

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER Lourdes-Noreen McKeen Residence for Geriatric Care		STREET ADDRESS, CITY, STATE, ZIP CODE 315 S Flagler Dr West Palm Beach, FL 33401	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, interview, and record review, the facility failed to implement infection control processes to prevent the spread of infection during 1 of 3 meals observed in the 2S dining room (lunch meal on 09/04/25) as evidenced by the staff failure to perform hand hygiene between resident contact; failure to implement and or follow Enhanced Barrier Precautions (EBP) for 4 of 8 sampled residents, Resident #41 who had an open wound, Resident #133 who had an indwelling urinary catheter, Resident #48 who had an indwelling urinary catheter, and Resident #97 who had a wound; and failure to disinfect the glucometer for 1 of 2 observations, after use for Resident #2. The findings included: Review of the policy titled Hand Hygiene (Copyright 2025) documented, in part, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy Explanation and compliance Guidelines: . 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 5. Hand hygiene technique when using soap and water: . c. rub hands together vigorously for at least 20 seconds . f. Use clean towel to turn off the faucet. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the attached Hand Hygiene Table documented hand hygiene should be performed, in part, between resident contacts, after handling contaminated objects, before applying and after removing personal protective equipment (PPE), including gloves, and before and after handling clean or soiled dressings. Review of the policy titled Infection Control & Enhanced Barrier Precautions Policy dated 04/18/224, documented in part, Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 1. Education: . b. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. 2. Initiation of Enhanced Barrier Precautions: . c. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. 4. High-contact resident care activities include: a. Dressing, b. Bathing, c. Transferring, d. Providing hygiene, e. Changing linens, F. Changing briefs or assisting with toileting, g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, h. Wound care: any skin opening requiring a dressing . (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 105420	Facility ID: 105420 If continuation sheet Page 1 of 25

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1) An observation during the lunch meal on 09/04/25 beginning at 12:30 PM was made in the 2S dining room. There was one small sink noted but no hand sanitizer in this dining room. Hand sanitizer was noted just outside of the dining room door and inside of a pantry located near the serving area. Staff H, Certified Nursing Assistant (CNA) was observed continuously from 12:30 PM to 12:50 PM. The CNA wheeled Resident #8 into the dining room from the common area. The CNA did not do any type of hand hygiene and proceeded to pass out silverware rolled in a cloth napkin and poured drinks for the five residents currently in the dining room. During the continued observation, four additional residents arrived to the dining room. Staff H continued to pass out silverware, drinks, and soup. The CNA placed her hands on a resident's shoulder in a gentle gesture and continued to assist other residents. The CNA obtained ice from a common ice bucket as per request. Staff H assisted Resident #115 to a table by pushing his wheelchair, then passed by Resident #4, gently rubbing his shoulder and head. An interview with Staff A, Registered Nurse (RN) during this observation revealed staff should be doing hand hygiene between tables. When asked where the hand sanitizer was located, the RN stated she would have to talk to the aides and get them some sanitizer. During this lunch observation, Staff C, CNA, washed her hands at the sink, after being spoken to by Staff A, RN. She went to the hand washing sink, washed her hands very quickly, in about 5 or 10 seconds, and then turned the faucet off with her bare hands, instead of using a paper towel. During an interview on 09/05/25 at 2:16 PM, when informed of the above observations in the dining room, the Infection Control Preventionist (ICP) stated, I need to do some more education. 2) Review of the record revealed Resident #41 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the Wound Evaluation by the wound care physician dated 08/11/25 documented Resident #41 had a new/reopened stage 3 pressure ulcer to her left lateral ankle, that was full thickness indicating it was open with skin loss that may extend down to and through underlying fascia all the way down to the bone. Review of the current orders revealed a treatment of Mupirocin ointment and a dressing as of 08/18/25. This was the second treatment order for this wound; the other having been initiated on 08/11/25. The record lacked any order for Enhanced Barrier Precautions. Review of current care plans documented Resident #41 had a stage 3 pressure ulcer. The current care plans lacked any documentation for enhanced barrier precautions. An observations on 09/03/25 at 9:54 AM lacked any indication or sign for EBP and lacked any PPE readily accessible for staff use for Resident #41. A wound care observation for Resident #41 was made on 09/04/25 beginning at approximately 11:15 AM with Staff A, Registered Nurse (RN). The RN gathered supplies to include gauze, normal saline, and a tube of Mupirocin ointment in a plastic bag with a label, from the treatment cart located off the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 09/02/25 at 1:33 PM revealed Resident #133 in his room lying in bed. The tubing for a urinary drainage devise was noted draining urine into a bag hanging from the bed frame. There was no sign to indicate the need for EBP nor was there any personal protective equipment (PPE) at the door or in the room. Photographic Evidence Obtained. An additional observation on 09/03/25 at 10:49 AM lacked any sign to indicate the need for EBP at the room of Resident #133, nor was there any PPE near the door or anywhere in that hallway. Photographic Evidence Obtained. During the continued interview on 09/05/25 beginning at 2:16 PM the ICP was told of the lack of EBP and PPE for Resident #133 and simply stated she would go place the sign and PPE at the door. 4) Record review revealed Resident #97 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE], documented a Brief Interview Mental Status score of 11 on a 0-15 scale, indicating moderate cognitive impairment. Review of medical diagnosis revealed Resident #97 had a history of local infection of the skin and subcutaneous tissue, Methicillin resistant Staphylococcus Aureus infection (contagious infection/MRSA) Review of a physician order dated 07/02/25 instructed staff to use Enhanced Barrier Precautions (EBP), which included gown and gloves for extended care or direct contact with skin, bedding, and clothing of Resident #97 due to a wound on his back. An observation was conducted on 09/03/25 at 10:10 AM, there was no EBP sign noted on Resident #97's door or no supplies noted near his room. Review of a lab culture result dated 05/20/25 revealed that Resident #97 was positive for MRSA to the back wound. During an interview on 09/04/25 at 12:50 PM, when asked do the nurses wear a gown when changing the dressing to Resident #97's wound, the resident's family member stated, No, they use to when he was downstairs, but not anymore. An observation of wound care was conducted on 09/05/2025 at 10:05 AM Staff O, Licensed Practical Nurse (LPN) was observed performing wound care to Resident #97 upper back wound. Staff O, LPN placed the wound supplies on a styrofoam tray and set up biohazard back. She washed her hands, applied gloves and removed the old dressing to the resident's wound. She removed her gloves, washed her hands and applied another pair of gloves. Staff O, LPN cleansed the wound with normal saline and pat dry and with the same dirty gloves she opened the pack of sterile q tips and packed the wound with a piece of iodoform strip that she had already precut, then she applied a new dressing. Staff O, LPN did not change her gloves after cleaning the resident's wound and she did not wear a gown while performing Resident #97's wound care as ordered. 5) Facility Policy titled Glucometer Disinfection documented in part. Policy explanation and compliance guidelines 3. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus. 4. glucometers will be cleaned and disinfected after each use and according to manufacture's instructions regardless of whether they are intended for single resident of multiple resident use. Procedure f. obtain capillary blood glucose sampling according to facility policy. G. remove and discard gloves, perform hand hygiene prior to exiting the room. H. reapply gloves i. retrieve (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Photographic Evidence Obtained. During an observation conducted on 09/03/25 at 8:57 AM, there was no EBP signage on the door. During an observation conducted on 09/03/25 at 5:03 PM, there was no EBP signage on the door. The resident was in the common area, seated in a wheelchair with the foley catheter bag covered and below waist level, urine appeared clear and yellow. Resident smiled but was non-verbal. During an interview conducted on 09/04/25 at 9:34 AM with the Infection Preventionist (IP), when asked who is responsible for placing the EBP signs on the door, the IP stated that the nurse assigned to the resident can place the sign and the supply cart is near the resident's room.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, interview, and record review, the facility failed to ensure of rendering dignified care and services for 2 of 29 sampled residents as evidenced by the voiced dislike of using a shampoo instead of an appropriate cleanser during a bath for Resident #31, and failure to treat and speak to Resident #31 and #41 in a dignified manner. The findings included: 1) Review of the policy Bed Baths (Copyright 2024) documented in part, 6. Wash the resident's eyes with water only, . 7. Wash the resident's face using soap or a facial cleaner . Review of the record revealed Resident #31 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #31 had a Brief Interview for Mental Status (BIMS) score of 11, on a 0 to 15 scale, indicating moderate cognitive impairment. This MDS also documented the resident needed substantial to maximum assistance from staff for toileting and bathing. During an interview on 09/02/25 at 11:32 AM, when asked if staff were attentive to his needs, Resident #31 stated on the evening shift he could wait two hours to get help to the bathroom. Resident #31 stated the weekends were worse and that staff were not attentive. When asked if staff treat him with respect and dignity, Resident #31 stated, several staff have told me to just go in my diaper. When asked how that made him feel, Resident #31 stated, It's an insult to my dignity. During a supplemental interview on 09/04/25 at 9:35 AM, Resident #31 stated, I forgot to tell you two things the other day. The aides are on their phones all the time and they speak [another language]. When asked if they are on their phones when they are caring for him, the resident stated yes. When asked if they speak [another language] in front of him, he stated yes. When asked how that made him feel, Resident #31 stated, I never know if they are talking about me or not. I don't like it. Observations revealed Resident #31 was provided morning care to include a sponge bath in his bathroom on 09/04/25 at 9:49 AM, by his private aide. The private aide put Head and Shoulders shampoo on a washcloth and gave it to the resident to wash his face. The private aide took another washcloth, put the same shampoo on it, and washed his back and groin. The private aide proceeded to rinse both clothes and rinse off the resident. The private aide also washed the resident's bottom with the shampoo. During an interview on 09/04/25 at 10:16 AM, when asked if he wanted the aides to use the shampoo for his sponge bath, Resident #31 stated, It's better than nothing. When asked why he used shampoo instead of soap to provide the sponge bath to Resident #31, the private aide stated, That is what was here. An observation of the sink area in the resident's bathroom revealed a bar of soap next to the bottle of shampoo. There was also a small plastic bin with three drawers under the sink. Resident #31 volunteered, My regular guy will be back tomorrow and knows where everything is. He knows what to use. When asked if there were additional soap and supplies in the bin, the resident stated yes. When told the directions on the shampoo say to avoid contact with eyes, the private aide stated, Oh, I'm sorry. An interview and observation was conducted on 09/04/25 at 10:24 AM with Staff G, Licensed Practical Nurse (LPN) assigned to Resident #31 that day. When informed the private aide used Head & Shoulders shampoo for a sponge bath, the LPN went into the room of Resident #31. The LPN saw the shampoo next to the bar of soap and confirmed there were appropriate cleansers in the plastic bin. When asked if she was still responsible for the care of the resident, even when that care was provided by a private aide, the LPN stated, Of course. During an interview on 09/05/25 at 1:59 PM, when told of the slow call bell response, bathing with shampoo, and verbal comments toward Resident #31, the Director of Nursing (DON) stated they do constant in-services on customer service and call bell education continuously. The DON agreed it should not take two hours to respond to a call bell and the resident should not be told to go in his diaper. 2) Review of the record revealed Resident #41 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the resident had a BIMS score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. During an interview on (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/03/25 at 11:57 AM, upon introduction and before asking any questions, Resident #41 stated, About 3/4 of the CNAs (Certified Nursing Assistants) are rude, not compassionate, and irritating. Just plain rude. I tell them if you don't like your job, you should not do it. Resident #41 further explained that she had reported her concerns during a care plan meeting when she first arrived at the facility. When asked if it got any better after her complaint, the resident stated, No improvement. Resident #41 further stated, I'm so tired of them saying I'll be back in 5 minutes or I'll be right back and it's 45 minutes before they return. Review of a grievance dated 07/07/25 documented Resident #41 complained about customer service, stating that staff were rude and call lights were not answered timely. The resolution was that staff were educated, and that it was also the resident's perception of staff. During the continued interview on 09/05/25 beginning at 1:59 PM, the DON explained that there were certain CNAs that Resident #41 liked, and if the other CNAs didn't have that bubbly personality, the resident may perceive it as rude. The DON agreed staff should not be saying they will be right back and not return for 45 minutes.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents rights for 2 of 8 sampled residents as evidenced by the failure to ensure showers and hair washing for Resident # 12, and failure to use room shower for Resident #97. The findings included: 1) Review of the record revealed that Resident #12 was admitted to the facility on [DATE] with diagnoses documented in part, Unspecified Dementia, Hemiplegia and Repeated Falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #12 had a Brief Interview for Mental Status (BIMS) score of 7 on a 0-15 scale, indicating the resident had severe cognitive impairment. Review of the Care Plan dated 01/25/23 revised on 01/22/25 revealed that Resident #12 required extensive assistance with bathing and showering, and Resident #12's daughter requested to have her mother's hair washed on shower days. An interview was conducted on 09/02/25 at 3:36 PM with Resident #12's daughter who stated that she is not sure of her mother's shower schedule and that her mom's hair looked greasy and had dandruff flakes, her daughter went on to state that staff told her that her mother refuses to have her hair washed in the shower which did not make sense to her since her mom has had her hair washed in the salon a few times and did not refuse it then. When Resident #12's daughter was asked if she had made this request to staff, she stated she told staff many times and even had discussed it during a care plan meeting. Observations of Resident #12 were conducted on 09/02/25 at 10:40 AM and 11:38 am with Resident #12 in bed sleeping. At 3:18 PM on 09/02/25, Resident #12 was awake and alert sitting in her wheelchair at the nurse's station and her hair appeared flat and greasy. During an observation on 09/03/25 at 1:03 PM, Resident #12 was eating lunch in the dining room and her hair appeared limp and greasy. During an interview on 09/04/25 at 10:37 AM, Staff F, Certified Nursing Assistant (CNA) stated that she has worked at the facility for 30 years and was asked if she knew Resident #12, and she replied, Yes. Staff F stated that Resident #12 is on the 11 PM- 7 AM shower schedule on Monday, Wednesday and Friday. When Staff F was asked what time of day Resident #12 likes to get out of bed, Staff F stated around 11:30 AM and that Resident #12 eats breakfast in her room and we keep checking on her in the morning to see if she will agree to get out of bed. Staff F was asked what time of day the 11PM-7AM nursing staff would typically give a resident a shower, and Staff F replied that they may ask the resident around 5:00-6:00 AM if the resident is awake and if the resident refused, they would not give the resident a shower. An interview was conducted with Staff E, Registered Nurse (RN) on 09/04/25 at 11:00 AM. Staff E was asked what happens if the scheduled shower day/time does not work for a resident, Staff E stated that they would have to change another resident's shower day/time. When Staff E was asked, what if the resident is scheduled during the 11PM-7AM shift and is not an early riser and refuses the shower on daily basis, Staff E stated that the resident would get a full bed bath that includes hair washing. Review of the Showering/Bathing Task record revealed that Resident #12 did not take a shower during the past 30 days (08/08/25-09/04/25) and Bed Bath was checked off. There was not a category on the task sheet to determine if Resident #12's hair was washed. (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 09/05/25 at 9:42AM, Resident #12 was in bed, and her hair appeared to be limp and oily. When Resident #12 was asked if she had her hair washed recently, she stated that she was not sure. When she was asked if she likes to have her hair washed, she replied, Yes. When asked if she likes to have her hair washed in the shower she replied, Wherever. An interview was conducted on 09/05/25 at 9:42 AM with Staff E who stated that she knew that Resident #12's daughter wanted her mom's hair to be washed on shower days. Staff F stated she had brought this matter up to her supervisors. Staff E went into Resident #12's room and agreed that Resident #12's hair did not look clean and needed to be washed. Staff E stated that she had washed Resident #12's hair in the past just to make sure it was done. When asked if it could be that the shower schedule of 11PM-7 AM may not work for Resident #12 she stated that if they changed Resident #12's shower schedule they would have to switch another resident's shower time. When Staff E was asked if a resident has a care plan for washing hair would it be a task to monitor, Staff E stated we do not track it because we assume the resident's hair is washed on their scheduled shower day. 2) Record review revealed that Resident #97 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE], documented a Brief Interview Mental Status score of 11 on a 0-15 scale, indicating moderate cognitive impairment. During an interview on 09/02/2025 at 12:05 PM, Resident #97's sister stated, I want to know why my brother can't use his own shower that's in his room. I've asked the main nurse twice and the DON. He got MRSA (methicillin resistant staph aureus) since he has been in this facility. Review of a wound culture lab result dated 05/22/25, revealed that Resident #97 was diagnosed with MRSA to the wound on his back. Review of a progress note dated 08/04/2025 revealed that Resident #97 was transferred to his current room. During an interview on 09/04/2025 at 10:20 AM, Resident #97's sister asked, Have you found out anything about him using the shower in his room? Come and see the shower. The shower was wheelchair accessible and equipped with grab bars all around and outside the shower with a handheld shower head. She stated, I really don't understand why he can't use the shower. He got MRSA here already. From having to use the same shower as that everyone else uses. During an interview on 09/05/2025 at 10:00 AM in Resident #97 bathroom, when asked is Resident #97 allowed to use the shower in his room. Staff O, Licensed Practical Nurse (LPN) stated, Yes, he can shower in here. When she was asked why there isn't a shower seat here, Staff O, LPN had no response. During an interview on 09/05/2025 at 10:31AM, When asked have you seen Resident #97 get a shower in his room. Staff O, LPN stated, Yes. During an interview on 09/05/2025 at 11:31 AM, When asked when you clean the bathroom in Resident #97 room, have you seen a shower chair, Staff N, Housekeeper stated, No shower chair. During an interview on 09/05/25 at 12:25 PM, when asked please confirm who told you Resident #97 wasn't allowed to use the shower in his room, the resident's sister stated the DON and Staff O, LPN. (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said that the DON said he is not allowed and Staff O, LPN said absolutely not. The resident's sister said when we first got in this room there was a shower seat and curtain in the bathroom then it disappeared. When Resident #97 was asked if staff had ever given him a shower in his room, he stated NO. During an interview on 09/05/25 at 2:35 pm, when asked if there was a reason why Resident #97 couldn't use the shower in his bathroom, the DON stated, What do you mean? She was made aware that the resident's sister said she told her he wasn't allowed to use the shower in his room. The DON stated, I don't recall speaking to her about the shower. She was made aware that the resident's sister said that Staff O, LPN, told her, absolutely not, when she asked her about the resident using the shower in his room. The DON stated, Maybe because it's not big enough and not safe. She was shown a picture of Resident #97's shower, and she replied, Wow it has safety bars, I don't see why not. I will just have to get maintenance to temp the water.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the desired code status was in place for 1 out of 29 sampled residents reviewed for Advanced Directives (Resident # 1). The findings included: Review of the facility's policy titled, Advance Directives dated [DATE] included, in part, the following: Policy Interpretation and Implementation . 4. Do not resuscitate orders (DNRO) will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR order. 5. The Interdisciplinary Care Planning Team will review advance directives with the resident during quarterly care planning sessions to determine if the resident wishes to make changes in such directives. Record review revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE]. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, on a scale of 0 to 15, which indicated the resident was moderately cognitively impaired. Review of the scanned documents in the electronic medical record (EMR) revealed a yellow copy signed DNR order dated [DATE]. Review of the current Physician's Orders revealed documentation that Resident #1 had an active order dated [DATE] for Full Code status. Review of the active care plans documented Resident #1 had an Advanced Directive. Goals were for Resident #1 and/or her representative to choose to be Do Not Resuscitate (DNR) code status. Interventions were to discuss and review Advance Directives/DNR status with the resident and/or her representative. Inform the resident and/or her representative that Advance Directives can be changed/revoked at any time. No CPR to be performed in the event resident is found with no pulse or respirations. Physician order for DNR in place. Staff to be made aware of residents' wishes. Review of the quarterly care plan meeting note dated [DATE] revealed the interdisciplinary team spoke with the resident's representatives via telephone and discussed in part the resident's advanced directives. This note documented, Advance Directives reviewed and remained in place with no changes. DNR and POA (power of attorney) on file. An interview conducted on [DATE] at 10:35 AM, with the Social Services Director (SSD), revealed that a telephone order for full code was entered into the electronic medical record on [DATE] by the admitting nurse, as per the hospital preliminary history and physical report. The SSD stated as of the care plan meeting on [DATE] the code status should have been changed from full code back to DNR. The SSD stated that it was her responsibility. When asked about the facility process for rescinding a DNR status, the SSD explained the words RESCIND would be written in large letters across the top of the DNR form.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide dining services to 1 of 3 sampled residents in the 4N and 2S dining rooms, as evidence by failure to provide supervision for Resident #50 and additional residents observed during mealtime. The findings included: 1) Record review revealed that Resident #50 was readmitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 08 on a 0-15, scale indicating moderate cognitive impairment. Review of the medical diagnosis documented a history of dysphagia (difficulty swallowing), malnutrition. An observation was conducted on 09/03/25 at 9:02 AM in the 4North dining room, Resident #50 and six other residents were observed in the dining room alone. Resident #50 was sitting at the table alone with a sippy cup with a red colored drink, of thickened consistency, with a straw inside of it. The resident was coughing profusely nonstop. Staff O, Licensed Practical Nurse (LPN) continued to stand at her medication cart that was parked across from the dining room and did not go into the dining room to check on the resident. When asked are you familiar with Resident #50 she stated, Yes. When asked if she normally coughs that way she stated, Yes. When asked if she should be using a straw with her thickened liquids, Staff O, LPN stated, I will have to check. Staff O, LPN proceeded with preparing medication and did not go to the dining room to assess Resident #50 (Photographic evidence obtained). An observation was conducted on 09/03/2025 9:21 AM, A Certified Nursing Assistant was observed entering the 4N dining room to assist Resident #50, who continued to cough. Review of the care plan dated 06/30/25 revealed that Resident #50 needs total assistance with activities of daily living due to fatigue, functional deficit and cognition. Another care plan focus revealed that Resident #50 was at risk for inadequate intake of nutrition and/or hydration related to poor appetite, unspecified protein calorie malnutrition and she will maintain or improve her hydration status by staff monitoring food and fluid intake and observing signs of dysphagia: such as pocketing food, choking, coughing. Review of a nutritional progress note dated 08/05/25 documented Resident #50 had meals in the dining room and required total assistance with meals. Review of the speech evaluation dated 05/12/25, revealed that speech therapy recommended for Resident #50 to have close supervision with oral intake and to facilitate safety, no use of straws was recommended because the resident was at risk for aspiration. 2) An observation of the lunch service in the 2S dining room was made on 09/02/25 beginning at 12:31 PM. There were four residents in the dining room at that time. One Certified Nursing Assistant (CNA) was offering the residents something to drink as they entered. Two other CNAs were bringing residents into the dining room. As of 09/02/25 at 12:45 PM there were twelve residents in the 2S dining room. Staff D, dietary aide, was plating the food while Staff H, Staff I, and Staff J, all CNAs, were delivering the food to the residents and setting them up for lunch. Continued observation was made in the dining room until 1:15 PM with no nurse observed. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of the lunch meals in the 2S dining room on 09/03/25 and 09/04/25 revealed Staff A, Registered Nurse (RN) sitting at the back table observing the residents and working on her laptop. During an interview on 09/04/25 at 12:52 PM, when asked why she was not in the dining room on 09/02/25, Staff A stated, We rotate (referring to the second nurse assigned to the unit). I'm not sure about the other nurse but I had two discharges on Tuesday (09/02/25). When asked if there was a schedule or how they knew who was to be in the dining room on which days, the RN stated, We just cover for each other and take turns. When told there were only three aides in the 2S dining room on Tuesday 09/02/25, Staff A stated, Oh and had no explanation.		

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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. Based on facility policy, observations, record reviews and interviews, the facility failed to provide wound care and services for 1 of 2 sampled residents as evidenced by failure to ensure Resident #85 had treatment ordered for a wound to his forehead. The findings included: Review of the facility policy titled Wound and Skin Care-Wound Assessment and Documentation, dated reviewed 06/13/24, documented in part Policy Explanation and Compliance Guidelines: 1. The purpose of wound assessment is the foundation of the care plan, assists in determining the cause (etiology) of the wound, essential tracking of the progress or deterioration of the wound, determining the effectiveness of the treatment plan, obtaining reimbursement, preventing litigation and for compliance. Record review revealed that Resident #85 was admitted to the facility of 07/17/24. Review of the annual comprehensive assessment documented a Brief Interview Mental Status (BIMS) score of 15 on 0-15 scale, indicating no cognitive impairment. During an observation conducted on 09/02/25 at 11:19 AM, Resident #85 was noted with a white square bandage on his forehead. The area appeared to be draining underneath the bandage. The bandage did not have a date or initials written on it. When asked what happened to your forehead, the resident stated Oh, I banged my head some time ago. When asked did you fall, he stated I'm not sure I think it happened in the shower. When asked were you in the shower alone, the resident stated Oh no. When asked is the bandage being changed, he stated, Yes, whenever I take a shower. When asked what days you are showered, the resident stated, I get a shower on Tuesday, Thursday, and Saturday. Review of the incident log did not reveal any documentation of Resident #85 obtaining a wound during an incident. An observation was conducted on 09/03/25 at 5:50 PM, Resident #85 was observed walking in the dining area with a white square bandage on his forehead. The bandage did not have a date or initials written on it. When asked what happened to your forehead, the resident stated, Oh that happened some time ago. When asked are the nurses changing the dressing, the resident stated Yes, they are taking care of it. Review of the weekly skin assessments dated 08/21/25 and 08/28/25, documented Resident #85 had no observed skin issues. An observation was conducted on 09/05/2025 at 9:25 AM, Resident #85 was noted with a white square bandage to his forehead. There were no date or initials written on the bandage. When asked how is your forehead, the resident stated They changed the dressing. It's up to date. During an interview on 09/05/2025 at 9:28 AM, when asked why Resident #85 had a bandage on his forehead, Staff O, Licensed Practical Nurse (LPN) stated, He doesn't need the bandage, the nurses just keep putting it on there he had a biopsy done a while ago. Staff O, LPN was made aware that Resident #85 doesn't have a treatment order to have a bandage. Staff O, LPN stated, I know and proceeded to walk down the hall. During an interview on 09/05/25 at 12:40 PM, the ADON was made aware that Resident #85 had been observed for four days with a bandage to his forehead, but no documentation was found in the record. She stated, Let me look in his record. The ADON looked in Resident #85's record and didn't find any documentation. The ADON was asked if she could assess the area to the resident's forehead, she said that she would get Staff N, Registered Nurse, Supervisor to assess the resident. The ADON called Staff N, Supervisor and told her to meet on 4N at Resident #85 room. During an interview on 09/05/25 at 1:55 PM on 4N unit, Staff N, Supervisor stated, I don't know anything about Resident #85 having a bandage. I make regular rounds on the residents. Staff N, Supervisor, was made aware that the resident had been observed with a bandage to his forehead since Tuesday and he said he bumped his head in the shower. She stated, If something would have happened with him, there would be an incident report. Staff N, Supervisor, was made aware that Resident #85 said that the bandage is being changed after he gets a shower but there were no treatment orders. An observation was conducted on 09/05/2025 at 3:20 with Staff N, Supervisor. who said that Resident #85 told her a different story about what happened. She stated, The resident said he bumped into the wall, probably due to his vision and no one else was present. When asked who was applying the bandage, she had no response. Staff N, Supervisor was observed removing the dressing from Resident #85 forehead. The (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound to the forehead was open and the skin exposed to the area was wet and white noted to the wound bed. There was a small amount of tan and red drainage on the bandage. Staff N, Supervisor, left the resident's room and returned with a treatment cart to provide care to the wound on Resident #85's forehead. (Photographic evidence obtained.)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, interview, and record review, the facility failed to ensure the provision of nutritional supplements as per physician order for 1 of 3 sampled residents, Resident #133. The findings included: Review of the policy Nutritional and dietary Supplements (Copyright 2025) documented in part, Nutritional Supplements refer to products that are used to complement a resident's dietary needs such as calorie or nutrient dense drinks, . 2. The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs. Review of the record revealed Resident #133 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 6, on a 0 to 15 scale, indicating severe cognitive impairment for Resident #133. Review of the current physician orders documented Resident #133 was to receive a Magic Cup and a Mighty Shake as of 08/29/25, both nutritional supplements, every meal for nutritional support. This order was written in response to the Registered Dietician's assessed needs and recommendations. An observation on 09/02/25 at 1:33 PM revealed Resident #133 in his room with his spouse. His lunch tray had been delivered, and the resident had eaten the food on his plate, having been fed by his wife. The tray lacked both the Magic Cup and the Mighty Shake, as per physician order and the meal ticket. Photographic Evidence Obtained. An observation on 09/04/25 at 9:09 AM revealed Resident #133 sitting up in bed. His breakfast tray had been delivered and was at bedside. There was no nutritional supplement provided for this meal. Photographic Evidence Obtained. During an interview on 09/04/25 at 1:10 PM, the spouse of Resident #133 stated that sometimes he gets nutritional supplements and other times he does not. The lunch tray was delivered at 1:16 PM and lacked any nutritional supplement. Photographic Evidence Obtained. During an interview on 09/04/25 at 1:21 PM, when asked the process to ensure the provision of nutritional supplements, the Registered Dietician (RD) explained if it was ordered it would be provided on the tray with each meal, as per the order and supplemental meal ticket. An observation was made of the resident's lunch tray at that time and the RD agreed the tray lacked any nutritional supplements and should have contained both the Magic Cup and Mighty Shake. Upon reviewing the other two photos, the RD stated she needed to do some education.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the administration of nutrition via a tube as per physician order for 1 of 3 sampled residents, Resident #102. The findings included: Review of the record revealed Resident #102 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE], documented Resident #102 had a Brief Interview for Mental Status (BIMS) score of 9, on a 0 to 15 scale, indicating the resident had moderate cognitive impairment. This same MDS also documented Resident #102 had coughing and swallowing difficulties while eating and received 50% or more of his nutrition via a tube. Review of the current physician order documented as of 08/21/25 Resident #102 was to receive Jevity 1.5 Calorie (a specific brand of nutritional feeding administered via a tube) at 70 ml (milliliters) per hour for 20 hours. This order specified to start the feeding via tube at 1 PM daily and to stop it the following day at 9 AM, to ensure 1400 milliliters of nutrition in the 20 hours. An observation on 09/03/25 at 10:17 AM revealed Resident #102 was not in his room. As per a family member he was receiving therapy services at that time. A 1000 ml container of Jevity 1.5 calorie was hanging on the IV pole. The label documented the feeding had been started on 09/02/25 at 1 PM and was to run at 60 ml per hour, instead of the ordered 70 ml per hour. There was approximately 225 ml left in the container. Photographic Evidence Obtained. This would indicate Resident #102 only received 775 ml of the ordered 1400 ml of nutrition, between the start on 09/02/25 at 1 PM and the stopping of nutrition on 09/03/25 that morning. An observation on 09/04/25 at 8:53 AM revealed the feeding had been turned off. The label on the Jevity container documented it had started on 09/04/25 at 5 AM and it was to run at 60 ml per hour, instead of the ordered 70 ml per hour. Photographic Evidence Obtained. An observation on 09/05/25 at 3:38 PM revealed the Jevity 1.5 calorie feeding was running at 60 ml per hour instead of the ordered 70 ml per hour. Photographic Evidence Obtained. The record lacked any documented reason for running the tube feeding at a slower rate and or not finishing the feeding as per order, as observed on 09/03/25 at 10:17 AM. A side-by-side review of the record and interview was conducted on 09/05/25 at 3:46 PM with Staff B, Registered Nurse (RN). Staff B confirmed the physician order documented Resident #102 was to receive the tube feeding at 70 ml per hour. The RN confirmed she had started the tube feeding for Resident #102 earlier that same day at about 1 PM. When asked if she checked the rate of administration upon initiating the feeding, the nurse explained the previous rate was programmed into the machine and came up automatically. The RN stated she just continued the previous rate and did not note what that rate was. When shown in the photo that the tube feeding was being administered at 60 ml per hour, the RN stated she needed to change it to 70 ml per hour as per the physician order. During an interview on 09/05/25 at 3:56 PM, the Registered Dietician (RD) explained Resident #102 had been admitted from the hospital with a new feeding tube on 08/19/25. The RD stated upon admission to the facility the order for the tube feeding was for 10 ml per hour. The RD stated the rate of administration gradually increased a few times a day until they reached the rate of 70 ml per hour as of 08/21/25. The RD confirmed that was also the current rate of administration. When asked if she ever checked the rate of administration, the RD stated she tries to check but hadn't done so recently for Resident #102. The RD was made aware the Jevity canisters this week were all documented as providing the feeding at 60 ml per hour, and that today it was observed running at 60 ml per hour. The RD lacked any reason for the slower rate of administration and stated she would do education now.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, observation and interview, the facility failed to ensure oxygen care and services for 3 of 4 sampled residents as evidenced by the failure to change and date oxygen tubing and clean filters for Resident #6, Resident #9 and Resident #88. The findings included: Review of the policy titled, Oxygen Safety-Nursing Service, dated 04/21/23 does not include any policy on the frequency of changing and dating oxygen tubing, and the procedure for cleaning the oxygen filter. 1) Review of the record revealed that Resident #6 was admitted to the facility on [DATE] with a recent readmission on [DATE] with diagnoses in part of Cerebral Infarction, Acute Respiratory Failure with Hypoxia, and Chronic Obstructive Pulmonary Disease (COPD). Review of the Physician Orders for Resident #6 revealed the following orders dated 04/02/25, Oxygen 2 Liters via nasal canula continuously every shift related to Acute Respiratory Failure with Hypoxia, and to change, label, and bag all tubing and masks for Oxygen, wipe down concentrator, nebulizer machine, and change concentrator filter every Sunday night shift. During an interview and observation on 09/03/25 at 9:39 AM, Resident #6 stated that her oxygen order is for 2 Liters and to use oxygen as needed. Resident #6's oxygen rate was set at 5 liters, the tubing was not labeled with a date, and the filter was full of dust. (Photographic Evidence Obtained.) 2) Review of records revealed Resident #9 was admitted to the facility on [DATE] with diagnoses in part of Parkinson's Disease without Dyskinesia, Pneumonitis due to inhalation of food and vomit, and Dysphagia. Review of Physician Orders dated 08/05/25 for Oxygen 2 liters per minute via nasal canula as needed and on 07/20/25 Physician Orders to change, label, bag all tubing and masks for Oxygen and wipe down concentrator, nebulizer machine, and change concentrator filter every Sunday night shift. During observations on 09/03/25 at 11:22 AM, Resident #9's Oxygen tubing was on the floor uncovered and the filter was dusty and not clean. (Photographic Evidence Obtained.) Two more observations were conducted on 09/04/25 at 10:10 AM and on 09/05/25 at 9:12 AM and Resident #9's oxygen tubing was wrapped on top of the Oxygen machine not in a bag, not dated and the filter was dirty. An interview was conducted on 09/05/25 at 11:06 AM with Staff E, Registered Nurse (RN) about the timing and cleaning process for oxygen tubing and filters. Staff E stated that oxygen tubing and filters are replaced/cleaned by the nurses on the Sunday night shift. When Staff E was asked who is supposed to label the tubing, she replied, whoever changes the tubing. Staff E was advised of the tubing that lacked a date and filter that was dirty for Resident #6 and Resident #9.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to remove expired inventory from the medication cart and the medication room on 4N for 2 out of 2 medication carts and for 1 of 2 medication rooms reviewed. The facility failed to ensure narcotic reconciliation on 2S for 1 of 2 medication carts reviewed. The findings included: 1. Review of the facility's policy titled, Disposal of Medication and Medication Related Supplies, dated [DATE], included the following: Procedure: B. When a dose of a controlled medication is removed from the container .or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record book on the line representing the dose. On [DATE] at 11:20 AM a review of the medication cart contents on 4N was conducted with another surveyor and with Staff O, LPN (Licensed Practical Nurse). It was observed that several medications in the medication cart were expired. Staff Nurse O agreed that the medications identified were expired and should be removed from inventory. During an observation of the medication supply room on 4N, several medications were noted to be expired, again verified with Staff O. The medications included resident specific and stock inventory. Staff O stated the night nurse is responsible for filling out the required log form so that expired resident specific medication can be collected. The expired stock inventory was collected by Central supply on [DATE] at 12:15PM. On [DATE] at 4:00 PM the medication room on 2S was checked along with one of the two medication carts on the unit with another surveyor and Staff K, LPN. During the narcotic medication review for Resident #136, the pill pack count for OXYCOD/APAP TAB 5-325 gm was 6 but the Medication Monitoring Control Record had a remaining count of 7. Staff K immediately acknowledged that she failed to sign out the waste with the off-going nurse during report. 2. Review of the facility policy titled Disposal of Medication and Medication-Related Supplies dated 05/2022 and documented in part: Policy: Medication in the DEA classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility with federal and state laws and regulations. Procedures: B. When a dose of controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record/book on the line representing that dose. E. When controlled medications are destroyed at the facility, licensed staff as allowed by state law will witness the destruction and ensure that the following information is entered on the (individual controlled substance accountability record/book): 1. date of destruction 2. resident name 3. name and strength of medication 4. prescription number 5. amount of medication destroyed 6. signature of witnesses. Medication storage review was conducted on [DATE] at 4:28 PM, on 2S Unit, with another surveyor present. Three residents were selected for review of narcotics. Staff K, LPN, was asked to show the Oxycodone 5/325 mg tablet that was prescribed for Resident #136. She removed the medication from the locked narcotic box and there were six pills in the packet. The controlled medication utilization record for Resident #136, revealed that there were seven Oxycodone 5/325mg pills remaining. Staff K, LPN stated Me and the nurse I relieved wasted one of the pills, because it was falling out of the pill packet. Staff K was asked who the other nurse was, she stated, Staff B, LPN. There was no signature documented on the narcotic reconciliation form by either nurse showing that the medication (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was wasted. When asked where she disposed of the pill, Staff K stated, In the pill buster located in the med room. When asked if she was present when the pill was waisted, she stated, I was standing at the door and the other nurse put it in the pill buster that was sitting on the counter. Staff K was asked to get the Assistant Director of Nursing (ADON) to review the discrepancy. Since Staff K had been gone for a while, the surveyors went to ADON's office to make her aware of the narcotic reconciliation discrepancy. Staff K was in her office. The ADON was asked to get Staff B to get her side of the story. The ADON called Staff B from her cell phone and had her on speaker while both surveyors listened to the call. When asked if she recalled wasting a medication with Staff K during change of shift, she stated, Yes we wasted, I think oxycodone. When asked if she recalled the resident's name that the narcotic was prescribed to, Staff B stated, I don't really remember the name. When asked where disposed of the narcotic, she stated In the trash can on the side of the medication cart. Staff B was asked to confirm what she stated, in which she did, and her story remained the same. Photographic Evidence Obtained During an interview on [DATE] at 5:10 PM, at the 4S nurses station Staff K was asked to confirm where the oxycodone was disposed, and she stated In the trash can, but couldn't recall which trash can. The ADON was made aware of Staff K previously stating a different location of where the narcotic was disposed of.		

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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. Based on observations, record review and interviews, the facility failed to ensure that it was free of medication errors for 2 of 2 sampled residents, as evidenced by a medication error rate of 15.38% with 26 opportunities due to failure to ensure that Resident #65 received medications ordered and was available for her, failure to ensure Resident#2 received medications as ordered. The findings included:1) An observation was conducted on 09/03/25 at 9:20 AM, Staff O, Licensed Practical Nurse (LPN) was observed administering medications for Resident #65. As she begun to prepare the medications, she stated, I do not have the Mag Ox or Calcium for the resident, so I will not give them to her. As the nurse prepared each medication the name was verified on the label of the medications. Staff O, LPN was asked how many pills were in the medicine cup she stated 10. She also had an inhaler. Staff O, LPN walked into the resident's room and the resident was on the phone. She asked the resident if she wanted her to come back. The resident shook her head yes. She left the room. An observation was conducted on 09/03/25 at 9:33 AM, Staff O, LPN entered Resident #65's room. She placed the medication cup and inhaler which was in a zip lock bag on the resident's bedside table without a barrier. Staff O, LPN, handed the Resident the cup of medications and she took them, then she prepared the inhaler for the resident and handed it to her to self-administer. Review of the physician orders for Resident #65 revealed an order that instructed staff to administer Mag Ox 400mg for hypomagnesemia twice a day at 9:00 and 5:00 PM and Calcium +D500-10MG daily for hypocalcemia at 9:00 AM. During an interview with Staff O, LPN on 09/03/25 at 10:16 AM, when asked if she administered the Mag Ox and Calcium to Resident #65, she stated, No, I have to order them from pharmacy. When asked are you able to order them directly from your computer she stated Yes. 2) An observation was conducted on 09/03/2025 at 9:27 AM, Staff O, LPN was observed preparing Resident #2's medication. As Staff O, LPN prepared each medication the name was verified on the label of the medication. She was asked how many pills she prepared in the cup, Staff O, LPN stated I have 7 pills she also had a red liquid supplement in a medicine cup that she prepared. The nurse walked into the resident's room and stated I have your pills do you want to drink this or do you need help. She placed the medicine cup on the bedside table without a barrier she did not wash her hands prior to administering medications. She assisted the resident with drinking the red liquid and assisted him with taking his pills. Review of the physician order dated 07/22/25 for Resident #2, revealed an order that instructed staff to apply Alclometasone Dipropionate Cream 0.05% topically for dry skin two times a day at 9:00 AM and 5:00 PM. During an interview on 09/03/25 at 10:25 AM, when asked have you administered the Alclometasone cream for Resident #2, Staff O, LPN stated Not yet. When asked to see the cream, the tube of medication was unopened and dated with the original order date 07/23/25. Photographic evidence obtained. Review of the July and August of 2025 Treatment Administration Record for Resident #2 revealed that the staff had documented administration of the Alclometasone cream to the resident. 3) An observation was conducted on 09/03/2025 at 5:47PM, Staff M, Registered Nurse (RN) was observed preparing the Humulin N Insulin pen to administer insulin to Resident #2. She stated, I'm going to administer 5 Units because the blood sugar was 205. She prepared the insulin pen by turning the dial to 5 Units and applied the insulin needle. The dosage on the pen was verified at 5 Units. Staff M, RN entered the resident's room and explained that she was going to administer 5 Units of insulin. Resident #2 asked why, she stated Remember I checked your blood sugar, and it was 205. Staff M, RN wiped the resident's left upper arm with alcohol and administered the insulin. When she went to sign the Medication Administration Record (MAR), she was asked how many units she administered and she stated, 5 Units. Staff M, RN was asked to look at the insulin order on the MAR again, after she reviewed, she stated, Oh, it says 6 Units, it looked like a 5.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to store medication properly for 1 of 29 sampled residents, as evidenced by medication being left at the bedside for Resident #32. The findings included:Record review revealed Resident #32 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 10, on a 0 to 15 scale, indicating moderate cognitive impairment.An observation was conducted on 09/02/25 at 11:10 AM revealed, a bottle of prescription medication was noted on Resident #32's nightstand (photographic evidence obtained).An observation conducted on 09/03/2025 at 11:26 AM, revealed a bottle of prescription topical medication was observed on Resident #32's nightstand.Review of the assessments for Resident #32 did not reveal an assessment for self-administration of medication.Review of the care plan revised on 07/2/25, documented that Resident #32 had an activities of daily living self-care deficit related to Lewy body dementia (progressive dementia that affects cognition and mobility). During an interview with Resident #32 on 09/04/2025 at 9:37 AM, observations revealed a prescription bottle of triamcinolone cream that was prescribed on 09/14/24 and to be applied for two weeks, was noted on Resident #32's nightstand. When asked what the medication was for, the resident stated, For my head. When asked do you apply it yourself, the resident stated No, the nurse does. During an interview on 09/04/2025 at 9:43 AM, when asked does Resident #32 have an order for a prescription medication that is to be applied to his scalp, Staff L, LPN reviewed the resident's orders in the computer and stated, He does not have an order for a prescription medication to be applied to his scalp only cerave lotion. She was made aware that a prescription medication had been observed on the resident's nightstand for the past three days and the resident said the nurses were applying the medication.During a phone conversation on 09/04/2025 at 9:46 AM, with Staff L, LPN and the resident's spouse, Staff L, LPN, stated, I'm calling about the triamcinolone prescription that was on [Resident #32's] nightstand. The spouse stated, He has always had that medication from the beginning since he has been there. Staff L, LPN stated, He was seen by the dermatologists in the facility, and they didn't see anything on the scalp. I will take the medication, and it will be at the nurse's station for you to pick up. The spouse stated, I don't need it. I guess if the dermatologist feels he needs it they will give it to him again. Staff L, LPN then took the medication from Resident's bedside.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, menu review, and interview, the facility failed to ensure food was provided as per preference for 1 of 1 sampled resident, Resident #41, who voiced concerns with food choices. The findings included: Review of the record revealed Resident #41 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the current physician orders documented Resident #41 was ordered a regular diet. During an interview on 09/03/25 at 12:06 PM, Resident #41 stated she had asked for poached eggs and they wouldn't make them. Resident #41 stated she saw them on the menu. On 09/04/25 at 8:55 AM, Resident #41 was in the common area on 2S awaiting breakfast. Staff C, Certified Nursing Assistant (CNA) was observed taking the breakfast order from Resident #41 while showing the resident the menu. Resident #41 stated, Since you don't have poached eggs, I'll take . Observation of the menu held by the CNA and shown to the resident documented poached eggs, but they were crossed off with a red mark through the words (Photographic Evidence Obtained). During an interview on 09/04/25 at 10:40 AM, when asked why the poached eggs were crossed off the menu that morning, Staff D, Dietary Aide stated, It was on the news this week that there was salmonella in the eggs, so we took them off (the menu). But they can have hard boiled eggs every other day. During an interview on 09/04/25 at 11:05 AM, when asked if she was told the reason poached eggs were crossed off the menu, Resident #41 stated she had not been informed. When asked if she had ever had the option of poached eggs since arriving at the facility, the resident stated she had not. During a supplemental interview on 09/05/25 at 12:34 PM, when asked if they have had poached eggs recently, or anytime in the past couple of months, Staff D stated, There was the egg shortage, then after that they had them for about a month, then they stopped again. During an interview on 09/05/25 at 12:34 PM, when asked when and why they stopped providing the poached eggs, the Food and Beverage Director stated it was taken off the menu in February of 2025 because of the egg shortage and inability to get pasteurized eggs. When asked why they did not reinstate the poached eggs, the Director stated they were in the process of implementing a new dietary system and new menus that don't include poached eggs, so they decided not to start providing them after the shortage, to then have to turn around and take them away. When told they were still on their dietary extensions and on a menu that was being shown to residents on 2S, although crossed out in pen, the Food and Beverage Director stated, Yes, that's on us and we should have updated them (referring to the dietary extensions). The Food and Beverage Director also agreed the menu being used on 2S included poached eggs and should not have been used currently by the staff.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to provide a therapeutic diet for 2 of 2 sampled residents as evidenced by failure to ensure that Resident #38 and Resident 50 are provided with thickened liquids. The findings included:1) Record review revealed Resident #38 was admitted to the facility on [DATE]. The initial comprehensive assessment dated [DATE] documented a Brief Interview Mental Status score of 07 on a 0-15 scale, indicating the resident had moderate cognitive impairment. There was documented medical diagnosis of dysphagia (difficulty swallowing). Review of the physician order dated 06/18/25 revealed that Resident #38, was on a regular diet, pureed texture, honey thickened consistency. An observation was conducted on 09/02/2025 at 12:22 PM, Resident #38 was sitting in the wheelchair sleeping with bedside table in front of him. There was a packet of thicken it powder, a white styrofoam cup with light yellow liquid and a spoon inside of it and 2 other styrofoam cups with straws inside of them. Photographic evidence obtained. During a conversation on 09/02/25 at 3:39 PM that Resident #38's daughter had with the DON and ADON, the daughter stated, I came here on Saturday, and the staff was giving my dad ensure without adding thicken it powder. He was coughing his lungs out.An observation was conducted on 09/03/2025 at 8:53 AM, There was a white styrofoam cup with straw in it dated 09/03/25 on Resident #38's bedside table. An interview was conducted on 09/04/25 at 4:02 PM with the Rehabilitation Director. A copy of the speech evaluation for Resident #38 was requested. She stated This resident is aspirating all the time, and it was recommended that the resident gets a feeding tube, but the family refused. He is on the thickest consistency for liquids. She was made aware that Resident #38 was observed with straws in his thickened liquids. Review of the speech evaluation dated 08/19/25, revealed that Resident #38 received speech therapy services three times a week and it was recommended by speech therapy for close supervision with oral intake and to facilitate safety, no use of straws was recommended because the resident is at risk for aspiration, dehydration, and malnutrition. 2) Record review revealed Resident #50 was readmitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 08 on a 0-15 scale, indicating the resident had moderate cognitive impairment. Review of the medical diagnosis documented a history of dysphagia (difficulty swallowing), and malnutrition.During an observation on 09/03/25 at 9:02 AM in the 4North dining room, Resident #50 was noted in dining room sitting at the table alone. She had a cup with a red drink of thickened consistency with a straw in it. The resident was coughing profusely nonstop. Staff O, Licensed Practical Nurse (LPN) continued to stand at her medication cart without going to check on the resident. When asked are you familiar with Resident #50 she stated, Yes. When asked if she normally coughs that way she stated, Yes. When asked if she should be using a straw with her thickened liquids, Staff O, LPN stated, I will have to check. Staff O, LPN proceeded with preparing medication and did not go to the dining room to assess Resident #50. Photographic evidence obtained.Review of a physician order dated 05/12/25 revealed Resident #50 was ordered a regular diet, pureed texture, and nectar consistency liquids.Review of the care plan dated 06/30/25 revealed that Resident #50 was at risk for inadequate intake of nutrition and/or hydration related to poor appetite, unspecified protein calorie malnutrition and she will maintain or improve her hydration status by monitoring food and fluid intake and observing and signs or dysphagia such as pocketing food, choking, and coughing.An interview was conducted on 09/04/25 at 4:02 PM with the Rehabilitation Director. A copy of the speech evaluation for Resident #50 was requested from her. She was made aware that Resident #50 was observed with a straw in her sippy cup with thickened liquids and she was coughing profusely.Review of the speech evaluation dated 05/12/25, revealed that speech therapy recommended for Resident #50 to have close supervision with oral intake and to facilitate safety, no use of straws was recommended because the resident was at risk for aspiration.		