STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115411	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Nursing Center	475 Washington Street Metter, GA 30439

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138 Based on observations, staff interviews, and record review, the facility failed to place a privacy bag over the indwelling urinary catheter drainage bag of one of two residents (R) (R251) reviewed with a urinary catheter. This failure had the potential to diminish R251's quality of life in an environment that promotes the maintenance or enhancement of each resident's quality of life. Findings include: A policy was requested and not provided. A review of the clinical record revealed that R251 was admitted to the facility on [DATE], and the Minimum Data Set (MDS) was in progress. A review of the Physician's Orders revealed an order dated 8/9/2024 for a urinary catheter. A review of R251's care plan dated 8/19/2024 revealed a focus area of an indwelling urinary catheter due to urinary retention. There were no interventions for placing the drainage bag in a privacy bag. An observation on 8/18/2024 at 2:23 pm revealed R251's urinary catheter drainage bag was not in a privacy bag and was uncovered. An observation on 8/18/2024 at 5:30 pm revealed R251 walking down Hall 300 with his urinary catheter drainage bag strapped to his leg, not in a privacy bag, and uncovered. An interview on 8/20/2024 at 1:03 pm with the Director of Nursing (DON) confirmed that R251's urinary catheter drainage bag should be covered with a dignity bag. An interview on 8/21/2024 at 4:08 pm with Certified Nursing Assistant (CNA) DD revealed that R251's urinary catheter drainage bag should be covered for dignity purposes. An interview on 8/21/2024 at 4:12 pm with the Administrator revealed that R251's urinary catheter drainage bag should not be exposed and should be covered for dignity purposes.

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, resident and staff interviews, and record review, the facility failed to ensure two of 54 residents (R) (R49 and R1) reviewed did not have unsecured, unauthorized medications and over-the-counter medication products stored at the bedside. This failure placed R49 and R1 at risk for inappropriate and unsafe medication use and had the potential to allow unauthorized access to medications to other residents and visitors in the facility. Finding include: 1. Record review revealed R49 had diagnoses including, but not limited to, vascular dementia, moderate without other behavioral disturbances, chronic obstructive pulmonary disease with acute exacerbation, and hypokalemia. A review of R49's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15 (indicating little to no cognitive impairment). A review of the Physician's Orders revealed an order dated 4/4/2024 for Ventolin HFA (high-flow aerosol) solution 108 mcg/act (micrograms/actuation) (a medication used to treat wheezing and shortness of breath [SOB]), one puff orally every six hours as needed for SOB. A review of R49's Self-Administration assessment dated [DATE] revealed the resident was not capable or approved to self-administer medications, including inhalants. Observation of R49's room on 8/18/2024 at 3:00 pm revealed a prescription albuterol inhaler (generic medication for Ventolin) in a small pan near the resident's bed within open view. In an interview at the time of observation on 8/18/2024 at 3:01 pm, R49 reported receiving the inhaler from a previous medical appointment. He stated that his nurse was aware of the medication and advised him to keep it in his room. He reported using the inhaler every now and then. During an interview and observation on 8/18/2024 at 4:07 pm in R49's room, the Unit Manager (UM)/Licensed Practical Nurse (LPN) confirmed the albuterol inhaler in R49's room. She reported that R49 was not assessed to self-administer medication or approved to have medication in his room. She reported being unaware of the medication in the room and removed the medications from the resident's room. She reported that her expectation was for nurses to monitor resident rooms for medications at the bedside. In an interview on 8/21/2024 at 12:22 pm, the Director of Nursing (DON) reported being unaware of R49 having prescription medication (albuterol inhaler) in his room. She described the risk of a resident receiving duplicate inhalant medication as a possibility of increased heart rate. She reported that once the resident returned from his appointment, the nurse should have placed the albuterol medication from the doctor's office on the medication cart and notified the physician. 2. A review of R1's medical record revealed diagnoses including, but not limited to, dementia, schizophrenia, and bipolar disorder. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R1's quarterly MDS dated [DATE] revealed a BIMS of seven (indicating severe cognitive impairment). A review of R1's clinical record revealed there was no assessment for self-administration of medication for R1. Observation of R1's room on 8/18/2024 at 5:03 pm revealed a bottle of mouthwash (containing six percent alcohol) on the bedside stand within open view. At the time of observation, an interview was conducted with R1 regarding the mouthwash. R1 reported using the mouthwash daily and that a friend purchased the mouthwash for her. During an observation of R1's room and an interview with the UM/LPN on 8/18/2024, the UM/LPM confirmed the unauthorized mouthwash product at the bedside. She reported that only alcohol-free base mouthwash products were allowed for resident use. The UM/LPN removed the mouthwash from the room. In an interview on 8/21/2024 at 4:49 pm, the DON reported that her expectation was for staff to remove any harmful products from resident rooms and to monitor for unauthorized medication products. She further stated the risk of a resident using unauthorized medication products could have an adverse effect on the resident's blood pressure and cause other medical complications.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 45811 Based on staff interviews, record review, and review of the facility policy titled, New Hire Checklist, the facility failed to ensure pre-employment screenings, specifically reference checks and fingerprinting, were conducted prior to employment for four of 10 employees reviewed. This deficient practice had the potential to place residents residing in the facility at risk of abuse, neglect, and exploitation from staff. The census was 101 residents. Findings include: A review of the facility policy titled New Hire Checklist, revised December 21, 2023, revealed information obtained upon hire included employee references (at least two), background checks to include sex offender state and nationwide, and fingerprint if applicable. The section titled Background and Criminal Checks stated, A background check will be conducted including, but not limited to, consumer credit history, criminal history, fingerprints, driving record, employment, military, education, and general public records, which will provide information concerning these areas, and your character and general reputation. Your former employers, educational institutions, managers, co-workers, and references, may be contacted as part of this process. During a review of employee files on 8/19/2024 at 2:30 pm with the Director of Human Resources, it was revealed the following information was not available: Dietary Supervisor LL was hired on 5/27/1998, and a reference check was not completed. Certified Nursing Assistant (CNA) MM was hired on 7/23/2024, and a reference check was not completed. Dietary [NAME] NN was hired on 7/23/2024, and a reference check was not completed. Activities Assistant OO was hired on 7/18/2024 and a fingerprint procedure was not completed. Activities Assistant OO worked 7/23/2024, 7/24/2024, 7/25/2024, 7/26/2024, 7/27/2024, 7/29/2024, 7/30/2024, 7/31, 2024, 8/1/2024, 8/2/2024, 8/5/2024, 8/6/2024, 8/8/2024, 8/10/2024, 8/11/2024, 8/13/2024, 8/14/2024, 8/15/2024, 8/16/2024, 8/19/2024 without having a fingerprint procedure completed. During an interview on 8/19/2024 at 2:40 pm, the Director of Human Resources verified the missing pre-employment requirements and revealed she did not obtain the information because she had been very busy and did not get around to calling the references. She further stated she missed the date to get fingerprinting done for Activities Assistant OO. She stated she had 30 days after hire to get the fingerprinting done. During an interview on 8/21/2024 at 7:30 pm, the Administrator stated he was unaware of the missing pre-employment requirements. He stated he did not have an explanation of why the information was not in the files.

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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. 49675 Based on observations, staff interviews, record review, and review of the facility policy titled RAI (Resident Assessment Instrument)/Care Planning Management, the facility failed to implement the person-centered comprehensive care plan for one of 12 residents (R) (R78) with a care plan for fall mats and two of two R (R49 and R68) with a care plan for oxygen (O2). This failure had the potential for R78, R49, and R68 to not receive treatment and/or care according to their needs. Findings include: A review of the facility's undated policy titled RAI/Care Planning Management revealed the section titled Process for Completing the MDS (Minimum Data Set), CAAs (Care Area Assessments), and Care Plans stated, Standard: It is the practice of this facility to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Objective: 1. To identify resident's individual needs and care requirements. 2. To assure [sic] that an interdisciplinary team assesses the emotional, psychosocial, mental, and physical needs of each resident. 1. A review of R78's clinical record revealed diagnoses including, but not limited to, paranoid schizophrenia, Alzheimer's disease with late onset, and vascular dementia, severe, with other behavioral disturbances. A review of R78's care plan, last revised on 7/23/2024, revealed that R78 was at risk for falls related to poor safety awareness, medication side effects, a history of behaviors, and had a history of falls. The goal was for R78 to be free of fall-related injuries through the review date. Interventions included a fall mat to be placed on the floor beside the bed. Observations on 8/18/2024 at 3:20 pm, 8/19/2024 at 9:37 am, and 8/20/2024 at 10:09 am revealed the resident was lying in bed asleep, and there was no fall mat on the floor. In an observation and interview on 8/20/2024 at 4:15 pm, Licensed Practical Nurse (LPN) AA verified the resident did not have a fall mat by his bedside and that his care plan included interventions of a fall mat. LPN AA stated it was her expectation that she and other nurses follow the resident's care plans and use the interventions the care team implemented for the safety of the resident. In an interview on 8/21/2024 at 4:14 pm, the Regional Director of Nursing revealed it was her expectation that staff follow care plans and ensure fall mats were placed by the bedside if included in the care plan. In an interview on 8/21/2024 at 6:36 pm, the MDS Coordinator revealed she expected staff to follow the care plans. She stated she reviewed changes every morning in clinical meetings, and then care plans were updated as needed. She further stated care plan changes were communicated to staff when they occur. 36377 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of R49's medical record revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD) with acute exacerbation and hypokalemia. A review of R49's Physician Orders revealed an order dated 7/10/2024 for O2 per nasal cannula (NC) at 2 liters per minute (LPM) at night and as needed (PRN). A review of R49's care plan revealed a focus area, last revised on 6/12/2024, for being at risk for respiratory complications related to the disease process of COPD, and the resident will take O2 on and off and adjust settings. The interventions included administering O2 as ordered and observing O2 settings every shift and PRN while in use. Observations on 8/18/2024 at 1:01 pm, 4:00 pm, and 5:55 pm and on 8/19/2024 at 11:00 am revealed R49 receiving O2 via a NC at 2.5 LPM instead of 2.0 LPM. An observation and interview on 8/19/2024 at 11:21 am with LPN CC confirmed that R49 was receiving O2 at 2.5 LPM instead of 2.0 LPM. LPN CC reported being unaware of the care plan to monitor and check periodically to ensure R49's oxygen was set on the ordered flow rate. During an observation and interview on 8/20/2024 at 10:48 am, the Unit Manager confirmed that R49 's O2 was set at 2.5 LPM instead of 2.0 LPM and adjusted the O2 to 2.0 LPM. She reported being unaware of the resident's care plan to monitor the O2 settings. 3. A review of R68's medical record revealed diagnoses including, but not limited to, acute chronic respiratory failure with hypoxia or hypercapnia and chronic atrial fibrillation. A review of R68's Physician Orders revealed an order dated 6/11/2024 for O2 per NC at 2 liters LPM PRN shortness of breath (SOB). A review of R68's care plan revealed a focus area, last revised on 8/12/2024, for altered respiratory status/difficulty breathing related to sleep apnea, respiratory failure, obesity with hypoventilation, and COPD. The interventions included administering oxygen as ordered. Observations on 8/18/2024 at 2:00 pm and 4:03 pm and 8/19/2024 at 9:00 am and 11:24 am revealed R68 receiving O2 via a NC at 2.5 LPM instead of 2.0 LPM. In an interview on 8/21/2024 at 6:36 pm, the MDS Coordinator reported her expectation was for staff to follow the resident's care plans. The MDS Coordinator stated updates or changes to a resident's care plan were addressed in the morning clinical meetings. Cross-Reference F695

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, staff interviews, and record review, the facility failed to follow the physician's orders for two residents (R) (R43 and R78). Specifically for an evaluation for Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST) for R43 and for gastrostomy tube (G-tube) water flushes for R78. This failure had the potential for R43 and R78 to not receive medical treatment according to their needs and placed them at risk for adverse consequences. Findings include: 1. A review of R43's Face Sheet revealed R43 was admitted to the facility on [DATE] with a diagnosis including, but not limited to, contracture of left hand. A review of the admission Minimum Data Set (MDS), dated [DATE], and the quarterly MDS, dated [DATE], revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status Score (BIMS) of 15 (indicating little to no cognitive impairment). Section O (Special Treatments, Procedures, and Programs) documented the resident did not receive PT, OT, or ST. A review of R43's Physician Orders revealed an order dated 5/2/2024 for evaluations for PT, OT, and ST. Observation during the survey from 8/18/2024 through 8/20/2024 revealed R43 lying in bed with no splint device, and his left hand third and fourth fingers were folded into the palm of his hands. During an interview on 8/18/2024 at 3:25 pm, R43 reported a concern about not receiving therapy services for a splint device and range of motion (ROM) for his left-hand contracture. In an interview on 8/21/2024 at 12:58 pm, the Unit Manager acknowledged that R43 had a physician order for therapy evaluation. She reported being unaware that the order was not followed up on. In an interview on 8/21/2024 at 1:10 pm, the Director of Rehabilitation confirmed the therapy department had not performed therapy evaluations for R43. She confirmed that she met the resident at the time of admission and was aware of his contracture. She stated she felt the resident would benefit from ROM therapy services and a splint device. In an interview on 8/21/2024 at 4:55 pm, the Director of Nursing (DON) reported that her expectation was for physician orders to be followed. 49675 2. A review of R78's Face Sheet revealed diagnoses including, but not limited to, dysphagia and unspecified severe protein-calorie malnutrition. A review of R78's Significant Change MDS, dated [DATE], revealed section K (Swallowing/Nutritional Status) documented R78 had a feeding tube and received 51 percent or more of total calories and 501 cubic centimeters (cc) or more per day of fluid intake through the feeding tube. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R78's care plan, revised on 8/12/2024, revealed R78 will receive feeding and hydration via G-tube as ordered. A review of the Physician's Orders revealed an order dated 8/10/2024 to flush the G-tube with 5 cc of water after each medication and flush the G-tube with 30 cc of water before and after feedings. Further review revealed an order dated 8/11/2204 for Jevity 1.5, give 237 milliliters (ml) every four hours. A review of the medication administration record (MAR) dated 8/2024 revealed no documentation of G-tube water flushes with medications or feeding. A review of the Progress Notes revealed no documentation of water flushes of the G-tube. In an interview on 8/20/2024 at 4:15 pm, Licensed Practical Nurse (LPN) AA verified water flushes of the G-tube were not documented on the MAR or in the clinical record. She revealed her expectations were for staff to follow physician orders by flushing the G-tube and document if it was performed. In an interview on 8/21/2024 at 4:14 pm, the Regional Director of Nursing revealed the nurse who receives the physician's order was responsible for transcribing it onto the MAR. She stated her expectation was for physician orders to be listed on the MAR and followed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, staff interviews, and record review, the facility failed to provide services to increase or prevent a decrease in range of motion (ROM) for one of 52 sampled residents (R) (R43). The deficient practice had the potential to place R43 at risk for medical complications, unmet needs, and a diminished quality of life. Findings include: A review of R43's Face Sheet revealed that R43 was admitted to the facility on [DATE] with a diagnosis including, but not limited to, contracture of the left hand. A review of the admission Minimum Data Set (MDS), dated [DATE] revealed section C (Cognitive Patterns) documented a Brief Interview for Mental Status Score (BIMS) of 15 (indicating little to no cognitive impairment). Section O (Special Treatments, Procedures, and Programs) documented the resident did not receive Physical Therapy (PT) or Occupational Therapy (OT). A review of R43's Physician Orders revealed an order dated 5/2/2024 for evaluations for PT, OT, and Speech Therapy. A review of 43's care plan, last revised on 7/26/2024, revealed a focus area of being at risk for complications related to contractures, being dependent on staff for ADLs (Activities of Daily Living), and having impaired mobility. Interventions included providing ROM as tolerated during ADL care. A review of the Plan of Care (POC) used by the Certified Nursing Assistants (CNAs) revealed no instruction to provide ROM to the resident's left hand. Continued review revealed the contracture of the left hand was not identified on the form. Observation during the survey from 8/18/2024 through 8/20/2024 revealed R43 lying in bed with no splint device, and his left hand third and fourth fingers were folded into the palm of his hands. In an interview on 8/18/2024 at 3:25 pm, R43 reported that staff was not providing ROM of his left hand. R43 reported that he did not have full flexion of the fingers on his left hand. He further stated he had not been evaluated by therapy since admission to the facility. In an interview on 8/21/2024 at 12:54 pm, CNA DD confirmed not providing ROM to R43's left hand. She reported being aware that the resident had a contracture of the left hand. In an interview on 8/21/2024 at 12:58 pm, the Unit Manager reported she was aware that R43 had a contracture of the left hand. She stated she thought the resident was referred for PT and OT to evaluate him to address the contracture. In an interview on 8/21/2024 at 1:10 pm, the Director of Rehabilitation stated the therapy department had not performed a therapy evaluation for R43. She confirmed that she was aware of the resident's contracture of his left hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/21/2024 at 4:55 pm, the Director of Nursing (DON) stated once the therapy department evaluated a resident, therapy recommendations were added to the CNA POC.

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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. 45811 Based on observations, staff interviews, record review, and review of the facility policy titled, F-689 Accidents -Water Temperatures, the facility failed to maintain safe water temperatures at the hand washing sink in 12 of 28 resident bathrooms and two of three resident shower rooms. In addition, the facility failed to ensure an environment free from chemical and environmental hazards in one of three shower rooms. This deficient practice placed the residents residing in the affected rooms and using the affected shower rooms at risk of avoidable injuries and a diminished quality of life. The census was 101 residents. Findings include: 1. A review of the facility's undated policy titled, F-689 Accidents - Water Temperatures, revealed the section titled F - 689 Description stated, The facility must ensure that the resident environment remains free of accident hazards as is possible and each resident received adequate supervision and assistance devices to prevent accidents. The section titled Purpose included, The purpose of recording your water temperatures is to assure the Surveyor that your facility is remaining as free from accidental burns and scalds as possible and that any issues are addressed in a prompt and consistent manner. During observation on 8/18/2024 at 2:00 pm, the hot water in the shared bathroom of Rooms A1 and A3 felt hot to touch. The surveyor was able to keep a hand under the water for only about five seconds. During an interview on 8/18/2024 at 2:45 pm, the Maintenance Director revealed he checked water temperatures every day and randomly picked rooms and sinks to test. On 8/18/2024, the following water temperatures in resident bathroom sinks were obtained by the Maintenance Director using the facility's calibrated thermometer: 4:23 pm Rooms A1 and A3 shared bathroom = 117 degrees Fahrenheit (F). 4:24 pm Rooms A9 and A11 shared bathroom = 116 degrees F. 4:50 pm Rooms B3 and B5 shared bathroom = 114 degrees F. 4:53 pm Rooms B7 and B9 shared bathroom = 114 degrees F. 4:56 pm Room B11 bathroom = 114 degrees F. 5:00 pm Room B1 bathroom = 112 degrees F. 5:05 pm Rooms A5 and A7 shared bathroom = 111 degrees F. 5:07 pm Rooms A10 and A12 shared bathroom = 110.3 degrees F. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5:10 pm Rooms D2 and D4 shared bathroom = 119 degrees F. 5:12 pm Rooms D1 and D3 shared bathroom = 123 degrees F. 5:15 pm Room D19 bathroom = 115 degrees F. 5:17 pm Room D16 bathroom = 111 degrees F. 5:19 pm D Hall Shower = 112 degrees F. 5:27pm C Hall Shower = 116 degrees F. A review of a temperature logbook dated 5/20/2024 through 8/16/2024 revealed documented temperatures for the shower rooms ranging from 112 to 118 degrees F. During an interview on 8/18/24 at 5:00 pm, the Director of Maintenance stated the hot water temperature should be 107 or 108 degrees F. He verified the temperatures documented in the logbook and stated someone had told him to keep the temperatures at 114 degrees F for the shower rooms. During an interview on 8/18/2024 at 6:00 pm, the Maintenance Director stated the mixing valve unit was set at 110 degrees F and further stated he turned the device down, but it went up to 116 degrees F. He stated the hot water heater in the Behavioral Unit was at 115 F, and he had turned it down. On 8/18/2024 at 6:15 pm, the Administrator was informed of the elevated water temperatures. He stated the temperatures of the entire building would be checked every shift until the temperatures were down, and the residents in the Behavior Unit would be monitored until the water temperatures were down. During an interview on 8/18/2024 at 6:45 pm, the Director of Maintenance stated the mixing valve was set at 112 degrees F. He stated he may have turned it up instead of down, and he turned it down. During an interview on 8/19/2024 at 10:00 am, the Director of Maintenance stated water temperatures in resident rooms were checked every four hours during the evening and night shifts, and the temperatures were below 110 degrees F. He stated he would continue to check the temperatures every four hours. During an interview and observation of hot water temperatures on 8/19/2024 at 1:00 pm with the Director of Maintenance, the following temperatures were observed: Rooms D1 and D3 shared bathroom = 116 degrees F. Rooms D6 and D8 shared bathroom = 115 degrees F. During an interview on 8/19/2024 at 1:45 pm, the Administrator stated he would notify the [NAME] President of the company to discuss the rising water temperatures in the Behavioral Unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/19/2024 at 2:30 pm, the [NAME] President stated there was a faulty thermostat on the re-circulation pump and the Director of Maintenance would re-adjust it, which should maintain the temperatures. During an interview on 8/19/2024 at 4:00 pm, the Director of Maintenance stated he checked the water temperatures in the building, and none were elevated. Observations of temperature checks with the Maintenance Director on 8/19/2024 at 6:25 pm revealed the water temperature in Rooms D1 and D3 shared bathroom = 100 degrees F and in Rooms D6 and D8 shared bathroom = 94 degrees F. 49675 2. Observations on 8/18/2024 at 5:27 pm, 8/19/2024 at 2:46 pm, and 8/19/2024 at 5:50 pm in the D Hall Shower Room located in the secured Behavioral Health Unit revealed a cart containing a bottle of 70 percent isopropyl alcohol and a hand-held hair dryer. The hair dryer was plugged into a wall electrical outlet on one side of the sink, with the cord running under the sink. Further observation revealed four wet floor signs, shoes, clothing, toilet paper, and towels scattered on the floor. During observation and interview on 8/19/2024 at 3:35 pm, the Administrator and the Maintenance Director confirmed the findings in the D Hall Shower Room. The Administrator unplugged the hair dryer from the wall and placed it on the cart next to the sink stating someone could get seriously hurt. He stated that the condition of the shower room was unacceptable and posed numerous accident hazards. During observation and interview on 8/19/2024 at 4:50 pm, Licensed Practical Nurse (LPN) BB confirmed the bottle of 70 percent isopropyl alcohol was on a cart and stated it should be in a locked cabinet. In an interview on 8/21/2024 at 4:53 pm, the Regional Director of Nursing revealed hazardous chemicals, such as isopropyl alcohol, should not be in resident shower rooms. A policy pertaining to environmental hazards was requested and not provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, staff interviews, record review, and review of the facility policy titled, Respiratory System Management Standard, the facility failed to ensure two residents (R) (R49 and R68) receiving oxygen (O2) therapy were administered O2 in accordance with the physician order. The deficient practice had the potential to increase the risk of respiratory complications for R49 and R68. The sample size was 52 residents. Findings include: A review of the facility's undated policy titled, Respiratory System Management Standard, revealed the section titled Oxygen Therapy Protocol stated, Standard oxygen therapy is the administration of oxygen at concentrations greater than ambient air to: Treat or prevent hypoxemia, decrease work of breathing, decrease myocardial work. Procedure to follow in order (1). Check the physician's orders in the resident's clinical record. 1. A review of R49's medical record revealed diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD) with acute exacerbation and hypokalemia. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed section O (Special Treatments and Programs) documented that R49 received O2 while a resident. A review of the Physician Orders revealed an order dated 7/10/2024 for O2 per nasal cannula (NC) at 2 liters per minute (LPM) at night and as needed (PRN). Observations on 8/18/2024 at 1:01 pm, 4:00 pm, and 5:55 pm, 8/19/2024 at 11:11 am, and 8/20/2024 at 10:48 am, revealed R49 receiving O2 by a concentrator and via a NC at 2.5 LPM. 2. A review of R68's medical record revealed diagnoses including, but not limited to, acute chronic respiratory failure with hypoxia and hypercapnia. A review of the quarterly MDS dated [DATE] revealed section O (Special Treatments and Programs) documented that R49 received O2 while a resident. A review of R68's Physician Orders revealed an order dated 6/11/2024 for O2 per NC at 2 liters LPM PRN shortness of breath (SOB). Observations on 8/18/2024 at 2:00 pm and 4:03 pm, 8/19/2024 at 9:00 am, and 8/20/2024 at 10:48 am revealed R68 receiving O2 by a concentrator and via a NC at 2.5 LPM. In an interview at the time of observations on 8/19/2024, Licensed Practical Nurse (LPN) CC confirmed that R49 and R68 were receiving O2 by a concentration and via a NC at 2.5 LPM instead of 2.0 LPM. LPN CC reported being unaware to monitor and ensure R49's O2 was set on the correct liter. She further stated she was unaware if the resident adjusted the O2 flow meter on the concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 8/20/2024 at 10:48 am, the Unit Manager confirmed that R49 and R68's O2 were set to 2.5 liters instead of 2.0 liters. She adjusted the O2 to 2.0 LPM for both residents. She reported that her expectation was to ensure residents were receiving O2 as ordered. She said that R49 was capable of putting on his NC appropriately but not competent in adjusting the flow meter for the correct liter per his physician's order. She reported that her expectation was for the nurse to monitor the O2 during the medication pass. She reported that the resident independently adjusting his O2 and staff not monitoring the O2 setting placed R49 at risk for complications. In an interview on 8/21/24 at 6:36 pm, the MDS Coordinator stated R49 had a history of adjusting the flow meter on his O2 concentrator. She reported that her expectation was for staff to monitor R49 and R68 's O2 settings. In an interview on 8/21/2024 at 12:17 pm, the Director of Nursing (DON) reported that her expectation was for staff to ensure O2 was administered according to the physician's order. She further stated that R49 was at risk of COPD exacerbation by receiving more than the ordered amount of O2.

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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. 45811 Based on observations, interviews, and a review of the facility's policy titled, Medication Administration Guidelines, the facility failed to ensure that one of two medication carts was locked and secured when unattended by the nurse. The deficient practice had the potential to allow unauthorized persons, including residents and visitors, to access medications. The census was 101 residents. Findings include: A review of the facility policy titled, Medication Administration Guidelines, dated August 2021, revealed the section titled Safe Medication Administration included, Medication carts are to be kept locked at all times and under the vision supervision of the licensed nurse. During observation on 8/18/2024 from 12:15 pm to 12:21 pm, Medication Cart 2 was parked in the hallway, unattended, and unlocked. The medication drawer was pulled, and it opened without a problem. Registered Nurse (RN) JJ approached the cart and locked it. During an observation on 8/18/2024 at 6:41 pm, Medication Cart 2 was parked in the hallway, unattended, out of sight of a nurse, and unlocked. Licensed Practical Nurse (LPN) II noticed the surveyor looking at the cart and locked it. During an interview on 8/18/2024 at 7:00 pm, RN JJ revealed the medication cart should be locked unless a nurse was at the cart. She confirmed that the cart was unlocked this shift and there was not a nurse at the cart. During an interview on 8/18/2024 at 7:05 pm, LPN II revealed the medication cart needs to be locked unless the nurse was at the cart. LPN II confirmed she left the cart opened earlier this shift and stated she had a resident who was transported to the emergency room and she forgot and left the cart open. During an interview on 8/21/2024 at 5:00 pm, the Unit Manager stated the medication cart should always be locked unless the nurse is present and giving medications. During an interview on 8/21/2024 at 5:30 pm, the Director of Nursing (DON) revealed the medication cart should be locked when the nurse is not present at the cart.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 36377 Based on observations and staff interviews, the facility failed to ensure three of three garbage dumpsters were maintained in sanitary conditions, free from trash and debris on the ground, and with secure fitting lids. The deficient practice had the potential to promote the harboring of pests, rodents, insects, and other organisms. The facility census was 101 residents. Findings include: Observation of the dumpster on 8/18/2024 at 3:15 pm with the Dietary Manager (DM) and Maintenance Director revealed trash piled up high and spilling over to the ground in three of three dumpsters. Further observation revealed opened bags of trash, exposing dirty briefs with fecal matter, wipes covered in feces were observed scattered on the ground surrounding the dumpsters. Continued observation revealed swarms of flies and at least 50 large clear white trash bags on the ground around the dumpsters. The large clear bags contained food, trash, and soiled personal care items. An interview at the time of observation on 8/18/2024 at 3:16 pm was conducted with the DM and Maintenance Director. Both staff members confirmed that the dumpsters were not being maintained in sanitary conditions. They confirmed the exposure of feces from the briefs, food items, and trash. The DM reported the problem with the dumpsters had existed since the previous Monday. She stated that trash bags on the ground increased due to not having enough room in the dumpsters to place the trash. The Maintenance Director reported the problem existed because the bill for the trash service had not been paid by the facility. In an interview on 8/18/2024 at 3:41 pm, the Maintenance Director revealed that trash was not picked up due to nonpayment to the trash pick-up company. He reported the trash started to pile up the previous Sunday. He stated the scheduled days for trash pick-up were Monday and Thursday, and the trash was last picked up on 8/8/2024. The Maintenance Director further stated he informed the Administrator of the failure of the trash being picked up on 8/13/2024. He stated he was not given specific instructions on what to do about the trash. In an interview on 8/21/2024 at 9:18 am, the Administrator confirmed the dumpsters were not maintained in sanitary conditions, and he had failed to provide staff with instructions on handling the trash pile up. He stated the corporate office was notified on 8/14/2024 about a problem with payment to the trash pick-up company, and he understood the bill was already paid. He stated having trash dumpsters in an unsanitary manner increased the risk of animals, pests, and insects. He stated he was unaware the bags were spilling trash on the ground and stated that if he had been notified of trash on the ground, he would have removed it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45811 Based on observations, staff interviews, and review of the facility's policies titled, Laundry Linen: Handling of, and Biohazardous/Infectious Waste, the facility failed to follow acceptable infection control practices to prevent cross-contamination during a glucometer check for one resident, during the storage of linen in one linen storage room, during the storage of soiled linen in two shower rooms, and during the storage of washbasins and urinals in three resident restrooms. These deficient practices had the potential to increase the risk of cross-contamination and spread infections. Findings include: 1. During observation of the glucometer procedure on 8/19/2024 at 10:30 am, Licensed Practical Nurse (LPN) GG performed a fingerstick blood sugar on one resident. Observation revealed LPN GG placed the supplies on the surface of the cart before entering the resident's room without sanitizing or placing a barrier on the cart. She performed the procedure and placed the used supplies (including the glucometer, used alcohol pad, and used fingerstick device) on the surface of the cart without sanitizing or using a barrier on the surface of the cart. In an interview at the time of the observation, LPN GG confirmed she did not use a barrier to put her supplies on. She stated she should have used a barrier under the meter and supplies. During an interview on 8/21/2024 at 4:30 pm, the Unit Manager stated the nurse should use a barrier to put the glucometer and supplies on and not just lay them on the surface of the cart. During an interview on 8/21/2024 at 4:45 pm, the Director of Nursing (DON) stated the nurse should use a barrier on the surface of the cart after using the glucometer. 49138 2. An observation on 8/18/2024 at 2:45 pm of room [ROOM NUMBER]A 400 Hall revealed one washbasin in the bathroom unbagged and not labeled with a resident's name. An observation on 8/18/2024 at 2:37 pm of room [ROOM NUMBER]B 400 Hall revealed one washbasin in the bathroom unbagged and not labeled with a resident's name. An observation on 8/18/2024 at 2:32 pm of room [ROOM NUMBER]B 200 Hall revealed three washbasins in the tub and one urinal hanging on the toilet paper holder unbagged and not labeled with a resident's name. In an interview on 8/20/24 at 3:25 pm, the DON confirmed all washbasins and urinals should be bagged and labeled with a resident's name. 49675 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of the facility policy titled, Laundry Linen: Handling of, revised September 2023, revealed the section titled, Transportation of Clean Linen included . 3. Cover stored linen to protect from contamination until the linen is distributed for resident use. 5. Transport collected and bagged linen by cart or soiled linen chute to the laundry area at regular intervals as needed. a. Do not allow hampers to overfill, lids must be closed. A review of facility policy titled, Biohazardous/Infectious Waste, revised September 2023, revealed the section titled Overview included The facility will dispose of Infectious Waste according to the Federal Government Environmental Protection Agency (EPA) requirements or according to state and local regulations, whichever is the strictest. The section titled Procedure included . 5. Dispose of sharps, used and unused, in an impervious, rigid, puncture-resistant, leak-proof on the sides and bottom, closable sharps container. Do not overfill. Observation on 8/19/2024 at 1:23 pm revealed a small storage room with an exit door from the main building that led to the outdoor laundry facility. The storage room contained two wire racks. The bottom shelf of the racks contained pillows that were touching the concrete floor. The other shelves contained linen which was uncovered and exposed to the environment. During an observation and interview on 8/19/2024 at 1:35 pm, the Account Manager stated he was over the laundry and housekeeping departments and confirmed the pillows in the storage room were touching the floor, and the linen was uncovered. He stated this was a mistake and would be corrected. Observations on 8/18/2024 at 5:19 pm and 8/19/2024 at 11:58 am of the D Hall Shower Room revealed a basket of soiled clothes, a plastic hamper of soiled towels, soiled towels lying on the floor, soiled toilet paper lying next to the toilet, a box fan turned on and running covered in dirt and dust sitting on the back of the toilet, numerous clothing items such as shoes and clothes hanging on grab bars and lying on the floor, two rolls of toilet paper lying on the floor, and a sharps container overfilled with a razor exposed. Observations on 8/18/2024 at 5:27 pm and 8/19/2024 at 11:55 am of the C Hall Shower Room revealed soiled wet towels in the shower stall, numerous soiled wet towels in a pile on the shower room floor, an overflowing trash can, and an uncovered plastic tub full of clothing on a shower bed. During observation and interview on 8/19/2024 at 3:35 pm, the Administrator and Maintenance Director confirmed the findings in both shower rooms. The Administrator stated the findings in the shower rooms were unacceptable. He acknowledged the identified concerns were infection control issues and would be corrected. During an observation and interview on 8/19/2024 at 4:50 pm, LPN BB confirmed a sharps container located in the D Hall Shower Room was full and had an exposed disposable razor. LPN BB stated the sharps container was full and needed to be changed out. In an interview on 8/21/2024 at 4:30 pm, the Infection Control Preventionist (ICP) stated her expectations were for staff to ensure linens were always covered during storage and for linen and clothing to be off of the floors to avoid exposure to contamination. She further stated sharps containers should be changed out when they were full and acknowledged these concerns could spread infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/21/2024 at 4:53 pm, the Regional Director of Nursing confirmed that sharps containers should be emptied when they are full. She revealed there was no one designated to change out sharp containers.