

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/31/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055983	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Coventry Court Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2040 S. Euclid Avenue Anaheim, CA 92802	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview and medical record review, the facility failed to obtain the informed consent for the use of psychotropic medication (medications affecting brain activity) for one of five final sampled residents (Resident 37) reviewed for unnecessary medications. * The facility failed to ensure an informed consent was obtained when alprazolam (antianxiety medication) was prescribed for an extended period for Resident 37. This failure posed the risk for Resident 37 and her responsible party to not be informed of the potential risks and benefits of the alprazolam medication. Findings: According to AFL 24-7 titled Assembly [NAME] (AB) 48 - Nursing Facility Resident Informed Consent Protection Act of 2023 dated 2/28/24, with an effective date of 1/1/24, the facilities must obtain a resident's written informed consent for treatment using psychotherapeutic drugs. Medical record review for Resident 37 was initiated on 7/29/24. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 37's Progress Notes - H&P Note dated 5/6/24, showed Resident 37 did not have the capacity to understand and make decisions. Review of Resident 37's Order Summary Report dated 7/31/24, showed a physician's order dated 7/22/24, to administer alprazolam 0.5 mg every six hours as needed for anxiety manifested by restlessness for 30 days. Further review of Resident 37's medical record did not show an informed consent for the use of alprazolam medication. On 7/31/24 at 1305 hours, an interview and concurrent medical record review for Resident 37 was conducted with RN 2. When asked about the informed consent for the use of the alprazolam medications, RN 2 reviewed Resident 37's medical record and was unable to find documentation the informed consent was obtained from Resident 37's responsible party for the use of the alprazolam medication. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055983	Facility ID: 055983 If continuation sheet Page 1 of 57

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 1009 hours, an interview and concurrent medical record review for Resident 37 was conducted with the DON. The DON was informed and verified the findings. The DON stated when a resident had a physician's order for a psychotropic medication, the physician should educate the resident or their responsible party regarding the medication's purpose, risks, and side effects. The resident or responsible party would sign the informed consent form which was a paper document to show they agreed and understood the treatment plan for the use of the psychotropic medication.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on interview, medical record review, and facility P&P review, the facility failed to provide and document in the medical record the information regarding their rights to formulate the advance directives and to ensure the POLST was accurate for three of 20 final sampled residents (Residents 2, 54, and 74). * Resident 2's POLST showed DNR status; however, the resident's medical record showed full code status. * Resident 74's responsible party had not been provided the information regarding their rights to formulate the advance directive. * Resident 54's POLST and code status did not match the resident's advance directive. These failures had the potential for the residents' decisions regarding their healthcare and treatment options not being honored. Findings: Review of the facility's P&P titled Advance Directives and Associated Documentation revised ,d+[DATE] showed it is the policy of the facility to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, to formulate an advance directive. Prior to, upon, or immediately after admission, a facility staff member shall provide the resident/family or responsible agent written information, in a manner easily understood by the resident or resident representative, regarding the right to formulate an advance directive. Document in the resident health record that, at the time of admission, the resident representative has been provided with written information regarding advance directives. Advance care planning will occur periodically to review the advance directive and/or preferences regarding treatment options with the resident or their representative to ensure they are still the wishes of the resident. Such reviews will be made during the assessment process and recorded in the medical record. 1. Medical record review for Resident 2 was initiated on [DATE]. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's H&P examination dated [DATE], showed Resident 2 did not have the capacity to understand and make decisions. Review of Resident 2's POLST dated [DATE], showed Resident 2's code status was DNR. Review of Resident 2's Order Summary Report dated active as of [DATE], showed a physician's order dated [DATE], for code status: DNR, comfort focused treatment, long term artificial nutrition including feeding tubes. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Social Services Assessment/Evaluation dated [DATE], showed full code status. On [DATE] at 0935 hours, an interview and concurrent medical record review was conducted with the SSA. The SSA stated the social services department was in charge of making sure the residents' POLSTs were accurate and reflect the current wishes of the residents or their representatives. The SSA stated the POLST in the residents' physical charts should reflect the current wishes of the residents or their representatives. The SSA verified Resident 2's POLST showed DNR; however, the social services assessment showed full code status. 2. Medical record review for Resident 74 was initiated on [DATE]. Resident 74 was admitted to the facility on [DATE]. Review of Resident 74's H&P examination dated [DATE], showed Resident 74 did not have the capacity to understand and make decisions. Review of Resident 74's POLST dated [DATE], showed Resident 74 did not have an advance directive. Review of Resident 74's Social Services Assessment/Evaluation dated [DATE], showed Resident 74 did not have an advance directive. Further review of Resident 74's medical record failed to show evidence Resident 74's representative was informed of their right to formulate an advance directive. On [DATE] at 0818 hours, an interview and concurrent medical record review was conducted with the SSA. The SSA verified Resident 74's representative was not informed of their right to formulate an advance directive. 48882 3. Medical record review for Resident 54 was initiated on [DATE]. Resident 54 was admitted to the facility on [DATE]. Review of Resident 54's H&P examination dated [DATE], showed Resident 54 had the capacity to understand and make decisions. Review of Resident 54's POLST dated [DATE], showed Resident 54 wanted CPR and full treatment to be done if the resident was found without a pulse and/or breathing. The section for Artificially Administered Nutrition showed no artificial means of nutrition, including feeding tubes was selected. Further review of the POLST showed Resident 54 had no advanced directive. Review of Resident 54's Advance Health Care Directive dated [DATE], under Part 2: Instructions for Health Care showed choice to prolong life was selected. Review of Resident 54's Social Services Assessment/Evaluation - V1 dated [DATE], showed Resident 54 had no advance directive. Review of Resident 54's MDS dated [DATE], Section S showed Resident 54 had no advance directive. (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 54's H&P examination dated [DATE], showed Resident 54 was not able to make all his needs known and could not make his own decisions. Review of Resident 54's Order Summary Report dated [DATE], showed a physician's order dated [DATE], for Resident 54's code status, full treatment with no artificial means of nutrition including feeding tubes. On [DATE] at 0835 hours, an interview was conducted with the Social Services Assistant and Social Services Resource Personnel. The Social Services Assistant verified the above findings. The Social Services Assistant verified Resident 54's code status did not match his Advance Directive wishes. On [DATE] at 1000 hours, an interview was conducted with the Social Services Resource Personnel. The Social Services Resource Personnel stated she spoke with Resident 54's family member to clarify the resident's advance directive. The Social Services Resource Personnel stated Resident 54's family member stated she wished to prolong life and to initiate feedings. On [DATE] at 1334 hours, an interview and concurrent medical record review for Resident 54 was conducted with the DON. The DON stated Resident 54's advance directive did not match his POLST. The DON was informed and acknowledged 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** 46787 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 20 final sampled residents (Resident 2) was free from the physical restraints. * The facility failed to obtain the informed consent and the restraint assessment was conducted prior to applying a compression glove (helps provide support, relief and recovery from sore muscles and painful joint stiffness in the wrists, palms, and fingers. It also helps to push the excess fluid out of the hand) on Resident 2's right hand. This failure posed the risk of compromising the resident's independence and psychosocial well-being. Findings: Review of the facility's P&P titled Restraint, Physical revised 2/2023 showed physical restraints for behavior control shall only be used with a written order designed to lead to a less restrictive way of managing, and ultimately elimination of, the behavior for which the restraint is applied. If it is determined that a resident requires the use of a restraint, a thorough assessment will be performed by the licensed nurse and documented in the resident's clinical record. Any resident using a physical restraint must have a documentation in the clinical chart that identifies the risks/benefits of the restraint. On 7/29/24 at 0815, 1230, 1415, and 1442 hours, Resident 2 was observed lying in bed with a compression glove on his right hand, with the right thumb fully covered with the glove and the rest of the fingers were exposed. Medical record review for Resident 2 was initiated on 7/29/24. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 2's H&P examination dated 7/24/23, showed Resident 2 did not have the capacity to understand and make decisions. Review of Resident 2's Order Summary Report showed a physician's order dated 7/29/24, for the resident will tolerate wearing glove to right hand for 1-2 hours in moments when feeling uncomfortable or when increase thumb sucking occurs in order to decrease thumb sucking behaviors and decrease risk for skin breakdown assessing skin prior to and post compression glove application to ensure skin integrity. Review of Resident 2's medical record failed to show documentation an informed consent was obtained prior to applying the compression glove on the right hand. Review of Resident 2's medical record failed to show documentation a restraint assessment was conducted prior to applying the compression glove on the right hand. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/29/24 at 1415 hours, an observation and concurrent interview with LVN 1 was conducted. LVN 1 verified Resident 2 should only be wearing the compression glove for one to two hours. LVN 1 stated she did not apply the compression glove for Resident 2 and she did not consider it as a restraint. On 7/29/24 at 1442 hours, an observation and concurrent interview with the OT was conducted. The OT verified Resident 2 should only be wearing the compression glove on the right hand for one to two hours. The OT stated she did not apply the compression glove for Resident 2. The OT stated the rehabilitation department was in charge of applying and removing the compression glove. The OT verified the compression glove was used to control Resident 2's thumb-sucking behaviors. The OT stated she did not consider the compression glove as a restraint.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on interview, medical record review, and facility P&P review, the facility failed to report the allegation of sexual abuse between two nonsampled residents (Residents 19 and 21) to the CDPH L&C and LTC Ombudsman Programs as per the facility's P&P. This failure had the potential for the residents to be vulnerable for further abuse. Findings: Review of the facility's P&P titled Abuse: Prevention of and Prohibition Against dated 10/2022 showed if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law. The Administrator or the individual making the allegation immediately reports his or her suspicion to the appropriate State or Federal agencies in the applicable timeframes. On 7/31/24 at 0901 hours, the CDPH, L&C Program received the OSLTCO S223 form dated 7/31/24, regarding Resident 19's family member complaint about Resident 21 exposed himself and did a sexual act in the bathroom. Resident 19's family member reported the sexual abuse incident to the facility's staff. a. Medical record review for Resident 19 was initiated on 7/31/24. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's H&P examination dated 3/1/24, showed Resident 19 was oriented to self. b. Medical record review for Resident 21 was initiated on 7/31/24. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's H&P examination dated 4/5/24, showed Resident 21 was alert. On 7/31/24 at 1048 hours, and interview was conducted with Family Member 1. Family Member 1 stated Resident 19 informed him about the inappropriate sexual behavior of Resident 21. Family Member 1 stated he reported to the charge nurse on Sunday 7/28/24, who was taking care of Resident 19. Family Member 1 further stated on Monday morning, 7/29/24, he informed the PT who worked with Resident 19 about the inappropriate sexual behavior of Resident 21. On 7/31/24 at 1306 hours, an interview for Residents 19 and 21 was conducted with CNA 5. CNA 5 stated Resident 19 was alert and understand what he was asked, not confused, and not speaking English language. CNA 5 stated Resident 21 was alert but with confusion and speak Spanish language only. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 1356 hours, an interview was conducted with the PTA. The PTA stated he spoke to Resident 19's family member on Monday and was informed about the inappropriate sexual behavior on one of the residents. The PTA stated and acknowledged he forgot to report right away about the allegation of sexual abuse. The PTA stated he reported the incident of allegation of abuse the following morning to the Administrator. On 7/31/24 at 1623 hours, an interview was conducted with the Administrator. The Administrator verified he was the abuse coordinator of the facility. The Administrator was asked when he became aware about the incident of allegation of sexual abuse. The Administrator stated he was made aware by the Ombudsman and the DON about the allegation of sexual abuse on 7/30/24 at 1509 hours. The Administrator acknowledged the allegation of sexual abuse report was late. On 8/1/24 at 0957 hours, a telephone interview was conducted with LVN 8. LVN 8 stated she was made aware by Resident 19's family member about the resident incident of other resident inappropriate sexual behavior. LVN 8 stated she reported the allegation of sexual abuse to her supervisor. On 8/1/24 at 1023 hours, a telephone interview was conducted with LVN 9. LVN 9 stated she was made aware about the resident incident by the family member. LVN 9 stated she reported to the DON on that Sunday afternoon about the information the resident family member provided to her and stated she spoke to the DON via telephone. LVN 9 stated she put the information in the communication for other nurses to monitor the resident and as well as the alleged resident. On 8/1/24 at 1047 hours, an interview was conducted with the DON. The DON acknowledged she received a report from the licensed nurse, but the information was very vague and not clear on what was going on and not a concern to investigate. The DON was informed of the above findings and verified the findings.		

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46787 Based on interview and medical record review, the facility failed to ensure the MDS for one of 20 final sampled residents (Resident 61) and one of three closed sampled records (Resident 487) were accurate. * Resident 487's fall was not identified on the MDS. * Resident 61 use of the chair and bed alarm was not identified in the MDS. These failures posed the risk of Residents 61 and 487 not being provided the necessary care to meet their specific needs. Findings: 1. Closed medical record review for Resident 487 was initiated on 7/29/24. Resident 487 was admitted to the facility on [DATE], and discharged to the acute care hospital on 7/11/24. Review of Resident 487's H&P examination dated 7/8/24, showed Resident 487 had fluctuating capacity to understand and make decisions. Review of Resident 487's Order Summary Report dated 7/6/24 to 7/12/24, showed a physician's order to send the resident via 911 for evaluation status post fall. Review of Resident 487's MDS dated [DATE], showed under Section J - Health Conditions, Resident 487 had any falls since admission was coded 0, indicating the resident had no falls. On 7/31/24 at 1447 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings and acknowledged the MDS was completed inaccurately. 39670 2. Medical record review for Resident 61 was initiated on 7/31/24. Resident 61 was admitted to the facility on [DATE]. Review of Resident 61's Order Summary Report dated 7/31/24, showed a physician's order dated 3/14/24, to apply a pressure pad alarm in bed and wheelchair due to poor safety awareness every shift. Review of Resident 61's plan of care addressing the risk for Resident 61's of fall dated 3/14/24, showed interventions included the use of a bed alarm in bed and wheelchair. Review of Resident 61's MDS dated [DATE], showed under Section P - Restraints and Alarms, Resident 61 use of the chair and bed alarm was coded 0, indicating not used. (continued on next page)		

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	On 8/1/24 at 0822 hours, an interview and concurrent medical record review for Resident 61 was conducted with the MDS Coordinator. The MDS Coordinator verified Resident 61's physician's order for the bed alarm and with a plan of care. The MDS verified and stated the use of the bed alarm was not coded in the MDS because the alarm was not considered a restraint. On 8/1/24 at 1335 hours, an interview and concurrent medical record review for Resident 61 was conducted with the DON. The DON was informed and verified the 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** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was implemented to reflect the individual care needs for one of 20 final sampled residents (Resident 54). * The facility failed to ensure Resident 54's left 1/2 (half) side rail was elevated as an enabler as per the care plan. This failure had the potential for Resident 54 to not be provided with appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Comprehensive Resident Centered Care Plan revised 1/2021 showed the IDT shall develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. Medical record review for Resident 54 was initiated on 7/29/24. Resident 54 was admitted to the facility on [DATE], with a diagnosis of hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the left non- dominant side. Review of Resident 54's quarterly MDS dated [DATE], showed Resident 54's BIMS score was 12, moderately impaired cognition. The MDS showed Resident 54 had an impairment on one side for both upper and lower extremities functional limitation. The MDS also showed Resident 54 required substantial to maximal assistance where the helper would do more than half the effort for rolling from left to right in bed. Review of Resident 54's Order Summary Report dated 7/31/24, showed a physician's order dated 5/16/24, to apply the left 1/2 side rail for bed mobility. Review of Resident 54's plan of care showed a care plan problem initiated on 6/4/24, addressing Resident 54's use of the left 1/2 side rail as an enabler. On 7/31/24 at 0813 hours, Resident 54 was observed lying in bed with the right 1/2 side rail elevated instead of the left side rail. On 7/31/24 at 0817 hours, an interview as conducted with CNA 11. CNA 11 stated Resident 54 was unable to lift his left shoulder and required assistance with repositioning. Concurrent observation of Resident 54 was conducted with CNA 11. CNA 11 verified Resident 54's right 1/2 side rail was elevated. CNA 11 stated Resident 54 used his right arm to grab the right side rail during care and for repositioning, to pull himself up in bed. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 1316 hours, an interview was conducted with LVN 7. LVN 7 stated Resident 54 had hemiplegia and weakness affecting his left side for both upper and lower extremities. LVN 7 stated Resident 54 used the left side rail during care and was unable to grab the right side rail with his left hand during care, due to his left-sided weakness. An observation and concurrent record review for Resident 54 was conducted with LVN 7. LVN 7 verified Resident 54 had a physician order for the left 1/2 side rail and verified Resident 54's right 1/2 side rail was elevated, with no side rails on the left side. On 8/1/24 at 1410 hours, the Administrator and DON were informed and acknowledged the above findings.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on interview and medical record review, the facility failed to provide the services to attain or maintain the highest practicable well-being for one of five sampled residents (Resident 69) reviewed for unnecessary medications. * Resident 69 was administered midodrine (antihypotensive medication used to treat low blood pressure) medication when Resident 69's systolic blood pressure was above the parameter prescribed by the physician. This failure had the potential to negatively affect Resident 69's health condition and well-being. Findings: Medical record review for Resident 69 was initiated on 7/29/24. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's Order Summary Report showed a physician's order dated 4/26/24, to administer midodrine 2.5 mg one tablet by mouth every eight hours for hypotension; and to hold if systolic blood pressure more than 120 mmHg. Review of Resident 69's MAR for July 2024 showed Resident 69 was administered the midodrine medication when the resident's systolic blood pressure was above 120 mmHg as follows: - On 7/2/24 at 2200 hours, a blood pressure of 128/70 mmHg; - On 7/3/24 at 2200 hours, a blood pressure of 121/70 mmHg; - On 7/4/24 at 2200 hours, a blood pressure of 122/70 mmHg; - On 7/9/24 at 2200 hours, a blood pressure of 122/66 mmHg; - On 7/12/24 at 2200 hours, a blood pressure of 132/70 mmHg; - On 7/13/24 at 2200 hours, a blood pressure of 134/60 mmHg; - On 7/15/24 at 2200 hours, a blood pressure of 126/84 mmHg; - On 7/20/24 at 2200 hours, a blood pressure of 132/68 mmHg; - On 7/21/24 at 2200 hours, a blood pressure of 122/70 mmHg; and - On 7/30/24 at 0600 hours, a blood pressure of 132/74 mmHg. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 1334 hours, an interview and concurrent medical record review for Resident 9 was conducted with RN 2. RN 2 stated when a checkmark was indicated on the MAR, it meant the medication was administered by the nurses. RN 2 verified the midodrine medication was administered to Resident 69 when the resident's systolic blood pressure was above the parameter prescribed by the physician. On 8/1/24 at 1015 hours, an interview and concurrent medical record review for Resident 69 was conducted with the DON. The DON was informed and verified the above findings. The DON stated the nurses should have held the midodrine medication when Resident 69's systolic blood pressure was above 120 mmHg.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure one of one final sampled resident (Resident 28) and two nonsampled residents (Residents 21 and 47) reviewed for Wander Guard use were remained free from the accident hazards. * The facility failed to monitor the Wander Guard for functionality for Residents 21, 28, and 47. This failure had the potential to place the residents at risk for serious injuries and posed the risk for not having accurate information documented to prevent further accidents and or injuries to the residents. Findings: Review of the facility's P&P titled Wander System Monitoring Program dated 1/2023 showed the residents identified to be at risk for wandering will be evaluated for a wander-monitoring device. Each monitoring device will be tested for placement and function per manufacturers recommendation. According to the Wander Guard Universal Tester Operating Instructions (undated), to test the bracelets daily as detailed in the instructions. Failure to test daily could result in injury to or death to a person. 1. Medical record review for Resident 28 was initiated on 7/31/24. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's Elopement/Wandering Evaluation dated 7/11/24, showed Resident 28 was evaluated as a high risk of elopement. Review of Resident 28's plan of care addressing the risk for injury related for elopement dated 7/13/24, showed the interventions included for the Wander Guard as ordered and to monitor for the placement and functionality. On 7/31/24 at 0827 hours, an interview for Resident 28 was conducted with CNA 6. CNA 6 stated Resident 28 had an episode of getting out in the back door and a staff saw him right away and redirected. CNA 6 stated Resident 28 had a wander guard on his right ankle. CNA 6 verified there was no attempt reported for Resident 28 getting out of the facility unassisted. 2. Medical record review for Resident 21 was initiated on 7/31/24. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's Order Summary Report dated 8/1/24, showed a physician's order dated 3/5/23, to monitor the placement and functionality of wander guard every shift, (+) if the device in place and functioning correctly, and (-) if not working and replaced. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 21's MAR for the month of July 2024 showed the initials of the licensed staff monitoring the placement and functioning of the wander guard. However, there were no information for (+) or (-) documented on the MAR as per the physician's order. On 8/1/24 at 0824 hours, an observation and concurrent interview was conducted with Resident 21. Resident 21 was observed in the wheelchair and able to propel himself in the hallway. When asked if he had any device on him, Resident 21 was able to show the Wander Guard on hid right ankle. 3. On 7/29/24 at 1119 hours, Resident 47 was sitting in his wheelchair and observed wih a wander guard device on his right forearm. Medical record review for Resident 47 was initiated on 7/29/24. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's Order Summary Report dated 8/1/24, showed a physician's order dated 7/18/23, to apply the Wander Guard to the resident's right wrist for safety and to alert the staff if the resident tries to get out of the facility unassisted. However, further review of the Order Summary report failed to show a physician's order to monitor the placement and functionality of the Wander Guard. Review of Resident 47's Elopement/Wandering Evaluation dated 5/30/24, showed Resident 47 was a high risk for elopement. On 8/1/24 at 0842 hours, an interview and concurrent medical record review for Residents 21, 28, and 47 was conducted with LVN 7. LVN 7 verified Residents 21, 28, and 47 had a Wander Guard placed due to an attempt going out of the facility unassisted. LVN 7 verified the monitoring of the Wander Guard for Residents 21, 28, and 47 were documented in the MAR. LVN 7 was asked on how the functioning of the Wander Guard was monitored, LVN 7 was not sure and asked the other staff. LVN 7 was able to show the Wander Guard tester device to check the functionality of the wander guard. LVN 7 stated the Maintenance Supervisor was checking the Wander Guard once a week. LVN 7 stated and acknowledged the monitoring of the functionality of the Wander Guard was not done. LVN 7 verified of the above findings. On 8/1/24 at 0848 hours, an interview and concurrent facility document review for Residents 21, 28, and 47 was conducted with Maintenance Supervisor. The Maintenance Supervisor stated he was responsible for checking the Wander Guard function on the exit doors of the facility and was able to show the log of checking the functioning of the Wander Guard done weekly. The Maintenance Supervisor was asked if he was responsible for checking the functionality of the Wander Guard on the residents, the Maintenance Supervisor stated no and stated the licensed nurses should check everyday. The Maintenance Supervisor stated the licensed staff should have the Wander Guard Tester device for checking the functioning of the the Wander Guard and should be available in the medication cart or nurses station for the licensed nurse use. On 8/1/24 at 1338 hours, an interview and concurrent medical record review for Residents 21, 28, and 47 was conducted with the DON. The DON was informed and verified the above findings.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services to maintain the IV access for one of one final sampled resident reviewed for IV care (Resident 79). * The facility failed to ensure the initial PICC line external catheter measurement was documented in the medical record and failed to confirm baseline measurements of the PICC line external catheter and arm circumference measurements prior to administration of IV antibiotics. These failures had the potential to delay the identification of catheter related complications for this resident. Findings: On 7/29/24 at 0951 hours, Resident 79 was observed in bed with a PICC line to the right upper arm with a two-port external catheter. A transparent dressing dated 7/24/24, was observed on the PICC line site. When asked about the PICC line, Resident 79 stated the PICC line was inserted at the acute care hospital. Medical record review for Resident 79 was initiated on 7/29/24. Resident 79 was admitted to the facility on [DATE]. Review of the LN- Initial Admission Record dated 7/2/24, showed Resident 79 had a right upper extremity PICC line with two lumens. Review of the Admission Note dated 7/2/24, showed Resident 79 was noted with a two-lumen PICC line on the right upper arm. The right upper arm circumference was documented as 26 cm and external length was 1 cm. Review of Resident 79's IV MAR for July 2024 showed Resident 79 was administered daptomycin (antibiotic) 500 mg intravenously one time daily for MRSA Bacteremia from 7/3/24 to 7/30/31, at 0900 hours. Further review of the IV MAR showed Resident 79's PICC line arm circumference and external length were measured weekly with dressing changes on 7/3, 7/10, 7/17, and 7/24/24. The IV MAR showed Resident 79's arm circumference was 26 cm and the external length of the PICC was 32 cm. Review of Resident 79's medical record failed to show documented evidence of Resident 79's baseline arm circumference and external length measurements of the PICC line from the acute care hospital and failed to show the nurse had confirmed the baseline measurements of Resident 79's arm circumference and the PICC line external length measurement prior to use of the PICC line. (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 1116 hours, an interview and concurrent medical record review for Resident 79 was conducted with RN 2. RN 2 stated for the residents admitted to the facility with a PICC line, the RN was responsible for measuring the external length of the PICC from the insertion site to the tip of the lumen and documenting the number of lumens, the resident's arm circumference, and the external length measurements. RN 2 stated the RN would also compare the measurements with the reports from the acute care hospital. RN 2 was asked what the nurse should do if the hospital records did not show the resident's PICC line measurements. RN 2 stated the nurse would call the acute care hospital to verify the resident's baseline external length and arm circumference prior to using the PICC line due to the potential for PICC line dislodgement during the transfer from the acute care hospital to the facility. RN 2 stated once the nurse called the acute care hospital to confirm the measurements, the nurse would document the measurements in the resident's medical record and request for the acute care hospital to send the documents. Concurrent medical record review for Resident 79 was conducted with RN 2. RN 2 verified the above findings. On 8/1/24 at 1334 hours, an interview was conducted with the DON. The DON stated for the residents admitted with a PICC line, she expected staff to measure the arm circumference and the external length of the PICC line catheter and compare with the resident's baseline measurement from the acute care hospital records. The DON further stated if the measurements were not indicated on the acute care hospital records, she expected the nurse to inform the physician and to call the acute care hospital to confirm and document in the resident's medical records. On 8/1/24 at 1410 hours, the DON and Administrator were informed and acknowledged the above findings.		

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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** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the safe respiratory care for three of three final sampled residents (Resident 8, 50, and 61) and one nonsampled resident (Resident 687) reviewed for respiratory care. * The facility failed to ensure Resident 8's CPAP machine was cleaned as per the manufacturer's user cleaning guidelines. * The facility failed to ensure Resident 61's oxygen tubing was not touching the floor. * The facility failed to ensure Resident 50's nebulizer tubing was dated and mask was stored in a bag when not in use. * The facility failed to ensure Resident 687 was administered the oxygen as ordered by the physician. Additionally, the facility failed to ensure the nebulizer tubing and oxygen tubing were changed and labeled as per the facility's P&P. These failures had the potential to adversely affect the health, well-being, and posed the risk for equipment contamination and respiratory complications. Findings: 1. Review of the facility's P&P titled Care of BiPAP (Bilevel Positive Airway Pressure) and CPAP dated 2/2022 showed specific cleaning instruction guidelines are obtained from the manufacturer of the CPAP device. The components of the machine such as the masks, nasal pillows, tubing and headgear should be cleaned with a mild detergent daily and allow to airdry. Tubing is to be changed once a month or as needed. On 7/30/24 at 1127 hours, an interview was conducted with Resident 8. Resident 8 was in bed and Resident 8's bedside table was noted to have a CPAP (ResMed AirSence 10) machine which was turned off with the tubing and the mask on the clear plastic bag. Resident 8 was asked if he was using the CPAP machine regularly, Resident 8 stated yes. Resident 8 was asked if the staff regularly cleaned his CPAP machine and tubing. Resident 8 stated the facility staff cleaned the CPAP machine once a week, the mask and tubing every after use. Resident 8 stated he did not know when the last time the CPAP mask, tubing, and strap were last changed. Review of the ResMed AirSence 10 (CPAP machine) user guide (undated) showed under the caring for the device section to regularly clean the tubing assembly, water tub, and mask to prevent the growth of the germs that can adversely affect the health. Medical record review for Resident 8 was initiated on 7/30/24. Resident 8 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], showed Resident 8 was cognitively intact. Section O showed Resident 8 was coded for the use of oxygen and non-invasive machine. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 8's Order Summary Report dated 7/30/24, showed a physician's order dated 12/6/23, for the following care of the CPAP machine: - to wash CPAP humidified container with hot water and soap, leave open to air dry every day shift; and - to wipe down CPAP mask visible residue with wet washcloth and leave to air dry. On 7/30/24 at 1133 hours, an interview for Resident 8 was conducted with CNA 6. CNA 6 stated the treatment nurses were responsible for cleaning the CPAP mask, and had seen the licensed nurses cleaning the machine. CNA 6 verified Resident 8's use of the CPAP every night. On 7/30/24 at 1144 hours, an interview for Resident 8 was conducted with LVN 3. LVN 3 was the treatment nurse and stated she was responsible for cleaning Resident 8's CPAP machine daily. LVN 3 stated she did not know on how often the CPAP machine was cleaned. On 7/31/24 at 0913 hours, an interview and concurrent medical record review for Resident 8 was conducted with the DON. The DON was asked for the copy of the CPAP machine user guide/manual. The DON verified there was no copy of the CPAP machine manual. The DON verified and acknowledged the facility did not follow the care and maintenance of the CPAP machine per the manufacturers user guide. The DON stated the cleaning and maintenance of the CPAP machine should have been followed to prevent respiratory complication and functioning of the machine. 2. On 7/29/24 at 1003 hours, and 7/31/24 at 0905 hours, Resident 61 was observed wearing a nasal cannula attached to an oxygen machine with a setting of four liters per minute. The nasal cannula oxygen tubing was observed on the floor. An observation and concurrent interview with LVN 7 in Resident 61's room was conducted. LVN 7 verified the oxygen tubing was on the floor. LVN 7 stated the oxygen tubing should have been placed on a clear plastic bag to reduce the risk of infection. Medical record review for Resident 61 was initiated on 7/31/24. Resident 61 was admitted to the facility on [DATE]. Review of Resident 61's Order Summary dated 7/31/24, showed a physician's order dated 7/1/24, to administer oxygen via nasal cannula at 2 liters/min continuously to keep the resident's oxygen saturation level above 90%. On 8/1/24 at 1335 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. 50967 3. On 7/29/24 at 0951 hours, Resident 50 was observed lying in bed awake, confused, and verbally nonresponsive. Resident 50's nebulizer mask was observed on top of the nebulizer machine (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask), not stored in a bag and the nebulizer tubing was not dated. The ADON/IP verified Resident 50's nebulizer mask was not stored in a bag when not in use and the nebulizer tubing was not dated. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 50 was initiated on 7/31/24. Resident 50 was admitted to the facility on [DATE]. Review of Resident 50's Order Summary Report showed a physician's order dated 2/10/24, for Ipratropium-Albuterol (bronchodilator) Solution 0.5-2.5 (3) mg/3 ml 3 ml inhale orally every four hours as needed for SOB or wheezing via nebulizer. On 7/30/24 at 1125 hours, an interview was conducted with LVN 4. LVN 4 stated the nebulizer mask, tubing, and plastic bag should be changed and dated weekly and as needed. LVN 4 also stated the nebulizer mask and tubing should be stored in a plastic bag when not in use. On 8/1/24 at 1428 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 50787 4. Review of the facility's P&P titled Oxygen Administration (mask, cannula, catheter, use of humidifier) dated 12/2023 showed the following: - turn the unit (oxygen) on the desired flow rate and assess equipment for proper functioning; - oxygen tubing is to be replaced every seven days. Medical record review for Resident 687 was conducted on 7/31/24. Resident 687 was admitted to the facility on [DATE]. Review of Resident 687's Order Summary Report showed an order dated 7/25/24, for continuous oxygen at two liters per minute via nasal cannula to keep oxygen saturation level above 90% every shift. On 07/29/24 at 0853 hours, an observation was conducted of Resident 687's room. Resident 687 was sitting in bed receiving oxygen via nasal cannula at three liters per minute. The oxygen tubing was not labeled nor dated. The nebulizer machine was placed on the bedside dresser. The nebulizer tubing was hanging inside a plastic bag and was not dated or labeled. On 07/29/24 at 0919 hours, an observation and concurrent interview was conducted with the ADON/IP. The ADON/IP verified Resident 687 was receiving oxygen at three liters per minute . The ADON/IP further verified the oxygen tubing and nebulizer tubing were not labeled.		

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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** 39453 Based on interview and medical record review, the facility failed to provide the adequate and appropriate pain management for one of five final sampled residents (Resident 69) reviewed for unnecessary medication use. * The facility failed to ensure the pain medication was administered as per the physicians' orders for Resident 69. This failure had the potential for Resident 69 to not receive effective treatment for pain. Findings: Medical record review for Resident 69 was initiated on 7/29/24. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's Order Summary Report showed the following physician's orders: - dated 3/4/24, to administer acetaminophen (over the counter pain medication) 325 mg two tablets by mouth every four hours as needed for general discomfort for pain levels of 1-3 (on a 0-10 pain scale with 0 = no pain and 10= worst pain); - dated 4/9/24, to administer Norco (hydrocodone-acetaminophen, a narcotic analgesic medication) 5-325 mg one tablet by mouth every four hours as needed for moderate pain for pain levels of 4-6; and - dated 4/9/24, to administer hydrocodone-acetaminophen (same as Norco) 10-325 mg one tablet by mouth every four hours as needed for severe pain for pain levels of 7-10. Review of Resident 69's MAR for July 2024 showed Resident 69 was administered the Norco 5-325 mg medication on the following dates and times when the resident's pain level was not within the levels of 4-6 for Norco 5-325 mg as ordered: - On 7/1/24 at 0550 hours, Resident 69 was documented with a pain level of 7. - On 7/5/24 at 0420 hours, Resident 69 was documented with a pain level of 7. - On 7/9/24 at 0445 hours, Resident 69 was documented with a pain level of 7. - On 7/12/24 at 2305 hours, Resident 69 was documented with a pain level of 7. - On 7/15/24 at 2400 hours, Resident 69 was documented with a pain level of 7. - On 7/19/24 at 0510 and 2350 hours, Resident 69 was documented with a pain level of 7. - On 7/21/24 at 0420 hours, Resident 69 was documented with a pain level of 7. - On 7/22/24 at 0550 hours, Resident 69 was documented with a pain level of 7. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 7/26/24 at 0630 hours, Resident 69 was documented with a pain level of 7. - On 7/27/24 at 0600 hours, Resident 69 was documented with a pain level of 7. - On 7/28/24 at 0430 hours, Resident 69 was documented with a pain level of 7. - On 7/29/24 at 0420 hours, Resident 69 was documented with a pain level of 7. On 7/31/24 at 1334 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 was informed and verified the above findings.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure two of nine final sampled residents reviewed for side rail use (Residents 50 and 54) remained free from the accident hazards associated with the use of elevated side rails. * The facility failed to obtain a physician's order and informed consent and failed to conduct a side rail evaluation prior to the use of the right half side rail for Resident 54. * The facility failed to ensure the proper assessment for Resident 50 prior to the use of the side rails. These failures have the potential to put Residents 50 and 54 at risk for serious injuries. Findings: The FDA issued a Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails. Residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc. , that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. Review of the facility's P&P titled Bed Rails revised 12/2023 showed it is the policy of the facility to attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails. After the facility has attempted alternatives to bed rails and determined that these alternatives failed to meet the resident's assessed needs, the facility's IDT will assess the resident for risks of entrapment. The risk and benefits regarding the use of bed rails will be considered for each resident. If the use of bed rails is recommended by the IDT, the facility must obtain informed consent from the resident, or if applicable the resident representative for the use of bed rails prior to installation or use. The facility will check the resident bed and if used, bed rails regularly to verify they are still installed correctly, and connections are secure as rails may shift or loosen over time. The facility will update the resident care plan as needed related to the identified and/or ongoing need or resident choice for the use of bed rails. 1. On 7/31/24 at 0813 hours, Resident 54 was observed in bed with the right half side rail elevated. Medical record review for Resident 54 was initiated on 7/29/24. Resident 54 was admitted to the facility on [DATE], with a diagnosis of hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the left non-dominant side. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 54's MDS dated [DATE], showed Resident 54's had moderately impaired cognition and one-sided impairment for both upper and lower extremity functional limitation. The MDS also showed Resident 54 required substantial to maximal assistance, where the helper would do more than half the effort, for rolling from left to right in bed. Review of Resident 54's Order Summary Report dated 7/31/24, showed a physician's order dated 5/16/24, to apply the left half side rail for bed mobility. Review of Resident 54's Plan of Care showed a care plan problem initiated on 6/4/24, addressing Resident 54's use of the left half side rail as an enabler. Review of Resident 54's medical record showed an informed consent was obtained on 6/4/24, for the use of the left half side rail for bed mobility. Review of Resident 54's Bed Rail Safety Evaluation dated 5/16/24, under the equipment factors, showed the resident used the left half side rail for bed mobility. Review of Resident 54's LN-Restraint/Enabling Device/Safety Device Evaluation dated 5/16/24, showed the device recommended was the left half side rail for bed mobility. Further review of Resident 54's medical record failed to show the following: - a physician's order for the use of the right half side rail, - an informed consent for the use of the right half side rail, - a bed rail safety evaluation for the right half side rail prior to use, and - a care plan problem addressing the use of the right half side rail. On 7/31/24 at 1316 hours, an interview was conducted with LVN 7. LVN 7 stated Resident 54 had hemiplegia affecting his left side with left sided weakness to his upper and lower extremities. LVN 7 stated Resident 54 used the left side rail because he was unable to grab the right side rail with his left hand during care, due to his left sided weakness. An observation and concurrent record review for Resident 54 was conducted with LVN 7. LVN 7 verified Resident 54 had a physician order for the left half side rail and LVN 7 verified Resident 54's right half side rail was elevated, with no side rail observed on the left side of the bed. On 7/31/24 at 1340 hours, an interview and concurrent record review for Resident 54 was conducted with the DOR. The DOR stated the physical therapy was responsible for screening the residents for bed mobility when conducting the bed side rail evaluations. The Director of Rehab stated for the residents with left sided weakness and required assistance with positioning in bed, to pull himself up, the side rail should be on the right side, on the non-affected side. Concurrent record review of Resident 54's Bed Rail Safety Evaluation dated 5/16/24, was conducted with the Director of Rehab. The Director of Rehab verified the evaluation was for the left half side rail. (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 1334 hours, an interview was conducted with the DON. The DON was asked about the facility's policy for the use of the side rails. The DON stated after a physician's order was obtained, the facility's IDT would conduct a bed side rail assessment and obtain an informed consent; the maintenance would perform an entrapment assessment; and a care plan would be initiated. The DON stated if a resident was able to move on one side of the body, the IDT would determine which side of the bed for the side rail to be placed. Concurrent record review for Resident 54 was conducted with the DON. The DON verified the above findings. The DON stated the side rail should be placed to match the physician's order. On 8/1/24 at 1410 hours, the Administrator and DON were informed and acknowledged the findings. 50967 2. On 7/29/24 at 0951 hours, Resident 50 was observed lying in bed awake with bilateral half side rails elevated. Resident 50 was confused and nonverbal. Medical record review for Resident 50 was initiated on 7/31/24. Resident 50 was admitted to the facility on [DATE]. Review of Resident 50's H&P examination dated 2/16/24, showed Resident 50 had a history of CVA or stroke and cognitive communicative deficit. Review of Resident 50's Order Summary Report showed a physician's order dated 5/24/24, for bilateral half side rails for positioning and ease in mobility as an enabler. On 7/30/24 at 1047 hours, an interview was conducted with CNA 7. CNA 7 stated she provided total assistance with Resident 50's dressing, repositioning, and personal hygiene. CNA 7 also stated Resident 50 could move his arms up; however, Resident 50 could not grab the side rails to help turn or reposition. On 7/30/24 at 1125 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified Resident 50's bilateral half side rails were elevated. On 7/31/24 at 1402 hours, an interview conducted with LVN 6. LVN 6 stated that Resident 50 was nonverbal and dependent on the staff for ADL care. LVN 6 also stated Resident 50 could not grab the side rails during repositioning. Record review of Resident 50's MDS dated [DATE], under the section GG for mobility, showed Resident 50 was dependent for upper dressing, roll to the left and right, and sitting to lying. On 8/1/24 at 1428 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged 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** 39453 Based on interview and medical record review, the facility failed to ensure two of five final sampled residents (Residents 14 and 37) reviewed for unnecessary medications were free from the unnecessary psychotropic medications. * The facility failed to ensure the physician's documentation of the rationale for extending the use of alprazolam (antianxiety medication) beyond the 14-day duration for Resident 37. * The facility failed to monitor Resident 14 for signs of orthostatic hypotension for the use of antipsychotic medication. These failures had the potential to place Residents 14 and 37 at risk for receiving unnecessary medication and increased risk of serious adverse reactions from the medications. Findings: 1. Review of the FDA black box warning for alprazolam showed the continued use of benzodiazepines, including Xanax (brand name for alprazolam), may lead to clinically significant physical dependence. The risks of dependence and withdrawal increase with longer treatment duration and higher daily dose. Medical record review for Resident 37 was initiated on 7/29/24. Resident 37 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 37's Progress Notes - H&P Note dated 5/6/24, showed Resident 37 did not have the capacity to understand and make decisions. Review of Resident 37's MAR for July 2024 showed the following: -A physician's order dated 6/14/24, to administer alprazolam 0.5 mg one tablet every six hours as needed for anxiety for 21 days. This order was discontinued on 7/5/24. Resident 37 was administered six doses of alprazolam medication from 7/1 to 7/4/24; - A physician's order dated 7/5/24, to administer alprazolam 0.5 mg one tablet every six hours as needed for anxiety for 14 days. This order was discontinued on 7/19/24. Resident 37 was administered 21 doses of alprazolam medication from 7/5 to 7/18/24; and - A physician's order dated 7/22/24, to administer alprazolam 0.5 mg every six hours as needed for anxiety manifested by restlessness for 30 days. Resident 37 was administered 14 doses of alprazolam medication from 7/22 to 7/31/24. Further review of Resident 37's medical records failed to show documented evidence of physician's rationale for extending the use of alprazolam medication beyond the fourteen-day period. (continued on next page)		

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/31/24 at 1305 hours, an interview and concurrent medical record review for Resident 37 was conducted with RN 2. When asked about the physician's orders for the alprazolam medications, RN 2 reviewed Resident 37's medical record and was unable to find documentation of the physician's rationale for extending the use of alprazolam medication beyond the fourteen-day period. On 8/1/24 at 1009 hours, an interview and concurrent medical record review for Resident 37 was conducted with the DON. The DON was informed and verified the findings. Cross reference to F552. 50953 2. Review of the facility's P&P titled Psychotropic Drug Use dated 8/2017, showed the Licensed Nurses shall review the classification of the drug, the appropriateness of the diagnosis, its indication/behavior monitors and related adverse effects prior to verification of admission orders with the Attending Physician. Medical record review for Resident 14 was initiated on 7/30/2024. Resident 14 was admitted to the facility on [DATE], with diagnosis of anxiety, bipolar disorder and schizophrenia. Review of Resident 14's Order Summary Report dated 7/30/24, showed the following orders dated: - 2/20/24, quetiapine fumarate (antipsychotic) 25 mg one tablet by mouth at bedtime manifested by auditory hallucination as evidence by hearing voices not present related to other schizophrenia - 5/10/22, clonazepam (anxiety) 1 mg one tablet by mouth every 12 hours for anxiety disorder manifested by verbalization of feeling anxious Review of Resident 14's comprehensive plan of care initiated on 4/1/24, showed a care plan problem initiated for schizophrenia m/b hallucinations. The interventions included to administer medications as ordered and monitor for side effects and effectiveness. However, the care plan failed to include intervention to monitor Resident 14 for signs of orthostatic hypotension related to the use of psychotropic medications. Review of Resident 14's MAR dated 7/1-31/24, failed to show documentation Resident 14 was monitored for signs of orthostatic hypotension. On 8/1/2024 at 1530 hours, an interview and concurrent medical record review for Resident 14 was conducted with the DON. The DON verified the findings and stated the blood pressure should be checked for the residents who were receiving the psychotropic medications to monitor for orthostatic hypotension.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39453 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the proper storage and disposal of medications for one of one medication storage room, three of four medication carts inspected for medication storage and labeling. In addition, the facility failed to ensure the medications were not stored at the bedside for one of 20 final sampled residents (Resident 35) and one nonsampled resident (Resident 66). * The facility failed to ensure the oral medications were stored separate from externally used medications in the medication room. * The facility failed to ensure the medications in the bubble packs (type of pre-formed, plastic packaging that seal individual tablets until they are taken) were secured, sealed and free from tears or damage for two nonsampled residents (Residents 1 and 88). * The facility failed to ensure Medication Cart C was not left unlocked and unattended. * The facility failed to ensure the medication for one discharge nonsampled resident (Resident 83) and expired medication for one nonsampled resident (Resident 56) were removed from the medication cart. * The facility failed to ensure an unopened insulin vial for one nonsampled resident (Resident 22) was stored in the medication refrigerator. * The facility failed to ensure Residents 35 and 66's medications were not kept at the bedside. These failures had the potential to negatively impact the residents' well being. Findings: Review of the facility's P&P titled Medication Storage in the Facility (undated) showed the following: - The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications; - Only licensed nurses, the consultant pharmacist, and those lawfully authorized to administer medications are allowed access to medications; - Medication rooms, medication carts, and medication supplies are locked or attended by persons with authorized access; - Orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions; (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Eye medications are kept separate from ear medications; - Medications requiring storage in a cool place are refrigerated unless otherwise directed on the label; - Refrigerated medications are kept in closed and labeled containers, with internal and external medications separated; and - Outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. 1. On [DATE] at 0926 hours, an inspection of the facility's Medication Room and concurrent interview was conducted with RN 1. a. The following was observed inside the medication cabinet: - Three boxes of Glutose (oral glucose gel, used to treat low blood sugar levels) was stored with Tylenol (over the counter medication used to relieve pain and reduce fever) suppositories and Prep-H (medication used to relieve internal swelling caused by hemorrhoids) suppositories; - A box of Salonpas lidocaine cream (medication used to provide pain relief) was stored with the ear wax removal drops, Refresh PM (medication use to relieve dry eyes) eye drops, and boxes of sodium chloride hypertonicity ophthalmic ointment (medication used to draw water out of a swollen cornea); - A box of oral Cepacol (lozenges used to temporarily relieve pain from minor mouth problems) and three bottles of Robitussin DM (medication used to temporarily relieve cough) was stored with three bottles of saline nasal spray. b. The following was observed inside Medication Refrigerator B: - One Humalog (fast-acting insulin used to control high blood sugar) pen and three Basaglar (long-acting insulin used to control high blood sugar) were observed inside the freezer area; - One bottle of oral lorazepam liquid (anxiety medication) was stored with Rhopressa 0.02% ophthalmic solution (medication used to reduce high eye pressure in glaucoma or ocular hypertension), Lantus (long-acting insulin used to control high blood sugar) pen, Humalog pen, Novolog (rapid-acting insulin used to control high blood sugar) and Humulin (short-acting insulin used to control high blood sugar) pens. RN 1 verified the above findings. 2. On [DATE] at 1059 hours, an inspection of Medication Cart B and concurrent interview was conducted with LVN 1. The following was observed: a. A bubble pack containing tamsulosin (medication used to treat symptoms of enlarged prostate gland) for Resident 83 was observed inside the cart. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Closed medical record review for Resident 83 was initiated on [DATE]. Resident 83 was admitted to the facility on [DATE]. Review of Resident 83's Order Summary Report showed a physician's order dated [DATE], for the resident may leave against medical advice. b. A bubble pack of entecavir (antiviral medication used to treat Hepatitis B) Resident 1 was observed with a tear on one of the individual bubbles where an entecavir medication was individually stored. c. A bubble pack of gabapentin (medication used to treat partial seizures and nerve pain) for Resident 88 was observed with a tear on two of the individual bubbles where gabapentin medications were individually stored, and a tape was used to secure the bubble pack. LVN 1 verified the above findings. 3. On [DATE] at 1132 hours, Medication Cart C parked in the hallway was observed unlocked and unattended. The visitors and unlicensed staff were observed passing by. The Clinical Resource verified the above findings. On [DATE] at 1142 hours, an interview was conducted with LVN 3. LVN 3 stated she was assigned to Medication Cart C. LVN 3 stated she went to the resident's room and did not close or push the lock button all the way in to lock the medication cart. 4. [DATE] at 1452 hours, an inspection of Medication Cart A and concurrent interview was conducted with RN 2. The following was observed: a. An unopened vial of Novolog for Resident 22 was observed inside the medication cart, not refrigerated. b. A vial of Humulin for Resident 56 was observed with an opened date of [DATE], and expiration date of [DATE]. RN 2 verified the above findings. 50787 5. On [DATE] at 0847 hours, an observation of Resident 35's room was conducted. A bottle of Frankincense and Myrrh Foot Pain Relief Rubbing Oil (used for temporary relief from burning, shooting, pricking, tingling, stabbing pain and numbness of the feet) and Longevity Essential Oil Deep Penetrating Joint and Pain Relief Antibacterial Antiviral Formula (used for pain and joint relief) were observed on Resident 35's bedside dresser. Resident 35 stated the CNA applied the Frankincense and Myrrh Foot Pain Relief Rubbing Oil on her legs and the Longevity Essential Oil Deep Penetrating Joint and Pain Relief Antibacterial Antiviral Formula was used for her neuropathy (weakness, numbness, and pain from nerve damage). Medical record review for Resident 35 was initiated on [DATE]. Resident 35 was readmitted to the facility on [DATE]. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 35's MDS dated [DATE] showed Resident 35's BIMS score of 15 (cognitive intact). Further review of Resident 35's medical record failed to show a physician's order for the Frankincense and Myrrh Foot Pain Relief Rubbing Oil and Longevity Essential Oil Deep Penetrating Joint and Pain Relief Antibacterial Antiviral Formula and a care plan problem addressing the use of the above medications. On [DATE] at 0919 hours, an observation and interview was conducted with the ADON/IP. The ADON/IP verified the above finding. The ADON/IP stated Resident 35 was not supposed to have the above medications at bedside. Resident 35 agreed to have the medication bottles removed and the ADON/IP stated she would have the physician called if the medications were needed. 6. On [DATE] at 0906 hours, an observation of Resident 66's room was conducted. A box of Arthro-7 (supplement used to treat joint pain) was observed on Resident 66's bedside dresser. Medical record review for Resident 66 was initiated on [DATE]. Resident 66 was admitted to the facility on [DATE]. Review of Resident 66's MDS dated [DATE], showed Resident 66 had moderate cognitive impairment. On [DATE] at 0908 hours, an observation and interview was conducted with LVN 1. LVN 1 verified the above finding and stated Resident 66 was not supposed have the medication at bedside. LVN 1 stated the resident's family brought him stuff and she did not see the medication before. LVN 1 was asked who supposed to be checking the resident's bedside and LVN 1 stated she checked the residents' bedside during her shift but did not check Resident 66's bedside yet. On [DATE] at 1030 hours, an interview was conducted with Resident 66. Resident 66 stated his family brought the box of Arthro-7 for him but had not take the medication. On [DATE] at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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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. 48882 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen when: * The facility failed to ensure the kitchen utensils and equipment were clean and stored in sanitary conditions. * The facility failed to ensure the kitchen utensils were in good condition. * The facility failed to ensure the personnel entering the kitchen donned hair covering in the kitchen. * The facility failed to ensure the proper labeling and dating of the foods in the kitchen was utilized once the food item was opened. * The facility failed to ensure the fan unit inside the walk-in refrigerator was clean and free of buildup. These failures had the potential to cause foodborne illnesses in a highly susceptible resident population of 88 facility residents who consumed food prepared in the kitchen. Findings: Review of the facility document titled Diet Type Report dated 7/29/24, showed 88 of 92 residents in the facility received food prepared in the kitchen. 1. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. On 7/29/24 at 0800 hours, during an initial tour of the kitchen, the following was observed: - a metal spoon with brown colored stain on both sides, - a metal lemon squeezer with dried black food particles, (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- multiple clean kitchen utensils stored on top of a dirty baking sheet pan. The sheet pan was observed with dried food particles, multiple dried brown dust particles, and two brownish colored screws. - the drawer holding the baking sheet pan, that contained clean cooking utensils was observed with an orange-brown discoloration on the inner bottom wall of the drawer. A white towel was used to wipe the drawer wall and the towel was observed with a brownish color stain. The CDM verified the above findings. 2. Review of the facility's P&P titled Sanitation dated 2023 showed all utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corruptions, open seam, cracks, and chipped areas. Plastic ware, china, and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. Review of the facility's P&P titled Can Opener and Base dated 2023 showed proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Metal shavings and shredding can result from a dull cutting blade or worn-out cogwheel. The can opener must be thoroughly cleaned each work shift and when necessary, more frequently. To replace the blade on the can opener, as needed. a. On 7/29/24 at 0800 hours, during the initial tour of the kitchen, a frayed plastic spatula was observed. The CDM verified the finding. b. On 7/30/24 at 1415 hours, during a follow-up visit in the kitchen, an observation was conducted of the stationary table can opener. The can opener was observed with chipped stainless-steel coating, exposing the blade. The CDM verified the finding. 3. According to the USDA Food Code 2022, Section 2-402.11 Hair Restraints, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. Review of the facility's P&P titled Dress Code dated 2023, under the section Proper Dress showed hat for hair, if hair is short; hair net for hair if hair is long. On 7/30/24 at 1120 hours, an observation and concurrent interview was conducted with the Maintenance Assistant. The Maintenance Assistant was observed in the kitchen passing the marked red line without a hair net. The Maintenance Supervisor verified the findings . When asked the Maintenance Assistant stated he should wear a hair net when entering the kitchen. On 8/1/24 at 1257 hours, an interview was conducted with the CDM. The CDM stated he expected individuals who entered the kitchen to stay behind the red line. If they needed to pass the red line, the individual should wear a hair net and a beard mask. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of the facility's P&P titled Labeling and Dating of Foods dated 2023 showed all food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures for either food safety or product rotation. The individual opening or preparing a food shall be responsible for date marking at the time of processing and/or storage. On 7/29/24 at 0800 hours, during the initial tour of the kitchen, the following was observed to be unlabeled with an open date or use-by date: - an opened bag of hamburger buns and - two opened bags of hot dog buns. The CDM verified the above findings. The CDM stated he did not know when the bags were opened, the items should have had an opened date when first opened. 5. According to the USDA Food Code 2022, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. Review of the facility's P&P titled Sanitation dated 2023 showed all equipment shall be maintained as necessary and kept in working order. On 7/29/24 at 0800 hours, during the initial tour of the kitchen, the fan unit inside the walk-in refrigerator was observed with grey colored fuzz. A white towel was used to wipe the substance and the grey fuzzy substance was observed on the towel. The CDM verified this finding. On 8/1/24 at 1405 hours, the Administrator and CDM were informed and acknowledged the above findings.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 48882 Based on interview, facility document review, and facility P&P review, the facility failed to ensure the education was provided to the staff and family/visitor on safe food handling of outside food as per the facility's P&P. This failure had the potential to cause foodborne illnesses to the medically vulnerable resident population who consumed food brought from outside sources. Findings: Review of CMS S&C-09-39 dated 5/29/09, showed the residents have the right to choose to accept food from visitors, family, friends, or other guests according to their rights to make choices. The CMS guideline further shows the facility has the responsibility under the food safety regulation to help the visitors to understand safe food handling practices such as not holding or transporting foods containing perishable ingredients at temperatures above 41 degrees Fahrenheit. Review of the facility's P&P titled Food Brought by Family and Visitor revised 7/21/21, showed the resident and or resident representative will be informed of the policy and provided safe food handling guidance in the form of verbal and writing. This guidance will be documented and retained by nursing or in the medical record as a progress note and/or care plan. Review of the facility's document titled Bringing in Food for a Resident dated 2023 failed to show instructions for safe food handling of food brought into the facility. On 8/1/24 at 1257 hours, an interview was conducted with the CDM. The CDM stated when visitors wanted to bring in food from outside, he was involved in speaking with them to ensure the therapeutic diets and textures were met. The CDM stated he did not discuss about the hand hygiene and prevention of the cross contamination with the visitors. When asked about the education provided to the staff regarding safe food handling to ensure the staff were able to provide appropriate education to the residents and visitors, the CDM stated that was the DSD's responsibility. On 8/1/24 at 1311 hours, an interview was conducted with the DSD. The DSD provided the facility document titled Bringing in Food for a Resident and stated he reviewed the contents of the document when conducting in-services to the staff regarding safe food handling. The DSD further stated the document was reviewed with the residents and families when the visitors wanted to bring in food from outside. The DSD was asked to show if the document addressed safe food handling. The DSD reviewed the document and stated the document did not discuss the safe food handling for preparing, cooling, and storage of food, or how to prevent cross contamination. On 8/1/24 1334 hours, an interview and concurrent review of the facility's P&P titled Food Brought by Family and Visitor and the facility document titled Bringing in Food for a Resident was conducted with the DON. The DON verified the facility documents did not provide education about the safe food handling. On 8/1/24 at 1405 hours, the Administrator and CDM were informed and acknowledged the findings.		

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 48882 Based on observation, interview, and facility P&P, the facility failed to ensure the garbage and refuse were properly stored in two out of three garbage dumpsters. The garbage dumpsters was observed overflowing with garbage which prevented the lids from fully closing. This failure had the potential to attract pests/rodents that carry diseases. Findings: According to the US Food Code 2022 5-501.113, Covering Receptacles, showed receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered with tight-fitting lids. Review of the facility's P&P titled Garbage and Rubbish Disposal revised 2/23 showed all garbage and rubbish containing food waste shall be kept in containers. All containers shall be provided with tight-fitting lids or covers, and such containers must be kept covered when stored or not in continuous use. On 7/29/24 at 0837 hours, an observation of the facility's outside garbage dumpsters was conducted with the Maintenance Supervisor. Two garbage dumpsters were observed with the lids propped open by trash bags and cardboard boxes, preventing the lid from fully closing. The Maintenance Supervisors verified the findings and stated the dumpster lids should be completely closed and trash should not pass the maximum loading level indicated on the dumpsters. On 8/1/24 at 1405 hours, the Administrator and CDM were informed and acknowledged the above findings.		

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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** 48882 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical records for four of 20 final sampled residents (Residents 14, 17, 20, and 50) were accurate and complete. * The facility failed to ensure Resident 50's RNA documentation was complete. * The facility failed to ensure Resident 17's Smoking Evaluation was accurately completed. * The facility failed to ensure Resident 50's RNA documentation was complete. * The facility failed to ensure Resident's TARs regarding the indwelling urinary catheter securement and monitoring Resident 14's edema were completed. * The facility failed to ensure Resident 14's medical record did not contain another resident's health information. These failures had the potential for the residents' care needs not being met as their medical information were inaccurate. Findings: Review of the facility's P&P titled Charting and Documentation undated showed the purpose is to provide the following: 1. A complete account of the resident's care, treatment, response to the care, signs symptoms, etc., as well as the progress of the resident's care. 2. Guidance to the physician in prescribing appropriate medications and treatments. 3. The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident. 4. Nursing service personnel with a record of the physical and mental status of the resident. 5. Assistant in the development of a Plan of Care for each resident. 1. Medical record review for Resident 17 was initiated on 7/29/24. Resident 17 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 17's H&P examination dated 12/2/23, showed Resident 17 had the capacity to understand and make decisions. (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 17's MDS dated [DATE], showed Resident 17 had no impairments in her functional limitation in range of motion for her upper extremity (shoulder, elbow, wrist, and hand). Review of Resident 17's Plan of Care showed a care plan problem dated 4/7/23, addressing Resident 17's potential for injury related to smoking and continuous use of cigarettes. The interventions showed to complete the smoking assessment, observe Resident 17 smoking in designated areas, and report noncompliance or unsafe smoking habits to the MD and responsible party. The care plan interventions further showed Resident 17 preferred to smoke unsupervised and had stated she was able to hold cigarettes and put it out safely in the smoking receptacle. Review of Resident 17's quarterly LN-Smoking Evaluation dated 5/22/24, showed Resident 17 smoked five times a day, did not have any dexterity problems, and was able to light her own cigarette. Under the Safety section, the evaluation showed Resident 17 was not able to safely light, hold, or dispose of safety materials, and did not need adaptive clothing, device, or assistance. On 7/30/24 at 0730 hours, a smoking observation was conducted of Resident 17. Resident 17 was observed on a wheelchair and wheeling herself through the facility's side door. Resident 17 was observed smoking and holding her cigarette with no observed limitations in her upper extremities. On 7/30/24 at 1433 hours, an interview as conducted with CNA 10. CNA 10 stated Resident 17 smoked four to five times a day and did not wear an apron when smoking. CNA 10 stated Resident 17 was able to feed herself with minimal set-up assistance required and hold her own cigarettes and light her cigarettes safely. On 7/31/24 at 1420 hours, an interview was conducted with the Activities Director. The Activities Director stated he was familiar with Resident 17 and had accompanied her to smoke on multiple occasions. The Activities Director stated Resident 17 did not have any impairment or weakness in her hands and upper extremities and that Resident 17 was able to light and hold her own cigarettes and deposit her smoking materials appropriately and safely. On 8/1/24 at 1334 hours, an interview was conducted with the DON. The DON stated Resident 17 was able to self-ambulate in her wheelchair, open facility doors, and feed herself. The DON stated she had observed Resident 17 smoking and stated Resident 17 did not have any upper extremity impairments. Concurrent record review for Resident 17 was conducted with the DON. The DON verified the above findings. The DON stated the smoking evaluation for Resident 17 was conducted inaccurately. When asked, the DON stated she expected the assessments and documentation to be accurate to reflect the resident's current condition. On 8/1/24 at 1410 hours, the DON and Administrator were informed and acknowledged the above findings. 50967 2. Medical record review for Resident 50 was initiated on 7/30/24. Resident 50 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 50's Order Summary Report showed a physician's order dated 6/6/24, for PRAFO application to the resident's RLE daily five times/week for up to four hours as tolerated; and to monitor skin integrity every shift every Monday, Tuesday, Wednesday, Thursday, and Friday. On 7/31/24 at 0853 hours, an interview was conducted with the RNA. The RNA stated Resident 50 had an order for PRAFO application on the right lower leg for four hours a day as tolerated by the resident and applied it between 0930 to 1030 hours. The RNA also stated she would check the resident for any signs of pain, redness on his skin prior to applying the PRAFO and document on the RNA sheet. On 7/31/24 at 0957 hours, Resident 50 was observed lying in bed asleep with no signs of pain or discomfort. The right lower extremity PRAFO was observed present. Resident 50 was confused and nonverbal. On 7/31/24 at 1415 hours, review of a copy of Resident 50's RNA sheet for PRAFO showed missing documentation from 7/24 to 7/26/24. On 7/31/24 at 1426 hours, a concurrent interview and document review was conducted with LVN 2. LVN 2 verified Resident 50's RNA sheet showed missing documentation for dates 7/24 to 7/26/24. LVN 2 stated she would report to the RN supervisor for any missing documentation. On 8/1/24 at 1428 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 47474 3. Medical record review for Resident 14 was initiated on 7/30/24. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's quarterly MDS dated [DATE], showed Resident 14 had a BIMS score of 15 which meant the resident was cognitively intact. Review of Resident 14's Order Summary Report for July 2024 showed a physician's order dated 5/9/22, to secure the Foley catheter with catheter strap or patch to thigh every shift. Further review of the Order Summary Report showed the physician's orders dated 6/20/22, to monitor the left and right lower extremities edema every shift. a. Review of Resident 14's TAR for July 2024 showed the entry to secure the Foley catheter; however, there were no nurses' initials on the following dates: - Wednesday, 7/3/24 - Wednesday, 7/10/24 - Sunday, 7/14/24 - Monday, 7/15/24 - Tuesday, 7/16/24 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Friday, 7/19/24 - Monday, 7/22/24 - Wednesday 7/24/24 b. Further review of Resident 14's TAR for July 2024, showed the entries for monitoring the left lower extremity and right lower extremity edema monitoring every shift; however, there were no nurses' initials on the following dates: - Wednesday, 7/3/24 - Wednesday, 7/10/24 - Sunday, 7/14/24 - Monday, 7/15/24 - Tuesday, 7/16/24 - Friday, 7/19/24 - Monday, 7/22/24 - Wednesday 7/24/24 On 7/31/24 at 1010 hours, a concurrent interview and medial record review with the DSD was conducted. The DSD verified the above findings regarding missing nurses' initials. On 8/1/24 at 1530 hours, an interview with the Administrator and DON was conducted. The Administrator and DON verified the above findings. 46787 4. Medical record review for Resident 14 was initiated on 7/29/24. Resident 14 was admitted to the facility on [DATE]. Further review of Resident 14's medical record showed an Integrative Psychology Progress Note dated 11/4/22, for Resident 20 was in Resident 14's medical record. On 8/1/24 at 0954 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of infections were implemented as evidenced by: * The facility failed to implement their infection control surveillance program for August 2023 through June 2024. The facility conducted surveillance of resident infections based on whether the residents were prescribed antimicrobials. Residents who were not prescribed antimicrobials were not included in the facility's infection control surveillance program. * The facility failed to accurately track and monitor for the infections for April and May 2024. * The facility failed to ensure the staff performed hand hygiene before and after meal tray distribution. * The facility failed to ensure the infection control practices were implemented in the facility's laundry room. These failures posed the risk for not identifying infections and controlling the transmission of communicable disease to other residents throughout the facility. Findings: Review of the facility's P&P titled Infection Prevention - Surveillance of Infections and Reporting, (undated), showed the facility to maintain an ongoing system of surveillance designed to identify possible communicable diseases or infections to ensure that measures are taken to prevent any potential outbreak. The IP/Designee will review the log during the morning routine to ensure all potential/ actual infections/ outbreaks are being identified. 1.a. Review of the facility's monthly Prevention and Control Surveillance Log from August 2023 to June 2024 showed the following surveillance data: - August 2023, total of 26 cases including 20 CAI and 6 HAI - September 2023, total of 21 cases including 15 CAI and 6 HAI - October 2023, total of 26 cases including 19 CAI and 7 HAI - November 2023, total of 23 cases including 18 CAI and 5 HAI - December 2023, total of 24 cases including 17 CAI and 7 HAI - January 2024, total of 26 cases including 20 CAI 20 and 6 HAI - February 2024, total of 30 cases including 22 CAI and 8 HAI (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- March 2024, total of 26 cases including 19 CAI and 7 HAI - April 2024, total of 33 cases including 25 CAI and 8 HAI - May 2024, total of 30 cases including 27 CAI and 3 HAI - June 2024, total of 28 cases including 21 CAI and 7 HAI Review of the facility's monthly Prevention and Control Surveillance log from August 2023 through June 2024 showed documentation of the residents having an HAI or CAI and prescribed with antimicrobial medications. Further review of the facility's monthly Prevention and Control Surveillance Log from August 2023 through June 2024 showed the facility failed to conduct surveillance for all resident infections, specific to the residents who had signs and symptoms of infection, met the McGeer's criteria (method used to retrospectively counting true infection), and were not prescribed antimicrobial medications. On 7/31/24 at 1300 hours, an interview was conducted with the ADON/IP. When asked if she included the residents with signs and symptoms of infection, met the McGeer's criteria, and were not prescribed antimicrobial medications on the monthly Prevention and Control Surveillance Log, the ADON/IP stated she did not. The ADON/IP stated the facility monitored the residents who met the McGeer's criteria but were not prescribed antimicrobial medications on the COC log. On 8/1/24 at 1102 hours, a follow-up interview and concurrent facility document review was conducted with the ADON/IP. The ADON/IP verified the monthly Prevention and Control Surveillance Log from August 2023 through June 2024 did not include the residents with symptoms of infection who met the McGeer's criteria but were not prescribed with antimicrobial medications. b. Review of the facility's monthly Prevention and Control Surveillance Log for April 2024 showed the following: - an onset date of 4/17/24, for Resident 29's amoxicillin (antibiotic) 875-125 mg one tablet by mouth every 12 hours for 14 days, the log did not show whether the resident had CAI, HAI or did not meet the McGeer's criteria. Review of the facility's monthly Prevention and Control Surveillance Log for May 2024 showed the following: - an onset date of 5/13/24, for Resident 537's doxycycline (antibiotic) 100 mg one tablet by mouth two times a day for 10 days, the log did not show whether the resident had CAI, HAI, or did not meet the McGeer's criteria. - an onset date of 5/4/24, for Resident 26's cefdinir (antibiotic) 300 mg one capsule by mouth two times a day for seven days, the log did not show whether the resident had CAI, HAI or did not meet the McGeer's criteria. - a total number of residents who did not meet the McGeer's criteria was two. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 537's Surveillance Data Collection Form dated 5/14/14, showed the resident's doxycycline did not meet the McGeer's criteria. On 7/31/24 at 1300 hours, an interview and concurrent facility document review was conducted with the ADON/IP. The ADON/IP verified the above findings and stated the surveillance log for April and May 2024 had missing entries for the section to indicate CAI, HAI, or did not meet the McGeer's criteria. The ADON/IP stated the log for May 2024 was inaccurate because the total number of residents who did not meet the McGeer's criteria should have been three. 2.a. Review of the facility's P&P titled Hand Hygiene dated 10/2022 showed all personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and or visitors. Under the Procedure section, it showed to use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non- antimicrobial) and water for the following situations: - after contact with objects in the immediate vicinity of the resident; - after removing gloves; - before and after eating or handling food; and - before and after assisting a resident with meals. On 7/29/24 at 1226 hours, a dining observation was conducted. CNA 2 was observed delivering a meal tray inside room [ROOM NUMBER]. CNA 2 then proceeded to remove the plate and cup covers. CNA 2 was then observed bringing the plate cover back to the meal cart and removing Resident 47's meal tray from the meal cart. CNA 2 then placed the meal tray on top of Resident 47's bedside table and donned gloves. CNA 2 was observed moving the resident's wheelchair and placing bib around the resident's neck. With her gloves hands, CNA 2 removed the plastic covers from Resident 47's drinks. CNA 2 then removed her gloves and left the room. CNA 2 proceeded to get another meal tray from the cart and brought it to Resident 61's room without perform hand hygiene. On 7/29/24 at 1233 hours, an interview was conducted with CNA 2. CNA 2 verified she donned gloves to move Resident 47's wheelchair and bedside table. CNA 2 verified she did not perform hand hygiene after removing her gloves, leaving the resident's room and before serving Resident 61's meal tray. CNA 2 was asked about the facility's protocol when delivering and serving multiple resident trays and after removing gloves. CNA 2 stated she should have used hand sanitizer after removing her gloves and before serving another resident's meal tray. b. On 7/29/24 at 1249 hours, a dining observation was conducted. CNA 3 was observed delivering a meal tray to Resident 43, proceeded to remove the plate cover and opened the milk carton then left the room. CNA 3 was then observed removing Resident 689's meal tray from the cart, delivering it to the resident, and removing the plate cover without performing hand hygiene. CNA 3 then left Resident 689's room and delivered Resident 688's meal tray to his room and removed the plate cover 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 - Some	On 7/29/24 at 1254 hours, an interview was conducted with CNA 3. CNA 3 verified the above findings and stated she was supposed to perform hand hygiene with each time she delivered a meal tray to a different resident. 3. Review of the facility's P&P titled Laundry dated January 2024 showed it is the policy of the facility that careful precautionary procedures must be followed by laundry personnel to prevent spread of infectious diseases to other staff members, residents, and visitors. On 7/29/24 at 1412 hours, an inspection of the laundry area and concurrent interview with CNA 1 and Laundry 1 was conducted. The pen holder with multiple writing materials, water bottle, and personal cell phone were observed on the laundry folding table. CNA 1 and Laundry 1 verified the findings and CNA 1 stated the water bottle and cell phone belong to her. Laundry 1 stated the laundry folding table was a clean area and should not have other things on the table. On 8/1/24 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their antibiotic stewardship program when the facility failed to conduct an assessment for the McGeer's criteria to determine the true infection. This failure had the potential for inaccurately identifying for true infections and potentially inhibited the residents' physicians from discontinuing the unnecessary antimicrobials. Findings: Review of the facility's P&P titled Antibiotic Stewardship, undated, showed it is the policy of the facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection Prevention and Control Program which will promote appropriate use of antibiotic while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute setting, while improving treatment efficacy and resident safety, and reducing treatment - related costs. The Core Elements of stewardship are the same for both acute care setting and nursing homes, as outlined by CDC (Center for Disease Control); however, facilities may have a difference in the implementation of these elements: leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data, education for clinicians, nursing staff, residents, and families about antibiotic resistance and opportunities for improvement. 1.a. Review of the facility's infection control binder showed Surveillance Data Collection Form being used to assess for McGeer's criteria to determine the true infection. Review of the facility's monthly Prevention and Control Surveillance Logs from August 2023 through June 2024 showed the following surveillance data. - August 2023, 26 infected residents with antibiotics - September 2023, 21 infected residents with antibiotics - October 2023, 26 infected residents with antibiotics - November 2023, 23 infected residents with antibiotics - December 2023, 24 infected residents with antibiotics - January 2024, 26 infected residents with antibiotics - February 2024, 30 infected residents with antibiotics - March 2024, 26 infected residents with antibiotics - April 2024, 33 infected residents with antibiotics (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- May 2024, 30 infected residents with antibiotics - June 2024, 28 infected residents with antibiotics However, the facility failed to show documentation the McGeer's/Surveillance Data Collection form was completed to assess for the true infection for the residents who were admitted from the acute care hospital with antibiotics: On 7/31/24 at 1300 hours, an interview and concurrent facility document review was conducted with the ADON/IP. The ADON/IP verified the above findings. The ADON/IP stated she did not complete the Surveillance Data Collection Form for the residents who were admitted from the acute care hospital with antibiotics. The ADON/IP stated she was trained to only complete the Surveillance Data Collection Form for the residents who were prescribed antibiotics at the facility. b. Medical record review for Resident 29 was initiated on 7/31/24. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's Surveillance Data Collection Form dated 5/15/24, showed Resident 29 met the McGeer's criteria and was prescribed Augmentin (antibiotic) 875-125 mg by mouth every 12 hours. However, the bottom portion of the form did not show if the infection was HAI, CAI, or did not meet the criteria. c. Medical record review for Resident 75 was initiated on 7/31/24. Resident 75 was admitted to the facility on [DATE], and readmitted [DATE]. Review of Resident 75's Surveillance Data Collection Form dated 6/3/24, showed Resident 75 was prescribed Levaquin (antibiotic) 500 mg by mouth daily for seven days and did not meet the McGeer's criteria. The Additional Notes section showed, Patient's clinical indication does not meet McGeer's criteria. Resident's ATB (antibiotic) started from the ER. Renal calculi. However, there was no documented evidence to show the facility had notified the physician that Resident 75's antibiotic did not meet the McGeer's criteria. d. Medical record review for Resident 537 was initiated on 7/31/24. Resident 537 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 537's Surveillance Data Collection Form dated 5/13/24, showed Resident 537 was prescribed doxycycline (antibiotic) 100 mg two times a day for seven days and Augmentin 875-125 mg two times a day for seven days and did not meet the McGeer's criteria. However, the bottom portion of the form did not show if the infection was HAI, CAI or did not meet the criteria; and the Additional Notes section showed, Recurrent infection. In addition, there was no documented evidence to show the physician was notified that Resident 537's antibiotic medications did not meet the McGeer's criteria. e. Medical record review for Resident 538 was initiated on 7/31/24. Resident 538 was admitted to the facility on [DATE], and readmitted on [DATE]. (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's monthly Prevention and Control Surveillance Log for April 2024 showed Resident 538 was prescribed mupirocin (antibiotic) external ointment 2 % for right foot wound dehiscence on 3/15/24. However, there was no documented evidence the Surveillance Data Collection Form was completed. On 7/31/24 at 1300 hours, an interview and concurrent facility document review was conducted with the ADON/IP. The ADON/IP verified the above findings. The ADON/IP stated the whole Surveillance Data Collection Form should be completed. The ADON/IP stated the licensed nurses initiated the McGeer's criteria tool/Surveillance Data Collection Form and she completed the bottom portion of the form to show if the infection was HAI, CAI, or did not meet the criteria. The ADON/IP stated she documented on the bottom portion of the Surveillance Data Collection Form if the prescribed antibiotic met the McGeer's criteria or not; and if it did not meet the criteria, she then would discuss it with the physician if the antibiotic should be continued or not. The ADON/IP also stated she would document the physician's decision on the bottom portion of the form. On 8/1/24 at 1420 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to offer and provide the education for influenza and pneumococcal immunizations for two of five final sampled residents (Residents 20 and 35) reviewed for immunizations. * The facility failed to obtain the consent and provide education on the influenza vaccine to Residents 20 and 35. * The facility failed to ensure Resident 35's Immunization Record was accurate for receiving the pneumococcal vaccine. These failures had the potential for the residents to be uninformed of the risks and benefits of receiving the influenza vaccine and potentially affect care provided. Findings: Review of the facility's P&P titled Infection Prevention- Immunizations, Influenza and Pneumococcal (Resident), undated, showed it is the policy of this facility to ensure that before entering the influenza and or pneumococcal immunization, each resident's legal representative receives education regarding the benefits and potential side effects of the immunization. Prior to vaccination, the resident and/ or resident representative will be provided information and education regarding the benefits and potential side effects of the influenza and/or pneumococcal immunization (Influenza and Pneumonia vaccine information sheet) 1. Medical record review for Resident 20 was initiated on 7/31/24. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's Immunization Record dated 10/26/23, showed the resident received the influenza vaccine. There was no documented evidence in Resident 20's medical record a consent for vaccination was signed by the resident or their representative. 2. Medical record review for Resident 35 was initiated on 7/31/24. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's Immunization Record dated 10/26/23, showed the resident received the influenza vaccine. There was no documented evidence the consent for vaccination was signed by the resident or their representative. Additionally, Resident 35's pneumoccal vaccine consent form did not show the resident had previously received the pneumococcal vaccine. On 8/1/24 at 0922 hours, an interview was conducted with the ADON/IP. The ADON/IP verified th above findings.		

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep all essential equipment working safely. 39453 Based on observation and interview, the facility failed to ensure the equipment was maintained in a safe operating condition. * The facility failed to ensure there was no ice buildup in the freezers of Medication Refrigerators A and B in Medication Room A. This failure had the potential for the equipment to not function in the way it was intended. Findings: On 7/30/24 at 0926 hours, an inspection of Medication Room A and concurrent interview was conducted with RN 1. The freezer compartments inside Medication Refrigerators A and B were surrounded with a buildup of ice. In addition, there was no cover observed on the freezer of Medication Refrigerator B. RN 1 verified the above findings. When asked who in charge of cleaning and maintaining the medication refrigerators, RN 1 stated she was unsure if the nursing department was in charge to clean the medication refrigerators. On 8/1/24 at 0958 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. The DON stated the ice build-up of the medication refrigerators should be reported to the Maintenance Department.		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate and complete for six of nine sampled residents (Residents 14, 20, 37, 50, 54, and 69) reviewed for side rails use. * The facility failed to ensure Residents 14, 20, 37, 50, and 69's entrapment assessments were accurate. * The facility failed to ensure Resident 14's bed entrapment assessment was complete. * The facility failed to ensure Resident 54's bed entrapment assessment was completed for the right half side rail prior to use. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapments may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Proper Use of Bed Rails revised 12/2023 showed the following: (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Entrapment is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail; - Bed rails are adjustable metal or rigid plastic bars that are attached to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examples of bed rails include, but are not limited to side rails, bed side rails, grab bars and assist bars; - Assessment should assess resident's risk of entrapment between mattress and bed rail or in the bed rail itself; and - The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes: (a) checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible. Rails should be selected and placed to discourage climbing over rails, (b) ensuring that the bed's dimensions are appropriate for the resident by confirming that the bed rails are appropriate for the size and weight of the resident using the bed, ensuring that the bed's dimensions are appropriate for the resident by, installing bed rails using the manufacturer's instructions and specifications to ensure a proper fit, inspecting and regularly checking the mattress and bed rails for areas of possible entrapment, and ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/or depth, (c) observing ongoing precautions such as following manufacturer's equipment alerts and recalls and increasing resident supervision, especially with the use of air-filled mattresses or therapeutic air-filled beds that may present a different entrapment risk than rail entrapment, (d) conducting routine preventative maintenance of beds and bed rails to ensure they meet current safety standards and are not in need of repair. During a concurrent observation, medical record review, and facility document review for Residents 20, 37, and 50 showed the residents' bed entrapment assessments were not accurate for Zone 5. For example: 1. On 7/29/24 at 0845 hours, during the initial tour of the facility, Resident 37 was observed lying in bed with the bilateral half padded side rails elevated. Resident 37 was confused and mumbled words; unable to verify the use of the side rails. Medical record review for Resident 37 was initiated on 7/29/24. Resident 37 was admitted to the facility on [DATE]. Review of Resident 37's H&P examination dated 5/6/24, showed Resident 37 did not have the capacity to make her own medical decisions. Review of Resident 37's Order Summary Report showed a physician's order dated 5/22/24, for bilateral half padded side rails to aid with bed mobility and minimize risk of injury in the event of seizure activity. Review of Resident 37's Bed Rail 7 Zones Entrapment assessment dated [DATE], showed, Pass was circled for Zones 1 through 7. (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/30/24 at 1033 hours, an observation and concurrent interview was conducted with the ADON/IP Nurse. The ADON/IP Nurse verified Resident 37's bilateral side rails were elevated. On 8/1/24 at 1030 hours, a concurrent interview and document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified he documented the entrapment assessment on Resident 37's Bed Rail 7 Zones Entrapment Assessment. When asked about the assessments of the entrapment, the Maintenance Supervisor verified the bed entrapment assessments for Zones 5 was inaccurate. The Maintenance Supervisor stated he should have marked not applicable, N/A, for Zone 5. The Maintenance Supervisor verified the above findings. On 8/1/24 at 1428 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 7/29/24 at 0951 hours, Resident 50 was observed lying in bed awake with bilateral half side rails elevated. Resident 50 was confused and nonverbal; unable to verify the use of the side rails. Medical record review for Resident 50 was initiated on 7/31/24. Resident 50 was admitted to the facility on [DATE]. Review of Resident 50's H&P examination dated 2/16/24, showed Resident 50 had history of CVA or stroke and cognitive communicative deficit. Review of Resident 50's Order Summary Report showed a physician's order dated 5/24/24, for bilateral half side rails for positioning and ease in mobility as an enabler. Review of Resident 50's Bed Rail 7 Zones Entrapment assessment dated [DATE], showed, Pass was circled for Zones 1 through 7. On 7/30/24 at 1125 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 verified Resident 50's bilateral half side rails were elevated. On 8/1/24 at 1030 hours, a concurrent interview and document review was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified he documented the entrapment assessment on Resident 50's Bed Rail 7 Zones Entrapment Assessment. When asked about the assessments of the entrapment, the Maintenance Supervisor verified the bed entrapment assessments for Zones 5 was inaccurate. The Maintenance Supervisor stated he should have marked N/A for Zone 5. On 8/1/24 at 1428 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 50787 3. On 7/29/24 at 1045 hours, Resident 20's bed was observed with half padded bilateral upper side rails. Medical record review for Resident 20 was initiated on 7/29/24. Resident 20 was admitted to the facility on [DATE]. (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 20's Order Summary Report showed a physician's order dated 6/4/24, for padded bilateral half side rail up when in bed to minimize risk for injury in the event of seizure activity with verified informed consent obtained by the MD from the resident/responsible party. On 7/30/24 at 1200 hours, an interview was conducted with Resident 20. Resident 20 stated she used the side rails when she moved around in bed. When asked if the side rails helped, Resident 20 stated the side rails helped her a lot in changing positions. On 7/31/24 at 0916 hours, a follow-up observation was conducted in Resident 20's room. Resident 20's bed was observed with wooden headboard, padded bilateral half upper side rails, and a waffle mattress. On 8/1/24 at 0958 hours, an observation and concurrent interview was conducted with the DOR. The DOR verified Resident 20 had bilateral half side rails. When asked about the purpose of the resident's side rail use, the DOR stated he was somewhat familiar of Resident 20 and the purpose of the side rail use was for bed mobility. Review of Resident 20's Bed Rail 7 Zones Entrapment assessment dated [DATE], showed all the zones passed the assessment. However, Resident 20 had no lower side rails and Zone 5 indicated passed. Review of Resident 20's Plan of Care showed a care plan problem initiated on 4/4/23, to address Resident 20's use of side rail as an enabler. The interventions/tasks included to assess the gaps between the mattress, bed frame or side rail; and the use of side rail will be reevaluated quarterly and/or as needed. On 8/01/24 at 1032 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated he checked off Zone 5 because there was no problem. The Maintenance Director was asked why Zone 5 was assessed, the Maintenance Director did not give a response. When asked if he should have documented N/A in Zone 5, the Maintenance Director stated could be. On 8/01/24 at 1420 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings. 46787 4. On 8/1/24 at 0931 hours, Resident 14 was observed lying in bed with the bilateral upper half side rails elevated. Medical record review for Resident 14 was initiated on 7/29/24. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's Order Summary Report showed a physician's order for bilateral half side rails for positioning and ease in mobility as an enabler. Review of Resident 14's Bed Rail 7 Zones Entrapment assessment dated [DATE], showed, Pass for Zone 5. (continued on next page)		

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 14's Bed Rail 7 Zones Entrapment assessment dated [DATE], showed the following sections were blank: - Zone 1 to 7 - Type of Mattress - Mattress Condition - Length and Width of Mattress On 8/1/24 at 1029 hours, an interview and concurrent medical record review was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified the above findings. The Maintenance Supervisor acknowledged Zone 5 should have been marked as N/A since Resident 14 is only using the bilateral upper side rails. 5. On 8/1/24 at 1027 hours, Resident 69 was observed lying in bed with the bilateral upper half side rails elevated. Medical record review for Resident 69 was initiated on 7/29/24. Resident 69 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 69's Order Summary Report showed a physician's order for bilateral half side rails up in bed to aid in bed mobility. Review of Resident 69's Bed Rail 7 Zones Entrapment assessment dated [DATE], showed, Pass for Zone 5. On 8/1/24 at 1029 hours, an interview and concurrent medical record review was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified the above findings. The Maintenance Director acknowledged that Zone 5 should have been marked as N/A since Resident 69 was only using the bilateral upper side rails. 48882 6. On 7/31/24 at 0813 hours, Resident 54 was observed in bed with the right half side rail elevated. Medical record review for Resident 54 was initiated on 7/29/24. Resident 54 was admitted to the facility on [DATE], with a diagnosis of hemiplegia and hemiparesis following a nontraumatic intracerebral hemorrhage affecting the left non- dominant side. Review of Resident 54's MDS dated [DATE], showed Resident 54's had moderately impaired cognition and had one-sided impairment for both upper and lower extremity functional limitation. The MDS also showed Resident 54 required substantial to maximal assistance, where the helper would do more than half the effort, for rolling from left to right in bed. (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 54's Order Summary Report dated 7/31/24, showed a physician's order dated 5/16/24, to apply the left half side rail for bed mobility. Review of Resident 54's Bed Rail 7 Zones Entrapment assessment dated [DATE], showed an entrapment assessment was conducted by the Maintenance Supervisor for the left half side rail. The assessment showed Zones 1, 2, 3, 4, 5, 6, 7, and 8 were marked as passed. Further review of Resident 54's medical record failed to show the following: - a physician's order for the use of the right half side rail, - a informed consent for the use of the right half side rail, - a bed rail safety evaluation, and - a bed rail entrapment assessment prior to the use of the right half side rail. On 7/31/24 at 1316 hours, an interview and concurrent observation was conducted with LVN 7. LVN 7 stated Resident 54 had left-sided weakness and used the left side rail to grab during care and repositioning. LVN 7 verified Resident 54's right half side rail was elevated and verified there were no side rails on the left side of the bed . On 8/1/24 at 1030 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor stated he was responsible for the side rail entrapment assessments. The Maintenance Supervisor stated the nurse would provide him with the authorization form for the resident, which would indicate the specific rail and side. Concurrent review of Resident 54's Bed Rail 7 Zones Entrapment assessment dated [DATE], was conducted with the Maintenance Supervisor. The Maintenance Supervisor verified he conducted the assessment for the left half side rail. The Maintenance Supervisor also verified Zone 5 was marked as pass. The Maintenance Supervisor acknowledged Zone 5 did not need to be measured and should be marked as not applicable. On 8/1/24 at 1334 hours, an interview was conducted with the DON. The DON was asked about the facility's policy for the use of side rails. The DON stated after a physician's order was obtained, the facility's IDT would conduct a bed side rail assessment and obtain an informed consent; the maintenance would perform an entrapment assessment; and a care plan would be initiated. The DON stated if a resident was able to move on one side of the body, the IDT would determine which side of the the side rail would be placed. Concurrent record review for Resident 54 was conducted with the DON. The DON verified the above findings. The DON stated the side rails should be placed to match the physician's order. On 8/1/24 at 1410 hours, the Administrator and DON were informed and acknowledged the findings.		