STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105790	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Senior Living North Naples	10949 Parnu Street Naples, FL 34109

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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** 40153 Based on observations, interviews and record review, the facility failed to ensure that the call light was within reach for 1 (Resident #26) of 1 resident sampled for accommodation of needs. The findings included: A record review showed Resident #26 was readmitted to the facility on [DATE] with diagnoses of Vascular Dementia, Depressive Disorder, and Hyperlipidemia. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 had a Brief Interview of Mental Status (BIMS) score of 07, which is severely cognitively impaired. A progress note dated 3/18/25 showed Resident #26 on the floor between the bed and the nightstand in his room. He was unable to explain what happened and said he was trying to grab something off the table. Recently, Resident #26 overestimated his own ability and was encouraged by Staff to use the call light constantly. Further chart review showed that Resident #26 had four falls in the last five months in the facility. The care plan initiated on 1/27/2025 revealed that Resident #26 was reminded to use the call bell for assistance when needed. In an observation conducted on 4/21/25 at 11:00 AM, Resident #26 was noted in the bed, and no call light was within reach. After a few minutes of trying to find the call light, this Surveyor was able to locate the call light, which was attached to the back of the privacy curtain and not within reach of Resident #26. In this observation, Resident #26 was asked how he called Staff for assistance, and he looked for the call light and then said, It is here somewhere. In an observation conducted on 4/22/25 at 9:32 AM, Resident #26 was noted in the bed, with the call light on his left side attached to the end of the bed not within arm reach. In this observation, this Surveyor asked Resident #26 if he could reach the call light and Resident #26 said no. Resident #26 then attempted to reach the call light but was not able too. In an observation conducted on 4/22/25 at 10:45 AM, Resident #26 was noted in bed with the call light on his left side attached to the end of the bed, not within arm's reach. In this observation, Resident #26 stated he was told to use the call light when he needed help from Staff. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation conducted on 4/23/25 at 8:56 AM, Resident #26 was sitting at the end of the left side of the bed eating breakfast. The call light was noted to be attached to the curtain on the right side of the bed, away from Resident's #26 reach. In an observation conducted on 4/23/25 at 1:10 PM, Resident #26 was in his bed with the call light within reach. In this observation, Resident #26 was asked if he could use the call light, which was located near his right hand. Resident #26 was able to press the call light, and a light illuminated outside Resident #26's room indicating that the call light bell was used in Resident #26's room. After a minute, the Staff was seen walking toward Resident #26's room. In an interview conducted on 4/22/25 at 11:40 AM with Staff A, Certified Nursing Assistant (CNA) stated, Resident #26 is at risk for falls, and they have to ensure that the call light is within reach of the Resident. She further reported Resident #26 sometimes uses the call light when he needs assistance but not always. In an interview conducted on 4/22/25 at 12:02 PM with Staff C, the Licensed Practical Nurse stated that she had been working in the facility for about three years. When asked if Resident #26 was at risk for falls, she said, Not really, but kind of. Sometimes, he likes to do things by himself and gets out of bed without staff assistance. Resident #26 usually does not use the call light to call for assistance. In an interview conducted on 4/23/25 at 10:49 AM with Staff D, the CNA stated that she had worked in the facility for [AGE] years. She was very familiar with Resident #26 and said he was at risk for falls. They need to make sure that the call light is within reach, and sometimes, Resident #26 gets out of bed without listening. He knows how to use the call light and uses it when he wants to. Sometimes, he will not use the call light and just get up.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations, interviews, and record review the facility failed develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 1 out of 1 resident with a Percutaneous Endoscopic Gastrostomy (PEG) tube (Resident # 56) and 1 out of 1 resident on Transmission Based Precautions (Resident #37). The findings included: Review of the facility's policy titled, Care Plans - Comprehensive with a revised date of 12/10/24 included in part the following: Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident. His/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The comprehensive care plan is based on thorough assessment that includes but is not limited to the Minimum Data Set (MDS). Each resident's comprehensive care plan is designed to: incorporate identified problem areas. Incorporate risk factors associated with identified problems. Record review for Resident #56 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Traumatic Subarachnoid Hemorrhage without Loss of Consciousness Subsequent Encounter, Cognitive Communication Deficit, and History of Falling. The Minimum Data Set (MDS) for Resident #56 dated 4/3/25 documented in Section C a Brief Interview of Mental Status score of 5 indicating severe cognitive impairment. In Section K it was documented that on admission the resident had a feeding tube (abdominal PEG tube). Review of the Physician's Orders for Resident #56 revealed in part the following: An order dated 4/22/25 PEG tube stoma (surgical opening) care: Cleanse with NS (normal saline), pat dry skin prep (protective film) peri wound let dry. apply calcium alginate (W silver) and secure with clean bordered gauze split dressing once daily. There was no order for EBP (Enhanced Barrier Precautions). Review of the Care Plan for Resident #56 revealed no care plan for PEG tube or for Enhanced Barrier Precautions. During an interview conducted on 4/21/25 at 10:30 AM with Resident #56 who stated he has a peg tube. Resident #56's wife was at bedside and said her husband has been eating for about a month now and they are not using the PEG tube, and it is scheduled to be removed next week at the doctor's office. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 4/23/25 Staff B MDS Coordinator who stated she has worked at the facility since July 2024 and Staff L MDS Coordinator who stated she has worked at the facility for 2 years. When asked who was responsible for putting in the nursing care plans for a resident, they said they were. When asked about Resident #56's care plan for having a PEG tube and EBP, they both acknowledged there was no care plan for the PEG tube or EBP. Staff L MDS Coordinator stated, I must have forgotten. 39026 2. Record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses of Sepsis, Cerebral Infarction, and Chronic Obstructive Pulmonary Disease (COPD). Her Brief Interview for Mental Status (BIMS) score was 15 on the quarterly Minimum Data Assessment (MDS) with an assessment reference date (ARD) of 3/12/25. This indicated the resident had intact cognition. A review of the Electronic Health Record (EHR) and the physician orders for Resident #37 was done and revealed the resident was on Contact Precautions since 4/19/25 for a Urinary Tract Infection with ESBL (Extended-spectrum beta-lactamase). ESBL are a type of enzyme or chemical produced by some bacteria. Contact precautions are indicated for someone with ESBL in the urine. A review of the resident's care plans revealed there was no care plan for contact precautions for Resident #37.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews and record review, facility failed to follow care plan interventions to prevent further falls for 1 (Resident #26) of 1 resident sampled for accidents. The findings included: Review of the facility's policy titled Care Plans-Comprehensive, revised on 12/10/24, showed the following: Each Resident's comprehensive care plan is designed to: a. Incorporate identified problem areas. b. Incorporate risk factors associated with identified problems. c. Build on the residents' strengths. d. Reflect on the residents' expressed wishes regarding care and treatment goals. e. Reflect treatment goals, timetables, and objectives in measurable outcomes. f. Identify the professional services responsible for each element of care.' g. Aid in preventing or reducing declines in the Resident's functional status and/or functional levels. h. Enhance the Resident's optimal functioning by focusing on a rehabilitative program and reflecting currently recognized standards of practice for problem areas and conditions. A record review showed Resident #26 was readmitted to the facility on [DATE] with diagnoses of Vascular Dementia, Depressive Disorder, and Hyperlipidemia. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #26 had a Brief Interview of Mental Status (BIMS) score of 07, which is severely cognitively impaired. A record review of the Event Report dated 1/25/25 revealed Resident #26 had a fall on 1/25/25 in his room and had a non-skid sock at the time of the incident. Immediate measures taken were safe footwear and neuro checks. The report stated that the call bell was within reach and that Resident #26 did not call for assistance. The Care plan was updated on 1/27/25 to remind Resident #26 to use the call light for assistance when needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Event Report dated 3/3/25 revealed Resident #26 had a fall on 3/3/25 in his room while ambulating to the bathroom wearing non-skid socks. Immediate measures taken were neuro checks on Resident #26. The call bell is within reach, and Resident #26 was encouraged to use it for assistance but does not always do so. The care plan was updated on 3/4/25 to remind Resident #26 not to ambulate unassisted. A record review of the Event Report dated 3/16/25 revealed Resident #26 had a fall on 3/16/25 and was found in the bathroom. He had slippers on at the time of this incident. Resident #26 was reminded to call for assistance, and he said, I understand. The care plan updated on 3/17/25 reminded Resident #26 to ask for assistance with toileting needs. A record review of the Event Report dated 3/17/25 revealed that Resident #26 fell in his room on 3/17/25. He had shoes on at the time of this incident. The bed was in the lowest position, and the call bell was within reach. The care plan updated on 3/18/25 for floor mats on the bilateral side of the bed. In an observation conducted on 4/21/25 at 11:00 AM, Resident #26 was noted in the bed in the lowest position, but no call light was within reach. Further observations showed no fall mats on either side of his bed. In an observation conducted on 4/22/25 at 9:32 AM, Resident #26 was noted in the bed, with the call light on his left side attached to the end of the bed not within arm's reach. Further observations showed no fall mats on either side of his bed. In an interview conducted on 4/22/25 at 11:40 AM with Staff A, the Certified Nursing Assistant (CNA) stated that Resident #27 is a fall risk. There are floor mats on each side of his bed, and the call light is within reach by his side. In an interview conducted on 4/22/25 at 11:50 AM, Staff B, MDS Coordinator, stated that after a resident falls, they will get together with the nursing team to review the care plan and the interventions in place. She will update or make changes to the interventions to reflect the circumstances of the fall and add any new interventions that are not already in place for the residents. Staff B reported adding the intervention of floor mats on 3/18/25 to the care plan for Resident #26. The Floor mats are placed as an order under the Physician's Orders tab. A review of the Physician's orders did not show that Resident #26 had an order for floor mats. In an observation conducted on 4/23/25 at 8:56 AM, Resident #26 was sitting at the end of the left side of the bed eating breakfast. The call light was noted to be attached to the curtain on the right side of the bed, away from Resident's #26 reach. Further observations showed no fall mats on either side of his bed. In an interview conducted on 4/23/25 at 10:49 AM with a CNA, Staff D stated that Resident #26 was at risk for falls and ensured the call light was within reach and floor mats were on each side of his bed. A review of the care plan initiated on 4/26/22 showed Resident #26 was at risk for falls related to weakness, unsteady gait at times, and a history of falls.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on record review, observations and interviews, the facility failed to ensure facility staff performed urinary indwelling catheter care technique consistent with accepted standards of practice and failed to follow the facility's policy titled, Catheter Care, Urinary as observed during indwelling urinary catheter care for 1 (Resident #22) of 1 resident sampled for urinary catheter. The findings included: Review of the facility's policy titled, Catheter Care, Urinary with a review date of 12/10/24 included in part the following: The purpose of this procedure is to prevent catheter-associated urinary tract infections. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter tubing free of kinks. Use standard precautions when handling or manipulating the drainage system. Ensure that the catheter remains secured to reduce friction and movement at the insertion site. (Note: Catheter tubing should be secured to the resident's inner thigh. Steps in the Procedure: 13. With nondominant hand separate the labia of female resident . maintain the position of this hand throughout the procedure. 15. For a female resident: use a washcloth with warm water and soap to cleanse the labia. Use one area of the washcloth for each downward stroke. Change the position of the washcloth with each downward stroke. Next, change the position of the washcloth cleanse around the urethral meatus. Do not allow the washcloth to drag on the resident's skin or bed linen. With a clean washcloth, rinse with warm water using the above technique. 18. Secure the catheter. Record review for Resident #22 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Presence of a Right Artificial Hip Joint, History of Falling, and Need for Assistance with Personal Care. The Minimum Data Set, dated dated dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #22 revealed in part the following orders: An antibiotic order for Bactrim DS (sulfamethoxazole-trimethoprim) tablet; 800-160 mg oral every 12 hours for diagnoses of UTI (Urinary Tract Infection); E.coli (bacteria) from 4/18/25 to 4/255/25. An order dated 3/13/25 for Indwelling Urinary Catheter; May change / re-insert as needed for occlusion/accidental removal. Size:16fr Coude catheter 10cc balloon as needed. An order dated 3/13/25 to irrigate Indwelling Urinary catheter with 60cc normal saline as needed for blockage or leakage as needed. There was no order for catheter care or for the catheter to be anchored to the resident's thigh. On 4/21/25 11:30 AM an observation was made of Resident #22 lying in bed wearing pants with the legs pulled up above the knee, the resident had an indwelling urinary catheter tubing coming out from under her leg and the tubing was not anchored. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 9:10 AM an observation of indwelling urinary catheter care performed by Staff H Certified Nursing Assistant for Resident #22. The resident's catheter tubing was unsecured. Staff H CNA gathered supplies, washed hands and began catheter care by wiping top groin and side of groin next to leg, the resident started having a bowel movement and the washcloth Staff H CNA was using along with her gloved hand became soiled with the bowel movement. Staff H CNA initially did not change her gloves and proceeded to fold over the soiled washcloth and continue cleaning the resident. Staff H CNA stepped back and stated I am sorry then changed her gloves without performing hand hygiene. Staff H CNA stood holding a clean washcloth for several minutes. On 4/24/25 at 9:30 AM Staff I Certified Nursing Assistant (CNA) member knocked at the resident's door. The two CNAs proceeded to clean the bowel movement which included turning the resident from side to side without securing the catheter tubing. Staff H CNA then continued to provide catheter care by holding the left side of the resident's labia with her left hand and wiping with the washcloth from top to bottom and around the catheter tubing, then wiped the resident's groin from top to bottom over the catheter tubing, then folded over the towel, she changed gloves again without performing hand hygiene. Staff I CNA then proceeded to dress the resident with a pair of pants on the resident up to her knees. Staff I raised the drainage bag above the bladder to insert the drainage bag inside the left pant leg, decided the drainage bag needed to be emptied of the urine and lowered the drainage bag to empty the urine. Staff I proceeded to put the drainage bag inside the pant leg while the catheter tubing was being pulled. When asked of Staff H CNA and Staff I CNA if they were finished with the catheter care, they both agreed it was completed. The catheter tubing was never secured in place to the resident's leg. During an interview conducted on 4/24/25 at 9:55 AM with Staff J Licensed Practical Nurse (LPN) stated she has worked at the facility since 2020. When asked if she was the nurse for Resident #22 today, she said yes. When asked who documents the catheter care, she said the CNAs document the care. When asked if the catheter tubing needs to be anchored, she said what does that mean? When explained anchored means secured, Staff J LPN said yes but she did not have a chance to look at the resident's catheter today. When asked if there was an order for catheter care, she acknowledged there was no order for catheter care. During an interview conducted on 4/24/25 at 10:00 AM with Staff H CNA stated she has worked at the facility for 3.5 years. When asked if she documents the catheter care, she said document? When asked if she writes it down in the resident's chart that she did catheter care, she did not respond. Staff J LPN asked if she could help ask Staff H CNA the question. Staff J LPN asked Staff H CNA about documenting catheter care. Staff H CNA did not respond.

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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** 40153 Based on observations, interviews and record review, the facility failed to complete a Quarterly Nutritional Assessment for 1 (Resident #48) of 2 residents sampled for Nutrition. The findings included: A record review showed Resident #48 was readmitted to the facility on [DATE] with diagnoses of Legally Blind, Dementia, and Psychosis Disturbances. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #26 had a Brief Interview of Mental Status (BIMS) score of 08, which is moderate to severe cognitive impairment. Section GG of the above MDS revealed that Resident #48 was coded for set-up or clean-up assistance for eating. In an observation conducted on 4/21/25 at 11:55 PM, Resident #48 was noted in the room with her lunch tray. The staff set up the tray for Resident #48 and left the room. The lunch plate was noted with the following: hot dog on a plate, chocolate cake on a square plate, and mixed vegetables in a bowl with a tablespoon. The meal ticket noted the following: hot dog, mixed vegetables, chocolate cake, and to send sandwiches/hotdogs/or hamburgers instead of the meal. In this observation, Resident #48 said that they always give her the same foods (hamburger, hotdog, peanut butter sandwich, and grilled cheese) for lunch and dinner, and she would like to get what everyone else gets for dinner. The care plan for Resident #48, revised on 3/14/2025, showed the following: Resident is at risk for altered nutrition due to end-stage Cerebral Atherosclerosis and is on hospice care. Potential for the unavoidable decline in parameters of nutrition with risk factors of Dementia, underweight, and Legally Blindness. A review of the Quarterly Nutrition assessment dated [DATE] showed that Resident #48 has an inadequate oral and suboptimal intake, as evidenced by leaving 25% or more of most meals uneaten. The goal is to offer foods/fluids of choice to promote quality of life by the following review period. Further chart review did not reveal that a Quarterly Nutrition Assessment was completed on Resident #48 after 12/27/24. A review of the Care Plan dated 3/14/25 did not show that it was updated or revised by the facility Clinical Dietitian. In an interview conducted on 4/23/25 at 9:40 AM with Staff B, the MDS Coordinator stated that the Clinical Dietitian updates all the nutrition care plans. Staff B said that she had not made any of the changes or interventions under the nutrition plan and that it was the responsibility of the Clinical Dietitian. In an interview conducted on 4/23/25 at 9:44 AM, the Dietary Manager said Resident #48 used to eat finger food and asked for regular food a few weeks ago. When they provided her with regular foods, she changed her mind and wanted finger food instead. Usually, they provide residents with the same choice on the daily menu, but last week, Resident #48's roommate's family said they would help Resident #48 with her menu selections. The Dietary Manager noted that the Registered Dietitian does a Quarterly Nutrition Assessment on all residents. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview conducted on 4/23/25 at 9:55 AM with the facility's Registered Dietitian, she stated that they do Quarterly Nutrition Assessments on all residents. She acknowledged that no Quarterly Assessment was done for Resident #48 and did not know why she did not complete the assessment. She is also responsible for updating the nutrition care plan for all residents. A review of the Quarterly Nutrition assessment dated [DATE] showed the following: Resident #48 with inadequate oral suboptimal intake as evidenced by being underweight and leaving 25% or more of meals uneaten. It further showed Resident #48 eats 1-75% of her meals in her room with assistance. She has declined all facility supplements (not documented previously) and remains under hospice care. The above assessment did not document that the Clinical Dietitian visited Resident #48 and spoke to her to obtain food preferences, likes, and dislikes.

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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** 41837 Based on observations, interviews and record review the facility failed to ensure accurate and effective system for reconciliation of controlled drugs in sufficient detail to enable an accurate reconciliation (Resident #51) and remove discontinued medications (Resident #215) from the med cart for 2 of 2 med carts reviewed. The findings included: 1. Record review for Resident #51 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Pleural Effusion and Necrotizing Enterocolitis Unspecified. The Minimum Data Set (MDS) dated [DATE] documented in Section C a Brief Interview of Mental Status (BIMS) score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #51 revealed an order dated 4/8/25 for Xanax (alprazolam) 0. 25 mg give 1 tablet oral every 6 hours PRN (as needed). Review of the Controlled Medication Utilization Record for Resident #15 for Alprazolam 0.25mg documented on 4/9/25 at 9:12 AM and again on 4/13/24 at 9:15 PM the medication was removed from the med cart. Review of the Medication Administration Record (MAR) for Resident #51 for the month of April revealed no documentation of Alprazolam 0.25mg being administered on 4/9/25 at 9:12 AM or on 4/13/24 at 9:15 PM. During an interview conducted on 4/23/25 at 1:35 PM Staff C (LPN) stated she has worked at the facility for 3 years. The LPN stated when the med is removed from the med cart we document it on the Controlled Medication Record and once the medication is administered she will document it on the Medication Administration Record for the resident. 2. Record review for Resident #215 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Need for Assistance With Personal Care and Muscle Weakness (Generalized). The MDS dated [DATE] documented in Section C a BIMS score of 13 indicating a cognitive response. Review of the Physician's Orders for Resident #215 revealed an order dated 3/18/25 for Alprazolam 0.25 mg give 1 tablet orally every 8 hours as need for anxiety/agitation. The medication was discontinued on 4/2/25. During an interview conducted on 4/23/25 at 1:45 PM Staff F LPN was asked about controlled medications. The LPN stated when the med is removed from the med cart we document it on the Controlled Medication Record and once the medication is administered she will document it on the Medication Administration Record for the resident. (continued on next page)

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	105790	A. Building B. Wing	04/24/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 4/23/25 at 3:02 PM with the Director of Nursing (DON) who was asked about discontinued controlled medications, the DON stated the meds should be removed from the med cart within a couple of days of the med being discontinued. The night shift nurse is responsible to check the cart nightly.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on interviews and record review the facility failed to ensure the facility's Consultant Pharmacist reported the monthly drug regimen review to the facility for 1 (Resident #19) of 5 residents reviewed for Unnecessary Medications and failed to ensure irregularities identified by the Consultant Pharmacist were addressed with a rationale by the Physician for 1 (Resident #2) of 5 residents reviewed for Unnecessary Medications. The findings included: Review of the facility's policy titled, Medication Regimen Review with a revised date of January 2018 included in part the following: The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The findings are phoned, faxed, or e-mailed within (24 hours) to the director of nursing or designee and are documented and stored with the other consultant pharmacist recommendations in the residents' (active record). The prescriber is notified if needed. Notification is dependent on severity of irregularity and is determined through consultation between consultant pharmacist and the director of nursing. Recommendations are acted upon and documented by the facility staff and/or the prescriber. Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreement. Review of the facility's policy titled, Documentation and Communication of Consultant Pharmacist Recommendations with a revised date of January 2018 included in part the following: Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. In the event of a problem requiring the immediate attention of the prescriber, the prescriber responsible or physician's designee is contacted by the consultant pharmacist or facility, and the prescriber response is documented on the consultant pharmacist review record or elsewhere in the resident's medical record. 1. Record review for Resident #2 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Urinary Tract Infection, Anxiety Disorder Unspecified, and Depression Unspecified. The Minimum Data Set, dated dated dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #2 revealed in part the following: An order dated 12/9/24 for Ambien (zolpidem) 5 mg; amt: 1 tablet oral at bedtime for sleep/insomnia. An order dated 12/9/24 for Protonix (pantoprazole) tablet (reduces production of stomach acid), delayed release 40 mg oral once a day. Review of the Pharmacy Recommendations for Resident #2 documented the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 Pantoprazole 40 mg no stop date. On 12/11/24 the physician disagreed (with no rationale for disagreeing). On 12/10/24 Zolpidem 5 mg pleas attempt dose reduction to zolpidem 2.5 mg at bedtime. On 12/11/24 the physician disagreed (with no rationale for disagreeing). Review of the medical record for Resident #2 revealed no documentation of rationale for disagreeing with the pharmacy recommendations 12/10/24. During a telephone interview conducted on 4/23/25 at 9:43 AM Staff M Consultant Pharmacist (CP) stated she has been working with the facility since 2023. The Consultant Pharmacist stated that the recommendation date is listed at the top of the form next to where the form states Recommendation Date. The Created date on located on the bottom of the form is the date when the PDF report was printed from the consultant pharmacy interface system. The Consultant Pharmacist stated she sends the report the facility on the date the report is printed. When asked about PRN (as needed) Psychotropic medications, she said they should only be for 14 days with a stop date, unless the doctor extends the order but still needs a stop date and documentation of rationale for the extended date. When asked about the Medication Regimen Review (MRR) for Resident #2 dated 12/10/24 in regard to the Pantoprazole 40 mg and the Physician disagreeing on 12/11/24, with no rationale, the CP stated the rationale may be written in the progress notes. When asked about the Medication Regimen Review (MRR) for Resident #215 dated 12/18/24 in regard to the Ativan 0.25 mg PRN greater than 14 days with the Physician documenting on 12/19/24 to continue the PRN order for 30 days with no rationale, the CP said again the rationale may be documented in the progress notes in the resident's record. During an interview conducted on 4/23/25 at 11:00 AM Staff N Nurse Practitioner (NP) was asked about psychotropic medications ordered PRN. She stated she believes the medications can be extended longer than 14 days, as she has sometimes seen the pharmacist recommendations that gives that option. If the recommendation asks for the rationale she will document the rationale. 39026 2. Record review revealed Resident #19 was admitted to the facility on [DATE]. Diagnoses included Acute Respiratory Disease, Encephalopathy, unspecified, and Chronic Obstructive Pulmonary Disease. The Brief Interview for Mental Status on the Quarterly Minimum Data Set assessment dated [DATE] was unable to be done. This indicated the resident had severe cognitive impairment. The resident was selected for an unnecessary medication review. Review of the monthly medication regimen review for October 2024 through April 2024 provided by the Director of Nursing (DON) revealed no medication review for November 2024. Review of the Electronic Health Record (EHR) failed to reveal a medication regimen review for Resident #19 for November 2024. An interview was conducted via telephone with the consultant pharmacist on 4/23/25 at 9:43 AM. She stated she has been working as the consultant pharmacist with the current pharmacy since 2023. When asked about the missing November 2024 pharmacy recommendation for Resident #19 she stated she saw it on her computer screen. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the DON on 4/23/25 at 1:15 PM. She stated she contacted the Consultant Pharmacist to get a copy of the November 2024 recommendation. The pharmacist could not print it out because there was glitch in the system. She provided a screenshot without Resident #19's name on the screenshot. She verified that there was no recommendation for Resident #19 for November 2024 in the facility or in the resident's EHR.

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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** 41837 Based on observations, interviews and record review the facility failed to ensure medications were secured at all times for 2 (Residents #213 and #214) of 16 sampled residents. The findings included: Review of the facility's policy titled, Storage of Medications with a revised date of January 2018 included in part the following: Medications and biologicals are stored safely, securely and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Review of the facility's policy titled, Self-Administration of Medications with a revised date of January 2018 included in part the following: In order to maintain the residents' hi level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medication by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition. The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered. Record review for Resident #213 revealed an admitted to the facility of 3/4/25. Diagnoses included in part: Fracture of Unspecified Part of Neck of Right Femur, Generalized Muscle Weakness, and Need for Assistance with Personal Care. The Admission Minimum Data Set (MDS) assessment with a target date of 3/25/25 documented Resident #213 scored 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. On 4/21/25 at 10:50 AM Resident #213 was observed sitting up in bed. The resident's spouse was sitting in a chair next to her. Two medicine cups were observed on the overbed table in front of Resident #213. One cup contained five different pills and a capsule. The other cup contained a liquid medication. During an interview conducted on 4/21/25 at 10:50 AM Resident #213 was asked about the medications in front of her. She said she cannot take all of the medication at the same time. Her husband then said he watches his wife take the medications. He said she takes too many medications at the same time, and she will get sick to her stomach. Resident #213 said she did not recognize all the medications in the cups, her husband was better at that. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a side by side observation conducted at the bedside of Resident #213 on 4/21/25 at 11:05 AM with Staff F Licensed Practical Nurse (LPN), she acknowledged she left the medications at the bedside for the resident to take because the husband insists. She said Resident #213 has been at the facility for about five days and the husband has been insisting to have the medications left at the bedside. Staff F LPN added there should be a care plan and an order for the medications to be left at the bedside. When asked if the resident had an order for self-administration, she said she was not sure. When asked if the resident had a care plan for the meds to be left at the bedside or self-administration, she said she did not do the care plans. During an interview conducted on 4/21/25 at 11:10 AM Staff E Registered Nurse (RN) stated she has worked at the facility for several years. When asked if Resident #213 had an order for self-administration of medications or an order to leave medications at the bedside, RN Staff E acknowledged there was no order. She also acknowledged the resident did not have a care plan or an evaluation for self-administration. On 4/21/25 at 11:22 AM, observation of Resident #213's room revealed the medicine cup with five pills and one capsule and the medicine cup with the liquid medication remained at the resident's bedside. Record review for Resident #213 revealed no order for self-administration of medications, no evaluation for self-administration of medications, and no care plan for self-administration of medications. 2. A record review for Resident #214 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part: Generalized muscle weakness, and need for assistance with personal care. The Admission MDS dated [DATE] documented Resident #214 scored 13 on the BIMS, indicating a cognitive response. On 4/21/25 at 10:10 AM an observation was made of Resident #214 sitting up in bed. A bottle of Sterile Eye Drop Lubricant was observed on the overbed table in front of the resident. During an interview conducted on 4/21/25 at 10:10 AM, Resident #214 was asked about the eye drops. She said she needed the eye drops. She said she had Macular Degeneration (eye disease), and her eyes get dry from reading. When asked if she put the drops in herself, she said no, her husband puts them in for her. During a side-by-side observation conducted on 4/22/25 at 9:55 AM, Staff K Licensed Practical Nurse (LPN) acknowledged Resident #214 had eye drops at the bedside on her overbed table, did not have an order for eye drops nor was the resident evaluated for self-administration. Staff K LPN instructed Resident #214's husband to take the eye drops home and she would obtain an order from the physician for the eye drops. Review of the clinical record for Resident #214 revealed no physician's order for eye drops, no evaluation for self-administration of the eye drops and no care plan for self-administration of medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record for Resident #214 revealed no order for eye drops, no order to self-administer, no evaluation for self-administration, and no care plan for self-administration of medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observations, record review, review of facility's policies and procedures, and interviews, the facility failed to follow infection prevention and control guidelines for 1 (Resident #37) of 1 resident on contact precautions. The facility failed to ensure the proper storage of respiratory care equipment for 2 (Residents #33 and #110) of 2 residents receiving nebulizer treatment and failed to perform hand hygiene as appropriate for 1(Resident #22) of 1 resident observed for catheter care. The findings included: The facility's policy titled Transmission Based Precautions reviewed 12/10/24 revealed Contact precautions are intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment. PPE (personal protective equipment) utilized included gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident environment. 1. Record review for Resident #37 revealed an admitted to the facility of 5/5/23. Diagnoses included Sepsis (life threatening complication of an infection), Cerebral Infarction (stroke), and Chronic Obstructive Pulmonary Disease (COPD). Review of the Quarterly Minimum Data Set (MDS) with an assessment reference date of 3/12/25 noted Resident #37 scored 15 on the Brief Interview for Mental Status, indicating intact cognition. Review of the Electronic Health Record (EHR), including physician orders for Resident #37 revealed the resident was on Contact Precautions since 4/19/25 for a Urinary Tract Infection with ESBL (Extended-spectrum beta-lactamase). ESBL are a type of enzyme or chemical produced by some bacteria. Contact precautions are indicated for someone with ESBL in the urine. On 4/24/25 at 9:00 AM, observed Registered Nurse (RN) Staff G prepare an injection of Ertapenem (antibiotic) solution 1 gram mixed with Lidocaine (anesthetic) for an intramuscular injection. RN Staff G prepared the injection by her medication cart and went into Resident #37's room. The sign on the door said contact precautions. RN Staff G went into the room with gloves on, pulled the curtain, repositioned the resident and pulled apart the brief to give the injection with gloves on. She did not don a gown or change her gloves prior to administering the injection. After she administered the injection, the resident asked the nurse reposition her. Staff G took off her gloves and repositioned the resident, the under pad, linen and blanket. In an interview, Staff G was asked if she saw the contact precaution sign. She stated yes, my mistake. On 4/24/25 at 10:00 a.m., during an interview the Administrator was informed of RN Staff G's failure to follow contact precautions for Resident #37. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review for Resident #33 revealed an admitted to the facility of 11/25/24. Diagnoses included Acute Respiratory Failure with Hypoxia (low oxygen level), Acute or Chronic Diastolic (Congestive) Heart Failure, and Type 2 Diabetes Mellitus without Complications. Review of the Quarterly MDS assessment with an assessment reference date of 4/10/25 revealed Resident #33 scored 15 on the BIMS, indicating intact cognition. On 4/21/25 at 1:42 PM observation of Resident #33's room revealed a nebulizer (machine used to inhale aerosol medications into the lungs) on top of the dresser next to the resident's bed. The nebulizer tubing and mask were observed lying on top on the nebulizer uncovered. In an interview during the observation, Resident #33 stated she recently had a nebulizer treatment and the tubing and masks were put back on the machine uncovered. 3. Record review revealed Resident #110 was admitted to the facility on [DATE] with diagnoses that included Lymphedema (swelling), Polyneuropathy (peripheral nervous system disorder) and Unspecified Systolic (Congestive) Heart Failure. Review of the Admission MDS with an assessment reference date of 3/21/25 revealed Resident #110 scored 15 on the BIMS, indicating intact cognition. On 4/21/25 at 10:49 AM an observation and interview were conducted with the resident. A nebulizer tubing and mask were observed uncovered on the resident's bedside dresser. In an interview Resident #110 said that he did not remember the last time he had a nebulizer treatment. He stated, It's supposed to be in a bag. On 4/23/25 at 1:30 PM during an interview, the Administrator was informed of the nebulizer tubing and mask stored uncovered on Resident #110's bedside dresser. 41837 4. Record review for Resident #22 revealed an admitted to the facility of 3/13/25 with diagnoses that included in part the following: Presence of a Right Artificial Hip Joint, History of Falling, and Need for Assistance with Personal Care. The Admission MDS dated [DATE] documented Resident #22 scored 15 on the BIMS, indicating a cognitive response. The MDS noted Resident #22 was always incontinent of bowel. Review of the Physician's Orders for Resident #22 revealed in part the following orders: An order dated 3/13/25 for Indwelling Urinary Catheter (Catheter inserted in the bladder to drain urine). An order dated 3/13/25 to irrigate the Indwelling Urinary catheter with 60 cc normal saline as needed for blockage or leakage as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no order for catheter care. On 4/21/25 at 11:30 AM Resident #22 was observed lying in bed wearing pants with the legs pulled up above the knee. The resident had an indwelling urinary catheter. On 04/24/25 at 9:10 AM Certified Nursing Assistant (CNA) Staff H was observed performing catheter care for Resident #22. As CNA Staff H began catheter care Resident #22 started having a bowel movement. CNA Staff H gloved hands became soiled with the bowel movement. CNA Staff H changed her gloves without performing hand hygiene. CNA Staff H changed her gloves an additional time during the catheter care procedure without performing hand hygiene. During an interview conducted on 4/24/25 at 10:00 AM CNA Staff H stated she has worked at the facility for three and a half years. When asked about hand hygiene with changing gloves, she said she washed her hands before she started the catheter care for Resident #22 and washed her hands again when she was finished with the catheter care.