STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105352	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare Sebring	3011 Kenilworth Blvd Sebring, FL 33870

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 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** 37999 Based on observations, record reviews, and interviews the facility failed to assess two residents (#73 and #178) out of twenty-eight sampled residents for the self-administration of medications and to ensure the self-administered medications were safely stored. Findings included: 1. On 5/18/24 at 12:14 p.m. Resident #73 was observed and interviewed in the resident's room. The observation revealed an allergy nasal spray bottle, 3 vials of an unknown type of eye drop and a medication bottle with a green top sitting on top of the bedside dresser underneath the resident's computer monitor. The resident reported having a lot of environmental allergies and the nasal spray was Fluticasone. Review of Resident #73's Admission Record revealed the resident was admitted on [DATE]. The record revealed diagnoses not limited to sequela unspecified fracture of right femur, unspecified rheumatoid arthritis, and history of falling. The Admission Record showed the resident suffered from almond, bread, tree, and shrub pollen allergies. Review of Resident #73's Order Summary Report, active as of 5/20/24 at 12:51 p.m., showed the resident did not have an order for Fluticasone nasal spray and an order had been received on 5/18/24 to start 5/19/24 for Artificial Tears Solution 1.4% (polyvinyl alcohol) - Instill 1 drop in both eyes one time a day for dry eyes, irritation. MAY KEEP AT BEDSIDE. The summary revealed an order received on 5/18/24 allowing the resident PER Advanced Registered Nurse Practitioner (ARNP) MAY KEEP EYE DROPS AT BEDSIDE. Review of Resident #73's May 2024 Medication Administration Record (MAR) showed an order for Artificial Tears solution, scheduled at 7 - 11 a.m., which started on 4/26/24 and discontinued at 4:54 p.m. on 5/14/24, an order which started on 5/15 and discontinued at 5/18/24 at 12:17 p.m. for Artificial Tears, and an order to start on 5/19/24 at 9:00 a.m. for Artificial Tears allowing for the resident to keep drops at bedside. The discontinued orders for Artificial Tears started on 4/26/24 and 5/14/24 did not reveal the resident was allowed to keep eye drops at bedside. Review of Resident #73's May MAR did not include an order for Fluticasone nasal spray. (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #73's Medication Self-Administration Safety Screen, dated 5/18/24 at 12:18 p.m., revealed the instructions were to complete this assessment prior to resident initiating self-administration of medication and with any medication order changes, change in function/condition that might affect the resident's ability to safely self-administer medications. Ongoing assessment should occur at a minimum of quarterly. Use clinical judgment with Section B to determine if or what level of self-administration will be allowed. The review revealed the list of medications being considered for resident self-administration as Tears One drop in each eye Once daily and storage was Bedside with resident. The screen did not reveal any other medication being considered for self-administration. The screening revealed, The resident can demonstrate secure storage of medications kept in room. Completely capable. The screening was completed by Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM). Review of Resident #73's care plan did not reveal the resident was able to self-administer medications. During an interview on 5/20/24 at 11:08 a.m. Staff E, LPN/UM reported the physician had screened (for self-administration of medications) Resident #73 on Friday (May 17th) and the Regional Nurse Consultant (RNC) had to find the appropriate screening. The staff member stated the screening should have included all medications if at bedside and at admission. Staff E stated the facility does ask or tells residents not to bring medications from home. The staff member reported the resident should have been care planned for self-administration. 2. On 5/18/24 at 11:08 a.m. Resident #178 was observed and interviewed lying in bed with an over-bed table in a reachable distance to the resident. The observation showed an unopened box of 20 pain relief topical patches and an opened roll-on pain reliever lying on the over-bed table and a tube of 100% Leptospermum Scoparium honey gel lying on the vanity across from the resident's bed. The resident stated her [family member] brought them (patches) in, did not think the facility even noticed (the resident) had them, and used the roll-on on arms 1-2 times a day. The resident reported not using the roll-on as often since starting therapy. The resident admitted to having a butt wound and did not know what (the facility) was putting on it. On 5/19/24 at 1:48 p.m. Resident #178 was observed lying in bed, the pain relief topical patches and roll-on pain reliever was no longer lying on the over-bed table. The resident stated the girl who took the patches told the resident they had to take them. Review of Resident #178's Admission Record showed the resident was admitted on [DATE] and diagnoses included but was not limited to sequela (of) unspecified injury to unspecified level of lumbar spinal cord, unspecified hemiplegia affecting right dominant side, and uncomplicated opioid dependence. Review of Resident #178's Admission/Readmission Nursing Evaluation, effective 5/18/24 at 9:18 p.m., showed the resident was to receive wound care, the resident's skin integrity was impaired with dry skin to nose and forehead, boggy bilateral heels, and redness to coccyx, the resident was medicated for pain and routine or as needed (PRN) pain medication had been ordered. The resident had reported sharp left lower leg pain that was alleviated with pain medication. The evaluation revealed the resident had not requested to self-administer any medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #178's Order Summary Report, active as of 1:05 p.m. on 5/20/24, did not reveal an order allowing for the resident to self-administer any medication. The report did not reveal an order for either pain relief topical patches or a roll-on pain reliever. The Order Report did reveal the following: - Wound Care: Sacrum Pressure Injury (PI) stage 2. Clean with normal saline (N/S), apply Honey Fiber and cover with border foam one time a day for treatment. Ordered 5/17/24. Review of Resident #178's Medication Administration Record (MAR) revealed the resident was receiving Oxycodone 10 milligram (mg) frequently as needed (PRN) for pain. The MAR did not reveal an order for pain relief patches, or a roll-on pain reliever was active or discontinued. Review of Resident #178's care plan showed the resident had mildly impaired cognitive function with short-term memory loss. The care plan showed the resident had acute/chronic pain related to (r/t) (blank). The interventions did not reveal the resident was allowed to self-administer pain medication. During an interview on 5/20/24 at 11:42 a.m. Staff E, LPN/UM reported Resident #178 should have been screened for self-administration for pain relief patches and/or roll-on pain reliever at bedside. The staff member stated in her opinion the resident did not have the capability to self-administer since staff had to do everything for the resident. Review of the policy titled, Resident Self-Administration of Medication, implemented 9/1/23, showed It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facilities interdisciplinary team has determined which medications may be self-administered safely. A review of the policies compliance guidelines revealed: 1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facilities interdisciplinary team. 2. Resident's preference will be documented on the appropriate form and placed in the medical record. 3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: a. The medications appropriate and safe for self-administration; b. The resident's physical capacity to: swallow without difficulty, open medication bottles, (and/or) administered injections; c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; d. The resident's capability to follow directions and tell time to know when the medications need to be taken; (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to the facility staff. f. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs. g. The resident's ability to ensure that medication is stored safely and securely. 7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medications. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy. 8. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families are the responsible parties are reminded of policy and procedures regarding resident self-administration when necessary. 13. The care plan must reflect resident self-administration and storage arrangements for such medications.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38007 Based on record review, interview and observation, the facility failed to ensure reasonable accommodations were made to ensure one resident (#29) of twenty four sampled residents was provided the right sized incontinent supplies. Findings included: An interview was conducted with Resident #29 on 5/18/24 at 11:52 a.m. in her room while she was in bed. She stated for the last two weeks she hasn't been able to get medium size pull ups. She said, That is what I always wear. Right now I'm wearing small youth and they are tight. I have severe diarrhea and these are so tight. She confirmed she has told staff members but could not recall their names. Review of the Admission Record for Resident #29 revealed her most recent admission to the facility was 2/28/23 with diagnoses to include depression, anxiety, muscle wasting and atrophy, difficulty in walking, muscle weakness and need for assistance with personal care. Review of a Quarterly Minimum Data Set (MDS) assessment, dated 3/27/24, revealed in Section C-Cognitive Patterns for the Brief Interview for Mental Status (BIMS) a score of 15, indicating the resident was cognitively intact. Section GG - Functional Abilities and Goals scored a 6 for independent for toileting hygiene. Section H - Bladder and Bowel shoed Resident #29 was always continent of bowel and bladder. A review of the active physician orders as of 5/20/24 revealed: Dicyclomine HCl Oral Capsule 10 MG (milligrams) - give 1 capsule by mouth two times a day for IBS (irritable bowel syndrome), start date of 5/10/24, Furosemide Oral Tablet 40 MG - give 1 tablet by mouth one time a day for edema, start date of 5/10/24, Loperamide HCl Capsule 2 MG - give 1 capsule by mouth as needed for loose stool after each loose stool, start date of 2/28/23. A review of the facility grievance log for May 2024 revealed no grievances for Resident #29. Review of Resident #29's current care plan revealed focus areas as: * The resident has bladder incontinence r/t (related to) dementia, impaired mobility, initiated 9/29/22. Interventions included: Brief use - the resident uses disposable briefs. Check and change prn (as needed), initiated 5/20/24. * The resident has bowel incontinence r/t immobility, initiated 9/29/22. Interventions included: check resident routinely and assist with toileting as needed, provide loose fitting, easy to remove clothing. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* The resident has an ADL (activities of daily living) self-care performance deficit r/t activity intolerance, dementia, impaired balance, limited mobility. Interventions included: toilet use - the resident is independent for toileting. An interview was conducted on 5/20/24 at 10:32 a.m. with Staff H, Certified Nursing Assistant (CNA). Staff H stated the facility has a chart that tells them what size briefs a resident wears. For Resident #29, Staff H logged into the electronic medical record and looked at the Kardex. Staff H stated she uses the restroom by herself so we wouldn't supply her any. A review of the Kardex for Resident #29 revealed in the Bladder/Bowel section the following: * Brief use: The resident uses disposable briefs. Check and change prn (as needed). * Incontinent: Check and change as required for incontinence. Wash, rinse and dry perineum. Change clothing prn after incontinence episodes. The Kardex was silent of what size disposable briefs Resident #29 wore. Resident #29 was interviewed on 5/19/24 at 10:30 a.m. and stated she had a shower and that her roommate went to the A Wing and got her some briefs. She now has four to use. An interview was conducted on 5/20/24 at 2:19 p.m. with Staff J, Central Supply. Staff J explained when a resident first comes into the facility she will measure them and if they gain weight they will remeasure if needed. She stated there was no list of residents and the sizes they wore for briefs or pull ups. She stated, No, I'm the only one who does this. She stated she knows everyone. She confirmed Resident #29 wore a medium. She said, She wears a medium pull up. She stated she thinks Resident #29 could fit in a small, but she prefers medium. She stated on Fridays she stocks the clean linen closet with a case of each size for residents. She stated residents will tell her if they need more. She stated, she leaves enough for the weekend. Staff J stated she doesn't order [NAME] because there is no one here who wears small. During an interview and observation on 5/20/24 at 2:24 p.m. with Staff J, Central Supply a 22 pack of youth small pull ups were observed to the side of Resident #29's bed. Staff J stated that maybe Resident #29's family member sent them because she only uses medium. At this time, Resident #29 confirmed another staff member gave them to her and stated, They really don't fit. On 5/20/24 at 2:36 p.m. two packages of youth extra small pull ups were found on the shelf in the supply shed behind the facility. (Photographic Evidence Obtained) In addition, multiple packages of medium briefs and medium pull ups were observed. Staff J, Central Supply clarified a resident wears briefs if incontinent and pull ups are a resident's choice. If they are care planned for briefs they can choose to wear pull ups. She stated she normally goes to each resident two times a week to see what they need. She confirmed she was not aware of Resident #29's current need for medium pull ups. On 5/20/24 at 6:53 p.m. the Director of Nursing stated a resident could ask staff for the size needed and staff can ask other staff if they are not sure of what size. She confirmed the Kardex does not provide the size needed for a resident. She stated she hadn't heard anything about Resident #29's need for medium pull ups.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38007 Based on record review, and staff interviews the facility failed to ensure the Preadmission Screening and Resident Review (PASARR) Level I for three residents (#63, #56 and #30) of twenty four sampled residents were revised for accuracy to include diagnoses recognized at the time of admission and later identified. Findings included: 1. Review of Resident #63's Admission Record revealed an original admitted [DATE] and a readmitted [DATE]. The Admission Record showed diagnoses to include anxiety disorder as of 2/26/24 and depression as of 2/26/24. Review of Resident #63's medical record revealed a PASARR Level I, dated 11/23/23, and new one completed on 4/16/24. The PASARR Level 1 completed on 4/16/24 did not include the diagnoses of anxiety and depression in Section 1 A MI (mental illness) or suspected MI. Review of the Minimum Data Set, dated dated [DATE], revealed: Section C - Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 7, indicating severe impairment. Section I - Active Diagnoses revealed anxiety and depression as checked. Review of Resident #63's active orders as of 5/20/24 revealed an order for Mirtazapine oral tablet 7.5 mg (milligrams)- give 1 tablet by mouth at bedtime for depression with weight loss, start date 5/1/24. The orders were silent of medication ordered for anxiety. An interview was conducted on 5/20/24 at 6:33 p.m. with the Social Services Director (SSD) and the Director of Nursing (DON). The DON confirmed the facility's PASARR process when a resident comes from the hospital was they reviewed the PASARRs and clinicals the next morning. If the resident has a diagnosis not on the PASARR or they notice medications; they would initiate a new one (PASARR). Then they would request a Level II based on [vendor name] recommendations. The SSD and DON confirmed a whole house audit is completed by the SSD on Fridays to ensure all PASARRs are complete and accurate and given to the DON for review. They confirmed Resident #63's PASARR Level I was not accurate. 2. Review of Resident #56's Admission Record revealed an original admitted [DATE] and a readmitted [DATE]. The Admission Record showed diagnoses to include other stimulant abuse 8/16/22, generalized anxiety disorder as of 7/28/23, persistent mood (affective) disorder as of 3/11/24, and a binge eating disorder as of 3/11/24. Review of Resident #56's medical record revealed a PASARR Level I dated 7/30/23. The PASARR Level 1 did not include the diagnosis of substance abuse in Section 1 A MI (mental illness) or suspected MI. The medical record was silent of a revised PASARR Level I for the new diagnosis of persistent mood (affective) disorder. Review of the Minimum Data Set, dated dated [DATE], revealed: (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Section C - Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Section I - Active Diagnoses revealed anxiety, other stimulant abuse and binge eating disorder. Review of Resident #56's active orders as of 5/19/24 revealed: *Depakote Oral Tablet Delayed Release 250 MG - give 1 tablet by mouth three times a day related to persistent mood [affective] disorder, start date of 3/11/24, *Nortriptylie HCl Oral Capsule 25 MG - give 50 mg by mouth two times a day for depression, start date of 5/10/24, *Xanax Oral Tablet 1 MG - give 1 tablet by mouth at bedtime for anxiety, start date of 12/14/23. An interview was conducted on 05/20/24 at 6:44 p.m. with the Social Services Director (SSD) and Director of Nursing (DON). The SSD confirmed the PASARR dated 7/30/23 was the most recent PASARR for Resident #56. She confirmed the diagnosis of stimulant abuse should have been documented on the PASARR Level I and that Resident #56's PASARR Level I should have been redone. 37999 3. Review of Resident #30's Admission Record revealed the resident had been admitted on [DATE] and included diagnoses not limited to unspecified intractable epilepsy without status epilepticus (onset 1/23/24), personal history of traumatic brain injury (onset 1/23/24), unspecified anxiety disorder (onset 3/19/24, adjustment insomnia (onset 3/4/24), and mood disorder due to known physiological condition with mixed features (onset 5/14/24). Review of Resident #30's Preadmission Screening and Resident Review, dated 2/2/24 and completed by the facility's Director of Nursing (DON) showed the resident had a Mental Illness diagnosis of anxiety disorder and no Intellectual Disability related to condition, epilepsy or traumatic brain injury (TBI). The section for other indications did not reveal the resident had or may have had a disorder resulting in functional limitations in major life activities, serious difficulty interacting appropriately and communicating effectively, serious difficulty in sustaining focused attention for a long period to permit completion of tasks, or serious difficulty in adapting to typical changes in circumstances. The completion of the PASARR revealed the resident had no diagnosis or suspicion of a Serious Mental Illness or Intellectual Disability therefore a Level II was not required. Review of Resident #30's care plan included the following: - Activities of Daily Living (ADL) Care Plan: The resident has an ADL self-care performance deficit related to (r/t) decline in function and motility r/t TBI. - Resident at times makes complaints and upon investigating, complaints are found to be untrue. Resident has a tendency to fabricate stories (ex. missing items). The intervention instructed staff to Acknowledge resident's behaviors as an attempt to communicate needs. - Resident uses psychotropic medications r/t depression, anxiety, and insomnia. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Hypnotic Care Plan: The resident is on sedative/hypnotic therapy r/t Insomnia. - Anti-Anxiety Care Plan: Resident is at risk for adverse side effects related to use of anti-anxiety medication. - Antidepressant Care Plan: Resident is at risk for adverse side effects related to use of antidepressant medications. - Mood Care Plan: Potential for mood state issues related to anxiety. - Seizure Disorder Care Plan: Potential for injury or aspiration related to history of seizures. Review of the policy titled, Resident Assessment - Coordination with PASARR Program, implemented 9/1/23, revealed: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. The compliance guidelines of the policy showed: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities, and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission. i. Negative Level 1 screen - permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later. ii. Positive Level 1 screen - Necessitates a PASARR level 2 evaluation prior to admission. b. PASARR Level 2 - a comprehensive evaluation by the appropriate state designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/ or rehabilitative services through individual needs. 2. The facility will only admit individuals with a mental disorder or intellectual disability who the state mental health or intellectual disability authority has determined as appropriate for admission. 6. The social services director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level 2 resident review. Examples include: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A resident whose intellectual disability or related condition was not previously identified in evaluated through PASARR. c. A resident transferred, admitted , or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observation, record review, and interview the facility failed to ensure a care plan had been developed and implemented for one resident (#70) out of one resident sampled for respiratory services. Findings included: On 5/18/24 at 12:31 p.m. Resident #70 was observed lying in bed with a Continuous Positive Airway Pressure (CPAP) machine on the bedside dresser next to the resident. The tubing and cannula attached to the machine were lying on top of it. The resident reported staff do not clean it, did not have anything to clean it with, and she would do it when she discharged to home. On 5/19/24 at 9:27 a.m. Resident #70 was observed lying in bed with the CPAP tubing and cannula sitting on top of the machine. Review of Resident #70's physician orders revealed an order for Bipap to be on every night at 129 setting, started on 3/19/24. The orders did not include an order to clean the equipment after resident use. Review of Resident #70's care plan, on 5/18/24 at 2:19 p.m., revealed no care plan related to the resident's respiratory status or use of respiratory equipment. (Photographic Evidence Obtained) Review of Resident #70's Admission Record revealed the resident was admitted on [DATE] with diagnoses not limited to subsequent encounter (for) unspecified injury of head and subsequent encounter for fracture of nasal bones with routine healing. An interview was conducted with Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM) on 5/20/24 at 10:08 a.m. Staff E stated yes there should be orders for staff to assist with cleaning the CPAP and Resident #70 was an exception, the resident did not want staff to assist with cleaning it and was alert and oriented. Staff E stated there should be a care plan regarding the resident not wanting staff to clean the CPAP. The staff reviewed the resident's care plan and confirmed there was no focus related to the resident having a CPAP. Staff E left the interview to ask the person responsible for developing the care plans to attend the interview. An interview was conducted with the Minimum Data Set (MDS) Coordinator on 5/20/24 at 10:18 a.m. The staff member stated yes there should have been a care plan for Resident #70's use of a CPAP and reported there is now. Review of Resident #70's Admission MDS assessment, dated 3/15/24, showed the resident did utilize non-specific oxygen therapy but did not reveal the resident used either CPAP or Bipap equipment. An additional review of Resident #70's Order Summary Report of active, as of 5/20/24 at 12:55 p.m., physician orders did not show staff were to clean or assist the resident with cleaning CPAP equipment. The review revealed active orders for: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare Sebring	3011 Kenilworth Blvd Sebring, FL 33870

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- BiPAP to be on every night at 129 settings at bedtime for BiPAP, start 3/19/24. - C-PAP to be on every night at 129 settings at bedtime for C-PAP, start on 5/20/24. An interview was conducted with the MDS Coordinator on 5/20/24 at 7:05 p.m. The MDS Coordinator reported reviewing Resident #70's care plan this morning with this writer and when later reviewing it, a care plan had been initiated for the resident's respiratory status on 3/10/24, but the MDS Coordinator had resolved it on 3/19/24 for an unknown reason. The MDS provided a revised care plan for Resident #70's respiratory status which showed the focus, goal, and interventions had been CANCELLED on 3/19/24. Review of the policy titled, Comprehensive Care Plans, implemented 9/1/23, showed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The policy definition of Person-centered care means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. The review of the compliance guidelines revealed: 1. The care planning process will include an assessment of the resident's strength and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma informed. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All care assessment areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the residence highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident' exercise of his or her right to refuse treatment. 6. The comprehensive care plan will include measurable objectives and time frames to meet the resident's needs as identified in the residence comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38007 Based on record review and interview the facility failed to revise the comprehensive care plan related to dialysis services for one resident (#45) of two residents sampled for dialysis. Findings included: Review of the Admission Record for Resident #45 revealed he was admitted to the facility on [DATE]. The Admission Record revealed diagnoses of end stage renal disease, and dependence on renal dialysis. Review of the active physician orders for May 2024 revealed and order for Dialysis - [Name of Dialysis Center, address and phone number] [name of transport company] transport chair time 0630 (a.m.)/PU (pick up) time 5:30-6a (a.m.) on Tuesday, Thursday and Saturday, 5/2/24 start. During an interview with Resident #45 on 5/18/24 at 12:54 p.m. he stated he goes to dialysis three times a week on Tuesday, Thursday and Saturdays. Review of the active care plan, initiated 2/22/23 and revised 11/20/23, revealed a Focus for renal failure with dialysis T/Th/S (Tuesday/Thursday/Saturday) at [name of dialysis center]. Interventions included: [name of dialysis center] on TU-TH-SA [name of transport company] pick up at 2:00 p.m., chair time is 2:30 p.m., revision 10/11/23. Review of the Dialysis List on the whiteboard in the nurses' station on the B Wing showed Resident #45's Chair time: 7:35 Leave: 12:10 .new time as of 4/24. (Photographic Evidence Obtained) An interview was conducted on 5/20/24 at 10:27 a.m. with Staff H, Certified Nursing Assistant (CNA). Staff H confirmed Resident #45 goes to dialysis. She reviewed the Dialysis List on the whiteboard in the B Wing nurses' station, at this time it was turned over, and stated his chair time is 7:35 (a.m.) so you would have him up at 6 (a.m.) for breakfast. She confirmed she would use this list as it tells staff who you should be expecting. During and interview on 5/20/24 at 11:00 a.m. the Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM) and Director of Nursing (DON) confirmed the physician's order for dialysis for Resident #45 showed a chair time of 6:30 a.m. and a pick up of 5:30 a.m. - 6:00 a.m., as of 5/2/24. They confirmed the care plan showed a chair time of 2:30 p.m. and a pick up time of 2:00 p.m. They confirmed the Dialysis List showed 7:35 a.m. (chair time). They confirmed the 12:10 p.m. time was the time Resident #45 left the dialysis center. The DON stated the 4/24/24 date might have been when he missed dialysis and that it should have been taken down. A care plan was provided for review on 5/20/24 for Resident #45 with a focus for Renal failure with dialysis T/Th/S at [name of dialysis center]. Interventions included: [name of dialysis center] on TU-TH-SA [name of transportation company] pick up at 5:30 a.m. Chair time is 6:30 a.m. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/24 shortly after the interview with Staff E, LPN/UM and the DON at 11:00 a.m., Staff I, Transportation confirmed Resident #45's chair time had changed and now the chair time is 7:35 a.m. on Tuesday, Thursday and Saturdays and he is picked up at 7:00 a.m. She stated the sheet at the nurses' station is correct. She confirmed that she ensures any new information was to be communicated to MDS (minimum data set staff) to update the care plan to make sure he gets to dialysis. She stated she forgot to notify MDS of the changes. Review of the policy titled, Comprehensive Care Plans, implemented 9/1/23, showed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The Policy Explanation and Compliance Guidelines revealed: 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the residence highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident' exercise of his or her right to refuse treatment. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews the facility failed to assess altered skin conditions and provide wound care according to facility protocol, physician orders, and professional standards for two residents (#15 and #71) out of two residents sampled for non-pressure related skin conditions. Findings included: 1. On 5/18/24 at 10:30 a.m. Resident #15 was observed sitting in the hallway between the two units of the facility. An undated white 2x2 bordered dressing stained with a red substance was observed on the resident's right ankle and a whitish/gray 2x2 bordered dressing dated 5/16/24 was observed on the resident's left ankle. The resident allowed photographic evidence to be obtained. On 5/18/24 at 3:04 p.m. Resident #15 was observed with the same dressings on each lower extremity. On 5/19/24 at 9:01 a.m. Resident #15 was observed with an undated 2x2 white bordered dressing stained with reddish-brown drainage on the right ankle. The observation revealed a dated 2x2 grayish-white dressing on the left ankle. On 5/19/24 at 1:35 p.m. Resident #15 was observed with the same dressings. Review of Resident #15's Admission Record showed the resident was admitted on [DATE] and readmitted on [DATE]. The record revealed diagnoses not limited to unspecified chronic obstructive pulmonary disease, history of falling, other specified glaucoma, and need for assistance with personal care. Review of Resident #15's May 2024 Medication Administration Record (MAR) revealed no order regarding the treatment of the resident's bilateral lower extremity skin alterations. Review of the resident's May 2024 Treatment Administration Record (TAR) showed the following orders: - Clean Skin Tear to left lower extremity. Cleanse with normal saline, pat dry. Change dressing daily and as needed (prn). Every shift for skin impairment for 14 days, discontinue (DC) order after 14 days and leave of absence (LOA). Complete weekly non-pressure wound UDA. Start date: 5/3/24 and discontinued on 5/15/24 at 10:53 a.m. - Clean Skin Tear to left lower extremity. Cleanse with normal saline, pat dry. Change dressing daily and prn every day shift for skin impairment for 14 days. DC order after 14 days and LOA. Complete weekly non-pressure wound UDA. Start date 5/16/24 at 7:00 a.m. and discontinued on 5/20/24 at 9:20 a.m. - Weekly skin checks Saturday 7 a.m. - 3 p.m. every day shift every Saturday. Review of the TAR showed Staff D, Licensed Practical Nurse (LPN) had changed Resident #15's left lower extremity (LLE) skin tear dressing on 5/16/24, as the observed dressing had revealed. The TAR documentation showed Staff B, LPN, had documented changing the LLE dressing on 5/17 and Staff A, LPN, had documented changing the dressing on 5/18 and 5/19/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the TAR showed Staff A, LPN, had completed Resident #15's Weekly Skin Check on 5/18/24. Review of Resident #15's Weekly Skin Checks revealed the following: - 5/18/24 at 2:40 p.m., Resident #15 had no new injury or wound identified, the resident had no external devices such as casts, prosthetics, or braces. The evaluation revealed the resident had no previously noted or described skin injuries or wounds. - 5/11/24 at 11:11 a.m., Resident #15 had no new injury/wound identified and no external devices. The description of new skin injury/wound section showed the left lower leg (rear) had a skin tear under treatment. No previously skin injuries/wounds were noted. - 5/3/24 at 3:07 p.m., Resident #15 had a new injury/wound identified to two re-opened skin tears on left lower leg (rear). No other previously skin injuries or wounds were noted. Review of Resident #15's Certified Nursing Assistant (CNA) task history of Skin Observations, from 4/21/24 to 5/20/24 at 2:28 p.m. revealed the resident had no scratches, red areas, discolorations, skin tears or open areas. Review of Resident #15's progress notes revealed on 5/3/24 at 3:30 p.m., the resident was found on the floor in room and two LLE skin tears had reopened. Review of Resident #15's Progress notes revealed a Nurse's Note, dated 5/15/24 at 6:54 a.m. revealing the resident has two skin tears on left lower leg both are dry and healing, no open areas noted, redness or drainage noted. Review of Resident #15's progress notes did not show any further documentation between 5/15 and 5/19/24 related to the resident's bilateral lower extremity skin conditions. An interview and observation were conducted with the Regional Nurse Consultant (RNC), on 5/20/24 at 9:00 a.m. The RNC viewed Resident #15's bilateral lower extremity dressings. The resident raised her right leg revealing an undated 2x2 grayish-white bordered dressing stained with reddish-colored drainage and a dated gray left leg dressing stained with drainage. The RNC confirmed the left ankle dressing was dated 5/16/24 and the right ankle dressing was not dated. During an interview on 5/20/24 at 9:48 a.m., the RNC confirmed staff should have addressed the wounds. The Director of Clinical Operations (DCO) reviewed Resident #15's orders, confirming the orders were for the left leg and there was no wound care order for the right leg. The DCO confirmed the Weekly Skin Assessment done on 5/18/24 did not show any new or previous skin issues. The RNC stated there was a progress note on 5/15/24 revealing 2 skin tears. The mentioned note was reviewed with the RNC and DCO which they confirmed revealed 2 skin tears to the left leg and did not mention the right leg. Review of Resident #15's Treatment Administration Record (TAR) revealed an order, scheduled for 10:00 a.m. to start on 5/22/24 for Wound Care: Cleanse right outer lower leg skin tear with normal saline (NS), pat dry, apply Triple Antibiotic Ointment (TAO) every other day and as needed until healed in the morning, every other day for wound care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Change of Condition dated 5/20/24 at 9:45 a.m. revealed Resident #15's skin was assessed, resident treatment was changed to right lower leg skin tear, clean with normal saline (n/s) and apply Triple Antibiotic (AAA) ointment every other day (QOD) and PRN until resolved. Resident left lower leg have multiple old, scabbed areas. One scab is red on left inner calf area, treatment for skin prep daily to that area. Resident has no adverse effect. Resident missed treatments to lower legs, MD and Power of Attorney (POA) notified. Review of Skin Observation progress note dated 5/20/24 at 10:05 a.m., showed Resident #15 has skin tear on right lower leg and multiple scabbed areas on left lower leg, resident has one scabbed area with redness around it on left inner calf that area has new treatment for skin prep daily. The note showed the resident had an existing skin tear, scabbed areas resolved. Review of Resident #15's care plan revealed: - The resident had an Activities of Daily Living (ADL) self-care performance deficit related to (r/t) Fatigue, Impaired balance, (and) Limited mobility. The interventions showed Skin Inspection: The resident requires SKIN inspection. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the Nurse. - The resident has potential/actual impairment to skin integrity r/t fragile skin, incontinence, and decline in function and mobility. The interventions instructed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. 2. On 5/18/24 at 11:21 a.m. Resident #71 was observed sitting in wheelchair in between the bed of room. The observation revealed an undated 4x4 white bordered gauze dressing to the inner left elbow with drainage noted. During the observation, Staff C, Registered Nurse (RN) observed the dressing and confirmed it was undated. The staff member reported the family had allowed the resident to her drag arm across the bed yesterday and the dressing had been applied. Review of Resident #71's Admission Record showed the resident was admitted on [DATE] with diagnoses including but not limited to unspecified cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following cerebral infarction, unspecified macular degeneration, and need for assistance with personal care. Review of a progress note dated 5/18/24 at 11:36 a.m. revealed the nurse was called by family to Resident #71's room and informed the resident bumped arm on bed resulting in a skin tear. The area was cleansed with normal saline (NS), steri-strips were applied, and covered with a dry sterile dressing (DSD). The note revealed the Nurse Practitioner had been notified. The note did not reveal any further details regarding the wound such as size or approximation of skin. Review of the Change In Condition Evaluation, dated 5/17/24 at 2:00 p.m. and locked on 5/18/24 at 12:00 p. m., revealed the physician had been notified on 5/17/24 at 3:00 p.m. and the spouse of Resident #71 had been notified on 5/18/24 at 1:30 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Situation, Background, Appearance (and) Review (SBAR) revealed the situation was Resident #71 had suffered a skin tear and the resident condition or symptoms had stayed the same, no changes to the resident's mental and functional status had been observed, and the behavioral, respiratory, cardiovascular, abdominal/GI, GU/Urine, Pain, Neurological, and Skin evaluations were Not clinically applicable to the change in condition being reported. The Appearance portion of the report was left blank and did not include a summary of the nurse's observations or evaluation. The Review and Notify section revealed the physician had been notified at 3:00 p.m. on 5/17/24 and the spouse was notified at 1:30 p.m. on 5/18/24 (the day after the incident and 1.5 hours after the SBAR was locked). Review of Resident #71's May Medication Administration Record (MAR) did not show an order had been received for wound care related to the resident's skin tear to inner left elbow. Review of Resident #71's May Treatment Administration Record (TAR) did not reveal an order had been obtained for wound care to the resident's inner left elbows skin tear at the time of or prior to the observation made with Staff C, RN on 5/18/24. The TAR did show an order with a start date of 5/20/24 at 7:00 a.m. instructing staff to Apply DSD to left elbow daily. Monitor skin tear one time a day for skin tear. Review of Resident #71's Active Order Summary, dated 5/20/24, revealed and order to Apply DSD to left elbow daily. Monitor skin tear one time a day for skin tear had been received on 5/19/24 and was to start on 5/20/24 (three days after the incident). Review of Resident #71's care plan revealed the following: - ADL Care Plan: The resident has an ADL self-care performance deficit r/t decline in function and mobility related Cerebrovascular Accident (CVA). The interventions included SKIN INSPECTION: The resident requires SKIN inspection PRN. Observe for redness, open areas, scratches, cuts, bruises, and report changes to the Nurse. - Resident has pressure ulcer or potential for pressure ulcer development r/t decline in function and mobility. The interventions included Monitor/document/report PRN any changes in skin status: appearance, color, wound healing, signs/symptoms (s/sx) of infection, wound size (length x width x depth), (and/or) stage. Review of the policy titled, Wound Treatment Management, implemented 9/1/23, revealed: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence- based treatments in accordance with current standards of practice and physician orders. The compliance guidelines showed: 1. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. 3. Dressing changes may be provided outside the frequency parameters in certain situations: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. feces has seeped underneath the dressing. b. The dressing has dislodged. c. The dressing is soiled otherwise, or is wet. 7. Treatments will be documented on the Treatment Administration Record. 8. The effectiveness of treatments will be monitored through ongoing evaluation of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the care rustics of the wound (see above). c. Changes in the residence goals and preferences, such as at end-of-life or in accordance with his/her rights. Review of the policy titled, Change in Condition, dated 2024, revealed: To ensure the facility promptly notifies the resident, his or her provider, and legal representative of changes in the resident's medical/ mental condition and/ or status (e.g. Changes in level of care, billing/ payments, resident rights, etc.). The process revealed the nurse supervisor/ charge nurse will notify the resident's provider or on call provider when there has been: a. An accident or incident involving the resident. b. An injury of an unknown source 2. When a resident has a change in condition that requires notification of the provider, the nurse supervisor/ charge nurse will call the DON/designee for guidance prior to notifying the provider to ensure all necessary information will be provided to the provider in order for the provider to make an informed decision regarding care and treatment that minimizes the need for a transfer to a higher level of care. (In the event of an emergency where 911 is necessary do not delay care notify 911 for immediate transport). 6. The nurse supervisor/ charge nurse will record in the resident's electronic health record (EHR) information relative to changes in the resident's medical/ mental condition or status.

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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** 36273 Based on record review and interview the facility failed to ensure a pharmacy recommendation and physician order was implemented for one resident (#65) of two residents sampled for monthly drug regimen review. Findings included: Review of Resident #65's electronic medical record revealed the resident was admitted to the facility on [DATE] and had diagnoses that included, but not limited to, major depressive disorder, recurrent, moderate, other specified persistent mood disorders, adjustment disorder with mixed anxiety and depressed mood. A review of the resident's physician orders revealed a current order, dated 4/7/2024, for Seroquel oral tablet 200 MG [milligram] (Quetiapine Fumarate) Give 1 tablet by mouth two times a day for mood disorder. During a review of Resident #65's medical record, specifically the Consultant Pharmacist Medication Regimen Review, dated 4/25/20247, it revealed a recommendation suggesting adding an order to monitor for behaviors related to the use of Quetiapine (Seroquel). The Consultant Pharmacist Medication Regimen Review was signed by the Director of Nursing (DON), not dated, marked done, and agreed upon by checking AGREE: Please write order. No further action was taken. During an interview with the DON on 5/20/2024 at 9:07 p.m. she confirmed the Pharmacist Medication Regimen Review for Resident #65, dated 4/25/2024, was signed by the her (DON), not dated, and agreed with but no order was added as suggested. The DON stated, This one was missed but it will be added.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare Sebring	3011 Kenilworth Blvd Sebring, FL 33870

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38007 Based on observation, interview and record review, the facility failed to monitor side effects for one residents (#63) related to diuretic therapy and pain medication of seven sampled residents. Findings included: Review of Resident #63's Admission Record revealed an original admitted [DATE] and a readmitted [DATE]. The Admission Record showed diagnoses to neuromuscular dysfunction of bladder, pain in right hip, obstructive and reflux uropathy, acute kidney failure, and chronic kidney disease stage 3B and osseous and subluxation stenosis of intervertebral foramina of lumbar region. During an interview and observation on 5/18/24 at 11:37 a.m. Resident #63 was in bed with a family member visiting. Resident #63 stated she doesn't get out of bed and was recently readmitted from the hospital. She confirmed she had wounds and receives all her medications. Review of the Minimum Data Set, dated dated [DATE], revealed: Section C - Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 7, indicating severe impairment. Section N - Medications revealed Resident #63 received diuretic medication. Review of Resident #63's active physician orders as of 5/19/24 revealed: *Foley Catheter for DX (diagnosis) CKD (chronic kidney disease) Size 16f (ft)10 ml (milliliter), balloon, date 4/24/24. *Pain evaluation every shift for monitoring of patient's pain level, date 4/23/24. *Wound care: cleanse buttocks open area with wound cleaner or N/S then apply mycology cream mixed with hydrocortisone cream to peri-wound for pruritus and redness BID x 14 days every day and night shift for treatment, date 5/16/24; *Acetaminophen Oral Tablet 325 MG (milligrams) give 2 tablet by mouth every 6 hours as needed for pain 1-4, start 4/23/24; *Furosemide Oral Tablet 40 MG give 1 tablet by mouth one time a day for edema, date 5/10/24; *Oxycodone HCl Oral Tablet 5 MG give 1 tablet by mouth every 4 hours as needed for pain, start 4/27/24; *Tamsulosin HCl Oral Capsule 0.4 MG give 1 capsule by mouth at bedtime for overactive bladder, start 5/10/24. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2024 Medication Administration Record (MAR) and Treatment Administration Record revealed the medications and treatments were administered as ordered for Resident #63. The MAR revealed Oxycodone HCl Oral Tablet was administered 35 times from 5/1/24 - 5/19/24. The MAR revealed the pain level was monitored. Review of the MAR and TAR revealed they were silent of monitoring for side effects of the pain medication and diuretic therapy. A review of the current care plan for Resident #63 revealed: * Focus - Pain Care Plan potential for alteration in comfort, initiated 3/4/24. Interventions included: notify MD (medical doctor) for new onset of pain, notify MD if pain medication is ineffective. *Focus - The resident is at risk for pain r/t (related to) declined function and mobility, initiated 11/30/23. The interventions included: Identify and record previous pain history and management of that pain and impact on function. Identify previous response to analgesia including pain relief, side effects and impact on function, monitor/document for side effects of pain medication. Observe for constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness and falls, monitor/record/report to nurse any s/sx (signs/symptoms) of non-verbal pain: changes in breathing (noisy, deep/shallow, labored, fast/slow); vocalizations (grunting, moans, yelling out, silence); mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); eyes (wide open/narrow slits/shut, glazed, tearing, no focus); face (sad, crying , worried, scared, clenched teeth, grimacing), body (tense, rigid, rocking, curled up, thrashing). During an interview on 5/20/24 at 11:14 a.m. Staff E, Licensed Practical Nurse/Unit Manager confirmed there was no monitoring for side effects of the pain medication and diuretic therapy. She stated, No there isn't and there should be.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38007 Based on observation, interview and record review, the facility failed to ensure behavior monitoring for psychotropic medication was in place for five residents (#32, #56, #59, #63 and #65) and failed to appropriately monitor the side effects for psychotropic medication for one resident (#56) of seven sampled residents. Findings included: 1. Review of Resident #56's Admission Record revealed an original admitted [DATE] and a readmitted [DATE]. The Admission Record showed diagnoses to include other stimulant abuse, generalized anxiety disorder, persistent mood (affective) disorder, binge eating disorder, and chronic pain syndrome. Review of the Minimum Data Set, dated dated [DATE], revealed: Section C - Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Section E - Behaviors showed no behaviors were exhibited. Section N - Medications showed the resident was taking antianxiety antidepressant medications. Observation on 5/18/24 at 12:27 p.m. revealed Resident #56's room door was closed with a sign that showed Keep door closed. Resident did not answer to the knock on the door. Review of Resident #56's active physician orders as of 5/19/24 revealed: *Depakote Oral Tablet Delayed Release 250 MG (milligram) - give 1 tablet by mouth three times a day related to persistent mood [affective] disorder, start date of 3/11/24, * Xanax Oral Tablet 1 MG - give 1 tablet by mouth at bedtime for anxiety, start 12/14/23, *Nortriptyline HCl Oral Capsule 25 MG - give 50 mg by mouth two times a day for depression, start date of 5/10/24, *Monitor for antianxiety side effects every shift and report to MD if present: 0-None, 1-Drowsiness, 2-Slurred speech, 3-Dizziness, 4-Nausea, 5-Aggressive/impulse behavior, 6-Constipation, 7-Diarrhea, 8-Changes in appetite, hypertension, 9-other every shift for medication monitoring monitor for antianxiety medication side effects and place number corresponding with side effect. If other-document nurse's note., start 4/23/24. Review of the May 2024 Medication Administration Record (MAR) for Resident #56 showed medications were administered as ordered and there was no behavior monitoring for antidepressant medication until 5/19/24. In addition, the monitoring for the antidepressant side effects was documented as check marks for each administration and not a number which corresponded with the type of side effect. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #56's active physician orders as of 5/19/24 revealed an order with a start date of 5/18/24 as: behavior monitoring - antidepressants behavior code: 0. None 1. Withdrawn 2. Anorexia 3. Crying 4. Social isolation 5. Apathy 6. Feeling of helplessness/worthlessness 7. Suicidal ideations 8. Insomnia 9. PN non pharmacological interventions code: 0, none 1. Activities 2. 1:1 3. Redirection 4. Repositioning 5. Food/fluids 6. Rest period 7. Quite [quiet] environment 8. Medication 9. PN Intervention outcome: I=improvement S= same W=Worsen N/A = not applicable every shift for antidepressant use codes applied to behavior; non pharmacological intervention, outcome. An interview with Staff K, Certified Nursing Assistant (CNA) on 5/20/24 at 10:21 a.m. revealed she has not had any issues with caring for Resident #56 but has heard others have. She stated he can tell you his needs and he watches the clock and puts his light on when he needs his pain pill. A review of the current care plan for Resident #56 revealed: * Focus - Antidepressant Care Plan resident is at risk for adverse side effects related to use of antidepressant medications, initiated 1/15/24. Interventions included: administer medications as ordered by physician. Observe/document side effects and effectiveness Q-shift (every shift). Observe/document/report PRN (as needed) adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL (activities of daily living), continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo; fatigue, insomnia, appetite loss, wt (weight) loss, n/v (nausea and vomiting), dry mouth, dry eyes. *Focus - The resident has a mood problem r/t (related to) Admission, being in a nursing facility, his age and pain, initiated 7/13/23 and revised 10/12/23. Interventions included administer medications as ordered. Administer medications as ordered. Monitor/document for side effects and effectiveness; behavioral health consults as needed ; monitor/record mood to determine if problems seem to be related to external causes, i. e. medications, treatments, concern over diagnosis. *Focus - Behavior Care Plan potential for impaired or inappropriate behaviors related to refusing to wear nonskid socks nor shoes. Plays music with explicit language loudly in hallways. Inappropriate behavior towards other residents (asking for a kiss). Resident is non-compliant with his smoking contract, as he was vaping in dining room, initiated 1/12/23 and revised 8/28/23. Interventions included: if reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. *Focus - The resident is verbally aggressive (cursing at staff, cursing in front of the other resident, in a loud manner when he is frustrated, does not get his way, and/or wants his pain meds) r/t ineffective coping skills, initiated 3/2/23. Interventions included: analyze of key times, places, circumstances, triggers, and what de-escalate behavior and document. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/20/24 starting at 11:17 a.m. Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM) confirmed there was no behavior monitoring for the antidepressants and the physician order for behavior monitoring for the antidepressants was not entered until 5/18/24. Staff E, LPN/UM stated the doctor discharged the monitoring for behavior and she wasn't sure why. She confirmed this was on 4/23/24 and the doctor discharged the monitoring for antipsychotics on 5/6/24 and wasn't sure why. She confirmed behaviors were not monitored from 4/23/24 - 5/18/24. Staff E confirmed the side effect monitoring for the antianxiety medication on the MAR was documented as check marks and not the required numbers. Staff E stated the check mark just means the nurse signed off on it and not that he did or did not have side effects. An observation and attempted interview was conducted on 5/20/24 at 2:53 p.m. with Resident #56. Resident #56 was observed on his electric wheelchair dressed for the day, clean and no behaviors exhibited. When addressed with a greeting he did not respond and continued to drive away on his electric wheelchair. 2. Review of Resident #59's Admission Record revealed an original admitted [DATE] and a readmitted [DATE]. The Admission Record showed diagnoses to encephalopathy, and major depressive disorder. Review of the Minimum Data Set, dated dated [DATE], revealed: Section C - Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. Section N - Medications showed the resident was taking an antidepressant medication. An observation from the hallway on 5/18/24 at 1:45 p.m. revealed Resident #59 in bed with bare chest and briefs exposed. At 2:10 p.m. Resident #59 was still in bed. An interview was attempted and the resident stated he didn't speak English. An observation was conducted on 5/19/24 at 10:05 a.m. and the privacy curtain was drawn for Resident #59 who was in bed. His roommate stated that Resident #59 never gets out of bed. Review of the May 2024 Medication Administration Record (MAR) for Resident #59 showed a physician order for Trazodone HCl Oral Tablet - give 100 mg by mouth at bedtime for depression, start 3/10/24. In review of the MAR this medication was administered as ordered. In review of the MAR and Treatment Administration Record (TAR) there was no behavior monitoring for the antidepressant medication. A review of the current care plan for Resident #59 revealed: * Focus - Antidepressant Care Plan resident is at risk for adverse side effects related to use of antidepressant medications, initiated 1/19/24. Interventions included: administer medications as ordered by physician. Observe/document side effects and effectiveness Q-shift. Observe/document/report PRN adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo; fatigue, insomnia, appetite loss, wt, n/v, dry mouth, dry eyes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Focus - Mood Care Plan Potential for mood state issues related to depressive disorder. Interventions included: consultation with psychological/psychiatric per order; encourage and allow open expression of feelings; report to the physician/psychiatrist changes in mood status. An observation on 5/20/24 at 10:05 a.m. revealed Resident #59 was in bed sleeping. During an interview on 5/20/24 at 10:23 a.m. Staff K, Certified Nursing Assistant (CNA) stated Resident #59 speaks a little English and that he is always in bed until you get him up. He would stay in bed 24/7. He doesn't get out of bed unless we get him out so he will go to lunch and then want to go right back to bed. An interview was conducted on 5/20/24 at 11:08 a.m. with Staff E, LPN/UM who confirmed Resident #59 was alert an oriented and he can sit on the edge of the bed by himself without assistance. She stated they try to encourage him to get up. She stated they do monitor for behaviors for Trazodone. She reviewed the orders and MAR and TAR for Resident #59 and confirmed there was not an order and there had been no monitoring for behaviors for Resident #59. She said there is supposed to be and she confirmed that excessive sleeping could be a behavior. 3. Review of Resident #63's Admission Record revealed an original admitted [DATE] and a readmitted [DATE]. The Admission Record showed diagnoses to include anxiety disorder and depression. During an interview and observation on 5/18/24 at 11:37 a.m. Resident #63 was in bed with a family member visiting. Resident #63 stated she doesn't get out of bed and was recently readmitted from the hospital. She confirmed she had wounds and receives all her medications. Review of the Minimum Data Set, dated dated [DATE], revealed: Section C - Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of 7, indicating severe impairment. Review of Resident #63's active orders as of 5/19/24 revealed an order for Mirtazapine oral tablet 7.5 mg (milligrams)- give 1 tablet by mouth at bedtime for depression with weight loss, start date 5/1/24. The orders were silent of medication ordered for anxiety. The orders were silent of an order to monitor for behaviors. Review of the May 2024 MAR revealed the Mirtazapine was administered as ordered for Resident #63. A review of the current care plan for Resident #63 revealed: * Focus - Antidepressant Care Plan resident is at risk for adverse side effects related to use of antidepressant medications. Depression with weight loss, initiated 5/18/24. Interventions included: administer medications as ordered by physician. Observe/document side effects and effectiveness Q-shift. Observe/document/report PRN adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls, dizziness/vertigo; fatigue, insomnia, appetite loss, wt, n/v, dry mouth, dry eyes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/24 at 11:14 a.m. Staff E, LPN/UM confirmed there wasn't an order to monitor behaviors for the antidepressant. She stated, There isn't and there should be. 36273 4. Review of Resident #65's Admission Record revealed he was admitted on [DATE]. The record included diagnoses not limited to personal history of traumatic brain injury, major depressive disorder, recurrent, moderate, other specified persistent mood disorders, adjustment disorder with mixed anxiety and depressed mood. Review of Resident #65's care plan related to antidepressant, anti-psychotic and psychotropic medications revealed, Focus - Antidepressant Care Plan: Resident is at risk for adverse side effects related to the use of antidepressant medications. Interventions: Administer medications as ordered by the physician. Observe/document side effects and effectiveness Q-shift. Observe/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs (problems), movement problems, tremors, muscle cramps, falls; dizziness/fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes. Focus - The resident uses psychotropic medications r/t depression Interventions: Administer medications as ordered by the physician. Observe for side effects Q-SHIFT. Observe/document/report PRN any adverse reactions of PSYCHOTROPIC medications Unsteady gait, tardive dyskinesia, EPS (shuffle gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person. Observe/record occurrence of for target behavior symptoms and document per facility protocol. Focus - Anti-psychotic Care Plan -The resident is at risk of adverse side effects related to use of antipsychotic medications. Interventions: Administer medications as ordered. Approach resident calmly. Attempt gradual dose reduction as indicated. Report results to physician as needed. Follow up with psych as indicated. Observe behavior. Observe for signs and symptoms, increase or decrease in behavior or adverse effects from the anti-psychotic medication. Redirect as needed. Report any adverse effects to MD. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #65's MAR revealed the following medication orders, not limited to: Seroquel Oral Tablet 400 MG give 1 tablet by mouth at bedtime related to OTHER SPECIFIED PERSISTENT MOOD DISORDERS; Trazadone HCl Oral Tablet 100 MG give 2 tablet by mouth at bedtime related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE; Zyprexa oral tablet 10 MG by mouth one time a day for depression; Seroquel Oral Tablet 200 MG give 1 tablet by mouth two times a day for mood disorder; and Lorazepam Oral tablet 0.5 MG give 1 tablet by mouth every 4 hours as needed for anxiety for 14 days (start date, 5/18). Review of Resident #65's active physician orders as of 5/17/24 revealed an order with a start date of 5/17/24 as: behavior monitoring - antidepressants behavior code: Use behavior codes as noted on the order. Monitor every shift for possible side effects and notify MD if noted. Monitor for antidepressant medication side effects and place number corresponding with side effect. If other-document nurse's note. Review of Resident #65's active physician orders as of 5/17/24 revealed an order with a start date of 5/17/24 as: Behavior monitoring for-Anti-anxiety Behavior code: Use behavior codes as noted on the order. Review of Resident #65's active physician orders as of 5/17/24 revealed an order with a start date of 5/17/24 as: Behavior monitoring for-sedative/hypnotics Behavior code: Use behavior codes as noted on the order. Review of Resident #65's TAR for behavior monitoring for Anti-anxiety, Antidepressants and sedative/hypnotics revealed on 5/17, 5/18, 5/19 and 5/20 the box was checked and initialed but there was no place to document a behavior code for behavior monitoring as ordered. Review of Resident #65's TAR for monitoring of Antidepressant side effects: monitor every shift for possible side effects and notify MD if noted, revealed on 5/17, 5/18, 5/19 and 5/20 the box was checked and initialed, but there was no place to document a number corresponding with the side effect as ordered. During an interview on 5/20/2024 at 9:12 p.m. with Staff L, LPN, she stated she was not sure if they code for behaviors. She would look in document manager for behaviors, it would typically be in the progress notes or care plan. During an interview on 5/20/2024 at 9:16 p.m. with Staff M, LPN, he stated he would ask the previous nurse about behaviors, they would let him know to continue care. He was not sure on coding for behaviors. 37999 5. Review of Resident #32's Admission Record revealed the resident was admitted on [DATE]. The record included diagnoses not limited to metabolic encephalopathy and adjustment disorder with mixed anxiety and depressed mood. Review of Resident #32's care plan revealed: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At risk for adverse side effects related to use of antidepressant medications, depression. The interventions instructed nursing staff to: - Administer medications as order by physician and observe/document side effects and effectiveness every (Q) shift. - Observe/document/report as needed (PRN) adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; Decline in ADL ability, continents, no avoiding; Constipation, fecal impaction, diarrhea; Gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; Dizziness/ vertical; Fatigue, insomnia; Appetite loss, weight loss, nausea/vomiting (n/v), dry mouth, dry eyes. Mood Care Plan: Potential for mood state issues related to depression. The interventions instructed nursing staff to: - Observe for effectiveness/ side effects of medications as ordered - see physicians orders. - Report to the physician/ psychiatrist changes in mood status. Review of the new evaluation for psychiatry services, dated 4/11/24, revealed the resident was currently taking 15 milligram (mg) of Mirtazapine at bedtime for depression, No behaviors reported by staff, and as symptoms can exacerbate on periodic basis in the facility setting we will follow up with this patient intermittently. Review of Resident #32's Order Summary Report, active as of 6:53 p.m. on 5/20/24 included: - Mirtazapine 15 milligram (mg) - Give 1 tablet orally at bedtime for depression. - Behavior Monitoring - Antidepressants. Behavior code: 0. None, 1. Withdrawn, 2. Anorexia, 3. Crying, 4. Social isolation, 5. Apathy, 6. Feeling of helplessness/worthlessness, 7. Suicidal ideations, 8. Insomnia, 9. PN. NON-PHARMALOGICAL INTERVENTIONS CODE: 0. None, 1. Activities, 2. 1:1, 3. Redirection, 4. Repositioning, 5. Food/fluids, 6. Rest period, 7. Quiet environment, 8. Medication, 9. PN. Intervention Outcome: I=Improvement, S=Same, W=Worsen, N/A=Not applicable, every day and night shift for Antidepressant use. Use codes applied to Behavior, non-pharmalogical intervention, (and) outcome. Review of Resident #32's May Medication Administration Record (MAR) showed the resident had received 15 mg of Mirtazapine at bedtime nightly as ordered. The MAR showed staff were ordered to monitor behavior signs, non-pharmalogical interventions (NPI), and outcome on 4/6/24 to the discontinuation of the order on 5/18/24 at 12:02 p.m. The behavior monitoring was not completed during the day shift on 5/1, 5/13, and 5/18/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #32's May MAR showed the order for behavior monitoring was to be completed with the documentation in accordance with the above-mentioned physician order however the MAR did not have any spaces to document the behavior signs, NPI, or outcomes as ordered, the order was written at 7:00 p.m. on 5/18/24. The MAR revealed no behavioral monitoring was completed during the day shift on 5/18/24. Review of the policy titled, Use of Psychotropic Medication, implemented on 9/1/23, revealed Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). The policy explanation and compliance guidelines revealed the following: 1. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: and antipsychotics, antidepressants, anti-anxiety, and hypnotics. 3. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their families and/more representatives, other professionals, and the interdisciplinary team. 4. The indications for use of any psychotropic drug will be documented in the medical record. b. For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed by the physician. i. Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed. ii. Non-pharmacological interventions that have been attempted, and the target symptoms for monitoring shall be included in the documentation. 7. Residents who use psychotropic drugs shall receive non pharmaceutical interventions to facilitate reduction or discontinuation of the psychotropic drugs. 12. The effects of the psychotropic medications on a residence physical, mental, and psychosocial well-being will be evaluated on an ongoing basis, such as: a. Upon physician evaluation (routine and as needed), b. During the pharmacist's monthly medication regimen review. c. During Minimum Data Set (MDS) review (quarterly, annually, significant change), and d. In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturers specifications, and the residence comprehensive plan of care. (continued on next page)

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	105352	A. Building B. Wing	05/20/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	13. The residents response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the residence medical record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37999 Based on observations, record reviews, and interviews the facility failed to ensure the medication error rate was less than 5.00%. Twenty-five medication administration opportunities were observed and four errors were identified for two residents (#78 and #3) of ten residents observed. These errors constituted a 16% medication error rate. Findings included: 1. On 5/19/24 at 2:09 p.m. an observation of medication administration with Staff C, Registered Nurse (RN) was conducted with Resident #78. Staff C dispensed the following medications: - Divalproex Delayed Release (DR) 250 milligram (mg) tablet - Magnesium Oxide 400 mg over the counter (otc) tablet On 5/19/24 at 2:09 p.m. the observation revealed the above medication profiles were colored red, showing the medications were late. Staff C, RN confirmed dispensing two tablets. Review of Resident #78 May Medication Administration Record (MAR) revealed the following medications and scheduled times to be administered: - Divalproex Sodium oral tablet Delayed Release 250 mg - Give 1 tablet by mouth three times a day for mood disorder. Scheduled for 1:00 p.m. with additional times of 9:00 a.m. and 9:00 p.m. - Magnesium Oxide oral tablet 400 mg - Give 1 tablet by mouth three times a day for low magnesium. Scheduled for 1:00 p.m. with additional times of 9:00 a.m. and 5:00 p.m. Review of the Medication Administration Audit Report for Resident #78 showed the above medications were dispensed at 2:10 p.m. and 2:11 p.m. 2. On 5/20/24 at 8:47 a.m., an observation of medication administration with Staff D, Licensed Practical Nurse (LPN), was conducted with Resident #3. Staff D dispensed the following medications: - Multi Vitamin with mineral otc tablet - Famotidine 10 mg otc tablet - Ferrous sulfate 5 grams/325 mg otc tablet - Gabapentin 600 mg tablet - Losartan 50 mg tablet - Memantine 10 mg tablet (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Metformin 850 mg tablet - Metoprolol 25 mg tablet - Potassium chloride 20 milliequivalent (meq) Extended Release (ER) Staff D, LPN confirmed dispensing 9 tablets prior to the administration. Staff D administered the medications for Resident #3. Review of Resident #3's May Medication Administration Record (MAR) revealed the following medications were to be administered per physician orders: - Daily Multiple Vitamins oral tablet (Multi Vitamin) - Give 1 tablet by mouth one time a day for supplement. - Famotidine oral tablet 20 mg - Give 1 tablet by mouth two times a day for Acid reflux. The review revealed Staff D had dispensed and administered a Multi Vitamin with mineral despite the physician order did not include minerals and 10 mg of Famotidine was administered instead of the ordered 20 mg. Review of the policy titled, Medication Administration, reviewed/revised 9/1/23, revealed: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. The policy's compliance guidelines included the following: - 10. Review MAR to identify medication to be administered. - 11. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37999 Based on observations, record reviews, and interviews the facility failed to implement an effective infection control program related to adhering to transmission-based precautions for one resident (#69) out of one resident observed with Contact Precautions and providing eye drops to one resident (#58) out of one resident observed during the administration of eye drops. Findings included: 1. On 5/18/24 at 12:36 p.m. an observation revealed Resident #69's had a sign posted on their door that showed, Special Contact Precautions in addition to standard precautions. The sign advised for All family and visitors: Please report to nurses station or see staff BEFORE entering room. The posting instructed Before entering, everyone MUST: - Perform hand hygiene with alcohol-based hand rub (ABHR) or soap and water. - Wear gown before entering and remove upon exiting. - Wear gloves before entering and remove upon exiting. - Before exiting, everyone MUST wash hands with soap and water. On 5/18/24 at 12:36 p.m., an observation was made of Staff C, Registered Nurse (RN) who knocked on the door to Resident #69's room and entered without donning a gown or gloving. Staff C exited the room and explained yes she should probably have put a gown on but was just seeing what the resident wanted (call light had been on). Staff C stated the resident was on contact precautions because of [chronic immune system disease] then reported Resident #69 had C-Diff. Review of Resident #69's physician orders revealed the resident was currently receiving Vancomycin 250 milligrams (mg) four times a day for C-Diff, dated 5/7 to 5/21/24. Review of the Centers of Disease Control and Prevention (CDC) Facts for Clinicians, located at https://www.cdc.gov/c-diff/hcp/clinical-overview/index.html, revealed Clostridioides difficile (C.diff) was a common cause of antibiotic associated diarrhea (AAD). It accounts for 15 to 25% of all events of AAD. Prevent C. diff by appropriately using antibiotics and implementing infection control recommendations to prevent transmission. The CDC shows C. diff is a spore-forming, gram-positive anaerobic bacillus that produces 2 exotoxins: toxin A and toxin B. C. diff shades in faces. Any surface, device, or material that becomes contaminated with feces could serve as a reservoir for the C. diff spores. C. diff spores can transfer to patients by the hands of healthcare personnel who have touched a contaminated surface or item. The treatment and recovery of C. diff included instructions for clinicians to wear gloves any gown when treating patients with potential infectious diarrhea, including C. diff, even during short visits. Gloves are important because hand sanitizer doesn't kill C. diff. In addition, hand washing alone may not be sufficient to eliminate all C. diff spores. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/24 at 1:36 p.m. Staff F, Registered Nurse/Infection Preventionist (RN/IP) stated Contact Precautions were used for any infection that was communicable say C. diff. Staff F explained for Contact Precautions, before entering, staff should wash hands with soap and water, don a gown, gloves, (and) mask depending on if splash-back may occur. Staff F reported hand hygiene was to be done with soap and water as alcohol did not kill spores. Staff F reported walking into Resident #69's room without Personal Protective Equipment (PPE) and not washing hands was not appropriate. The Director of Nursing stated they received Special Contact precaution signs from a local state department. 2. On 5/19/24 at 1:52 p.m. Staff A, Licensed Practical Nurse (LPN) was observed during the administration of medications with Resident #58. Staff A dispensed one tablet and removed one bottle of eye drops from the medication cart, sanitizing hands then entered the resident's room. The staff member administered, with bare hands, one drop in right eye, missing, then dropped another in the right eye, then administered one drop into the left eye. An interview was conducted with Staff A on 5/19/24 at 2:05 p.m. and confirmed she should have worn gloves to administer the eye drops. During an interview on 5/19/24 at 1:52 p.m., Staff F, RN/IP stated Staff A, LPN should have gloved, administered eye drop in one eye, complete hand hygiene preferably ABHR then glove and place another drop in the other eye. Review of the policy titled, Administration of Eye Drops or Ointments, implemented 9/1/23, revealed Eye medications are administered as ordered by the physician and in accordance with professional standards of practice to lubricate the eye or treat certain eye conditions. The review of explanation and compliance guidelines instructed: 1. Verify orders and labeling prior to administration. 2. Gather supplies: medication, gloves, and tissues/ gauze/ cotton balls. Prepare a clean, dry surface for placing medication caps. 3. Wash hands or utilize alcohol-based hand rub and apply gloves. 4. Position resident with head tilted back. 5. Administration: a. remove medication cap in place on clean, dry surface (i.e. Tissue or paper towel) to prevent contamination. b. Steady hand holding the medication, as needed, on residence forehead. c. With other hand pull down lower lid to form a pouch of the conjunctival sac, avoiding placement of drops directly on the eyeball. d. For eye drops: squeeze the prescribed number of drops into the conjunctival sac, avoiding placement of the drops directly on the eyeball. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I. Replace the medication cap. Avoid touching the inside of the cap. Remove gloves and perform hand hygiene. 7. If administering medication to both eyes, use a different gloved finger to apply pressure to the inner tier duct. If the eye medication is an antibiotic or antiviral, change gloves in between. If an eye infected, treat that infected eye last.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observation, record review, and interview the facility failed to provide an environment that was clean, safe, and sanitary for residents on one units (B Wing) of two units and two shower rooms (A Wing and B Wing) of two shower rooms. Findings included: On 5/20/24 starting at 3:00 p.m., observations were made of the resident rooms and shower rooms on the A Wing and B Wing. The following was observed: - A wheelchair in hallway across from the activity room with a ball of an unknown pink substance stuck to the seat of the chair and armrests that were ripped revealing foam interior. The was observed on 5/18/24, 5/19/24 and 5/20/24. - An observation of room [ROOM NUMBER] Bed A revealed a bottle of a name brand lotion, name brand dandruff shampoo, and another bottle of a name brand lotion sitting on the bedside dresser. The observation also revealed a bottle of an unknown green liquid in a basin sitting on top of a dresser. - An observation was made of a jar of name brand lotion on the bedside dresser of room [ROOM NUMBER] Bed B. - A bottle of body and hair cleanser was observed sitting on a dresser across from the beds in room [ROOM NUMBER]. - A can of name brand lubricant/degreaser sitting on the over-bed table in room [ROOM NUMBER]. The shower room on the 200 hall (B Wing) was observed at 3:42 p.m. and revealed an ant crawling in the shower, toilet was running with water and dark stain on inside of toilet bowl, and bowel movement swirling in the bowl, black bio growth was observed on the floor of the shower, the plastic ceiling light cover was cracked, and the shower chair had black bio growth on the blue chair back and leg rest, on the joints of the plastic frame, and under the seat. The continued environmental tour revealed the following observations: - at 3:49 p.m. from the hallway, an aerosol can of a brand disinfectant spray on the bedside table of room [ROOM NUMBER] bed B; - at 3:49 p.m. an aerosol can of a name brand deodorant/anti-perspirant was observed on the over-bed table of room [ROOM NUMBER] Bed B; - the wall next to the air conditioning unit of room [ROOM NUMBER] was bubbled and cracked; (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- room [ROOM NUMBER] had a bottle of a name brand diabetic lotion, a bottle of a name brand dry moisture lotion, a large bottle of non-alcohol mouthwash on the room's vanity, and a bottle of body mist without a diffuser on the window sill. In addition, at 4:01 p.m. the observation of the 100-hall shower room (A Wing) revealed a washcloth hanging from the handrail in the first shower stall, one washcloth hanging from the frame of the white plastic shower chair, a bottle of body wash, and a bottle of shampoo sitting on the hand rail of the shower. 36273 On 5/20/2024 at 3:38 p.m. an observation of room [ROOM NUMBER] B revealed a can of activICE (over the counter topical pain reliever) sitting on the table next to the bathroom door. The cap was missing. The resident in the room stated it was hers but she can't use it anymore because the spray top is missing due to falling on the floor. 38007 During an interview on 5/20/24 at 7:05 p.m. the Nursing Home Administrator (NHA) stated they do room rounds daily. The expectation is if staff see something they would report it. If it is something simple they would resolve it. During an interview on 5/20/24 at 7:16 p.m. the Housekeeping and Laundry Director stated they generally clean, mop and sweep each room everyday, once a day for each room. If there is a spill or something needs to be cleaned again they go back into rooms as needed. She confirmed there are a total of 11 staff members for housekeeping and laundry. She confirmed she hasn't been notified of items in resident rooms of concern or anything related to shower equipment or shower rooms. She stated CNAs (certified nursing assistants) are supposed to keep personal items bagged up in a plastic bag. Review of the policy titled, Safe and Homelike Environment, implemented 9/1/23, revealed the policy as: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Policy Explanation and Compliance guidelines: 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.