STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millcroft Living	255 Possum Park Road Newark, DE 19711

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28270 Based on record review, interview, and policy review, the facility failed to ensure one of 25 sampled residents (Resident(R) 18) was afforded the opportunity to be included in all aspects of person-centered care planning. Findings include: Review of the facility's policy titled, Care Plan, Comprehensive, Person-Centered Care, revised March 2022, read in pertinent part, 1. The Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident . The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care plan conferences. Review of R18's Face Sheet, located in electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with diagnoses of major depressive disorder, sarcoidosis, and erythema intertrigo. Review of the Care Plan Conference Summary Form, provided by the facility, revealed no documented evidence that the resident attended the care plan meeting held on 06/05/24. Review of R18's quarterly Minimum Data Set (MDS), located in the EMR under the MDS tab and with an Assessment Reference Date (ARD) of 09/09/24, revealed R18 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Review of the Care Plan Conference Summary, found under the Care Plan tab of the EMR revealed the last conference meeting was held 09/11/24. There was no documentation the resident attended the meeting. During an interview on 11/24/24 at 2:10 PM, R18 stated, I have not been invited to the care plan meeting in a while. During an interview on 11/25/24 at 4:03 PM, the Social Services Director confirmed inviting R18 to the care plan meetings had been missed.

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, record review, interview, and review of facility policy, the facility failed to maintain the personal privacy of one resident (R3) during medication administration from a sample of 25 residents. This failure had the potential to cause embarrassment to the resident. Findings include: Review of R3's Admission Record, located in the resident's electronic medical records (EMR) section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included sarcopenia (muscle loss) and osteoarthritis. Review of R3's Physicians Orders for November, located in the resident's EMR section titled Orders, revealed that the resident was to receive a Lidocaine 4% pain patch every morning. Observation during medication administration on 11/26/24 at 9:05 am revealed Licensed Practical Nurse (LPN) 1 administering a Lidocaine pain patch to R3's left shoulder. R3 was seated in her wheelchair at the nurses' station. LPN1 pulled the resident's shirt over the resident's shoulder, exposing the resident's shoulder and upper chest area. The LPN did not ask the resident if she wanted to return to her room to apply the pain patch. There was a male cognitively impaired resident sitting at the nurses' station along with three staff members and a visitor in the hallway. During an interview on11/25/24 at 1:30 PM, LPN1 stated that she should have taken the R3 back to her room to apply the pain patch. During an interview on 11/25/24 at 3:30 PM, the Director of Nursing confirmed LPN1 should have taken R3 to apply the resident's pain patch. The DON stated the nurse's action was a violation of R3's dignity and privacy. Review of the facility's policy titled, Dignity, with a revision date of February 2021 reads in part, Staff promote, maintain, and protect resident privacy including bodily privacy during assistance with personal care, and during treatment procedure.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on interview, record review, and policy review, the facility failed to provide written notification of the bed hold policy to the resident and responsible party (RP) for one of five residents (Resident (R) 287) reviewed for hospitalization out of a total sample of 25. The failure had the potential to affect the residents planning on returning to the facility. Findings include: Review of R287's Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed R287 was admitted to the facility on [DATE] with acute respiratory failure and dysphagia (difficulty swallowing). On 10/30/23 R287 was diagnosed with COVID-19 and discharged to a hospital on 11/10/23. Review of R287's Health Status Note, dated 11/10/23 at 9:34 AM and located in the EMR under the Progress Note tab, revealed, . Resident sent out to the ER [emergency room] for further evaluation. Spouse notified and she also requested bed hold until issue is resolved . Review of the Misc (miscellaneous), Prog (progress) Notes, and Evaluations tabs of R287's EMR revealed no documented evidence that written information regarding the facility's bed-hold policy was provided to the resident or representative. During an interview on 11/26/24 at 3:23 PM, the Social Services Director (SSD) stated the nurses were responsible for verbally notifying families about the bed hold policy when resident went out to the hospital. During an interview on 11/26/24 at 3:28 PM, the Administrator stated a copy of the bed hold paper was sent with the resident or given to emergency medical technicians (EMTs) by nursing or social services as the resident left for the hospital. During an interview on 11/26/24 at 4:05 PM, Unit Manager (UM) 2 reported the bed hold form was in the facility's discharge packet. UM2 stated nursing staff asked the resident to sign it, if able; otherwise, the nurses called the responsible party and documented their verbal response on the form. UM2 stated the form was sent with the resident to the hospital or faxed to the hospital. During an interview on 11/26/24 at 4:12 PM, the Assistant Director of Nursing (ADON) stated the discharge packet the nurses used when sending a resident out to the hospital included the bed hold policy and authorization form, and unless the nurse documented they sent it out, there was no evidence the resident or representative received the papers. During an interview on 11/26/24 at 4:45 PM, the ADON stated a Progress Note showed R287's wife was called and verbally requested a bed hold. The ADON confirmed there was no documented evidence in the EMR or within other facility files that the resident or spouse were notified in writing about the bed hold policy. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Bed-Holds and Returns, revised March 2022 and provided by the facility, revealed, . All residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence [hospitalization or therapeutic leave]. Residents are provided written information about these policies at least twice: well in advance of any transfer (e.g., in the admission packet); and at the time of transfer [or, if the transfer was an emergency, within 24 hours] .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, interview, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure one resident (Resident (R) 22 out of 25 sampled residents had an accurate Minimum Data Set (MDS) assessment. This had the potential to cause the resident to have unmet care needs. Findings include: Review of the RAI Manual, dated 10/01/19, indicated, . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. Review of R22's Admission Record, located in the resident's electronic medical record (EMR) section titled Profile, revealed the resident was admitted to the facility with diagnoses that included congestive heart failure and shortness of breath. Review of R22's Physician Orders, dated 09/23/24 and located in the resident's EMR section titled Orders, revealed the resident was to receive continuous oxygen therapy at two liters via nasal cannula. A review of the R22's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/29/24 and located in the resident's EMR section titled MDS, failed to document in Section O Special Procedures, Treatments, and Programs that the resident was receiving continuous oxygen therapy. During an observation on 11/25/24 at 4:33 PM, R22 was observed receiving oxygen therapy. During an interview on 11/25/24 at 5:10 PM, the MDS Coordinator (MDSC)reviewed the resident's physician orders and medication and treatment records to determine whether the resident was ordered on oxygen therapy. The MDSC reviewed the admission MDS dated [DATE] and confirmed the oxygen therapy had not been recorded in Section O.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 16752 Based on observation, interview, record review, and review of facility policy, the facility failed to revise care plans for three of 25 sampled residents (R22, R65, and R70). The care plan for R22 was not revised to reflect his oxygen therapy. The care plan for R65 was not revised to reflect an incident of wandering into a female resident's room. R70's care plan was not revised to reflect the resident's urinary catheter. This failure had the potential to affect care provided to the residents. Findings include: 1. Review of R22's Admission Record, located in the resident's electronic medical record (EMR) section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included congestive heart failure and shortness of breath. Review of R22's Physician Orders, dated 09/23/24 and located in the resident's EMR section titled Orders, revealed the resident was to receive continuous oxygen therapy at two liters via nasal cannula. A review of R22's Care Plan, located in the resident's EMR section titled Care Plans, revealed the resident's care plan was not revised to reflect the use of continuous oxygen therapy. An observation on 11/14/24 at 1:44 pm revealed R22 in bed reading. The resident was wearing a nasal cannula with oxygen flowing at three liters per minute. 2. Review of R65's Admission Record, located in the resident EMR section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included cognitive-communication, dementia, anxiety disorders, and altered mental status. Review of R65's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/24 and located in the resident's EMR section titled MDS, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS), score of 00 which indicated R65 was severely impaired in cognitive skills for daily decision making. It was recorded that the resident did not exhibit any wandering behaviors during this assessment period. A review of the facility's Accident and Incident Log revealed on 06/17/24, there was an incident of R65 entering a female resident's and pulling down his pants. The facility completed an investigation of the incident; however, the facility failed to revise R65's care plan to reflect the incident and what interventions were put in place to protect other residents from R65's wandering behaviors 3. Review of R70's Admission Record, located in the resident's EMR section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI), hydronephrosis, urinary retention, and chronic kidney disease. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the R70's admission MDS, with an ARD of 10/13/24 and located under the MDS tab of the EMR, revealed the resident had a BIMS score of 13 out of 15, which indicated her cognition was intact and able to make decisions regarding her care. The resident was assessed to be incontinent of bladder and bowel. Review of R70's Discharge Orders, located in the resident's EMR section titled` Miscellaneous and dated 11/20/24, revealed the resident was treated for urinary retention and received a urinary catheter. Review of R70's Care Plan, located in the resident's EMR section titled Care Plan, revealed the resident's care plan was not revised to reflect the addition of the urinary catheter. During an interview on 11/25/24 at 5:10 PM, the MDS Coordinator (MDSC) stated that any nurse could revise a resident's care plan to reflect changes in the resident's condition and care needs. On 11/24/24 at 4:15 pm, an interview with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) revealed that care plans were reviewed and revised during the Interdisciplinary Team Meetings. The ADON and DON confirmed It was an expectation that nurses review and revise a resident's care plan as the need arises. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, with a revision date of March 2022, revealed, . Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment .

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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** 42440 Based on interview, record review, and policy review, the facility failed to increase the frequency of assessments when a resident was diagnosed with COVID-19 for one of three residents (Resident (R) 287) reviewed for COVID-19 infection out of a total sample of 25. The lack of assessment could result in the facility not noticing symptoms which warranted further treatment and intervention. Findings include: Review of R287's Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed R287 was admitted to the facility on [DATE] with acute respiratory failure and dysphagia (difficulty swallowing). Review of R287's Order Summary Report, located in the EMR under the Orders tab, revealed an order dated 07/26/23 which read, Monitor the following at least daily. Vital Signs - Temp, Pulse, Respirations, Pulse OX [oxygen saturation level], B/P [blood pressure], for COVID-19 symptoms of Fever, Chills, Cough, Shortness of Breath . if symptoms occur, place resident in transmission-based precautions and notify the physician and your Infection Preventionist. Review of R287's Health Status Note, dated 10/30/23 at 4:59 PM and located in the EMR under the Progress Note tab, revealed, . Resident was tested for Covid-19 during outbreak testing. Covid antigen test was positive . Review of R287's Care Plan tab revealed a problem area dated 10/30/23 of COVID-19 with interventions to . Monitor and document vital signs as ordered. Notify MD of significant abnormalities . Resident on Droplet Isolation precautions . It was recorded that the problem was resolved on 11/09/23. Review of R287's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/01/23 and located in the MDS tab of the EMR, revealed R287 scored 14 out of 15 on his Brief Interview for Mental Status (BIMS), which indicated he was cognitively intact. It was recorded R287 had diagnoses that included COVID-19. During an interview on 11/25/24 at 2:30 PM, Licensed Practical Nurse (LPN) 3 stated nurses completed a COVID-19 Assessment located in the EMR under the Evaluations tab every shift when a resident had COVID. LPN3 stated the assessment included vital signs, lung sounds, and a symptom tracker. LPN3 stated the Infection Preventionist (IP) put an order into the EMR, and nurses signed off that they completed the assessment every shift for residents who had COVID-19. Review of R287's EMR revealed less than daily documentation of assessments, including vital signs, during a ten-day COVID-19 isolation period from 10/30/24 to 11/09/24. Review of R287's Evaluations, Progress Notes, and Wts (weights)/Vitals tabs of the EMR revealed no COVID-19 Assessments. There was no documented evidence that R287's vital signs or lung sounds were assessed on 11/02/23 through 11/05/23, or on 11/07/23 or 11/08/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/26/24 at 11:11 AM, the IP stated she input orders for nurses to complete the COVID-19 assessment, and she expected nurses to document a note every shift on a resident with COVID-19, as well as vital signs, symptoms, and any complications. The IP confirmed R287's EMR had no documented evidence that the assessments had been completed. During an interview on 11/26/24 at 12:00 PM, the Director of Nursing (DON) reported he expected nurses to document assessments every shift with vital signs and symptoms at a minimum when a resident had COVID-19. He confirmed less than daily assessments were completed for R287. Review of the facility's policy, Coronavirus Disease (COVID-19) - Identification and Management of Ill Residents, revised September 2022, revealed, . Clinical monitoring of residents with suspected or confirmed SARS-CoV-2 infection is increased, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observation, interviews, record review, and review of facility policy, the facility failed to provide supervision for one of five residents (Resident (R) 65) reviewed for supervision out of a total sample of 25. The failure had the potential to cause harm to R65 due to his behavior of wandering. Findings include: Review of R65's Admission Record, located in the resident's electronic medical record (EMR) section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included cognitive communication, dementia, anxiety disorders, and altered mental status. Review of R65's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/24 and located in the resident's EMR section titled MDS, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of 00 which indicated the resident was severely impaired in cognitive skills for daily decision making. It was recorded that the resident did not exhibit any wandering behaviors during this assessment period. Review of the facility's Accident and Incident Log revealed on 06/17/24 there was an incident of R65 entering a female resident's and pulling down his pants. A review of the facility's investigation, dated 06/17/24, revealed that R65 had wandered into a female resident's room during the night. The investigation revealed the R65 had pulled down his pants and sat down on a chair next to the female resident's bed. According to the facility's investigation, the female resident woke up while R65 was in her room. The female resident took pictures of R65 while he was in her room and called for the nursing staff to remove R65. By the time nursing staff arrived in the female resident's room, R65 had returned to his room. The facility's investigation documented that the female resident was examined for any injuries. The female resident informed the staff that R65 had not touched her and that she did not want to report the incident. It was documented the female resident wanted to make sure that R65 never entered her room again. Review of R65's Care Plan, located under the Care Plan tab of the EMR, revealed no documented evidence the facility revised R65's care plan to reflect the incident. There was no documented evidence that interventions were identified and implemented to help protect R65 or other residents from R65's wandering behaviors. During an interview on 11/24/24 at 4:30 PM, the Social Services Director (SSD) stated the incident was discussed with the Interdisciplinary team; however, the SSD was unable to provide documentation of what was discussed in the IDT meeting and how the facility ensured the safety of R65 and the female resident. In an interview on 11/25/24 at 6:10 PM, the Medical Director stated he remembered the incident. The Medical Director stated R65 had severely impaired cognition and he felt the resident was attempting to go to the bathroom at night and mistakenly wandered into the female resident's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/26/24 at 1:30 PM, the Assistant Director of Nursing (ADON) stated she was unable to provide information of what interventions were in place to ensure R65 did not return to the female resident's room. The ADON stated she was unable to provide any documentation of interventions that were identified and implemented to protect R65 or other residents. Review of the facility policy titled, . Incident/accident reports will be reviewed by the safety committee for trends related to accidents or safety hazards in the facility and to analyze any individual resident vulnerabilities .

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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** 16752 Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for urinary catheters for one of three residents (Resident (R) 70) reviewed for urinary catheters out of a total sample of 25. The facility failed to have physician orders for the use of a urinary catheter and failed to ensure the drainage bag and tubing were not placed directly on the floor, inhibiting the proper flow of urine. The failure had the potential for the resident to develop reoccurring urinary tract infections (UTIs). Findings include: Review of R70's Admission Record, located in the resident's electronic medical record (EMR) section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI), hydronephrosis, urinary retention, and chronic kidney disease. Review of the R70's admission Minimum Data Set (MDS), with an Assessment Reference Date of ARD of 10/13/24 and located under the MDS tab of the EMR, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated her cognition was intact. The resident was assessed to be incontinent of bladder and bowel. Review of R70's hospital Discharge Orders, located in the resident's EMR section titled` Miscellaneous and dated 11/20/24, revealed the resident was treated for urinary retention and received a urinary catheter. Review of R70's Physicians Orders for November 2024, located in the resident's EMR section titled Orders, revealed the ER orders for the resident's urinary catheter were not transcribed to the monthly physician orders. Review of R70's Care Plan, located in the resident's EMR section titled Care Plan revealed the resident's care plan was not revised to reflect the addition of the urinary catheter. During an observation on 11/25/24 at 8:45 AM, R70 was observed lying in bed with her eyes closed. Her urinary drainage bag with privacy covering was lying on the floor. During an observation on 11/25/24 at 1:30 PM, R70 was lying in bed. The resident's urinary drainage bag and tubing were lying on the floor. During an interview on 11/25/24 at 1:30 PM, Licensed Practical Nurse (LPN) 2 stated that R70's urinary drainage tubing and bag were not properly positioned to promote urine flow. LPN 2 stated that R70 was sent to the hospital two weeks ago for a UTI and had the urinary catheter inserted there. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/25/24 at 2:55 PM, the LPN Supervisor and LPN2 revealed the discharge orders for the urinary catheter were not transcribed to the resident's monthly orders. LPN2 stated she thought the evening supervisor had transcribed the orders from the emergency room and revised the resident's care plan to reflect the catheter. LPN2 acknowledged that she should have reviewed the resident's chart to ensure that the orders had been transcribed.

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	085021	A. Building B. Wing	11/26/2024

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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** 37590 Based on observation, interview, and record review, the facility failed to administer oxygen at the physician prescribed dose for two of five residents (Residents (R) 9 and 22) reviewed for respiratory care out of a total sample of 25. This had the potential to cause the residents respiratory distress. Findings include: 1. Review of R9's Admission Record, located in the Profile tab of the electronic medical record, (EMR) revealed the resident was admitted to the facility on [DATE] with diagnoses that included pneumonia, chronic obstructive pulmonary disease (COPD), and chronic respiratory failure. Review of R9's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/26/24 and located under the MDS tab of the EMR, revealed R9 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident was moderately cognitively impaired. Review of R9's Physician Orders, located in the EMR under the Physician Orders tab, revealed an order dated 10/16/24 for oxygen for symptoms of hypoxia via nasal cannula at 3 LPM. During an observation on 11/24/24 at 12:25 PM, R9 was observed seated in her wheelchair in her room with her eyes closed. The resident had an oxygen cannula in place, running from a concentrator that was set at 4. 5 liters per minute (LPM). During an observation on 11/25/24 at 9:15AM, R9's oxygen concentrator was again set at 4.5 LPM. During an interview on 11/25/24 at 6:11PM, the Medical Director stated that R9 had a risk potential for hypoxia due to ongoing lung concerns related to COPD. He added that the resident's oxygen should be set at the ordered level and any variation required physician notification. During an observation and interview on 11/26/24 at 10:37 AM, R9 was seated in her wheelchair in her room. The resident's oxygen concentrator was set at 2LPM. Licensed Practical Nurse (LPN) 1 confirmed the oxygen concentrator was set at 2 LPM. LPN1 confirmed the oxygen was to be set at 3 LPM. She stated she had checked the concentrator's settings when she began her shift and believed another staff member may have changed the settings by mistake. 16752 2. Review of R22's Admission Record, located in the resident's electronic medical record (EMR) section titled Profile, revealed the resident was admitted to the facility on [DATE] with diagnoses that included congestive heart failure and shortness of breath. Review of R22's Physician Orders, dated 09/23/24 and located in the resident's EMR section titled Orders, revealed the resident was to receive continuous oxygen therapy at two liters via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R22's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/29/24 and located in the resident's EMR section titled MDS failed to record the resident was receiving continuous oxygen therapy. Review of R22's Care Plan, located in the resident's EMR section titled Care Plans, revealed the resident's care was not revised to reflect the use of continuous oxygen therapy. During an observation on 11/24/24 at 1:44 PM, R22 was observed lying in bed reading. The resident was wearing a nasal cannula with oxygen flowing at three liters per minute. The tubing was dated 11/22/24, and the oxygen concentrator filter had a large amount of dust debris. During an observation on 11/25/24 at 2:00 PM, R22's oxygen setting was at three liters per minute, and the filter on the oxygen concentrator had a built up of dust debris. During an interview on 11/25/24 at 4:30 PM, the Medical Director stated the expectation was that oxygen would be delivered according to the physicians' orders. The Medical Director stated if there was a need to change the oxygen setting to increase the resident's oxygen level saturation levels the nurses are expected to inform the physician of the change. During an interview on 11/26/24, the Licensed Practical Nurse (LPN) Supervisor confirmed the nurses were responsible for cleaning the filters on the oxygen concentrators and ensuring the oxygen setting was according to the physicians' orders.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on interview, record review, and policy review, the facility failed to document an end date for an as needed (PRN) psychotropic medication for one of six residents (Resident (R) 294) reviewed for unnecessary medications out of a total sample of 25. The failure had the potential for residents to receive psychotropic medications without ongoing assessment by a physician or practitioner for continued appropriateness. Findings include: Review of R294's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed R294 was admitted to the facility on [DATE]. R294 had diagnoses which included anxiety, depression, and bipolar disorder. Review of R294's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/28/24 and located in the MDS tab of the EMR, revealed R294 scored 14 out of 15 on her Brief Interview for Mental Status (BIMS), which indicated she was cognitively intact. Review of R294's Encounter, dated 09/20/24 at 1:00 AM and located in the EMR under the Progress Note tab, revealed a Nurse Practitioner entry, . Currently on buspirone [an anti-anxiety medication] 10 mg, endorses anxiety and wants clonazepam [an anti-anxiety medication] . Review of R294's Order Summary Report, located in the EMR under the Orders tab, revealed an order dated 09/20/24 for clonazepam 0.5mg every 24 hours as needed for anxiety. There was no end date for the as needed anti-anxiety medication. During an interview on 11/25/24 at 1:06 PM, R294 stated she took her PRN anxiety medication once in a blue moon. She stated she typically did not need it due to getting buspirone twice a day. During an interview on 11/25/24 at 2:20 PM, Licensed Practical Nurse (LPN) 3 stated the unit managers entered new orders into the EMR. LPN3 stated PRN psychotropic medications were expected to have an end date of 14 days, unless ordered for longer. LPN 3 confirmed R294 had orders in the EMR for PRN clonazepam since 9/20/24 with no end date. During an interview on 11/25/24 at 2:50 PM, Unit Manager (UM) 1 reported the unit managers entered or verified orders in the EMR. UM1 stated the PRN clonazepam order for R294 was entered by a nurse practitioner and verified by a unit manager. UM1 stated the nurse practitioner was expected to enter a stop date for PRN psychotropics, and the unit manager who verified orders was expected to check and reach out to the nurse practitioner for an end date of 14 days or a rationale for orders with end dates beyond 14 days. During an interview on 11/25/24 at 3:00 PM, the Assistant Director of Nursing (ADON) stated that PRN psychotropic medications were expected to have a 14-day end date and then be renewed as needed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/25/24 at 3:05 PM, the Director of Nursing (DON) reported the expectation that PRN psychotropics have a 14-day end date or rationale to extend past that. Review of the facility's policy, Psychotropic Medication Use, dated July 2022, revealed, . Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to l4 days. For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16752 Based on observations, record reviews, interviews, and a review of facility policy, the facility failed to secure one of three (Second floor medication cart) medication carts on one of two nursing units. The facility failed to dispose of expired supplies in one of two (Second floor medication storage room) medication storage rooms. These failures had the potential to result in residents being subject to unsafe or ineffective treatment or adverse effects leading to more serious illnesses and could permit unauthorized access to residents' medications. Findings include: 1. Observation on [DATE] at 6:34 PM revealed the second-floor medication cart was unlocked and was located between rooms [ROOM NUMBERS], approximately six steps away from the nurses' station. The cart remained unlocked for nine minutes and fifty-eight seconds. The top drawer contained insulin pens and over-the-counter medications. The second drawer contains residents' medications and a locked narcotic box. No staff were present, and the cart was not within the line of sight of any staff member. Resident (R) 36 was seated in a wheelchair at the nurses' station, making several attempts to stand up. Two other unidentified residents were seated at the nurses' station. Review of R36's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE] revealed R36 was severely impaired in decision-making skills, utilized a wheelchair and walker for mobility, and had no range of motion limitations. During an interview on [DATE] at 6:50 PM, Licensed Practical Nurses (LPN) 4 and LPN 5 revealed they were both sharing a cart and unaware that the medication cart was unlocked. LPN 5 acknowledged that R36 tended to wander, and the unlocked medication cart posed a hazard for the resident. 2. On [DATE] at 10:15 am an inspection of the medication room on the second floor revealed the following concerns: One of two boxes of Magellan hypodermic safety needles with an expiration date of [DATE] (47 needles in the box). One of one box of three cc syringes 23-gauge x 1-inch needles with an expiration date of [DATE]. Seven of seven Care fusion extension sets with clear connectors with the expiration dates ranging from , d+[DATE] to ,d+[DATE]. One of one container of Osmolyte 1.5 calorie nutritional supplement with expiration date of [DATE]. Two of two Meflix dressings with expiration dates of ,d+[DATE] and ,d+[DATE]. One of One Mesalt Cleansing dressing with 20% Chloride with an expiration date of [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Five of five [NAME] Amorphous Hydrogel Wound dressings with expiration dates of [DATE] and [DATE]. During an interview on [DATE] at 11:15 AM, the LPN Supervisor for the unit revealed he tried to inspect the medication room on a weekly basis. He stated he had missed those items found during the inspection of the medication. room Review of the facility's policy titled, Security of Medication Cart, with a revision date of [DATE], revealed, . The medication cart shall be secured during medication passes . Medication carts must be securely locked at all times when out of the nurse's view . When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room . Review of the facility's policy titled, Medication Storage and Labeling, with a revision date of February 2023, revealed, . If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37590 Based on observations, interviews, and policy review, the facility failed to ensure food was served under sanitary conditions and failed to ensure the kitchen was kept in a clean and sanitary manner to prevent contamination from foreign substances and the potential for development of foodborne illnesses. This deficient practice has the potential to affect 89 of 91 residents who received meals and beverages prepared in and served from the facility's kitchen. Findings include: During the initial kitchen tour on 11/24/24 at 8:54 AM, upon entrance to the kitchen through the dishwasher area, observation of the floor, the floor underneath the dishwasher, freezer, cooler, and shelf revealed trash, food debris, dust/dirt, and a greasy blackish-brown substance. The substance was found throughout the kitchen on the floors, legs/feet of equipment, and underneath freestanding coolers and freezers, as well as the range, ovens, prep tables, and shelving. The greasy substance stained the baseboards and walls. Observation of the commercial juice machine revealed the water lines were stained with a brownish-red colored substance. The outside of the tubing was also covered in dust. The drip tray was stained with a reddish colored substance. The reddish colored substance covered the spout covers. The 3-compartment sink was observed, and a black grease interceptor box was located underneath the area. The box was covered in food debris and a brownish greasy substance. During the tour Cook1 was asked who was responsible for cleaning the floor. He confirmed that it was cleaned twice daily. Review of the kitchen's Utility Cleaning Schedule provided by the Certified Dietary Manager (CDM) on 11/24/24, outlined each area of the kitchen and how often it was to be cleaned. The schedule was broken down into daily, weekly, and monthly requirements. Per the schedule, staff were to sweep/mop kitchen floors, under equipment and dry storage twice daily and as needed. During an interview on 11/24/24 at 11:17 AM, the CDM was advised of the concerns related to the juice machine, the interceptor box, and the floor. She stated that the floors were cleaned daily along with the area around the interceptor box. The CDM added that the juice machine vendor was responsible for cleaning the internal parts of the machine including the tubing, but that the facility staff were to clean the drip pan daily and run the grate through the dishwasher. During a subsequent kitchen observation on 11/25/24 at 10:51 AM, the floor appeared to have been cleaned, but there was still debris and the brownish stains still visible underneath the kitchen equipment. The CDM was asked about the floor, and she stated that the staff was cleaning the floor as scheduled but stated that the floor was hard to keep clean. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/26/24 at 10:32 AM, the Administrator was advised of the concerns with the kitchen floor. He stated that he felt the concern was related to the meal delivery carts tracking dirt, dust, and debris in the kitchen, but added that he felt the kitchen could use a deep cleaning.