STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055570	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Elizabeth Healthcare Center	2800 N. Harbor Blvd. Fullerton, CA 92835

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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 0558 Level of Harm - Potential for minimal harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility P&P review, the facility failed to follow up on the request of the resident to have the bilateral grab bars for one of 16 final sampled resident (Resident 29). This failure had the potential for Resident 29 not to receive care timely. Findings: Review of the facility's P&P titled Resident Rights: Accommodation of Needs and Preferences and Homelike Environment Policy (undated) showed the facility will assess and interview the residents for the need to make reasonable accommodations, such as necessary adaptive devices. Medical record review for Resident 29 was initiated on 12/11/24. Resident 29 was admitted to the facility on [DATE]. On 12/11/24 at 0810 hours, a concurrent observation and interview was conducted with Resident 29. Resident 29 was observed awake, sitting up in bed, and had turned on the call light. Resident 29 stated on the previous day, he asked a staff member for the bilateral grab bars. Resident 29 further stated he would like to have them to help with his turning or repositioning in bed and sometimes he used them to sit in the middle of the bed. Resident 29 stated he felt upset because the staff member did not respond regarding his request for the bilateral grab bars. On 12/11/24 at 0825 hours, an interview was conducted with LVN 5. LVN 5 stated Resident 29 had previously requested the bilateral grab bars and LVN 5 would need to inform the request to the resident's the physician. On 12/11/24 at 1300 hours, a follow-up interview was conducted with LVN 5. LVN 5 was asked if he had informed the physician about the bilateral grab bars. LVN 5 stated he informed RN 1 but did not follow up afterwards. LVN 5 stated he would follow up, and verified the findings. On 12/11/24 at 1320 hours, an interview was conducted with RN 1. RN 1 was asked if she had informed the resident's physician regarding the resident's request for the bilateral grab bars for Resident 29. RN 1 stated she had not and would do it.

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 - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 50787 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the privacy was provided for one of three final sampled residents (Resident 8). * The privacy curtain was not pulled completely in Resident 8's room when the licensed nurse administered the medications via GT. This failure had the potential to negatively affect the dignity of the resident and violate the resident's rights to privacy. Findings: Review of the facility's P&P titled Medication Administration via Tube Feeding revised 12/2023, under the section for procedures, showed to screen resident for privacy. Review of the facility's P&P titled Resident's Rights: Dignity and Privacy dated 11/2021, under the section for procedures, showed the residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from passers-by. On 12/11/24 at 0840 hours, during an observation, LVN 4 went inside Resident 8's room to administer medications via GT. LVN 4 did not completely pull the privacy curtain when administered the medications to Resident 8. The room door was open and Resident 8 was exposed to the hallway when LVN 4 was administering the resident's medications via GT. Other residents and staff members were observed passing by the hallway during this procedure. On 12/11/24 at 1520 hours, an interview was conducted with LVN 4. LVN verified Resident 8 was not provided with complete privacy during the medication administration. On 12/17/24 at 0902 hours, during an interview, the DON verified all of the above findings.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of 16 final sampled residents (Residents 12 and 40) and one nonsampled resident (Resident 38) were free from the unnecessary restraints. * The facility failed to obtain the order and informed consent, complete the restraint assessment, and develop a care plan problem for the use of Tab alarm prior to applying a Tab alarm for Resident 40's bed and wheelchair. * The facility failed to obatain an informed consent and complete the restraint assessment for the use of pad alarm prior to applying a pad alarm for Resident 38's bed and wheelchair. * The facility failed to obatain an informed consent and complete the restraint assessment for the use of Tab alarm prior to applying a Tab alarm for Resident 12's bed and wheelchair. These failures posed the risk of compromising the residents' independence and psychosocial well-being. Findings: 1. Review of the facility's P&P titled Restraint, Physical revised 5/2007 showed a physician's order is necessary for the use of a physical restraint, explain the potential negative outcomes of restraint use, and medical symptoms that warrant the use of restraints must be documented in the resident's medical record, ongoing assessments, and care plans. Review of the facility's P&P titled Informed Consent revised 5/2019 showed a physician's orders related to the use of psychotherapeutic drug and physical restraint should not be initiated until an informed consent is obtained. Medical record review for Resident 40 was initiated on 12/12/24. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's H&P examination dated 11/11/24, showed Resident 40 had the capacity to understand and make decisions. Review of Resident 40's MDS dated [DATE], showed Resident 40's BIMS score was three (meaning the resident had severe cognitive impairment). Review of Resident 40's Order Summary Report dated 12/12/24, did not show an active order for the use of Tab alarm in bed and wheelchair. Review of Resident 40's Restraint/Enabling Device/Safety Device Evaluation dated 12/9/24, did not show an assessment was completed for the use of the Tab alarm in bed or wheelchair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 40's Plan of Care failed to show a care plan problem was developed to address the use of Tab alarm in bed or wheelchair. On 12/12/24 at 0845 hours, Resident 40 was observed lying in bed asleep. The Tab alarm in bed was observed in placed and turned on with the device light blinking. On 12/12/24 at 1155 hours, a concurrent observation and interview was conducted with CNA 4. Resident 40 was observed lying in bed with the Tab alarm on. Resident 40 was awake, alert, and could answer to yes or no questions. CNA 4 verified Resident 40's Tab alarm was attached to the resident in the bed and the device light was blinking. CNA 4 stated Resident 40 had the Tab alarm in bed since admission for fall prevention. On 12/12/24 at 1356 hours, a concurrent interview and medical record review was conducted with the DON. The DON was asked to show the order of Resident 40's Tab alarm in bed or wheelchair in the resident's medical record. The DON verified the above findings and confirmed there was no order for the use of Tab alarm for Resident 40 while in bed and wheelchair. On 12/12/24 at 1429 hours, a concurrent interview and medical record review was conducted with LVN 7. LVN 7 was asked to show Resident 40's order, informed consent, restraint assessment, and care plan for the Tab alarm in bed and wheelchair. LVN 7 reviewed Resident 40's medical record and verified there were no order, informed consent, restraint/device assessment, and care plan problem for Resident 40's Tab alarm for the bed and wheelchair. On 12/17/24 at 0818 hours, an interview was conducted with LVN 5. LVN 5 was asked if Resident 40 had a Tab alarm in bed and wheelchair. LVN 5 stated Resident 40 did not have the order, assessment, and care plan problem for the use of the Tab alarm in bed or wheelchair. In addition, LVN 5 stated the nursing staff member must assess the resident first if he needed the Tab alarm then get an order from the physician, obtain an informed consent, and develop a care plan problem. On 12/17/24 at 0928 hours, an interview was conducted with the DON. The DON was asked regarding the facility's restraint P&P. The DON stated the licensed nurses must assess the resident, complete the safety/restraint/enabling device evaluation, obtain an order, inform the responsible party for consent and develop a care plan problem. The facility did not consider the Tab alarms as restraints unless the resident would say I cannot move, then the facility would discontinue the Tab alarm. When the DON was asked if the resident was confused and could not verbalize their needs, how would the facility determine if the Tab alarm was appropriate for the resident, the DON stated if the resident was confused, the nursing staff member would monitor the resident's behavior. The DON stated inappropriate use of the Tab alarm could affect the residents' well-being. The DON stated Resident 40 must have the order, informed consent, assessment, and care plan problem for the Tab alarms if he needed them. The DON was informed and acknowledged the above findings. 32179 2. Medical record review of Resident 38 was initiated on 12/12/24. Resident 38 was admitted to the facility on [DATE], and readmitted on [DATE]. On 12/12/24 at 0805 hours, Resident 38 was observed sitting up in a wheelchair with a pad alarm attached. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 0900 hours and 12/16/24 at 0800 hours, Resident 38 was observed sitting up in bed with a pad alarm. On 12/16/24 at 0810 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 was asked to show Resident 38's informed consent for the use of pad sensor alarm in the bed and wheelchair; however, the LVN was unable to provide the documentation. LVN 4 verified the findings. On 12/16/24 at 0830 hours, a concurrent interview and medical record review was conducted with the DON. The DON was asked to show the facility's assessment that was completed for Resident 38's use of the sensor pad alarm in bed and wheelchair. The DON was unable to provide the documentation. The DON verified the findings. On 12/16/24 at 0845 hours, an interview was conducted with CNA 10. CNA 10 stated they placed the sensor pad alarm in the bed and wheelchair because Resident 38 had episodes of attempting to get up unassisted. 50953 3. Medical record review for Resident 12 was initiated on 12/11/24. Resident 12 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 12's H&P examination dated 12/14/23, showed Resident 12 had no capacity to understand and make decisions. Review of Resident 12's MDS dated [DATE], showed a BIMS score of eight (meaning moderately impaired cognition). Review of Resident 12's Order Summary Report showed the following physician's orders: - dated 12/12/23, for a Tab alarm in bed and wheelchair to alert the staff member that the resident was getting out of bed or wheelchair unassisted - dated 12/12/23, for a floor pad on the left side of bed for safety On 12/11/24 at 0938 hours, Resident 12 was observed lying in bed awake with no signs of pain or discomfort. The Tab alarm in bed was observed in placed and turned on with the device light blinking. On 12/13/24 at 0812 hours, a concurrent observation of Resident 12 and interview was conducted with CNA 11. Resident 12 was observed lying in bed, awake, alert, and able to answer to yes or no questions. CNA 11 verified the findings. On 12/13/24 at 1150 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 12 had no episodes of getting up from the wheelchair or bed in the past month unassisted. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 0953 hours, a concurrent interview and medical record review was conducted with the MDS Coordinator. The MDS Coordinator was asked to show the informed consents for the Tab alarm for the bed and wheelchair. The MDS Coordinator reviewed Resident 12's medical record and verified there was no informed consent for the use of the Tab alarm in bed and wheelchair. On 12/17/24 at 0945 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop and implement the comprehensive person-centered care plans for four of 16 final sampled residents (Residents 2, 22, 49, and 456). * The facility failed to develop a care plan problem to address Resident 22's refusal to shower, turn positions, change diaper, and take medications. * The facility failed to implement the intervention for 1:1 (one staff member to one resident) assistance during meals to address Resident 49's weight loss. * The facility failed to develop a care plan to address the use of oxygen and CPAP for Resident 456. * The facility failed to ensure Resident 2's care plan problem addressing diabetes mellitus included the use of insulin as ordered. These failures placed the residents at risk of not being provided appropriate, consistent, and individualized care. Findings: 1. Review of the facility's P&P titled Comprehensive Person-Centered care planning dated 8/2019 showed the resident has the right to refused or discontinue treatment. In the event that a resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk. Medical record review for Resident 22 was initiated on 12/11/24. Resident 22 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 22's H&P examination dated 6/5/24, showed the resident had a capacity to understand and make decisions. On 12/13/24 at 0823 hours, a concurrent observation and interview was conducted with Resident 22. Resident 22 was observed lying in bed. On 12/13/24 at 0908 hours, an interview was conducted with CNA 9. CNA 9 stated Resident 22 had episodes of refusing to take showers, turn and reposition in bed, and have the diapers changed. CNA 9 stated the licensed nurses were aware of Resident 22's refusals for the above care. On 12/16/24 at 0843 hours, a concurrent interview and medical record review was conducted with the DSD. The DSD verified there was no care plan problem developed to address Resident's 22's refusal to shower, turn positions, change diaper, and take medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Medical record review for Resident 49 was initiated on 12/11/24. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's H&P examination dated 11/15/24, showed the resident had a capacity to understand and make decisions. Review of Resident 49's Order Summary Report dated 12/12/24 showed the following physician orders: - dated 11/15/14, for the resident to have 1:1 meal assistance feeder with the meals. On 12/11/24 at 1223 hours, during the dining observation for Resident 49. Resident 49 was observed eating by himself. There was no staff member observed assisting the resident with his meal. On 12/13/24 at 1242 hours, during the dining observation for Resident 49, the resident was observed refusing to eat his lunch. Resident 49 requested for an ice cream. There were no staff observed helping Resident 49 with his meals. On 12/16/24 at 1323 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 verified Resident 49 had a 36 lbs weight loss in 26 days. LVN 4 verified there was an order for 1:1 meal assistance feeder during the meals; however, the 1:1 meal assistance was not implemented. On 12/17/24 at 0945 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings. Cross reference to F692. 45064 3. Review of the facility's P&P titled Comprehensive Person-Centered Care Planning revised on 8/2019 showed it is the policy of this facility that the IDT shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Medical record review for Resident 456 was initiated on 12/12/24. Resident 456 was admitted to the facility on [DATE]. Review of Resident 456's H&P examination dated 11/30/24, showed the resident had the capacity to understand and make decisions. Reviewed of Resident 456's Order Summary Report showed the following physician orders: - dated 11/29/24, for oxygen at 2 liters per minute via nasal canula continuously every shift - dated 12/5/24, for CPAP setting: continues at 4 PSI, apply CPAP Q HS and remove in the morning every shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 1000 hours, a concurrent observation and interview was conducted with Resident 456. Resident 456 was lying in bed with an oxygen at 2 liters per minute via nasal canula and CPAP machine at the bedside. Resident 456 stated he used the oxygen during the day and the CPAP at night. Review of Resident 456's medical record failed to show a care plan problem was developed for the resident's use of oxygen and CPAP. On 12/12/24 at 1225 hours, a concurrent interview and medical record review was conducted with the DON. The DON reviewed Resident 456's medical record and verified the facility failed to develop a care plan problem specific to the use of oxygen and CPAP for Resident 456. 32179 4. Medical record review for Resident 2 was initiated on 12/11/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's Order Summary report dated 12/12/24, showed the following physician orders: - dated 11/28/24, to administer Insulin gargline solution (a long-acting, synthetic version of human insulin to help manage diabetes mellitus) 100 unit per ml inject 16 unit subcutenously at bedtime - dated 11/28/24 to administer lispro insulin (a fast-acting, synthetic insulin that helps people with type 1 and type 2 diabetes manage their blood sugar levels) one unit dial solution pen injector 100 unit per ml inject per sliding scale subcatnouelsy before meals and bedtime Review of Resident 2's care plan problem dated 4/23/24, showed Resident 2 had diabetes mellitus and was prescribed metformin hydrochloride oral tablet 500 mg. The care plan interventions included monitoring, documenting, and reporting to the resident's physician for the signs and symptoms of hypo and hyperglycemia. However, the care plan problem failed to address the use of insulin as ordered by the physician. On 12/12/24 at 1550 hours, an interview and concurrent medical record review were conducted with LVN 3. LVN 3 was asked if Resident 2 had received two types of insulin. LVN 3 stated, yes, insulin lispro and glargine. LVN 3 was then asked if any care plan problem was developed to address the use of insulin. LVN 3 was unable to provide the documentation and verified the findings.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, facility document review, and facility P&P review, the facility failed to follow the professional standards of clinical practice accepted for the administration of GT medications for one of two residents (final sampled resident, Resident 8) observed for medication administration receiving GT medications. * LVN 4 did not flush the GT in between the administering of three of eight medications for Resident 8. This failure had the potential to disrupt the flow of medications and clog the GT affecting the patency and placement of Resident 8's GT. Findings: Review of the facility's P&P titled Medication Administration via Feeding Tube revised 12/2023 showed under Guidelines: If administering several medications, administer each one separately, the tube should be flushed with at least 5 ml of water between medications. According to the NIH's National Library of Medicine Open Resources for Nursing (Open RN) Nursing Skills 2021 page 14, under Enteral Medication Administration: medications given through enteral feeding tube should not be mixed because of the risks of physical and chemical incompatibilities, tube obstruction, and altered therapeutic drug responses. Between each medication, the tube is flushed with 15 ml of water. Review of Resident 8's medical record was initiated on 12/11/24. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's Order Summary Report dated 12/12/24, showed the following physician orders: - dated 10/7/24, aspirin (nonsteroidal anti-inflammatory drug) 81 mg one tablet via GT one time a day - dated 10/14/24, sodium chloride (supplement) 1 gm one tablet via GT two times a day - dated 10/7/24, cyanocobalamin (vitamin B 12 supplement) 1000 mcg one tablet via GT one time a day - dated 10/10/24, multivitamin one tablet via GT one time a day - dated 10/7/24, Cozaar (antihypertensive medication) 50 mg one tablet via GT one time a day - dated 12/9/24, Azithromycin (antibiotic) 250 mg one tablet by mouth one time a day - dated 10/20/24, demeclocycline hcl (antibiotic) 150 mg one tablet via GT two times a day - dated 11/20/24, acetaminophen (analgesic medication) 325 mg two tablets via GT every four hours as needed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/24 at 0840 hours, a concurrent medication administration observation for Resident 8 and interview was conducted with LVN 4. LVN 4 administered eight medications via GT to Resident 8. Resident 8's GT was flushed in between the first five medications administered (aspirin, sodium chloride, cyanocobalamin, multivitamin, and Cozaar). LVN 4 did not flush the GT in between the last three medications administered (Azithromycin, demeclocycline hcl, and acetaminophen). LVN 4 stated the process of administering the medications via GT included flushing the GT with 10-15 ml of water after each medication administered. LVN 4 acknowledged he might have missed flushing the GT for the last few medications administered to the resident. On 12/17/24 at 0902 hours, an interview with the DON was conducted. The DON verified all of the above findings.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50953 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate services needed to maintain the acceptable parameters of nutritional status were provided for one of one final sampled resident (Resident 49) reviewed for weight loss. * The facility failed to ensure the RD's recommendations on 12/12/24, were followed up with the physician and addressed in the IDT weight variance meeting when Resident 49 had a severe weight loss of 36 lbs in 26 days. This failure had the potential for Resident 49 not to receive the necessary intervention to prevent further weight loss. Finding : Review of the facility's P&P titled Nutrition Care Management revised dated 7/2021 showed the recommendation based on the nutritional goals will be communicated via electronic system and the Licensed Nurse will confirm to document the physician prescription. The MD declination of RDN recommendation will be documented in the Progress Notes. The expectation that the RDN will be carried out before any effects. Medical record review for Resident 49 was initiated on 12/11/24. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's H&P examination dated 11/15/24, showed the resident had capacity to understand and make decisions. Review of Resident 49's Weight Summary showed the following weights: - on 11/15/24, 233 lbs; - on 11/18/24, 223 lbs, a weight loss of 10 lbs from 11/15; - on 11/23/24, 220 lbs; a weight loss of 3 lbs from 11/18; - on 11/25/24, 216 lbs; a weight loss of 4 lbs from 11/23; - on 12/3/24, 202 lbs; a weight loss of 14 lbs from 11/25; and - on 12/10/24, 197 lbs; a weight loss of 5 lbs from 12/3 Review of Resident 49's Order Summary report showed a physician's order dated 11/27/24, for a mechanical soft chopped diet, regular with thin liquid. Review of Resident 49's Nutrition IDT note dated 12/12/24, showed Resident 49 with 36 lbs weight loss in 26 days which was undesirable weight loss related to the resident's poor oral intake. The IDT recommendations/comments showed the RD had the following recommendations: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- fortify the current diet order; - one pack Arginaid (nutritional supplement) BID x 14 days; and - 30 ml of ProStat (liquid protein supplement) every day On 12/16/24 at 1353 hours, a concurrent interview and medical record review was conducted with the RD. The RD was asked what the facility's plan was to address Resident 49's weight loss. The RD stated she had some recommendations for Resident 49 weight loss related to the resident's poor oral intake. Review of Resident 49's medical record with the RD failed to show the recommendations of the RD on 12/12/24, was communicated with the resident's physician. The RD verified the recommendations made on 12/12/24, were not followed. On 12/16/24 at 1431 hours, a concurrent interview and medical record review was conducted with the RD and DON. Review of Resident 49's medical record failed to show documentation the facility had communicated and followed up with the resident's physician regarding the RD's recommendations on 12/12/24. On 12/17/24 at 0945 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings. Cross reference to F656, example #2.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49644 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 6) reviewed for respiratory care was provided with the appropriate respiratory care when: * The facility failed to ensure the physician's order for CPAP had a schedule when to apply and remove the CPAP for Resident 6. Additionally, Resident 6's medical record did not show the CPAP was applied from 12/9 to 12/11/24. * The facility failed to ensure the physician's order for cleaning and maintenance of Resident 6's CPAP was accurate. The physician's order showed to clean the humidified container but Resident 6's CPAP had no humidified container. These failures had the potential to affect the respiratory health and well-being of Resident 6. Findings: Review of the facility's P&P titled BiPAP and CPAP (undated) showed the cleaning and maintenance: hand wash the tubing once a week with warm water and soap and allow to air dry. Review of the facility's P&P titled Physician Orders revised 11/2019 showed the physician's orders shall be obtained prior to the initiation of any medication or treatment. The guidelines section showed all orders must be specific and complete with all the necessary details to carry out the prescribed orders without any question. On 12/11/24 at 0917 hours, a concurrent observation and interview was conducted with Resident 6. Resident 6 stated she did not put her CPAP on for two nights. Resident 6 further stated she was supposed to have the CPAP on every night to help her with her breathing. Resident 6 stated she did not refuse the CPAP and the CPAP was not offered to her by the staff member. Medical record review for Resident 6 was initiated on 12/11/24. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's MDS dated [DATE], showed Resident 6's cognition was moderately impaired. Review of Resident 6's Order Summary Report for December 2024 showed the following physician's orders: - dated 12/9/24, to apply CPAP setting: pressure 4.0 cm H20. The order failed to show the schedule for when to apply and remove the CPAP. - dated 11/25/24, to clean the humidified container: wash with hot water and soap, leave open to air dry every Sunday. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Review of Resident 6's medical record did not show Resident 6's CPAP was applied from 12/9 to 12/11/24. On 12/13/24 at 1007 hours, a concurrent interview and medical record review was conducted with LVN 1. LVN 1 verified the order for the CPAP setting was incomplete. LVN 1 stated the licensed nurse should have clarified this order. LVN 1 further stated the order should have the times for the CPAP setting, such as when the machine to be on at bedtime and off in the morning when the resident wakes up. LVN 1 acknowledged there was no documentation Resident 6 had the CPAP applied from 12/9 to 12/11/24. On 12/13/24 at 1450 hours, a concurrent interview and medical record review was conducted with LVN2. LVN 2 acknowledged the order for the CPAP setting was incomplete. LVN 2 stated the licensed nurse should have verified with the physician to obtain the correct order. LVN 2 further stated the physician's order should have the instruction when to apply and remove the CPAP. On 12/17/24 at 0736 hours, a concurrent interview and medical record review was conducted with the DON. The DON was informed of the above findings. The DON stated Resident 6's physician's order should include the schedule to apply the CPAP at hour of sleep and remove the CPAP when the resident woke up in the morning. The DON acknowledged there was no documentation Resident 6's CPAP was applied from 12/9 to 12/11/24. The DON stated the physician's order did not go through the MAR because the order did not include when to apply the CPAP. b. Review of Resident 6's TAR for December 2024 showed the CPAP humidified container was washed with hot water and soap, left open to air dry on 12/1/24 and 12/8/24. On 12/13/24 at 1450 hours, a concurrent interview and medical record review was conducted with LVN 2. LVN 2 verified Resident 6's TAR showed the CPAP humidified container was washed with hot water on 12/1 and 12/8/24. LVN 2 acknowledged the physician's order was incorrect because Resident 6's CPAP had no humidified container. LVN further stated Resident 6's CPAP had a filter. LVN 2 stated the licensed nurse should have checked Resident 6's CPAP, called the respiratory therapist from the home care provider, and called Resident 6's physician. On 12/17/24 at 0736 hours, a concurrent interview and medical record review was conducted with the DON. The DON verified the physician's order to wash Resident 6's CPAP humidified container with hot water. The DON stated the staff should not use hot water because the CPAP was made of plastic. The DON acknowledged Resident 6's CPAP had no humidified container. The DON further stated the licensed nurse should have clarified the physician's order that Resident 6's CPAP had no humidified container and should have checked with the manufacturer. The DON stated there was no documentation Resident 6's CPAP filter was cleaned because there was no physician's order to clean the CPAP filter. The DON stated Resident 6's CPAP filter was cleaned on 12/13/24. The DON stated if the filter was not cleaned, then the CPAP would not be effectively functioning as it should be.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32179 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being for one of 16 final sampled residents (Resident 354). * The facility failed to completely assess Resident 354 for pain prior to administering oxycodone (narcotic analgesic medication). This failure had the potential to cause increased pain and distress to the resident. Findings: Review of the facility's P&P titled Recognition and Management of Pain dated 7/2017 showed the pain will be documented in the EHR using a scale of 1-10 (with zero = no pain and 10 = worst pain). Monitoring: the interdiscplincary Care plan will reflect the location and the type of pain, pharmacologial and non pharmcological intervention, with evalution and revision as indicated. Medical record review for Resident 354 was initiated on 12/11/24. Resident 354 was admitted to the facility on [DATE]. Review of Resident 354's care plan to address the resident's pain medication therapy related to spine fractures dated 12/12/24, showed the approaches included the following: - administering analgesic medication as per the orders - giving medication 1/2 hour before treatments or care - anticipating the need for pain relief and responding immediately to any complaints of pain - following the pain scale to medicate as ordered - monitoring and recording pain characteristics: quality (e.g., sharp, burning); severity (1 to 10 pain scale); anatomical location; onset; duration (e.g., continuous, intermittent); aggravating factors; and relieving factors - monitoring, recording, and reporting to the nurse for any signs/symptoms of non-verbal pain: changes in breathing (noisy, deep/shallow, labored, fast/slow); vocalizations (grunting, moans, yelling out, silence); mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); eyes (wide open/narrow slits/shut, glazed, tearing, no focus); face (sad, crying, worried, scared, clenched teeth, grimacing); and body (tense, rigid, rocking, curled up, thrashing). Review of Resident 354's Order Summary Report showed the following physician orders: - dated 12/6/24, to administer oxycodone hcl 10 mg one tablet by mouth every six hours as needed for severe pain (pain levels 7-10). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 12/6/24, Tylenol (analgesic) 325 mg two tablets by mouth every six hours for pain management. On 12/11/24 at 0940 hours, Resident 354 was observed turned on the call light and requested for a pain medication from RN 2. Resident 354 stated he would like to have the pain medication before exercising with the physical therapist. RN 2 went into the room and stated they would let the nurse know. RN 2 did not assess Resident 354's pain level or offer nonpharmacological interventions. On 12/11/24 at 1020 hours, an interview was conducted with Resident 354. Resident 354 was asked if any of the staff member responded to the call light. Resident 354 stated a staff member came in and was informed of the resident's need for pain medication. Resident 354 stated the staff member responded that it would take a long time and did not explain why. Resident 354 expressed a concern that this had happened before. Resident 354 felt upset because he had to wait approximately one hour to get his pain medication. Resident 354 stated the staff member did not ask what his pain level was, assess his pain, or offer any other alternatives. On 12/11/24 at 1025 hours, during an observation, the PT and OT were both observed going into the room to provide exercise to Resident 354. Resident 354 refused to perform exercise before getting the pain medication and stated he needed it before exercising. On 12/11/24 at 1040 hours, an interview was conducted with the OT. The OT stated Resident 354 would like to have a pain medication administered before exercising. The OT stated she informed LVN 4. On 12/11/24 at 1055 hours, an interview was conducted with RN 2. RN 2 stated she informed LVN 4 about Resident 354's pain but LVN 4 was busy. RN 2 was asked if they assessed the pain level of Resident 354 and followed up with the resident about the pain or offered nonpharmacological interventions. RN 2 acknowledged they did not ask or follow up on Resident 354's pain level. RN 2 was asked if another nurse could administer Resident 354's pain medication when the assigned LVN was busy. RN 2 stated they could and verified the above findings. On 12/11/24 at 1120 hours, LVN 4 was observed administering oxycodone medication for pain to Resident 354. LVN 4 did not ask Resident 354's pain level, location, and frequency of pain. On 12/11/24 at 1130 hours, a concurrent interview and medical record review was conducted with LVN 4. LVN 4 stated he did not ask or assess Resident 354's pain level, quality, anatomical location, onset, duration, aggravating factors, and relieving factors. LVN 4 verified the above findings. On 12/17/24 at 1000 hours, the DON was informed and verified the findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50787 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services when: * The facility failed to ensure the accurate and complete documentation of the controlled medications administered for one nonsampled resident (Resident 356). * The facility failed to ensure the narcotic sheets had the nurses' initials and signatures for one of two medication carts (Medication Cart 1). * Medication Cart 1 was left unlocked in an area where the residents, other staff, or visitors could access it. These failures had the potential for the medications to be administered in error and opportunities for drug diversion or drug misuse. Findings: 1. Review of the facility's P&P titled Controlled Medications revised 12/2019 showed when a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: date of administration, amount administered, signature of nurse administering the dose, completed after the medication is actually administered. Review of the facility's P&P titled Medication Administration revised 8/2021 showed the staff member administering the medication must record such information on the resident's MAR before administering the next resident's medication. Review of Medication Cart 2's Controlled Substances Book for the narcotic count sheets showed on 12/7/24 at 1100 hours, there were 17 tablets of oxycodone 5 mg as amount on hand for Resident 356, and one tablet was removed with a total amount of 16 tablets left and documented on the narcotic count of Resident 356's oxycodone 5 mg tablet medication. Medical record review for Resident 365 was initiated on 12/13/24. Resident 365 was admitted to the facility on [DATE]. Review of Resident 356's Order Summary Report dated 12/12/24, showed an order dated 12/6/24, for oxycodone hcl oral tablet 5 mg by mouth every four hours as needed for moderate pain (pain levels 4-6, using the 0-10 pain scale; zero meaning no pain and 10 meaning worst pain) to severe pain (pain levels 7-10). Review of Resident 356's MAR failed to show documented evidence the oxycodone hcl medication was administered to Resident 356 on 12/7/24 at 1100 hours. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/17/24 at 0902 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and verified all of the above findings. 2. Review of the facility's P&P titled Controlled Medication revised 12/2019 showed at each shift change, a physical inventory of all controlled medications is conducted by the licensed nurses and is documented on an audit record. Alternatively, the shift change audit may be recorded on the accountability record is there is a designated column for the audit. Review of Medication Cart 1's Controlled Substances Book for the narcotic count sheet showed multiple entries were missing the nurses' signatures and initials when the incoming and outgoing nurses counted the narcotic medication on the following dates and times: - 9/28/24 at 1500 - 2300 hours, for the incoming nurse - 10/3/24 at 0700 - 1500 hours, for the outgoing nurse - 10/7/24 at 0700 - 1500 hours, for the outgoing nurse - 10/11/24 at 2300- 0700 hours, for the outgoing nurse - 10/11/24 at 1500 - 2300 hours, for the incoming nurse - 10/27/24 at 0700- 1500 hours, for the incoming nurse - 11/14/24 at 1500 - 2300 hours, for the outgoing nurse - 11/15/24 at 0700- 1500 hours, for the incoming nurse On 12/13/24 at 0835 hours, a concurrent interview and facility document review was conducted with the DON. The DON reviewed Medication Cart 1's Controlled Substances Book and verified there were no signatures and initials from the nurses for the above dates and times. The DON verified it should have been done. 3. Review of the facility's P&P titled Medication Access and Storage revised 2/2019 showed the medication rooms, carts, and medication supplies are locked or attended by the persons with authorized access. On 12/11/24 at 0840 hours, a concurrent observation and interview was conducted with LVN 4. LVN 4 left the medication cart unlocked and went into a resident's room to administer the medications. LVN 4 verified the medication cart was not locked when he went inside the resident's room to administer medications. On 2/17/24 at 0902 hours, an interview was conducted with the DON. The DON was informed and verified all of the above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on interview, medical record review, and facility P& P review, the facility failed to ensure two of five final sampled residents (Residents 6 and 49) reviewed for unnecessary medications were free from the unnecessary psychotropic medications. * There were no specific resident-centered goals to monitor for increased appetite for Resident 6's use of mirtazapine (antidepressant medication). * There was no evidence of non-pharmacological interventions for Resident 49's use of escitalopram (antidepressant medication) These failures had the potential to result in unnecessary use of, ineffective and/ or lack of monitoring or interventions for psychotropic medications that could negatively affect Residents 6 and 49's highest practicable mental, physical, and psychosocial well- being. Findings: 1. Review of the facility's P&P titled Psychotropic Drug Use revised 8/2017 showed the licensed nurses shall review the classification of the drug, the appropriateness of the diagnosis, its indication/ behavior monitoring and related adverse side effects prior to verification of admission orders with the attending physician. The residents with prescribed psychotropic drugs will be monitored for adverse consequences, and effectiveness of medications are in place by the Psychotropic Drug Review Committee. Medical record review for Resident 6 was initiated on 12/12/24. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's Order Summary Report dated 12/16/24, showed the following physician orders: - dated 11/25/24, for mirtazapine (antidepressant medication) oral tablet 30 mg one tablet by mouth at bedtime for depression manifested by poor oral intake - dated 11/25/24, for antidepressants' common side effects: sedation, drowsiness, headache, decreased appetite, blurred vision, urinary retention; extrapyramidal symptoms every shift - dated 11/25/24, to monitor episodes of depression as evidenced by poor meal intake every shift Review of Resident 6's MAR for December 2024 showed the following: - mirtazapine oral tablet 30 mg was documented as administered from 12/1 nightly until 12/11/24. - monitoring of common side effects with documented results of negative observation including decreased appetite on all the shifts from 12/1 to 12/12/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- monitoring of the episodes of the depression as evidenced by poor meal intake every shift was documented as follows: the resident did not eat on 12/1, 12/3, 12/5 to 12/12 from 0700-1300 hours, 12/1, 12/2, 12/7 to 12/10 from 1300-2300 hours, 12/1 to 12/11 from 2300-0700 hours; the resident refused meals on 12/2 from 0700-1300 hours, and 12/4 to 12/6, and 12/11/24 from 1300-2300 hours. Review of Resident 6's CNA Plan of Care Response dated 12/1 to 12/16/24, showed the percentage of the resident's meals eaten as follows: - From 0-25%, 20 episodes - From 26- 50%, 13 episodes - From 51-75%, nine episodes - From 76- 100%, seven episodes Further review of Resident 6's medical record failed to show documented evidence of specific resident-centered goal to monitor and evaluate if the mirtazapine was effectively used. On 12/13/24 at 1455 hours, a telephone interview was conducted with the facility's Pharmacy Consultant. The Pharmacy Consultant was asked about the process of medication review on new admissions. The Pharmacy Consultant stated the facility's pharmacist would review the newly admitted medications within 24 hours. The facility's drug regimen review was performed monthly or as often as needed. The Pharmacy Consultant stated they did not review Resident 6's drug regimen review as of yet. On 12/17/24 at 0902 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the indication for poor meal intake did not specify the percentage that needed to be monitored. The DON verified the above findings and acknowledged the facility did not have a specific order for for the use of mirtazapine. 2. Review of the facility's P&P titled Psychotropic medications revised 8/2017 showed the newly admitted residents with psychiatric, mood or behavior disorders, mental and psychosocial difficulties and/or with physician's orders for psychotropic medications will be referred to the facility's Psychotropic Drug Review Committee and/or Psychiatrist to ensure a review of plan of care shows individualized, person centered care approaches to manage behavior with non- pharmacological interventions. Medical record review for Resident 49 was initiated on 12/13/24. Resident 49 was admitted to the facility on [DATE]. Review of Resident 49's H&P examination dated 11/15/24, showed Lexapro (antidepressant) 5 mg daily as one of the medications listed. A review of psychiatric symptoms showed no depression, no anxiety, and no panic attacks. The assessment and plan section showed the resident with depressive disorder recurrent eurythmic (feeling of cheerfulness calmness) at this time. Resident 49 was on Lexapro daily. Review of Resident 49's Order Summary Report dated 12/12/ 24, showed the following physician orders: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 11/15/24, for antidepressants' common side effects: sedation, drowsiness, headache, decreased appetite; less common side effect: dry mouth blurred vision, urinary retention; rare side effects: extra pyramidal every shift - dated 11/15/24, to monitor episodes of depression as evidenced by verbalization of feeling depressed every shift - dated 11/15/24, for escitalopram oxalate (Lexapro) oral tablet 5 mg by mouth one time a day for depression manifested by verbalization of feeling depressed Review of Resident 49's care plan revised 11/16/24, showed a care plan problem addressing the use of the antidepressant medications related to depression manifested by verbalization of feeling depressed. The interventions including for non- pharmacological interventions were as follows: done back rub, redirections, speak to/approach in a calm manner reposition/offer snacks/ encourage to express feelings, take to activities, provide reassurance, and frequent family visits. On 12/16/24 at 1124 hours, a concurrent interview and medical record review was conducted with LVN 8. LVN 8 reviewed Resident 49's orders related to Lexapro use and was unable to show the non-pharmacological interventions were implemented and monitored for the effectiveness in the physician's order, nurses notes, or MAR. LVN 8 acknowledged there was no documentation of the implementation of non-pharmacological interventions. On 12/17/24 at 0902 hours, an interview was conducted with the DON. The DON verified the above findings and acknowledged there was no documentation of nonpharmacological interventions in place for the use of the Lexapro medication.

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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 - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 19.35%. One of three licensed nurses (LVN 4) observed during the medication administration was found to have made errors. * LVN 4 failed to ensure the full dosages for six of eight prescribed medications were administered to Resident 8 as per the physician's orders. This failure had the potential to negatively affect the residents' health. Findings: On 12/11/24 at 0755 hours, during a medication administration observation, LVN 4 administered the following medications to Resident 8 via GT: - aspirin (nonsteroidal anti-inflammatory drug) 81 mg - Cozaar (antihypertensive medication) 50 mg - demeclocycline hcl (antibiotic medication) 150 mg one tablet - Azithromycin (antibiotic medication) 250 mg one tablet - cyanocobalamin (vitamin B 12 supplement medication) 1000 mcg one tablet - multivitamins with minerals (supplement medication) one tablet - acetaminophen (analgesic medication) 325 mg two tablets - sodium chloride tablets (supplement supplement) one tablet LVN 4 separately crushed the eight medications, placed them in a cup and individually labeled with the names of the medications. LVN 4 administered the medications individually via GT. After the administration, the medication cups used were inspected for medication residue with LVN 4. LVN 4 verified the medication cups for aspirin, demeclocycline, Azithromycin, vitamin B 12, multivitamins with minerals and acetaminophen still had medication residue. LVN 4 was asked if he administered all the medications, LVN 4 stated technically, no. Medical record review for Resident 8 was initiated on 12/11/24. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's Order Summary Report dated 12/12/24, showed the following physician's orders scheduled for 0900 hours: - dated 10/7/24, aspirin 81 mg give one tablet via GT one time a day (continued on next page)

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	055570	A. Building B. Wing	12/17/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 10/14/24, sodium chloride 1 gm one tablet via GT two times a day - dated 10/7/24, cyanocobalamin 1000 mcg one tablet via GT one time a day - dated 10/10/24, multivitamin one tablet via GT one time a day - dated 10/7/24, Cozaar (antihypertensive medication) 50 mg one tablet via GT one time a day - dated 12/9/24, Azithromycin 250 mg one tablet by mouth one time a day - dated 10/20/24, demeclocycline hcl 150 mg one tablet via GT two times a day - dated 11/20/24, acetaminophen 325 mg two tablets via GT every four hours as needed On 12/17/24 at 0902 hours, an interview was conducted with the DON. The DON verified the above findings.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 50787 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the medications were properly labeled and stored safely. * The facility failed to ensure the single use dressing was discarded after use. * The facility failed to ensure the topical medication was accurately labeled in accordance with currently accepted professional principles, including the expiration date. These failures had the potential to negatively impact the residents' well being. Findings: 1. Review of the facility's P&P titled Medication Access and Storage revised 2/2019 showed in part, the contaminated medications, or those without secure closures are immediately removed from stock .the provider pharmacy dispenses medications in containers that meet the legal requirements including requirements of good manufacturing practices where applicable. On 12/12/24 at 0757 hours, a concurrent inspection of the treatment cart and interview was conducted with LVN 2. An opened package of Puracol (used for wound management) wound dressing was observed inside the treatment cart with a small cut out piece of the wound dressing. The Puracol dressing package's description showed it was a single use only dressing. LVN 2 stated if they only needed a small piece, the remaining dressing was placed in a storage bag, dated, and used within 24 hours. LVN 2 verified the package was a single time use and confirmed the finding. 2. Review of the facility's P&P titled Administration of Medications, and Fluids, Intravenous revised 12/2019 showed the expiration date of the solution/medications should be ascertained prior to administration. On 12/12/24 at 0757 hours, a concurrent inspection of the treatment cart inspection and interview was conducted with LVN 2. The treatment cart had a 16 ounce jar of zinc oxide skin protectant (skin treatment) with no information of the expiration date. LVN 2 verified the zinc oxide jar did not have an expiration date, and discarded the jar. On 12/17/24 at 0902 hours, an interview was conducted with the DON. The DON verified the above findings.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on interview, medical record review, and facility P&P review, the facility failed to ensure two of 16 final sampled residents (Residents 456 and 904) had accurate and complete medical records. * The facility failed to ensure the information on Resident 456's POLST was accurate and updated. * The facility failed to ensure Resident 904's TAR documentation regarding multiple wound treatment orders were completed. These failures had the potential for the residents' health care needs to not be met as the medical record was incomplete and inaccurate. Findings: Review of the facility's P&P titled Documentation (undated) showed the resident's clinical record is a concise and accurate account of treatment, care, response to care, signs, symptoms, and progress of the resident's condition. 1. Medical record review for Resident 456 was initiated on 12/12/24. Resident 456 was admitted to the facility on [DATE]. Review of Resident 456's H&P examination dated 11/30/24, showed the resident had the capacity to understand and make decisions. Review of Resident 456's POLST dated 11/29/24, showed under Section D, no advance directive. Review of Resident 456's Progress Note dated 12/2/24, showed Resident 456 had an existing advance directive but did not have a copy at this time. The documentation showed Resident 456's family member would check their records if a copy was available. Reviewed of Resident 456's IDT Care Plan Review Note dated 12/4/24, showed the SSD would follow up with the resident's family member regarding Resident 456's existing advance directive, no available copy at this time. On 12/12/24 at 1435 hours, a concurrent interview and medical record review was conducted with the SSD. The SSD verified Resident 456's POLST was not updated and showed the resident did not have an advanced directive. The SSD stated the POLST should have been updated. 50967 2. Medical record review for Resident 904 was initiated on 12/17/24. Resident 904 was admitted to the facility on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 904's Order Summary Report dated 12/12/24, showed the following physician's orders dated 12/7/24: - left foot third digit unstageable pressure injury: cleanse with normal saline, pat dry, paint with betadine solution (a topical antiseptic that provides infection protection against a variety of germs for minor cuts, scrapes, and burns), and leave open to air every day shift for 30 days; - left foot fourth digit unstageable pressure injury: cleanse with normal saline, pat dry, paint with betadine solution, and leave open to air every day shift for 30 days; - left hand skin tear: cleanse with normal saline, pat dry, apply Triple antibiotic ointment, and cover with a dry dressing every day shift for 21 days; - left lateral aspect of forearm skin tear with periwound staining: cleanse with normal saline, pat dry, apply Triple antibiotic ointment, and cover with a dry dressing every day shift for 21 days; - right forearm skin tear with periwound staining, to cleanse with normal saline, pat dry, apply Triple antibiotic ointment, and cover with a dry dressing every day shift for 21 days; - right groin fold open wound: cleanse with normal saline, pat dry, apply Medihoney (a medical-grade wound care product made from honey and used to treat wounds and burns), and cover with a dry dressing every day shift for 21 days; and - Stage 2 sacrococcyx pressure injury: cleanse with normal saline, pat dry, apply hydrogel (a non-ionic/neutral gel used to treat all types and stages of wounds), and cover with a foam dressing every day shift for 21 days. On 12/17/24 at 0901 hours, a concurrent interview and medical record review was conducted with LVN 7. Resident 904's TAR for December 2024 was reviewed with LVN 7. LVN 7 verified missing initials by the nurses to show the wound care treatments were provided to Resident 904 on the following dates: - 12/8, 12/9, and 12/14/24, for the left foot third digit unstageable pressure injury; - 12/8, 12/9, and 12/14/24, for the left foot fourth digit unstageable pressure injury; - 12/8 and 12/9/24, for the left hand skin tear; - 12/7 to 12/11/24, for the left lateral aspect of forearm skin tear with periwound staining; - 12/7 to 12/11/24, for the right forearm skin tear; - 12/8 and 12/9/24, for the right groin fold; and - 12/8 and 12/9/24, for the Stage 2 sacrococcyx pressure injury. On 12/17/24 at 0928 hours, an interview with the DON was conducted. The DON stated the licensed nurses must document after any ordered treatments were provided. The DON was informed and acknowledged the above findings. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/24 at 1040 hours, a concurrent interview and medical record review with LVN 2 was conducted. LVN 2 verified and stated she provided the treatment on 12/14/24, for Resident 904's left foot third and fourth digit unstageable pressure injury; however, she did not document that the wound care was provided to the resident as ordered. In addition, LVN 2 stated she must document after the wound care treatments were performed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46787 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection control practices to help prevent the development and transmission of diseases and infections. * The facility failed to follow their water management program to regularly test water temperatures as per the facility's P&P. * The facility failed to ensure the staff performed hand hygiene as per the facility's P&P. * The facility failed to ensure the best practice was performed for infection prevention and control when an antibiotic vial was not disinfected prior connecting the intravenous solution to the antibiotic vial. * The facility failed to ensure the staff performed hand hygiene after removing gloves between resident care. These failures had the potential for increased risk of infections and compromising the residents' medical conditions. Findings: 1. According to the CMS QSO 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease dated 6/2/17, the facility must develop and adhere to the policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. These facilities must have water management plans and documentation that, at a minimum, ensure each facility: - Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system; - Develops and implements a water management program that considers the ASHRAE industry standards and the CDC toolkit; and - Specifies testing protocols and acceptable rangers for control measures and documents the results of testing and corrective actions when control limits are not maintained. Review of the facility's P&P titled Legionella Water Management Program revised 10/2024 showed the purpose of the policy is to provide identification of areas that could be potential to develop legionella and minimize risk associated with bacteria and organisms in water supply. The Building Description section showed hot water is heated for resident rooms, showers, and nurse's stations to 105 to 120 degrees Fahrenheit. The Monitoring Control Measures section showed the sinks and showers will maintain appropriate temperatures. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Water Temperature revised 12/2022 showed it is the policy of the facility to monitor and measure water temperatures and make sure the temperatures are maintained within desired ranges. Resident rooms/common areas are to be checked monthly, more frequently when indicated. Review of facility's documents failed to show documented evidence the water temperatures throughout the facility were tested monthly as per the facility's P&P. On 12/17/24 at 0747 hours, a concurrent interview and facility document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor acknowledged and verified the above findings. On 12/17/24 at 1010 hours, an interview was conducted with the Administrator. The Administrator acknowledged the above findings. 49644 2. Review of the facility's P&P titled Infection Control Prevention and Control Program - Hand Hygiene (undated) showed this facility considers hand hygiene the primary means to prevent the spread of infections. Use of an alcohol-based hand-rub; or, alternatively, soap (antimicrobial or non-antimicrobial) and water after removing gloves .the use of alcohol-based hand rub; or alternatively soap and water for the following situations including, before and after handling medications and after handling contaminated equipment, etc wash hands with soap and water to prevent the spread of infections. a. On 12/13/24 at 1039 hours, during the wound treatment observation, LVN 2 was wearing a gown, performing hand hygiene, donning the gloves, sanitizing Resident 50's side table, and removing the gloves. LVN 2 did not perform hand hygiene after removing the gloves. On 12/13/24 at 1045 hours, an interview was conducted with LVN 2. LVN 2 verified she did not perform hand hygiene after removing her gloves. LVN 2 stated she should have performed the hand hygiene to prevent cross contamination and spread of infection. On 12/13/24 at 1416 hours, an interview was conducted with the IP. The IP stated the infection could spread from the staff' member's hand if the handwashing was not done after removing the gloves. On 12/17/24 at 0933 hours, an interview was conducted with the DON. The DON acknowledged the above findings. 50787 b. On 12/11/24 at 0755 hours, during a medication administration observation with LVN 4, LVN 4 was preparing the medications to administer to a resident. While preparing the mediations, a sharpie fell on the floor. LVN 4 picked up the sharpie, placed it on top of the medication cart, and proceeded with the medication preparation without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. On 12/11/24 at 0927 hours, during a medication administration observation with LVN 4, LVN 4 sanitized the blood pressure machine and stethoscope using Sani cloth with gloves on. LVN 4 removed his gloves, used the computer, then continued preparing the medications for a resident. LVN 4 did not perform a hand hygiene. d. On 12/11/24 at 0927 hours, LVN 4 finished administering medications to a resident. LVN 4 washed his hands, turned off the faucet with his newly washed hands and proceeded to dry his hands with paper. On 2/11/24 at 1520 hours, an interview was conducted with LVN 4. LVN 4 verified and acknowledged the above findings. 3. Review of the CDC Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated 4/20/24, showed under standard precautions 5c. Injection and Medication Safety Reerences and Resources to disinfect the access diaphragms of medication vials before inserting a device into the vial. On 12/11/24 at 1433 hours, RN 1 was observed preparing IV medication, ceftriaxone sodium (antibiotic medication) 1 gm to be mixed with dextrose 5% solution 50 ml. During the medication preparation, RN 1 was observed disinfecting the IV tubing and connected it to the dextrose 5% IV solution bag. RN 1 failed to disinfect the ceftriaxone vial prior to connecting to the dextrose 5 % solution bag. On 12/13/24 at 1049 hours, an interview was conducted with RN 1. RN 1 confirmed the above findings and stated she was trained by the supervisor to disinfect the top of the vial prior to connecting to the solution to prevent the contaminants from ending up in the medication inside the vial. On 12/17/24 at 0902 hours, an interview was conducted with the DON. The DON verified all of the above findings. 50953 4. On 12/11/24 at 1036 hours, during an initial tour of the facility, CNA 8 was observed taking care of Resident 49. CNA 8 removed her gloves after taking care of Resident 49 and put on a new pair of gloves without performing a hand hygiene. CNA 8 proceeded to take care of another resident. On 12/11/24 at 1101 hours, an interview was conducted with CNA 8. CNA 8 acknowledged she did not perform hand washing after providing care for Resident 49. On 12/16/24 at 0843 hours, an interview was conducted with the DSD. The DSD stated all staff needed to perform handwashing before and after removing gloves and when taking care of one resident to another. On 12/17/24 at 1035 hours, an interview was conducted with the DON. The DON was informed and acknowledged above findings.