

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075348	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Advanced Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 169 Davenport Avenue New Haven, CT 06519	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, facility documentation, and staff interviews for 1 of 5 for (Resident # 70), reviewed for dignity, the facility failed to ensure staff interacted with the resident respectfully. The findings includes: Resident #70's diagnosis included Chronic Congestive Heart Failure (CHF), back pain, diabetes mellitus, anxiety and depression. The Annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #70 as cognitively intact, used a walker, was independent with toileting hygiene and had occasional pain that interfered with sleep and day-to-day activities. The care plan dated 1/7/2025 for Resident #70 requires assistance with toileting using a wheeled walker and has a history of falls. An intervention is directed to call for assistance when needed. On 1/16/2024 Resident #70 reported to a surveyor on 1/15/2025 that urine was on the bedside floor, and she/he was attempting to clean the urine up with linens on the floor but instead called staff for assistance. Nurse Aide (NA #8) returned with an open bag for Resident # 70 to place the soiled linens. Resident #70 also indicated she/he told NA#8 s/he needed help, NA#8 placed the soiled linens in the bag then told Resident #70 s/he could have done the task independently. The facility filed a report of allegations to the state agency on 1/16/2025 and start the investigation. The facility interview with NA #8 during the investigation indicated NA #8 during conversation did tell Resident #70 s/he could have clean the urine up without assistance from her/him. NA #8 has seen Resident #70 complete many tasks independently. Further review of facility interviews of the investigation identified Resident #70 felt NA#8 was disrespectful, not abusive in anyway, and agreed with the interviewer further training in customer service was needed. On 1/17/2025 while the Director of Nursing Services (DNS) was conducting the interview with NA #8, the DNS indicated NA#8 would be removed from Resident #70's assignment and a discussion regarding customer service and treating residents respectful at which time NA# 8 verbalized understanding. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with NA #8 on 1/22/2024 at 6:30 AM indicated Resident #70 called for assistance on 1/15/2025 in the morning, near change of shift and she/he (NA #8) returned to the room with a bag for soiled linen and opened the bag thinking Resident #70 was going to place the linen in the bag, but Resident #70 became upset wanting NA #8 to do it. NA#8 indicated she/he proceeded to place the soiled linen in the bag and left the room.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Reasonably accommodate the needs and preferences of each resident. 46046 Based on clinical record review, observations and interviews for 1 of 2 residents (Resident #118) reviewed for environment, the facility failed to ensure resident furniture was maintained and in proper working order. The findings include. An observation on 9/17/2025 at 9:50 AM identified Resident #118's closet cabinet doors ajar and the wood at edges of the open sides and bottom of the cabinet doors was noted to be peeling apart. The cabinet door did not stay closed. A 3-drawer dresser at the side of the cabinet against the wall was also found to have drawers that did not stay closed. An observation and interview on 1/28/25 at 9:15 AM with the Director of Maintenance identified Resident # 118 3-drawer cabinet top drawer open and once closed reopened. The Director of Maintenance attempted to move the dresser slightly and all drawers came open at which time she/he indicated the drawer would be fixed or replaced. The closet cabinet doors were noted to be splitting, splintered at the outer edges and bottom of each door was noted missing magnets to keep the cabinet doors closed. Attached to the closet cabinet were 3 more smaller drawers. The second drawer was found difficult to open and close at which time the Director of Maintenance indicated the drawer would be repaired. While turning to leave the room the surveyor bumped into the dresser top drawer which had reopened again while viewing the resident closet doors and drawers. The Maintenance Director indicated the opening of drawers could be a safety concern and would be repaired or replaced.		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record review, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #22) reviewed for abuse, the facility failed to ensure personal funds were secure. The findings include: Resident #22 's diagnoses included Cerebral Palsy, mood disorder, and delusional disorder. The Resident Care Plan dated 4/2/24 identified the resident has short term memory loss related to cerebral palsy and delusional disorder. Interventions included for staff not rushing the resident when he/she is trying to remember something. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #22 as severely cognitively impaired and noted the resident was dependent for all personal care, and hygiene. Review of the state agency reporting filed by Resident #22's family member identified a staff member was given \$50.00 for the resident to use as needed and the money has since gone missing. The family member believes the money was stolen. In an interview and review of bank statements with the Business Office Manager on 1/22/25 at 12:50 PM identified there was no deposit of \$50.00 in Resident # 22's personal fund account. The Business Office Manager stated the resident's family member brought in \$50.00 a few months back and would not allow her to deposit the money into the resident's account, as she/he wanted it to be left on the nursing medication cart to allow Resident #22 to have 24-hour access to the money. The Business Office Manager also stated that she told the resident's family member Resident # 22 would have access to the money if it were in her/his account. The family member further indicates she/he left it with the nurse on the floor, however, she/he does not remember which nurse. She/he also stated that DSS came in to investigate this situation about a month ago. In an interview with Social Worker (SW) on 1/22/25 at 2:00 PM identified she was not aware Resident #22's family member gave a nurse \$50.00 to keep on the medication cart and is now alleging that the money has gone missing. The DNS further indicated she was made aware; she would investigate the allegations as well as reimburse the resident. In an interview with the Administrator on 1/23/25 at 9:30 identified she was not aware of the money and the allegations. The Administrator also stated if the resident/family did not want the money deposited into Resident # 22's personal funds account she would have provided a locked box in the resident's room. In an interview with Licensed Practical Nurse (LPN#2) on 1/23/25 at 10:45 AM identified she was the nurse that took the money from the resident's family member. LPN #2 also stated the \$50.00 is locked in the narcotics box in the medication cart. She showed the surveyor an envelope the money was in and the dates and amounts when it was spent. The envelope indicated the money was given to her in June 2023, the amount was \$50.00, and the remaining amount is \$1.25. (continued on next page)		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and policy review with the Administrator on 1/23/25 at 11:54 AM identified the facility policy directs staff to place money into a personal funds account and if the resident/family refuse to place the money in the account. Residents will be provided they a locked box in the resident's room to keep the money. The Administrator further stated that any staff member receiving money should secure it and then contact Social Services to set up a locked box for the resident's room. Review of the facility policy, Personal Resident Funds dated 1/19/18 given to surveyor onsite directed in part, should the resident bring private funds to the facility it is the resident's obligation to request a locked box to secure funds. Which will be provided by the facility.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 46046 Based on clinical record review, facility policy review and interviews for 1 of 1 resident (Resident #89) reviewed for Advanced Directives, the facility failed to ensure staff provided evidence of the resident's advanced directive paperwork. The findings include. Resident #89's diagnoses included chronic Congested Heart Failure, acute respiratory failure, chronic kidney disease, and type 2 diabetes mellitus. A physician's order dated 6/28/2024 directed code status as Full Code with special instructions to ensure Resident #89 signs the advanced directives form and to place a copy in the medical clinical record. Resident #89's baseline care plan dated 10/16/2024 indicated Full Code status. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #89 as cognitively intact. An interview and chart review with Licensed Practical Nurse (LPN #8) on 1/29/25 at 11:26 AM identified no advanced directive sheets in the paper or electronic medical record. LPN # 8 further indicated she/he was not sure why the resident's advanced directive was not in the medical record and indicated she/he would contact the nursing supervisor. An interview with Registered Nurse (RN #1) the nursing supervisor on 1/30/2025 at 1:05 PM indicated the resident's advanced directive sheets must have been misplaced and when she/he had time s/he would look for the papers. When asked if the papers could have been thinned from the chart mistakenly or if any documentation of the advanced directives being completed RN #1 no it would have not been thinned from the chart. The facility policy labeled Advanced Directives indicated in part residents without advanced directives will be provided with an Advanced Directive handout upon admission. The form located in the admission packet will be reviewed with nursing and after reviewing the options, the completed form is filed in the medical record by nursing and a physician's order is obtained. This process is completed by nursing within 24 hours.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, observations, facility documentation, facility policy and interviews for 1 of 3 residents (Resident # 173) reviewed for personal property, the facility failed to ensure the resident's personal medication was not missing and for 2 of 2 residents (Residents # 164 and # 181) reviewed for environment, the facility failed to ensure a shared room had a functioning bathroom sink and for 1 of 2 residents (Resident #118) reviewed for environment, the facility failed to ensure resident furniture was maintained and in proper working order. The findings included: 1.Resident #173 's diagnoses included carcinoma in situ of prostate, secondary malignant neoplasm of genital organs and Type 2 diabetes mellitus. The annual Minimum Data Set assessment dated [DATE] identified Resident #173 as cognitively intact and requires set up for eating. The resident is independent with bed mobility and toilet transfers. The care plan dated 12/10/24 identified Resident #173 has a diagnosis of cancer and noted the resident is not receiving chemotherapy Interventions included to administer antiemetics as ordered for nausea/vomiting. A physician's order dated 12/24/24 directed to give 5mg Revlimid (treatment of myeloma) oral once in the morning, with special instructions of 21 days on and 7 days off. A physician's order dated 1/17/25 directed to give 5mg Revlimid oral once in the morning, with special instructions of 21 days on and 7 days off and to store in narcotic box. Interview with Person #2 on 1/16/25 at 12:29 PM indicated about a month ago Resident #173 should have had 6 Revlimid medication left, however, only had two and indicated she/he was not sure why the medication was missing. Interview with charge nurse LPN#7 on 1/29/25 at 11:46 AM indicated she is familiar with Resident #173 and the specific directions medications should be administered. LPN#7 reported that she is aware there had been missing medication for Resident #173 and believes this might have happened when Resident #173 was on a different unit, over a month ago. LPN # 7 was unable to recall a date. LPN # 7 indicated after the incident, the nurses and Person #2 started counting the medication once it arrived at the facility and the medication was moved to the narcotic box. LPN #7 identified she did not believe there was any other missing medication since the incident. An interview with RN #1 on 1/29/25 at 12:14 PM indicated although the facility does not encourage outside medication (medication not coming from contacted pharmacy). However, if medication comes from a family member it should be documented in the progress note. RN#1 also stated the medication container should reflect what the medication is and how much is left in the container. She also indicated any nurse on the shift can receive medication from a family member. She further indicated that Revlimid was not a narcotic therefore there was no need for a medication count sheet to be completed. RN #1 stated she has not reviewed any complaints regarding Resident #173 medication count being off. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nurse's notes did not indicate any concern regarding missing medication. Interview with Social Worker (SW#2) on 1/29/25 at 1:54 PM indicated she/he was not made aware of any missing items/medications related Resident #173. Interview with LPN #11 on 1/29/25 at 1:55 PM indicated she was not informed of any missing medication related to Resident #173. Interview with the Director of Nursing Services (DNS) on 1/29/25 at 2:01 PM indicated she was not made aware of any missing medication for Resident #173. She reported that the policy/ expectation is that any concerns regarding missing medication should be reported to the chain of command (RN supervisor, Advanced Practice Registered Nurse (APRN, DNS and Medical Doctor) so an investigation can be started. Facility Medications Brought in by family policy indicates in part, if a medication is brought in from the outside, the DNS and nursing staff, with the support of the attending physician and consultant pharmacist, shall check the medication to ensure: the contents of each container are labeled in accordance with established policies and the contents of each container have been verified by the licensed pharmacist. 2. An observation on 1/16/2025 at 11:00 AM of Residents # 164 and # 181 shared bathroom identified a sign on the sink DO NOT USE Leaking. Resident #164 indicated the sign was put up by maintenance and had been present for 3 weeks. Resident # 164 also indicated the staff go to another room to get water to wash her/him. An observation, review of facility document and interview on 1/28/25 at 9:15 AM with the Maintenance Director identified the bathroom in Resident # 164 and Resident # 181 room with the sign still posted to the faucet indicating DO NOT USE leaking. Several soiled bath blankets were on the floor under the sink and an emesis basin on the side of the sink. The Maintenance Director indicated s/he was not aware of the sign placed on the sink or who may have placed the sign but was aware of several sinks that had been put in by a contractor and identified this sink one was leaking. The Maintenance Director also indicated the contractor came back to check the sink in the residents room and identified it needed a part. A new faucet was ordered and will be installed today by facility staff. During review of the Maintenance Book for the unit on 1/28/25 identified a tan entry Sink does not work! placed in the book on 1/8/2025 (20 days ago) and initialed by Maintenance Worker #1 that indicated the resident bathroom was without use of a sink for 20 days. An interview with NA#4 on 1/28/25 at 9:30 AM indicated since the sink has been broken the staff use other residents bathroom faucets to get the water to wash Resident # 164 and Resident # 181 and vebralized both residents in the room require assistance. An interview with Maintenance Worker #1 and the Maintenance Director on 1/28/25 at 9:40 AM indicated they did not know who placed the sign on the leaking sink but did know the sink was awaiting a part. (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and observation of a picture of the current bathroom condition with the Director of Nursing Services (DNS) on 1/28/2025 at 10:00 AM indicated this was unacceptable and if s/he knew about the sink the residents would have moved to another room with a working faucet until this one could be repaired. 3. An observation on 9/17/2025 at 9:50 AM identified Resident #118's closet cabinet doors ajar and the wood at edges of the open sides and bottom of the cabinet doors was noted to be peeling apart. The cabinet door did not stay closed. A 3-drawer dresser at the side of the cabinet against the wall was also found to have drawers that did not stay closed. An observation and interview on 1/28/25 at 9:15 AM with the Director of Maintenance identified Resident # 118 3-drawer cabinet top drawer open and once closed reopened. The Director of Maintenance attempted to move the dresser slightly and all drawers came open at which time she/he indicated the drawer would be fixed or replaced. The closet cabinet doors were noted to be splitting, splintered at the outer edges and bottom of each door was noted missing magnets to keep the cabinet doors closed. Attached to the closet cabinet were 3 more smaller drawers. The second drawer was found difficult to open and close at which time the Director of Maintenance indicated the drawer would be repaired. While turning to leave the room the surveyor bumped into the dresser top drawer which had reopened again while viewing the resident closet doors and drawers. The Maintenance Director indicated the opening of drawers could be a safety concern and would be repaired or replaced. 49100		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 2 of 5 sampled residents (Resident #144) reviewed for abuse, the facility failed implement policies to ensure the protection residents following an allegation of abuse and for (Resident # 214), the facility failed to timely followed up on Resident # 214 concerns regarding Resident # 1's physical and verbal abuse toward staff to rule out Resident # 1 was not a danger to self and others. The findings include: 1. Resident #144's diagnoses included history of dysuria (painful urination)and bipolar disorder. The annual MDS assessment 10/1/24 identified Resident #144 as cognitively intact, frequently incontinent of urine and required one person assist with ambulation and toileting needs. The Resident Care Plan (RCP) dated 12/30/24 identified Resident #144 had a concern related to ADL function. Interventions included providing assist of one with transfers and toileting. A Reportable Event Summary dated 1/16/25 identified Resident #144 alleged the nurse, LPN #6 offered Tylenol and stated s/he could go to the hospital if in that much pain. A review of LPN #6's punch detail dated 1/15/25 through 1/22/25 identified she remained on the schedule on 1/16/25 from 3:15 PM through 1/17/25 at 6:15 AM. An interview with the (interim) DNS on 1/27/25 at 2:12 PM identified she thought she had LPN #6 removed from the schedule pending investigation but was unable to explain why LPN #6 instead remained on the schedule. The DNS further identified LPN #6 should have been removed from the schedule until the end of the investigation which concluded on 1/17/25 after 3:00 PM. An interview with LPN #6 on 1/27/25 at 2:46 PM identified she was not removed from the schedule at any time following the allegation. A review of the facility policy for Resident Abuse dated 9/16/18 directs that any staff member named in an allegation of abuse will be removed from the schedule pending investigation. 2. Resident # 1's diagnoses included dementia with behavioral disturbances, anxiety disorder and schizophrenia. The care plan dated 1/13/25 for ADL Function resident exhibits behaviors as evidenced by aggression and combative to staff. Interventions included: approach the resident in a calm and consistent manner, use resident's name and explain purpose before approaching, provide the resident with opportunity to express feeling and provide 1:1 and group visits, if refuse care reproach and to monitor mood / behavior and when changes to MD. A review of the psychiatric and psychological notes dated 1/13/25 through 1/25/25 identified the resident exhibited aggression toward staff, memory problems and confusion, utilized antipsychotic and anti-anxiety medication and noted the resident was not a danger to self and other. (continued on next page)		

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 37721 Based on review of Resident Assessment during survey, review of facility documentation and interviews for 17 of 17 residents (Residents 84,90,195,197,11,40,62,173,79,24,68,100,120,192,80,194,64), the facility failed to ensure the residents Minimum Data Set (MDS) assessment were transmitted timely to the state agency. The findings included: A review of Residents 84,90,195,197,11,40,62,173,79,24,68,100,120,192,80,194,64 MDS assessment submitted to the state agency for the period of 2023 through December 2024. A review MDS Coordinator (LPN) Report for the period of 2023 through December 2024 on 1/28/25 at 9:15 AM and again at 3:15 PM identified MDS assessment needs to be completed 7 dates from Assessment Reference Date (ARD) set date and then 7 days to sign and transmit from there. 15 days total from the set date to transmission. The MDS Coordinator also indicated she assumed her role in December 2024. and was aware that MDS assessment had not been submitted timely to the state agency. The MDS Coordinator also indicated that the administrator was aware of the late MDS transmission to the state agency and was providing support to assist her to get caught up.		

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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** 46046 Based on clinical record reviews, observations, facility policy and interviews for 1 of 6 residents (Resident #111) reviewed for specialized treatment, the facility failed to ensure staff developed a care plan reflecting the needs of a resident receiving dialysis care and for 1 of 2 residents (Resident # 109), reviewed for communication- Sensory, the facility failed to ensure that the care plan reflected the residents' sensory needs. The findings included: 1. Resident #111's diagnosis includes end stage renal disease with dependence on renal dialysis. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #111 as cognitively intact. The care plan dated 12/20/2024 for Resident was at increased risk for alterations in nutritional status secondary to renal dialysis. Interventions included providing a renal diet and supplements. An interview and record review with RN #1 (Nursing Supervisor) on 1/25/2025 at identified there was no specific care plan related to the resident's dialysis access site and specific needs reflected in the facility policy were found. RN #1 indicated she/he would add the missing care plan. After surveyor inquiry, a care plan was created dated 1/26/2025 indicating Resident #111 was at risk for complications secondary to hemodialysis. Interventions included : to encourage adherence to fluid restriction, assist with obtaining transportation to dialysis, communicate with the dialysis center with communication book and in event of a vascular access emergency to apply pressure to the dialysis access site and call 911, to monitor the access site for patency bruit and thrill daily and after each dialysis visit and to monitor resident after return from dialysis for changes in vital signs, pain or discomfort. The facility policy labeled Comprehensive Care Plan given onsite indicated in part, a comprehensive, person-centered care plan that meets the resident's physical, psychosocial and functional needs is to be developed and implemented for each resident. 2. Resident #109 's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), dyspnea and major depressive disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 109 as cognitive intact and independent with personal hygiene, upper body dressing and noted the resident requires assistance with eating. The MDS also indicated Resident #109 requires corrective lenses. The care plan dated 11/28/24 did not identify care area or interventions for Resident #109 eyeglasses. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 1/17/25 at 9:48 AM identified Resident # 109 had broken glasses. Resident # 109 indicated that the facility is aware of her/his broken glasses, but nothing has been done to address the concern. A follow up interview with Resident #109 on 1/28/25 at 9:25 AM identified she/he still has not received new glasses. Resident # 109 also reported s/he has told the new social worker and nursing regarding her/his concern as well as the Ombudsman Office. Interview with Social Workers 1 and #2 on 1/28/25 12:56 PM identified s/he was not informed about Resident #109 broken glasses. Interview with LPN#4 on 1/28/25 at 01:34 PM indicated each discipline are responsible for completing their sections on the MDS assessment. However, it is reported that the MDS Coordinator is responsible for competing in the nursing sections. LPN #4 was unable to locate the care area related to residents' glasses and indicated she/he believes this may have been an oversight. After surveyors' inquiry, on 1/27/2025 at 12:34 PM a nursing note reflecting the status of Residents #109 glasses and a referral to have them fixed. 49100		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, policy the facility and interviews for 2 of 4 residents (Resident # 104) reviewed for urinary retention, the facility failed to revised the care plan after the resident returned from an inpatient stay and for 1 of 1 resident (Resident # 207)reviewed for care planning, the facility failed to ensure staff revised the residents a resident's care plan to reflect resident's choice regarding bathroom preferences . The findings included: 1.Resident #104 's diagnoses included urinary retention, and Urinary Tract Infection (UTI). The annual Minimum Data Set assessment dated [DATE] identified Resident #104 as cognitively intact and required maximum assistance with personal hygiene, toileting and bathing. A physician's order dated 12/17/24 directed to begin voiding trials in 5 days of discharge as a Foley catheter was in placed while in the hospital. A nurse's note dated 12/17/24 at 10:37 PM identified Resident # 104 returned from the hospital with a diagnosis of urinary retention. A physician's order dated 1/13/25 directed to perform a bladder scan every 6 hours while awake if possible and to conduct intermittent catheterization for (Post Void Residual urine) PVR greater than 600. If there is no bladder scanner then scheduled intermittent catheterizations every 6 hours while awake. The Resident Care Plan dated 1/14/25 identified the resident had urinary incontinence. Interventions included providing incontinent care every 2 hours and anticipating toileting needs. There were no revised interventions for urinary retention on the care plan. On 1/21/25 in an interview with nursing supervisor RN #1 at 10:09 AM identified all physician's orders/nursing interventions should be included in the care plan and documented in the nursing notes. Review of the facility policy, Comprehensive Care Planning, dated 9/16/18, and currently in effect, directed in part, The interdisciplinary Team must review and update the care plan when the resident has been readmitted to the facility from a hospital stay. 2. Resident #207's diagnoses included diabetes mellitus and sepsis. The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #207 as cognitively intact, noted utilization of a walker and wheelchair, noted dependence for toileting and toilet transfer and indicated the resident was frequently incontinent of bowel and bladder. A nursing admission observation dated 10/11/2024 at 9:33 PM indicated in part Resident #207 required no assistance with personal care and had no difficulty controlling his/her bowel or bladder and indicated Resident # 207 had a surgical incision on the top of the right and left feet. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A physician's order dated 10/12/2024 directed non weight bearing status. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #207 as cognitively intact, required substantial maximum assistance for toileting and toilet transfers which did not occur and was frequently incontinent of bowel and bladder. A physician's order dated 11/20/2024 directed non weight bearing status to left foot and to keep dressing clean dry and intact until follow-up appointment. A physician's order on 12/2/2024 directed to provide Occupational Therapy (OT) for muscle weakness and on 12/3/2024 to provide OT for 5 sessions x 60 days for self-care training. The care plan dated 1/22/2025 revised on 1/4/2024 and 1/6/2025 indicated Resident #207 was incontinent of bowel and bladder. Interventions included in part to turn and reposition every 2 hours, apply barrier cream with incontinent care and to report any changes in skin to the physician. The care plan further indicated Resident #207 had a lack in ability to perform Activities of Daily Living (ADL) functions with rehabilitation potential. Interventions also included using the bedpan and bathroom. An interview and record review with LPN #8 on 1/29/25 at 11:35AM identified Resident # 207 was noted on the September and October 2024 MDS assessment as frequently incontinent of bowel and bladder. However, LPN # 8 was unable to locate an assessment of Resident #207's ability to participate in a bowel and bladder retraining program. An interview on 1/25/2025 at 11:25 AM with NA#8 indicated Resident #207 wanted to be independent and identified the resident does not use the bathroom or the commode but goes in the adult incontinent brief. NA# 8 also indicated she/he did not recall any plan for the resident to try to use the bathroom toilet, commode or bedpan An interview, record review and facility policy review on 1/25/2025 at 11:35 AM with LPN#8 indicated she/he was unable to find any bowel and bladder retraining or any refusals to use the commode or refusal of incontinent care by staff. LPN #8 further indicated not knowing if therapy was aware Resident #207 was not using the commode provided but shared while working second shift, she noted Resident #207 did not urinate or move bowels when the resident was in the wheelchair but waited until transferred back into bed to have urinate or move bowel into the diaper and cleans and changes his/herself. LPN # 8 indicated she/he would discuss this matter with the supervisor. On 1/29/25 at 12:40 an interview, record review, review of therapy notes/evaluations and discharge notes and review of facility policy with the Nursing Supervisor RN #1 identified Resident #207 as frequently incontinent of bowel and bladder on the MDS assessments and the facility policy indicated in part if a resident was frequently incontinent, they would be evaluated for participation in a bowel and bladder program. However, RN #1 was unable to provide any evidence that an evaluation was completed. The OT notes from December 2024 indicated the goal was to use commode. RN #1 indicated the need to speak to the staff who care for Resident #207 to learn resident's status, talk to therapy to see if they can assist resident further, and revise the care plan. RN #1 also indicated s/he would speak to Resident #207 to ensure the resident's preferences are reflected in the care plan. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility policy labeled Comprehensive Care Plan indicated in part, a comprehensive, person-centered care plan that meets the resident's physical, psychosocial and functional needs is to be developed and implemented for each resident. 48792		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. 37721 Based on clinical review, facility documentation, facility policy and interviews for of 1 of 5 sampled residents (Resident #144) reviewed for abuse, the facility failed to offer Activities of Daily Living (ADL) care to a resident who required toileting assist. The findings include: Resident #144 's diagnoses included the history of dysuria (painful urination) and bipolar disorder. The annual MDS assessment 10/1/24 identified Resident #144 as cognitively intact, frequently incontinent of urine and required one person assist with ambulation and toileting needs. The RCP dated 12/30/24 identified Resident #144 had a concern related to ADL function. Interventions included providing assist of one with transfers and toileting. The Point of Care History dated 1/15/24 at 5:41 AM during the 11:00 PM to 7:00 AM identified Resident #144 was last provided incontinent care on 1/15/25 at 8:44 PM and noted incontinent care and toileting needs 'Did not occur' during the 11:00 PM to 7:00 AM shift. An interview with Resident #144 on 1/16/25 (no time) identified s/he was last provided incontinent care at 9:00 PM the preceding night (1/15/25) and the 3rd shift (11:00 PM to 7:00 AM) staff did not check on h/her once until 6: 00 AM on 1/16/25 and that s/he was soaked with urine. The care plan was revised dated 1/16/25 to include offering incontinent care to Resident #144 during the 11:00 PM to 7:00 AM shift, provide incontinent pads/pull ups and anticipate toileting needs. A staff statement dated 1/17/25 identified NA #3 was assigned to Resident #144 on 1/15/25 overnight to 1/16/25 during the 11:00 PM to 7:00 AM shift. NA #3 identified she did not normally wake up Resident #144 for incontinent care during the night as s/he preferred not being changed unless awake and calling. NA #3 further identified she did not provide incontinent care to Resident #144 during the 11:00 PM to 7:00 AM shift until 5:41 AM when requested. A Reportable Event Summary dated 1/22/25 identified Resident #144 was last changed on 1/15/25 at 9:00 PM and did not wake up until 5:41 AM (indicating the resident went 7 hours without the benefit of incontinent care) when s/he requested to be changed which was completed. The care plan was revised to wake Resident #144 during rounds to offer incontinent care. An interview with the (interim) DNS on 1/27/25 at 2:12 PM identified she spoke with NA #3 who confirmed Resident #144 was not offered toileting on 1/15/25 overnight to 1/16/25 during the 11:00 PM shift to 7:00 AM shift as, according to NA #3, Resident #144 preferred not to be awakened for incontinent care. The DNS provided education to NA #3 to offer incontinent care during the 11:00 pm to 7:00 AM shift. The DNS further identified she would expect that staff check and offer to provide incontinent care to residents requiring assistance with toileting needs. If a resident does not want to be woken at night, the care plan should indicate the resident preference. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the facility policy for Activities of Daily Living directed residents will be provided care, treatment and services to maintain their ability to carry out ADL's. Appropriate care and services will be carried out for residents who are unable to independently perform elimination/toileting needs. Attempts to interview NA #3 were unsuccessful.		

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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** 37721 Based on clinical record reviews, review of facility documents, policy review and interviews for 1 of 2 residents (Resident # 144) reviewed for pain, the facility failed to ensure a a resident with reports of increasing pain was reported/assessed by an Registered Nurse and for 1 of 5 residents (Resident #324), reviewed for dignity, the facility failed to ensure a follow-up appointment with a specialist provider was provided as scheduled . The findings included: 1. Resident #144's diagnosest included history of dysuria (painful urination) and bipolar disorder. The annual MDS assessment 10/1/24 identified Resident #144 was cognitively intact, frequently incontinent of urine and required one person assist bed mobility and ambulation. The RCP dated 12/30/24 identified Resident #144 had a positive Preadmission Screening and Resident Review (PASRR) for a serious mental illness, refused medications and exhibited aggression at times. Interventions included providing education on the importance of taking medications and reapproach if refusing. The physician's orders dated 1/1/25 directed acetaminophen (Tylenol) 650 Milligrams (MG) every (6) hours as needed for pain or fever over 100.4F. The Medication Administration Record (MAR) dated 1/1/25 through 1/ 1/24 identified acetaminophen 650 mg was administered one time on 1/12/25 at 9:49 AM with good effect. An interview with Resident #144 on 1/16/25 (no time) identified on 1/15/25 during the 3:00 PM to 11:00 PM shift, she/he argued with the nurse, LPN #6, about only having Tylenol in place for pain and was told s/he could go to the hospital if preferred. A nurse's note dated 1/15/245 at 8:24 PM identified Resident #144 was alert and oriented and able to make needs known. Resident #144 complained of pain and when offered Tylenol (acetaminophen), refused stating it would not help the pain. The supervisor was notified, and no new orders were given. Resident #144 was notified and refused the Tylenol stating s/he was in too much pain to take anything. When reapproached, Resident #144 continued to refuse the medication. Education was provided for the reason s/he needed the medication. A Reportable Event Summary dated 1/22/25 identified Resident #144 was requesting Tramadol (opioid agonist pain medication) which was not prescribed. Tylenol was offered, and Resident #144 was told if s/he had pain she/he could go to the hospital. LPN #6 was interviewed and indicated Tylenol was offered, Resident #144 refused, and the nursing supervisor was notified with no further physician's orders. LPN #6 informed Resident #144 that if the pain was substantial to manage at the facility, s/he could go to the hospital as the next option and education on pain management was provided. An interview with the (interim) DNS on 1/27/25 at 2:12 PM identified she would have expected the nursing supervisor to be notified if a resident was complaining of 'too much pain' so an assessment could be completed for further consideration to send to the emergency room for evaluation. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with RN #1 on 1/27/25 at 2:46 PM identified she was the assigned nursing supervisor on 1/15/25 during the 7:00 AM to 3:00 PM. RN #1 identified between 3:00 PM - 4:00 PM during change of shift, she was contacted by LPN #6 who reported Resident #144 was having some pain. RN #1 instructed LPN #6 to obtain vital signs and offer Tylenol. RN #1 further instructed if Tylenol was ineffective, she would contact the APRN. RN #1 identified LPN #1 did not notify her Resident #144 was continually refusing Tylenol or that she was 'in too much pain'. RN #1 further identified if she was made aware she would have assessed Resident #144 and contacted the APRN. An interview with RN #3 on 1/27/25 at 3:16 PM identified he was the assigned nursing supervisor on 1/15/25 during the 3:00 PM to 11:00 PM shift. RN #3 identified he was not notified at any point during his shift of any concerns related to Resident #144. RN #3 further identified had he been made aware of a resident complaining of 'too much pain', he would have conducted an assessment and notified the APRN. An interview with LPN #6 on 1/28/25 at 2:12 PM identified she was the assigned nurse for Resident #144 during the 3:00 PM to 11:00 PM shift on 1/15/25. LPN #6 identified at approximately 5:00 PM Resident #144 complained of pain all over which was not unusual and was requesting Tramadol which had been previously prescribed for pain. In response LPN #6 offered Tylenol, but Resident #144 refused. LPN #6 reported the pain to RN #1 who instructed her to obtain vital signs. LPN #6 attempted to obtain vital signs, but Resident #144 refused stating she was in pain. LPN #6 also made two additional attempts to offer Tylenol and Resident #144 continued to refuse. LPN #6 informed Resident #144 she would add the concern related to pain and the use of Tramadol in the APRN book and that if the resident was in that much pain, s/he could go to the emergency room as a matter of providing education. LPN #6 identified she did not update the nursing supervisor Resident # 144 had refused vital signs, repeatedly refused Tylenol when offered and Resident #144 was in 'that much pain'. LPN #6 further identified she was not aware if the nursing supervisor checked on Resident #144 during the shift. A review of the facility policy for Change of Condition dated 1/19/18 notes every change of condition is to be assessed and documented properly. Any alteration in the resident's baseline is considered a change in condition. The LPN is to collect data and administer provider ordered treatments or medications as indicated. The RN is also to be notified accordingly. The RN will assess to determine if a change of condition had occurred and then make the APRN/MD aware by in person or telephone notification using the Situation-Background-Recommendation (SBAR) format. 2. Resident #324 was admitted to the facility on [DATE]. The residents' diagnoses included atrial fibrillation (an abnormal heart rhythm) and heart failure. A care plan dated 12/2/2024 identified Resident #324 had an alteration in cardiac status related to heart failure and atrial fibrillation. Interventions included: assessing changes in cardiac status, cardiology consultation and follow-up to check for edema or signs of cardiac overload. The admission MDS assessment dated [DATE] identified Resident #324 was cognitively intact and dependent on staff for wheelchair mobility. On 1/17/2025 at 12:13 PM, Resident #324 verbalized she/he missed her/his cardiologist appointment on 1/15/2025. Resident #324 further indicated she/he was in the lobby when staff told her/him that she/he would not be able to attend the 1/15/2025 appointment due to no staff escort. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/2025 at 10:55 AM, an interview with LPN#12 identified Resident #324 would have required an escort (either a staff member or family member) to attend her/his doctor's appointment on 1/15/2025. LPN #12 further indicated that on 1/15/2025, shortly after 3:00 PM, the Director of Recreation informed her that Resident # 324 did not make it to her/his doctor's appointment. A review of the medical record, including nursing progress notes, failed to identify that Resident #324 had missed a doctor's appointment. On 1/22/25 at 11:15 AM, an interview and record review of a transportation/appointment slip, and a daily transportation list dated 1/15/2025 with Transport Staff #1 identified Resident # 324 was scheduled to attend a cardiovascular appointment on 1/15/2025 at 2:00 PM via wheelchair and accompanied by a staff escort (Escort #1). Transport Staff #1 indicated that she was not aware of why the resident did not make it to the appointment. Transport Staff #1 further indicated that if the resident was to be accompanied by a staff escort, the escort would have been in the lobby waiting with the resident for the transportation van. On 1/22/2025 at 11:39 AM an interview and record review of the facility daily staffing breakdown for 1/15/2025 with the Regional Director of Human Resource (HR) and payroll identified Escort #1 did not work on 1/15/2025. On 1/22/2025 at 1:04 PM an interview with the Director of Recreation identified she was covering the front desk on 1/15/2025. The Director of Recreation indicated the transport van arrived to pick up Resident #324 for her/his doctor's appointment on 1/15/25. The Director of Recreation indicated that Resident #324 required an escort, but there was no escort with the resident. The Director of Recreation further indicated that she called Front Desk Security Staff #1, who at the time was covering the transportation desk. The Director of Recreation indicated that the transportation desk did not get back to her with a solution and the transport van left after about ten minutes without the resident. The Recreation Director further indicated that after the transportation van left, she took the resident back to the nursing unit and informed staff the resident had not made it to the appointment. On 1/22/2025 at 1:20 PM an interview with Front Desk Security Staff identified she did not recall a call from the Director of Recreation and indicated she was not aware Resident #324 had not made it to her/his appointment. On 1/23/2025 at 2:59 PM an interview with the DNS identified when an escort does not show up in time for a resident's pick-up time, the front desk would contact the nursing supervisor or the transportation desk. The DNS further indicated that the expectation was for the transportation desk to call the nursing supervisor who would then arrange for an alternate escort. The facility policy for sending escorts with residents to appointments notes pre-appointment preparation for the assigned escorts should include reviewing the resident's care plan, the resident's specific needs and verifying appointment details. However, the policy failed to identify a process for the unavailability of an escort. 48880		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical reviews, observations, review of policy and interviews for 1 of 4 residents reviewed for smoking (Resident #21), the facility failed to provide a safe smoking environment and for 1 of 4 residents (Resident #187) reviewed for accidents, the facility failed to ensure staff reported resident behavior that presented as a fire hazard. The findings included: 1. Resident 21's diagnoses included dementia and schizophrenia. The quarterly MDS assessment dated [DATE] identified Resident #21 as cognitively intact and required partial/moderate assistance with personal hygiene and substantial/maximal assistance for lower body dressing. The Facility Smoker list documentation dated 1/10/2025 identified Resident #21 as a smoker. Observation on 1/27/202 from 1:31 PM to 1:55 PM during the facility smoking break identified the following: a. There were 12 residents participating in the smoking break. Resident #21 was observed sitting in his/her wheelchair near the edge of the tent in the smoking patio. Resident #21 was wearing a smoking apron. Resident # 21's smoking apron was noted to be folding with the wind, resulting in her/his legs being uncovered. The security staff (Front Desk Security Staff #1) was observed behind the smoking cart located on the other side of the white tent. Front Desk Security Staff #1 had her back turned to the residents located under the tent while she was discarding items into a garbage can located next to the smoking cart. An interview with Front Desk Security Staff #1 identified she was not paying attention due to completing other tasks. Front Desk Security Staff #1 further indicated that had she noticed Resident # 21's leg uncovered, she would have repositioned the smoking apron. Additionally, Front Desk Security Staff #1 indicated the straps located toward the middle of the smoking apron were not used for residents in wheelchairs because she would not be able to strap them around the residents' waists. On 1/28/2024 at 1:07 PM, an interview and record review with the nursing supervisor (RN#1) identified the resident had an active care plan dated 10/9/2023, indicating the resident was at risk for dropping cigarettes during smoking breaks. Interventions included the application of a smoking apron during facility smoking times and encouraging resident to use a cigarette filter to have more room to hold onto the cigarette. Additionally, the medical record indicated the last smoking observation to assess Resident #21's smoking safety was on 4/25/2023. RN#1 indicated that nursing supervisors complete the smoking observation forms on admission and if there is a change in a resident's condition. RN#1 also indicated she was not sure if smoking observations were done quarterly. On 1/28/2025 at 1:48 PM an interview and record review with the MDS Coordinator (LPN#4) identified the last smoking assessment completed was on 4/25/2025 and the resident's care plan indicated the need for a smoking apron and a cigarette filter. LPN #4 indicated that smoking assessments should be done quarterly by the floor nurse. Furthermore, LPN#4 indicated that the interdisciplinary team is responsible for updating care plans. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/2025 at 3:30 PM an interview with the DNS indicated the staff assigned to supervise smoking should keep a direct line of sight of all residents smoking. Additionally, the DNS indicated smoking observations should be completed quarterly and that the DNS is responsible for overseeing quarterly assessments, including smoking assessments. After surveyor inquiry, a smoking assessment was completed for Resident #21 on 1/28/2025. b. An observation of the smoking cart, smoking patio, and the inside of the facility by the entrance to the smoking patio failed to identify a fire blanket was available for emergency use. Front Desk Security Staff #1 indicated she was not aware of a fire blanket being available. On 1/28/2025 at 1:40 PM an additional observation of Resident #21 during the smoking break identified that a fire blanket had become available after to surveyor inquiry. Additionally, observation identified Resident #21 had a smoking apron but did not have a cigarette filter. An observation of the smoking cart failed to identify the presence of a smoking filter or special holders. An interview with Front Desk Security Staff #1 indicated she was not aware of any filter being available. The facility policy for smoking identified smoking evaluations should be completed on admission, re-admission, quarterly, and with significant changes in condition. Additionally, the policy indicated that the supervised observation would determine resident safety and recommendations for any smoking safety apparatus. The facility smoking policy also indicated the staff member assigned to smoking supervision should have direct sight of residents to respond to emergency situations. 2. Resident 187's diagnoses included visual hallucinations and insomnia. The Annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #187 was cognitively intact. The care plan dated 11/25/2024 indicated Resident #187 had the potential for alteration in psychosocial wellbeing due to visual hallucinations. Intervention included in part to consult social services and psychiatric services as needed. An observation on 1/16/25 at 10:45 AM identified upon entering Resident # 187's room the lighting in room was pink, resident removed a piece of thin pink paper from on top of his/her overbed light a second piece remained on the other half of the light and indicated there was too much light during the day. An interview and observation 1/16/2025 at 12:20 PM with the Director of Maintenance identified with Resident #187 a few days ago and the resident indicated she/he wanted a roll shade to replace the taped in place of the fabric over her/his window, so I ordered one. The Director of Maintenance further indicated s/he had seen the paper on the overbed light on previous occasions and Resident #187 would remove it then put it back again. The Director of Maintenance indicated this practice was fire risk. The Maintenance Director denied informing the Administrator or the Director of Nursing Services (DNS) about Resident #187's unsafe practice and denied asking Resident #187 why he/she covers the overbed light to see if an alternative remedy could be made. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 1/16/2025 at 1:25 PM with the DNS and the Administrator identified they did not know Resident #187 was placing thin paper over the overbed light fixture stating this was a safety concern. They also indicated staff had not informed them of Resident #187's unsafe practice/behavior, but the issue would be corrected immediately. After surveyor inquiry, the care plan dated 1/14/2025 indicated Resident #187 chose to exercise personal preference as evidenced by placing paper items on top of the light to dim the room. Interventions included removing the second light bulb in the fixture to lower the light in the room, in addition to providing a battery powered light and to monitor the resident's behavior. 48880		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, facility policy and documentation for 1 of 1 resident (Resident # 104) reviewed for urinary retention, the facility failed to follow the resident's discharge summary physician's order for urinary retention and for 1 of 1 resident reviewed for Bowel and Bladder Incontinence (Resident #207), the facility failed to assess a resident with frequent incontinence for participation in a bowel and bladder re-training program. The findings included: 1. Resident #104 's diagnoses included urinary retention, and Urinary Tract Infection (UTI). The annual Minimum Data Set assessment dated [DATE] identified Resident #104 as cognitively intact and required maximum assistance with personal hygiene, toileting and bathing. A nurse's note dated 12/17/24 at 10:37 PM identified Resident # 104 returned from the hospital with a diagnosis of urinary retention. A physician's order dated 1/13/25 directed to perform a bladder scan every 6 hours while awake if possible and to conduct intermittent catheterization for (Post Void Residual urine) PVR greater than 600. If there is no bladder scanner then scheduled intermittent catheterizations every 6 hours while awake. The Resident Care Plan dated 1/14/25 identified the resident had urinary incontinence. Interventions included providing incontinent care every 2 hours and anticipating toileting needs. There were no revised interventions for urinary retention on the care plan. Review of the Treatment Administration Record (TAR) from 12/1/24 through 1/22/25 did not indicate that voiding trials, bladder scans, and intermittent catheterizations were done. On 1/21/25 in an interview with nursing supervisor RN #1 at 10:09 AM identified upon return from the hospital, the nurse would get verbal report from the facility, assess the resident upon return and review the W-10/ Intra- Agency Discharge Summary for any changed or new orders. RN #1 further indicated she would call the Advanced Practice Registered Nurse (APRN) if after hours or if APRN is in the facility she would review the discharge paperwork with him/her to confirm any new or changed physician's orders. RN#1 was unsure why Resident # 104's voiding trials were not documented per the 12/17/24 W-10 Intra-Agency Discharge Summary Report per physician's order. When asked why a bladder scan and/or intermittent catheterization was not completed as ordered per discharge summary dated 1/23/25, RN#1 identified the facility did not have a bladder scanner. RN #1 further stated the unit secretary reported no bladder scan to the urologist's office. When asked what her expectation would be for a resident with urinary retention, she stated that she would expect the resident to be on a voiding pattern every 6 -8 hours and if they did not void, they would have intermittent catheterization. RN #1 also identified this information should be included in the care plan and documented in the nursing notes. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Unit Secretary#1 on 1/21/25 at 10:00 AM identified she did not see the order on the W-10 Intra-Agency Discharge Summary Report for bladder scanning and therefore did not report to the urologist's office the facility did not have a scanner. In an interview with APRN #1 on 1/22/25 at 2:30 PM identified he would expect the nurses to do bladder scans, and/or intermittent catheterization as needed and watch for signs of UTI. If retention persists or a resident has a high PVR he would want the resident referred to urology. Review of facility policy, Policy for Management of Urinary Retention, undated, but current notes in part for chronic retention, catheterization, intermittent or indwelling, as appropriate. 2.Resident #207's diagnoses included diabetes mellitus and sepsis. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #207 as cognitively intact, noted utilization of a walker and wheelchair, noted dependence for toileting and toilet transfer and indicated the resident was frequently incontinent of bowel and bladder. A nursing admission observation dated 10/11/2024 at 9:33 PM indicated in part Resident #207 required no assistance with personal care and had no difficulty controlling his/her bowel or bladder and indicated Resident # 207 had a surgical incision on the top of the right and left feet. A physician's order dated 10/12/2024 directed non weight bearing status. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #207 was cognitively intact, required substantial maximum assistance for toileting and toilet transfers (which did not occur) and was frequently incontinent of bowel and bladder. A physician's order dated 11/20/2024 directed non weight bearing status to left foot and to keep dressing clean dry and intact until follow-up appointment. A physician's order on 12/2/2024 was directed providing Occupational Therapy (OT) for muscle weakness and on 12/3/2024 to provide OT for 5 sessions x 60 days for self-care training. The care plan dated 1/22/2025 was revised and reviewed on 1/4/2024 and 1/6/2025 identified Resident #207 as incontinent of bowel and bladder. Intervention included: to turn and reposition every 2 hours, apply barrier cream with incontinent care and to report any changes in skin to the physician. The care plan further indicated Resident #207 had a lack in ability to perform ADL with rehabilitation potential. Interventions included the use of the bedpan and bathroom. An interview and record review with LPN #8 on 1/29/25 at 11:35AM identified the resident was noted on the September and October 2024 MDS assessment to be frequently incontinent of bowel and bladder and indicated she/he was unable to locate an assessment of Resident #207's ability to participate in a bowel and bladder retraining program. An interview on 1/25/2025 at 11:25 AM with Nurse Aide (NA#8) indicated Resident #207 wants to be independent did not use the bathroom or the commode but goes in the adult incontinent brief. NA 3 8 also did not recall any plan to have the resident try to use the bathroom toilet, commode or bedpan (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview, record review, and facility policy review on 1/25/2025 at 11:35 AM with LPN#8 identified she/he was unable to find any bowel and bladder retraining or any refusals to use the commode or to refusal of incontinent care documented by the staff. LPN #8 further indicated she/he did not know if therapy was aware Resident #207 was not using the commode but shared while working second shift, she noted Resident #207 did not urinate or move bowels when up in the wheelchair but waited until transferred back into bed then urinated or had bowel movement in the diaper and the resident would clean and change his/herself. LPN # 8-further indicated she would discuss this with the supervisor. On 1/29/25 at 12:40 PM during an interview, record review, review of therapy notes/evaluations and discharge notes and review of facility policy with the Nursing Supervisor RN #1 identified Resident #207 was frequently incontinent of bowel and bladder on the MDS assessments and the facility policy indicated in part if a resident was frequently incontinent the resident would be evaluated for participation in a bowel and bladder program. However, RN #1 was unable to provide any evidence of an evaluation completed. The facility policy labeled Bowel and Bladder Program notes in part each resident with occasional or frequent incontinence shall be assessed for participation in a bowel and bladder program on admission, quarterly, and with a change in condition to establish continence or maximize control. 48792		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on review of the clinical record, facility policy review and interviews for 1 of 5 residents (Resident #105) reviewed for nutrition, the facility failed to ensure staff obtained a readmission weight timely and obtained re-weights for a resident at nutritional risk. The findings include: Resident #105's diagnoses included diabetes mellitus and abnormal weight loss. Resident #105's weight on 9/2/2024 was 120.3 pounds. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #105 was cognitively intact had no or no known weight loss and the resident weighed 120 Pounds. The Readmission Quarterly Nutritional Assessment indicated Resident #105 was readmitted from the hospital on 9/11/2024. The readmission weight was still pending but the hospital weight was 125 pounds with weights stable for 3 months and Resident #105 remained at nutritional risk. Resident #105's weight on 9/30/2024(14 days after readmission) was 125.4 pounds (a 5.1-pound weight gain since 9/2/2024). Resident #105's weight on 10/15/2024 was 127.3 pounds (a 2.1-pound weight gain since 9/30/2024). Entries for Resident #105's weight on 11/6/2024 at 1:07 PM and 11/07 2024 at 2:27 PM were struck out as invalid leaving no accurate monthly weight for the month of November 2024 for a resident with nutritional risk. (The invalid weights on 11/6/24 and 11/07/24 both indicated 112.1 pounds) A Dietician Progress Note dated 11/12/2024 at 1:27 PM indicated in part Resident # 105 was currently showing significant undesirable weight loss in one month and a reweight was requested to further assess trends. A Weight Change Assessment- Nutrition Progress Note completed by the Dietician on 11/21/2024 at 3:21 PM indicated Resident #105 was showing an undesirable/unplanned weight loss for 1, 3, and 6 months and a reweight was requested. Resident #105's weight on 12/9/2024 was 125.9 pounds) a 1.4-pound weight gain since 10/15/2024. A dietician progress note dated 12/9/2024 at 3:48 PM noted a review of Resident # 104's updated monthly weight obtained highly which suspected an outlier weight in November 2024 and now shows a significant weight gain while the resident continues to appear thin and indicated the outlier weights will be struck out form the chart and staff will continue to monitor trends. The care plan dated 12/18/2024 indicated Resident #105 was at increased risk for alterations in nutritional status. Intervention included providing current diet, monitoring weights per the facility policy. Resident #105's weight on 1/15/2025 was 111.6 pounds (a 14.3-pound weight loss since 12/9/2024). (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A reweight was completed on 1/16/2025 which noted 107.9 pounds at 12:33 PM and on 1/16/2025 at 12:34 PM another weight was obtained recorded at 108.2 pounds (a 2.7-pound weight loss since 12/9/2024). An interview, review of clinical record and facility documentation on 1/23/2025 at 11:58 AM with LPN#13 identified the weight book has no list for November 2024 but the computer weights that indicate invalid can be opened and identified a weight was 112.1 pounds. LPN #13 further indicated for requested reweighs nursing wait for the dieticians to send a form to request a reweight and once weights are obtained, they are sent to the dietician. LPN #13 indicated this is why so many sheets are not in the weight book. An interview and record review with Dietician #1 and #2 on 1/23/2025 at 1:30 PM identified reweighs are requested by the dieticians monthly and given the nursing unit and returned when completed. Dietician #1 indicated Resident #105's weight was discussed during the at-risk meeting. The first of November 2024 was considered and outlier, no reweight was completed the second entry was not a reweigh just a copy of the first weight. Dietician #1 further indicated the team talk with staff about obtaining reweighs but ultimately it is up to nursing to obtain the reweighs. The facility policy labeled Weight Policy notes new, and readmission weights will be obtained within 24 hours of admission/readmission and any resident displaying a significant change in weight of greater than or equal to 5% gain/loss in one month will be reported to the Registered Dietician and reweighed. The nurse aide under the supervision of the licensed nurse or the dietician will obtain all weights.		

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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** 48792 Based on clinical record review, observation, facility documentation, facility policy and interviews for 1 or 2 residents (Resident #78) reviewed for specialized treatment, the facility failed to ensure respiratory equipment was in working condition. The findings include: Resident #78 's diagnoses included Malignant Neoplasm of the Larynx, acute respiratory failure with hypoxia, and pulmonary hypertension. The Resident Care Plan dated 4/6/24 identified resident had an alteration in respiratory status. Interventions included to assess for changes in respiratory status and suction as needed. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #78 was cognitively intact and required maximum assistance with toileting, bathing, and supervision with personal hygiene. A physician's order dated 12/27/24 directed to clean and suction stoma/laryngectomy tube several times per day and to use saline irrigations to loosen any mucous. If patient is still having trouble breathing, remove the laryngectomy tube and repeat the suction technique. On 1/27/25 at 1:00 PM the Resident # 78 communicated that she/he had no power in his/her room since Friday (1/24/25) Her/his suction machine was not working. The resident stated she/he told everyone on Friday; however, she/he was unable to identify any staff by name. The resident also stated she/he told maintenance. Observation and interview with the Regional Administrator on 1/27/25 at 1:00 PM identified he was not aware that the residents' room did not have power. He stated that there is an electrician on site to determine what the problem is at this time. The surveyor asked the Regional Administrator to turn the suction machine on, when he did there was no power. He was unable to state what the backup plan should have been. In an interview with LPN #1 on 1/27/25 at 1:10 PM identified she was unaware that the resident did not have power over the weekend. She was made aware on Monday 1/27/25. At 1:30 PM returned to unit, Regional Administrator stated that the power is back on, it was a tripped breaker. The suction machine was working. In an interview with the DNS on 1/27/25 at 1:40 PM identified she was unaware of the loss of power. She further stated that her expectation would be that the nurse supervisor report to her any power outage issues, and the resident would be moved to a room with power. There is no battery powered suction machines in the facility. In an interview with Maintenance Staff #1 on 1/27/25 at 1:50 PM identified Resident # 78 told him the power was off in his/her room at approximately 6:30 PM on Friday. He also stated that he investigated the issue and discovered it was a breaker so he called the supervisor who said he/she would call an electrician, and the electrician came out today. He also identified that he told everyone on the unit about the loss of power, including the charge nurse. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an Interview with the DNS on 1/27/25 at 2:00 PM identified she would have expected the Director of Maintenance to call the electrician and have them come out immediately. The maintenance staff is on site until 7:00 PM on Fridays. In an Interview with the Director of Maintenance on 1/27/25 at 2:20 PM identified he was aware that Resident # 78 was without power but not the room number. He further stated he told his staff member to take room [ROOM NUMBER] offline and move the resident to a different room. If he had known about the room number, he would have given the same direction. In an interview with NA#2 on 1/27/25 at 3:00 PM identified she worked on Sunday 1/26/25 but was unaware that the resident's power was out. She was called to the resident's room at least once. In an interview with LPN #3 on 1/27/25 at 3:05 PM identified she worked Sunday 1-26-25 but was unaware that Resident # 78's power was out. She also stated the resident's call bell was working. Review of the 24-hour report from Friday 1/24/25 through 1/27/25 identified Resident # 78 room had no power. In an interview with nursing supervisor RN #2 on 1/27/25 at 3:38 PM he was not aware Resident # 78's room did not have power. He further stated that if he knew of a power outage, he would have moved the resident to another room. Maintenance Staff #1 was here on Friday evening; however, he did not mention anything about Resident # 78 not having power. In an interview with the Director of Maintenance on 1/28/25 at 11:10 PM identified each room has its own breaker and the call bells are on another circuit. He confirmed that there was an electrician on site all weekend and if he had known about Resident # 78's power outage, he would have had the electrician identify and correct the issue. The Director of Maintenance also stated that he spoke with the nursing staff that were on over the weekend, and no one was aware of the issue. In an interview with the Medical Director on 1/28/25 at 3:00 PM, it was identified the resident was at risk by not having power to his/her suction machine. His expectation would be that the resident would be moved to another room with power. The Medical Director indicated he was unaware of any power issues at the facility. Attempts were made to contact the weekend supervisor but were unsuccessful. Although requested, a policy on power outages was not obtained.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record reviews, review of facility policy and interviews for 5 of 6 residents (Residents #14, #39, #84, #111 and #424) reviewed for dialysis, the facility failed to ensure staff consistently monitored vital signs, the resident's hemodialysis access sites and follow facility policy. The findings included. 1. Resident #14's diagnosis includes diabetic chronic kidney disease. A physician's order dated 9/3/2024 directed for Resident #14 to go to specialized treatment center 3 times per week due to renal failure. The quarterly Minimum Data Set (MDS) dated [DATE] indicted Resident #14 was cognitively intact and had received dialysis. The care plan dated 11/29/2024 indicated Resident #14 was at risk for complications related to renal function requiring dialysis. Interventions included checking hemodialysis access site for signs of bleeding, infection or abnormality, to check access bruit and thrill daily and to monitor vital signs. An interview clinical record review and review of facility policy with RN #1 (nursing supervisor), on 1/23/2025 at 12:49 AM indicated every dialysis resident should have standing orders for the nurses to document. However she/he could not find any physician's order just occasional documentation in the nurses notes for Resident #14 but was able to locate a care plan. 2. Resident #39's diagnosis includes End Stage Renal failure. The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #39 was cognitively intact and received dialysis. The care plan dated 12/30/2024 indicated Resident #39 was at risk for complications related to requiring dialysis. Interventions included: checking hemodialysis access site for signs of bleeding, infection or abnormality, to check access bruit and thrill daily, in an emergency to apply pressure to the access site and call 911, and to monitor resident post dialysis for any changes in vital signs or complications. An interview clinical record review and review of facility policy with RN #1 (nursing supervisor) on 1/23/2025 at 1:00 PM ending at 1:10 PM identified every dialysis resident should have standing orders for the nurses to document but she/he could not find any physician's orders or consistent documentation for Resident #39 but was able to locate a care plan. RN #1 further indicated physician's orders will need to be entered so the nurses can document. After surveyor inquiry, physician's orders were obtained on 1/26/2025 to obtain vital signs before and after dialysis, to check the bruit and thrill of the dialysis Arterial-vascular (A/V) Fistula, to check for bleeding at the site and report changes to the APRN /MD every shift. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #84's diagnoses included kidney failure and stage 4 kidney disease. A physician's order dated 6/6/2024 directed to obtain dialysis treatment 3 times a week for renal failure. The annual Minimum Data Set (MDS) dated [DATE] indicated Resident #84 was cognitively intact and did not receive dialysis. The care plan dated 12/11/2024 indicated Resident #84 was at risk for complications related to the need for dialysis. Interventions included in part: to monitor the dialysis access site for patency, bruit and thrill daily and after each dialysis treatment if bleeding apply pressure and call 911. The interventions also included to monitor resident vital signs for changes upon return from dialysis and for any complications. An interview clinical record review and review of facility policy with RN #1 (nursing supervisor) on 1/23/2025 at 1:10 PM to 1:20 PM indicated every dialysis resident should have standing orders for the nurses to document . However, she/he could not find any physician's orders just occasional documentation of some blood pressure taken after dialysis which was not consistent but was able to locate a care plan. 4. Resident #111's diagnosis included end stage renal disease and dependence on renal dialysis. The annual Minimum Data Set (MDS) dated [DATE] indicated resident #11 was cognitively intact. An interview and record review with the Nursing Supervisor (RN #1) on 1/25/2025 at 1:20 PM to 1:25 PM identified no specific physicians' orders or consistent documentation related to monitoring the dialysis access site and specific needs for a resident receiving renal dialysis as reflected in the facility policy were found in the medical record. RN 31 further indicate she/he would have information added. On 1/26/2025 after inquiry, physicians' orders were obtained and directed to monitor the dialysis access site every shift for complications checking for bruit and thrill, bruising and bleeding, and to check vital signs before and after dialysis twice daily. After inquiry, a plan of care was created dated 1/26/2025 indicating Resident #111 was at risk for complications secondary to hemodialysis. Interventions included : to encourage adherence to fluid restriction, assist with obtaining transportation to dialysis, communicate with the dialysis center with communication book and in event of a vascular access emergency to apply pressure to the dialysis access site and call 911, monitor the access site for patency bruit and thrill daily and after each dialysis visit and to monitor resident after return from dialysis for changes in vital signs, pain or discomfort. 5. Resident #424's diagnosis includes chronic kidney disease. The admission nursing assessment dated [DATE] indicated Resident #424 was alert and oriented. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 12/31/2024 directed to obtain vital signs before and after dialysis. The care plan dated 1/1/2025 indicated Resident#424 was at risk for complications of infection hypotension, altered electrolyte status due to the need for renal dialysis and other contributing comorbidities. Interventions included: to transport to dialysis as ordered, communicate with the dialysis center via the communication book, monitor the hemodialysis site daily and after each dialysis treatment for bleeding, bruit and thrill, infection, and in the event of an emergency apply pressure to the vascular access site and call 911. An interview and record review with RN #1 on 1/23/2025 at 1:25 PM to 1:30 PM indicated Resident #424 went to dialysis on 1/17/2025 with no vital signs documented before or after dialysis as ordered by the physician. The facility policy labeled Monitoring Residents Receiving Hemodialysis indicated in part : the facility's policy is to maintain ongoing assessment and monitoring of residents receiving hemodialysis in order to optimize the benefit from treatment and avoid complications The procedure include to check the vascular access site for signs and symptoms of infection or bleeding, have the bruit and thrill of a vascular device checked and documented, to have the site washed with soap and water daily, to take vital signs upon return from dialysis treatments and as needed and noted in case of emergency with the vascular access site bleeding to apply direct digital pressure and to call 911.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on clinical record reviews, reviews of facility policy and staff interviews for 1 of 1 resident (Resident #166), reviewed for physician visits, the facility failed to ensure that physician visits were completed timely. The findings include: Resident #166 was admitted on [DATE]. The residents' diagnoses included chronic kidney disease, and atrial fibrillation (an abnormal heart rhythm). The quarterly MDS assessment dated [DATE] indicated Resident #166 was cognitively intact and had clear speech. Additionally, the MDS identified Resident #166's primary medical condition category as medically complex conditions. On 1/16/2025 at 12:49 PM an interview with Resident #166 identified the resident would like to see his/her primary care physician (PCP) to coordinate his/her care. Resident #166 indicated she/he has seen five different APRN's while at the facility but has not seen a Medical Doctor (MD). A review of the clinical record from 6/4/2022 through 1/16/2025 identified the last note by a physician (MD) was an admission history and physical dated 6/7/2022. Other notes categorized as physician notes in the electronic medical record were written by non-physician providers. On 1/28/2025 at 1:35 PM, an interview with the Medical Director Resident #166's attending physician identified the Advanced Practice Registered Nurse (APRN) would see residents and the Medical Director would go in every sixty days and sign orders. The Medical Director indicated that when he examines residents, he will write a note in the electronic medical record, and he has seen residents who have requested to be evaluated. The Medical Director also indicated he had been with the facility for six months and he may have examined Resident #166 and may not have written a note. On 1/28/2025 at 3:07 PM during an interview and record review with the DNS identified the last physician note in the resident's medical record was an admission history and physical note dated 6/7/2022. The DNS further indicated that the attending physician alternated with the APRN for the required number of visits and examined residents. Additionally, the DNS indicated the physician's progress notes are uploaded to the resident's medical record by the facility. The DNS further indicated she/he could not explain why there were no physician notes since 6/7/2022. The DNS indicated the facility tracks physician visits by their notes and by the sign-in book at the front desk. Review of facility policy for physician services given onsite during the survey notes the physician should write, sign, and date progress notes at each visit. The facility policy further indicated that a resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least every 60 days thereafter.		

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

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Observe each nurse aide's job performance and give regular training. 46046 Based on review of facility documentation of Employee files and staff interview for 4 of 4 Nurse Aides (Nurse Aides # 5, # 6, # 7 and # 8,) reviewed for yearly annual inservices, the facility failed to ensure annual performance evaluations were completed. the findings included. On 1/28/25 at 2:00 PM an interview and review of Employee files, facility document review with the Human Resource (HR) Director and the Director of Nursing Services (DNS) identified no performance evaluations for NA#5, #6, #7, and #8 since 4/4/2022 to present. Although the DNS indicated she/he would look in the nursing offices for the missing employee evaluations in case the evaluations were located elsewhere, no performance evaluations were provided.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, observations, facility documentation, facility policy and interviews for 28 of 28 sampled residents (Resident #105, #89, #151, #183, #19, #474, #113, #475, #190, #476, #96, #163, #148, #133, #21, #100, #200, #199, #177, #479, #185, #182, #188, #143, #198, #147, #193, #211) reviewed for medication storage, the facility failed to develop and implement policies for the recordkeeping of individual use and chain of custody controlled substances, failed to maintain an unbroken chain of custody for controlled medications once received and distributed to nursing unit(s) and failed to document inventory across shifts and failed to maintain an accurate disposition log for the destruction and return of unused controlled medication. The findings included: 1 a Resident #143's diagnosis includes Opioid dependence. The quarterly MDS assessment dated [DATE] identified Resident # 143 had intact cognition and required set up assist with eating and independent with dressing. The care plan dated [DATE] identified Resident #143 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and to monitor for changes. The physician's orders dated [DATE] directed Methadone 119 Milligram (MG) once daily Monday through Friday between 7:00 AM and 3:00 PM. Medication nurse to sign off on the order and Methadone 119mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. An observation on [DATE] at 9:58 AM identified LPN #5 standing behind the medication cart outside Resident #143's room. The top surface area was absent of any Medical Record or electronic device for the purpose of viewing clinical information. LPN #5 opened the top drawer and removed a labeled, pre-prepared dose of methadone 119mg for Resident #143. LPN #5 then proceeded into Resident #143's room, verify the resident's identity and hand the single dose vial to h/her. Resident #143 opened the bottle, breaking the seal, self-administered the methadone returned the empty bottle back to LPN #5. LPN #5 then exited the resident room and place the empty bottle in a designated area of the medication cart for disposal. b Resident #105's diagnosis includes Opioid dependence. The quarterly MDS assessment dated [DATE] identified Resident #105 had intact cognition and required set up assist with eating and independent with dressing. The care plan dated [DATE] identified Resident #105 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's orders dated [DATE] directed Methadone 40mg once daily Monday through Friday between 7:00 AM and 3:00 PM. Medication nurse to sign off on the order and Methadone 40mg once daily Saturday and Sunday between 4:00 AM and 7:00 AM. Charge nurse to administer Methadone on the 11:00 PM - 7:00 AM shift on Saturday through Sunday weekly. c. Resident #89's diagnosis includes Opioid dependence. The quarterly MDS assessment dated [DATE] identified Resident #89 had intact cognition and required set up assist with eating and assist of one with dressing. The care plan dated [DATE] identified Resident #89 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone for self-administration and to monitor for changes if Methadone dose was adjusted. The physician's orders [DATE] directed Methadone 100mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 100mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. d. Resident #151's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #151 had intact cognition and independent with eating and dressing. The care plan dated [DATE] identified Resident #151 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and to monitor for changes. The physician's orders dated [DATE] directed Methadone 130mg once daily Monday through Friday between 7:00 AM and 3:00 PM. Medication nurse to sign off on the order and Methadone 130mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. The charge nurse to administer the Methadone dose on the 11:00 PM to 7:00 AM shift Saturday and Sunday. e. Resident #183's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #183 had intact cognition and required set up assist with eating and was independent with dressing. The physician's orders dated [DATE] directed Methadone 130mg once daily Monday through Friday between 7:00 AM and 3:00 PM. Medication nurse to sign off on the order. Additionally, physician's order dated [DATE] directed Methadone 130mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. The care plan dated [DATE] identified Resident #183 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and to monitor for changes. f. Resident #19 had diagnoses that included Opioid abuse. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission MDS assessment dated [DATE] identified Resident #19 had intact cognition, required set up assist with eating and assist of one with dressing. The care plan dated [DATE] identified Resident #19 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes. The physician's orders dated[DATE] directed Methadone 10mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 10mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. g. Resident #474's diagnosis includes Opioid dependence. The care plan dated [DATE] identified Resident #474 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone for self-administration and to monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 65mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 65mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. The admission MDS assessment dated [DATE] identified Resident #474 had intact cognition independent with eating and required assist of one with dressing. h. Resident #113's diagnosis includes Opioid dependence. The quarterly MDS assessment dated [DATE] identified Resident #113 had intact cognition and required set up assist with eating and was independent with dressing. The care plan dated [DATE] identified Resident #113 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone for self-administration and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 120mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 120mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. The charge nurse to administer the Methadone dose on the 11:00 PM to 7:00 AM shift Saturday and Sunday. i. Resident #475's dignosis includes Opioid abuse. The care plan dated [DATE] identified Resident #475 received Methadone maintenance treatment therapy. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interventions included providing the resident with a daily dose of Methadone and monitor for changes. The admission MDS assessment dated [DATE] identified Resident #475 had intact cognition required set up assist with eating and was independent and dressing. The physician's orders dated [DATE] directed Methadone 100mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 100mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. j. Resident #190's diagnosis includes Opioid dependence. The quarterly MDS assessment dated [DATE] identified Resident #190 had intact cognition and required set up assist with eating and was independent with dressing. The care plan dated [DATE] identified Resident #190 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone for self-administration and to monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 100mg once daily Monday through Friday between 7:00 AM and 3:00 PM an, Methadone 100mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. k. Resident #476's diagnosis includes Opioid abuse. The care plan dated [DATE] identified Resident #476 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone. The admission MDS assessment dated [DATE] identified Resident #476 had intact cognition and required set up assist with eating and substantial one person assist with dressing. The physician's orders dated [DATE] directed Methadone 120mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 120mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. l. Resident #96's diagnosis includes Opioid abuse. The care plan dated [DATE] identified Resident #96 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and to monitor for changes if Methadone dose was adjusted. The admission MDS assessment dated [DATE] identified Resident #96 had intact cognition and required set up assist with eating and substantial,d+[DATE] person assist with dressing. The physician's orders dated [DATE] directed Methadone 50mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 50mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	m. Resident #163's diagnosis includes Opioid abuse. The care plan dated [DATE] identified Resident #163 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 100mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 100mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. The admission MDS assessment dated [DATE] identified Resident #163 had intact cognition, required set up assist with eating and one person assist with dressing. n. Resident #148's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #148 had moderate cognitive impairment, required set up assist with eating and ,d+[DATE] person assist with dressing. The care plan dated [DATE] identified Resident #148 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 160mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 160mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. o. Resident #21's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #21 had intact cognition, required set up assist with eating and 1 person assist with dressing. The care plan dated [DATE] identified Resident #21 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 99mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 99mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. p. Resident #133's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #133 had moderately impaired cognition, required set up assist with eating and 1 person assist with dressing. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician's orders dated [DATE] directed Methadone 30mg once daily Monday through Friday between 7:00 AM and 3:00 PM, to be administered by Methadone nurse and Methadone 30mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM, To be administered by the 11:00 PM to 7:00 AM shift. Empty bottles to be returned to the nursing supervisor after administration. The care plan dated [DATE] identified Resident #133 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. q. Resident #100's diagnosis that includes Opioid abuse. The annual MDS assessment dated [DATE] identified Resident #100 had intact cognition was independent with eating and dressing. The care plan dated [DATE] identified Resident #100 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 5mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 5mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM, To be administered by the 11:00 PM to 7:00 AM shift. r. Resident #200's diagnosis includes Opioid abuse. The admission MDS assessment dated [DATE] identified Resident #200 was severely cognitively impaired and dependent with eating and dressing. The care plan dated [DATE] identified Resident #200 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 10mg once daily Monday through Friday between 7:00 AM and 3:00 PM, Methadone nurse to sign off orders and Methadone 10mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. s. Resident #199's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #199 had intact cognition, required set up assist with eating was independent with dressing. The care plan dated [DATE] identified Resident #199 received Methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 80mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 80mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM, nursing to return bottles to nursing supervisor after administration. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	t. Resident #177's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #177 had moderately impaired cognition, required set up assist with eating one person assist with dressing. The care plan dated [DATE] identified Resident #177 received methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 80mg once daily Monday through Friday between 7:00 AM and 3:00 PM, methadone to be signed off by the nurse; and Methadone 80mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM, charge nurse will administer on the 11:00 PM -7:00 AM shift Saturday through Sunday. u. Resident #479's diagnosis includes Opioid abuse. The admission MDS assessment dated [DATE] identified Resident #479 had intact cognition, required set up assist with eating one person assist with dressing. The care plan dated [DATE] identified Resident #479 received methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 120mg once daily Monday through Friday between 7:00 AM and 3:00 PM, methadone to be signed off by the nurse and Methadone 120mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. v. Resident #185's diagnosis includes Opioid abuse. The annual MDS assessment dated [DATE] identified Resident #185 had intact cognition, required set up assist with eating and was independent with dressing. The care plan dated [DATE] identified Resident #185 received methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 80mg once daily Monday through Friday between 7:00 AM and 3:00 PM, methadone to be signed off by the nurse and Methadone 80mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM, charge nurse will administer on the 11:00 PM -7:00 AM shift Saturday through Sunday. w. Resident #182's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #182 had intact cognition, required set up assist with eating and was independent with dressing. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated [DATE] identified Resident #182 received methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 130mg once daily Monday through Friday between 7:00 AM and 3:00 PM, methadone to be signed off by the nurse and Methadone 130mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. x. Resident #188's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #188 had intact cognition, required set up assist with eating and was independent with dressing. The physician's orders dated [DATE] directed Methadone 65mg once daily Monday through Friday between 7:00 AM and 3:00 PM, methadone to be signed off by the nurse and Methadone 65mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM, charge nurse will administer on the 11:00 PM -7:00 AM shift Saturday through Sunday. The care plan dated [DATE] identified Resident #188 received methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. y. Resident #198's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #198 had intact cognition, required set up assist with eating and was independent with dressing. The care plan dated [DATE] identified Resident #198 received methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 115mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 115mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM. z. Resident #147's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #147 had intact cognition, required set up assist with eating and was independent with dressing. The care plan dated [DATE] identified Resident #147 received methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 135mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 135mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM, charge nurse will administer on the 11:00 PM -7:00 AM shift Saturday through Sunday. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the (interim) DNS on [DATE] at 10:17 AM identified the assigned nurse overseeing the administration of methadone was responsible for signing off in the Medication Administration Record (MAR). The DNS further identified residents should be signing a chain of custody following self-administration of the methadone. 1. aa. Resident #193's diagnosis includes Opioid abuse. The quarterly MDS assessment dated [DATE] identified Resident #193 had intact cognition, required set up assist with eating and assist of one with dressing. The care plan dated [DATE] identified Resident #193 received methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 150mg once daily Monday through Friday between 7:00 AM and 3:00 PM and Methadone 150mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM, charge nurse will administer on the 11:00 PM -7:00 AM shift Saturday through Sunday. 1.bb. Resident #211's diagnosis includes Opioid abuse. The admission MDS assessment dated [DATE] identified Resident #211 had intact cognition, independent with eating dressing. The care plan dated [DATE] identified Resident #211 received methadone maintenance treatment therapy. Interventions included providing the resident with a daily dose of Methadone and monitor for changes if Methadone dose was adjusted. The physician's orders dated [DATE] directed Methadone 120mg once daily Monday through Friday between 7:00 AM and 3:00 PM, methadone nurse to sign off order and Methadone 120mg once daily Saturday through Sunday between 4:00 AM and 7:00 AM, charge nurse will administer on the 11:00 PM -7:00 AM shift Saturday through Sunday. An interview with LPN #5 on [DATE] at 9:58 AM identified she has been employed at the facility for three years. Since October of 2024, LPN #5 held the primary role of methadone nurse, responsible for the acquiring and maintaining the chain of custody of the methadone at this, and other facilities. During her time at the facility, residents were not required to sign for the medication at the time of self-administration. LPN #5 further identified that while individual chain of custody procedures was implemented in the other facilities she works, it was not a standard of practice in this facility. Instead, only the medication nurse was responsible for signing for the methadone in the MAR. An interview with the (interim) DNS on [DATE] at 10:17 AM identified the assigned nurse overseeing the administration of methadone was responsible for signing off in the MAR. The DNS further identified residents should be signing a chain of custody following self-administration of the methadone but had not been completing routine audits to ensure the process was being followed. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interviews for Resident #105, Resident #151, Resident #190, Resident #476 and Resident #96 on [DATE] at 9:27 AM identified they all self-administer their own medication and (after to surveyor inquiry) began signing for their Methadone following self-administration. The facility failed to maintain accurate record keeping for individual use and chain of custody for prescribed methadone. A review of the facility policy for Methadone Maintenance failed to include resident participation in self-medication administration and individual record keeping of tapering doses. 2. A review of the facility chain of custody for Methadone received at the facility dated [DATE] through [DATE] identified no documented chain of custody by two nurses once the methadone was received, no documented chain of custody when the Methadone was brought to the nursing units for weekend dispensing and no accounting between shifts by nursing staff. An interview with LPN #5 on [DATE] at 9:58 AM identified, beginning [DATE], she held the primary role of methadone nurse, responsible for acquiring and maintaining the chain of custody of the methadone for the facility. LPN #5 identified she obtained a two-week supply of the methadone from a community substance use treatment clinic for each resident involved in the medication assisted program. A chain of custody was signed by herself and the clinic nurse when obtaining the methadone. LPN #5 then transported the medication back to the facility. A subsequent interview and facility documentation review on [DATE] at 9:15 AM with LPN #5 identified she routinely checked in the methadone with the nursing supervisor on Tuesdays after returning from the clinic. However, did not require a second nurse to sign a chain of custody after the medication was received by the facility as she was solely responsible for its distribution. LPN #5 further identified she also routinely signed out and provided methadone for the weekend staff and store it in a separate medication room on a nursing unit. LPN #5 identified she previously maintained a logbook for chain of custody for the methadone for the weekends. However, the book has not been maintained by LPN #5 who continued to provide methadone to the nursing units for the weekend without obtaining a chain of custody signature from another nurse. Additionally, LPN #5 identified there was no record keeping across shifts for the methadone where two nurses signed alongside each other. Further, LPN #5 identified that while she followed standards of practice in other facilities where she performed the same duties, she followed the practice that was already established by this facility and never questioned the standard of practice. An interview with RN #1 on [DATE] at 9:20 AM identified she occasionally worked the 11:00 PM to 7:00 AM shift as the nursing supervisor including weekends when methadone was administered. LPN #5 was responsible for bringing the medications to the unit for the weekend. There previously was a chain of custody logbook on the unit that noted the accounting of the methadone when used. However, RN #1 had not seen the book in some time and had not inquired about the status. An interview with the DNS on [DATE] at 11:04 AM identified she was unaware there was no accurate record keeping and accountability of the methadone once received. The DNS identified it was expected that two nurses sign for the methadone once in the building and any time it was provided to the nursing unit for weekend dosing with documented record keeping between two licensed staff across all shifts. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A subsequent interview with RN #1 on [DATE] at 11:22 AM further identified she routinely worked as the nursing supervisor on the 7:00 AM to 3:00 PM shift on Tuesdays but never participated in checking in the methadone to the facility alongside LPN #5. The facility failed to maintain complete and accurate record keeping and accounting of methadone, failed to maintain documented chain of custody once the methadone was brought back to the facility, when dispersed to nursing units for weekend dosing and failed to maintain complete documented accountability of the methadone across shifts between two licensed staff. A review of the facility policy for Methadone maintenance dated [DATE] directs that methadone is stored at the facility as any other controlled substance and counted at the beginning and end of each shift. A revised policy dated [DATE] failed not include this requirement. The facility policy for Controlled Substance Handling (no date) directs all controlled drugs are subject to special receipt, handling, storage, disposal and record keeping. All controlled drugs delivered to the facility are counted by two nurses to verify the count and then stored in a double locked cabinet with two separate keys with the medication nurse maintaining possession of the keys. A controlled accountability record shall be prepared when receiving and checking in a controlled drug. A physical inventory of all controlled rugs is made at the change of each shift by two licensed staff and documented on an audit record. 3. A review of the 19 of 19 Methadone Destruction Worksheets representing residents who had been discharged , leave of absence or expired identified only one nursing signature belonging to LPN #5 and the worksheet did not include the signature of the resident (as able). An interview with LPN #5 on [DATE] at 9:58 AM identified, beginning [DATE], she held the primary role of methadone nurse, responsible for acquiring and maintaining the chain of custody of the methadone for the facility. LPN #5 further identified that while destruction of the methadone took place with another nurse, she was unable to explain why each log contained just her signature with no documented second signature by a licensed staff or who any staff was for a procedure that routinely took place alongside another licensed staff. Further, LPN #5 was unable to explain why the resident also did not sign the Methadone Destruction Worksheets, when able. LPN #5 identified any unused methadone was destroyed at the facility with a copy provided to the clinic. An interview with Person #1, Nursing Supervisor for the community outpatient Methadone clinic where services were provided on [DATE] at 12:00 PM identified it was acceptable practice for the facility to perform medication destruction for unused methadone at the facility and provide a copy of the destruction log upon completion. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DNS on [DATE] at 11:04 AM identified Methadone was destroyed at the facility and not consistent with facility policy she would expect all destruction logs to be signed by two licensed staff alongside each other at the time of destruction and was not aware the procedure was not being followed. A review of the facility policy for Methadone Maintenance dated [DATE] directed directs the clinic to be notified and unused bottles to be returned to the clinic. A review of the facility policy for Controlled Drug Handling (no date) directs discontinued controlled drugs are to be returned to the nursing office after the count has been verified and stored in a double locked cabinet in the nursing office until permission to destroy had been obtained.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49100 Based on tour of the dietary department and staff interview, the facility failed to ensure food was served at an appropriate temperature to maintain palpable taste. The findings include: A tour of the dietary department between 1/16/25 through 1/27/25 with the Food Service Director identified below: Observation of the tray line on 1/22/25 at 7 :00 AM identified the eggs temperature for scrambled eggs at 196 degrees Fahrenheit and hot cereal was at 195 degrees Fahrenheit. During the plating, the scrambled eggs were placed in a heating tray. Observation on 1/22/25 at 7:40 AM of the plating for the last (4th) food chart identified the food chart leaving the kitchen at 8:19AM. Observation on 1/22/25 at 8:23 AM of food cart arrival to third floor, unit D3. Observation on 1/22/25 at 8: 36AM of the food cart identified the door was left open. Observation on 1/22/25 at 8:48AM of last meal tray leaving the kitchen in a food cart identified during a test tray scrambled eggs were tempted at 88.2 degrees and Oatmeal was 131.2 degrees. An interview with the Food Service Director on 1/22/25 at 8:48AM identified the expectation is that food should be hot and should be served hot. The food Service Director identified that she/he believes the food was not served at the correct temperature due to the timing the food was served and the containers' ability to maintain the temperatures while in transport.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49100 Based on tour of the dietary department and staff interview, the facility failed to serve food under sanitary conditions. The findings include: The tour of the dietary department between 1/16/25 through 1/27/25 with the Food Service Director identified the following. On 1/27/25 a one test tray was ordered. The dietary department provided baked chicken, rice and assorted vegetables. Observation on 1/22/25 at 11:58AM of the identified a black, thin, hair-like object in the assorted vegetable. The interview with the Food Service Director on 1/27/25 at 12:23 PM identified he believes the A black, thin, hair-like object in the assorted vegetable might be a string which may have come from the lining of the vegetable bag. The Food Service Director also indicated he believes in the future it would be better to defrost the vegetables/ spread them out to ensure no stings were in them.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46046 Based on observation, facility policy review and staff interviews, the facility failed to ensure staff followed correct infection control practices for a resident (Resident #86) requiring droplet and contact precautions and failed to ensure staff followed appropriate infection control practices when a resident bathroom sink (Resident #164 and #181) was out of service. The findings included: 1. On 01/21/25 at 12:11 PM observation identified NA # 4 entering Resident #86's room wearing an isolation gown, gloves, and face shield over a regular face mask. Signage outside the door indicated the need for contact and droplet precautions and a cart with Person Protective Equipment (PPE) including N95 masks was located just outside the doorway. Further observations identified after NA #4 doffed the gown into the trash in the room along with the gloves and carried the face shield to the sink at the nurse's station, washed hands and place the face shield in another location behind the nursing station. An interview with NA #4 on 1/21/2025 at 12:15 PM indicated s/he should have worn, and N-95 mask not a regular mask but had forgotten to do so. On 1/21/2025 12:20 PM an interview with the charge nurse LPN #8 indicated an N-95 mask should have been worn by NA#4 due to the precautions Resident #86 required. On 1/22/2025 at 11:00AM an interview with the Infection Preventionist (IP) LPN #8 indicated identified an N-95 mask along with other PPE should have been worn when entering Resident #86's room and a new mask would be required each time. The IP(LPN #8) further indicated face shields can be reused once wiped down with a Sani Wipe and kept hung in the back room of the nursing station until needed. The facility Policy labeled Covid 19 indicated in part Contact and Droplet Precautions are to be initiated with signage outside the door, and staff are to utilize full PPE including gown, fit tested N-95 mask, eye protection and gloves, when entering the room 2. An observation on 1/16/2025 at 11:00AM identified a sign on the bathroom sink in the shared room of Resident #164 and #181. Resident # 164 indicated the sink had been broken for 3 weeks and verbalized the maintenance staff had placed the sign on the sink and the nurse aides obtained water from another room. An interview on 1/28/2025 at 9:30 AM with NA #4 indicated staff had been going to other resident's rooms to get water to wash Resident #181 and #164. On 1/28/2025 at 9:50 AM an interview with an observation of a picture taken of the bathroom with the Director of Nursing Services (DNS) indicated she/he was not aware of the sink being out of service and that staff going into other resident's bathrooms to obtain water to bathe residents in another room is against appropriate infection control practices. The DNS indicated the faucet will be fixed immediately and if she/he had known about the problem with the sink she/he would have moved the affected residents to another room until the faucet could be repaired.		

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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. 46046 Based on review of facility Infection Control Program, facility documentation and interviews, the facility failed to ensure staff conducted and maintained documentation of yearly ongoing review of antibiotic use within the facility based on Antibiotic stewardship guidelines. The findings included: On 1/22/2025 9:30 AM and interview and review of facility documents with LPN # 9, the Infection Preventionist (IP) in the role at the facility for last 2 months identified no evidence of ongoing surveillance of infections only a binder containing the past two years 2023 and 2024 of the monthly list of antibiotics used in the facility for each resident which was provided by the pharmacy to nursing. Although the IP, LPN #9 provided blank McGeer's forms to use during the antibiotic surveillance process, s/he identified she/he had not utilized them the form yet. LPN #1 identified she/had state infection control training which was minimal training and indicates she/he had been pulled away frequently from Infection Control duties to provide resident care for the shift when licensed nurses called out. LPN #9 was unable to provide any completed McGeer's forms since the last survey was concluded on 4/4/2022. A binder from a year prior to the last survey was found which included monthly tracking of infections and antibiotic use but none since the last survey 4/4/2022. LPN #9 was able to verbalize how antibiotic stewardship works but was not aware of the need to track each infection, check the antibiotic appropriateness, follow trends monthly and review trends with the medical staff. LPN #9 also indicated s/he was told the prior IP before him/her, left and took the information with them. LPN #9 indicated she/he was notified of residents who are on new antibiotics during morning standup or afternoon stand down meetings by staff directly or by the Admission Director. LPN #9 was unaware of an infection control committee or pharmacy committee. However, LPN # 9 was able to show the last month (12/2024) report from the laboratory on sensitivity and resistance patterns. On 1/22/2025 at 11:30 AM an interview with the Director of Nursing services (DNS) indicated s/he was the RN who was overseeing the IP (LPN #9) and indicated the prior IP left the position and took the infection tracking information with him/her and therefore the facility was unable to provide evidence of infection control being reviewed at the medical staff meetings held since 4/4/2022. The facility policy labeled Antibiotic Stewardship indicated in part; the facility Medical Director in conjunction with the Infection Preventionist, Director of Nursing services and consultant pharmacist will assume the leadership roles in antibiotic stewardship and the activities will be coordinated through the Pharmacy Committee and the Infection control Committee. The activities will include regular review of antibiotic utilization patterns and sensitivity patterns at the committee meetings, distribution of educational materials to staff on improving safe and effective use of antibiotics as well as materials on preventing overprescribing and reports back to prescribers on potential mis-prescribing/ overprescribing as identified by the pharmacy and infection control committees or as identified through the monthly drug regimen reviews.		

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 48880 Based on observations, review of facility documentation, review of and staff interview for 10 of 10 residents (Resident #1, #5, #27, #49, #67, #97, #110, #122, #124 and #133) reviewed for Environment, the facility failed to provide assessments for rationale for the residents' beds against wall. The findings included. An observation and interview with the Administrator on 1/29/2025 from 12:25 PM to 12:50 PM of resident beds in rooms of 10 residents identified one side of the bed completely or a few inches against the wall. Residents #1, #5, #27, #49, #67, #97, #110, #122, #124 and #133 beds were noted to have one side against or close to the wall. The Administrator indicated s/he and the Maintenance Director recently did a walk through and told a couple of residents about the need to not have the beds against the wall but may have been moved back. The Administrator indicated the facility is due to have some updates of resident rooms throughout the facility completed. However, this is a slow process and she/he hope that by adjusting the wall cabinet and drawer location it might provide more room. In conclusion the facility failed to ensure there was a clearance of 3 feet around both sides and the foot of each bed.		