident have current skin issues? No 08/19/2024- Diabetic foot ulcer Length: 0.4 cm Width: 0.4 cm Depth: 0.1 cm 10/12/2024- Pressure ulcer/ injury: Length: 1.5 cm Width: 1 cm Depth: 0.2 cm (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16's Care plan dated 9/20/2024 showed the resident has potential/actual impairment to skin integrity of the body related to fragile skin. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Follow facility protocols for treatment of injury. During an interview with Licensed Practical Nurse (LPN) #13 on 10/14/2024 at 3:00 PM, she confirmed Resident #16 should have had weekly skin evaluations completed as indicated on the physician's order. During an interview with Assistant Director of Nursing (ADON) on 10/14/2024 at 3:07 PM, she confirmed Resident #16 should have had weekly skin evaluations completed as indicated on the physician's order. During an interview with the Nurse Consultant by telephone on 10/14/2024 at 6:19 PM, he confirmed Resident #16's pressure ulcer was changed from a diabetic ulcer to a pressure ulcer on 10/12/2024 because it was not a diabetic ulcer as documented on 5/22/2024 it is pressure ulcer. The Nurse Consultant confirmed that weekly skin evaluations were not completed for Resident #16 as ordered by the physician. A review of the quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 8/25/2024 revealed on the Brief Interview of Mental Status (BIMS) Resident #8 scored 11 indicating moderate cognitive impairment. Resident #8 had a diagnosis of Psychotic Disorder (other than schizophrenia). Resident #8 was taking high risk prescribed medications to treat depression, anxiety, and fluid retention A plan of care for Resident #8 (Revision on: 05/28/2024) revealed Resident #8 used anti-anxiety medications Risperdal 0.5 mg tablet related to anxiety disorder. A review of the Order Summary Report Resident #8 had an order for Risperidone 0.5 milligram (MG) related to psychosis. On 10/14/24 at 4:40 PM, during an interview the Director of Nursing stated Risperdal was an antipsychotic, not an antianxiety medication, therefore should be reflected on the care plan or MDS as an antipsychotic.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 Based on observation, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure the comprehensive care plan addressed individualized appropriate care and services for 4 (Resident #45, #13, #35, #21) of 4 sample mix residents reviewed for care plan. The findings are: 1. On 10/07/24 at 9:47 AM, the Surveyor observed Resident #45 lying in bed with eyes closed and unshaven with hair on their face. Review of Resident #45's Care Plan dated 5/8/2024 did not note the resident's Activities of Daily Living (ADL) requirements. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/2024 revealed the resident is dependent on staff for shower/bath. Review of Resident #45's shower log from 9/27/2024 through 10/12/2024 revealed the resident received a shower/bath on: 9/27/2024 9/28/2024 10/11/2024 10/12/2024 On 10/10/24 at 11:12 AM, the Surveyor observed Resident #45 lying in bed, remaining unshaven, with hair on their face. 2. On 10/08/24 at 11:04 AM, the Surveyor observed Resident #13 sitting in their wheelchair in dayroom. Resident #13's right arm is flaccid and right hand is contracted with no device present. Review of Resident #13's Admission Record with an admitted [DATE] revealed a diagnosis of paralysis/weakness affecting the right dominant side. Review of Resident #13's Care Plan, dated 5/8/2024, revealed it did not address the resident's flaccid right arm or contracted right hand. Review of Resident #13's Quarterly MDS with an ARD of 8/17/2024 Section GG0115.functional limitation in range of motion impairment on one side of upper extremity. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/09/24 at 2:37 PM, the Surveyor observed Resident #13 sitting outside in the smoking area. Resident's right arm is flaccid and right hand is contracted with no device present. On 10/11/24 2:44 PM, the Surveyor observed Resident #13 in their room with Licensed Practical Nurse (LPN) #11. No device or intervention was observed in Resident #13's right hand that is contracted. On 10/11/2024 at 3:03 PM, the surveyor interviewed LPN #11, who confirmed Resident #13's right arm is flaccid and right hand is contracted with no device present. LPN #11 confirmed the resident is not care planned for flaccid right arm or contracted right hand. 3. During an interview with Resident #35 on 10/08/2024 11:14 AM, the resident said, I have issues with my legs. Review of Resident #35's Admission Record with a date of 6/8/2022 revealed the resident had a diagnosis of over active muscle activity for a paralyzed person with cerebral palsy. Review of Resident #35's Care plan with an initiation date of 6/3/2024 noted the resident has limited physical mobility related to contractures. Review of Resident #35's annual MDS with an ARD of 8/25/2024 noted in Section GG0115 that the resident has impairment on one side. On 10/9/2024 at 2:24 PM, the Surveyor asked Resident #35 if Certified Nursing Assistant (CNA) #12 could pull back the resident's blanket so the surveyor could see their legs and the resident agreed. CNA #12 pulled back the resident's blanket and surveyor observed resident's legs were not contracted. Both legs were in a locked position straight out. During an interview with CNA #12 on 10/9/2024 at 2:26 PM, the CNA confirmed Resident #35 could not bend either of their legs. During an interview with Resident #35 on 10/10/2024 at 2:43 PM, the resident confirmed not being able to bend their legs and that they stay in a straight position. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility provided a polity titled Care Plans, Comprehensive Person-Centered with a revision date of December 2016 that noted Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/ her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. b. Include an assessment of the resident's strengths and needs. 8. The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems; k. Reflect treatment goals, timetables and objectives in measurable outcomes; l. Identify the professional services that are responsible for each element of care; m. Aid in preventing or reducing decline in the resident's functional status and/ or functional levels. 10 Identify problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. 12. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37925 38200 48977 Based on record review and interview, the facility failed to ensure care plans were revised to reflect the most recent care needs for 3 (Residents #13, #16, and #21) sampled residents whose care plans were reviewed. The findings are: 1. On 10/07/2024 at 10:07 AM, Certified Nursing Assistant (CNA) #9 was observed propelling Resident #21 in the hall using a mechanical lift with no other staff member assisting her. CNA #10 was heard telling CNA #9 the resident had to be in a shower chair and was not supposed to be in the lift. CNA #9 propelled the resident to the resident's room in the lift without assistance of another staff member. CNA #10 entered the room with a shower chair and closed the resident's door. Resident #21's Medical Diagnosis health record was reviewed and indicated the resident had diagnoses of a condition of rigidity of the joint (contracture) of the left hip and a decline (atrophy) in the muscle and decrease in size (wasting) of multiple sites, difficulty in making decisions for everyday life (dementia) and a change in how the brain works (metabolic encephalopathy). An Order Summary Report was reviewed and indicated Glargine insulin 100 units per milliliter (unit/ml) and to inject 20 units under the skin (subcutaneously) at bedtime with an ordered date of 06/16/2024. Risperidone (antipsychotic) 0.5 milligrams (mg) included instructions to take 1 tablet twice a day every other day and was ordered on 02/19/2024. An annual Minimum Data report, with an Assessment Reference Date of 07/20/2024, was reviewed and indicated Resident #21 had a Brief Interview for Mental Status score of 7, which indicated severely cognitively impaired, an impairment in the lower extremity and required substantial/maximal assist with a shower/bath, received insulin injections during the last 7 days or since admission/entry or re-entry and was taking an antipsychotic, high-risk drugs. A care plan, dated as reviewed 07/29/2024, was reviewed and had no indication of how Resident #21 was to be transferred, how many staff were required to assist with the transfer, or the resident was taking insulin and antipsychotic high-risk medications. On 10/14/2024 at 1:34 PM, CNA #9 was interviewed and stated she didn't know much about the resident's care needs and started working at the facility on 09/21/2024. She stated the resident could not walk or propel self in the wheelchair. She stated staff used a lift to get the resident from the bed to the shower chair for showers and baths. She stated she did not know the mechanical lift required two people when she used the mechanical lift Monday, 10/07/2024, to transport the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #13's Order Summary Report was reviewed and indicated the resident had diagnoses of a disease affecting the body's blood sugar level (diabetes mellitus type 2) and high blood pressure (hypertension). The order summary report indicted the following orders: a. Apixaban 5 mg, take 1 tablet by mouth twice a day and it was ordered on 01/29/2024. b. Furosemide 40 mg, take 1 tablet by mouth twice a day and it was ordered on 01/29/2024; c. Tresiba 100 UNIT/ML, inject 15 units under the skin (SQ) at bedtime every night and it was ordered on 07/24/2024. The quarterly Minimum Data Set with an ARD of 08/17/2024 indicated Resident #13 had a Brief Interview for Mental Status score of 4, which indicated the resident was severely cognitively impaired, was taking an anticoagulant, a diuretic, and the box to indicate the days the resident received insulin injections was blank. Review of Resident #13's care plan, dated as last revised 07/29/2024, was reviewed and did not address the resident's use of an anticoagulant, insulin or address the signs and symptoms to monitor for the use of a diuretic. 3. Review of Resident #16's Admission Record revealed the resident was admitted on [DATE] with diagnoses of type 2 diabetes mellitus, and an unstageable pressure ulcer. Review of Resident #16's Skin Only Evaluation dated 05/22/2024, 7/16/2024, 7/23/2024, 7/24/2024, 7/25/2024, 7/31/2024, 8/6/2024, and 8/19/2024 revealed Resident #13 had a diabetic foot ulcer. Review of Resident #16's Progress notes dated 8/19/2024 revealed a late entry skin issue that noted the resident with a diabetic foot ulcer to the left great toe. Review of Resident #16's Care plan dated 9/20/2024 noted the Resident had potential/actual impairment to skin integrity of the body related to fragile skin. Follow facility protocols for treatment of injury. The care plan was not revised to note current pressure wound and interventions. During an interview with the Assistant Director of Nursing (ADON) on 10/14/2024 at 3:07 PM, she confirmed Resident #16 has had a left great toe wound since 5/22/2024 and that the care plan should have been revised to reflect current wound and interventions. Facility provided a policy titled Care Plans, Comprehensive Person-Centered with a revision date of December 2016 that noted Policy Interpretation and Implementation13. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 48977 Based on observation, interview, record review, facility document review, facility policy review, the facility failed to ensure female residents had hair removed from their face for 1 (Resident #35) of 1 sample mix resident to promote good hygiene; ensure male residents had been kept clean shaved for 1 (Resident #45) of 1 sample mix residents to promote good grooming; and to ensure that 1 (Resident #32) of 1 sample mix residents received regular scheduled baths and/or showers . The findings are: 1. On 10/7/24 at 12:30 PM, the Surveyor observed Resident #35 sitting in a wheelchair in dining room. The resident observed to have hair on their chin. Review of Resident #35's Admission Record with an admitted [DATE] noted the resident has diagnoses of a paralyzed person with cerebral palsy and high pressure in the eyes (Primary angle glaucoma bilateral.) Review of Resident #35's Care plan, initiated date of 6/3/2024, revealed the resident had an activities of daily living (ADL) self-care performance deficit related to (r/t) confusion. Bathing/ showering: Provide sponge bath when a full bath or shower cannot be tolerated. Review of Resident #35's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/25/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 08 (08-12 indicates moderately impaired) and is dependent for personal hygiene that includes shaving. Review of Resident #35's tub/shower transfer log for the past thirty (30) days documents from 9/17/2024 through 10/12/2024 and revealed the resident was bathed on 9/27/2024, 10/10/2024, 10/11/2024; 10/12/2024. On 10/7/24 at 2:12 PM, the Surveyor observed Resident #35 in their room in bed with hair still present on chin. Resident #35 confirmed wanting hair removed from their chin. On 10/8/2024 at 9:03 AM, the Surveyor observed Resident #35 in the day room near the nurses' station with hair still present on chin. On 10/9/2024 at 10:23 AM, the Surveyor observed Resident #35 being wheeled to the cafeteria by a staff member with hair visible on Resident's chin. 2. On 10/07/24 at 9:47 AM, the Surveyor observed Resident #45 lying in bed with facial hair that appears to be unshaved. Review of Resident #45's Care Plan with an initiate date of 6/4/2024 does not reveal the Resident is care planned for ADL care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #45's quarterly MDS with an ARD of 07/24/2024 revealed the resident has a Staff Assessment for Mental Status (SAMS) score of 3 (indicates moderately impaired) and is dependent for hygiene that included shaving. Review of Resident #45's shower log for the past thirty (30) days showed from 9/27/2024 through 10/12/2024 the resident received a shower/ bath on 9/27/2024, 9/28/2024, 10/11/2024, 10/12/2024. On 10/10/2024 11:12 AM, the Surveyor observed Resident #45 lying in bed with facial hair that appears to be unshaved. During an interview with Certified Nursing Assistant (CNA) #12 on 10/14/2024 at 2:56 PM, she confirmed both Resident #35 and Resident #45 have hair on their face that needs removing and it's good hygiene and dignity to shave the residents. During an interview with the Assistant Director of Nursing (ADON) on 10/14/2024 at 3:07 PM, she confirmed both Resident #35 and Resident #45 have hair on their face that needs removing and that both residents have not been showered/ bathed as scheduled. She also confirmed that is part of good hygiene to shave the residents. Facility policy titled Shaving the Resident with a revision date of 6/1/2012 noted Purpose the purpose of this procedure is to promote cleanliness and to provide skin care. Reporting 1. Notify the supervisor if the resident refuses the procedure. A review of the significant change Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 6/3/2024 revealed Resident #32 had memory problems, severely impaired cognition, never or rarely made decisions. Resident #32 had diagnoses of bacteremia (bacteria in the bloodstream), cough, and wound infection. A plan of care for Resident #32 (revision on: 05/29/2024) revealed Resident #32 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to (r/t) cognitive deficits. On 10/09/2024 at 3:40 PM, the Surveyor was provided with the Bath Schedule for 7-3 shift and 3-11 shift which revealed Resident #32 received a bath Monday, Wednesday, and Friday. On 10/10/24 at 3:17 PM, A review of Skin Monitoring: Comprehensive CNA Shower Review for the months of September and October revealed Resident #32 had a bed bath on 09/18/2024, 9/19/2024, 09/27/2024 and 10/07/2024 and a wash up by hospice on 09/23/2024 and 09/25/2024. On 10/10/2024 at 4:40 PM, the Administrator stated if Resident #32 only received 6 baths in the past two months that likely means Resident #32 has not been getting baths/showers. The Administrator stated it was the facility's responsibility to take care of their residents and Resident #32 cannot refuse a bath/shower because the resident does not talk.

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NAME OF PROVIDER OR SUPPLIER Pine Bluff Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 6810 South Hazel Street Pine Bluff, AR 71603	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38200 Based on observation, interview, record review, and facility document review, it was determined the facility failed to ensure residents who have physician orders for weekly skin evaluations had their skin evaluated for 4 (Resident #13, #35, #63, #366) of 4 sample mix residents with orders for weekly skin evaluations; and to ensure residents with a contracture had a treatment in place to prevent further decline in accordance with professional standards of practice for 1 (Resident #13) of 1 sample mix residents. The finding are: 1. On 10/8/2024 at 11:03 AM, the surveyor observed a dressing on Resident #13's right lower leg. Resident #13 told the surveyor it was covering an open spot. Review of Resident #13's Order Summary Report dated 5/20/2024 noted weekly nursing assessment and body audit on Wednesdays, right lower leg swelling with small cluster of blisters: cleanse with wound cleanser, pat & dry, paint with betadine, apply abdominal (ABD) pads and wrap with gauze one time a day every Monday, Wednesday, Friday for wound care and every 24 hours as needed for wound care. On 10/9/2024 at 10:36 AM, skin assessments section Skin Only Evaluation reviewed and revealed skin assessments conducted on: 5/30/2024 6/7/2024 7/8/2024 7/15/2024 7/18/2024 7/22/2024 7/25/2024 7/30/2024 10/8/2024 Review of Resident #13's Care Plan, dated 7/26/2024, noted staff were to monitor/ document location, size and treatment of skin injury and to report abnormalities, failure to heal, signs and symptoms of infection, or maceration to the physician. Weekly treatment documentation is to include measurement of each area of skin breakdown's width, depth, type of tissue and drainage and any other notable changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/17/2024 documented Resident #13 was not at risk of pressure ulcer/ injuries and that there were no unhealed pressure ulcers/ injuries. The MDS showed the resident had no other ulcers, wounds, or skin problems. 2. Review of Resident #35's Order Summary, dated 5/21/2024, noted weekly nursing assessment and body audit one time a day. Review of Resident #35's Skin assessments section Skin Only Evaluation reviewed and revealed skin assessments conducted on: 6/5/2024 7/7/2024 7/16/2024 7/16/2024 7/25/2024 3. Review of Resident #63's Order Summary Report, dated 5/20/2024, noted complete nursing assessment/ body audit every week on 7 PM-7 AM. Review of Resident #63's Skin assessments section Skin Only Evaluation reviewed and revealed skin assessments conducted on: 7/2/2024 7/2/2024 7/9/2024 4. Review of Resident #366's Order Summary Report dated 7/24/2023 noted weekly summary and body audit once a week on Saturday, 7 AM to 3 PM shift. Review of Resident #366's Skin assessments section Skin Only Evaluation reviewed and revealed skin assessments conducted on: 7/6/2024 7/13/2024 7/20/2024 7/27/2024 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 10/8/2024 at 11:04 AM, the Surveyor observed Resident #13's right arm to be flaccid and right hand is contracted with no device present. Review of Resident #13's Admission Record revealed a diagnosis of hemiplegia affecting right dominant side. Review of Resident #13's Care Plan dated 5/9/2024 does not have the resident care planned for a flaccid arm or contracted right hand. Review of Resident #13's Quarterly MDS with an ARD of 8/17/2024 noted in section GG0115.functional limitation in range of motion impairment on one side of upper extremity. On 10/9/2024 at 2:37 PM, the Surveyor observed Resident #13 sitting outside in the smoking area. Resident #13's right hand was contracted with no device present. On 10/11/24 at 2:44 PM, the Surveyor observed Resident #13 in room with LPN #11 who was getting ready to perform tracheostomy care and the surveyor observed no device in resident #13's right hand that appears contracted. During an interview with Certified Nursing Assistant (CNA) #12 on 10/14/2024 at 2:56 PM, she confirmed Resident #13 has a right-hand contracture and no device has been present in the right hand. During an interview with Licensed Practical Nurse (LPN) #11 n 10/11/2024 at 3:03 PM, he confirmed Resident #13's right arm is flaccid (complete lack of voluntary movement in a limb) and right hand is contracted with no device present. LPN #11 confirmed the resident is not care planned for flaccid right arm or contracted right hand. A facility policy titled Treatment of Contractures indicated, Elders of this facility will be provided care to prevent formation of progression of contractures and deformities. Contractures are joint deformities caused by immobility. Contractures develop rapidly and are difficult or impossible to reverse without surgery. When muscles are week, contractures place the muscles in a position of mechanical disadvantage and weakness and muscle wasting from lack of use leads to atrophy. Procedure: Contracture treatment: Restorative staff, nursing staff and therapy staff will work closely to prevent the progression of contractures. Contractures treatment will include slow, gentle stretching and massage. Range of Motion (ROM) exercises will be provided following the facility's Range of Motion Exercise Policy and Procedure. Contracture plans will be developed and supervised by a skilled therapy and the Restorative Nurse Coordinator. Restorative nursing staff will report any changes in ROM to the Restorative Nurse Coordinator immediately for further assessment and revision to the restorative care plan. Use of handrolls to prevent hand/ finger contractures: Handrolls should be considered part of routine care of all dependent elders. May be applied based on nursing assessment and nursing judgement orders and no physician order is required unless elder has severe deformities/ contractures of hand(s).

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 37925

38200

Based on observation, record review, interview and facility policy review, the facility failed to ensure a mechanical lift was properly used to for 1 (Resident #21) sampled resident reviewed for mechanical lift transfer, and failed to ensure residents were assessed to smoke during the facility designate smoke break times for 1 (Resident #13) of 1 sample mix resident reviewed for smoking.

The findings are:

1. Resident #21's Medical Diagnosis health record was reviewed, which indicated the resident had diagnoses of a condition of rigidity of the joint (contracture) of the left hip and a decline (atrophy) in the muscle and decrease in size (wasting) of multiple sites.

An annual Minimum Data report, with an Assessment Reference Date of 07/20/2024, was reviewed and indicated Resident #21 had a Brief Interview for Mental Status score 7, which indicated severely cognitively impaired and an impairment in the lower extremity and required substantial/maximal assist with a shower/bath.

A care plan, dated as reviewed 07/29/2024, was reviewed and had no indication of how Resident #21 was to be transferred or how many staff were required to assist with the transfer.

On 10/07/2024 at 10:07 AM, Certified Nursing Assistant (CNA) #9 was observed propelling Resident #21 in the hall using a mechanical lift with no other staff member assisting her. CNA #10 was heard telling CNA #9 the resident had to be in a shower chair and was not supposed to be in the lift. CNA #9 propelled the resident to the resident's room without assistance of another staff member. CNA #10 entered the room with a shower chair and closed the resident's door.

On 10/14/2024 at 1:34 PM, CNA #9 was interviewed and stated she didn't know much about the resident's care needs, and had started working at the facility on 09/21/2024. She stated the resident could not walk or propel self in the wheelchair. She stated staff used a lift to get the resident from the bed to the shower chair for showers and baths. She stated she did not know the mechanical lift required two people when she used the mechanical lift Monday, 10/07/2024, to transport the resident. She stated resident safety was an important reason to have the right amount of staff for transferring residents using the mechanical lift. She stated a CNA walked her through using the mechanical lift regarding the education she received on how to transfer residents.

A Safe Lifting and Movement of Residents policy, dated as revised July 2017 and provided by the Assistant Director of Nursing (ADON)on 10/14/2024, was reviewed and indicated the facility uses appropriate techniques and devices to lift and move residents to protect the safety and well-being of staff and resident and to promote quality of care. The policy indicated the residents' individual needs for transfer assistance would be assessed and staff would document resident transferring and lifting needs in the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The owner's manual for the [brand name] lift, with no date, and provided by the ADON on 10/14/2024, was reviewed. The manual indicated on page 5 the lift should be used solely for transferring a user/patient from one utility (beds, bathtubs, toilets, etc. [etcetera]) to another. The patient lift should not be used for transporting or moving any patient from one location to another location. 2. Review of Resident #13's Admission Record revealed the resident was admitted on [DATE] with a diagnosis of cognitive communication deficit, chronic respiratory failure with low oxygen, paralysis/ weakness affecting right dominant side, chronic obstructive pulmonary disease (COPD), and surgically created airway/tracheostomy complication. A review of quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/17/2024 revealed a score of 4 (indicates severe cognitive impairment) on the Brief Interview for Mental Status (MDS). On 10/08/2024 at 10:08 AM, the Surveyor observed a smoke break where Resident #13 was present and smoking with no smoking apron. One staff member was present supervising the smoke break, CNA #18, who was asked if all residents were assessed for smoking, and she said yes. Review of Resident #13's Assessments did not reveal the resident was assessed for smoking. Review of Resident #13's Care Plan revealed the resident is a smoker, had a goal stating the resident will not suffer injury from unsafe smoking, and direction for staff to instruct the resident about the facility's smoking policy and safety concerns, and observe clothing and skin for signs of cigarette burns. During an interview with Resident #13 on 10/08/2024 at 11:05 AM, Resident #13 revealed they do not wear a smoking apron while smoking. On 10/09/2024 at 10:13 AM, the Surveyor observed Resident #13 outside smoking during smoke break. Resident does not have on a smoking apron. During an interview with Licensed Practical Nurse (LPN) #13 on 10/14/2024 at 3:00 PM, she confirmed residents should be assessed prior to being able to smoke to ensure residents safety and confirmed Resident #13 has no smoking assessment. During an interview with, the Assistant Director of Nursing (ADON) on 10/14/2024 at 3:07 PM, she confirmed residents should be assessed prior to being able to smoke to ensure residents safety and confirmed Resident #13 has no smoking assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled Smoking Policy- Residents with a revision date of 2017 noted Policy Statement This facility shall establish and maintain safe resident smoking practices. Policy Interpretation and Implementation 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: a. Current level of tobacco consumption; b. Method of tobacco consumption (standard cigarettes; electronic cigarettes, pipe, etc.); c. Desire to quit smoking, if a current smoker; and d. Ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). 7. The staff shall consult with the Attending Physician and the Director of Nursing Services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 8. The resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48977 Based on observation, interviews, record reviews, and facility policy reviews the facility failed to ensure incontinence care was provided in a clean and sanitary manner to promote cleanliness for 2 (Resident #32 and #33) sampled residents. The findings include: 1. A review of the significant change Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 6/01/2024 revealed Resident #33's Brief Interview of Mental Status (BIMS) score was 14, indicating the resident was cognitively intact. Resident #33 was occasional incontinent of bowel and bladder. a. A plan of care (Revision on: 06/10/2024) revealed Resident #33 had episodes of occasional incontinence related to (r/t) impaired mobility. b. On 10/03/2024 at 9:30 AM, the Surveyor observed Certified Nursing Assistant CNA #14 improperly cleaning Resident #33 genital area by wiping in a back-and-forth motion with one wipe, a practice that can spread germs and cause urinary tract infections. c. On 10/03/2024 at 9:40 AM, the Surveyor asked CNA #14 if they were trained to wipe more than once with one wipe without folding. CNA #14 stated no ma'am. 2. A review of the significant change Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 6/3/2024 revealed Resident #32 had memory problems, severely impaired cognition, never or rarely made decisions. Resident #32 had diagnoses of bacteremia, cough unspecified, and wound infection. a. A plan of care for Resident #32 (revision on: 05/29/2024) revealed Resident #32 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to (r/t) cognitive deficits. b. On 10/07/2024 at 1:03 PM, the Surveyor noted Resident #32 was lying in the bed with a wet ring around the buttock area. c. On 10/08/2024 at 2:30 PM, Surveyor observed CNA #15 provide incontinence care to Resident #32. CNA #15 improperly cleaned the resident by not cleaning all of the genital area which had been exposed to urine and potentially feces. Resident #32 was incontinent of urine during care and CNA #15 did not clean the resident a second time. d. On 10/08/2024 at 2:50 PM, CNA #15 stated she did not clean all of the genital area because it was too hard due to the Resident's contracture. CNA #15 stated she did not clean Resident #32 after the incontinence episode during care. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 10/10/2024 at 4:40 PM, the Administrator stated if the sheet under the resident's buttock was wet, that indicated lack of care, staff not doing rounds every 2 hours, and/or we do not care about our residents. The Administrator stated when providing incontinence care the entire genital area should be cleaned to prevent Urinary Tract Infection (UTI), yeast infections, poor wound healing. f. A policy titled Perineal Care Protocol noted perineal care would be provided every shift as needed based on the individual needs of the resident.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.

37925

Based on observation, record review and interview, the facility failed to ensure a Percutaneous Endoscopic Gastrostomy (PEG) tube was properly checked for placement before fluids and medications were administered, and failed to ensure the enteral feeding rate was set per the physician's orders for 1 (Resident #31) sampled resident reviewed for enteral feeding.

The findings are:

On 10/07/2024 at 10:36 AM, Resident #31 was lying in bed on the right side with a wedge pillow behind the back and the head of bed (hob) was elevated. [Brand name] enteral feeding was hanging, and the feeding pump rate was set at 95 milliliters/hour (ml/hr) and flush set at 50 ml every (q)1 hr. The feeding bottle was labeled with the resident's name, room number, date and the rate indicated 95 ml/hr. There was not a time to indicate when the bottle was hung or the nurse initials who initiated the feeding.

Resident #31's Order Summary Report was reviewed and indicated the resident had a diagnosis of difficulty swallowing (dysphagia) and an encounter for attention to a surgical opening in the abdominal wall for a feeding tube (gastrostomy). An enteral feed order dated 09/16/2024 indicated the resident was to receive [brand name] enteral feeding at 90 ml/hr with 50 ml/hr of water. An enteral feed order dated 05/08/2024 indicated the [feeding] tube was to be checked for placement before starting the enteral feeding, medication administration, or flushing the tube.

Resident #31's care plan, dated as last reviewed 08/12/2024, was reviewed and indicated the resident required tube feeding. An intervention indicated the PEG tube would be checked for tube placement and gastric contents/residual volume (fluid from the stomach) per the facility's protocol. Another intervention indicated to see the Medical Doctor's orders for the current feeding orders.

On 10/08/2024 at 9:15 AM, Resident #31 was lying in bed awake with hob elevated. The enteral feeding bottle was reviewed, and the label was dated 10-8 [10/08/2024] and indicated a rate of 95 ml/hr. The feeding pump rate was set at 95 ml/hr.

On 10/10/2024 at 7:53 AM, Resident #31 was lying in bed on the back with hob up. The enteral feeding tube was disconnected from the resident and hanging on the pole. The enteral feeding bottle was reviewed and dated 10-10 [10/10/2024] and the rate indicated 95 ml/hr. The feeding pump was off at this time.

On 10/10/2024 at 9:10 AM, Registered Nurse (RN) #6 drew up 5 ml of air into a 60 ml syringe and placed the bell of a stethoscope on Resident #31's stomach and checked the PEG tube placement by pushing the 5 ml of air through the PEG tube. She administered water, medications, and more water through the PEG tube. She connected the enteral feeding tube to the resident's PEG tube and started the feeding pump.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/2024 at 9:15 AM, RN #6 was interviewed and asked how she was instructed to check the PEG tube for placement. She stated to draw back 5 ml of air, place the stethoscope on the stomach and then listen for a swoosh sound to indicate tube was intact and in the correct spot. She was asked if she received training or education from the facility on how to check the PEG tube for placement. She stated she had not. An Enteral Feedings-Safety Precautions policy, dated as revised May 2014 and provided by the Assistant Director of Nursing on 10/14/2024, was reviewed and indicated to prevent errors in administration to check the rate of administration (ml/hour). The policy indicated to have the following on the formula label: initials, date, and time the formula was hung/administered. The policy indicated to prevent inhaling fluid into the lungs (aspiration), the enteral tube placement should be checked prior to each feeding and administration of medication but it did not specify how.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 48977 Based on observation, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure surgically created airway/ tracheostomy care was provided as physician ordered to prevent possible respiratory infections for 1 (Resident #13) of 1 residents with a tracheostomy; to ensure respiratory supplies were properly stored and readily available for 2 (Resident #13, #32) for 2 sample mix residents. The findings are: On 10/08/2024 at 11:07 AM, the Surveyor observed gauze around Resident #13's tracheostomy to be light brown in color with what appears to be dried blood. During an interviewer with Resident #13 the resident confirmed the gauze hasn't been changed and when asked how often they change it she said sometimes. Review of Resident #13's Admission Record revealed the resident was admitted on [DATE] with a diagnoses of Tracheostomy complication. Review of Resident #13's Order Summary Report with an order date of 4/19/2024 noted tracheostomy (trach) care every 24 hours and as needed (PRN), clean trach site with half normal saline (NS) and half peroxide then rinse with NS and apply dry dressing daily and PRN two times a day related to tracheostomy complications. Review of Resident #13's Care Plan with an initiated date of 5/6/2024 noted the resident has impaired immunity related to (r/t) trach in place, use universal precautions as appropriate, the resident has a tracheostomy r/t impaired breathing mechanics, tube out procedures: Keep extra trach tube and tube inserted into trachea (obturator, a device used to insert a tracheostomy tube. It fits inside the tube to provide a smooth surface that guides the tracheostomy tube as it is being inserted) at bedside. Review of Resident #13's Treatment Administration Record (TAR) with a start date of 5/20/2024 noted trach care two times a day at 8:00 AM and 8:00 PM. Resident had trach care performed on 10/2/2024 at 8:00 PM, 10/3/2024 at 8:00 PM, 10/4/2024 at 8:00 AM, 10/7/2024 at 8:00 AM resident refused, 10/7/2024 at 8:00 PM. Physician order was changed to reflect trach care every day shift starting on 10/10/2024. Resident did not receive trach care until 10/13/2024. Review of facility procedure titled Performing Tracheostomy Care Using Sterile Technique noted Step by Step perform hand hygiene and put on appropriate PPE as indicated; auscultate lung sounds and assess respiratory rate. Assess pain level and need for pain medication; place a liquid-absorbing towel across the client's chest to help prevent bacteria and other organisms form transmitting onto the clients linen; Hyper-oxygenate the client using 100% oxygen for at least 30 seconds or by having the client take five or six deep breaths. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pine Bluff Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 6810 South Hazel Street Pine Bluff, AR 71603	

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/2024 at 2:44 PM, the Surveyor observed Resident #13's tracheostomy care performed by Licensed Practical Nurse (LPN) #11. The surveyor entered Resident #13's room and LPN #11 had already donned surgical gloves prior to surveyor entering. The surveyor did not observe an obturator at the bedside. LPN #11 closed the Resident's door with his surgical gloves on and did not change them. Surveyor observed LPN #11 removing items from the trach kit and placing the items on the sterile field on the overbed table without sanitizing the table first. LPN #11 placed sterile gloves, cotton tipped swab, fenestrated gauze, neck ties, pipettes, bristled brush and 0.9% sodium chloride irrigation containers on sterile field. LPN #11 poured fluid in the tracheostomy supply tray. LPN #11 attempted to remove the obturator from the resident's tracheostomy but appeared to have a hard time getting it removed. LPN was able to remove obturator and placed it in 0.9% sodium chloride solution and used bristled brush to clean for approximately two (2) minutes. The obturator was observed full of green/ brown mucus. While holding the obturator the LPN opened another container of 0.9% Sodium Chloride solution and poured it into another tray within the tracheostomy tray kit. LPN #11 changed his surgical gloves, did not sanitized hands. LPN #11 placed obturator on sterile field. LPN #11 removed old fenestrated gauze. Trach site appears to have dried blood, area is red. LPN #11 cleansed trach site with 0.9% sodium chloride solution on gauze. LPN #11 unhooked trach ties and cleansed around trach are removing copious amounts of brown/ green mucus. Resident #13 refused to have trach ties changed. Resident #13 began coughing up mucus. LPN #11 re-secured inner cannula with tracheostomy ties and told the resident he would be right back he needed to get more gauze. LPN #11 removed gloves and left the room at 2:58 PM with obturator left on sterile field. LPN #11 returned to the room at 3:00 PM with more gauze but did not shut the Resident's door. LPN #11 did not sanitize hands before donning surgical gloves. LPN #11 recleaned trach area with gauze and recleaned obturator with bristled brush. LPN #11 replaced fenestrated gauze with new fenestrated gauze, placed obturator with visible mucus still on it back in Resident's tracheostomy site. LPN #11 did not put on personal protective equipment (PPE) while performing tracheostomy care. During an interview with LPN #11 on 10/11/2024 at 3:04 PM, he confirmed he should have worn sterile gloves while performing tracheostomy care because it is a sterile procedure, that he should have worn PPE and that he should've sanitized his hands before putting on and changing gloves for infection control purpose. LPN #13 was unable to answer when the Surveyor asked where the spare obturator was located. Resident #13 pulled it out of the dresser drawer. LPN #11 said the extra respiratory supplies should be stored in the medication room. During an interview with the Nurse Consultant n 10/11/2024 at 3:11 PM, he confirmed LPN #11 should have sanitized his hands, sanitized bedside table prior to sterile field being placed on it, worn sterile gloves while performing trach care, should have worn PPE during trach care, and replaced obturator with a new one for infection control purposes. The Nurse Consultant confirmed the spare obturator should be kept at the head of Resident #13's bed not in the medication room. The Nurse Consultant also confirmed tracheostomy care has not been performed as ordered according to Resident #13's TAR. During an interview with the Assistant Director of Nursing (ADON)on 10/14/2024 at 3:07 PM, she confirmed LPN #11 should have sanitized his hands, sanitized bedside table prior to sterile field being placed on it, worn sterile gloves while performing trach care, should have worn PPE during trach care, and replaced obturator with a new one for infection control purposes. The ADON confirmed the spare obturator should be kept at the head of Resident #13's bed not in the medication room. The ADON also confirmed tracheostomy care has not been performed as ordered according to Resident #13's TAR. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A facility policy titled Tracheostomy Care noted, Policy This facility will minimize risks of infection and other complications associated with tracheostomy care at all times. Clean technique, using sterile supplies will be used for care of non-established and established tracheostomies. Procedure Non-Established & Established Tracheostomy Stoma: Stoma care is provided every 24 hours or as needed; if elder is immunocompromised or with acute infective illness, sterile techniques will be utilized; tracheostomy stoma will be cleansed with sterile normal saline. Tracheostomy Tube Changes tracheostomy tubes with inner cannula will be changed every thirty (30) days and as needed; Supplies for tracheostomy care and emergent tracheostomy tube replacement/ change must be available at the bedside or in a readily accessible location at all times. Stoma Care using sterile cotton-tipped applicators, gauze and sodium chloride clean the tracheostomy stoma starting at the stoma site under faceplate extending 5-10 centimeters (cm) in all directions from the stoma; using dry gauze or dry cotton tipped applicators, pat lightly at skin and exposed outer cannula surfaces.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48977 Based on interviews and facility policy review the facility failed to ensure the facility had full-time Director of Nursing (DON) coverage. The findings include: On 10/08/2024 at 3:35 PM, the Surveyor was provided a calendar for the months of July, August, September, and October. The Surveyor noted there was not a DON employed, nor an interim filling in for role of DON, at the facility from August 10, 2024-August 18, 2024. On 10/14/2024 at 1:00 PM, the Surveyor was provided check stubs of the Director of Nursing's which did not reflect fulltime hours consistently during a two-week timeframe. On 10/14/2024 at 4:40 PM, the Administrator stated sometimes we had DON coverage sometimes we did not. A policy titled Staffing noted the facility provided sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with the facility assessment.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 48977 Based on observations, interviews, and facility policy review, the facility failed to ensure daily staffing was posted visible for resident and visitor with all the required components. The findings include: On 10/10/2024 at 9:00 AM, the Surveyor noted there was no posting of the daily staffing and resident census visible for visitors and residents to see. The Surveyor noted on previous sign in sheet there was no tally of actual hours worked per shift for direct care staff. On 10/10/2024 at 2:00 PM, Licensed Practical Nurse #7 the facility's Staff Coordinator stated she did not know it was required to have a visible posting which included the facility name, date, census, nursing staff responsible for director care, and a tally of actual hours worked per shift. On 10/14/2024 at 04:40 PM, the Administrator stated there was not a daily posting for staffing which included all the required components. A policy titled Posting Direct Care Daily Staffing Numbers noted the facility would post daily for each shift the number of nursing personnel responsible for providing direct care to residents. The Information on the form shall include the facility name, date, census, category of licensed and unlicensed staff working each shift, and actual time worked that shift for each category.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925 38200 Based on record review, and interview, the facility failed to accurately account for a controlled medication after administration for 1 (Resident #50) resident who was reviewed for pharmaceutical services and failed to ensure pharmaceuticals available for the residents during medication administration were dispensed with the accurate dosage for 1 (Resident #63) sampled resident reviewed for medication dosages. The findings are: Resident #50's Order Summary Report was reviewed and indicated the resident had a diagnosis of a disorder associated with mood swings from depressive lows to manic highs (bipolar). Clonazepam 0.5 milligram (mg) was ordered 08/31/2024 to give 1 tablet by mouth every 8 hours as needed for anxiety. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/15/2024 was reviewed and indicated Resident #50 had a Staff Assessment for Mental Status (SAMS) score of 2, which indicated moderately cognitively impaired and was taking antipsychotic medications. Review of a care plan, dated as last reviewed 06/19/2024, showed Resident #50 used psychotropic medications and to monitor/ document any adverse reactions such as frequent falls loss of appetite or behavior symptoms not usual to the person. The September 2024 electronic Medication Administration Record (eMAR) was reviewed and indicated a dose of Clonazepam 0.5 mg was administered on the 7th at 2144 (9:44 PM) and on the 8th at 0057 AM (12:57 AM) and the follow-up code, E, was documented with each dose and indicated the medication was effective. The narcotic log for the secured unit was reviewed and on page 38, indicated Clonazepam 1 mg was ordered to be taken three times a day. On 09/07/2024 at 220 (10:00 PM) a dose was documented as wasted due to an order change and there was only one signature on the line. On page 45 of the narcotic log, Clonazepam 0.5 mg was ordered every 8 hours as needed and the page was started on 10/05/2024. The page did not indicate if the order was moved from another page. The balance remaining was 60 tablets, and no medication had been signed out on this page. On 10/14/2024 at 6:30 PM, Licensed Practical Nurse (LPN) #7 was interviewed with concurrent observations. She was asked to show this surveyor the prior page of Clonazepam 0.5 mg for September 2024 which reflected the September eMAR. LPN #7 after reviewing all the folded pages for Clonazepam 0.5 mg, she stated she did not see another page for Clonazepam 0.5 mg, only Clonazepam 1 mg tablets. She stated the process of signing out controlled substances was the nurse signs the medication out when punched out of the medication cart. She stated if an error/discrepancy was identified in the controlled substance log, the nurses were instructed to call the Director of Nursing and Administrator. On 10/14/2024, this surveyor informed the ADON and Administrator of a discrepancy for Resident #50's Clonazepam 0.5 mg documentation for September 2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #63's Admission Record revealed the resident was admitted on [DATE] with a diagnosis of Essential Hypertension. Review of Resident #63's Care Plan with an initiation date of 5/9/2024 noted the resident has high blood pressure issues and prescribed Nifedipine extended release (ER) 60 milligrams (mg). Review of Resident #63's Order Summary Report noted Nifedipine Tab ER 24 hour (HR) 60 mg give 1 tablet orally two times a day related (r/t) to high blood pressure with a start date of 5/20/2024. Review of Resident 63's Medication Administration Record (MAR) for May 2024, June 2024, and July 2024 noted the resident was prescribed Nifedipine tab ER 24 HR 60 MG give 1 tablet orally two times a day related to Essential Hypertension with a start date of 5/20/2024 at 8:00 AM. Review of Resident #63's [Pharmacy] prescription order summary dated 10/11/2024 revealed Nifedipine ER 90 MG was dispensed to the facility on [DATE] quantity (QTY) 60; 12/22/2023 QTY 60; 1/25/2024 QTY 60; 2/27/2024 QTY 62; 3/25/2024 QTY 60; 4/25/2024 QTY 62; 5/22/2024 QTY 60; 6/20/2024 QTY 62; 6/21/2024 QTY 60; 9/13/2024 QTY 60. During an interview with the Nurse Consultant on 10/11/2024 at 2:55 PM, he confirmed that Resident #63 did not receive the physician ordered dose of Nifedipine ER 60 mg two times a day for hypertension, however the resident was ordered and received Nifedipine ER 90 mg two times a day from 5/20/2025 through Resident #63's discharge on 7/9/2024. During an interview with the Assistant Director of Nursing (ADON) on 10/14/2024 at 3:07 PM, she confirmed Resident #63 did not have their correct dosage of Nifedipine ordered from the pharmacy from 5/9/2024 through discharge on 7/9/2024 and that the resident continued to receive 90 milligrams versus the ordered 60 milligrams and that the pharmacy should have been notified immediately about the change. Facility policy titled Pharmacy Services Overview with a revision date of April 2007 noted Policy Interpretation and Implementation f. Help the facility assure that medications are requested, received, and administered in a timely manner as ordered by the authorized prescribers. Facility policy titled Medication and Treatment Orders with a revision date of July 2016 noted Policy Statement Orders for medications and treatments will be consistent with principles of safe and effective order writing. Policy Interpretation and Implementation 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. 9. Orders for medications must include: a. Name and strength of the drug.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 48977 Based on record reviews, interviews, and facility policy review, the facility failed to ensure Monthly Medication Regimens (MMR) were completed at least monthly for 1 (Resident #8) sampled resident. The findings include: A review of the quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 8/25/2024 revealed on the Brief Interview of Mental Status (BIMS) Resident #8 scored 11, indicating moderate cognitive impairment. Resident #8 was taking high risk medications used to treat depression, anxiety, and fluid retention. A plan of care for Resident #8 (Revision on: 05/28/2024) revealed Resident #8 used antidepressant medication related to depression. On 10/14/24 at 4:40 PM, during an interview the Administrator stated the facility could not provide any documentation to prove MMRs were completed. A policy titled Medication Regimen Reviews noted the Consultant Pharmacy shall review the medication regimen of each resident at least monthly.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 37925 48977 Based on record review and interview, the facility failed to ensure a pharmacist recommendations for psychotropic medications were addressed for 3 (Residents #8, #50 and #57) sampled residents reviewed for medication regimen review recommendations. The findings are: 1. Resident #50's Order Summary Report was reviewed and indicated the resident had a diagnosis of a disorder associated with mood swings from depressive lows to manic highs (bipolar). Trazodone (psychotropic medication) 50 milligrams (mg) take one tablet by mouth at bedtime was ordered on 01/30/2024. The order summary report indicated the resident should be observed closely for side effects of antipsychotic medications including disorientation and increased agitation. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/15/2024 was reviewed and indicated Resident #50 had a Staff Assessment for Mental Status (SAMS) score of 2, which indicated moderately cognitively impaired, and the resident was taking antipsychotic medications. A Care Plan, dated as last reviewed 06/19/2024, was reviewed and indicated Resident #50 used psychotropic medications and to monitor/document any adverse reactions such as frequent falls loss of appetite or behavior symptoms not usual to the person. A pharmacy medication regimen review (MRR) form, dated 08/17/2024, was reviewed and indicated the resident had been taking Trazodone since 01/2024 and to evaluate the current dose and consider a dose reduction. As of 10/08/2024, the recommendation had not been addressed by the physician. 2. Resident #57's Order Summary Report was reviewed and indicated the resident had a diagnosis of a type of disorder affecting a person's movements, ability to communicate, think, feel and behave clearly (catatonic schizophrenia). Resident #57's admission Minimum Data Set, with an Assessment Reference Date of 08/21/2024, was reviewed and indicated the resident had a Staff Assessment for Mental Status score of 3, which indicated severely cognitively impaired and received antipsychotic medication. Haloperidol (antipsychotic) solution inject 5 mg/ml intramuscularly every 8 hours as needed (PRN) for agitation was ordered 09/06/2024. A pharmacy MRR form dated 09/12/2024, was reviewed and indicated a PRN psychotropic order needed a 14 day stop day and the physician would need to re-evaluate the need for Haloperidol. The recommendation indicated a duration greater than 14 days would need a physician rationale. As of 10/08/2024, the recommendation had not been addressed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Tapering Medications and Gradual Drug Dose Reduction policy, dated as revised April 2007 and provided by the Assistant Director of Nursing (ADON), was reviewed and indicated after medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences. The policy indicated residents who use antipsychotic drugs shall receive gradual dose reductions, unless clinically contraindicated, to discontinue the use of such drugs. 3. A review of the quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 8/25/2024 revealed on the Brief Interview of Mental Status (BIMS) Resident #8 scored 11 indicating moderate cognitive impairment. Resident #8 had a diagnosis of Psychotic Disorder (other than schizophrenia). A plan of care for Resident #8 (Revision on: 05/30/2024) revealed Resident #8 was at low risk for falls related to psychoactive drug use. A review of the Order Summary Report Resident #8 had an order for Risperidone 0.5 milligram (MG) related to psychosis. An unaddressed Consolidated Report to DON (Director of Nursing) and Medical Director dated 7/28/2024 noted Resident #8 has been taking risperidone O, mirtazapine 7.5 mg, and duloxetine 30 mg since 12/2023. Please evaluate the current dose and consider a dose reduction. An unaddressed Recommendations Pending Response dated 8/18/2024 noted Resident #8 has been taking risperidone 0.5 mg, mirtazapine 7.5 mg, and duloxetine 30 mg since 12/2O23. Please evaluate the current dose and consider a dose reduction. On 10/14/24 at 4:40 PM, during an interview the Administrator stated the Medical Director did not provide a rationale or reason as to why he was not going to attempt the (GDR) with the medication. The Administrator stated the Gradual Dose Reduction (GDR) suggestion for Resident #8's Risperdal was not addressed or attempted.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 37925 Based on observation, record review, and interview, the facility failed to ensure the medication error rate was less than 5 percent (%) during the medication administration observation of 4 (Residents #31, #36, #37 and #54) of 4 sampled residents who received medications from 1 Registered Nurse (RN) and 1 Licensed Practical Nurse (LPN). 29 opportunities of medication administration were observed and 7 of the 29 medications were not administered in accordance with physician's orders, resulting in a medication error rate of 24.14%. The findings are: 1. On 10/10/2024 at 8:08 AM, RN #6 entered Resident #36's room to administer medication she had prepared. She obtained the resident's blood pressure and heart rate and indicated the heart rate was 58 and she was going to hold the resident's Coreg (Carvedilol) 25 milligram (mg) tablet. She administered Albuterol Sulfate 90 micrograms (mcg) inhaler, 2 puffs, to the resident. Resident #36's Order Summary Report was reviewed and indicated the resident had diagnoses of an irregular heartbeat (atrial fibrillation) and a lung condition which causes difficulty breathing (chronic obstructive pulmonary disease). Carvedilol 25 mg was ordered to take 1 tablet by mouth two times a day and no parameters were indicated on the order. Albuterol Sulfate inhalation (90 Base) mcg was ordered to inhale 2 puffs orally four times a day. The electronic Medication Administration Record (eMAR) was reviewed and indicated the Albuterol inhalation solution was last administered at 0600 (6:00 AM) and was not scheduled to be administered again until 1200 (12:00 PM). On 10/11/2024 at 2:23 PM, Registered Nurse (RN) #6 was interviewed with concurrent observations, and she was asked to review Resident #36's orders for Carvedilol and Albuterol inhalation 90 mcg. She stated she had not notified the provider that she administered the resident's Albuterol inhalation 90 mcg 2 hours early or that she held the Carvedilol because she thought there were parameters but observed there were none. 2. On 10/10/024 at 8:52 AM, RN #6 was preparing medications for Resident #31 and stated Zinc Gluconate was ordered but Zinc Sulfate was available on the medication cart, and this was not the correct medication. She stated she would have to call the provider. The medication was omitted during the 8 AM medication administration for this resident. On 10/10/2024 at 2:45 PM, RN #6 informed this surveyor she had spoken with the Nurse Practitioner and the Zinc Gluconate order was changed to Zinc Sulfate. 3. On 10/10/2024 at 9:44 AM, Licensed Practical Nurse (LPN) #7 was preparing medications for Resident #37 and after she administered the resident's medications and refreshed her screen, she stated another medication was showing as due, Phenobarbital, and she would give it later. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/2024 at 11:47 AM, this surveyor reviewed Resident #37's eMAR and observed Phenobarbital 64.8 mg tablet was documented as administered. This surveyor reviewed the narcotic log, and the medication was signed out at 10:30 AM by LPN #7. The eMAR indicated Phenobarbital was to be administered at 0800 (8:00 AM) and 2000 (8:00 PM). The medication was administered 2 and a half hours late. 4. On 10/10/2024 at 11:01 AM, LPN #7 had prepared medications for Resident #54. She administered Apixaban 5 mg tablet, Gabapentin 300 mg capsule and Metoprolol Tartrate 50 mg tablet with the other scheduled medications. Resident #54's Order Summary Report was reviewed and indicated the resident had diagnoses of a coagulation defect (the blood will not clot as it should), high blood pressure (hypertension) and fibromyalgia (a condition causing widespread body pain and tiredness). Apixaban 5 mg was ordered to take twice a day, Gabapentin 300 mg was ordered to take 2 capsules three times a day, and Metoprolol Tartrate 50 mg was ordered to take 1 tablet twice a day. Resident #54's eMAR was reviewed and indicated Apixaban was scheduled at 0800 and 2000 and was administered 3 hours late. Metoprolol Tartrate was ordered at 0800 and 1600 (4:00 PM) and was administered 3 hours late. Gabapentin was ordered at 0800, 1300 (1:00 PM) and 2000 and was given 3 hours late, leaving 2 hours between the administered and next scheduled time. An Adverse Consequences and Medication Errors policy, dated as revised April 2014, was reviewed and indicated a medication error was defined as the preparation or administration of drugs or biologicals which was not in accordance with the physician's orders, manufacture's specifications, or accepted professional standards of the professional providing services. Examples of medication errors included: a drug ordered but not administered, wrong drug, and wrong time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/14/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served in accordance with the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed. The findings are: 1. The week 3-day lunch menu for 2024 to 2025 specified for the residents on regular diets, and mechanical soft diets to receive 3 ounces of ham and 1/2 cup of white beans and for the residents on pureed diets to receive a #8 scoop (1/2 cup) of pureed ham and a #8 (1/2 cup) of pureed white beans. 2. On 10/7/24 at 8:57 AM, Dietary [NAME] (DC) #1 used a 4-ounce spoon to place 7 servings of black-eyed peas from a container dated 10/04/2024 into a blender and pureed. When asked during an interview if black eyed peas were on the menu, DC #1 stated we are having lima beans for lunch, and using leftover black-eyed peas for the pureed. 2. On 10/07/24 at 11:09 AM, ten small pieces of ham weighed 3 ounces, which is the amount each resident should have received. DC #1 used tongs to place 30 small pieces of ham into a blender, resulting in 3 servings, although 4 servings were needed. To achieve the correct number of servings, DC #1 should have used 40 pieces of ham, instead of 30. DC #1 #1 added 7 dinner rolls plus 3 more slices of bread, added broth and pureed. Total of 3 servings, instead of 4 servings. At 11:16 AM, he poured the pureed meat mixture into a pan and placed it on a pan of hot water on the stove to be served to the residents on pureed diets. 3. On 10/7/24 at 11:30 AM, ten small pieces of ham weighed 3 ounces, which is the amount each resident should have received. DC #1 used a tong to place 60 small pieces of ham into a blender, resulting in 6 servings, although he needed 13 servings instead. To achieve the correct number of servings, DC #1 should have used 130 pieces of ham, instead of 60 4. On 10/07/24 at 12:51 PM, one small slice of ham weighed 1.4 ounces was served to the residents on regular diets, instead of 3 ounces. 5. On 10/07/24 at 12:54 PM, DA#4 weighed the same pieces of ham used in preparation of the mechanical soft diet's meat and the pureed diets meat and stated all 10 small pieces of the meat weighed 3 ounces. DA #4 weighed the same amount of ham served to the residents who required regular diets and stated the meat weighed 1.4 ounces.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 03508 Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 1 of 1 meal observed. The findings are: 1. On 10/07/24 at 8:57 AM, Dietary [NAME] (DC) #1 used a 4-ounce spoon to place 7 servings of black-eyed peas from a container dated 10/04/2024 into a blender and pureed. When asked during an interview if black eyed peas were on the menu, DC #1 stated we are having lima beans for lunch, and using leftover black-eyed peas for the pureed. DC #1 poured the pureed black-eyed peas into a pan, covered it with foil and placed it in the oven. The consistency of the pureed black-eyed peas was mushy and not formed. 2. On 10/7/24 at 10:56 AM, DC #1 used a 4 ounce ladle spoon to place 9 servings of turnip greens into a blender, and pureed. At 11:01 AM, DC #1 poured the pureed turnip greens into a pan and placed it in pan of hot water on the stove. The consistency of the pureed turnip green was watery and not formed. 3. On 10/7/24 at 11:09 AM, the DC#1 used tongs to place 30 small pieces of ham into a blender, added 7 dinner rolls plus 3 more slices of bread, added broth and pureed. Total of 3 servings, instead of 5 servings. On 10/07/24 11:16 AM, he poured the pureed meat into a pan and placed it on a pan of hot water on the stove. The consistency of the pureed meat was thick with visible pieces of ham skins in the mixture. 4. On 10/7/24 at 11:41 AM, DC #1 placed 5 servings of hot was cornbread into a blender, added milk and pureed. At 11:47 AM, DC#1 poured the pureed hot water cornbread into a pan and placed it in a pan of hot water on the stove. The consistency of the pureed cornbread was thick. 5. On 10/7/24 at 1:06 PM, when asked during an interview, Dietary Aide #2 stated the pureed turnip greens were not real smooth, but not clumpy; the black-eyed peas were smooth and looked like a milk shake; pureed ham was thick like mashed potatoes with the skin on them; pureed corn bread looked like raw dough.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 03508

Based on observation and interview, the facility failed to ensure the kitchen was free of pests; kitchen floor was free of dirt and, grease; food items stored in the refrigerator and freezer were covered, sealed, and dated; leftover foods were used in a manner to maintain food quality; expired dairy products was promptly removed/discarded on or before the expiration or use by date to prevent the growth of bacteria; ice machine was maintained in clean and sanitary condition and dietary staff washed their hands before handling clean equipment when contaminated, dairy product was maintained at 41 degrees Fahrenheit or below and hot food items were maintained at above 135 degrees Fahrenheit on the steam table.

The findings are:

1. On [DATE] at 8:59 AM, the following observations were made in the kitchen:

a. One roach was crawling around the hand washing sink, and one-half dead around the food preparation sink. The surveyor pointed them out the half dead roach to Dietary Aide (DA) #2, who removed the roach.

b. The floor around the oven and grill had an accumulation of grease and food crumbs.

c. The body of the grill and oven had a build-up of grease with caked in greasy foods on them.

d. DA #2 stated if it is constantly cleaned like it supposed to be cleaned, it will not look like it is now. There was loose foil and food crumbs on the floor behind the oven and grill.

e. An opened bottle of grape jelly was on the counter. The manufacturer's specification on the bottle indicated to refrigerate after opening. DA #2 stated jelly should not be left out, they supposed to be refrigerated.

2. On [DATE] at 9:10 AM, the following observations were made on a shelf in the walk-in refrigerator:

a. An opened container of diced tomatoes with a sage colorization. DA #2 stated it's starting to turn bad.

b. One leftover container of pasta sauce dated [DATE]. DA #2 stated they supposed to store it for only 3 days.

b. A plastic bag that contained leftover scrambled eggs and a plastic bag that contained pureed sausage and whole sausage, were on a shelf in the refrigerator.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. On [DATE] at 9:11 AM, when asked during an interview what were in the plastic bags and what are they used for, DA #2 stated they are scrambled eggs and pureed sausage and sausage patties. They use them the next day for the residents on mechanical and pureed diets. The quality of the food is gone when reheating them the next day, the sausage will feel rubbery. d. Two containers of cottage cheese with an expiration date of [DATE]. e. One container of sour cream with an expiration date [DATE]. c. There were 15 bags of bread, 12 bags of hot dog buns and 4 bags of hamburger buns with the received date of [DATE]. The manufacturer specification on the box indicated to keep frozen at 0 or below. 3. On [DATE] at 9:31 AM, the following observations were made on a shelf in the freezer: a. An open box of diced chicken. The box was not covered or sealed. b. An opened box of hamburger patties. The box was not covered or sealed. c. An opened box of corndog. The box was not covered or sealed. d. An opened box of turkey sausage. The box was not covered or sealed. e. An opened box of marinara sauce with 150 counts of marinara sauce with an expiration date of [DATE]. f. An opened bag of chicken tenders. The box was not sealed. g. An opened box of corn on the knob. The box was not covered or sealed. h. An opened box of cookie dough. The box was not covered or sealed. On [DATE] at 9:42 AM, the following observations were made in the cabinet in the kitchen: a. An opened bag of grits. The was no indication of when it was opened. b. An opened bag of oatmeal. The bag was not sealed. 4. On [DATE] at 9:43 AM, the following observations were made in the storage room: a. An opened bag of salt was on a shelf. The bag was not sealed. b. An opened box with 150 counts of marinara sauce was on a shelf with an expiration of date of [DATE]. c. An opened bag of rice. The box was not covered, and the bag was not sealed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. On [DATE] at 10:11 AM, the ice machine in the nourishment room behind the nurses' station for 300 hall had a wet, reddish-pink, slimy residue on the panel. It was pointed out to DA #2 and asked if the residue build up could be wiped off. She used a tissue and wiped it off. The reddish-pink residue easily transferred to the tissue. DA #2 during interview stated that was slimy wet reddish pink residue. She doesn't know who uses the ice from ice machine. The receptionist stated the ice is used by the Certified Nursing Assistant to fill the water pitchers in the resident's rooms. On [DATE] 7:45 AM, the maintenance supervisor, stated he cleaned the ice machine every month. 5. On [DATE] at 11:05 AM, DC #1 turned on the hand washing sink, washed his hands, turned off the hand washing sink faucet with his bare hands, contaminating his hands. Without rewashing his hands, he picked up a clean blade and attached it to the base of the blender to be used in pureeing the food items to be served to the residents who required pureed diets. 6. On [DATE] at 11:20 AM, (Dietary Cook) DC #1 turned on the hand washing sink, washed his hands, turned off the hand washing sink faucet with his bare hands, contaminating his hands. Without rewashing his hands, he picked up a clean blade and attached it to the base of the blender to be used in pureeing the food items to be served to the residents who required pureed diets. DC #1 stated he should have washed his hands. 7. On [DATE] at 11:23 AM, the DA #3 lifted a trash can lid and threw away tissue paper. Without washing his hands, he picked up glasses by the rims and poured beverages in them to serve to at the lunch meal. DA #3 stated he should have washed his hands. 8 On [DATE] at 11:56 AM, DA #5 wore gloves on her hands when she was preparing ham and cheese sandwiches. She turned on the food preparation sink and rinsed off a spatula, turned off the sink faucet with her gloved hands, contaminating the gloves. Without changing gloves and washing her hands, she removed slices of bread from the bread bag and placed them on the liner on the counter, removed slices of bologna from the packet and placed them on top of a slice of bread. DA #5 stated she should have washed her hands. 9. On [DATE] at 12:10 PM, the temperature of the steak fingers of the food items when checked on the steam table by the DC #1. The steak fingers were 125 degrees Fahrenheit. The above food items were not reheated before being served to the residents. 10. On [DATE] at 2:25 PM, the temperature of the egg salad sandwich in a paper plate at bottom shelf of the food cart by the steam table was checked by the DA #2 and was 47.2 degrees Fahrenheit. DA #2 stated they should have been in the refrigerator. 11. On [DATE] at 12:33 PM, DA #2 was asked if she could check the temperature of the ham sandwiches in in a paper plate at the bottom shelf of the food cart by the steam table. The DA #2 stated it was 58 degrees Fahrenheit. DA #2 was asked if the sandwiches were not cold enough, where should they be stored. DA #2 indicated the sandwiches would be closer to temperature if they weren't sitting out for an hour. DC #1 stated to toss them. 12. On [DATE] at 1:14 PM, the surveyor observed DA #4 taking a food cart that contained left over cup of milk from lunch in the walk-in refrigerator. DA #4 was asked if she could check the temperature of the leftover milk in the cup. DA #4 stated it was 54.2 degrees Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. A facility policy titled, Hand Washing and Glove Usage, undated and provided by the Administrator, indicated hands should be washed before starting work and after touching anything else dirty.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 37925 Based on interview, the facility failed to develop and implement a facility assessment. This failed practice had the potential to affect all the residents residing in the facility. The total census was 63. The findings are: On 10/07/2024 the survey team entered the facility. The Administrator provided documents for review, but there was no facility assessment included in the information provided. On 10/11/2024 at 8:43 AM, the Nurse Consultant was informed by this surveyor the facility assessment was needed for review. The nurse consultant returned and stated he had spoken with the Administrator, and she informed him the facility did not have a facility assessment in place. On 10/14/2024 at 4:15 PM, the Administrator was interviewed and asked who was responsible for completing the facility assessment. She stated the Administrator and had no explanation why the facility assessment had not been completed. She informed this surveyor she became the Administrator at the facility on 11/23/2023. She was asked what the purpose of the facility assessment was. The following were some of the reasons she stated: to see where the facility's strengths and weaknesses were, if a performance improvement plan (PIP) was needed, and to see if someone needed to assess the building. On 10/14/2024, the Assistant Director of Nursing (ADON) provided a Facility Assessment Tool, dated 08/18/2017, which was reviewed and included no information for the facility. The facility assessment tool indicated the intent of the facility assessment was for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents required.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925 38200 48977 Based on observation, record review, interview, and facility policy review, the facility failed to ensure enhance barrier precautions were consistently implemented during care for 1 (Resident #31) sampled resident with a Percutaneous Endoscopic Gastrostomy (PEG) tube; failed to ensure a water management program included the necessary components; failed to ensure laundry was transported in a manner to decrease the potential for contamination; failed to ensure the required personal protective equipment (PPE) was used during a resident care activity for 2 (Residents #33 and #35) sampled residents: Resident #33, during incontinent care and Resident #35, during care of and opening in the neck leading to the wind pipe (Tracheostomy); failed to perform appropriate hand hygiene during a resident care activity for 2 (Residents #33 and #35) sampled residents and failed to maintain a technique of remaining free of germs (aseptic) during a resident care activity for 1 (Resident #35) sampled resident reviewed for tracheostomy care. The findings are: 1. On 10/07/24 at 10:36 AM, Resident #31 was observed lying in bed with eyes closed on the right side with a wedge pillow behind the back and the head of bed was elevated. An EBP sign was posted on the wall to the left side of the doorway and an isolation cabinet was outside of room. A feeding pump was in the room and a bottle of [brand name] enteral feeding and a bag of clear fluids were hanging on the pole with the feeding pump. The enteral feeding rate was set at 95 milliliters/hour (ml/hr), and the flush rate was set at 50 ml every (q) 1 hr on the feeding pump. Resident #31's Order Summary Report was reviewed and indicated the resident had a diagnoses of difficulty swallowing (dysphagia) and an encounter for attention to a surgical opening in the abdominal wall for a feeding tube (gastrostomy). An enteral feed order dated 09/16/2024 indicated the resident was to receive [brand name] enteral feeding at a rate of 90 ml/hr with a rate of 50 ml/hr of water. Resident #31's care plan, dated as last reviewed 08/12/2024, was reviewed and there was no indication to use enhanced barrier precautions during care/use of the resident's PEG tube. On 10/10/2024 at 9:15 AM, RN #6 was interviewed and asked if she was familiar with enhance barrier precautions. She stated she was. She was asked what personal protective equipment (PPE) was required for a resident on EBP. She stated she would have to follow up on the answer because she was not sure at this time. She was asked if she put on a gown [isolation] and gloves before administering the medications through the resident's feeding tube. She stated she put on gloves and confirmed she did not put on a gown. She stated she could not recall if she had received any education or training on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Policies and Practices-Infection Control policy, dated as revised October 2018 and provided by the Assistant Director of Nursing (ADON), was reviewed and indicated all personnel would be trained on the facility's infection control policies and practices upon hire and periodically thereafter, which would include where and how to find and use pertinent procedures and equipment related to infection control. On 10/24/2024, the ADON was asked to provide a policy for enhanced barrier precautions. Prior to the survey team's exit on 10/14/2024, no EBP policy was provided. 2. On 10/10/2024 at 4:50 PM, the Maintenance Supervisor provided information for the facility's water management program. He was interviewed about the water management program. He stated the water management program did not include any information on Legionella monitoring. He stated he would be attending a meeting at a local hospital next month to find out about water management and get more information from the local hospital's program to incorporate at the facility. On 10/10/2024, the water management information provided by the Maintenance Supervisor was reviewed and did not include a description of the building's water system using text and flow diagrams to indicate where Legionella and other opportunistic waterborne pathogens could grow and spread, measures to prevent the growth of Legionella and other opportunistic waterborne pathogens or established ways to intervene when control limits were not met. On 10/14/2024 at 4:15 PM, the Administrator was interviewed and she stated Maintenance, and the Housekeeping Supervisor were part of the water management team. She stated the Maintenance Supervisor oversaw the water management program. She was asked to provide a policy for the water management program. She stated she had not seen an actual policy for water management program. A Water Supply Program policy, dated as revised November 2009 and located in the Water Saving Program binder provided by the Maintenance Supervisor, was reviewed and indicated the facility handled and maintained their water supply according to the recommendations of the Centers for Disease Control (CDC), the Healthcare Infection Control Practices Advisory Committee and the Food and Drug Administration (FDA). The policy indicated the purpose was to maintain a sanitary water supply and control the spread of waterborne microorganisms. 3. On 10/09/2024 at 2:53 PM, the Housekeeping Supervisor was observed pushing a rack of hanging laundry in the 500 hallway with a green sheet only covering the top portion of the laundry. She stopped in the hall near a resident's room, pulled back the green sheet, removed clothing from the rack and left one side of the laundry rack with clothes uncovered and entered a resident's room, leaving the rack unattended. There was a housekeeper with a housekeeping cart in the hall at this time cleaning resident's rooms. On 10/14/2024 at 8:39 AM, Laundry Technician (Tech) #8, was interviewed and was asked how linens were transported to the residents. She pointed to a hanging rack and stated on the clothing rack covered with a sheet. 4. On 10/08/2024 at 11:07 AM, the Surveyor observed gauze around Resident #13's tracheostomy to be light brown in color with appears to be dried blood. During interview Resident #13 Resident confirmed the gauze hasn't been changed and when asked how often staff change the gauze Resident #13 said sometimes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #13's Admission Record revealed the resident was admitted on [DATE] with a diagnoses of Tracheostomy complication. Review of Resident #13's Order Summary Report with an order date of 4/19/2024 noted tracheostomy (trach) care every 24 hours and as needed (PRN), clean trach site with half normal saline (NS) and half peroxide then rinse with NS and apply dry dressing daily and PRN two times a day related to tracheostomy complications. Review of Resident #13's Care Plan with an initiated date of 5/6/3034 noted the resident has impaired immunity related to (r/t) trach in place, use universal precautions as appropriate, the resident has a tracheostomy r/t Impaired breathing mechanics. On 10/11/2024 at 2:44 PM, the Surveyor observed Resident #13's tracheostomy care performed by Licensed Practical Nurse (LPN) #11. The surveyor entered Resident #13's room and LPN #11 had already donned surgical gloves prior to surveyor entering. The surveyor did not observe an obturator at the bedside. LPN #11 closed the Resident's door with his surgical gloves on and did not change them. Surveyor observed LPN #11 remove items from trach kit and place the sterile field on the overbed table without sanitizing the table first. LPN #11 placed sterile gloves, Q-Tip's, fenestrated gauze, neck ties, pipettes, bristled brush and 0.9% sodium chloride irrigation containers on sterile field. LPN #11 poured fluid in tracheostomy supply tray. LPN #11 attempted to remove the obturator (The obturator is used to insert a tracheostomy tube. It fits inside the tube to provide a smooth surface that guides the tracheostomy tube as it is being inserted) from the Resident's tracheostomy but appeared to have a hard time getting it removed. LPN #11 was able to remove the obturator and placed it in 0.9% sodium chloride solution and used a bristled brush to clean for approximately two (2) minutes. Obturator was observed to be full of green/brown mucus. While holding the obturator the LPN opened another container of 0.9% sodium chloride solution and poured it into another tray within the tracheostomy tray kit. LPN #11 changed his surgical gloves but did not sanitized hands. LPN #11 placed the obturator on sterile field. LPN #11 removed old fenestrated gauze. Trach site appears to have dried blood, area is red. LPN #11 cleansed trach site with 0.9% Sodium Chloride solution on gauze. LPN #11 unhooked trach ties and cleansed around trach are removing copious amounts of brown/ green mucus. Resident #13 refused to have trach ties changed. Resident #13 began coughing up mucus. LPN #11 re-secured inner cannula with tracheostomy ties and told the resident he would be right back he needed to get more gauze. LPN #11 removed gloves and left the room at 2:58 PM with obturator left on sterile field. LPN #11 returned to the room at 3:00 PM with more gauze but did not shut the Resident's door. LPN did not sanitize hands before putting on surgical gloves. LPN #11 re-cleaned trach area with gauze and recleaned obturator with bristled brush. LPN #11 replaced fenestrated gauze with new fenestrated gauze, placed obturator with visible mucus still on it back in Resident's tracheostomy site. LPN #11 did not put on PPE while performing tracheostomy care. During an interview with LPN #11 on 10/11/2024 at 3:04 PM, he confirmed he should have worn sterile gloves while performing tracheostomy care because it is a sterile procedure, and he should have worn PPE, and sanitized his hands before putting on and changing gloves for infection control purpose. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Nurse Consultant on 10/11/2024 at 3:11 PM, he confirmed LPN #11 should have sanitized his hands, sanitized bedside table prior to sterile field being placed on it, worn sterile gloves while performing trach care, should have worn PPE during trach care, and replaced obturator with a new one for infection control purposes. The Nurse Consultant also confirmed tracheostomy care has not been performed as ordered according to Resident #13's Treatment Administration Record (TAR) for October 2024. During an interview with, the Assistant Director on 10/14/2024 at 3:07 PM, she confirmed LPN #11 should have sanitized his hands, sanitized bedside table prior to sterile field being placed on it, worn sterile gloves while performing trach care, should have worn PPE during trach care, and replaced obturator with a new one for infection control purposes. The ADON also confirmed tracheostomy care has not been performed as ordered according to Resident #13's TAR for October 2024. Review of Resident #13's (TAR with a start date of 5/20/2024 noted trach care two times a day at 8:00 AM and 8:00 PM. Resident #13 had trach care performed on 10/2/2024 at 8:00 PM, 10/3/2024 at 8:00 PM, 10/4/2024 at 8:00 AM, 10/7/2024 at 8:00 AM resident refused, 10/7/2024 at 8:00 PM. The physician order was changed to reflect trach care every day shift starting on 10/10/2024. Resident did not receive trach care until 10/13/2024. Facility policy titled Tracheostomy Care noted Policy This facility will minimize risks of infection and other complications associated with tracheostomy care at all times. Clean technique, using sterile supplies will be used for care of non-established and established tracheostomies. Procedure Non-Established & Established Tracheostomy Stoma: Stoma care is provided every 24 hours or as needed; if elder is immunocompromised or with acute infective illness, sterile techniques will be utilized; tracheostomy stoma will be cleansed with sterile normal saline. Tracheostomy Tube Changes tracheostomy tubes with inner cannula will be changed every thirty (30) days and as needed; Stoma Care using sterile cotton-tipped applicators, gauze and sodium chloride clean the tracheostomy stoma starting at the stoma site under faceplate extending 5-10 centimeters (cm) in all directions from the stoma; using dry gauze or dry cotton tipped applicators, pat lightly at skin and exposed outer cannula surfaces. Facility procedure titled Performing Tracheostomy Care Using Sterile Technique noted Step by Step perform hand hygiene and put on appropriate PPE as indicated; place a liquid-absorbing towel across the client's chest to help prevent bacteria and other organisms form transmitting onto the client's linen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled Policies and Practices- Infection Control with a revision date of July 2014 noted Policy Statement The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation 1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status, or payer source. 2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility; b. Maintain a safe, sanitary and comfortable environment for personnel, residents, visitors, and the general public; c. Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions. d. Establish guidelines for the availability and accessibility of supplies and equipment necessary for Standard and Transmission-Based Precautions. 4. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter. 5. A review of the significant change Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 6/01/2024 revealed Resident #33's Brief Interview of Mental Status (BIMS) score was 14, indicating the resident was cognitively intact. Resident #33 was occasional unable to control bowel and bladder Review of the plan of care for Resident #33 (Revision on: 06/10/2024) Resident #33 had episodes of occasional incontinence related to (r/t) impaired mobility. On 10/03/2024 at 9:30 AM, the Surveyor observed Certified Nursing Assistant (CNA) #14 and #15 providing incontinent care to Resident #33. The Surveyor observed CNA #15 removed the incontinence pad and place on the floor. The Surveyor observed CNA #14 and #15 apply a clean brief and clothing then placed Resident #33 onto the wet sheet. CNA #15 handled the mechanical lift with the same gloves used to provide incontinence care. The Surveyor observed another CNA take the mechanical lift off the hall prior to cleaning. On 10/03/2024 at 9:40 AM, during an interview CNA #15 stated she did not change gloves during the process of providing care or transferring the resident. CNA #15 stated by handling the mechanical lift with dirty gloves and the lift was taken to another hall for potential use she cross contaminated and potentially cross contaminated to another hall. CNA#14 stated she placed the dirty linen on the floor and by doing so cross contaminated. On 10/10/2024 at 4:40 PM, the Administrator stated by staff placing a clean brief and clothing on the resident then placing the resident on top of a sheet wet with urine caused wet clothing and cross contamination. A review of the significant change Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 6/3/2024 revealed Resident #32 had memory problems, severely impaired cognition, and never or rarely made decisions. Resident #32 had diagnoses of bacteremia (a condition in which bacteria gets in the blood stream, cough, and wound infection). A plan of care for Resident #32 (revision on: 05/29/2024) revealed Resident #32 was dependent on staff for meeting emotional, intellectual, physical, and social needs related to (r/t) cognitive deficits. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/08/2024 at 2:30 PM, the Surveyor observed Licensed Practical Nurse (LPN) #16 toss dirty linen on the floor while providing care to Resident #32. The Surveyor observed LPN #16 reconnected Resident's PEG tube feeding with the same gloves used to provide incontinence care. On 10/08/2024 at 2:50 PM, LPN #16 stated she cross contaminated when she reconnected the PEG tube with dirty gloves and tossed dirty linen on the floor. On 10/10/2024 at 4:40 PM, the Administrator stated dirty linen should always be placed in a bag when staff are providing care. A policy titled Standard Precautions noted standard precautions will be used in the care of all residents. Standard Precautions presume that all blood, body fluids, secretions, and excretions, non-intact skin, and mucous membranes may contain transmissible infectious agents.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 37925 Based on record review, interview, and facility policy review, the facility failed to ensure the antibiotic stewardship program was consistently implemented for 1 (Resident #13) sampled resident who was taking an antibiotic. The findings are: On 10/11/2024 at 5:00 PM, the Nurse Consultant was interviewed and stated he had been at the facility only a few days but managed to catch up 4 months of the infection control tracking logs. He stated he would train the next Infection Preventionist once someone was hired. On 10/14/2024, the Assistant Director of Nursing (ADON) provided the antibiotic stewardship infection mapping and an Order Listing Report for June 2024, July 2024, August 2024 and September 2024. There was no information provided for October 2024. The information was reviewed and did not include a tracking log to indicate what signs/symptoms the resident had, the start date of the symptoms, if the condition required lab tests such as a urine sample/culture, and no criteria to indicate if the antibiotic was necessary. The September Order Listing Report was reviewed and indicated Resident #13 was taking Doxycycline 100 milligrams (mg) tablets one by mouth twice a day for a skin infection in the right lower leg. The medication order indicated a revised date of 09/11/2024. There was no duration of therapy or stop date indicated on the order. An Antibiotic Stewardship policy, dated as revised December 2016 and provided by the Administrator on 10/07/2024, was reviewed and indicated the purpose of the facility's antibiotic stewardship program was to monitor the use of antibiotics in the residents. The policy indicated the prescriber would provide complete antibiotic orders to include the drug name, dose, frequency of administration, duration of treatment (start and stop date or number of days of therapy), route of administration, and indication for use.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 37925 Based on record review, interview, and facility policy review, the facility failed to ensure an individual was designated as the Infection Preventionist (IP), who had time to monitor and manage the infection prevention and control program. The findings are: On 10/07/2024, the survey team entered the facility. The Administrator provided a document titled Number 21, which was reviewed and indicated the facility did not have an IP. On 10/11/2024, the facility's in-service binder was reviewed and there were no in-services/trainings on any infection control topics from October 2023 to October 14, 2024. On 10/14/2024, the Assistant Director of Nursing was informed the in-service binder did not include any infection control in-services/trainings for the staff. She stated she would investigate the matter. On 10/14/2024 at 4:15 PM, the Administrator was interviewed and stated she had not designated a staff member to fill in as IP until someone was hired. An Infection Preventionist policy, dated as revised on July 2016 and provided by the Administrator on 10/07/2024, was reviewed and indicated the IP was responsible for coordinating the carrying out and updating of the established infection prevention and control policies and practices. The policy indicated the IP would collect, analyze, and provide infection and antibiotic usage data to nursing staff and health care practitioners and provide education and training. On 10/14/2024, prior to the survey team's exit from the facility, no in-services/training information on infection control was provided for review.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 37925 Based on record review, interview, and facility policy review, the facility failed to ensure a pneumococcal vaccine was provided for 1 (Resident #59) of 5 (Resident's #13, #16, #31, #33, and #59) sampled residents and failed to provide documentation of education provided to a resident after an influenza vaccination was declined for 1 (Resident #33) of 5 (Resident's 13, #16, #31, #33, and #59) sample residents reviewed for immunizations. The findings are: Resident #59's Admission Record was reviewed and indicated the Resident's original admitted was 06/22/2023. The admission record indicated the resident had no know drug allergies and diagnoses of difficulty in the ability to think which interferes with daily living (dementia) and a disease affecting the body's blood sugar level (type 2 diabetes mellitus). Resident #59's electronic health record was reviewed and there was no indication if the resident consented to or declined the pneumococcal vaccine. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/17/2024 was reviewed and indicated Resident #59 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated cognitively intact, and a pneumococcal vaccine was not offered. On 10/14/2024, the Assistant Director of Nursing (ADON) was asked to provide documentation that Resident #59 had received or declined the pneumococcal vaccine. At 1:00 PM, the ADON stated she could not provide any information regarding the pneumococcal vaccine for this resident. Resident #33's immunization screen was reviewed and indicated the resident refused the influenza vaccine, but it did not indicate the date of the refusal. Resident #33's Order Summary Report was reviewed and indicated the resident had a diagnosis of a disease which causes an abnormally high blood sugar level (type 2 diabetes mellitus with hyperglycemia). A significant change MDS with an ARD of 06/01/2024, was reviewed and indicated Resident #33 had a BIMS of 14, which indicated cognitively intact and had refused the influenza vaccine, but no date was indicated for the refusal. On 10/14/2024, the ADON was asked to provide documentation of Resident #33's declination consent and the education provided to the resident. At 1:00 PM, the ADON provided a copy of the resident's immunization screen which only indicated the resident refused the influenza vaccine and no date was indicated for the refusal. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Pneumococcal Vaccine policy, with a revision date of October 2019, provided by the Administrator on 10/07/2024, was reviewed and indicated all residents would be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy indicated the pneumococcal vaccine would be offered within 30 days of admission to the facility unless medically contraindicated, the resident refused, or the resident has already been vaccinated. An Influenza Vaccine policy, with a revision date of October 2019, provided by the Administrator on 10/07/2024, was reviewed and indicated all residents would be offered annually to promote the benefits associated with the vaccination against influenza. The policy indicated the significant risks and benefits would be provided to the residents and the resident's refusal would be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record.