STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045438	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Village Medical Center	6400 Trinity Drive 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48977 Based on observations, interviews, record review, and facility policy review the facility failed to ensure the personal and medical information was protected for 3 (Resident #1, #40, #236) of 4 sampled residents potentially violating the Health Insurance Portability and Accountability Act (HIPPA). The findings include: 1. A review of the plan of care for Resident #236 revealed the resident had an admitted [DATE]. a. On 01/15/25 at 08:39 AM, this surveyor observed Licensed Practical Nurse (LPN) #2 enter Resident #236's room to administer medication. LPN #2 turned her back to the door. This surveyor observed the open unlocked laptop, on top of the medication cart in the hallway, open displaying Resident #236 ' s personal and medical information including name, date of birth, code status, and physician's orders. b. On 01/15/25 at 08:56 AM, LPN #2 stated, I did not lock or close the laptop. I waited for the computer to timeout. 2. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/29/2024 revealed Resident #40 had a Brief Interview of Mental Status (BIMS) score of 09 indicating moderately impaired cognition. a. A review of the plan of care for Resident #40 revealed Resident #40 had an admitted [DATE]. b. On 01/15/25 at 07:14 PM, this surveyor observed LPN #5 enter Resident #40's room to administer medication. LPN #5 turned her back to the door. This surveyor observed the open unlocked laptop, on top of the medication cart in the hallway, displaying Resident #40 ' s personal and medical information including name, date of birth, code status, and physician's orders. This surveyor also observed LPN #5 walk down the hall to retrieve oxygen tubing leaving the computer screen open and unlocked. c. On 01/15/25 at 07:20 PM, LPN #5 stated she did not close or lock the computer screen prior to walking away, and someone could have seen the resident's information. 3. A review of the quarterly MDS with an ARD of 12/13/2024 revealed Resident #1 had a BIMS score of 15, indicating cognitively intact. (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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. A review of the plan of care for Resident #1 (revision date 6/20/20223) revealed Resident #1 was a full code. b. On 01/15/25 at 07:28 PM, this surveyor observed LPN #6 walk away to get an over-the-counter medication leaving the laptop on and displaying Resident #1 ' s personal and medical information such as name date of birth, code status, and physician's orders. c. On 01/15/25 at 07:30 PM, LPN #6 stated she did not lock or close the computer screen prior to walking away. LPN #6 stated I knew better and should have closed the computer screen. 4. On 01/16/25 01:00 PM, the Director of Nursing (DON) stated the nurses should lock or close the computer screen prior to walking away from their computers, because if the computer screen is open to the resident personal and medical information it is a Health Insurance Portability and Accountability Act (HIPPA) violation. 5. A review of the policy titled HIPPA Basics for Providers: Security, & Breach Notification Rules dated February 2023 noted the privacy rules require you to: secure patient records containing PHI, so they aren't readily available to those who don't need to see them. PHI information includes common identifiers, such as name, address, birth date, and social security number.

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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** 46724 51885 Based on interviews, record review, and facility policy review, it was determined that the facility failed to ensure care plans were revised to reflect residents' most recent care needs for 2 (Residents #24 and #45) of 18 sampled residents whose care plans were reviewed. The findings are: 1. Resident #24 had diagnoses of diabetes mellitus with foot ulcer, adjustment disorder with depressed mood and myocardial infarction. The annual minimum data set (MDS) with an assessment reference date (ARD) of 10/18/24 indicated Resident #24 had a brief interview of mental status (BIMS) score of 15, indicating the resident was cognitively intact. The MDS indicated the resident had no impairment to upper or lower extremities, used a wheelchair for ambulation, was dependent on staff for toileting, dressing and personal hygiene, and required partial assistance with transfers from bed to chair and back and had no falls since previous assessment. On 01/13/25 at 12:36 PM a review of the electronic health record (EHR) revealed a progress note from 12/13/2024 by the nurse Practitioner (NP) that addressed a fall Resident #24 had sustained after falling asleep in [pronoun] wheelchair at bedside, and that the resident was falling more frequently. The note documented the NP had talked to Resident #24 and the resident agreed to stay in bed if in [pronoun] room and if up in wheelchair the resident would sit at nurse's station or in an area where staff could monitor closer to prevent falls. A review of the EHR disclosed a fall risk assessment dated [DATE] indicating Resident #24 was at risk for falls. Review of the Care Plan with a revision date of 12/20/2023 indicated Resident #24 was at risk for fall due to history of falls at previous nursing facility, poor safety awareness and incontinence. The care plan was not updated with any new interventions after the fall on 12/13/2024. On 01/16/2025 at 1:57 PM Licensed Practical Nurse (LPN) #14, the MDS Coordinator, stated the care plans were updated as necessary and at least quarterly. She reported she gathered her information for any changes at morning meeting and by review of the residents ' orders. When asked if incidents and accidents were monitored and interventions added or changed, she replied yes, and that incidents and accidents were discussed during the morning meetings. The facility policy for Care Plan, Comprehensive Person-Centered, revised March 2022, indicated assessments are ongoing care plans will be revised as information about the resident and residents condition change. The policy goes on to say the care plan will be updated after a significant change, when desired outcome is not met, after readmission and at least quarterly (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident #45 ' s Order Summary indicated a diagnosis of depression. An antipsychotic medication was ordered [antipsychotic medication name] Oral (1) 2 milligram (mg) tablet 1 time a day for depression with an order date of 11/29/2024 and start date of 11/30/2024. An order for [antidepressant medication name] (1) 40 milligram (mg) tablet 1 time a day was ordered for depression on 12/02/2024 with a start date 12/03/2024. A review of Resident #45's admission Minimum Data Sheet (MDS), with an Assessment Reference Date (ARD) of 12/04/2024, indicated a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact. The MDS indicated Resident #45 was taking an antipsychotic medication, [antipsychotic medication name]. A review of Resident #45's Care Plan, dated 12/05/2024, indicated the resident was taking [antidepressant medication name] and [antipsychotic medication name] for depression. The care plan did not indicate [antipsychotic mediation name] was an antipsychotic medication. The care plan did not indicate to monitor for signs or symptoms of an adverse reaction to an antipsychotic medication. On 01/16/2025 at 11:16 AM, the MDS Coordinator was interviewed with concurrent observations, and she produced the Resident Assessment Instrument (RAI) with the most recent update of October 2024. The MDS Coordinator reviewed the resident ' s most recent MDS, Section N (medication section) and stated the resident was on antipsychotic medication. The MDS Coordinator stated she was responsible for the care plans. She reviewed the resident's most recent care plan dated 12/04/2024 and stated she documented the [antipsychotic medication name] under depression because that was what it was ordered for. She stated the [antipsychotic medication name] should have been documented under an antipsychotic medication because that is what the medication is categorized as. She stated the care plan should have indicated to monitor for signs and symptoms of adverse reactions to the medication. A Care Plans, Comprehensive Person-Centered policy, dated as revised March 2022 and provided by the Director of Nursing (DON) was reviewed and indicated the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem area and their causes, and relevant clinical decision making.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48977 Based on observations, interviews, record review, and facility policy review the facility failed to ensure the care planned positioning device was in place to prevent further contracture for 1 of 1 sampled (Resident #27) resident reviewed for positioning. The findings include: A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/17/2024 revealed Resident #27 had a Brief Interview of Mental Status (BIMS) score of 15 that indicated cognitively intact. A review of a plan of care for Resident #27 (revision date 01/04/2023) revealed Resident #27 had an Activities of Daily Living (ADL) self-care performance deficit related to cerebrovascular accident (CVA) with left non-dominant side. An intervention in place noted place carrot in left hand. On 01/13/25 at 10:51 AM, this surveyor observed contracture to Resident #27's hand with no positioning device in place and noted a hand roll on the nightstand. Resident #27 stated the facility used to place a carrot in each hand, but the resident did not know what happened to them. On 01/14/25 at 09:07 AM, this surveyor observed Resident #27 lying in bed. This surveyor noted there was no device in place to prevent further contracture. On 01/15/25 at 10:15 AM, this surveyor observed Resident #27 lying in bed. This surveyor noted there was no device in place to prevent further contracture. On 01/15/25 at 10:46 AM, Licensed Practical Nurse (LPN) #1 stated Hospice had instructed them to no longer use the carrot due to a past fracture of the index finger but could not provide any documentation noting this order. On 01/15/25 at 01:39 PM, the Director of Nursing (DON) provided this surveyor with a care plan from hospice. The DON stated the care plan did not address the contracture. A review of the policy Range of Motion Exercise revision date October 2010 did not contain any pertinent information regarding the deficient practice.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 46724 Based on observation, interview, and record review, the facility failed to ensure the use of a physical restraint was used to treat a resident's medical symptoms, and was not being used for staff convenience for 1 (Resident #28) of 2 sampled residents (Residents #1 and #28) reviewed for physical restraint use and failed to perform a side rail assessment prior to installing side rails for 2 (Residents #1 and #28) of 2 (Residents #1 and #28) sampled residents reviewed for side rail use. The findings are: 1. Resident #28 had diagnoses of gastrostomy and pressure ulcer to sacral region. A quarterly Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 11/29/24 indicated a staff assessment of mental status (SAMS) of severely impaired. Resident #28 had an impairment of both upper and lower extremities, was non- ambulatory, and was totally dependent on staff for bed mobility, turning, positioning and transfers. The MDS indicated Resident #28 has had no falls since entry, reentry, or prior to assessment and bd side rails were not used. Physician orders for January 2025 did not include an order for bedrails. The care plan with a revision date of 08/15/2024 indicated that residents were totally dependent on two (2) staff for turning and repositioning and that resident was bedfast all or most of the time, was at risk for falls and used side rails for pillow positioning and turning. Resident #28 was observed on 01/13/2025, 01/14/2024, 01/16/2025 throughout each day lying in bed with both side rails up. On 01/16/2025 at 10:51 AM Certified Nursing Assistant (CNA) #11 said bed rails were used to protect residents from falling out of bed. She stated Resident #28 did not move on [pronoun] own and required total care from staff. CNA #11 stated the rails were monitored every 2 hours during rounds. On 01/16/2025 at 10:51 AM Licensed Practical Nurse (LPN) #12 said she was not familiar with Resident #28 but bed rails were monitored during rounds by CNAs and nurses. On 01/16/2025 at 11:07 AM LPN #13, who had worked at the facility for 3 years, stated she was familiar with Resident #28 ' s care. She was not sure when bed rails were initiated for the resident but stated they were used for safety. She also indicated the bed rails could be a risk if one of the resident ' s extremities were to get caught on a rail while being turned. LPN #13described Resident #28 as requiring total care and voiced that the resident did not move on their own. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/16/2025 at 11:15 AM the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed in their office. The ADON reported every resident in the facility used side rails to assist with positioning and only 1/3 of rails were used. They went on to explain everyone was evaluated on admission for use of bedrails. The DON stated Resident #28's daughter requests side rails be used. The Electronic Health Record (EHR) did not include a risk versus benefit nor a responsible party notification of bedrail use. The facility policy for bed rails indicated they would only be used after attempted alternatives fail and a risk versus benefit assessment is completed. The inter-disciplinary team must evaluate the alternatives tried and how they failed, input from resident ' s family and consultation with attending physician. 2. On 01/13/2025 at 9:48 AM, Resident #1 was lying in bed awake and there were side rails on both sides of the bed in use. Resident #1's Order Summary Report was reviewed and indicated a diagnosis of seizures accompanied by changes in consciousness or other symptoms (symptomatic epilepsy and epileptic syndromes with complex partial seizures). There was no order indicating the use of side rails. On 01/14/2025 at 3:50 PM, Resident #1's electronic health record (EHR) was reviewed and there was no bed rail assessment located. On 01/16/2025 at 1:29 PM, Resident #1's care plan, dated 12/20/2024, was reviewed and indicated the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to physical limitations and requested the assist rails remain down bilaterally. On 01/26/2025 at 2:49 PM, Certified Nursing Assistant (CNA) #15 was interviewed and stated the resident had side rails on her bed to help with turning and to prevent the resident from falling. She stated the resident was able to move in bed but required assistance with some movements, but she did not specify which movements. On 01/16/2025 at 3:09 PM, LPN #1 was interviewed and stated Resident #1 had side rails on the bed to assist with turning and repositioning. She reviewed the resident's electronic health record and confirmed the resident had a history of seizures but stated she had never witnessed the resident having a seizure. On 01/16/2025 at 3:19 PM, the Assistant Director of Nursing (ADON) was interviewed and stated the resident used the side rails to help turn in bed. She stated the side rails should be care planned and documented quarterly. As of 01/16/2025 at 4:20 PM, prior to the exit, neither the DON nor ADON provided a bed rail assessment for this Resident #1. 37925

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48977 Based on record review, interview, and facility policy review the facility failed to ensure gradual psychotropic (anti-anxiety) dose reductions (GDR) were attempted in the absence of a physician's documented evaluation of the specific risks versus benefits of continuing the as needed (PRN) medication past 14 days and a documented explanation as to why a dose reduction attempt would be contraindicated, in order to ascertain the smallest effective dose and minimize the potential for adverse drug effects for 1 (Resident #27) of 5 sampled residents reviewed for unnecessary medications. The findings include: A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/17/2024 revealed Resident #27 has a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognitively intact. A review of the plan of care for Resident #27 (revision date 04/05/2024) revealed Resident #27 used anti-anxiety medications. A review of the Note to Attending Physician/Prescriber printed date 08/25/2024 noted Resident #27 had an order for [benzodiazepine medication name] (a medication used to treat anxiety disorders) 2 milligram (MG)/milliliter (ML) every (Q) 4 hours as needed (PRN). A review of Resident #27 ' s electronic medical recorded did not reveal documentation related to gradual dose reduction attempts or justification. On 01/16/2025 at 02:00 PM, the Director of Nursing (DON) stated the facility would just have to accept the tag for Resident #27 taking an antianxiety medication past 14 days without documentation from the physician to extend the medication. A review of the policy titled Drug Regimen Review noted drug regimen review consists of a review and analysis of prescribed medication therapy and medication use review, including nursing documentation of medication ordering and administration. The consultant pharmacist reviews the medication regimen of each resident at least monthly. Findings and recommendations are reported to the Administrator, Director of Nursing, the responsible physician, and the Medical Director, where appropriate.

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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. 48977 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure the medication error rate was not greater than 5%. The Medication error occurred with 2 (Resident #44, #6) of 4 sampled residents observed for medication administration. Medication error rate was calculated at 7.14%. The findings include: 1. A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/2024 revealed Resident #44 had a Brief Interview of Mental Status (BIMS) score of 15 indicating cognitively intact. a. A review of the plan of care for Resident #44 (revision date 01/18/2023) revealed Resident #44 had alteration in cardiovascular/circulatory function related to hypertension (high blood pressure) and hyperlipidemia (abnormally high levels of fats in the blood). b. A review of the Medication Administration Record (MAR) revealed Resident #44 had an order for [calcium channel blocker medication name], a medication used to treat hypertension and chest pain, 90 milligrams (MG) of 1 tablet by mouth 1 time a day. c. On 01/15/25 at 08:12 AM, this surveyor observed Licensed Practical Nurse (LPN) #1 administer [calcium channel blocker medication name] 30 mg to Resident #44. d. On 01/15/25 at 09:34 AM, LPN #1 stated Resident #44 had been receiving 30mg of antihypertensive medication, which was not the amount ordered. LPN #1 stated the resident was not receiving enough of the medication. e. On 01/15/2025 at 10:46 AM, the Director of Nursing (DON) stated the error with Resident #44 ' s medication was due to a change in the pharmacy. The DON stated, That is not an excuse, it was still the facility's responsibility to ensure the resident received the accurate doses. 2. A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/2024 revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated cognitively intact. a. A review of the plan of care for Resident #1 (revision date 08/16/2023) revealed Resident #1 had a diagnosis of arthritis, the swelling and tenderness of one or more joints, which put the resident at risk for pain. b. A review of the MAR revealed Resident #1 had an order to apply [nonsteroidal anti-inflammatory (NSAID) medication name] to bilateral ankles and knees topically every 4 hours. c. On 01/15/25 at 07:30 PM, this surveyor observed LPN #6 apply [NSAID medication name] to Resident #1 ' s to right lateral leg, right knee, right foot, and left foot. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 01/15/25 at 07:30 PM, while applying the medication LPN #6 stated, I apply the cream to the outside of the right leg and knee, right foot. LPN #6 stated on the left side the resident just liked it on the foot. e. On 01/16/25 09:00 AM, LPN #1 stated, I apply the [NSAID medication name] gel from [Resident #1] knee down. f. A policy titled Administering Medications revision date April 2019 noted Medications are administered in a safe and timely manner, and as prescribed. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dose, right time, and right method (route) of administration before giving the medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 48977 37925 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the facility was free of significant medication errors for 1 (Resident #44) of 1 sampled resident who was administered the wrong dose of [calcium channel blocker medication name] for the entire month of January 2025 and failed to ensure [long acting insulin name] insulin was not administered past 28 days of use for 1 (Resident #66) of 1 sampled resident reviewed for insulin use. The findings include: 1. A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/2024 revealed Resident #44 had a Brief Interview of Mental Status (BIMS) score of 15 indicating cognitively intact. A review of the plan of care for Resident #44 (revision date 01/18/2023) revealed Resident #44 had alterations in cardiovascular/circulatory function related to hypertension (high blood pressure) and hyperlipidemia (abnormally high levels of fats in the blood). A review of the Medication Administration Record (MAR) Resident #44 revealed an order for [calcium channel blocker medication name], a medication used to treat hypertension and chest pain, 90 milligram (MG) 1 tablet by mouth 1 time a day. On 01/15/25 at 08:12 AM, this surveyor observed Licensed Practical Nurse (LPN) #1 administer [calcium channel blocker medication name] extended release (ER) 30 mg to Resident #44. On 01/15/25 at 09:34 AM, LPN #1 stated Resident #44 had been receiving 30mg of antihypertensive medication, which was not the amount ordered. LPN #1 stated the resident was not receiving enough of the medication. A review of the Packing Slip dated 12/31/2024 revealed the facility received [calcium channel blocker medication name] extended release (ER) 30 mg from the pharmacy. On 01/15/2025 at 10:46 AM, the Director of Nursing (DON) stated the error with Resident #44 ' s medication was due to a change in the pharmacy. The DON stated, that is not an excuse it is still the facility's responsibility to ensure the resident received the accurate dose. A policy titled Administering Medications, revision date April 2019, was reviewed and indicated medications are administered in a safe and timely manner, and as prescribed. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dose, right time, and right method (route) of administration before giving the medication. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Village Medical Center	6400 Trinity Drive Pine Bluff, AR 71603

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 01/16/2025 at 9:29 AM, this surveyor reviewed the medications and biologicals stored in the medication cart for the residents on B Hall. There was a vial of [long-acting insulin name] insulin for resident #66 stored in the drawer with two dates. The date written on the vial was 12/13 and the date written on the label was 12/18/24. Resident #66 ' s Order Summary Report was reviewed and indicated a diagnosis of a condition where the body does not regulate and use sugar properly leading to high blood sugar levels (type 2 diabetes mellitus). A physician's order dated 09/02/2024 indicated insulin [long-acting insulin name] inject 5 unit subcutaneously one time a day. Resident #66 electronic medication administration record (eMAR) was reviewed and indicated insulin [long-acting insulin name] subcutaneous inject 5 unit subcutaneously one time a day. The time on the eMAR indicated 0600 (6:00 AM) and there was a checkmark in the box for 01/16/2025. A checkmark indicated administered according to the chart codes/follow up codes located on the eMAR. On 01/16/2025 at 9:34 AM, Licensed Practical Nurse (LPN) #12 was interviewed with concurrent observations and stated she was not sure if 12/13 or 12/18/24 was the correct date which indicated the vial was accessed for use. On 01/16/2025 at 2:41 PM, LPN #12 was interviewed and stated [long-acting insulin name] insulin can be used for 28 days once the top has been accessed. She stated the vial of insulin was disposed of and reordered once 28 days had been reached. She was asked to look at a calendar and count the number of days [long-acting insulin name] insulin had been in use and she stated yesterday [01/15/2025] was 28 days and the insulin should have been disposed of and reordered. LPN #12 stated Resident #66 did not have another vial of insulin at the facility and she would have to reorder the insulin today. On 01/16/2025 at 3:16 PM, the Director of Nursing (DON) was interviewed and stated the nurses were responsible for checking the dates on the insulin to ensure vial could be used. The Food and Drug Administration (FDA) website (https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/021081s071lbl.pdf) for [long-acting insulin name] insulin was reviewed and page 27 indicated [long-acting insulin name] vials in use should be thrown away after 28 days, even if it still has insulin left in it.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48977 37925 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure medications and biologics were securely stored away at all times to prevent unauthorized individuals from potentially gaining access to the medication and/or biologics and failed to discard insulin after 28 days in use for 1 (Resident #66) 1 sampled resident reviewed for [long-acting insulin name] insulin use. The findings include: 1. On 01/15/25 at 08:39 AM, this surveyor observed Licensed Practical Nurse (LPN) #2 enter a resident's room to administer medication. This surveyor noted LPN #2 turned her back to the unlocked medication cart. On 01/15/25 at 08:56 AM, LPN #2 stated, I did not lock the medication cart. I should have. On 01/15/25 at 07:14 PM, this surveyor observed LPN #5 enter a resident's room to administer medication. This surveyor noted LPN #5 turned her back to the unlocked medication cart. This surveyor also observed LPN #5 walk down the hall while the medication cart remained unlocked. On 01/15/25 at 07:20 PM, LPN #5 stated she did not close or lock the computer screen prior to walking away, and someone could have gotten into the medication cart. On 01/15/25 at 07:28 PM, this surveyor observed LPN #6 walk down the hall while the medication cart remained unlocked. On 01/15/25 at 07:30 PM, LPN #6 stated she did not lock the medication cart prior to walking away. On 01/16/25 01:00 PM, the Director of Nursing (DON) stated the nurse should lock the medication cart prior to walking away, because there are medications and controlled medications no one without authorization should have access to. 2. On 01/16/2025 at 9:29 AM, this surveyor reviewed the medications and biologicals stored in the medication cart for the residents on B Hall. There was a vial of [long-acting insulin name] insulin for resident #66 stored in the drawer with two dates. The date written on the vial was 12/13 and the date written on the label was 12/18/24. Resident #66's Order Summary Report was reviewed and indicated a diagnosis of a condition where the body does not regulate and use sugar properly leading to high blood sugar levels (type 2 diabetes mellitus). A physician's order dated 09/02/2024 indicated insulin [long-acting insulin name] inject 5 unit subcutaneously one time a day. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #66's electronic medication administration record (eMAR) was reviewed and indicated insulin [long-acting insulin name] subcutaneous inject 5 unit subcutaneously one time a day. The time on the eMAR indicated 0600 (6:00 AM) and there was a checkmark in the box for 01/16/2025. A checkmark indicated administered according to the chart codes/follow up codes located on the eMAR. On 01/16/2025 at 9:34 AM, LPN #12 was interviewed with concurrent observations and stated she was not sure if 12/13 or 12/18/24 was the correct date which indicated the vial was accessed for use. On 01/16/2025 at 2:41 PM, LPN #12 was interviewed and stated [long-acting insulin name] insulin could be used for 28 days once the top has been accessed. She stated the vial of insulin was disposed of and reordered once 28 days had been reached. She was asked to look at a calendar and count the number of days [long-acting insulin name] insulin had been in use and she stated yesterday [01/15/2025] was 28 days and the insulin should have been disposed of and reordered. She stated Resident #66 did not have another vial of insulin at the facility and she would have to reorder the insulin today. On 01/16/2025 at 3:16 PM, the DON was interviewed and stated the nurses were responsible for checking the dates on the insulin to ensure the vial could be used. An information sheet provided by the DON on 01/16/2025 was reviewed and indicated [long-acting insulin name] insulin in use (opened) could be stored for 28 days. The Food and Drug Administration (FDA) website (https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/021081s071lbl.pdf) for [long-acting insulin name] insulin was reviewed and page 27 indicated [long-acting insulin name] vials in use should be thrown away after 28 days, even if it still has insulin left in it. A Storage of Medications policy, dated as revised November 2020, was reviewed and indicated discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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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 according to the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed. The findings are: 1. The 1/13/25 Resident meal of the month lunch menu documented the residents who received regular diets, mechanical soft diets, and residents who received chopped diets were to receive 2 slices of pizza. Residents who required pureed diets were to receive 2 #8 scoops (1 cup of pureed pizza and residents on mechanical soft diets were to receive ground pizza. 2. On 1/13/25 at 11:42 AM, during the lunch meal preparation, Dietary [NAME] (DC) #10 placed 6 slices of pepperoni pizza on a pan liner on top of the counter and sliced them into squares. DC #10 then transferred the squares pieces into a pan and stated she did it for the residents who received chopped meat. DC #10 placed the pan in the oven to be served to the residents who received chopped diets, instead of total of 12 slices of chopped pepperoni pizza since the menu indicated 2 slices of pizza for each resident. 3. On 1/13/25 at 12:17 PM, during the lunch meal preparation, DC #10 placed 4 slices of pepperoni pizza on a pan liner on top of the counter and stated we have 4 residents on mechanical soft diets. DC # 10 sliced 4 slices of pepperoni pizza, transferred them into a pan and placed it on the steam table to be served to 5 residents who received mechanical soft diets, instead of a total of 10 slices of ground pizza since the menu indicated 2 slices of pizza for each resident. At 1:19 PM, DC #10 was interviewed and was asked the reason residents on mechanical soft diets and residents on chopped diets only received 1 slice of pizza. DC #10 stated she used one slice because the Dietary Manager instructed, she gave a slice of pizza each. 4. On 1/13/25 at12:45 PM, the following observations were made during the noon meal service. a. DC #9 used a #8 scoop to serve a single portion of pureed pizza to the residents who received pureed diets, instead of 2#8 scoops. On 1/16/25 at 10:46 AM, DC #9 was interviewed and was asked what scoop size she had used to serve pureed pepperoni pizza at the lunch meal on 01/13/25 and how many servings she gave to each resident. She stated she used a #8 scoop, and she gave a serving each. DC #9 was interviewed and was asked if she reviewed the menu before deciding on how much pureed pizza to serve to the residents on pureed diets and she stated she didn't review the menu. 5. DC #9 used a #10 scoop (1/3 cup) to serve a single portion of pepperoni pizza cut in the shape of cubes, a total of 10 pieces, to the residents on mechanical soft diets, instead of ground pizza. At 01:14 PM, DC #9 was interviewed and was asked what scoop size she had used to serve mechanical soft pepperoni pizza and how many pieces of cut pizza were in the scoop served to the residents who received mechanical soft diets, and she stated she used a #10 scoop and there were about 10 pieces of cut pizza in the scoop she gave to each resident. She stated she gave a serving each.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 those residents who required pureed diets for 1 of 1 meal observed. The findings are. 1. On 1/13/25 at 11:22 AM, DC #7 used a 4-ounce spoon to put 9 servings of boiled, seasoned squash into a blender and poured the juice from the squash over it, covering the squash. As DC #7 began to puree the squash the consistency of the pureed squash was too runny. DC #7 added a cup of thickener and pureed it some more. At 11:23 AM, DC #7 poured the pureed squash into a pan, and placed it in a pan of hot water on the stove. The consistency was still runny. The pureed squash remained thin when it was served to the residents who required pureed diets. At 1:15 PM, DC #7 was interviewed and was asked if she could describe the consistency of the pureed squash served to the residents on pureed diets, and DC #7 stated she thought it was a little thin, and she should have added more thickener. 2. On 1/13/25 at 11:51 AM, DC #7 placed 16 servings of pepperoni pizza into the blender, added 3 cups of tomato sauce, pureed. The pureed pizza was still thick, so DC #7 added 8 -5 oz. cans of tomato juice and pureed it some more. At 12:03 PM, DC #7 poured the pureed pizza into a pan and placed it in a pan of hot water on the stove. The consistency of the pureed pizza was not smooth. There were pieces of pizza in the mixture. At 1:15 PM, DC #7 was interviewed and was asked if she could describe the consistency of the pureed pizza. DC # 7 stated the pureed pizza had a couple pieces of pizza in it and she should have pureed it longer.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 Based on observation, interview, record review, and facility policy review, the facility failed to ensure food items in the refrigerator, freezer and storage room were covered, and sealed; leftovers meat products were used in a manner to maintain food quality; dented cans were promptly removed from stock; 1 of 2 ice machines was maintained in clean and sanitary condition; dietary staff washed their hands before handling food or clean equipment; ceiling tiles, air vents, dish washer wall , kitchen door frames were free of, debris, dirt, rust, stains, baseboards were secured, and hot food items were maintained at temperature of 135 degrees or above for 1 of 1 meal observed. The Findings are: 1. On 1/13/25 at 8:41 AM, the following observations were made in the kitchen areas. a. A bag of coffee filters with loose coffee in it to be brewed was on the counter by the coffee machine. b. An opened bag of pizza was on the counter by the steam table. The bag was not sealed. c. An opened box of apple pie was on top of the plate warmer. The box was not covered. 2. On 1/13/25 at 8:43 AM, the following observations were made in the refrigerator. a. A bag of leftover sausage dated 01/13/2025 and a bag of leftover scrambled eggs dated 01/13/25 were in a pan on a shelf in the refrigerator. Dietary [NAME] (DC) #7 was interviewed and was asked what leftover sausage and leftover eggs were used for. She stated she used them at the breakfast meal the next day for mechanical soft diets and pureed diets. b. An opened bag of shredded cheese was on a shelf. The bag was not sealed. c. A pan of leftover spaghetti dated 01/11/2025 was on a shelf. The pan was not fully covered, exposing the food items to air. 3. On 1/13/25 at 8:51 AM, the following observations were made on a shelf in the walk-in freezer located outside the kitchen: a. An opened box of corndogs. The box was not covered or sealed. b. An opened box of steak fingers. The box was not covered or sealed. c. An opened box of dough sheets. The box was not covered. 4. On 1/13/25 at 9:00 AM, the following observations were made in the storage room: a. There were 3 dented cans of English peas on a shelf in the storage room: b. An opened bag of flour tortillas. 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 - Some	5. On 1/13/25 at 9:21 AM, the area in the ice machine panel where ice forms before dropping into the ice collector had wet black, and brown, slimy residue on it. The Dietary Manager was interviewed and was asked if she could wipe the area where the residue mixtures were observed. She did so, and the black, and brownish slimy residue easily transferred to the tissue. She was asked to describe the appearance of what was observed. The Dietary Manager confirmed it was black with brownish, slimy and grungy. The Dietary Manager was interviewed and stated the maintenance man cleaned the ice machine every 3 months, the CNAs [Certified Nursing Assistants] use it for the water pitchers in the residents' rooms and sometimes it is used in the kitchen to fill beverages. 6. On 1/13/25 at 9:27 AM, DC #7 placed gloves on her hands and opened a bag of shredded lettuce with a knife and emptied it into a pan, which contaminated the gloves. Using the same contaminated gloves, DC #1 leveled the shredded lettuce in the pan, then proceeded to cut the tomatoes and cucumbers and place them on top of the lettuce to be served to the residents for lunch meal. DC #2 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment. She stated she should have removed the gloves and washed her hands. 7. On 1/13/25 at 9:38 AM, the following observations were made in the kitchen: a. The ceiling tiles throughout the kitchen had stains on them. b. Ceiling vents in the dish room had rust stains on them. c. A ceiling tile in the storage room was loose. d. The wall on the clean side of the dish washing machine room was chipped and exposing the cement. e. The door frame leading to the dishwashing machine had rust stains on it. f. The ceiling vent above the dishwashing machine and the panels around ceiling tiles had rusty colored stains. g. The wall paint by the dirty dish window was peeling. The area exposed had stains on it. The wall below the dirty dish window had sage color stains on it. h. The baseboard under the dish washing machine was loose, the area that was exposed had sage color. 8. On 1/13/25 At 9:44 AM, Dietary Aide (DA) #8 lifted the lid of the trash can to dispose of gloves, contaminating her hands by touching the trash can lid. After disposing of the gloves, DA #8 pulled a new pair from the glove box and placed them on her hands, contaminating with her hands while handling the outside of the gloves. DA #8 then used the contaminated gloves to pick up clean plates from the clean side of the clean rack and when she was about to place them on the plate warmer. DA #8 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment. She stated she should have washed her hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On 1/13/25 at 11:34 AM, Dietary [NAME] #9 wore gloves on her hands to open boxes of pecan pies, removing the pies and placing them on a cutting board. However, using the same contaminated gloves, without changing gloves and washing her hands, DC #9 cut the pecan pies and placed each slice into individual plates to be served to the residents for lunch. 10. On1/13/25 at 12:24 PM, the temperatures of the food items when checked and read by DC # 7 were: a. Pureed pizza 105.9 degrees Fahrenheit. b. Mechanical soft pizza 104.3 degrees Fahrenheit. c. Chopped crusted pizza 109.5 degrees Fahrenheit. The above food items were not reheated before being served to the residents. 11. A review of facility policy titled, Use of Leftovers, initiated 2019, provided by the Dietary Manager on 1/16/2025 indicated, leftover foods should not be used for pureed diets. 12. A review of a facility policy titled, Handwashing and Glove Usage in Food service, initiated 2016 and provided by the Dietary Manager on 1/8/2025 indicated food handlers should wash their hands before starting work, after touching dirty dishes or clothing and after touching anything else such as dirty equipment.

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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. 46724 Based on observation, interview, record review and facility policy review the facility failed to ensure enhanced barrier precautions (EBP) were being followed to prevent the spread of possible infection for one (Resident #28) of four sampled residents who were on EBP. The findings are: Resident # 28 had diagnoses of gastrostomy, cerebral infarction, bipolar disorder, diabetes mellitus type 2, and Alzheimer's disease. The review of Physician Orders for January 2025 did not indicate an order for enhanced barrier precautions. On 01/13/2025 at 9:12 AM, EBP signage was observed on Resident #28's door and a stocked personal protective equipment (PPE) cart was on Resident 28's side of the room. On 01/13/25 at 09:13 AM, Certified Nursing Assistant (CNA) #3 was observed at Resident #28's bedside, preforming incontinent care, without PPE on. When asked, CNA #3 stated she had changed the resident without donning PPE. On 01/13/2025 at 1:22 PM, Hospice CNA #4 was observed bathing Resident #28 without PPE on. When questioned, CNA #4, responded it was her first time working with the resident and she was not aware Resident #28 was on EBP. The Quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/29/24 indicated a staff assessment of mental status (SAMS) score of severely impaired, and was dependent for eating (tube fed), toileting, bathing, turning and positioning, and was always incontinent of bowel and bladder. The MDS also indicated one stage 3 pressure ulcer. On 01/16/2025 at 10:51 AM, CNA #11 verified she had been educated on EBP. She was able to correctly explain why it is used, where supplies were located and said she identified residents with EBP by the signage on the door and by looking at the electronic medical record (EMR) tasks. On 01/16/2025 at 10:57 AM, LPN #12 verified education on EBP, was able to identify which residents were on EBP, how they were identified, and correctly respond that EBP is used for infection control. On 01/16/2025 at 11:00 AM, LPN #13 reported education on EBP and reported it was to protect staff, resident, and other residents from infection. She explained how residents with EBP were identified and which PPE was required. (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 the facility's Policy for Enhanced Barrier Precautions indicated EBP are used for infection prevention and control. The EBP policy stated gloves and gowns are to be used during high contact with residents such as bathing, incontinent care, transferring, wound care and when a resident has an indwelling device such as a urinary catheter or feeding tube. The policy went on to state that signs are posted outside the resident ' s room and PPE is available outside resident ' s room.