STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115435	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hartwell Health and Rehabilitation	94 Cade Street Hartwell, GA 30643

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50272 Based on observations, staff interviews, record review, review of facility's policy titled, , Housekeeping, review of the documents titled, Patient Room Cleaning Standard and 10 Step Patient Room Cleaning, the facility failed to maintain clean exhaust fans for six shared bathrooms out of 35 bathrooms. This had the potential to compromise the hygiene and safety of the shared bathroom environments, increasing the risk of infection and negatively impacting the health and well-being of residents. The facility census was 84. Findings Include: A review of the facility's policy titled Housekeeping, dated 12/29/2023, under the section titled Intent revealed, It is the intent of this center to maintain a clean and sanitary center that is free from odor and other environmental factors that may affect the quality of life of our patients. Under the section titled Guidelines revealed, This center should be cleaned in a manner that is consistent with protocols and recommendations from the manufacturer of the chemicals and supplies used. A review of the facility standards document titled, Patient Room Cleaning Standard, revealed Dust: Always dust starting with high level surfaces (top to bottom/high to low). 1. Using the microfiber dusting tool begin at the entranceway and working around the room in a circle. 2. Never dust above a patient. 3. Dust the patient room first, the bathroom last. 4. Remove dusting tool head and place in dirty receptacle. A review of the facility's manufacturer protocol/recommendations titled 10 Step Patient Room Cleaning, revealed on the 3rd step to high dust and on the 8th step room inspection. An observation on 10/22/2024 at 10:07 am revealed that the exhaust fans in the shared bathroom of room [ROOM NUMBER] and room [ROOM NUMBER] were covered with a thick layer of white, fuzzy substance, indicating a significant buildup of dust and possible mold. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 10/22/2024 at 10:45 am revealed that the exhaust fan in the shared bathroom of room [ROOM NUMBER] and room [ROOM NUMBER] was covered with a thick layer of white, fuzzy substance, indicating a significant buildup of dust and possible mold. An observation on 10/22/2024 at 11:04 am revealed that the exhaust fans in the shared bathroom of room [ROOM NUMBER] and room [ROOM NUMBER] were covered with a thick layer of white, fuzzy substance, indicating a significant buildup of dust and possible mold. Observation and interview on 10/23/2024 at 1:49 pm with the Maintenance Supervisor (MS) revealed that the exhaust fans in resident rooms should be cleaned daily. MS revealed it was brought to his attention that the fans in certain resident rooms were dusty. MS communicated this concern to the Administrator, who then informed the Housekeeping Supervisor (HS). MS revealed that the housekeeping aides were instructed to clean the exhaust fans in all resident rooms. Additionally, the MS revealed that he conducted an internal test once a month on all exhaust fans located in resident bathrooms to ensure they were clean, he inspected the exhaust fans on the roof of the facility, and he maintained inspection logs for these activities. Interview on 10/24/2024 at 9:48 am with Environmental Service Aide (ESA) AA, who oversaw Hall 1 revealed that she dusted the exhaust fans every two weeks and checked them daily. Although ESA AA mentioned that the HS had instructed her to check the exhaust fans daily, she dusted them every two weeks and as needed. ESA AA confirmed that she had in-service training regarding infection control. Interview on 10/24/2024 at 9:57 am with ESA BB revealed that she was responsible for Hall 3. ESA BB stated that she checked the exhaust fans at least twice a week but was not aware of any specific policies or protocols regarding how often they should be cleaned. ESA BB noted that she was informed about the dirty exhaust fans in residents' rooms on 10/22/2024. Interview on 10/24/2024 at 9:56 am with Environmental Service Supervisor (ESS) revealed that ESAs were encouraged to inspect the exhaust fans in residents' rooms daily. ESS verified that the ESA's should be cleaning the exhaust fans approximately three times a week. ESS confirmed that on Hall 3, there were two to three rooms where the exhaust fans had more debris than in others. ESS expectation was that the environmental aides check the exhaust fans daily. ESS revealed that ESA BB on Hall 3 was relatively new and required frequent reminders about various tasks. In an interview on 10/24/2024 at 10:43 am with the Administrator revealed that the expectations for cleaning included thoroughly sanitizing the entire room from top to bottom, which specifically encompasses ensuring that the exhaust fans are free of dust.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46579 Based on observation, staff interviews, record reviews, and review of the facility's policies titled, Elopement, Anti-Wandering Equipment, and Bedside Storage of Medications, the facility failed to ensure two residents (R) (R54 and R68) with wander guards, were properly assessed for an elopement risk, and that their skin under the wander guard was properly assessed for breakdown. In addition, the facility failed to adequately assess R32 for self-administration of medication. This failure had the potential to place the residents at risk for adverse consequences. The sample size was 30 residents. Findings include: Review of the facility policy titled Elopement with a review date of 12/29/2023, revealed that the intent is to promote person-centered care for patients at risk for elopement. The policy also revealed that elopement is defined when a patient leaves the premises or a safe area without authorization and/or necessary supervision. The assessment section of the procedure states that the center will take a proactive approach for new residents and assess new admissions for elopement risk. It then continues by stating that the licensed nurse will re-assess resident at least quarterly, annually, with any significant change, and upon readmission to the center. Review of the undated policy titled Anti-Wandering Equipment Policy revealed that the facility uses anti-wandering equipment inside the facility to alert staff when a resident that is at risk for elopement is close to the front entrance. It also stated that residents that have exhibited one or more of the following behaviors meet the criteria of placement of wander guard transmitter: aimless wandering and/or has exit seeking behaviors, resident states or has stated that they will leave the facility, and the resident ambulates with or without assistive devices and has impaired cognition. Review of the undated facility policy titled, Bedside Storage of Medications revealed, under section titled, Intent To support self-administration of medication by appropriate patients within the nursing center while facilitating medication security. Under section titled Guideline, it documented, The Pharmacy supports bedside medication storage for patients who are able to self-administer medications upon the written order of the prescriber and when it is deemed appropriate in the judgment of the nursing center's interdisciplinary patient assessment team. Furthermore, under section titled Procedure revealed, A medication-specific order is required from the prescriber for bedside medication storage (e.g., add May keep at bedside to each applicable medication order). Bedside medications may be labeled May keep at bedside by the provider pharmacy upon request. An assessment for self-administration of medications is completed and kept in patient's care plan in the medical records. The manner of storage must prevent access by other patients. Lockable drawers or cabinets are REQUIRED. Patients who self-administer medications are asked during each med pass if he/she has taken any meds. Each dose self-administered at bedside is documented on the Medication Administration Record (MAR). The patient informs nursing staff when as needed (PRN) doses have been taken. Nurses and aides report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and give unauthorized medications to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of this procedure and related policy when necessary. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of the Electronic Medical Record (EMR) revealed that R54 was admitted to the facility on [DATE] with diagnoses that included but are not limited to Alzheimer's disease, adjustment disorder with mixed anxiety, depressed mood, and dementia. Review of the physician orders revealed that there were no orders for behavior monitoring, a wander guard, or skin checks for the area under the wander guard bracelet. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed for Section C (Cognitive Patterns) R54 had a Brief Interview for Mental Status (BIMS) score of 11, that indicated moderately impaired cognition; Section E (Behaviors) revealed no behaviors at the time of the assessment; Section GG (Functional Abilities and Goals) revealed the resident was ambulatory with no assistive devices used. Review of the care plan revealed R54 was at risk for elopement related to exist seeking behavior as evidenced by a history of aimless wandering, exit seeking behavior, and the resident left the property twice on 8/1/2024. Interventions included staff were to provide one on one supervision while outside, provide activities of interest, redirect as needed, and use of a wander guard on resident's wrist. Review of the assessments revealed R54 had an elopement risk assessment dated [DATE] with an elopement risk score of 14 indicating moderate risk. The risk assessment was signed on 10/24/2024 by Social Services. Social Services also completed a behavioral assessment on 8/2/2024, after the resident had left the building twice the prior day on 8/1/2024. 2. Review of the EMR revealed R68 was admitted to the facility on [DATE] with diagnoses that included but were not limited to metabolic encephalopathy, cognitive communication deficient, dementia and delirium. Review of physician orders revealed there were no orders for behavior monitoring, a wander guard, or skin monitoring under and around the wander guard. Review of the Admission/5-day MDS assessment dated [DATE] revealed for Section C (Cognitive Patterns) R68 had a BIMS score of seven, that indicated moderately impaired cognition; Section E (Behaviors) revealed delusions and behavioral symptoms occurred daily that were not directed towards others and Section GG (Functional Abilities and Goals) revealed R68 was ambulatory and did not require any assistive devices for mobility. Review of the care plan revealed that on 9/5/2024, R68 was at risk for wandering and elopement, related to a diagnosis of dementia. That risk was evidenced by the resident being a new admission, highly confused, frequent request to go home, and ambulated independently with or without assistive devices. Interventions included, distract resident from wandering, redirect to appropriate places, and a wander guard placed on resident. Review of assessment's that were completed after R68's admission by social services included but not limited to the following: 1. A behavioral assessment dated and signed on 8/9/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A wander guard was not an intervention added for the resident at that time. 3. A comprehensive nursing assessment dated of 8/6/2024. 4. An elopement risk assessment dated [DATE] revealed R68 had an elopement risk score of 20, which meant there was a moderate risk. However, the assessment was not signed until 10/24/2024. Review of an additional Elopement Risk Assessment for R68 dated 10/24/2024 revealed that there was no elopement risk. Observation on 10/22/2024 at 1:54 pm revealed R68 ambulating in the hallway. An observation inside R68's room revealed five black bags full and tied up, and a stack of books on the over-the-bed table. R68 entered the room and revealed that she was going home, and that the recliner was given to her by a friend. R68 further revealed she did not know how she was going to get the recliner home but that all her other belongings were bagged, and the stack of books was ready to go with her. R68 was dressed, and a wander guard bracelet was on her right wrist. Observation on 10/23/2024 at 9:45 am revealed R68 ambulating in the hallway, headed to her room. Inside her room it was noted that black bags were still tied and was laying throughout the room. The stack of books was stacked on her bed. R68 was pleasant and revealed that she was still waiting to go home. The wander guard was still on her right wrist. Interview on 10/24/2024 at 4:00 pm, the Social Services Director revealed she had been here for 15 to [AGE] years, and use of a wonder guard depended on cognitive status. If they exhibited exit seeking behavior, staff discussed it in morning meeting and then they would place it on them. She revealed they do not need an order. The SSD did not know about assessments the nurses did. Interview on 10/24/2024 at 4:47 pm, the Director of Nursing (DON) revealed the elopement and wander guard process. The elopement risk assessment is included in the comprehensive assessment at admission. It is also completed when MDS assessments are completed, quarterly and annually. She revealed a wander guard is used when residents demonstrate certain behaviors, and they start by doing an elopement risk assessment. She revealed that they did not need an order, the physician knows about it, and it should be care planned. She revealed the nurse should document in the chart that the wander guard is in place and that skin is intact, and she thought it was on the electronic Medication Administration Record (eMAR). 50272 3. Review of the EMR for R32 revealed she was admitted to the facility on [DATE]. R40 had diagnoses that included but not limited to, unspecified dementia (moderate) with other behavioral disturbance, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, unspecified sequelae of cerebral infarction, other lack of coordination, pain (unspecified). Review of R32's quarterly Minimum Data Set (MDS) dated [DATE] documented in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) of 13, which indicated the resident was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan revised on 8/12/2024, revealed R32 was care planned for cognitive impairment related to dementia and history of cerebrovascular accident (CVA), as evidence by memory problem, poor decision making/needs cues, on dementia medications, memory problem short term, and impaired decision making in new situation. Review of the care plan revised on 8/12/2024, revealed R32 was care planned for risk for communication difficulties related to dementia and history of CVA as evidence by ability limited to making concrete requests and hearing mildly impaired. Further review of the care plan revealed R32 had not been cared planned for any kind of self-administration of medication. Review of consolidated physician orders for R32 with print date of 10/24/2024 revealed no orders were found for Mentholatum Original Ointment (Topical Analgesic Rub). Review of the EMR for R32 revealed on 10/23/2024 the facility had conducted an Assessment Self-Administration of Medications, documenting the medications under consideration was [Name] vapor rub. The assessment documented that R32 was unable to correctly state the name of the medication and what it was used for, and that the resident could read the print on the prescription label but requires assistance. R32 was unable to correctly state the common side effects of each medication. R32 was unable to correctly state what time the medications are to be taken. R32 is unable to correctly state the proper dosage for each medication. R32 was unable to demonstrate proper handwashing techniques prior to and following medication administration. R32 was able to correctly measure the appropriate amount of medication from the container, but only with assistance. R32 was unable to correctly document self-administration of medications. R32 was unable to demonstrate secure storage for medications kept in their room. R32 was able to correctly state situations warranting the administration of PRN medications but requires assistance. R32 was unable to correctly document the administration of PRN medications. R32 was able to correctly request medications stored at the nurses' station but needs assistance. R32 was able to open and close medication containers but requires assistance. Approval for self-administration has not been granted. Additionally, there was no physician's order for self-administration of the specific medication under consideration. Review of the EMR for R32 revealed on 10/23/2024 the facility had conducted an Patient Education V2, and an explanation of non-ordered items by the physician was covered, specifically noting that menthol ointment was not recommended for use on the lips. R32 representative notified of this education. Furthermore, R32 was able to voice understanding in response to the education provided. Observation and interview on 10/22/2024 at 10:18 am with R32 revealed that a container of Mentholatum Original Ointment (Topical Analgesic Rub) was observed on her bedside table. R32 stated that she uses it on her lips when they get dry and mentioned that she has been using it for a long time. R32 also noted that the staff is aware of the ointment's presence but do not address it. Observation and interview on 10/23/2024 at 11:48 am revealed that the same container of Mentholatum Original Ointment (Topical Analgesic Rub) 28 G was again observed on her bedside table. R32 stated that she used the ointment on her lips earlier that day. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/23/2024 at 11:53 am in R32's room with Licensed Practical Nurse (LPN) DD revealed, that she had not seen the Mentholatum Original Ointment (Topical Analgesic Rub) on R32's bedside table. LPN DD further mentioned that R32 was not allowed to have the topical analgesic rub because there was no order for it. LPN DD immediately took the Mentholatum Original Ointment (Topical Analgesic Rub) from R32's bedside table. LPN DD indicated that she checks residents' rooms multiple times a day and was not in the facility on 10/22/2024. LPN DD noted that Certified Nursing Assistants (CNAs) have received in-service education regarding bedside medication, but she did not recall when this training was conducted. LPN DD expressed concerns about negative outcomes from having unprescribed medication at the bedside, stating that R32 could have a reaction, take the medication incorrectly, become ill and require hospitalization , or that a roommate could access it. Interview on 10/24/2024 at 10:27 am with the Director of Nursing (DON) revealed that residents with bedside medication are supposed to have orders, and there is a process that must be followed. The DON indicated that the family was informed of this process and that assessments must be conducted before any medication can be used. The DON stated that an assessment was done on R32, who does not qualify to have medication on her bedside table. When asked to clarify why [Name] Vapor Rub was mentioned, she explained that it was the brand name of the rub. The DON further emphasized that trained staff and nurses are aware of the process and policies, and they consistently check for bedside medications, following the established procedures diligently. Interview on 10/24/2024 at 10:32 am with the Administrator revealed that the process for having bedside medication involves obtaining an order, proper documentation, and making residents aware of the policy. The Administrator indicated that a lockbox should be used for these medications and that administration and documentation are essential. The Administrator stated her expectations are that residents who are cognitively able will follow the process and procedures. The Administrator expressed concerns about negative outcomes from not documenting medications, stating that it could harm the patient and lead to adverse consequences. Administrator emphasized the importance of staff being observant during their rounds and reporting any issues to the DON or charge nurse, as well as involving families in these matters. Furthermore, the Administrator noted that as part of the admission process, there was a list of prohibited items that families are made aware of.

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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** 50524 Based on observations, resident and staff interviews, record reviews, and review of the facility's policy titled, Skilled Nursing Services Use of Oxygen Therapy, the facility failed to ensure one of 11 residents (R) (R33) receiving oxygen therapy, was administered oxygen in accordance with the physician order. Specifically, R33 did not receive oxygen at the accurate flow rate prescribed by the physician. The deficient practice had the potential to cause respiratory complications for R33. Findings include: Review of the facility's policy titled Skilled Nursing Services Use of Oxygen Therapy, dated 7/1/2024 revealed, Intent: To ensure that patients maintain optimal oxygenation via the proper device and concentration when appropriate and medically indicated. Guideline: . oxygen with liter flow as ordered . Review of the Electronic Health Records (EHR) revealed R33 was admitted on [DATE] with diagnoses that included but not limited to paroxysmal atrial fibrillation, hypertensive heart disease with heart failure and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognition): Brief Interview for Mental Status (BIMS) score of 2 (two) which indicated severe cognitively impaired; Section I (Diagnoses): anemia, coronary artery disease (CAD), heart failure, hypertension and peripheral vascular disease (PVD); and Section O (Special Treatments): oxygen therapy Review of care plan reviewed 8/27/2024 revealed, Focus: Breathing patterns, altered. Evidenced by: As needed (PRN) oxygen. Goal: Patient will demonstrate an effective respiratory rate, depth, and pattern during the review period. Intervention: Oxygen (O2) at two liters (L) nasal canula (NC) PRN. Review of Physician's orders dated 9/2/2024 included but not limited to: Oxygen (O2) via nasal cannula 2 Liter per Minute (LPM) nasally as needed (prn), other (document in order notes) bedtime and prn to maintain sats >90% (oxygen) saturation above 90 percent). Diagnosis (Dx): chronic diastolic (congestive) heart failure, and vital signs every Sunday on night shift, that included but not limited to, O2 Saturation check. Dx: Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of facility's document dated 9/24/2024 from Registered Respiratory Therapist (RRT) EE documented orders not reflecting the liter flow the resident is receiving. A resident had an order for 2LNC prn but was on 4L. If the resident needs 4 L then I recommend center changing the order. I also recommend center completes self-audit to ensure that orders reflect patient usage. Review of facility's Education In-Service Attendance Record revealed no documentation of staff in-service education or self-audit done after recommendations from RRT EE and prior to survey. Observation on 10/22/2024 at 11:14 am revealed R33 sitting in chair beside bed in her room with oxygen cannula in place in her nostrils for oxygen therapy with the oxygen concentrator flow rate set at 2.5 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 10/23/24 10:30 am, and at 3:53 pm revealed R33 sitting in chair beside bed in her room with oxygen cannula in place in her nostrils for oxygen therapy with the oxygen concentrator flow rate set at 1.75 LPM. Interview on 10/23/2024 at 3:53 pm with Licensed Practical Nurse (LPN) DD confirmed the oxygen liter flow rate was not set on two liters per medical doctor (MD)'s order. She stated she did not check the oxygen flow liter this shift. She also stated she was supposed to check R33's flow liter and monitor her oxygen saturation but she did not get a chance to do it. Interview on 10/23/2024 at 4:00 pm with Director of Nursing (DON) revealed she was aware that residents on oxygen were not getting the accurate liter flow as ordered at times and it was commonly not correct. She revealed it was noted the day before that R33's oxygen flow liter was more than what was ordered, this had been happening for a while and had been discussed in meetings. The DON further revealed the corporate RRT EE visited the facility routinely, and in September 2024, RRT EE noticed that a few residents on oxygen were not getting the correct amount as ordered by the MD. The DON confirmed RRT EE recommended the facility contact the MD to change the order and complete self-audit to ensure that orders reflect patient usage. She stated the orders for the liter flow are on the Medication Administration Record (MAR) and she expected the nurses to follow the orders. She further stated her expectations were for staff to check the residents' liter flow rate each time they enter the residents' rooms and at least twice per shift. The DON stated if R33 did not receive the correct amount of oxygen liter flow as ordered, the outcome for R33 would be respiratory compromise.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50877 Based on observations, record review, staff interview, and review of the facility's policy titled Oral Inhalation and Nebulizer Administration, the facility failed to properly administer an oral steroid inhaler for one of nine residents (R) R6 observed during medication administration. This failure had the potential to reduce the efficacy of the medication. Findings include: Review facility's policy titled Oral Inhalation and Nebulizer Administration, dated 2022 revealed, that if a steroid inhaler is used, have patient thoroughly rinse mouth with water and spit out after use to minimize risk of oral pharyngeal candidiasis (thrush). Review of clinical records revealed R6 was admitted on [DATE] with chronic obstruction pulmonary disease (COPD), atrial fibrillation (AF), and peripheral vascular disease (PVD). Review of the quarterly Minimum Data Set (MDS) assessment dated revealed, R6 had a Brief Interview for Mental Status (BIMS) of eight; thus, the resident had mildly impaired cognition. She has no behaviors or psychosis to be noted. Record review further revealed that R6 needs minimal assistance with activities of daily living due to lower body weakness. Review of physician orders for R6 revealed an order dated 4/8/2024 for fluticasone furoate/vilanterol trifenatate 100 mcg (microgram)-25 mcg/dose powder for inhalation, one puff two times per day for Dx (diagnosis) of persistent atrial fibrillation. Observation on 10/23/2024 at 8:14 am during medication administration revealed, Licensed Practical Nurse (LPN) JJ administered the fluticasone furoate/vilanterol trifenatate 100 mcg-25 mcg/dose powder to R6 with one puff by inhalation. However, during the administration, the nurse did not instruct nor educate the resident about rinsing her mouth after medication administration of the inhaler. During an interview on 10/23/2024 at 8:22 am, LPN JJ confirmed and verified that she did not rinse R6's mouth after inhaler administration. During an interview on 10/23/2024 at 11:31 am, Director of Nursing revealed, that inhalers should be administered per physician's orders and as policy dictates.

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Hartwell Health and Rehabilitation	94 Cade Street Hartwell, GA 30643

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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. 50877 Based on observations, record review, staff interviews, and review of the facility's policy titled Medication Beyond-Use and Expiration Dates, the facility failed to remove expired insulin pens from two of three medication carts observed. This failure had the potential for residents to be administered expired medications. Findings include: Review of the undated facility's policy titled Medication Beyond-Use and Expiration Dates, under the section titled Guidelines revealed, An expiration date indicates the last date at which the manufacturer guarantees a drug's full potency and safety Medication should not be stored, transported, or administered after beyond-use or expiration date. Observation on 10/24/2024 at 9:38 am of Licensed Practical Nurse (LPN) DD while working on Medication Hall Three cart, revealed one Humalog insulin pen with a sticker that indicated a discard date of 10/21/2024. There was no identifiable open date on the pen. Interview on 10/24/2024 at 9:44 am with LPN DD, while working on Hall Three medication cart, confirmed the Humalog insulin pen had a sticker with discard date of 10/21/2024. She removed the Humalog insulin pen from Hall Three cart and placed it in the medication storage room, in a destruction bin. Observation on 10/24/2024 at 9:50 am of RN FF while working on Medication Hall Two cart, revealed one Novolog insulin pen with a sticker that indicated an open date of 9/23/2024 and a discard date of 10/21/2024. Interview on 10/24/2024 at 9:54 am with RN FF confirmed the Novolog insulin pen had a sticker with an open date of 9/23/2024 and a discard date of 10/21/2024. He removed the Novolog insulin pen from Hall Two cart and placed it in the medication storage room, in a destruction bin. He further stated he will report this to the Director of Nursing (DON). Interview on 10/24/2024 at 10:27 am, with the DON stated that all insulins should be stored per protocol and procedural standards. She stated that all expired medications should be removed and discarded according to manufacturer's instruction or facility policy.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50272 Based on observation, record review, resident and staff interviews, and review of facilities policies titled, Fall Management and Documentation in the Medical Record revealed, the facility failed to maintain accurately documented resident record in accordance with accepted professional standards and practices regarding falls for one Resident (R) R32 out of 29 sampled residents. The facility census was 84. Findings Include: A review of the policy titled, Fall Management dated 12/29/2023 under the section titled Overview revealed, Each patient is assisted in attaining/maintaining his or her highest practicable level of function by providing the patient adequate supervision, assistive devices and/or functional programs as appropriate to minimize the risk for falls. Each patient's risk for falls is evaluated by the interdisciplinary team (IDT). A plan of care is developed and implemented based on this evaluation with ongoing review. If a fall occurs, the interdisciplinary team conducts an evaluation to ensure appropriate measures are in place to minimize the risk of future falls. The Director of Nursing/Designee is responsible for coordination of an interdisciplinary approach to managing the processes for prediction, risk assessment, treatment, evaluation, monitoring, and calculation of patient falls. Each center will take a proactive approach for new patients admitted and will consider all patients to be at risk for falls until reviewed by the IDT. Under the section titled, Falls Defined: revealed, Current CMS guidelines regarding falls states that a fall is defined as anytime a patient is on the floor including whether the event was witnessed/un-witnessed. Under section titled Fall Management Practice Guidelines revealed, Fall Event: Complete the Initial Event in the EHR to capture the investigation of the fall and assessment of the patient; Assess the patient at least every shift for 72 hours or until the patient is stable. Document the assessment findings in the medical record; Review falls with the IDT in the morning meeting to facilitate appropriate actions taken and documentation is accurate and complete (including Initial Event in EHR); Review the event and patient status at the next scheduled PAR and/or UR meeting as indicated. A review of the policy titled, Documentation in the Medical Record dated 12/29/2023 under section titled Intent revealed, It is the intent of this center that services provided to the patient or changes in the patient's condition is recorded in the patient's medical record. Under the section titled Guideline revealed, Pertinent observations, medications given, services performed, etc., should be recorded in the patient's medical record; Incidents, accidents or changes, in the patients' condition should be recorded; Information recorded in the patient's medical record is confidential and may not be released to unauthorized persons. Refer requests for information to the Charge Nurse, Health Information Technician, or to the Director of Nursing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Electronic Health Record (EHR) for R32 revealed she was admitted to the facility on [DATE]with diagnoses that included but not limited to, displaced fracture of medial malleolus of left tibia, unsteadiness on feet , other lack of coordination , muscle weakness (generalized) , abnormal posture, initial encounter for closed fracture unspecified dementia (moderate) with other behavioral disturbance, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, unspecified sequelae of cerebral infarction, paroxysmal atrial fibrillation, other idiopathic peripheral autonomic neuropathy, spondylolysis (lumbar region), encounter for prophylactic measures (unspecified), and pain (unspecified). A review of R32's quarterly Minimum Data Set (MDS) dated [DATE] documented in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) of 13, which indicated the resident was cognitively intact; Section J (Health Conditions) revealed one fall with major injury since admission or prior assessment, whichever is more recent. A review of the care plan revised on 8/12/2024, revealed R32 was care planned for fall risk related to fracture related to fall. A review of the facility provided Matrix for Providers dated 10/21/2024 indicated R32 had a fall with major injury (FMI) however, a review of the facility provided incident report fall list, for the last twelve (months) revealed R32 had a fall on 8/2/2024 in resident room-bed with the type of injury documented as no apparent injury. A review of nurse's notes for R32 located the EHR, dated 8/2/2024 at 5:50 am revealed, patient (pt) noted lying beside bed on the floor, pt stated that she got up to cook breakfast, pt assessed and passive range of motion (ROM) performed. small bruise noted on left side of arm. Moves all extremities freely, no bumps or bruises noted to head. Neuro-checks initiated. Pt assisted into bed with two (x 2) person assist and repositioned in bed for comfort. At 7:08 am representative (RP) called and notified of pt fall, and small bruise noted to left wrist. RP voiced understanding A review of nurse's notes for R32 located the EHR dated 8/2/2024 revealed, Resident complains (c/o) of left ankle pain, bruising noted with some swelling. Now ordered (N/O) x-ray left ankle. Son aware of new orders. A review of nurse's notes for R32 located in the EHR, dated on 8/2/2024 documented, x-ray report of left ankle received and noted osteopenia and probable fracture of the medial malleolus. Medical Director (MD) notified and gave new orders for ankle brace and ortho consultation. I informed MD it would likely be Monday before we were able to get either and he stated that was fine, it was non-emergent, but resident is to remain non-weight bearing to left ankle. RP notified and voiced understanding. A record review on 10/23/2024 of nurse's notes, located in the EHR, dated on 8/5/2024 documented, resident returned to facility wearing an orthopedic boot to left foot. Follow-up (F/U) with Physician Assistant-Certified (PA-C) at clinic 8/28/2024 at 10:10 am. A record review on 10/23/2024 of nurse's notes, located in the EHR, dated on 8/11/2024 documented, 1300: Boot removed from left lower extremity (LLE) Comprehensive Nursing Assessment: bruising noted, pedal pulses =, no significant pain, ankle rotated inward, no heel discoloration, skin intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review on 10/23/2024 of patient report X-ray findings for R32 dated 8/2/2024 revealed, a technologist was called into the facility regarding pain and arrived at 18:10 pm (6:10 pm) and left at 18:20 pm (6:20 pm). R32 report findings revealed, four views of the left ankle obtained. There is no comparison study available. Images obtained show a fracture lucency which extends through the cortex of the of the medial malleolus. There is near anatomic alignment of the fracture fragments. No additional fractures or dislocations are seen. There is diffuse osteopenia. Impressions: Osteopenia and probable fracture of the medial malleolus. Recommend clinical correlation. A record review on 10/23/2024 of document titled Event Follow-Up V2.0, dated 8/3/2024 revealed under section titled Physical Status, resident with recent fall. Resident with fractured right (R) ankle. New orders for ortho consults. As needed (PRN) Tylenol given by day shift with good effects. No complaints of pain currently. Resident resting quietly in bed with eyes closed and respirations even and regular. After reviewing the document titled Event Follow-Up V2.0, dated 8/3/2024 it was noted that the facility incorrectly recorded a fracture on R32's right ankle, when in fact, R32 had a fracture of the left ankle. A record review on 10/23/2024 of document titled, Event Follow-Up V2.0, dated 8/4/2024 revealed under Physical Status, patient had recent fall resulting in fracture (FX) of right ankle, patient able to planter and dorsi flex right foot without pan, pedal pulses =, no swelling. After reviewing the document titled Event Follow-Up V2.0, dated 8/4/2024 it was noted that the facility incorrectly recorded a fracture on R32's right ankle, when in fact, R32 had a fracture of the left ankle. A record review on 10/23/2024 of document titled Therapy Referral dated 9/5/2024 revealed under section titled Nursing to Therapy, prior level of function and/or comments: post fracture right ankle from fall. Furthermore, under section titled Therapy Screen R32 dx included displaced fracture of medial malleolus of left tibia. After reviewing the document titled Therapy Referral, dated 9/5/2024 it was noted that the facility incorrectly recorded a fracture on R32's right ankle, when in fact, R32 had a fracture of the left ankle as evidence by her dx of displaced fracture of medial malleolus of left tibia. Record review on 10/23/2024 of Physician Orders dated 9/17/2024 revealed, weight bearing as tolerated (WBAT) LLE. Dx: Displaced fracture of medial malleolus of left tibia, initial encounter for closed fracture Record review on 10/23/2024 of Physician Orders dated 9/17/2024 revealed, custom order follow-up Orthopedic appointment for 11/19/2024 at 10:20 am. Dx: Displaced fracture of medial malleolus of left tibia, initial encounter for closed fracture. Interview and observation on 10/22/2024 at 10:18 am revealed R32 was observed in her room sitting in her sofa chair with a boot on her left ankle, dressed and groomed, watching television. R32 stated she had a fall while getting up from bed and has a swollen ankle, she stated she had not had any other falls since the last fall. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/24/2024 at 10:16 am with the Director of Nursing (DON) stated charting should have been changed to fall with major injury. DON stated the facility has a clinical meeting every morning and they do their meetings regarding falls on the Interdisciplinary Team (IDT) morning meeting. DON stated it was overseen and that the status should have been changed to fall with major injury. DON further revealed the first nurse that notes the fall with injury is responsible of the status change. DON stated it was her expectations that all staff follow the process and the policy, and expects that the change of status to be recorded on the EHR, and that it was the facilities duty to report any findings to corporate. Interview on 10/24/2024 at 10:38 am with the Administrator revealed that it was the clinical team's responsibility to update the status of falls, with the nurse manager overseeing this information and facilitating team discussions. The Administrator emphasized her expectation that the staff continues to meet regularly as a cohesive clinical team. Administrator further stated that all documentation should be consistent and comprehensive, ensuring that the status of falls was accurately recorded.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 50524 Based on observations, staff interviews and review of the facility's policy titled, Guidelines for Eyewash Stations and Emergency Showers, the facility failed to maintain one of one eyewash station observed in a safe, functional manner by ensuring proper drainage. Specifically, water flowed from an open pipe below the eyewash station onto the floor and onto the feet of staff using the sink. This deficiency had the potential to cause falls and injury to staff utilizing the eye wash station. Findings include: Review of facility's policy titled Guidelines for Eyewash Stations and Emergency Showers (undated) documented Location: Adequate drainage; Provide a drain for the large amounts of water used in flushing or ensure a plan exists to manage and remove the water if a drain does not exist. Inspection: Ensure proper drainage or collect run-off water under the device. Observation on 10/23/2024 at 12:03 pm during tour of the laundry department revealed water flowing from an open pipe below the eye wash station when the eye wash station was in use. Water was observed flowing from under the eye wash station and onto the feet of the surveyor and Laundry Aide (LA) GG's feet. LA GG used a towel and placed it on the floor to cover the water which continued to flow until the eye wash station was turned off. Observation on 10/24/2024 at10:13 am revealed the Maintenance Director (MD) turned on the eye wash station and the water from the open pipe under the eye wash station flowed on the floor. The MD placed a bucket under the pipe to collect the water to prevent it from flowing on the floor until he turned off the eye wash station. Interview on 10/23/2024 at 12:03 pm with LA GG confirmed the pipe under the eye wash station was always open and whenever the eye wash station was in use, the water flowed from the open pipe to the floor where the person was standing who used the eye wash station. She stated no one had used it in a long time. Interview on 10/24/2024 at 10:13 am with the Maintenance Director revealed the open pipe below the eye wash station was there before he came to the facility five years ago. He revealed he checked the eye wash station each month and he placed a bucket under the open pipe to catch the water from flowing on the floor when the eye wash station pipe was turned on. He stated in an emergency, as long as the eye wash station was working, that was the important thing. He further stated that no one will slip and fall on the floor because it was concrete. Interview on 10/24/2024 at 10:49 am with the Administrator revealed her expectations would be for the water not to spill on the floor under the eyewash station and the water should drain in place. She also stated the outcome could cause a slip and fall because of the water flowing on the floor was a hazard.