STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105438	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Ridge Haven	4927 Voorhees Rd New Port Richey, FL 34653

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 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 record review and interview, the facility failed to provide care and treatments in accordance with professional standards of practices as evidence by the lack of documentation of blood pressures prior to the administration of blood pressure medication for two (#3 and #7) of seven residents sampled, failed to document the blood sugars as ordered by the physician for two (#5, and #8) of three sampled residents for monitoring of blood sugar levels, and failed to administer medications as ordered for two diabetic residents (#4 and #10) out of three residents reviewed. Findings included: 1. Review of the Admission Record showed Resident #3 was admitted to the facility on [DATE] and discharged on [DATE]. The resident was admitted for a thirty day respite stay. The admitting diagnoses included end stage renal disease, type 2 diabetes mellitus with hyperglycemia, orthostatic hypotension, unspecified dementia and dependence on renal dialysis. Review of Resident #3's Minimum Data Set Assessment (MDS) dated [DATE], Section C-Cognitive Patterns, showed the resident had a Brief Interview for Mental Status (BIMS) score of 8 revealing moderate cognitive impairment. Review of Resident #3's Care Plan dated 09/30/2024 showed Resident #3 was at risk for cardiovascular complications related to: atrial fibrillation, hypertension, pacemaker, orthostatic hypotension. The interventions included: administer medication as ordered, assess for signs and symptoms of hypotension. Review of the Medication Reconciliation dated 09/19/2024 for Resident #3, given to the facility upon the resident's admission, showed the resident was prescribed Midodrine HCL Tablet, 2.5 milligram (MG) tablet by mouth three times a day as needed for hypotension; hold for systolic blood pressure more than 150 millimeters of mercury (mmHg). Review of the History and Physical dated 08/20/2024 from the hospital for Resident #3, revealed the resident had orthostatic hypotension and it is not uncommon for the resident to lose consciousness and his blood pressure to drop twenty points. Review of Order Summary Report dated 09/27/2024 for Resident #3's admission to the facility shows the medication Midodrine HCL Tablet 2.5 MG was ordered from the pharmacy by the facility on 09/28/2024 for the resident. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's Medication Administration Record (MAR) from 10/01/2024 through 10/31/2024, showed the medication Midodrine HCL Tablet 2.5 MG was to be administered to Resident #3 one tablet by mouth for orthostatic hypotension, hold if systolic blood pressure (SBP) over 150 mmHg. Review of the MAR showed no record of Resident #3 being given the medication or having his blood pressure checked on the following dates and times: 1. 10/01/2024 - 6:00 am, 2:00 pm, 10:00 pm 2. 10/02/2024 - 6:00 am, 2:00 pm, 10:00 pm 3. 10/03/2024 - 6:00 am (this was the day of the resident's discharge from the facility) 2. Review of the Admission Record, dated 11/5/24, revealed Resident #7 was originally admitted on [DATE] and readmitted on [DATE]. The clinical record for the resident revealed a discharge on 10/26/24 to an acute care facility. The record included diagnoses not limited to atherosclerotic heart disease of native coronary artery without angina pectoris, non-ruptured cerebral aneurysm, chronic diastolic (congestive) heart failure, and essential (primary) hypertension. Review of the October Medication Administration Record (MAR), printed on 11/4/24 at 3:24 p.m., showed Resident #7 was to receive, per physician orders, Midodrine Hydrochloride (HCl) oral tablet 5 milligram (mg) - Give 1 tablet by mouth one time a day every Tuesday (Tue), Thursday (Thu), (and) Saturday (Sat) for hypotension, Hold if less than 100. The MAR revealed the order started on 8/13/24. The MAR revealed a chart code showing 4 equaled (=) Vitals Outside of Parameters for Administration, 9 = Other/See progress notes, ineffective date 2024-01-09, and a checkmark revealed the medication had been administered. The vasoconstrictor medication, Midodrine, was scheduled to be administered at 9:00 a.m. and on 10/1/24 (Tue) the medication was held due to 4 vitals outside of parameters. On 10/3, 10/8, 10/17, 10/19, 10/22, and 10/26/24, the medication was not given due to 9 see progress notes. On 10/5, 10/10, 10/12, 10/15, and 10/24/24 the medication had been administered. The MAR and Treatment Administration Record (TAR) did not include documentation of the resident's blood pressures and the order to administer Midodrine did not include an area to document the resident's blood pressures. Review of the Weights and Vitals Summary for Resident #7 showed one blood pressure had been documented during October. The resident's blood pressure was documented as 112/63 on 10/26/24 at 3:28 p.m. The summary did not reveal the resident's blood pressure on 10/1/24 causing staff to hold the medication. Review of the progress notes dated 10/11 to 10/27/24 for Resident #7 showed on 10/26/24 the Advanced Practitioner Registered Nurse (APRN) documented a blood pressure of 112/63 for the resident. The review of additional progress notes, including electronic MAR (eMAR) notes did not reveal any documentation of other blood pressures being taken or the physician being notified the medication, Midodrine, had been held due to a blood pressure of less than 100. Review of the Care Plan for Resident #7 showed the resident was at risk for cardiovascular complications related to: heart failure, coronary artery disease (CAD), peripheral vascular disease (PVD), anemia, cerebral vascular accident (CVA), right middle cerebral artery (MCA) aneurysm, morbid obesity, (and) history (hx) myocardial infarction (MI). The goal revealed the resident would be free from cardiac complications through review date (12/4/24) and included interventions not limited to: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Administer medication as ordered (Refer to POS/MAR for current order), monitor for side effects. - Assess for signs/symptoms (s/s) of bradycardia, hypotension, dizziness, etc. - Vital signs as ordered and as needed (prn) (Refer to POS/TAR for current order). 3. Review of the Admission Record showed Resident #5 was admitted to the facility on [DATE] with admitting diagnosis including type 2 diabetes mellitus. Review of Minimum Data Set (MDS) assessment dated [DATE], Part C-Cognitive Patterns, showed the resident had a Brief Interview for Mental Status (BIMS) score of 14 revealing the resident was cognitively intact. Review of the Care Plan for Resident #5, dated 08/24/2024, showed the resident had a diagnosis of diabetes and was at risk for hyperglycemia and hypoglycemia. Care plan interventions included blood glucose monitoring and sliding scale insulin as ordered, administer medications as ordered and observe for signs and symptoms of unstable blood sugars. An interview was conducted with the Director of Nursing (DON) on 11/05/2024 at 4:30 pm. The DON said blood glucose test results are charted by exception meaning if the blood glucose level is within normal limits it is not documented on the resident's chart or in a progress note. Review of a Health Status Note dated 10/07/2024 at 7:15 am, written by Staff J, Registered Nurse (RN) the resident was alert with altered mental status revealed Resident #5's blood glucose level was 61. The resident was given an intramuscular diabetic medication with positive results of the resident becoming alert and oriented after fifteen minutes. The resident's physician's office was notified and Staff J received orders for blood glucose checks twice per day. Review of physician order dated 10/07/2024 at 7:09 am, showed an order for Resident #5 for the hypoglycemia protocol: continue to check blood glucose every fifteen minutes until blood sugar is over 70 milligrams per deciliter (mg/dl). Review of physician order dated 10/07/2024 at 7:13 am, showed an order for glucose finger stick and call physician if Resident #5's blood sugar is below 70 mg/dl or over 400 mg/dl. Review of the Medication Administration Record for Resident #5 dated 10/21/2024 through 10/31/2024 showed blood glucose levels were not recorded on the following dates: 1. 10/08/2024 day 2. 10/08/2024 night 3. 10/09/2024 day 4. 10/09/2024 night 5. 10/10/2024 day (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. 10/10/2024 night 7. 10/11/2024 day 8. 10/11/2024 night 9. 10/12/2024 day 10. 10/12/2024 night 4. On 11/4/24 and 11/5/24 random observations were made of Resident #8 propelling self in a wheelchair in the hallway or sitting in the doorway of her room. Review of the Admission Record showed Resident #8 was admitted on [DATE]. The record included diagnoses not limited to type 2 diabetes mellitus without complications and morbid (severe) obesity due to excess calories. Review of the October Medication Administration Record (MAR) for Resident #8 revealed a physician order dated 10/4/24 instructing staff to Blood sugar check twice daily (BID) x 7 days, two times a day for Diabetes Mellitus. Check blood sugar daily before meal **Call MD if <60 or >400**. The order had been scheduled for 6 a.m. and 9 p.m. then discontinued on 10/20/24. The order did not include an area for staff to document blood glucose levels and the MAR and TAR did not include an additional area for staff to document the resident's blood glucose levels. The electronic MAR did show the blood sugar checks had been completed from 10/4 at 9:00 p.m. till 10/20 at 9:00 p.m. Review of the Blood Sugar Summary on 11/4/24 at 4:05 p.m. revealed documentation of Resident #8's blood sugars: - 10/5/24 at 1:23 a.m. - 123.0 milligram/deciliter (mg/dl) - 10/5/24 at 5:32 a.m. - 135.0 mg/dl No documentation of a blood glucose level before the noon or evening meal per the physician order or at the scheduled time of 9:00 p.m. The MAR revealed staff had documented a blood sugar level had been obtained on 10/5/24 at the scheduled time of 9:00 p.m. - 10/6/24 at 6:36 a.m. - 122.0 mg/dl - 10/6/24 at 9:03 p.m. - 153.0 mg/dl No documentation of a blood glucose level had been obtained prior to the noon or evening meal per the physician order. - 10/7/24 at 5:06 a.m. - 125.0 mg/dl No documentation of a blood glucose level had been obtained prior to the noon or evening meal per the physician order or at the scheduled time of 9:00 p.m. The MAR showed staff had obtained a level at 9:00 p. m. on 10/7/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of a blood glucose level on 10/8 or 10/9/24. Staff had electronically documented levels had been obtained on those dates. - 10/10/24 at 5:24 a.m. - 122.0 mg/dl No documentation of a blood glucose level had been obtained prior to the noon or evening meal per the physician order or at the scheduled time of 9:00 p.m. on 10/10/24. Staff had documented on the MAR a 9:00 p.m. level had been obtained and progress notes showed staff had documented the resident had received as needed medication administrations at 7:49 p.m. and 7:50 p.m. with electronic documentation of their effectiveness at 9:25 p.m. - 10/11/24 at 7:31 a.m. - 114.0 mg/dl The progress notes, MAR, and blood sugar summary showed no documentation of a blood glucose level had been obtained prior to the noon or evening meals or at the scheduled time of 9:00 p.m. on 10/11/24 however staff documented on the MAR a level had been obtained as scheduled at 9:00 p.m. Review of the Care Plan for Resident #8 revealed the resident had a diagnosis of diabetes and was at risk for hyper/hypo glycemia. The goal was for the resident to remain free from complications related to hyper/hypoglycemia through (the) next review date. The interventions instructed staff to (obtain) Accu-checks (blood glucose levels) and sliding scale insulin as ordered (Refer to POS/MAR for current orders) and labs as ordered and report results to physician (Refer to POS/TARs for current orders). Review of the policy - Blood Glucose Monitoring & Disinfecting, revised 5/1/23 included instructions for the procedure. The procedure instructed staff to: - Prepare glucose meter for testing. - Wipe tip of finger with alcohol swab and allow to dry. - [NAME] the site with lancet. - Transfer drop of blood to test strip. - Apply pressure to puncture site with gauze pad or alcohol swab. - Test blood specimen per manufactures guidelines. - Read results. - Discard test strip and other materials. - Discard lancet in sharps container. - Remove gloves. - Perform hand hygiene. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Clean and disinfect the meter with disinfecting wipes (per manufacture guidelines). - Place meter in medication cart. - Document result in electronic medical record. An interview was conducted with the Director of Nursing (DON) on 11/4/24 at 4:00 p.m. The DON reviewed Resident #8's MAR and said it shows up on the order and depends on how staff put it in. A review of the Blood Glucose Vital Summary was completed with the DON showing the blood glucose levels are not documented as ordered. During an interview on 11/5/24 at 4:29 p.m. with the DON and Executive Director (ED), the DON stated she would document a blood sugar but the order hadn't been put in (the computer) like that and the facility documents by exception so she would expect if outside the parameters there would be a note. 49227 5. During an observation and interview with Resident #4 on 11/4/24 at 3:30 P.M. she said sometimes she got her insulin late and they forget to take my fingerstick. Review of Resident #4's admission record showed 3/15/24 was the initial admitted . -Resident #4's diagnoses include type 1 DM with hyperglycemia. Review of Resident #4's order summary report for active orders as of 11/5/24, and October 2024 Medication Administration report, showed the following orders: -Blood sugar checks as needed of signs and symptoms of hypoglycemia or hyperglycemia -Hypoglycemia protocol: continue to check blood glucose every 15 minutes until blood sugar is over 70 mg/dl, -Byetta 0.2 ml every Monday for DM -Glucagon Emergency Kit for blood sugar less than 70 mg/dl and unable to take oral [swallow] -Humalog insulin 14 units before meals for DM bring snack with 6:30 A.M. Insulin -Humalog insulin inject as per sliding scale: If 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 10 units, greater than 400 give 12 units and notify the doctor, before meals and at bedtime for DM. Bring snack with 06:30 A.M. insulin. -Lantus Insulin 60 units every 12 hours for DM -Trulicity 0.75 once every seven days for DM Review of Resident #4's Care Plan showed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Focus: Resident #4 has a diagnosis of diabetes and is at risk for hypo/hyper glycemia, initiated 3/15/24 -Goal: Resident #4 will remain free from complications related to hypoglycemia and hyperglycemia . -Intervention to include: Accu-Check and sliding scale insulin as ordered., administer medications as ordered. Observe for signs and symptoms of unstable blood sugars tremors/shaking/nausea/vomiting, drowsiness increased thirst rapid/bounding pulse deep respirations change in mental status . Review of Resident #4's medication administration audit report, schedule date 10/1/24 to 10/31/24 showed the following: On 10/1/24 Humalog insulin 14 units before meals scheduled 8:30 A.M. was administered at 10:13 A.M. On 10/1/24 Humalog insulin per sliding scale (SS) scheduled 8:30 A.M. was administered at 10:13 A.M. On 10/1/24 Lantus insulin 60 units scheduled at 9:00 A.M. was administered at 10:13 A.M. On 10/1/24 Humalog insulin per SS before meals scheduled 9:00 P.M. was administered at 11:48 P.M. On 10/1/24 Lantus insulin 60 units scheduled at 9:00 P.M. was administered at 11:48 P.M. On 10/2/24 Humalog insulin 14 units before meals scheduled 8:30 A.M. was administered at 10:45 A.M. On 10/2/24 Humalog insulin per SS before meals scheduled 8:30 A.M. was administered at 10:45 A.M. On 10/2/24 Humalog insulin 14 units before meals scheduled 11:30 A.M. was administered at 12:47 P.M. On 10/2/24 Humalog insulin per SS before meals scheduled 11:30 A.M. was administered at 12:47 P.M. On 10/3/24 Humalog insulin 14 units before meals scheduled 4:30 P.M. was administered at 6:20 P.M. On 10/3/24 Humalog insulin per SS before meals scheduled 4:30 P.M. was administered at 6:20 P.M. On 10/3/24 Humalog insulin per SS before meals scheduled 9:00 PM was administered at 10:19 P.M. On 10/3/24 Lantus insulin 60 units scheduled at 9:00 P.M. was administered at 10:18 P.M. On 10/5/24 Humalog insulin per SS before meals scheduled 8:30 A.M. was administered at 9:55 A.M. On 10/5/24 Humalog insulin 14 units before meals scheduled 08:30 A.M. was administered at 9:56 A.M. On 10/5/24 Humalog insulin per SS before meals scheduled 9:00 PM was administered at 10:37 P.M. On 10/5/24 Lantus insulin 60 units scheduled at 9:00 P.M. was administered at 10:37 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	On 10/6/24 Humalog insulin 14 units before meals scheduled 4:30 P.M. was administered at 5:59 P.M. On 10/6/24 Humalog insulin per SS before meals scheduled 4:30 P.M. was administered at 6:00 P.M On 10/7/24 Humalog insulin 14 units before meals scheduled 8:30 A.M. was administered at 10:55 A.M. On 10/7/24 Humalog insulin per sliding scale (SS) before meals scheduled at 8:30 A.M. was administered at 10:54 A.M. On 10/7/24 Lantus insulin 60 units scheduled at 9:00 A.M. was administered at 10:55 A.M. On 10/7/24 Humalog insulin 14 units before meals scheduled at 11:3 A.M. was administered at 4:06 P.M. On 10/7/24 Humalog insulin per SS before meals scheduled 4:30 P.M. medication administration time not documented On 10/7/24 Humalog insulin 14 units before meals scheduled at 4:30 P.M., medication administration time was not documented On 10/7/24 Byetta 0.2 ml scheduled at 5:00 P.M., medication administration was not documented. On 10/8/24 Humalog insulin per sliding scale (SS) before meals scheduled at 8:30 A.M. was administered at 9:56 A.M. On 10/8/24 Humalog insulin 14 units before meals scheduled 8:30 A.M. was administered at 9:56 A.M. On 10/8/24 Humalog insulin per sliding scale (SS) before meals scheduled at 4:30 P.M. medication administration time is not documented On 10/8/24 Lantus insulin 60 units scheduled for 9:00 P.M. was administered at 10:22 P.M. On 10/8/24 Humalog insulin per sliding scale (SS) before meals scheduled at 9:00 P.M. was administered at 10:14 P.M. On 10/12/24 Humalog insulin per SS before meals scheduled 9:00 P.M., medication administration time not documented On 10/12/24 Humalog insulin 14 units before meals scheduled 9:00 P.M., medication administration time was not documented On 10/9/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. the medication administration time is not documented. On 10/9/24 Humalog insulin 14 units before meals scheduled 11:30 A.M. the medication administration time was not documented. On 10/11/24 Humalog insulin per SS before meals scheduled 8:30 A.M. was administered at 2:42 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	On 10/11/24 Humalog insulin 14 units before meals scheduled 08:30 A.M. was administered at 2:43 P.M. On 10/11/24 Lantus insulin 60 units scheduled at 9:00 A.M. was administered at 2:43 PM. On 10/12/24 Humalog insulin 14 units before meals scheduled at 11:30 was administered at 8:59 A.M. On 10/12/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 8:59 A.M. On 10/13/24 Humalog insulin 14 units before meals scheduled at 11:30 was administered at 9:30 A.M. On 10/13/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 9:30 A.M. On 10/13/24 Lantus insulin 60 units scheduled for 9:00 P.M. was administered at on 10/14/24 at 2:39 A.M. On 10/13/24 Humalog insulin per sliding scale (SS) before meals scheduled at 9:00 P.M. was administered at 10/14/24 at 2:40 A.M. On 10/14/24 Humalog insulin 14 units before meals scheduled at 11:30 was administered at 9:18 A.M. On 10/14/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 9:18 A.M. On 10/15/24 Humalog insulin per sliding scale (SS) before meals scheduled at 8:30 A.M. was administered at 11:50 A.M. On 10/15/24 Humalog insulin 14 units before meals scheduled at 8:30 A.M. was administered at 11:50 A.M. On 10/15/24 Lantus insulin 60 units scheduled at 9:00 A.M. was administered at 10:50 A.M. On 10/15/24 Lantus insulin 60 units scheduled for 9:00 P.M. was administered at 11:16 P.M. On 10/15/24 Humalog insulin per sliding scale (SS) before meals scheduled at 9:00 P.M. was administered at 11:16 P.M. On 10/16/24 Humalog insulin per sliding scale (SS) before meals scheduled at 8:30 A.M. was administered at 1:44 P.M. On 10/16/24 Humalog insulin 14 units before meals scheduled at 8:30 A.M. was administered at 1:44 P.M. On 10/16/24 Lantus insulin 60 units scheduled at 9:00 A.M. was administered at 1:44 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	On 10/16/24 Humalog insulin 14 units before meals scheduled at 11:30 A.M. was administered at 1:44 P.M. On 10/16/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 1:44 P.M. On 10/16/24 Humalog insulin per sliding scale (SS) before meals scheduled at 9:00 P.M. the medication administration time was not documented. On 10/16/24 Humalog insulin 14 units before meals scheduled 9:00 P.M. the medication administration time was not documented. On 10/17/24 Humalog insulin 14 units before meals scheduled at 11:30 A.M. was administered at 7:46 A.M. On 10/17/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 7:47 A.M. On 10/17/24 Humalog insulin per sliding scale (SS) before meals scheduled at 9:00 P.M. the medication administration time was not documented. On 10/17/24 Humalog insulin 14 units before meals scheduled 9:00 P.M. the medication administration time was not documented. On 10/18/24 Humalog insulin 14 units before meals scheduled at 11:30 was administered at 7:29 A.M. On 10/18/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 7:29 A.M. On 10/18/24 Humalog insulin per sliding scale (SS) before meals scheduled at 9:00 P.M. the medication administration time was not documented. On 10/18/24 Humalog insulin 14 units before meals scheduled 9:00 P.M. the medication administration time was not documented On 10/19/24 Humalog insulin 14 units before meals scheduled at 8:30 was administered at 12:14 P.M. On 10/19/24 Humalog insulin per sliding scale (SS) before meals scheduled at 8:30 A.M. was administered at 12:14 P.M. On 10/19/24 Lantus insulin 60 units scheduled at 9:00 A.M. was administered at 12:14 P.M On 10/19/24 Humalog insulin per sliding scale (SS) before meals scheduled at 9:00 P.M. the medication administration time was not documented. On 10/19/24 Humalog insulin 14 units before meals scheduled 9:00 P.M. the medication administration time was not documented (continued on next page)

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	105438	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Ridge Haven	4927 Voorhees Rd New Port Richey, FL 34653

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/20/24 Humalog insulin 14 units before meals scheduled at 8:30 A.M. was administered at 2:21 P.M. On 10/20/24 Humalog insulin per sliding scale (SS) before meals scheduled at 8:30 A.M. was administered at 2:21 P.M. On 10/20/24 Lantus insulin 60 units scheduled at 9:00 A.M. was administered at 2:21 P.M. On 10/20/24 Humalog insulin 14 units before meals scheduled at 11:30 was administered at 2:21 P.M. On 10/20/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 2:21 P.M. On 10/20/24 Humalog insulin 14 units before meals scheduled at 4:30 P.M. was administered at 2:21 P.M. On 10/20/24 Humalog insulin per sliding scale (SS) before meals scheduled at 4:30 P.M. was administered at 2:21 P.M. On 10/22/24 Humalog insulin 14 units before meals scheduled at 11:30 was administered at 7:25 A.M. On 10/22/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 7:25 A.M. On 10/22/24 Humalog insulin per sliding scale (SS) before meals scheduled at 9:00 P.M. was administered at 10:48 P.M. On 10/22/24 Lantus insulin 60 units scheduled at 9:00 P.M. was administered at 10:48 P.M. On 10/23/24 Humalog insulin 14 units before meals scheduled at 11:30 was administered at 8:19 A.M. On 10/23/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 8:19 A.M. On 10/24/24 Humalog insulin 14 units before meals scheduled at 11:30 was administered at 9:41 A.M. On 10/24/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 9:41 A.M. On 10/25/24 Humalog insulin 14 units before meals scheduled at 8:30 A. M. was administered at 3:12 P.M. On 10/25/24 Humalog insulin per sliding scale (SS) before meals scheduled at 8:30 A.M. was administered at 3:12 P.M. On 10/25/24 Lantus insulin 60 units scheduled at 9:00 A.M. was administered at 3:13 P.M. On 10/25/24 Trulicity .75 mg scheduled at 9:00 A.M. was administered at 3:15 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	On 10/25/24 Humalog insulin 14 units before meals scheduled at 11:30 was administered at 3:14 P.M. On 10/25/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 3:14 P.M. On 10/26/24 Humalog insulin 14 units before meals scheduled for 8:30 A.M. was administered at 7:18 A.M. On 10/26/24 Humalog insulin per sliding scale (SS) before meals scheduled at 8:30 A.M. was administered at 7:18 A.M. On 10/27/24 Humalog insulin per sliding scale (SS) before meals scheduled at 9:00 P.M. was administered at 10:58 P.M. On 10/27/24 Lantus insulin 60 units scheduled at 9:00 P.M. was administered at 10:57 P.M. On 10/29/24 Humalog insulin per sliding scale (SS) before meals scheduled at 4:30 P.M. was administered at 5:45 P.M. On 10/29/24 Humalog insulin 14 units before meals scheduled at 4:30 P.M. was administered at 5:45 P.M. On 10/31/24 Humalog insulin 14 units before meals scheduled at 11:30 was administered at 12:43 P.M. On 10/31/24 Humalog insulin per sliding scale (SS) before meals scheduled at 11:30 A.M. was administered at 12:44 P.M. 6. Review of Resident #10 admission record showed 6/14/2015 was the initial admitted . Resident #10's diagnoses include Type 2 diabetes mellitus with hyperglycemia (high blood sugar levels), type 2 diabetes mellitus with hypoglycemia (low blood sugar levels), and diabetic polyneuropathy (nerve disease). Review of Resident #10's order summary report for active orders as of 11/5/24, and October 2024 Medication Administration report, showed the following orders, controlled carbohydrate diet, hypoglycemia protocol: continue to check blood glucose every 15 minutes until blood sugar is over 70 mg/dl, Basaglar Kwik Pen 30 units daily for DM, Basaglar Kwik Pen 10 units daily at bedtime for DM, Trulicity 3 mg every seven days for diabetes, and Metformin 500 mg twice daily for diabetes. Review of Resident #10's medication administration report, schedule date 10/1/24 to 10/31/24 showed the following: On 10/1/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 12:27 P.M. On 10/2/24 Basaglar 30 units scheduled at 9:00 A.M. and was administered at 12:53 P.M. On 10/2/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 12:38 P.M. On 10/2/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 12:38 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	On 10/3/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 12:38 P.M On 10/3/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 12:50 P.M. On 10/4/24 Metformin 500 mg scheduled for 9:00 A.M. administered at 12:44 P.M. On 10/4/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 12:51 P.M On 10/5/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 12:18 P.M On 10/5/24 Trulicity 3 mg scheduled at 9:00 A.M. and was administered at 12:19 P.M. On 10/6/24 at 9:00 A.M. Resident #10's blood sugar (BS) was 48 mg/dl, unable to find documentation the hypoglycemia protocol was initiated. On 10/6/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 11:19 A.M. On 10/7/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 1:44 P.M. On 10/7/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 1:58 P.M. On 10/9/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 1:09 P.M. On 10/9/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 1:09 P.M. On 10/12/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 1:28 P.M. On 10/17/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 10:32 A.M. On 10/17/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 10:32 A.M. On 10/22/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 10:28 A.M. On 10/22/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 10:30 A.M. On 10/25/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 12:12 P.M. On 10/26/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 12:54 P.M. On 10/26/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 1:05 P.M. On 10/28/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 11:06 A.M. On 10/28/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 11:06 A.M. On 10/29/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 11:13 A.M. On 10/29/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 2:13 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	On 10/30/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 12:14 A.M. On 10/30/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 12:13 P.M. On 10/31/24 Metformin 500 mg scheduled for 9:00 A.M. was administered at 12:34 P.M. On 10/31/24 Basaglar 30 units scheduled at 9:00 A.M. was administered at 2:37 P.M. On 11/5/24 at 4:32 P.M. during record review and interview, the Director of Nursing (DON) was shown an entry in Resident #10's medication administration audit report for Metformin 500 mg scheduled for 9:00 A.M. The DON said her expectations was for medications to be given on time Review of the facility's policy titled, administering medications revised, April 2019, showed the information below. Policy Statement: medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: . 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: 5a. enhancing optimal therapeutic effect of the medication; . 7. Medications are administered within (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record (MAR) space provided for that drug and dose 50732

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999 Based on observations, record reviews, and interviews the facility failed to ensure one (#7) out of two residents received Dialysis as scheduled per physician orders, failed to arrange transportation to an alternate site during a period of evacuation, failed to notify the Healthcare Proxy and physician of missed Dialysis treatments, failed to coordinate treatments with the Dialysis center resulting in a wellness check by law enforcement. Findings included: Review of the Admission Record revealed Resident #7 was originally admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to End Stage Renal Disease (ESRD) and dependence on renal dialysis. Review of the Skilled Nursing Facility/Nursing Facility (SNF/NF) Transfer form, dated 10/26/24, showed Resident #7 had been transferred to an acute care facility on that date at 00:01 a.m. The form showed the resident was alert and disoriented but could follow simple instructions. Review of progress notes for Resident #7 showed on 10/26/24 at 10:56 a.m., Staff E, Registered Nurse (RN) reported contacting the transport (company) to follow up (f/u) on this resident's transport to Dialysis. Transport was set up for 10/31/24 - 1/31/25, at this time transport was set up for 10/29/24 pick up (p/u) is between 9:40 a.m. and 10:10 a.m., confirmation number 2521250. Asked if they could be her (here) this am (a.m.) for transport, and they stated it would be 3 to 4 hours before they could get here. Her Dialysis chair time is at 10:30 am. Contacted (transport vendor) to transport (Resident #7) to the emergency room (ER), estimated time of arrival (ETA) is approximately 30 minutes. A note 10/26/24 at 11:05 a.m. showed Staff E had encouraged the resident to drink water. The note written by Staff E on 10/26/24 at 11:08 a.m. showed the transport vendor arrived at 11:10 a.m. to transport the resident to an acute care facility for dialysis with no complaints of pain or discomfort. The note written by Staff E on 10/26/24 at 4:27 p.m. showed the acute care facility did not provide outpatient dialysis and resident was admitted for dialysis. Review of the Advanced Practitioner Registered Nurse (APRN) note dated 10/27/24 at 6:36 p.m. revealed Resident #7 was seen on 10/26/24 for follow up dialysis. The APRN documented the resident is seen today for missing her dialysis appointment and had informed the resident of being transferred to hospital for treatment. The note revealed the resident was dependent on dialysis for ESRD, was resting in bed and denied complaints of pain or distress. The assessment/plan revealed the resident's ESRD was unstable and the plan was for hemodialysis as per schedule. Review of Resident #7's care plan showed the following: - had the potential for complications related to dialysis diagnosis End Stage Renal Disease (ESRD) renal failure. On occasion (the resident) will choose not to attend regularly scheduled dialysis appointments. Dialysis: May go to dialysis on Tuesday, Thursday, and Saturdays, chair time 11:30 a.m., pick up time 10:30. The interventions included instructions for staff to make transportation arrangements for dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- (Resident) has an advance directive; Health Proxy naming son as decision maker on file in center. Lack of capacity documentation on file. The interventions instructed staff to Discuss life-prolonging procedures with the appointed health care representative as (resident) has been determined to be incapacitated. Review of the facilities timeline for Resident #7's Dialysis during the period the facility had to evacuate for a storm and the return to the property showed the following: - 10/8 evacuation - Dialysis (vendor) New Port [NAME] (NPR) - 10/10 Dialysis closed - missed - 10/12 to ER for Dialysis - 10/15 Dialysis center Brooksville - 10/17 Dialysis center Brooksville - 10/19 Dialysis center Brooksville - 10/22 Dialysis center Brooksville - planned to repopulate - 10/24 Missed Dialysis - 10/25 Repopulated - unable to set up transport - needs 3 business days. - 10/26 to ER for Dialysis An interview was conducted with a Registered Nurse of the Dialysis Center in Brooksville where Resident #7 had been evacuated to, the RN stated the center had reopened in the afternoon of 10/10/24 and was unable to say whether there had been issues with transportation on that day. The RN was unable to answer any further questions for this writer and asked if the centers administrator could call, as of 11/8/24 no return call has been received. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an acute care facility notes regarding Resident #7 showed on 10/12/24 at 7:05 p.m. the resident presented with need of dialysis treatment. The history of present illness revealed a female with history of dementia presents to the ED via Emergency Medical Services (EMS) with complaints of the patient being in need of dialysis. EMS states that the patients living facility called them due to the patient not being able to receive dialysis treatment from the hurricane. An echocardiogram, on 10/12/24 at 7:17 p.m. revealed normal sinus rhythm and no chest pain. An chest Xray, 10/12/24 at 7:59 p.m. was completed for chest pain. The Impression and Plan related to the visit on 10/12/24 revealed a sacral decubitus ulcer, dialysis patient, and a urinary tract infection (UTI) and the disposition of the patient was to the Observation Telemetry Unit. The nephrology consult note dated 10/13/24 at 4:32 p.m. showed the resident had 'a history of ESRD, on hemodialysis Tuesday, Thursday, (and) Saturday was admitted to the hospital secondary not being able get dialysis. The nephrology assessment/plan included will schedule for hemodialysis in a.m. The discharge summary dated 10/14/24 at 10:39 a.m. showed Resident #7 had no distress, no new complaints, and Dialysis today. The facility provided the hospital's notes which showed they had been sent to this facility on 11/5/24 at 3:55 p.m., 22 days after the resident had been discharged from the hospital following dialysis treatments. Review of Resident #7's progress notes and Medication Administration Record (MAR) did not reveal information the resident had been admitted to an acute care facility on 10/12 and had not returned to the evacuation facility until 10/14/24. A note dated 10/12/24 at 1:57 p.m. showed an attempt was made to contact the resident's healthcare proxy to notify that the facility was keeping track of the day to day status of our ability to return. The review showed no progress note dated 10/12- 10/14/24 showing the resident's healthcare proxy had been notified of the resident's transfer to an acute care facility. An interview was conducted on 11/5/24 at 9:55 a.m. with the Executive Director (ED). The ED reported the facility was still in it's investigation phase of the allegation related to Resident #7's Dialysis care. The ED reported interviewing the nurse (Staff F) who had cared for the resident on Thursday 10/24/24 (the day Resident #7 had missed Dialysis) and Staff F (Licensed Practical Nurse, LPN) statement said on 10/24/24 Staff F asked Staff G (Staffing Coordinator) if the staff member could verify the chair time for Resident #7's dialysis and transportation. Staff F reported Staff G's response was transportation was not happening. Staff F reported to the ED of not documenting Resident #7 had missed dialysis. The DON entered the interview, providing the Treatment reports from the Dialysis center where the resident had received dialysis during the evacuation, and stated she had arranged chair times with the Dialysis Center in the city of evacuation to happen at 10:30 on Tuesday, Thursday, and Saturday and the resident had missed Dialysis on 10/10 due to the hurricane so she told staff to transport to the hospital on 10/12. The DON stated the resident had gone to the Dialysis center on 10/15, 10/17, 10/19, and 10/22/24. She stated she had received a telephone call from her staff members at 6 a.m. while in Vegas (regarding the resident's transport). The DON stated she had attempted to set up transport for 10/26 but was told transport needed 3 business day notice and had called another transport company who could transport after a 3-4 hour wait so the patient was sent to the emergency room for Dialysis on 10/26/24. The ED reported Staff G had reported an attempt was made with the staff member at the sister facility to find out why transport was not there on 10/24/24 to transport the resident to Dialysis and was unable to secure transport and had informed Staff F so other alternatives could have been implemented. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Dialysis Centers Treatment Detail Reports showed Resident #7 had received Dialysis services on 10/17, 10/19, and 10/22/24. The reports did not include documentation the resident had received Dialysis on 10/15 per the documented facility timeline and as the DON had reported. The treatment reports showed they had been sent on 11/5/24 at 10:42 a.m., 14 days after the resident had received the last dialysis session at the Brooksville location. Review of the hospital's documentation for the Resident's admission on 10/26/24, revealed, .history of end-stage renal disease on dialysis Tuesday, Thursday, (and) Saturday. (Resident) is here due to missed dialysis. (Resident) has no complaints however reports that (pronoun) last dialysis was Tuesday, (pronoun) missed Thursday because (pronoun) dialysis center was evacuated, and when (pronoun) came for dialysis today, was told that the center schedule is too busy and subsequently brought here by EMS. Labs were reviewed. (Resident) potassium is within normal limits, no evident of critical fluid overload. Regardless, (pronoun) does require dialysis due to (pronoun) scheduling difficulties and significant delay. Discussed with nephrology. Will be admitted for dialysis and further management. Will need case management consult as may need a new dialysis center. An interview was conducted on 11/1/24 at 3:16 p.m. with the originating Dialysis Centers administrator. The staff member stated Resident #7 was to receive Dialysis on Tuesday, Thursday, and Saturdays. The center had attempted to contact the facility on 10/11/24 for a safety check as the resident had missed a treatment on 10/10. The administrator reported receiving a call on 10/14 from the Brooksville hospital for orders to dialyze Resident #7 and on 10/15/24 the center was told by the hospital the resident was no longer there. The administrator contacted the Director of Nursing (DON) on 10/15 and was told they didn't have any plans to set up Dialysis and if the resident didn't feel good they would transport to the hospital for treatment. The Dialysis administrator reported setting up treatment at the local Dialysis center for 10/17, 10/19, and 10/22 which the DON was notified of. After Resident #7 missed the treatment on 10/24, the administrator attempted to contact the facility DON and was informed she was on vacation and the facility had not returned to the New Port [NAME] facility. The center requested a wellness check on 10/25/24 from law enforcement for Resident #7. The Dialysis center administrator reported there had been a lack of communication between the facility and Dialysis center. An interview was conducted on 11/5/24 at 9:32 a.m. with Resident #7's family member and healthcare proxy (HCP). The family member reported not being informed of the resident's missed Dialysis appointments and the nurse at the hospital had informed them the resident had missed 2 appointments. The family member stated on 10/27/24, day after the resident was transferred to the acute care facility, the resident would not talk to them and was not eating or drinking. The HCP reported the resident still was not eating, was drinking very little, and the nurses were giving the resident liquid Morphine for pain. An interview was conducted with the DON and ED on 11/5/24 at 4:29 p.m., the DON stated Resident #7 had received treatment on 10/15/24 from the Dialysis Center in Brooksville. The DON stated she had set up dialysis treatment for Resident #7 at the dialysis center in Brooksville for 10/15, 10/17, 10/19, and 10/22/24 with a chair time of 10:30 a.m. She reported she did not know what the dialysis center had sent to the facility (the morning of 11/5) as she had given the reports to this writer as soon as they had been received. The DON reiterated Resident #7 would have gone to the dialysis center on 10/15, 10/17, 10/19, and 10/22/24. The ED stated the facility did not know why transport did not show up for Resident #7 on 10/25 and the nurse (Staff F) had not followed up. The ED reported law enforcement was in the facility for Resident #7(wellness check) on Friday (10/25/24). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility contracts with Dialysis centers (3) revealed the contracts were entered into with previous facility owners and did not include a contract with the current owners. Also the contracts did not include the Dialysis center in which Resident #7 was currently scheduled to receive treatments. Review of the policy - Coordination of Hemodialysis Services, revised 7/2/2019, revealed residents requiring an outside ESRD facility will have services coordinated by the facility. There will be communication between the facility and the ESRD facility regarding the resident. The facility will establish a dialysis the agreement/ arrangement if there are any residents requiring dialysis services. The agreement shall include how the residents care is to be managed. The procedure revealed the facility should initiated pre- Dialysis communication forms to be sent to the Center, the Center should complete the communication form or provide the treatment information to the facility and upon the resident's return to the facility, nursing was to review the communication form, complete the post-dialysis information on the Dialysis communication form and file the completed form in the resident's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105438	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at Ridge Haven	4927 Voorhees Rd New Port Richey, FL 34653

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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 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** 37999 Based on record review and interview, the facility failed to ensure the accounting of narcotic medications were accurately documented for one (#7) of two residents. Findings included: Review of the Admission Record, dated 11/5/24, showed Resident #7 was originally admitted on [DATE], readmitted on [DATE], and discharged to an acute care facility on 10/26/24. The record included diagnoses not limited to chronic pain syndrome and unspecified gout. Review of the October Medication Administration Record (MAR) revealed Resident #7's physician order for oxyCODONE-Acetaminophen Oral Tablet 5-325 milligram (mg) (Oxycodone w/ Acetaminophen) - Give 1 tablet by mouth every 6 hours as needed for pain. The start date for this order was 8/11/24. The MAR revealed the resident received Oxycodone-Acetaminophen on 10/3, 10/7, 3 times on 10/9 (12:39 a.m., 8:16 a.m., and 2:14 p.m.), 10/10, 10/15, 10/19, 10/22, 10/23, and twice on 10/25 (5:48 a.m. and 9:13 p.m.). The MAR showed the resident had received a total of 12 doses during the month of October. Review of one of two Medication Monitoring/Control Records for Resident #7's oxyCODONE/Acetaminophen 5-325 mg tablets revealed 30 tablets of the medication had been received on 8/20/24. The descending count of tablets showed 2 tablets were administered during September, leaving a total of 28 tablets available for administration. The second Control Record showed 26 tablets had been received on 10/7/24. The record instructed for the name of the receiving Licensed Nurse to be printed, the name written appeared to be a S with a humped squiggle, the name was illegible. The records revealed the following was removed from the available tablets of the residents scheduled II narcotic medication during the month of October: 10/3, 10/7, 10/8/24 at an illegible time, twice on 10/9/24 at 8:17 a.m. and 2:14 p.m., three times on 10/10/24 at 7:40 a.m., 2:30 p.m., and one illegible time, 10/11/24 at an illegible time, 10/14/24 at 10:50 p.m., 10/15/24 at 12 noon, twice on 10/16/24, 10/19/24 at an illegible time, 10/22/24 at an illegible time, 10/23/24, 10/24/24, 10/25/24 at 9:15 p.m. The Control Records revealed Resident #7 had received 18 doses and 2 tablets had been wasted. Review of the MAR and Control Records for Resident #7 showed the following discrepancies: - Control record documentation of administration on 10/8/24 at an illegible time was not recorded on MAR. - Control record documentation of administration on 10/9/24 at 12:39 a.m. was not recorded on MAR. - Control record documentation of administration on 10/10/24 at 7:40 a.m. was not recorded on MAR. - Control record documentation of administration on 10/10/24 at an illegible time was not recorded on MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Control record documentation showed on 10/10/24 at an illegible time was wasted. The Record did not show in the Record of Waste and Spoilage that the medication had been wasted by 2 staff members as shown. - Control record documentation of administration on 10/11/24 at an illegible time was not recorded on MAR. - Control record documentation of administration on 10/14/24 at 10:50 p.m. was not recorded on MAR. - Control record documentation of administrations on 10/16/24 at 3 p.m. and 9:32 p.m. were recorded on MAR. Review of Policy - Preparation and General Guidelines IIA7: Controlled Substances, dated August 2019, revealed Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal state laws and regulations. The procedure included the following: A. The Director of Nursing and the consultant pharmacist in collaboration maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to the controlled medications. E. Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substances administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration (MAR, Accountability Record). 2) Amount administered (Accountability Record). 3) Remaining quantity (Accountability Record). 4) Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record). An interview was conducted with Staff A, Licensed Practical Nurse (LPN) on 11/5/24 at 9:19 a.m. The staff member reported the process of administering narcotic medications was to sign off the narcotic on the computer and sign off the narcotic sheet. An interview was conducted with Staff B, Licensed Practical Nurse (LPN) on 11/5/24 at 9:23 a.m. The staff member reported the process for administering narcotic medications was after popping the medication out (of blister card), sign it out on the narcotic record and in the computer. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/5/24 at 4:29 p.m. with the Director of Nursing (DON) and the Executive Director (ED), the DON reviewed Resident #7's Control Records for Oxycodone/Acetaminophen tablets and confirmed nurses were to sign out on both the MAR and the record. She confirmed not knowing who had signed the record in area of S with a squiggle as it was illegible, stating she would have to check the schedule. The DON stated the expectation would be for the document to legible.