STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115516	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Lilburn	788 Indian Trail Road Lilburn, GA 30047

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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, record review, staff interviews, and review of the facility policy, titled, Clean air filters, the facility failed to maintain clean Packaged Terminal Air Conditioner (PTAC) filters for one room [ROOM NUMBER] out of 18 rooms in B Hall. This deficient practice had the potential to compromise the health and safety of the residents by increasing the risk of infections. Findings Include: 1. A review of the facility's policy, titled Clean air filters, revealed the Steps section was, 2. Remove air filter and inspect for cleanliness. If filter is dirty either wash or replace depending on type of filter. If clean, reinstall filter. An observation on 5/12/2025 at 3:04 pm and 5/14/2025 at 4:42 pm, observed in room [ROOM NUMBER], PTAC filters with grey, fuzzy debris. Interview walking rounds on 5/15/2025 at 9:45 am with the Maintenance Director (MD) confirmed dirty PTAC unit. MD revealed the maintenance staff clean the filters monthly and they keep a log of this; however, they didn't get a chance due to other areas that needed his attention. MD stated his expectation was for environmental issues to be taken care of as soon as possible. He stated the staff report issues to maintenance via the maintenance logbook located at each nursing desk and they now have TELS system that the staff are becoming acclimated in its use. MD stated he was not aware of any Maintenance policy. The Administrator confirmed the facility does not have a Maintenance or Environmental policy. The Administrator asked the MD to immediately correct and address the area of concern. An interview conducted on 5/15/2025 at 3:43 pm, the Administrator stated the Maintenance Director and Housekeeping Director oversee cleaning the PTAC filters. She stated her expectations are for PTAC filters to be clean. The Administrator stated a possible negative outcome could be a resident could have an allergic reaction.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44757 Based on observations, record review, and staff interviews the facility failed to document behavior monitoring for two resident(s) (R) (R10 and R56) of 63 sampled residents who required behavior monitoring for psychotropic medication use. Findings include: 1. admitted : 10/28/2016 with the following pertinent diagnoses: primary generalized (osteo)arthritis, type 2 diabetes mellitus without complications, essential (primary) hypertension, depression, unspecified, anxiety disorder, unspecified, active acute embolism and thrombosis of unspecified deep veins of left lower extremity, other idiopathic peripheral autonomic neuropathy, insomnia, unspecified, pain in left knee, pain in left hand, pain in unspecified knee, pain in left wrist, abrasion, left knee, sequela, and rheumatoid arthritis, unspecified. A review of the quarterly minimum data set (MDS) dated [DATE] revealed Section C - Brief Interview of Mental Status (BIMS) 12, indicating mild cognitive impairment. Section D: indicating mild depressive symptoms. Section E: No potential indicators for psychosis and no behaviors exhibited. A review of the Physician Orders for R10 documented: 1. Xanax (alprazolam) - Schedule IV tablet; 0.25mg; amt: 1 tablet; Quantity: 30; oral [DX: Anxiety disorder, unspecified] Once a Day - PRN; PRN 1 Side Effects: Falls, dizziness, or headaches; Subdued, sedated, lethargic, or withdrawn; Muscle/nonspecific pain or unexplained abnormal movement; Decline in physical functioning (e.g., mobility or activities of daily living (ADLs) Psychomotor agitation (restlessness, pacing, hand wringing); Psychomotor retardation (slowed speech, thinking, movement) 2. Zoloft (sertraline) tablet; 50 mg; amt: 3 tablet; oral [DX: Depression, unspecified] Once A Day; 09:00 am Trazodone tablet; 150 mg; amt: 1/2 tablet; oral 3. Buspirone tablet; 5 mg; amt: 1; oral [DX: Depression, unspecified] Three Times A Day; 9:00 am, 1:00 pm, 5:00 pm Side Effects: Subdued, sedated, lethargic, or withdrawn; Mental Status Changes Order Description: Monitor resident for s/s of Behaviors and Mood related to depression, anxiety and chronic pain secondary to rheumatoid arthritis Frequency: Every Shift (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Behavior Monitoring revealed that the following dates have not been recorded: May-5/5(am), 5/10-5/12(pm), April-4/3(pm), 4/13(pm), 4/17(pm), 4/23(pm), 4/26(am+pm), 4/30(pm), 3/5(pm), 3/6(pm), 3/11(pm), 3/25(pm), Feb-2/5(pm), 2/11(pm), 2/16(pm), 2/18(pm), 2/19(pm), Jan-1/2(pm), 1/11(pm), 1/12(pm), 1/13(pm), 1/17(pm), 1/19(pm), 1/22(pm), 1/23(am+pm). Observation and interview on 5/15/2025 at 3:32 pm R10 was awake and alert watching television in her room. R10 revealed her pain gets bad sometimes, and she would like to take more pain medication, but she is fine right now and does not want any changes. R10 confirms that she does suffer from insomnia, and the pain interferes with her sleep at times, but is fine right now. 50272 2.A review of the Electronic Health Record (EHR) for R56 revealed she was admitted on [DATE] and has the following diagnosis but not limited to schizophrenia, post-traumatic stress syndrome (PTSD), bipolar disorder and depression. A review of R56's admission Minimum Data Set (MDS) dated [DATE] documented in section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) of 12, indicating cognitively intact. A record review of R56's care plan with a start date of 2/19/2021 revealed R56 to be care planned for medications and behaviors (r/t) PTSD, major depressive disorder and mild anxiety disorder. The care plan stated R56's interventions are to report changes in mood and behaviors to nurse, physician, social worker, treat as per orders (every shift; days, evenings and nights). A record review of R56's physician orders revealed a prescription for five (5) milligrams (mg) of Abilify (atypical antipsychotic). The medication was prescribed for schizophrenia, psychotic disturbance, bipolar disorder and depression and is to be administered twice a day with a start date of 9/11/2024. Furthermore, a record review of R56's physician orders dated 11/18/2023, requires behavior monitoring to be documented every shift (days and nights). Behavior monitoring instructions to direct staff to chart on observed behaviors that include but not limited to sad mood/tearful, anxious mood/attention seeking, insomnia, physical aggression, sexually inappropriate, wanders and/or destroys property. Record review of R56's Medication Administration Record (MAR) for March, April, and May 2025 revealed the following days with no charting of behavior monitoring. Record review of R56's Medication Administration Record (MAR) for March, April, and May 2025 revealed the following days with no charting of behavior monitoring. March 2025 - behavior monitoring was not documented on the day shift for March 2, 5, 10, 13, 14, 18, 19, 24, and 28. On the night shift, documentation was missing for March 14, 18, 24, and 25. April 2025 - behavior monitoring was not documented on the day shift for April 2; April 7 through 11; April 13 and 14; April 16 through 18; April 21 through 24; and April 30. It appears April 16 was listed twice. On the night shift, documentation was missing for April 1, 9, 12, 21, and 23. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	May 2025 - behavior monitoring was not documented on the day shift for May 2 and from May 5 through May 7. An interview conducted on 5/15/2025 at 11:13 am, Licensed Practical Nurse (LPN) JJ explained it is the responsibility of the nurse assigned to each hall to complete behavior monitoring documentation for residents on their shift. LPN JJ reported having multiple residents with behavior monitoring orders that require documentation every shift. She revealed she knows the orders are present because they appear on the Medication Administration Record (MAR) and emphasized that there is no reason they should be missed. LPN JJ acknowledged that the expectation is for the nurse to document any behaviors observed during their shift. Interview on 5/15/2025 at 12:08 pm with the Director of Health Services (DHS) revealed the nurse scheduled for a shift is responsible for completing behavior monitoring documentation during that shift. The DHS stated that behavior monitoring is a physician's order and must be followed. She explained that failure to complete the required documentation may result in communication breakdowns and a lack of necessary follow-up and without proper documentation, staff are unable to respond effectively to resident needs. Interview on 5/15/2025 at 3:47 pm with the Administrator revealed that without proper monitoring and documentation, a resident who requires behavior oversight could be involved in an incident, could sustain injuries, could pose a risk to themselves or others.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50272 Based on observations, staff interviews, record review, and a review of the facility's policy titled, Care Plans, the facility failed to follow care plan related to (r/t) allergy restrictions concerning chocolate for one resident (R) (R56) out of 63 sample residents. This failure had the potential to result in an adverse allergic reaction. Findings included: Review of the policy titled, Care Plans, dated 2022, indicated, Admission Comprehensive Plan of Care - 3. The comprehensive person -centered care plan is developed to include measurable goals and time frames to meet a patient/resident's medical, nursing and psychosocial needs the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial needs that are identified in the comprehensive assessment. A review of the Electronic Health Record (EHR) for R56 revealed she was admitted on [DATE] and has the following diagnosis but not limited to schizophrenia, dementia, post-traumatic stress syndrome (PTSD), bipolar disorder and depression. Furthermore, R56's EHR documented a food allergy to chocolate dated 12/8/2020. A review of R56's admission Minimum Data Set (MDS) dated [DATE] documented in section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) of 12, indicating cognitively intact. A record review of R56's care plan with a start date of 9/22/2023 revealed R56 to be care planned to have a food allergy to chocolate. The care plan documented that R56 will not receive food with allergy ingredients. An observation and interview conducted on 5/14/2025 at 12:59 pm, R56's bedside tray was observed to contain a wrapped piece of chocolate cake, untouched. Upon verifying the meal tray slip, it was documented twice that R56 had an allergy to chocolate, and it listed the chocolate cake as Black Forest Cake. When asked, R56 confirmed that she did not eat the cake because she is allergic to chocolate. An interview was conducted on 5/14/2025 at 1:02 pm, Registered Nurse (RN) DD explained that when staff retrieve trays from the cart, they are required to verify the tray slip to ensure accuracy and alignment with the resident's dietary needs, including allergies. She confirmed that R56 is known to have a chocolate allergy and should not have been served chocolate cake. RN DD emphasized that the expectation is for all staff to check the tray ticket for the correct name, food, and allergy information to prevent potential harm such as an anaphylactic reaction. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/14/2025 at 1:05 pm, Certified Nursing Assistant (CNA) EE stated she has been employed at the facility for about five months and regularly passes meal trays on the hall where room [ROOM NUMBER] (R56) is located. She confirmed she checked the resident's name, informed them of the items on the tray, and assisted with setup. She stated she verifies that residents are not receiving incorrect food and confirmed that R56 is allergic to chocolate. She recognized the cake on the tray as chocolate but admitted she was unsure what Black Forest Cake meant and did not realize it contained chocolate. An interview was conducted on 5/14/2025 at 1:28 pm, Dietary Aide (DA) FF stated she has worked in the facility for six years. She was on the tray line and said she follows the tray ticket instructions for portions and items to be included. DA FF acknowledged the possibility that she may have unintentionally placed an incorrect item on a tray. An interview was conducted on 5/14/2025 at 1:31 pm, Dietary Aide (DA) GG stated she has been working in the facility for nearly three years. Her role involves checking tray tickets and verifying that the correct meal components are included. She confirmed she added the chocolate cake to tray's and stated that if a resident has a chocolate allergy, they are typically given fruit instead. An interview was conducted on 5/14/2025 at 1:35 pm, Dietary Aide (DA) HH confirmed her responsibility was to add drinks, desserts, condiments, and silverware on the day in question. She stated she ensures the tray slip matches the items included but emphasized that DA GG was the last person verifying the trays before they were placed on the cart. An interview was conducted on 5/14/2025 at 1:39 pm, Dietary Aide (DA) II stated she had been employed at the facility for about a week. On the day in question, she stated she was stationed in the middle of the tray line serving beverages and desserts, including the cake. She confirmed that DA GG was responsible for final verification. DA II stated she checks the tray tickets but did not notice any residents listed with a chocolate allergy. An interview was conducted on 5/14/2025 at 1:43 pm, Dietary Kitchen Manager (DKM), who has served in her role for two years, explained the process: cooks plate the food per the tray ticket, and dietary aides add beverages, condiments, and desserts. She stated that dietary staff are trained to review tray slips, which include residents' allergies at the top and bottom. DKM confirmed that if a resident is allergic to chocolate, it should be visibly indicated, and substitutions such as fruit are expected. Observations and interviews were conducted on 5/14/2025 at 1:52 pm, in R56's room, DKM, DA FF, DA GG, DA HH observed and confirmed R56's tray to contain a piece of chocolate cake. DA GG stated she was sure she had removed the chocolate cake, but she could not confirm if another staff member placed it back. She mentioned she was aware that R56 is allergic to chocolate. Staff present collectively acknowledged that R56 is allergic to chocolate and should not have served it. The DKM stated her expectation is for all dietary staff to follow tray tickets carefully and the failure to adhere to these protocols has the potential to result in an allergic reaction and resident dissatisfaction. An interview was conducted on 5/15/2025 at 3:47 pm, The Administrator emphasized that the care plan must be followed consistently by all staff involved in meal service. Failure to do so may result in a resident receiving a food item they are allergic to, which could lead to a lot of medical issues.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50940 Based on record reviews, staff interviews, and a review of the facility's policy titled, Care Plan the facility failed to update the care plan for resident (R) R30 to accurately reflect the resident's code status for one of 63 sampled residents. This failure had the potential to result in the provision of care that was not aligned with the resident's end-of-life wishes, potentially causing physical and emotional harm. Findings include: Review of the facility policy titled Care Plans, updated 7/27/2023 reveals under Policy .section 7 .Update care plan electronically. When applicable, write a new goal, discontinue approaches and /or add approaches Care Plan Review and Update: 1 .Care plan updates/reviews will be performed within 7 days of each quarterly assessment, each acute change in condition, and as needed following each hospital stay. 2. Discontinued problems, goals, or approaches should be indicated directly on the care plan .Updates to the care plans should be made with any changes in condition at the time of change in condition occurred . A review of Resident's (R)30 electronic records revealed she was admitted on [DATE] with the following diagnoses: cerebrovascular accident (CVA), hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting the right side, bedbound status, chronic obstructive pulmonary disease (COPD), heart failure, type 2 diabetes mellitus, essential hypertension, atherosclerotic heart disease, peripheral vascular disease, chronic kidney disease stage 3, thromboembolism, anemia, respiratory failure with hypoxia, neoplasms of soft tissue and skin, and localized swelling/mass/lump of the right upper limb. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. Review of physician orders showed: 6/11/2024: Code status-DNR (Do Not Resuscitate). 3/19/2025: Do not hospitalize or send out for appointments per resident choice. 3/19/2025: Referral to [Named Hospice Company] for evaluation and treatment. Review of the POLST (Physician Orders for Life-Sustaining Treatment), signed on 8/19/2024 by the physician and the resident, indicated that R30 elected to allow natural death (DNR). Review of the care plan for R30 showed a problem initiated on 7/27/2023 and last reviewed on 3/11/2025, which incorrectly documented the resident as a full code. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted with Licensed Practical Nurse (LPN BB) on 5/14/2025 at 9:30 am, she stated that to verify a resident's code status, she can check multiple sources. In the computer system she would check the physician orders, the banner in the electronic record, and the resident's care plan. They also have the Advance Directive and Code Status Report on the crash cart and in the narcotic book on each medication. When the surveyor requested to review R30's care plan, LPN BB acknowledged that the advance directive was not correct and stated she would notify the Social Worker to fix it. She added that while nurses can make certain updates to care plans, advance directive changes are handled by either the Social Worker or MDS Coordinator. In an interview with the Social Work (SW) Director on 5/14/2025 at 9:40 am, she explained that upon admission, discussions regarding code status are conducted with the resident and/or responsible party, and the necessary documentation is completed. The POLST form is scanned into the system, and the code status is reviewed during the care plan meetings. She confirmed that resident R30 initially had full code status, which was later changed to DNR and hospice. She acknowledged that the care plan was inaccurate regarding the resident's current code status and should have been updated promptly at the time of the change to reflect this. The Social Work Director admitted she was unsure how the update was missed.

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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** 50940 Based on observations, staff and resident interviews, record reviews, and review of the facility's policy titled, Medication Administration: General Guidelines, the facility failed to administer medications as per physician's orders for two residents of 63 sampled residents. This deficient practice may result in residents not receiving necessary treatment, posing a risk to their health and safety. Findings include: Review of the facility's policy titled: Medication Administration: General Guideline, reveals the Policy statement, Medications are administered as prescribed, in accordance with good nursing principles and practices an only by persons legally authorized to do so .Procedure: .2. Medications are administered in accordance with written orders of the attending physician .9 . The individual records the administration on the patient/resident's MAR at the time the medication is given. At the end of each medication pass, the person administering the medications review the paper MAR or the electronic version of e-MAR to ascertain that all necessary doses were administered, and all administered doses were documented. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications .13. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time .that dosage administration is initiated and circled and for facilities utilizing the e-MAR system for not administering medication at scheduled time. An explanatory note is entered on the reverse side of the record provided for PRN indication and general medication notes and for e-MAR the note can be typed into the appropriate space provided within the electronic system. If more than two consecutive doses of the vital medication are withheld or revised, the physician is notified. 1). A review of Resident's (R)57 Admission Record revealed that R57 was admitted to the facility in 2021 with diagnoses including, but not limited to, Chronic Obstructive Pulmonary Disease (COPD), malignant neoplasm of the prostate, degenerative joint disease (DJD), venous insufficiency with deep vein thrombosis (DVT), anemia, Gastroesophageal Reflux disease) GERD), chronic hepatitis C, peritoneal abscess, diverticulosis of the large intestine, and a history of alcohol dependence. Review of his most recent quarterly MDS indicates a BIMS score of 15, indicating intact cognition. On 3/5/2024, the resident was diagnosed with herpes zoster (shingles-viral disease characterized by a painful skin rash with blisters). Review of the physician orders reveals the following orders to treat shingles: Acyclovir cream 5%, to be applied twice daily to the rash on the right thigh, right lower leg, and right buttock from 3/7/2024 through 3/15/2024, and Acyclovir 400 mg tablets, to be taken orally five times per day for 10 days, starting 3/5/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The first oral dose on 3/5/2024 was not administered due to the medication being unavailable, as documented in the Medication Administration Record (MAR). The medication became available on 3/6/2024 and was administered as ordered by the physician, five times daily from 3/6/2024 through 3/16/2024, at 12:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Out of the 50 scheduled doses during this period, three were not signed as administered. R57 wrote a complaint to the state stating that staff not giving his shingles medications like the doctor scheduled for him to take them. In an interview with R57 on 5/12/2025 at 12:35 pm in his room, the surveyor conducted an in-depth interview with the resident regarding his complaint. The resident presented a personally created table documenting dates and times he believed he received the prescribed medication. On the resident-created medication table, several blanks were noted, suggesting missed doses. However, upon comparison of the resident-created table with the Medication Administration Record (MAR), the surveyor was able to verify that R57 was receiving medications consistently, with the exception of three instances: 3/6/2024 at 8:00 am; 3/10/2024 at 8:00 am; and 3/10/2024 at 9:00 am. In an interview conducted on 5/14/2025 at 2:00 pm., the Infection Control Nurse (IP) admitted that it is hard to determine whether the medication was actually given or simply not documented in those three instances where it was not checked off in the MAR. She further stated that during medication administration, nurses are not allowed to leave any blanks on the MAR In an interview with the Director of Health Services (DHS) on 5/14/2025 at 2:15 pm, she stated that her expectation is for staff to document all administered medications. If a medication is not given, it should still be signed off with a reason noted, such as medication not available or resident refused. 2. Review of Resident's 326 electronic medical record (EMR) revealed he was admitted to the facility on [DATE] post left fourth and fifth toes amputation and discharged against medical advice (AMA) on 7/21/2024 at 11:56 am. Review of the hospital rehabilitation physical therapy (PT) assessment dated [DATE] revealed that the patient demonstrated a high level of motivation and good cognitive function, orientation: oriented x4. Review of R 326 Physician Orders revealed the following orders: 7/20/2024 ceftazidime (ceftazidime 2 g/50 mL-D5% intravenous solution) every 8 hours (6 am, 2:00pm, 10:00 pm. Infusion Therapy FLUSH: 3mL 0.9% Normal Saline (NS) intravenous (IV) before, between and after each infusion and 3 mL 0.9% NS IV every 8 hours to maintain patency. A complaint was submitted to the State Agency, alleging that the resident was admitted on the evening of Friday, July 19, 2024 for a six-week course of IV antibiotics to be administered every 8 hours via a Periferrally Inserted Central Cathether (PICC) line. However, the resident was not receiving any IV medications as ordered. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the hospital discharge documentation revealed a medication list indicating the medications the resident was to receive, including the date and time of the next scheduled dose. It was documented that the new medication, Ceftazidime 2 g/50 mL in D5% intravenous solution, was to be administered every 8 hours, with the next dose scheduled for 7/19/2024 at 6:00 pm. Review of the Medication Administration Record (MAR) revealed that the first dose of IV antibiotic Ceftazidime 2 g/50 mL was administered on 7/20/2024 at 10:00 pm, indicating that the resident was without the IV medication-ordered to be given every eight hours-for approximately 28 hours. The second dose of the antibiotic was administered on 7/21/2024 at 6:00 am. Shortly thereafter, the resident's family took the resident home against medical advice. During a medication pass observation conducted on 5/12/2025, from 8:00 am to 10:00 am, the surveyor observed RN AA administering medications. No blanks were noted on the MAR. When asked about proper documentation of medication administration, RN AA stated that nurses are not permitted to leave blanks and that he always documents the appropriate response, depending on the situation. In an interview with the DHS on 5/14/2025 at 2:15 PM, she stated that her expectation is for staff to document all administered medications. If a medication is not given, it must still be documented with a reason noted, such as medication not available or resident refused. She further explained that if the medication was not available from the pharmacy, staff have access to CUBE X or PYXIS, where emergency medications are stored, and could have obtained it from there. If the medication was not available in CUBE X, the nurse should have contacted the physician to inform them of the situation and request an alternative antibiotic that was available, to prevent a gap in essential treatment for the resident.

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	115516	A. Building B. Wing	05/15/2025

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50272 Based on observations, record review, and interviews with residents and staff, the facility failed to adhere to documented food preferences and allergy-related restrictions concerning chocolate for one resident (R56) out of 63 sample residents. The facility census was 86. This failure had the potential to result in an adverse allergic reaction, decline in the residents' trust in the facility's ability to meet their dietary needs, thereby impacting overall quality of care and resident safety Findings Include: The facility did not provide a policy related to (r/t) adhering to food preferences and allergy-related restrictions. A review of the Electronic Health Record (EHR) for R56 revealed she was admitted on [DATE] and has the following diagnosis but not limited to schizophrenia, dementia, post-traumatic stress syndrome (PTSD), bipolar disorder and depression. Furthermore, R56's EHR documented a food allergy to chocolate dated 12/8/2020. A review of R56's admission Minimum Data Set (MDS) dated [DATE] documented in section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) of 12, indicating cognitively intact. A record review of R56's care plan with a start date of 12/8/2020 revealed R56 to be care planned to have a food allergy to chocolate with a start date of 9/22/2023. The care plan documented that R56 will not receive food with allergy ingredients. An observation and interview conducted on 5/12/2025 at 12:42 pm, R56's meal tray slip listed spaghetti with meat sauce; however, it was observed she received broccoli chicken rice casserole instead. R56's broccoli chicken rice casserole was observed untouched and when asked why she had not eaten her food she stated she disliked rice and that she sometimes receives the wrong meal. Furthermore, it was observed that rice was listed as dislikes on her food slip. Certified Nursing Assistant (CNA) CC confirmed that the meal was not spaghetti with sauce. An observation and interview conducted on 5/14/2025 at 12:59 am, R56's bedside tray was observed to contain a wrapped piece of chocolate cake, untouched. Upon verifying the meal tray slip, it was documented twice that R56 had an allergy to chocolate, and it listed the chocolate cake as Black Forest Cake. When asked, R56 confirmed that she did not eat the cake because she is allergic to chocolate. An interview was conducted on 5/14/2025 at 1:02 pm, Registered Nurse (RN) DD explained that when staff retrieve trays from the cart, they are required to verify the tray slip to ensure accuracy and alignment with the resident's dietary needs, including allergies. She confirmed that R56 is known to have a chocolate allergy and should not have been served chocolate cake. RN DD emphasized that the expectation is for all staff to check the tray ticket for the correct name, food, and allergy information to prevent potential harm such as an anaphylactic reaction. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 05/14/2025 at 1:05 pm, Certified Nursing Assistant (CNA) EE stated she has been employed at the facility for about five months and regularly passes meal trays on the hall where R56 is located. She confirmed she checked the resident's name, informed them of the items on the tray, and assisted with setup. She stated she verifies that residents are not receiving incorrect food and confirmed that R56 is allergic to chocolate. She recognized the cake on the tray as chocolate but admitted she was unsure what Black Forest Cake meant and did not realize it contained chocolate. An interview was conducted on 5/14/2025 at 1:28 pm, Dietary Aide (DA) FF stated she has worked in the facility for six years. She was on the tray line and said she follows the tray ticket instructions for portions and items to be included. DA FF acknowledged the possibility that she may have unintentionally placed an incorrect item on a tray. An interview was conducted on 5/14/2025 at 1:31 PM, Dietary Aide (DA) GG stated she has been working in the facility for nearly three years. Her role involves checking tray tickets and verifying that the correct meal components are included. She confirmed she added the chocolate cake to tray's and stated that if a resident has a chocolate allergy, they are typically given fruit instead. An interview was conducted on 5/14/2025 at 1:35 pm, Dietary Aide (DA) HH confirmed her responsibility was to add drinks, desserts, condiments, and silverware on the day in question. She stated she ensures the tray slip matches the items included but emphasized that DA GG was the last person verifying the trays before they were placed on the cart. An interview was conducted on 5/14/2025 at 1:39 pm, Dietary Aide (DA) II stated she had been employed at the facility for about a week. On the day in question, she stated she was stationed in the middle of the tray line serving beverages and desserts, including the cake. She confirmed that DA GG was responsible for final verification. DA II stated she checks the tray tickets but did not notice any residents listed with a chocolate allergy. An interview was conducted on 5/14/2025 at 1:43 pm, Dietary Kitchen Manager (DKM), who has served in her role for two years, explained the process: cooks plate the food per the tray ticket, and dietary aides add beverages, condiments, and desserts. She stated that dietary staff are trained to review tray slips, which include residents' allergies at the top and bottom. DKM confirmed that if a resident is allergic to chocolate, it should be visibly indicated, and substitutions such as fruit are expected. Observations and interviews were conducted on 5/14/2025 at 1:52 pm, in R56's room, DKM, DA FF, DA GG, DA HH observed and confirmed R56's tray to contain a piece of chocolate cake. DA GG stated she was sure she had removed the chocolate cake, but she could not confirm if another staff member placed it back. She mentioned she was aware that R56 is allergic to chocolate. The DKM further confirmed that R56 is also not supposed to have rice, and this preference was not followed. Staff present collectively acknowledged that R56 does not like rice and is allergic to chocolate and should not have been served. The DKM stated her expectation is for all dietary staff to follow tray tickets carefully and the failure to adhere to these protocols has the potential to result in an allergic reaction and resident dissatisfaction. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 5/15/2025 at 3:47 pm, the Administrator stated that the expectation is for dietary staff to follow tray slips carefully, especially regarding resident allergies and food preferences. Additionally, CNAs are expected to verify the tray slip before serving the tray to the resident, ensuring that the correct meal is provided. Failure to do so may result in a resident receiving a food item they are allergic to, which could lead to serious medical complications.

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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. 50940 Based on observations, staff interviews, record review, and review of the facility's policies titled, Infection Prevention-Hand Hygiene, Infection Control: Glucometer Cleaning and Disinfecting, and Infection Control Prevention and Control Activities, the facility failed to perform hand hygiene and sanitize shared medical equipment while providing care to four residents during medication pass. The facility sample was 63 residents. This failure had the potential to increase the risk of infection transmission among residents and staff. Findings include: Review of the facility's policy titled, Infection Prevention-Hand Hygiene, updated 10/15/2024 revealed the Policy section included D. Indications Requiring Hand Wash or Hand Rub. 1. Before and after contact with the resident. 2. Before donning gloves, including sterile gloves 4. After contact with a resident's intact skin, (i. e., taking blood pressure, pulse, and lifting/turning a resident) .7. Immediately after removal of personal protective equipment (e.g., gloves, gown, facemasks). Review of the facility's policy titled Infection Control: Glucometer Cleaning and Disinfecting, updated 8/15/2024 revealed the Policy section included C 4. Glucometers that are shared must be cleaned and disinfected between each patient/resident use. D. Hand Hygiene and Gloves. 1. Perform hand hygiene immediately before donning gloves .4. Perform hand hygiene immediately after removing of gloves and before and before touching medical supplies intended for use on other patients/residents. E. Cleaning and Disinfection. Note: The Glucose Meter must be cleaned and disinfected after each patient/resident use to minimize the risk of transmission of blood-borne pathogens between patients/residents and healthcare professionals 4. Clean and disinfect the meter by using the EPA approved wipes Germicidal and Disinfectant Wipes. Wipe all external areas of the meter including both the front and back surfaces until visibly clean . Review of the facility's policy titled Infection Control Prevention and Control Activities, revised 2/1/2018 revealed the Policy section included Hand Washing. 1. Hands should be washed often. 2 Hands will be washed immediately after gloves are removed, between patient contact, equipment handling and when otherwise indicated to wash hands between tasks . Gloves: 1. Wash hands immediately to avoid transfer of microorganisms to other environments 4 .Hand washing, as per policy, is mandatory after glove removal . Occupational Health If applicable, tools are cleaned as outlined above when soiled and prior to leaving testing area. An observation on 5/13/2025 at 8:15 am revealed Registered Nurse (RN) AA performing a medication pass for Resident (R) 65. The RN pulled the medication cart to the room and began preparing medications without performing hand hygiene. In the middle of the task, he realized one medication was missing and went to the medication room to retrieve it. Upon returning, he resumed the task without performing any hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN AA was then interrupted by another staff member and briefly stepped into an adjacent resident's room after securing the medication cart. He returned shortly thereafter and resumed the medication pass, again without performing hand hygiene. He retrieved all prepared medications and entered the resident's room without sanitizing his hands. When administering eye drops, he donned gloves but did not perform hand hygiene before or after removing the gloves, or upon exiting the room. RN AA checked the resident's blood pressure, then returned the BP machine to the cart without cleaning it and proceeded to the next resident. He did not sanitize his hands upon leaving the room or before moving to the next resident. At the following resident's room, RN AA began preparing medications for R55 without sanitizing his hands. He also brought the previously used, uncleaned BP machine into the room, checked the resident's blood pressure, and administered medications. The RN neither sanitized the BP machine after use nor performed hand hygiene before proceeding to the third resident. Then RN AA rolled his cart to the third resident, R48. The RN failed to perform hand hygiene before starting the medication pass, as well as upon entering and exiting the third resident's room. Next, RN AA rolled his medication cart to the fourth resident, R426. RN AA failed to perform hand hygiene again before initiating the medication pass or upon entering the fourth resident's room. The RN proceeded to check the resident's blood pressure and blood glucose levels before administering medications. After completing the task, he returned the blood pressure cuff and glucometer to the medication cart and was observed sanitizing only the glucometer using a few small, square alcohol prep pads. He then sanitized his hands with hand sanitizer. When asked by the surveyor whether the blood pressure cuff should have been sanitized after being used on different residents, the RN responded that he did not believe it was necessary, as there was no risk of blood exposure, unlike with a glucometer. When further questioned about hand hygiene between residents during the med pass, the RN acknowledged that he should have sanitized his hands but failed to do so. Later that day, on 5/13/2025 at 3:00 pm, RN AA approached the surveyor and admitted he was mistaken and should have sanitized the blood pressure cuff between each resident's use. An interview with the Infection Control Nurse (IC) on 5/14/2025 at 2:05 pm revealed that her expectation is for staff to always sanitize their hands prior to entering a resident's room and before providing care. Using alcohol-based hand rub is appropriate if hands are not visibly soiled, but after three consecutive uses, hand washing is required. If providing care to more than one resident, hands must be sanitized between residents. Regarding cleaning of shared equipment, the IC nurse stated that it must be cleaned between each resident's use using Micro-Kill wipes. In an interview with the Director of Health Services (DHS) on 5/14/2025 at 2:15 pm, she stated that staff are expected to practice frequent hand hygiene, especially when providing resident care. She emphasized that staff must sanitize their hands prior to starting a med pass, upon entering a room, before administering medications, and upon leaving the room. Regarding shared equipment, the DHS stated that staff are expected to properly clean all shared equipment between resident use by using disinfectant wipes and allowing the equipment to completely dry. She noted that using small, square alcohol prep pads is not acceptable for cleaning shared equipment.