STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105700	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northdale Rehabilitation Center	3030 Bearss Ave Tampa, FL 33618

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50732 Based on observation, interview, and record review, the facility failed to reasonably accommodate the needs of one (Resident #45) of 21 residents related to not placing the call light within the resident's reach. Findings included: On 05/19/2024 at 1:00 p.m., the call light was observed on the floor, behind the headboard of Resident #45's bed. (Photographic Evidence Obtained.) On 5/20/2024 4:46 p.m., the call light was observed on the floor, behind the headboard of Resident #45's bed. The call light had not been moved from the previous day. (Photographic Evidence Obtained.) On 5/21/2024 11:57 a.m. the call light was observed on the floor, behind the headboard of Resident #45's bed. The call light had not been moved from the previous day. (Photographic Evidence Obtained.) Review of Resident #45's Admission Record revealed she was admitted to the facility on [DATE] from an acute care hospital. Her medical diagnoses included but were not limited to repeated falls. Review of Resident #45's Minimum Data Set (MDS), dated [DATE], Section C - Cognitive Patterns revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. A review of Resident #45's active care plan included the following: -Focus effective 4/16/2024 of Risk for Falls AEB (as evidenced by) gait/balance problems, history of falls, generalized weakness. Interventions include Assistive devices as needed (walker). Bed in low position. Call light and frequently needed items in reach. Cue for safety awareness. On 5/21/2024 at 3:15 p.m., an interview was conducted with Staff A, Licensed Practical Nurse (LPN). She confirmed the expectation was that all call lights should always be accessible and within reach of the resident. Staff A also confirmed the expectation of the staff was to make sure the call light was within reach of the resident before exiting the resident's room. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/2024 at 3:40 p.m., an interview was conducted with Staff B, Certified Nursing Assistant (CNA). She confirmed the expectation was that call lights should be within reach of the resident. Staff B stated, If the call light is on the floor, pick it up and put it within reach of the resident. On 5/21/2024 at 4:15 p.m., an interview was conducted with Staff C, Registered Nurse (RN)/Unit Manager (UM). She confirmed the expectation was that all call lights should be within reach of the resident. Staff C also confirmed that if the call light was not within reach of the resident, the call light should be readjusted for the resident. Staff C stated the facility had Staff Angels that were assigned resident rooms to check daily to make sure the residents had no concerns, and the call lights were within reach of the resident. Staff C was shown the pictures taken of the call light in Resident #45's room. Staff C said, Well, the resident sometimes readjusts the light. She does leave the room sometimes and walks around with her walker. I've seen her talking to the DON (Director of Nursing) in her office before. On 5/21/2024 at 1:25 p.m., the DON confirmed the expectation was that call lights should be within reach of the resident. On 5/22/2024 at 11:10 a.m., the DON stated the facility did not have a call light policy.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43453 Based on observation, interview, and facility policy review, the facility failed to ensure Air Conditioning (A/C) filters were maintained in a safe and sanitary manner in seven (69, 70, 132, 133, 135,136 and 157) of 26 resident rooms during three of three days of survey. Findings included: During multiple facility tours on 05/19/21, 05/20/21 and 05/21/24 observations were made of A/C filters with dirt and blanketed debris in rooms 69, 70, 132, 133, 135,136 and 157. (Photographic evidence was obtained). On 05/22/24 at 9:32 a.m., an interview was conducted with the Director of Maintenance (DOM) and the Nursing Home Administrator (NHA). The NHA stated they did not have a policy on A/C maintenance but would contact their corporate to obtain a copy. The DOM stated the A/C filters were last cleaned on 02/23/24. He stated they had a checklist they followed to make sure they covered all the rooms. He stated their policy was to clean the filters and change them quarterly. He stated he had just looked at some of the rooms. He said, I looked at the A/C filters. Some of them were very bad and some were not as bad. We will start cleaning today. Review of the August 2023 facility policy titled HVAC [Heating, Ventilation and Air Conditioning] Systems Inspection and Maintenance] showed the center's HVAC systems are inspected and maintained periodically to ensure proper functioning. Review of the procedure showed: Filters: (1.) Clean/replace air conditioner filters as needed. All filters may not need to be replaced or cleaned every week, but all filters must be changed in a 4-week period (monthly). Equipment Inspection: (4.) Change all filters, . Seasonal Maintenance: (5.) Filters must be cleaned or changed on a regular basis. Determine if filters should be changed more frequently.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on record review, staff interview, and review of the facility's policy, the facility failed to complete the Preadmission Screening and Resident Reviews (PASRR) for residents with a mental disorder and individuals with intellectual disability following a qualifying mental health diagnosis for 10 (Residents #17, #36, #60, #84, #88, #10, #8, #58, #73, and #87) out of 21 residents sampled for PASRRs. Findings included: Review of Resident #17's admission record showed the resident was admitted to the facility on [DATE]. The admission record showed diagnoses to include Bipolar disorder and anxiety disorder. Review of a level I PASRR for Resident #17 dated 01/27/24 showed a blank PASRR and the qualifying diagnoses were not checked. Review of Resident #36's admission record showed the resident was admitted to the facility on [DATE]. The admission record showed diagnoses to include Major depressive disorder and anxiety disorder. Review of a level I PASRR for Resident #36 dated 11/09/23 showed a blank PASARR and the qualifying diagnoses were not checked. Review of Resident #60's admission record showed the resident was admitted to the facility on [DATE]. The admission record showed diagnoses to include Major depressive disorder, generalized anxiety disorder, and epilepsy. Review of a level I PASRR for Resident #60 dated 04/19/23 showed a blank PASRR and the qualifying diagnoses were not checked. Review of Resident #84's admission record showed the resident was admitted to the facility on [DATE]. The admission record showed diagnoses to include unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and Alzheimer's disease. Review of a level I PASRR for Resident #84 dated 07/20/23 showed a blank PASRR and the qualifying diagnoses were not checked. The review further showed a level II PASRR was not considered. Review of Resident #88's admission record showed the resident was admitted to the facility on [DATE]. The admission record showed diagnoses to include Major depressive disorder and other specified anxiety disorders. Review of a level I PASRR for Resident #88 dated 09/12/23 showed a blank PASRR and the qualifying diagnoses were not checked. On 05/20/24 at 3:18 p.m., an interview was conducted with the Regional Nurse Consultant (RNC). She stated the PASRRs should be updated if there were new diagnosis or if they were not correctly documented upon admission. She stated if they required a review for a level II PASARR, it should be submitted. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing (DON) on 05/20/24 at 3:25 p.m. The DON reviewed the requested level I PASRRs and stated there were concerns related to the diagnoses not checked. She said, They should have been checked. Our process is to make sure before the resident comes to the facility, we read their history and make sure they have a current PASRR. We have psych or their provider evaluate the resident and update the PASRR with current diagnoses. The DON stated they reviewed PASRRs in their morning meetings. She stated they should have been updated accordingly. The RNC stated on 05/20/24 at 03:20 p.m. the facility did not have a PASRR policy. 48823 Review of the Admission Record dated 10/15/2019 for Resident #58 showed the resident was admitted on [DATE] with original admission on 10/15/2019. The record included the resident diagnoses of dementia (11/1/2023), anxiety (10/22/2019), major depressive disorder (10/22/2019), persistent mood affective disorder (11/21/2023), hallucinations (11/07/2023), cognitive communication deficit (11/05/2019). Review of Resident #58's Pre-Admission Screening and Resident Review (PASRR) , dated 9/18/2023 showed: a. Under Section I B - Finding is based on (check all that apply) only documented history was checked. Review of medical record/Minimum Data Set (MDS) for Resident #58 dated 04/29/2024 revealed. Section A - admitted [DATE], assessment date 04/29/2024. Section C - cognitive patterns revealed a Brief Interview for Mental Status (BIMS) 02 which revealed resident is cognitively impaired. Section I - active diagnoses under neurological revealed non-Alzheimer's dementia, under psychiatric/mood disorder revealed depression, and under other revealed persistent mood affective disorder Review of plan of care focuses for Resident #58 dated 5/22/2024 revealed. Has impaired cognitive function related to dementia (11/1/2023) Uses psychotropic medication therapy related to depression, dementia, and anxiety (11/3/2023) Is at risk for decreased nutritional status related to dementia (11/1/2023) Is at risk for activity of daily living self-care deficit related to dementia (11/1/2023) Review of psych health progress note for Resident #58 dated 4/16/2024 revealed. Reason for visit is re-evaluation of an established patient. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	History of present illness includes but is not limited to - past psych history major depressive disorder (MDD), anxiety disorder, and dementia. The residents' record showed an incomplete level I PASRR Review of the Admission Record dated 5/2/2024 for Resident #73 showed the resident was admitted on [DATE] with initial admission on 11/22/2023. The record included the resident diagnoses of anxiety (date 11/22/2023), and vascular dementia (date 11/22/2023). Review of Resident #73 Pre-Admission Screening and Resident Review (PASRR) , dated 7/18/2023 showed: a. Under Section I B - Finding is based on (check all that apply) documented history and individual, legal representative or family report was checked. b. Under Section II question 5 -related neurocognitive disorder (including Alzheimer's disease? - yes was checked. c. Under Section II question 7 - yes was checked for comprehensive mental status exam and medical/functional history prior to onset accompanying the level I PASRR (no information provided with PASRR). Review of medical record/Minimum Data Set (MDS) for Resident #73 dated 05/05/2024 revealed. Section A - admitted [DATE], assessment date 5/5/2024. Section C - cognitive patterns revealed a Brief Interview for Mental Status (BIMS) 00 which showed resident was cognitively impaired. Section I - active diagnoses under neurological revealed non-Alzheimer's dementia, under psychiatric/mood disorder showed anxiety. Review of plan of care focuses for Resident #73 dated 5/22/2024 showed. Uses psychotropic medication therapy related to insomnia (12/26/2023) At risk for mood problem related to insomnia (5/7/2024) At risk for decreased nutritional status related to dementia (11/22/2023) Resident has impaired cognitive function related to dementia (11/22/2023) Review of psych health progress note for Resident #73 dated 2/27/2024 showed: Reason for visiting psychotropic medication interdisciplinary review. History of present illness includes but is not limited to - past psych history includes dementia and anxiety. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The residents' record showed an incomplete level I PASRR Review of the Admission Record dated 10/13/2023 for Resident #87 showed the resident was admitted on [DATE] with initial admission on 9/2/2023. The record included the resident diagnoses of dementia (primary diagnosis date 10/13/2023), mood disorder (date 10/16/2023), major depressive disorder (date 10/16/2023), and anxiety (date 10/13/2023). Review of Resident #87 Pre-Admission Screening and Resident Review (PASRR) , dated 8/28/2023 showed: Section 1 A - anxiety disorder and depressive disorder were checked Section I B - Finding is based on (check all that apply) documented history was checked (no documentation was attached). Section II question 5 - dementia was checked no. Section II question 7 - does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)/ no was checked Review of medical record/Minimum Data Set (MDS) for Resident #87 dated 03/04/2024 showed: Section A - admitted [DATE], assessment date 03/04/2024. Section C - cognitive patterns showed a Brief Interview for Mental Status (BIMS) 09 which indicated resident was moderately impaired. Section I - active diagnoses under neurological revealed non-Alzheimer's dementia, under psychiatric/mood disorder revealed anxiety and depression, and other mood disorders due to known physiological condition. Review of plan of care focuses for Resident #87 dated 5/22/2024 showed: Resident has impaired cognitive function related to dementia (9/8/2023) Uses psychotropic medication therapy related to major depressive disorder (10/17/2023) At risk for mood problem related to insomnia (5/7/2024) At risk for decreased nutritional status related to dementia (11/22/2023) Review of psych health progress note for Resident #87 dated 4/16/2024 revealed. Reason for visiting re-evaluation of an established patient. History of present illness includes but is not limited to - dementia and anxiety. Currently on Seroquel, does no have a diagnosis will decrease at bedtime and then discontinue. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assessment today revealed resident has advanced dementia. The residents' record showed an incomplete level I PASRR 50732 Review of Resident #10's admission record showed she was admitted to the facility on [DATE] with diagnoses to include major depressive disorder. Review of Level I Preadmission Screening and Resident Review (PASRR) for Resident #10 dated 08/03/2022 revealed an incomplete PASRR with the qualifying diagnosis not checked. Review of Resident #8's admission record showed she was admitted to the facility on [DATE] with diagnoses to include major depressive disorder and anxiety disorder. Review of Level I PASRR for Resident #8 dated 04/18/2018 revealed an incomplete PASRR with the qualifying diagnoses not checked.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768 Based on observation, interview, and record review, the facility failed to ensure the Comprehensive Resident Centered Care Plan was updated related to falls for one (Resident #58) of four sampled residents. Findings included: During an observation on 05/21/2024 at 1:15 p.m., Resident #58 was sitting at bedside in the wheelchair. She was dressed and groomed for the day. White, open back sliders were on her feet. A pair of tennis / enclosed shoes were next to the wall. She had fluids at the bedside. A scoop mattress was in place. The bed was in the lower position. The call light was within reach. Review of the care plans showed Resident #58 was at risk for falls as evidenced by history of repeat falls due to confusion, gait/balance problems, and generalized weakness and was initiated on 11/01/2023. Interventions included to offer / assist to watch TV in the dining room before dinner as of 05/13/2024 and anti-tippers to wheelchair as of 05/19/2024. Resident #58 was admitted on [DATE]. Review of the Admission Record showed diagnoses included but not limited to dementia, repeated falls, weakness, abnormalities of gait and mobility, right foot drop and congestive heart failure. Review of the quarterly Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of 02 or severely impaired. Section GG showed she required partial to moderate assist for toileting and maximum assist for sit to stand. Review of progress notes showed a Situation, Background, Assessment, and Recommendation (SBAR) dated 05/10/2024 at 21:34 (9:34 p.m.) showed Falls. Review of the Post-Fall Review dated 05/14/2024 (4 days post fall) showed on 05/10/24 at 17:15 (5:15 p.m.), the resident was observed sitting on her buttocks next to her wheelchair. She stated she fell out of her wheelchair on to her buttocks, while she was trying to reach her TV remote. Resident denied any pain. Interdisciplinary Team (IDT) reviewed incident; resident usually ate in dinner in the dining room. Updated the care plan to offer/assist to watch TV in the dining room before dinner. During an interview on 05/21/2024 at 1:51 p.m., the Director of Nursing (DON) stated she was unable to locate documentation in the progress notes regarding the fall on 05/10/2024 (the date of the fall). The DON verified the documentation regarding the fall was only in the Post-Fall Review with the IDT on 05/14/2024 (four days post fall). She verified an intervention was not into place, per the care plan review, until 05/13/2024 (3 days post fall). The DON stated the interventions were to be put into place at the time of the fall. The IDT reviewed the fall and the care plan at the time of the meeting. The Therapy Director (TD) stated the resident was already on case load during the incident. The Occupational Therapist working with her educated her on using a reacher for reaching. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy, Comprehensive Person-Centered Care Plans, revised 8/2023 showed the center will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Fundamental Information: The comprehensive care plan will describe the following: 1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required are provided to the resident to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. A comprehensive care plan will be: iii. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments and as changes in the resident's care and treatment occur. The Comprehensive plan of care will should include the following: reflect interventions to meet both short and long term resident goals; include interventions to prevent avoidable decline in function or functional level; include interventions to attempt to manage risk factors; be periodically reviewed and revised by the interdisciplinary team as changes in the resident's care and treatment occur. Procedure: 13. Re-evaluate and modify care plans: as needed to reflect changes in care, service and treatment; with significant change in status assessment. 14. Care plan evaluation will occur in response to changes in the resident's physical, emotional, functional, psychosocial, or communicative status as they occur.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43453 Based on observation, interview, and record review, the facility did not ensure proper medication storage for six (Residents #57, #60, #97, #88, #8 and #10) out of 21 residents sampled for three of three days. Findings included: During a facility tour on 05/19/24 at 11:48 a.m., Resident #57 was observed with a bottle of a medication labeled (Mucus relief) at bedside. The resident did not answer when asked how often he took the medication. Review of an admission record for Resident #57 showed he was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) dated [DATE] showed the resident had a BIMS (Brief Interview for Mental Status) score of 12, which indicated his cognition was moderately impaired. Review of physician orders for Resident #57 dated 05/22/24 revealed the resident did not have self-administration orders. The orders showed the resident was not prescribed this medication. Review of a care plan dated 10/28/23 revealed Resident #57 did not have a focus to keep medications at bedside or to self-administer. During tours conducted in Resident #97's room on 05/19/24 at 12:48 p.m., 05/20/24 at 4:58 PM and 05/21/24 at 11:25 a.m., observations were made of [brand name] eye drops on top of his nightstand. Resident #97 stated he had been using the eye drops multiple times a day due to itchy eyes. Review of an admission record for Resident #97 showed he was admitted to the facility on [DATE]. An MDS dated [DATE] showed the resident had a BIMS of 13, which indicated his cognition was moderately impaired. Review of physician orders for Resident #97 on 05/21/24 at 11:30 a.m., showed the resident did not have self-administration orders. Review of physician orders dated 05/22/24 showed an order for eye drops was initiated on 05/21/24. Review of a care plan dated 03/14/24 revealed Resident #57 did not have a focus to keep medications at bedside or to self-administer. On 05/19/24 at 11:4., Resident #88 was observed in his room with a bottle of Multi Vitamin tablets on his bedside table. The resident stated he had been taking these vitamins daily for months. Review of an admission record for Resident #88 showed he was readmitted to the facility on [DATE]. An MDS dated [DATE] showed the resident had a BIMS score of 15, meaning he was cognitively intact. Review of Physician orders for Resident #88 on 05/19/24 at 12:45 p.m., revealed the resident did not have self-administration orders. Review of physician orders dated 05/22/24 showed an order was initiated on 05/21/24 to self-administer the medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a care plan initiated 09/12/23 showed the resident did not have a focus to keep medications at bedside or to self-administer. On 05/21/24 at 12:04 p.m., an observation was made of [brand name] eye drops at Resident #60's bedside table stored in a clear plastic bag. She stated she used the eyedrops almost daily for itchy eyes. She stated sometimes the staff helped her with her eye drops. Review of an admission record for Resident #60 showed she was readmitted to the facility on [DATE]. An MDS dated [DATE] showed the resident had a BIMS score of 15, meaning she was cognitively intact. Review of Physician orders for Resident #60 dated 05/22/24 revealed the resident did not have self-administration orders. The orders showed the resident was not prescribed this medication. Review of a care plan initiated 01/11/23 showed the resident did not have a focus to keep medications at bedside or to self-administer. On 05/21/24 at 8:23 a.m., an interview was conducted with Staff D, Registered Nurse (RN) who observed Resident #97's eye drops at bedside. She stated they had removed other medications from some rooms, but she did not know this resident had any medications at bedside. She explained the policy was to have any medications locked up and an assessment to follow if a resident was able to self-administer. On 05/21/24 at 11:30 a.m., an interview was conducted with Staff A, Licensed Practical Nurse (LPN). She stated all their residents required supervision for all medication administration. She stated if she saw medications at the bedside or in the resident's possession, she would confiscate them and notify the physician. An interview was conducted on 05/21/24 at 12:50 p.m. with Staff C, RN Unit Manager. She confirmed medications should be secured and not left unattended in resident's rooms. She stated the residents should have orders. She stated medications included topical creams, eye drops, ear drops and any over-the-counter substances. She stated some families liked to bring medications to the residents. She stated they were constantly educating residents and families. She stated when staff find these medications, they should remove them and notify the physician and the Responsible Party for follow-up. On 05/21/24 at 12:54 p.m., an interview was conducted with Staff F, RN Unit Manager. She confirmed the residents should not have medications at the bedside. She stated all medications should be secured even if a resident had self-administration orders. She stated as far as she was concerned, none of their residents had self-administration orders. A follow-up interview was conducted on 05/21/24 at 1:22 p.m. with the Director of Nursing (DON) and the Regional Nurse consultant (RNC). The DON stated there should be no medications left at the bedside. She stated if they were able to keep them, they must be locked, and the resident must be able to tell what they were for. She stated the resident should have orders and a care plan. The RNC stated the medications should be locked for the safety of their residents and their roommates. She stated all medication administration should be supervised unless the resident had orders. The DON confirmed they did not currently have anyone on self-administration orders. (Photographic evidence was obtained). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105700	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northdale Rehabilitation Center	3030 Bearss Ave Tampa, FL 33618

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50732 On 5/19/2024 at 11:15 a.m., during a facility tour, Resident #10 was observed with three bottles of medication at bedside. The medications observed were [brand name] glaucoma medication, [brand name] lubrication eye drops, [brand name] nasal spray, and [brand name] pain relief cream. When the resident was asked about the medications, she stated that she sometimes took the medications herself and other times the staff helped her. (Photographic Evidence Obtained) On 5/20/2024 at 4:30 p.m. and 5/21/2024 at 3:00 p.m., Resident #10 was observed with only one medication, [brand name] pain relief cream, at the bedside. (Photographic Evidence Obtained) Review of an Admission Record for Resident #10 showed she was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS), dated [DATE], Section C - Cognitive Patterns showed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Review of the Physician orders for Resident #10, dated 05/22/2024, showed the resident did not have self-administration orders on any medications. The resident was prescribed [brand name] Glaucoma medication and [brand name] pain relief cream, however, there were no Physician orders for [brand name] of lubrication eye drops or [brand name] for nasal spray, which were both over-the-counter medications. Review of the Active Care Plan revealed Resident #10 did not have a focus to keep medications at the bedside or self-administer. On 05/21/24 at 11:50 a.m., an interview was conducted with Staff E, LPN. She stated if a resident had medications on them, she would call the doctor to obtain self-administration orders if appropriate. She stated [brand name] for Resident #10 was a medication and should be treated as so. She stated the resident should have been assessed for safety. During tours conducted in Resident #8's room on 5/19/2024 at 12:40 p.m. and 5/20/2024 at 4:00 p.m., observations were made of [brand name] immune support gummies, an over-the-counter supplement, on top of her dresser. Resident #8 was unable to verbalize responses to questions due to her medical condition. (Photographic Evidence Obtained) Review of an Admission Record for Resident #8 showed she was admitted to the facility on [DATE]. A quarterly MDS, dated [DATE], Section C - Cognitive Patterns revealed a BIMS score of 0 out of 15, indicating the resident has severe cognitive impairment. Review of the Physician Orders for Resident #8, dated 05/22/2024, revealed the resident did not have self-administrations orders for any medications. The orders showed the resident was not prescribed this medication. Review of the Active Care Plan revealed Resident #8 did not have a focus to keep medications at bedside or self-administer.

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43453 Based on observation, interview, and facility policy review, the facility failed to ensure their pest control program was effective during three of four days of survey in six (Rooms #69, #70, #133, #135, #143 and #157) out of 26 rooms and affecting one (Resident #88) out of 21 sampled residents. Findings included: During multiple facility tours on 05/19/24, 05/20/24, and 05/21/24, observations were made of live and dead insects and ants in resident rooms #69, #70, #133, #135, #143 and #157. On 05/19/24 at 11:45 a.m., the Environmental Services (EVS) manager and surveyor observed a live insect crawling outside room [ROOM NUMBER]. She stated the insect was a cockroach. She stated their process was to kill the bug and document on the maintenance log. She stated she would disinfect the area where she stomped at the insect and let maintenance know. On 05/19/24 at 11:47 a.m., an interview was conducted with Resident #88 who was alert and oriented with a BIMS (Brief Interview for Mental Status) of 15. He stated he had lived at this facility for several years and his room had always had a problem with ants and roaches. He stated he had mentioned it to staff several times. During this interview the surveyor observed numerous dead ants on the resident's window sill and live ants on the floor and the walls by the dresser. During a tour of room [ROOM NUMBER] on 05/19/24 at 12:14 p.m., an observation was made of a live insect. On 05/19/24 at 12:43 p.m., an observation of an insect was made by the resident's head of the bed. On 05/19/24 at 1:11 p.m., an observation was made of a live insect on the floor by the resident's bed. During subsequent tours on 05/20/24 and 05/21/24, similar observations of insects were made in resident's rooms. On 05/21/24 at 01:37 p.m., an interview was conducted with the Nursing Home Administrator (NHA) and the Director of Maintenance (DOM). The DOM stated he was to be notified when there were sighting of pests and insects at the facility. He stated the staff were to document the location of the sighting so the contracted vendor could treat the areas accordingly. The DOM stated he was notified there were roaches in resident rooms. He reviewed photographic evidence and stated he did not know about any of the resident rooms having ants. He stated he was surprised there were that many ants in the resident's room. The NHA stated the facility had a binder at the front lobby that was used to communicate pest sightings. The DOM stated whoever made an observation should notify him via phone or write it down in the book. He reviewed the pest log book and confirmed there was no documentation of insect/pest sightings at the facility. The NHA stated it appeared the problem was communication. He stated nursing staff should be following their process of reporting any incidents of pests/insects observed in resident's areas. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a document titled pest sighting/evidence log showed from November 2023 to April 2024 it was documented checked logbook without pest/insect sighting documentation. During survey period on 05/19/24 and 05/20/24 and 05/21/24 the log confirmed there were sightings of roaches. Review of a facility policy titled, Pest Control dated 02/20/18, showed a purpose: routine inspections are conducted at each facility for evidence of pests. Insect or pest sightings are documented in the pest control book at the nurse's station and communicated to the maintenance supervisor. (Photographic evidence was obtained).