STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105291	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Melbourne	606 E Sheridan Rd Melbourne, FL 32901

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on observation, interview, and record review, the facility failed to ensure an evaluation for self-administration of medication was completed, failed to obtain a physician's order for self-administration of medications, and failed to ensure medications were stored securely at the resident's bedside for 1 of 5 residents reviewed for choices, of a total sample of 41 residents, (#51). Findings: Resident # 51, an [AGE] year-old female was admitted to the facility on [DATE], with diagnoses that included, toxic encephalopathy, wedge compression fracture of Thoracic (T) 7-T8 vertebra, diabetes with diabetic neuropathy, chronic obstructive pulmonary disease, lack of coordination, and anxiety disorder. Review of the resident's admission Minimum Data Set assessment dated [DATE], revealed the resident's cognition was moderately impaired, with a Brief Interview For Mental Status score of 10 out of 15. On 5/07/24 at 10:30 AM, resident # 51 sat in her wheelchair in her room, with her tray table positioned in front of her. A vial of Brimonidine Tartrate Ophthalmic Solution 0.2%, and a vial of Timolol Ophthalmic Solution 0.5 % was noted on the resident's tray table. Resident #51 said she always kept the eye drops with her, and when asked how many drops she placed in her eyes, the resident stated, However many drops can get in there. Brimonidine eye drops is used alone or together with other medicines to lower pressure inside the eye that is caused by open-angle glaucoma or ocular (eye) hypertension, (retrieved on 5/10/24 from mayoclinic.org). Timolol is used to treat glaucoma . it works by decreasing the pressure in the eye, (retrieved on 5/10/24 from medlineplus.gov). (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/07/24 at 10:38 AM, Licensed Practical Nurse (LPN) A stated resident #51 was ordered two different eye drops which she self-administered. Review of the resident's physician orders conducted with LPN A showed orders dated 4/23/24 for Brimonidine Tartrate Ophthalmic Solution 0.2%, and Timolol Ophthalmic Solution 0.5%, with instructions to instill one drop in both eyes two times a day for glaucoma. An order for self-administration of the medications could not be identified. This was acknowledged by the LPN. The resident's Electronic Medical Record (EMR) indicated the medications were to be administered by the clinician, and the options unsupervised/supervised administration was not checked. An assessment/ evaluation for self-administration of medication could not be identified for the resident. This was acknowledged by the LPN, and he explained a resident must be evaluated for self administration, and have a physician's order to self-administer any medication. On 5/07/24 at 10:47 AM, the 100/200 Unit LPN/Unit Manager (UM) stated for a resident to self-administer medication, an assessment for self-administration had to be completed, and if medications were to be stored at the resident's bedside, they would be kept in a locked drawer. The resident's clinical records were reviewed with the LPN/UM and revealed no documentation or physician's orders to indicate the resident was evaluated and approved for self-administration of medications. The LPN/UM stated if the medications were to be administered by the resident, it would be indicated on the physician's orders, and self-administration would be selected. On 5/08/24 at approximately 10:00 AM, the Director of Nursing (DON) stated she was made aware of the medications at resident #51's bedside. She stated residents had to have an evaluation, and physician's order in place, to self-administer medications. Review of the Medication Self-Administration Review completed on 5/07/24 after resident #51 was observed by the surveyor with eye drops in her room that were self-administered by the resident , indicated the resident required assistance to correctly read label and/or identify each medication, and to administer eye drops or eye ointment correctly. The document instructed staff to, Complete this assessment prior to resident self-administration of medication. The evaluation read, Resident may NOT self-administer medications. The policy Self-Administration of Medication issued 9/06/2017, revised 10/13/21, and reviewed 08/29/23 read, The facility will ensure that each resident who requests to self-administer medications is assessed by the interdisciplinary team (IDT) to determine if the resident is safe to self-administer medications . Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the room of, or room with, residents who self-administer.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on interview and record review, the facility failed to refer a resident with a newly evident mental disorder for Level II Preadmission Screening and Resident Review (PASARR) evaluation and determination for 4 of 4 residents reviewed for PASARR, of a total sample of 41 residents, (#24, #47, #59 and #93). Findings: 1. Resident #24 was admitted to the facility from an acute care hospital on 8/01/22 with diagnoses that included paranoid schizophrenia, type II diabetes mellitus (DM), depression, bilateral below the knee complete traumatic amputation, and patient noncompliance with medication regimen. Review of resident #24's PASSAR Level I Screen dated 6/08/22, revealed a diagnosis of depressive disorder. Although he was identified as having received services for mental illness (MI) in the past, the MI did not affect his daily life, and there was no diagnosis of dementia. The document indicated a PASSAR Level II Screen was not required. The Minimum Data Set (MDS) Quarterly assessment dated [DATE], revealed resident #24 had a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. He had frequent depressed moods, low energy, and social isolation. He did not display any behaviors and was independent for personal care, mobility, and incontinence care. Active diagnoses included depression and schizophrenia with use of antipsychotic medications. Review of active orders dated 5/09/24 on the summary report revealed resident #24 was taking several medications to include Depakote prescribed for bipolar disorder, Paroxetine for depression, and Vraylar, an antipsychotic used to treat paranoid schizophrenia. He also had orders for monitoring of side effects from antipsychotic medications. Review of progress notes for resident #24 revealed a behavior note dated 3/31/24 that stated, CNA (Certified Nursing Assistant) attempted to provide patient care, resident became extremely upset, began yelling/cussing and using derogatory terms towards aide. Redirection attempted but ineffective resident just became increasingly upset. Review of the medical record for resident #24 revealed several care plans with review date of 3/26/24 for ADL (activities of daily living), psychotropic medications, and behaviors. The ADL care plan stated the resident had a performance deficit related to activity intolerance with shower refusals. There was a care plan for monitoring of psychotropic medications related to depression, anxiety, schizophrenia, and bipolar disorder. Interventions included medication administration, changes in behavior/mood/cognition, decline in ADL ability, hostility, aggressive or impulsive behavior, and social isolation. Resident #24 had a behavior care plan, revised on 4/12/24, which stated he had a problem with poor boundaries with staff and making inappropriate comments including sexual comments towards female staff and racial remarks. Interventions included medication administration and reporting behaviors to psychiatrist. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/24 at 12:14 PM, Resident #24 was observed in his room sat up in bed. His face was unshaven but clean and he was wearing clean clothing. He appeared sweaty and agitated. Resident #24's side of the room was disorganized and there was a smell of feces. There were several areas where dried feces were observed including the bedside commode, bedside table, hand sanitizer bottle on nightstand, and bed sheet. On 05/09/24 at 01:21 PM, the Director of Nursing (DON), stated resident #24 had behavior issues and would get upset very easily. She stated there were only certain staff members who could redirect his behavior when he was upset. His mother was very involved in his care because she would help calm him down. The DON explained they had tried to clean his room, but he would not allow it. She stated he had refused care in the past including personal care and showers. She acknowledged she was unaware a new PASSAR Level I Screen was needed for the newly identified MI diagnoses. 2. Resident #93 was initially admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital. His diagnoses included a history of cerebral infarction, type II DM, delusional disorder, and depression. Review of resident #93's PASSAR Level I Screen dated 11/15/22, revealed no MI or dementia diagnosis. The document indicated a PASSAR Level II Screen was not required. The MDS Quarterly assessment dated [DATE], revealed resident #93 had a BIMS score of 9/15 indicating moderate cognitive impairment. He had no moods or behaviors and required substantial assistance for personal care. Active diagnoses included depression and psychotic disorder. Review of the Admission MDS dated [DATE] revealed there were no active MI disorders and a later Quarterly MDS assessment dated [DATE] had a diagnosis of psychotic disorder. Review of the active orders summary report dated 5/09/24 revealed resident #93 had orders for Lexapro to be given in the morning for mood. Lexapro is an antidepressant medication used to treat certain types of anxiety and depression, (retrieved on 5/20/24 from www.drugs.com). Review of resident #93's progress notes revealed a nursing note dated 3/22/23 asking for medication consent for antipsychotic medication due to increased agitation, and increased behaviors signed by the physician and the psychiatrist. On 4/12/24 a psychotherapy note indicated staff described the resident as being agitated, generally unhappy, and noncompliant. The resident was referred to psychiatric services for depression, anxiety, and to assess adjustment due to staff concerns about resistance to care. The psychiatrist's diagnosis was adjustment disorder with mixed anxiety and depressed mood. Review of the medical record for resident #93 revealed a care plan revised on 1/14/24 for antidepressant medication use related to depression. Interventions included observe for side effects of change in behavior, mood, and cognition. A care plan revised on 1/24/24 revealed resident #93 was resistant to care related to adjustment to nursing home placement with episodes of medication refusal, refusal of care, and refusal of assistance with personal care. On 5/06/24 at 03:13 PM, observed resident #93 wandering the hallway in his wheelchair with a sad demeanor. He stated he was doing ok and that he had not eaten lunch because it was not good. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/24 at 10:29 AM, Licensed Practical Nurse (LPN) H stated she had worked with resident #93 for a while and was very familiar with him. Resident #93 refused care sometimes when he was not in the mood. LPN H described resident #93 as sometimes non-compliant with wearing his splint, but did not have behaviors often. On 05/09/24 at 01:28 PM, the DON confirmed resident #93 had a PASSAR Level I completed on initial admission. She acknowledged the resident had a diagnosis of depression and delusional disorder on initial admission to the facility and therefore the initial PASSAR Level I was incorrect. She confirmed no new PASSAR Level I's was completed for the MI diagnoses. 45646 3. Resident #59 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, chronic kidney disease, heart failure, dementia and chronic obstructive pulmonary disease. Review of the MDS quarterly assessment with assessment reference date (ARD) of 3/26/24 revealed resident #59 had a BIMS score of 06/15 which indicated he had severe cognitive impairment. The document indicated her active diagnoses included anxiety disorder, depression, bipolar disorder and schizophrenia. A care plan initiated 6/13/23 and revised 9/25/23 read, The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs [related to] muscle weakness, heart failure, dementia, and schizoaffective disorder. Review of resident #59's electronic medical record (EMR) revealed diagnoses of schizoaffective disorder with an onset date of 2/24/21, bipolar disorder with an onset date of 2/24/21, anxiety disorder with an onset date of 12/27/22 and depression with an onset date of 12/27/22. The record contained a Level I PASARR screening form dated 2/24/21 which did not indicate the resident had a MI or suspected MI. The record did not contain a Level II PASARR screening form. 48878 4. Resident #47 was admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Her diagnosis included cognitive communication deficit, transient ischemic attack, and depression. She had new diagnoses after her admission that included psychotic disorder on 5/18/22, delusional disorder on 8/30/22, anxiety disorder on 10/25/22, and unspecified dementia, unspecified severity, with psychotic disturbance on 10/25/22. Resident #47's Annual MDS assessment with an ARD of 3/10/24 revealed the resident scored 3 out of 15 on the BIMS which indicated she had severely impaired cognitive skills for daily decision making. The assessment noted the resident received antipsychotic, antianxiety, and antidepressant medications. The MDS also noted the resident did not exhibit behavioral symptoms or rejection of care necessary to achieve the resident's goals for health and well-being. Review of resident #47's medical record revealed a care plan initiated on 2/04/22 and revised on 3/12/24 indicated the resident used psychotropic medications related to diagnoses to include delusions, psychotic disorder, and behavior management. The interventions included following up with the psychiatric medical doctor as needed. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/08/24 at 8:45 AM, the Nursing Home Administrator (NHA) and the DON conveyed it was the Social Service Director and the DON's responsibility to ensure the resident's PASARRs were completed and submitted timely. The NHA stated the expectation was the Social Service Director audit all residents on admission and collaborated with the DON if there was a change in diagnosis for a new PASARR screen to be completed. The DON verified resident #47's PASARR level I dated 1/28/22 prior to admission from the hospital was incorrect and she could not find an updated PASARR level I. The DON also stated the resident had a new diagnosis of dementia, delusional disorder, and psychotic disorder for which a new PASARR level I was not performed. The DON acknowledged the resident should have had another PASARR level I performed upon admission and again when the resident was diagnosed with a new mental disorder. The facility's PASARR policy read, The facility will ensure that potential admissions are screened for possible serious mental disorders or intellectual disabilities and related conditions. This initial pre-screening is referred to as PASARR Level I and is completed prior to admission to a nursing facility. A negative Level I screen permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later .Any resident with newly evident or possible serious mental disorder, ID (intellectual disability) or a related condition must be referred, by the facility to the appropriate state-designated mental health or intellectual disability authority for review .Individuals who may not have previously been identified by PASARR to have MD(mental disorder), ID or a related condition include, but is not limited to a resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on interview and record review the facility failed to develop a baseline care plan for nutrition in the required timeframe for 1 of 4 residents reviewed for nutrition, of a total sample of 41 residents, (#165). Findings: Resident #165 was admitted to the facility on [DATE], with diagnoses including diabetes type II, cognitive communication deficit, dementia, and dysphagia. On 5/07/24 at 12:28 PM, resident #165's meal ticket showed the resident was on a mechanically altered diet. Certified Nursing Assistant (CNA) E removed the resident's meal tray, and stated the resident consumed approximately 20 to 25% of her meal. On 5/08/24 at 12:03 PM, resident #165 sat in her wheelchair in her room, with her lunch tray set up on the over bed table positioned in front of her. The resident's eyes were closed, and she was not eating. Review of the resident's physician's orders revealed the resident was on a mechanically altered texture, consistent carbohydrate diet. A Mini Nutritional assessment dated [DATE] indicated the resident was at risk of malnutrition. A review of the resident's clinical records revealed no baseline care plan, nor a comprehensive care plan for nutrition could be identified. On 5/09/24 at 8:49 AM, the 100/200 Licensed Practical Nurse/ Unit Manager (LPN/ UM) stated nursing staff completed the Mini Nutritional Assessment for resident #165, and a baseline care plan for nutrition should have been initiated for the resident based on results of the assessment. Review of the resident's clinical records was conducted with the LPN/UM, and she acknowledged neither a baseline nor a comprehensive care plan to address the resident's nutrition risk was identified. On 5/09/24 at 8:52 AM, the Director of Nursing (DON) stated baseline care plans were developed by the admitting nurse and were completed within 48 hours of admission. The resident's clinical records were reviewed with the DON, and neither a baseline care plan nor a comprehensive care plan for nutrition was identified. She stated the resident was admitted to the facility on a mechanical soft diet and acknowledged the Mini Nutritional Assessment conducted for resident #165 dated 4/26/24 indicated the resident was at risk for malnutrition. She said a baseline care plan should have been developed. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy Baseline Care Plan issued 8/28/2017, and reviewed 8/11/2023 read, The baseline care plan must-be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including .Dietary orders .The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is developed within 48 hours of the resident's admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46665 Based on observation, interviews, and record review, the facility failed to identify an accurate diagnosis for anti-psychotic medication use for 1 of 5 residents reviewed for unnecessary medications, of a total sample of 41 residents, (#71). Finding: Review of the medical record revealed resident #71, a [AGE] year-old female was admitted on [DATE], and readmitted on [DATE] from an acute care hospital with diagnoses that included dementia, anxiety disorder, bipolar disorder current episode mixed mild, and schizoaffective disorder, unspecified. The Minimum Data Set (MDS) 5-day Assessment with Assessment Reference Date 3/06/24 showed the resident scored 12 out of 15 on the Brief Interview for Mental Status that indicated she was moderately cognitively impaired. She had no indicators of psychosis (hallucinations/delusions) or behavioral symptoms. The assessment noted she required staff assistance to complete activities of daily living (ADLs), she had active diagnoses of non-Alzheimer's dementia, anxiety disorder, bi-polar disorder, and schizophrenia. She did not require the use of restraints or alarms, and she received high risk anti-psychotic, anti-anxiety, and hypnotic medications during the look-back period. The Preadmission Screening and Resident Review (PASARR) (Agency for Health Care Administration MedServ Form 004, Part A, March 2017) form completed by the hospital on 3/06/22 indicated a mental illness (MI) or suspected mental illness (SMI) of bipolar disorder. The comprehensive care plan included focuses for self-care performance deficits, dementia/impaired cognition, mood or behavior changes, adverse effects of sedative and anti-depressant medications, and read, The resident uses antipsychotic medications DX: (Diagnosis) bipolar mania, schizoaffective disorder and is followed by psychiatry. The Order Summary Report noted active physician's medication orders for Zolpidem (hypnotic)10 Milligrams (MG) for insomnia, Mirtazapine (anti-depressant) 15 MG for depression/appetite, and Olanzapine (anti-psychotic) 2.5 MG for bipolar disorder and schizoaffective disorder. On 5/07/24 at 10:13 AM, resident #71 was observed in her room sitting in a recliner. She stated she was not interested in participating in conversation with the surveyor. On 5/08/24 at 11:43 AM, Certified Nursing Assistant I stated resident #71 was often included on her assignment and knew her well. She said the resident enjoyed spending time in her room watching television and relaxing in a recliner. On 5/09/24 at 9:19 AM, The Director of Nursing (DON) explained the behavioral health monthly meetings were conducted with facility staff, the pharmacy, and psychiatric providers. She said residents' psychiatric plans of care were discussed and included any behavioral changes, gradual dose reductions of medications, and appropriate diagnoses. The DON stated resident #71's diagnosis of schizoaffective disorder was used because it had been noted on hospital records. She did not explain why the record was not revised to reflect the facility's psychiatrist diagnosis assessments. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed a revised PASARR form was completed by the DON on 2/06/24 and marked for a MI or SMI of anxiety disorder, bipolar disorder, and schizoaffective disorder. On 5/09/24 at 10:14 AM, the MDS Lead Coordinator said she completed assessments, and diagnoses were auto populated from the electronic medical record into the MDS. She explained she followed the Resident Assessment Instrument (RAI) instructions and checked the accuracy of active diagnoses with reviews of the most recent physician's progress notes and orders. She said psychiatric diagnoses that required clarification were obtained from the treating psychiatrist to ensure they were correct. She checked the medical record and acknowledged the psychiatrist's notes did not include a diagnosis of schizophrenia or schizoaffective disorder. She reviewed the 3/06/24 MDS and said it was marked for schizophrenia and was not active according to the doctor's notes. Psychotherapy notes completed by the psychologist from 5/03/23 to 9/01/23 noted diagnoses of bipolar disorder and anxiety. The weekly Psychiatric Follow Up notes completed by the psychiatrist from 2/20/23 to 3/13/24 documented the resident was assessed to have bipolar disorder and grief. In an interview with the facility's psychiatrist on 5/09/24 at 8:38 AM, he recalled resident #71, and said he treated her at the facility. He said he conducted face to face evaluations and documented his assessments on the Psychiatric Follow Up Notes which indicated the proper diagnosis. He said he rarely used a diagnosis of schizoaffective disorder and stated, Sometimes they just put that in there. Review of the facility's standards and guidelines dated 8/22/23 and titled Comprehensive Care Plans and Revisions read, The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. a. The instructions for completing the RAI are found in the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument Instruction User's Manual 3.0 . Review of the CMS RAI version 3.0 Manual read, . Steps for Assessment 1. Medical record sources for physician diagnoses include the most recent history and physical ., progress notes, and other resources as available. Identify diagnoses: The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days.

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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** 48878 Based on interview and record review, the facility failed to indicate the duration of as needed (PRN) anti-anxiety/anxiolytic medications for 1 of 5 residents reviewed for unnecessary medications and psychotropic medications, of a total sample of 41 residents, (#47). Findings: Review of the medical record revealed resident #47 was admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Her diagnosis included cognitive communication deficit, transient ischemic attack, and depression. She had new diagnoses after her admission that included psychotic disorder 5/18/22, delusional disorder 8/30/22, anxiety disorder 10/25/22, and unspecified dementia, unspecified severity, with psychotic disturbance 10/25/22. Resident #47's Annual Minimum Data Set (MDS) assessment with an assessment reference date of 3/10/24 revealed a score of 3/15 on the Brief Interview for Mental Status exam which indicated she had severely impaired cognitive skills for daily decision making. The Annual MDS noted the resident received antipsychotic, antianxiety, and antidepressant medications. The MDS assessment also noted the resident did not exhibit behavior symptoms or rejection of care that is necessary to achieve the resident's goals for health and well-being. Review of resident #47's medical record revealed a care plan initiated on 2/04/22 and revised on 3/12/24 indicated the resident used psychotropic medications related to diagnoses including delusions, psychotic disorder, and behavior management. The interventions included follow up with the psychiatric medical doctor as needed. Resident #47's Order Summary Report and the Medication Administration Record (MAR) showed the resident had an active order dated 11/27/24 for Lorazepam 1 milligram (mg) by mouth every 6 hours PRN for anxiety with no stop date. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include but are not limited to anti-anxiety medication. Based on a comprehensive assessment of the resident, the facility must ensure that PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order, (retrieved on 5/14/24 from www.ecfr.gov). Review of the MAR revealed the resident received 24 doses of Lorazepam PRN between 11/30/23 and 5/07/24. The 14-day duration for the PRN medication should have been 11/27/23 to 12/11/23. The MAR indicated the resident received 17 doses of Lorazepam after the 14- day duration had passed. Further review of the medical record revealed the physician did not provide a rationale for the extended time-period for Lorazepam use and did not indicate a specific duration for the anti-anxiety PRN order. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/08/24 at 12:42 PM, Registered Nurse (RN) B stated if a PRN medication was administered for anxiety, it should only be given for 14 days unless the doctor gave a new order with a rationale for it to be continued. RN B confirmed resident #47 had an active order for Lorazepam PRN for anxiety since 11/27/23 with no stop date which should have been limited to 14 days. He acknowledged he administered the medication to the resident yesterday, 5/07/24. RN B also confirmed there was not a provider rationale for continuing the medication past the 14 days. He stated he could not provide an answer as to why resident #47's PRN Lorazepam did not have a rationale for continuing the medication past the 14 days. On 5/8/24 at 12:51 PM, the Director of Nursing (DON) stated PRN psychotropic medications should be discontinued after 14 days unless the physician assessed the resident and documented the reason the medication needed to be continued. She acknowledged resident #47's PRN Lorazepam order should have had a 14-day stop date and the psychiatric follow-up note dated 4/04/24 by the psychiatrist showed Lorazepam with no duration or rationale for continued use. The facility's Psychotropic Medication Management Policy read, A psychotropic drug is defined in the regulations at 483.45 (c) (3), as 'any drug that affects brain activities associated with mental processes and behavior.' Psychotropic drugs include but are not limited to the following categories: anti-psychotics, anti-depressants, anti-anxiety, and hypnotics .Based on a comprehensive assessment of a resident, the facility must ensure .limiting the timeframe for PRN psychotropic medications, which are not antipsychotic medications, to 14 days, unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner .The resident's medical record must show documentation of adequate indications for a medication's use.

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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** 32131 Based on interview, and record review, the facility failed to ensure documentation in the medical record was complete and accurate according to accepted professional standards and practices regarding self-administration of medications for 1 of 5 residents reviewed for choices, of a total sample of 41 residents, (#51). Findings: Resident # 51, an [AGE] year-old female was admitted to the facility on [DATE], with diagnoses including, toxic encephalopathy, wedge compression fracture of Thoracic (T) 7-T8 vertebra, diabetes mellitus with diabetic neuropathy, chronic obstructive pulmonary disease, lack of coordination, and anxiety disorder. The resident's physician orders dated 4/23/24 was for Brimonidine Tartrate Ophthalmic Solution 0.2%, and Timolol Ophthalmic Solution 0.5%, with instructions to instill one drop in both eyes two times a day for glaucoma. Brimonidine eye drops is used alone or together with other medicines to lower pressure inside the eye that is caused by open-angle glaucoma or ocular (eye) hypertension, (retrieved on 5/15/24 from mayoclinic.org). Timolol is used to treat glaucoma . it works by decreasing the pressure in the eye, (retrieved on 5/15/24 from medlineplus.gov). On 5/07/24 at 10:30 AM, resident # 51 sat in her wheelchair in her room with her tray table positioned in front of her. A vial of Brimonidine Tartrate Ophthalmic Solution 0.2%, and a vial of Timolol Ophthalmic Solution 0.5 % was noted on the resident's tray table. Resident #51 said she always kept the eye drops with her, and when asked how many drops she placed in her eyes, the resident stated, However many drops can get in there. Review of the resident's Medication Administration Record (MAR) for the period 4/23/24 through 5/09/24 revealed nurses' signatures to indicate the medications were administered by the clinician. There was no physician order for self-administration of the medications. On 5/07/24 at 10:38 AM, Licensed Practical Nurse (LPN) A stated resident #51 was ordered two different eye drops which she self-administered. A review of the resident's physician orders conducted with LPN A revealed the medication was to be administered by the clinician. LPN A acknowledged the, Unsupervised/supervised administration box was not checked. On 5/07/24 at 10:57 AM, LPN A stated the resident's family wanted her to self-administer the eye drops and made the request approximately two weeks ago. The LPN stated there was no documentation regarding the request. He said when he gave medications to the resident's roommate, resident #51 instilled her eye drops. He acknowledged the documented administration was not done by him. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/08/24 at 3:29 PM, Registered Nurse (RN) C confirmed she was resident #51's primary nurse. She stated she opened the lid of the eye drops and offered to give them for resident #51, but the resident gave them on her own. The RN said she signed off on the resident's MAR indicating the eye drops were administered by staff. Review of the MAR for the period 4/23/24 through 5/09/23 revealed LPN A's signature on 4/25/24, 4/29/24, 4/30/24, and on 5/06/24. RN C's signature was noted on 4/24/24, 4/28/24, 5/01/24, 5/02/24, and on 5/05/24 indicating the resident's eye drops were administered by the clinician. However, the resident self-administered the medication for an unknown length of time during the period reviewed. On 5/09/24 at 12:32 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) for the 100/200 units stated she was not aware resident #51 self-administered her eye drops. She stated some nurses said they watched the resident administer the eye drops. The LPN/UM acknowledged the documentation/order for unsupervised/supervised self-administration of the eye drops for resident #51 could not be identified, and the medications were to be administered by the clinician. A review of the resident's MAR for the period 4/23/24 through 5/09/24 was conducted with the LPN/UM. She acknowledged signatures by nurses on the MAR indicated the eye drops were administered by the nurses. The LPN/UM stated the expectation was for nurses to ensure documentation was complete and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32131 Based on observation, interview, and record review, the facility failed to ensure blood glucose monitors were cleaned and disinfected appropriately between resident use to prevent the potential for transmission of blood borne pathogens on 1 of 3 Units, (Unit 200), failed to ensure appropriate Personal Protective Equipment (PPE) was donned as required prior to room entry for 1 of 1 resident on Transmission Based Precautions (TBP), (#165), failed to ensure indwelling catheter drainage bag was kept off the floor to prevent the potential of infection for 1 of 1 resident reviewed for indwelling catheter, (#165), and failed to ensure proper handling of glassware by staff during dining, of a total sample of 41 residents. Findings: 1. On 5/06/24 at 11:52 AM, during medication administration observation, Licensed Practical Nurse (LPN) A monitored blood glucose (BG) for resident #164. On 5/06/24 at 11:55 AM, LPN A proceeded to clean the glucose monitor he used with an alcohol prep pad. The LPN stated he had two glucose monitors in his medication cart, he alternated the use, then cleaned the glucose monitors with alcohol prep between resident use. On 5/06/24 at 11:56 AM, LPN A monitored BG for resident #16. He then proceeded to clean the glucose monitor again with alcohol prep. LPN A stated he used Super Sani-cloth (purple top) wipe for cleaning his medication cart but did not use the Super Sani-cloth wipes for cleaning/disinfecting the glucose monitors, he confirmed he used alcohol prep for the glucometers. Review of the manufacturers' guide for the glucose monitors used by the facility revealed only wipes with Environmental Protection Agency (EPA) registration numbers listed in the guide were to be used to clean and disinfect the blood glucose monitor. The list included the bleach germicidal wipes (yellow top), and the Super Sani-cloth wipes. Alcohol prep was not listed as a recommended cleaning/disinfecting agent for the glucose monitors. On 5/06/24 at 12:10 PM, and at 1:03 PM, the Registered Nurse/Infection Preventionist (RN/IP), stated staff could use alcohol prep, yellow top bleach germicidal wipes, or the Super Sani-cloth purple top wipes to clean the reusable blood glucose monitor. The manufacture's guide was reviewed with the RN/IP and revealed only wipes with EPA registration numbers listed in the guide were recommended for use to clean and sanitize the glucose monitors. The information was acknowledged by the RN/IP, and she stated staff were supposed to follow the manufacturer's guide. She said she thought alcohol was ok for use on the glucose monitors. On 5/06/24 at 1:11 PM, the LPN/Unit Manager (UM) stated glucose monitors must be cleaned and disinfected as recommended. On 5/07/24 at 9:35 AM, LPN A stated during his shift he had four residents who needed blood glucose monitoring. Record review revealed six residents on LPN A's assignment actually required blood glucose monitoring, and none of the residents had a diagnosis of a blood borne pathogen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/08/24 at 9:06 AM, the Staff Development Coordinator (SDC) stated cleaning/disinfecting of the glucose monitor was taught using the facility's Infection Prevention and Control Program (IPCP) and Plan, in combination with the manufacturer's guide. She stated education was conducted on hire, during orientation, and annually, and competency for glucose monitor cleaning had to be completed for all nurses. The Staff Development Coordinator explained there were two glucose monitors on each medication cart which the nurses used alternately. She stated the glucose monitor must be cleaned and disinfected. She said alcohol prep could be used to clean the monitors, but the Super Sani-wipe cloth (purple top) wipes must be used to disinfect the glucose monitors. Review of the Competency checklist for Glucometer Cleaning Procedures revealed nurses were checked off for the cleaning and disinfecting procedures. The document read, Open cap of the disinfecting container and pull out 1 towelette. The use of alcohol prep was not documented/indicated. 2. Resident #165 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus type II, cognitive communication deficit, dementia, and dysphagia. Observation on 5/07/24 at 10:15 AM, showed signage for contact precautions posted on resident #165's door, and an overdoor container with the required, and adequate supply of PPE noted. Review of the medical record revealed a physician's order dated 5/01/24 for contact precautions for ten days due to Extended-Spectrum Beta-Lactamase (ESBL) in the urine, with end date of 5/11/24. ESBLs are enzymes or chemicals produced by germs like certain bacteria. These enzymes make bacterial infections harder to treat with antibiotics, (retrieved on 5/15/24 from webmd.com). On 5/07/24 at 12:12 PM, Certified Nursing Assistant (CNA) E was observed in the resident's room leaning over her bed, not wearing any gown or gloves. On exit from the room, the CNA stated she went in to remove the resident's meal tray. She stated the resident was on contact isolation, and acknowledged she leaned over the resident's bed and could have come in physical contact with the resident's bed linen. When asked why she had not worn the appropriate PPE as directed by the posted signage, she said it was a, Bad habit, and confirmed she should have donned gown and gloves prior to entry into the resident's room. On 5/07/24 at 12:31 PM, RN D stated resident #165 was on contact isolation for ESBL in her urine. The RN said directives from the Infection Preventionist was for staff to wear gown, and gloves while coming in contact with linen, emptying the Foley catheter, providing activities of daily living care, or if there was the possibility of them coming in physical contact with the resident's environment. On 5/07/24 at 12:36 PM, the LPN/ UM for the 100/200 Units, stated the protocol for contact isolation was for staff to wear a gown, and gloves if coming in contact with the resident. On 5/09/24 at 12:27 PM, the Infection Preventionist stated the appropriate PPE must be worn if staff was coming in contact with the resident's linen or environment. The Center for Disease Control and Prevention signage for Contact Isolation used by the facility directs that Providers and Staff must also: Put on gloves before room entry .Put on gown before room entry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #165 was admitted to the facility on [DATE], with diagnoses including diabetes mellitus type II, cognitive communication deficit, dementia, and dysphagia. A physician's order dated 4/26/24 for indwelling catheter to straight drainage, with instructions to change for infection, obstruction or when the closed system was compromised. Observations on 5/07/24 at 10:15 AM, and 11:09 AM, noted the drainage bag of the indwelling catheter was on the floor. On 5/07/24 at 12:12 PM, CNA E acknowledged resident #165 was included in her assignment, and verbalized the resident had an indwelling catheter. The CNA stated she checked the resident's indwelling catheter every two hours. Observation of the indwelling catheter was conducted with CNA E. She acknowledged the indwelling catheter drainage bag was on the floor. When asked why the drainage bag should not be on the floor, CNA E said she was not sure. On 5/07/24 at 12:25 PM, LPN A acknowledged the indwelling catheter drainage bag was on the floor, and stated the drainage bag should not be on the floor for several reasons including the potential for infection. On 5/07/24 at 12:31 PM, RN D, the resident's primary nurse stated the indwelling catheter drainage bag should not be on floor due to the potential of infection. On 5/07/24 at 12:36 PM, the LPN/ UM for the 100/200 Unit confirmed the indwelling catheter drainage bag was not supposed to be on floor. The policy Indwelling Urinary Catheter (Foley) Management issued 4/01/2022, and reviewed 8/24/2023, instructed the indwelling catheter collecting bag was not to rest on the floor. 45646 4. During lunch observation in the main dining room on 5/06/24 at 12:02 PM, a resident requested a drink refill. The Minimum Data Set (MDS) Licensed Practical Nurse (LPN) took the glass from the resident's table. She was observed holding the glass in her left hand with her thumb and fourth finger directly touching the rim of the glass. She held the straw in the glass between her first and second fingers which overlapped the top of the glass and and also touched the rim. The MDS LPN asked another staff member where the pitcher of juice was located. She then proceeded to the area, put the glass down and filled it with juice. The MDS LPN then picked up the glass and headed toward the resident's table. When asked if she was going to serve the glass she had touched the rim of to the resident, she stated, Yes, why? The MDS LPN was reminded she had touched the rim of the glass with four of her fingers. She stated she did not realize she had done that and acknowledged she would not want to drink from a glass which had been handled by the rim. During an interview with the Infection Preventionist on 5/09/24 at 12:23 PM, she stated staff were to handle cups and glasses by holding the sides of the glass. She demonstrated the proper way to handle a glass when served to a resident. The Infection Preventionist confirmed staff handling glassware by the rim was a problem and acknowledged it presented a potential to spread infection. She explained staff members should always handle cups and glasses away from the rim to avoid potential cross contamination and should never touch the rim.