STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105268	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health Center	2501 N Australian Avenue West Palm Beach, FL 33407

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167 Based on policy review, observation, interview and record review the facility failed to report and investigate an injury of unknown origin (bruise), for 1 of 6 sampled residents reviewed for abuse (Resident #36). The facility also failed to ensure a thorough investigation as evidenced by documented inconsistencies for 1 of 6 sampled residents reviewed for abuse (Resident #10). The findings included: 1) Review of the policy titled abuse-identification of types dated 10/04/22 indicated it is the policy of this facility to identify abuse, neglect and exploitation of residents and misappropriation of resident property. This includes but is not limited to identifying and understanding the different types of abuse and possible indicators. Definition of abuse-is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment by an individual, including a caretaker, of goods or services that are residents from abuse. Necessary to attain or maintain physical, mental and psychological well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. This policy documented injuries of unknown source-an injury should be classified as an injury of unknown source when all of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The procedure included: 1) the facility will apply the following definitions to identify abuse, neglect and exploitation. 2) the facility staff should report any suspected abuse, neglect, or exploitation noted based on the below definitions to the executive director or director of nursing. 3) based on the reports of suspected abuse, neglect, or exploitation noted based on the below definitions the facility will follow the abuse-investigation policy and the abuse-protection policy. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hrs. after the allegation is made. If the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the state survey agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures. 1). Record review revealed Resident #36 was admitted to the facility on [DATE], with diagnoses including: anxiety disorder, bipolar disorder, and psychotic disorder. Review of the significant change minimum data set (MDS) assessment, reference date 04/12/24, recorded a brief interview for mental status (BIMS) score of 11, which indicated Resident #36 was cognitively moderately impaired. This MDS recorded the following moods: Feeling down, depressed, or hopeless. Feeling tired or having little energy. Feeling bad about self - or that failure or have let self or family down. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual. Review of physician order dated 08/21/23 indicated weekly skin checks on Mondays. On 06/17/24 at 11:09 AM observed Resident #36 in her room, sitting up in wheelchair. An interview process was conducted with her. The surveyor asked her questions regarding abuse. She stated that on Memorial Day, a person in the facility named [ ] punched her right upper arm. The resident was noted with a bluish/purple bruise to the outside aspect of the right upper arm (deltoid area). Resident #36 claimed the bruise was much bigger. Subsequently, she started pointing to the bruised area, while stating, this whole area was bruised, touching her upper deltoid down to above the elbow area. Resident #36 also said that another person in the facility named [ ] slapped her in the face and her stomach and stepped on her big toe on purpose. She claimed she has been abused a lot in the facility. When inquired about reporting the abuse. She voiced that the facility was aware of the abuse because she had reported it to a staff member (unknown name). On 06/20/24 at 11:53 AM an interview was conducted with Staff B, a licensed practical nurse (LPN), regarding Resident #36. She revealed she works with Resident #36 a lot. When asked about the bruise to the resident right upper arm (deltoid area), she said she was not aware of the bruise, when asked about skin assessment, and inquired when was the last time her skin was checked? Staff B revealed her skin assessment should be done weekly. She said the last skin assessment was completed on 06/17/24. During that time a review of the skin assessment document was conducted. The record did not indicate any skin issue, it did not reflect the bruise on the resident's skin. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/24 at 12:03 PM an interview was held with the Social Service Director (SSD) regarding Resident #36. When inquired about the resident, the SSD voiced that Resident #36 is fun, she loves pop culture, she likes to watch the shows with the famous singers. When asked specifically about the resident's skin does the resident have any bruises? SSD revealed she was not aware of any bruise on the resident's skin. When mentioned that the resident had said a person named [ ] had punched her in the right upper arm (deltoid area). The SSD said that must be a famous person's name, as she gives people she encounters famous people names. When informed the resident also voiced [ ] had slapped her and hurt her big toe. The SSD stated, that name could be one of the famous people as well. The surveyor informed the SSD that the surveyor had observed a bruise to the resident right upper arm on 06/17/24 at 11:09 AM. The surveyor then advised the SSD to contact the director of nursing (DON), so that they could go and talk to the resident together. At 12:13 PM the SSD, DON, and the Regional Clinical Consultant accompanied the group to the Resident's room. The SSD asked Resident #36 about the bruise. The resident explained to the group that a person named [ ] punched her in the right upper arm on Memorial Day. During that time the DON proceeded to check the resident's right upper arm, she and the SSD acknowledged the bruise. The SSD informed the surveyor that she had not started an investigation process for the resident as she was not made aware of the bruise, but she will start an investigation immediately. During that time, again, the surveyor informed the SSD the surveyor had seen the bruise on 06/17/24 at 11:09 AM and no skin issue was documented on the skin assessment document dated 6/17/24 at 12:30 PM. During a subsequent interview held with the SSD on 06/20/24 at approximately 12:46 PM, the SSD voiced had she been made aware of the bruise she would have initiated an investigation process. A subsequent observation and interview were conducted on 06/20/24 at approximately 1:15 PM, by another nurse surveyor with the Regional Clinical Consultant who was present. He asked Resident #36 if he could see the bruise on her right arm. Resident #36 lifted the short sleeve to her blouse and a blue/purple bruise, about 3 to 4 cm across was noted. When asked what happened to her arm, Resident #36 stated, I was punched by LD. When asked when she was punched, Resident #36 stated, on Memorial Day. The resident continued and stated she was slapped, followed by something about her toe. When asked if she reported the slap, Resident #36 stated she had told the receptionist. When asked if she was talking about the receptionist at the entrance or at the nurse's station, the resident pointed to the nurse's station, which was in the opposite direction to the lobby. When asked if she recalled the name of the person, she reported the slap to Resident #36 named Staff C, who was a certified nursing assistant who was suspended earlier in the day for an unrelated issue, as per the Regional Clinical Consultant. During the conversation the resident also mentioned [ ] (a famous person's name) and another staff or two. 50895 2) An interview conducted with Resident #10 on 06/18/24 at 11:05 AM revealed that she was hit in the nose by a male resident. Resident #10 stated I started bleeding. They called the MD, and the MD came and said I have a cut on my nose. He treated me and thank God, I see I don't have a scar there. Per record review, an assessment performed on 5/12/2024 showed that this resident understands and is understood. Her brief interview for mental status (BIMS) score is 13, which indicates that she is cognitively intact. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/24 2:58 PM, the director of social services (SSD) was asked if she remembered an incident that occurred to Resident #10 in the dining room. The SSD responded: she was walking around and the man in the wheelchair took his cup and he threw it at her face. I had to do an incident report. She had a bruise, a little scratch. Review of the report submitted to the State documented the allegation of physical abuse occurred on 4/29/24 at 2:01 PM. The allegation details listed a detailed description of any outcome to the resident, including any physical injuries and psychosocial outcome. It documented There were no physical injuries noted. The victim decided to go to her room after altercation and not participate in the Ice Scream [sig] Social even though it was recommended to have them sit very far from one another and closely monitored. This description was entered by SSD at 4:03 PM. In the report section on steps taken immediately in response to the incident, the SSD wrote on 4/30/24 at 8:58 AM: her BIMS are much higher than the alleged perpetrator. She is able to comprehend and has good recall. She proceeded with wanting to enjoy the ice scream social as she had originally intended. Continued observations were made during ice scream social . In the summary of the facility's interview with the following participants section, the SSD wrote on 5/1/24 that the interview with Resident #10 was also inconclusive, since she reacted passively to the altercation and due to her psychiatric dx, is incapable of providing real details. During an interview on 06/20/24 at 1:12 AM the SSD was asked how she knew that there were no physical injuries sustained to Resident #10 on 4/29/24 from being hit in the face. The SSD responded, at the immediate there was no visual indication that there was injury. When the social worker was told that Resident #10 said she was bleeding, the SSD responded, she was not bleeding. When SSD was asked: Were you there? SSD stated I was not present when it occurred. Someone ran to my office letting me know what had happened and I went over there. The SSD was made aware of discrepancies between the incident report that said no injury and the Resident's interview. SSD was also made aware of the discrepancies on the incident report that describe that the resident went to her room after the altercation and later describe that the resident proceeded to enjoy the ice cream social. When asked why there was this discrepancy the SSD said initially she went to her room and then she really wanted the ice cream, so she went back to the social. They were kept far apart. The SSD added that she told Resident #10 we will ensure you are not in danger and come on, let's go back to the social. A record review of a progress note written by the [NAME] Unit Manager, RN, on 4/29/2024 at 2:37 PM said that the resident sustained a laceration to the nose and first aid was provided. During an interview on 06/20/24 at 11:50 AM the [NAME] Unit Manager was asked what he remembers about the incident that occurred regarding resident #10 when she was in the dining room. The RN replied the activities director brought it me that she saw Resident #10 and the guy in the dining room and that he hit her with a coffee cup. I think she had a small cut, a laceration on the bridge of her nose.

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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 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** 25404 Based on record review and interview, the facility failed to ensure nursing staff followed physician orders for 3 of 7 sampled residents reviewed for medication use. Staff held insulin without an order and failed to provide an ordered hypertensive (blood pressure) medication as per ordered parameters for Resident #38. Staff failed to follow physician orders for blood pressure and heart rate parameters for Residents #26 and #53. The findings included: 1) Review of the record revealed Resident #38 was admitted to the facility on [DATE] with diagnoses to include diabetes, hypertension (high blood pressure), and end-stage renal disease receiving dialysis services. Review of the current physician orders revealed the following: a) As of 10/21/23 staff were to provide 0.1 mg (milligrams) of clonidine every eight hours as needed for a systolic blood pressure greater than 160. b) As of 03/11/24 staff were to provide 5 units of Humalog insulin before meals and at bedtime. This order did not include any parameters to hold the medication. c) As of 05/09/24 staff were to provide 23 units of rezoglar insulin at bedtime. This order did not include any parameters to hold the medication. Review of the Medication Administration Records (MARs) for April, May, and June 2024 revealed staff were monitoring the resident's blood pressure twice daily. Further review of these MARs and corresponding progress notes, related to the insulin, revealed the following: c) On 05/02/24 at 2100 (9 PM) the 5 units of Humalog insulin were held. d) On 06/11/24 at 2100 the 5 units of Humalog insulin were held. e) On 06/11/24 at 2100 the 23 units of rezoglar insulin were held. f) On 06/12/24 at 0600 (6 AM) the 5 units of Humalog insulin were held. The corresponding progress notes all documented the Vitals outside of parameters of administration. These insulin orders lacked any parameters. The progress notes also lacked any evidence the physician was notified. Further review of these MARS and corresponding progress notes, revealed the following blood pressure readings with a systolic reading greater than 160: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g) On 04/02/24 at 0900 (9 AM) the resident's blood pressure was 197/91. h) On 04/05/24 at 2000 (8 PM) the reading was 176/67. i) On 04/06/24 at 0900 the reading was 195/82. j) On 04/09/24 at 0900 the reading was 166/88. k) On 04/11/24 at 0900 the reading was 168/76. l) On 04/12/24 at 0900 the reading was 174/81. m) On 04/16/24 at 0900 the reading was 237/83. n) On 04/20/24 at 0900 the reading was 169/90. o) On 04/25/24 at 0900 the reading was 169/77. p) On 04/26/24 at 0900 the reading was 174/79. q) On 05/14/24 at 0600 the reading was 168/64. r) On 05/28/24 at 0600 the reading was 215/89. s) On 06/02/24 at 0900 the reading was 161/77. t) On 06/11/24 at 0800 the reading was 191/81. u) On 06/13/24 at 1700 the reading was 180/100. The record lacked any evidence nurses administered the ordered clonidine, as per the parameters to give the medication with a systolic reading greater than 160. During a side-by-side review of the record and interview on 06/19/24 at 2:51 PM, Staff A, Registered Nurse (RN), one of the nurses who care for Resident #38, agreed with the above findings and had no explanation as to why she had failed to provide the clonidine as per order, except that Resident #38 often refuses medications. The RN agreed the refusal should have been documented. During a side-by-side review of the record and interview on 06/20 24 in the morning, the Director of Nursing (DON) agreed with the findings. 33103 2) Review of Resident #26 Record review revealed Resident #26 was admitted to the facility on [DATE] with a diagnosis to include Hypertensive Chronic Kidney Disease, Anxiety Disorder, Atrial Fibrillation, Hyperlipidemia, Cardiac Pacemaker, Dementia, Cardiomyopathy, Type II Diabetes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Physicians Orders document Diltiazem HCl tablet 30 MG. Give 1 tablet by mouth two times a day (9:00 AM and 5:00 PM) for hypertension, to hold for SBP less than 130. start date 02/06/24. On the following dates the systolic blood pressure (SBP) was less than 130 and the nurse gave the resident the medication Diltiazem HCl tablet 30 MG. 06/01/24 9:00 AM: B/P 126/78 and 5:00 PM: B/P 120/67 06/02/24 9:00 AM: B/P 129/73 06/03/24 9:00 AM: B/P 125/66 06/08/24 9:00 AM: B/P 115/55 06/11/24 9:00 AM: B/P 128/80 and 5:00 PM: B/P 110/74 06/13/24 5:00 PM: B/P 119/60 06/14/24 9:00 AM: B/P 127/60 06/15/24 5:00 PM: B/P 127/81 06/17/24 9:00 AM: B/P 110/56 06/19/24 5:00 PM: B/P 116/65 05/01/24 9:00 AM: B/P 129/79 and 5:00 PM: B/P 116/67 05/05/24 9:00 AM: B/P 129/78 05/07/24 5:00 PM: B/P 122/78 05/09/24 9:00 AM: B/P 129/79 05/10/24 9:00 AM: B/P 128/69 and 5:00 PM: B/P 121/68 05/11/24 9:00 AM: B/P 101/74 05/12/24 5:00 PM: B/P 122/79 05/13/24 9:00 AM: B/P 124/68 and 5:00 PM: B/P 127/76 05/14/24 5:00 PM: B/P 119/68 05/15/24 9:00 AM: B/P 121/64 05/16/24 5:00 PM: B/P 129/73 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/17/24 9:00 AM: B/P 123/65 05/20/24 5:00 PM: B/P 128/76 05/25/24 9:00 AM: B/P 121/67 05/26/24 5:00 PM: B/P 128/71 05/27/24 9:00 AM: B/P 124/62 05/30/24 5:00 PM: B/P 128/71 05/31/24 9:00 AM: B/P 107/57 04/02/24 5:00 PM: B/P 126/77 04/04/24 9:00 AM: B/P 112/67 and 5:00 PM: B/P 113/76 04/05/24 9:00 AM: B/P 117/76 and 5:00 PM: B/P 117/76 04/06/24 9:00 AM: B/P 122/67 and 5:00 PM: B/P 118/61 04/10/24 9:00 AM: B/P 116/85 and 5:00 PM: B/P 121/59 04/11/24 5:00 PM: B/P 128/73 04/12/24 9:00 AM: B/P 129/78 and 5:00 PM: B/P 113/54 04/13/24 5:00 PM: B/P 126/84 04/14/24 9:00 AM: B/P 124/84 04/15/24 5:00 PM: B/P 117/65 04/16/24 9:00 AM: B/P 117/65 and 5:00 PM: B/P 126/85 04/17/24 9:00 AM: B/P 118/67 and 5:00 PM: B/P 126/85 04/19/24 5:00 PM: B/P 121/67 04/21/24 9:00 AM: B/P 124/79 04/22/24 9:00 AM: B/P 125/89 04/26/24 5:00 PM: B/P 120/61 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) A review of Resident #53's record revealed Resident #53 was admitted to the facility on [DATE] with a diagnosis to include Hypertension, Dementia, Alzheimer's Disease, Chronic Kidney Disease. A review of the Physician Orders revealed Resident #53 was on Amlodipine Besylate Tab 5 MG. hold if SBP (Systolic Blood Pressure) is less than 110 or Heart Rate is less than 60. The start date is 07/04/22. Review of the MARS (Medication Administration Record) for April 2024, May 2024, and June 2024 documented the Amlodipine Besylate Tab 5 MG 1 tablet twice daily with an order to hold if systolic blood pressure (SBP) is less than 110 or Heart rate is less than 60 start date 07/04/22. The following dates show the medication was given outside parameters to hold. 04/07/24 5:00 PM: B/P 98/74 04/16/24 18:13: Heart rate 58 04/17/24 5:00 PM: Heart rate 54 05/11/24 9:00 AM: B/P 105/54 and Heart rate 58 05/16/24 9:00 AM: Heart rate 56 05/27/24 9:00 AM: Heart rate 56 06/15/24 9:00 AM: Heart rate 56 05/18/24 9:00 AM: Heart rate 55 During an interview on 06/20/24 at 9:36 AM with the DON (Director of Nursing), she was asked to review the MARS for April 2024, May 2024 and June 2024 for Resident #26 and Resident #53. She reviewed the MARS for these residents and acknowledged the medications were given when it specifically documented to hold the medication. She stated I did in-service after pharmacist mentioned it on another resident. I did the Inservice on 04/29/24. During an interview on 06/20/24 at 10:02 AM with RN Unit Manager, he was asked to review the physician orders vs the MARS for April 2024, May 2024 and June 2024. He acknowledged that the nurses did not hold the medication as per physician order. During an interview on 06/20/24 at 10:20 AM, with Staff G, LPN (Licensed Practical Nurse) she was asked to review Resident #26 and Resident #53 orders and MAR for these residents. She was asked to look at the resident's B/P vs the medication order on the days she worked and gave the medication. She didn't understand what the concern was and was asked if she should have held the medications for when the systolic B/P was below 130 for Resident #26. She did not have an answer and why she gave it.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 50895 Based on observation, interview, record review, and policy review, the facility failed to ensure that pain management was provided for 1 of 1 sampled residents observed in pain (Resident #74). The findings included: Review of the Therapy Related Care Plan: Pain Management 2021 that is used as a guide for the facility (per Regional Clinical Consultant) instructs staff to complete a thorough pain assessment, to assess for verbal and nonverbal signs of pain, to implement interventions for pain, and to notify prescriber when pain control is not maintained. On 06/17/24 at 12:36 PM, observation revealed Resident #74 sat in the dining room and made loud verbal whines. No one approached the resident in a timely manner to follow-up on his needs. Later that afternoon at 2:30 PM, Resident #74 was heard groaning while he sat in the wheelchair in his room close to the bed next to the door. At the same time, Staff E, Certified Nursing Assistant (CNA), was observed in his room as she fed the resident in the bed near the window. This CNA did not stop feeding that resident to attend to # 74's needs. No other staff came into this resident's room to check up on Resident #74 in a timely manner. On 06/20/24 at 12:22 PM, an interview was conducted with Staff E, the CNA assigned to Resident #74 during the 7:00 AM-3:30 PM shift on Monday, 06/17/24. This CNA was asked how she knows when Resident #74 is in pain. She responded: With him you know. He usually hits his leg or cries out when he's in pain. So, we bring him to the nurse. When asked if you are busy with another resident what do you do if he is calling out? The CNA answered you get the nurse. She usually gives him pain medicine. When asked if the resident appears more comfortable after he receives pain medication, she answered yes. When asked do you remember how he was feeling on Monday, the CNA responded, I don't remember anything about Monday. A record review of Resident #74's comprehensive care plan, illustrates that the facility was aware that Resident #74 was at risk for generalized pain/discomfort. Interventions listed in the care plan for pain updated 05/31/24 included to observe and report to the nurse any signs or symptoms of non-verbal pain including vocalizations, moans, and yelling out. Interventions listed also included to anticipate the resident's need for pain relief and to respond immediately to any complaint of pain. In addition, it is noted in the record review that Resident #74 used an indwelling catheter secondary to a urinary tract disorder. There were orders related to the catheter which included to record this resident's pain level. A record review of the Progress Notes for Resident #74 showed that there were no progress notes written on 06/17/24. In addition, a review of the medication administration showed that there was no medication for pain given on 06/17/24. A record review showed that Resident #74 had a diagnosis of unspecified dementia, unspecified severity, with other behavioral disturbance. The resident also has anxiety disorder, and unspecified mood disorder. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/19/24 at 10:20 AM Staff D, LPN (Licensed Practical Nurse) was told that on Monday, Resident # 74 was heard making loud whining noises. The LPN was asked what she thought the loud vocalizations meant. The LPN answered: He can speak clearly when he feels like it. I know sometimes he screams. He used to be on ibuprofen. If I hear him now I give him Tylenol. He doesn't do it often, but sometimes. When the LPN was asked to clarify what she interprets this scream to mean? LPN answered pain. When asked does he understand when you ask him if he's in pain the LPN answered, he can shake his head but most of the time he doesn't answer. On 06/20/24 at 12:05 PM Staff F, LPN, was asked how she knows if Resident #74 is in pain she responded: He has pain on his left leg and if you see him hitting his leg that means he's in pain. Sometimes you will see him scream in pain. Staff F was asked what she does when he's in pain and she responded I give him Tylenol. And I tell them not to let him sit in the chair too long because then he will get in pain. On 06/20/24 at 12:44 PM, during a second interview with Staff F, LPN, was told that Resident #74 was heard crying out twice on Monday. The LPN was asked if anyone reported to her on Monday that the resident was in pain. Staff F answered, I gave him pain meds on Monday. Staff F was told that there was no documentation in the medication administration records that shows that medication was given for pain. The LPN responded I gave him medicine. It's everyday. If it's not in the morning, it's in the afternoon. Let me show you. The LPN opened up documentation from 06/19/24 that revealed that Resident #74 received medication for pain. Staff F did not work on 06/19/24. The LPN was asked again if she remembers anyone reporting that Resident #74 was in pain on Monday. Staff F stated No. I don't remember if he got medication on Monday. He was in the front all day. When asked to clarify what in the front meant the LPN stated that in the front means in the dining room or patio where residents eat and participate in activities.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on record review and interview, the facility failed to ensure consultant pharmacy services for 4 of 7 sampled residents reviewed for medication use. The consultant pharmacist failed to identify a psychotropic medication used PRN (as needed) that was ordered greater than 14 days and had no documented end date or specified duration for Resident #22. The consultant pharmacist failed to identify that nurses were holding insulin without an order and not providing an ordered hypertensive (blood pressure) medication as per ordered parameters for Resident #38, and staff were not following physician orders for blood pressure and heart rate parameters for Resident #26 and #52. The findings included: 1) Review of the record revealed Resident #22 was admitted to the facility on [DATE], with an admission to Hospice services as of 10/05/23. Admitting diagnoses included anxiety disorder. Review of the current order dated 02/29/24 documented the use of 0.5 milligrams of lorazepam (an anti-anxiety medication that is also a psychotropic medication), every four hours as needed for anxiety. Further review of this order lacked any end date or duration for use of the medication. During a phone interview on 06/20/24 at 11:07 AM, when asked about the PRN lorazepam use greater than 14 days, the consultant pharmacist stated there should be a re-evaluation for use to continue the medication more than 14 days, and agreed the medication should have a specific duration of time. 2) Review of the record revealed Resident #38 was admitted to the facility on [DATE] with diagnoses to include diabetes, hypertension (high blood pressure), and end-stage renal disease receiving dialysis services. Review of the current physician orders revealed the following: a) As of 10/21/23 staff were to provide 0.1 mg (milligrams) of clonidine every eight hours as needed for a systolic blood pressure greater than 160. b) As of 03/11/24 staff were to provide 5 units of Humalog insulin before meals and at bedtime. This order did not include any hold parameters. c) As of 05/09/24 staff were to provide 23 units of rezoglar insulin at bedtime. This order did not include any hold parameters. Review of the Medication Administration Records (MARs) for April, May, and June 2024 revealed staff were monitoring the resident's blood pressure twice daily. Further review of these MARs and corresponding progress notes, related to the insulin, revealed insulin was held once in May 2024. Further review revealed the nurses failed to administer PRN clonidine ten times in April 2024 and twice in May 2024. (Refer to F684 for specific dates and times.) (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the continued phone interview on 06/20/24 beginning at 11:07 AM, the consultant pharmacist stated he looked at all the medications and parameters for the residents. When asked if he had identified the concerns with the insulin and clonidine, the consultant pharmacist stated he had not made any recommendations regarding the insulin or clonidine in the past 6 months. 33103 2) Review of Resident #26 Record review revealed Resident #26 was admitted to the facility on [DATE] with a diagnosis to include Hypertensive Chronic Kidney Disease, Anxiety Disorder, Atrial Fibrillation, Hyperlipidemia, Cardiac Pacemaker, Dementia, Cardiomyopathy, Type II Diabetes. A review of the Physicians Orders document Diltiazem HCl tablet 30 MG. Give 1 tablet by mouth two times a day (9:00 AM and 5:00 PM) for hypertension, to hold for SBP less than 130. start date 02/06/24. On the following dates the systolic blood pressure (SBP) was less than 130 and the nurse gave the resident the medication Diltiazem HCl tablet 30 MG. 06/01/24 9:00 AM: B/P 126/78 and 5:00 PM: B/P 120/67 06/02/24 9:00 AM: B/P 129/73 06/03/24 9:00 AM: B/P 125/66 06/08/24 9:00 AM: B/P 115/55 06/11/24 9:00 AM: B/P 128/80 and 5:00 PM: B/P 110/74 06/13/24 5:00 PM: B/P 119/60 06/14/24 9:00 AM: B/P 127/60 06/15/24 5:00 PM: B/P 127/81 06/17/24 9:00 AM: B/P 110/56 06/19/24 5:00 PM B/P 116/65 05/01/24 9:00 AM: B/P 129/79 and 5:00 PM: B/P 116/67 05/05/24 9:00 AM: B/P 129/78 05/07/24 5:00 PM B/P 122/78 05/09/24 9:00 AM: B/P 129/79 05/10/24 9:00 AM: B/P 128/69 and 5:00 PM: B/P 121/68 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/11/24 9:00 AM: B/P 101/74 05/12/24 5:00 PM: B/P 122/79 05/13/24 9:00 AM: B/P 124/68 and 5:00 PM B/P 127/76 05/14/24 5:00 PM B/P 119/68 05/15/24 9:00 AM: B/P 121/64 05/16/24 5:00 PM: B/P 129/73 05/17/24 9:00 AM: B/P 123/65 05/20/24 5:00 PM: B/P 128/76 05/25/24 9:00 AM: B/P 121/67 05/26/24 5:00 PM B/P 128/71 05/27/24 9:00 AM: B/P 124/62 05/30/24 5:00 PM: B/P 128/71 05/31/24 9:00 AM: B/P 107/57 04/02/24 5:00 PM: B/P 126/77 04/04/24 9:00 AM: B/P 112/67 and 5:00 PM: B/P 113/76 04/05/24 9:00 AM: B/P 117/76 and 5:00 PM: B/P 117/76 04/06/24 9:00 AM: B/P 122/67 and 5:00 PM: B/P 118/61 04/10/24 9:00 AM: B/P 116/85 and 5:00 PM: B/P 121/59 04/11/24 5:00 PM: B/P 128/73 04/12/24 9:00 AM: B/P 129/78 and 5:00 PM: B/P 113/54 04/13/24 5:00 PM: B/P 126/84 04/14/24 9:00 AM: B/P 124/84 04/15/24 5:00 PM: B/P 117/65 04/16/24 9:00 AM: B/P 117/65 and 5:00 PM: B/P 126/85 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/17/24 9:00 AM: B/P 118/67 and 5:00 PM: B/P 126/85 04/19/24 5:00 PM: B/P 121/67 04/21/24 9:00 AM: B/P 124/79 04/22/24 9:00 AM: B/P 125/89 04/26/24 5:00 PM: B/P 120/61 3) A review of Resident #53 record review revealed Resident #53 was admitted to the facility on [DATE] with a diagnosis to include Hypertension, Dementia, Alzheimer's Disease, Chronic Kidney Disease. A review of the Physician Orders reveal Resident #53 was on Amlodipine Besylate Tab 5 MG. hold SBP (Systolic Blood Pressure) is less than 110 or Heart Rate is less than 60. The start date is 07/04/22. Review of the MARS (Medication Administration Record) for April 2024, May 2024, and June 2024 reveal the Amlodipine Besylate Tab 5 MG 1 tablet twice daily with an order to hold if systolic blood pressure (SBP) is less than110 or Heart rate is less than 60 start date 07/04/22. The following dates show the medication was given outside parameters to hold: 04/07/24 5:00 PM: B/P 98/74 04/16/24 18:13: Heart rate 58 04/17/24 5:00 PM: Heart rate 54 05/11/24 9:00 AM: B/P 105/54 and Heart rate 58 05/16/24 9:00 AM: Heart rate 56 05/27/24 9:00 AM: Heart rate 56 06/15/24 9:00 AM: Heart rate 56 05/18/24 9:00 AM: Heart rate 55 Review of the Pharmacy Reviews for 12/24-05/24 by the Pharmacist does not mention anything that he had concerns with the nurse giving a medication when it should have been held. During an interview on 06/20/24 at 9:36 AM with the DON (Director of Nursing), she was asked to review the MARS (Medication Administration Record) for April 2024, May 2024 and June 2024 for Resident #26 and Resident #53. She reviewed the MARS for these residents and acknowledged the medications were given when it specifically documented to hold the medication. She stated I did in-service after pharmacist mentioned it on another resident. I did the Inservice on 04/29/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/24 at 10:02 AM with RN, Unit Manager, he was asked to review the physician orders vs the MARS for April 2024, May 2024 and June 2024. He acknowledged that the nurses did not hold the medication as per physician order. During an interview on 06/20/24 at 10:20 AM, with Staff G, LPN (Licensed Practical Nurse) she was asked to Review Resident #23 and Resident #53 orders and MAR for these residents. She was asked to look at the resident's B/P vs the medication order on the days she worked and gave the medication. She didn't understand what the concern was and was asked if she should have held the medications for when the systolic B/P was below 130 for Resident #26. She did not have an answer and why she gave it. During a telephone interview on 06/20/24 at 10:51 AM with the Pharmacist he stated that I look at all medications and parameters, but I don't make recommendations he then stated I would make a recommendation if I had a concern but had no concerns with these two residents.

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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** 25404 Based on policy review, record review, and interview, the facility failed to ensure psychotropic medications for 1 of 7 residents reviewed for medication use, were limited to 14 days or extended only with an indicated duration for use. Resident #22 had a PRN (as needed) order for lorazepam, a psychotropic medication, initiated on 02/29/24, with no indication for the duration of use. The findings included: 1) Review of the policy 3.8 Psychotropic Medication Use, revised 10/24/22 documented, 9. For psychotropic medications, excluding antipsychotics, that the attending physician believes a PRN order for longer than 14 days in appropriate, the attending physician can extend the prescription beyond 14 days for the resident by documenting their rationale in the resident's medical record. This policy lacked that the PRN order needed to indicate a duration for use, as per regulatory compliance. Review of the record revealed Resident #22 was admitted to the facility on [DATE], with an admission to Hospice services as of 10/05/23. Admitting diagnoses included anxiety disorder. Review of the current order dated 02/29/24 documented the use of 0.5 milligrams of Lorazepam (an anti-anxiety medication that is also a psychotropic medication), every four hours, as needed for anxiety. Further review of this order lacked any end date or duration for the medication. Review of the most current psychiatric progress note dated 03/12/24 documented Resident #22 was prescribed the Lorazepam 0.5 mg every four hours PRN (as needed), but lacked any duration of use. During a phone interview on 06/20/24 at 11:07 AM, when asked about the PRN Lorazepam use greater than 14 days, the consultant pharmacist stated there should be a re-evaluation for use to continue the medication more than 14 days, and agreed the medication should have a specific duration of time. The consultant pharmacist stated his last recommendation related to the Lorazepam was on 02/28/24, as it was ordered every two hour as needed, and the order was changed to every four hours, as needed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on policy review, record review, and interview, the facility failed to ensure complete and accurate clinical records for 1 of 7 sampled residents reviewed for medication use, as evidenced by contradictions in psychotropic medication doses for Resident #37; and for 1 of 1 sampled resident on transmission based precautions (TBPs) as evidenced by the lack of timely orders for contact precautions for Resident #61. The findings included: Review of the policy Nursing Documentation reviewed 08/10/2023 documented, Medical Records: . The medical record must also reflect the resident's condition and the care and services provided across all disciplines to ensure information is available to facilitate communication among the interdisciplinary team. The medical record must contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident' progress, including his/her response to treatment and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions. 1) Review of the record revealed Resident #37 was admitted to the facility on [DATE], had a short hospitalization as of 05/27/23 with readmission to the facility on [DATE]. Resident diagnoses included anxiety disorder, depression, and psychotic disorder with delusions. Review of the current physician orders revealed the following: a) As of 03/19/24 the resident was prescribed clonazepam (an antianxiety medication) 0.5 mg (milligrams) once daily. b) As of 01/18/24 the resident was prescribed seroquel (an antipsychotic medication) 100 mg in the morning and 50 mg at bedtime. c) As of 12/08/23 the resident was prescribed trazodone (an antidepressant medication) 25 mg at bedtime. Review of the most current physician progress note dated 06/10/24, by the physician who ordered the above three medications, documented Resident #37 was on clonazepam 1 mg, seroquel 50 mg and 25 mg, and trazodone 50 mg. These doses contradicted the current active orders. Review of the previous physician progress note dated 02/15/24, by the nurse practitioner, documented Resident #37 was on trazodone 50 mg at bedtime, which contradicted the order. During a side-by-side review of the record and interview on 06/20/24 at 2:19 PM, the Director of Nursing (DON) agreed with the inaccurate physician documentation related to the medication usage for Resident #37. 38212 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) The policy titled, Contact Precautions and reviewed by the facility on 06/03/24 documents in part: 2. The licensed professional independent practitioner orders isolation for suspected or diagnosed infections. During a review of the residents on Enhanced Barrier Precautions and Contact Precautions it was noted that Resident #61 did not have an order written for contact precaution until 2 days after the results were reviewed by the facility. The laboratory results of the stool sample collected on Resident #61 indicated her stool was positive for Clostridium difficile (C. Difficile) on 06/14/24 and documented as reviewed by the facility on 06/15/24. The chart was reviewed for Resident #61 and the order for contact precautions were written on 06/17/24. On 06/20/24 at 10:05 AM, an interview was conducted with the Infection Preventionist. She was asked about the order for the contact precautions on Resident #61 and why they were written 2 days post confirmation of the facilities review of the laboratory results. She stated she always does her audits of the Isolation and Enhanced Barrier Precautions on Mondays and she realized she hadn't written the order for Resident #61's contact isolation. She stated she does not ever back date anything, so the order was written after the diagnosis and precautions were instituted.