STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115524	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Brandon Wilde	4275 Owens Road Evans, GA 30809

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 28193 Based on observations, staff interviews, record review, and review of the facility's policy titled, Dignity, the facility failed to treat residents with dignity for one out of three Residents (R) (R8) observed during dining and for one out of three Residents (R) (262) observed during medication administration. Specifically, the facility failed to ensure R8 received a meal tray at mealtime due to a lack of sufficient dining table space causing R8 to observe other residents eating their meals while waiting for a space to become available and assistance. In addition, the facility failed to ensure R262's blood glucose testing procedure was completed in a private area to protect the resident's dignity. Findings include: Review of the facility's policy titled, Dignity, revised 2/2021, under the Policy Statement revealed, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-bring, level of satisfaction with life, and feelings of self-worth and self-esteem. Under the section titled Policy Interpretation and Implementation revealed, 1. Residents are treated with dignity and respect at all times, and 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: 5e. provided with a dignified dining experience 11. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 1.Reveiw of the Admission Record revealed R8 admitted with diagnoses that included but not limited to diagnoses of mild cognitive impairment, memory deficit following other cerebrovascular disease, and moderate protein-calorie malnutrition. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/2024, Section C (Cognitive Patterns) revealed, R8 had severe impairment in cognitive skills for daily decision making and had short-term and long-term memory problems per a staff assessment of mental status (SAMS); Section G (Functional Status) revealed, R8 was dependent on staff for eating and required the use of a wheelchair propelled by staff for locomotion. Review of R8's Care Plan included a problem, initiated 1/17/2022, that indicated the resident was malnourished due to having a low body mass index (BMI) for their advanced age, cognitive impairment, limited mobility, and was on hospice care. An intervention directed staff to assist the resident with meals as needed (initiated 1/17/2022). (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Dietary Progress Note dated 12/6/2024 at 9:22 am revealed R8 had good food intake, consuming approximately 90 percent of most meals, and was fed by staff. Review of R8's Order Summary Report with active orders as of 2/18/2025 revealed a physician's order dated 2/18/2022 for a regular soft diet with bite-sized, Level 6 dysphagia/chopped texture and regular consistency liquids. Review of R8's Kardex, with care instructions as of 2/18/2025, directed staff to assist the resident with meals as needed. During a dining observation on 2/17/2025 at 11:48 am, R8 was noted sitting off to the side of the secure unit dining room during mealtime, observing other residents eating their lunch. Four staff members could be seen on the unit assisting residents to eat. While observing other residents eating their meals over the next 31 minutes, R8 was attempting to get staff's attention by clapping and verbalizing. At 12:19 pm, the Staffing Coordinator arrived in the dining room, pulled a bedside table next to R8's wheelchair, and began to feed the resident. During an interview on 2/19/2025 at 2:12 pm, the Staffing Coordinator stated he was a Certified Nurse Aide (CNA) and only went back to feed on the secure unit when he was needed. He stated he did not go back there every day and had been asked to go and assist the staff to feed residents on Monday (2/24/2025). During an interview on 2/19/2025 at 2:29 pm, Licensed Practical Nurse (LPN) #4 stated she had worked at the facility for three years, and there were fourteen residents currently residing on the secure unit, including six feeders. She indicated that, depending on how much help was available, with one staff person for each resident, there were three or four residents who had to wait to be moved to the dining table once staff was finished assisting someone else. She stated the residents sat over to the side of the dining room until they could be moved to the table. She also indicated staff were not allowed to assist more than one resident at a time with eating, so for those residents who had to wait, there was a hot box where their food was kept warm, and their beverages were kept cold in the refrigerator until staff were available to feed them. LPN #4 also stated this process happened every day, for every meal, as there was not enough staff or room to provide one-to-one feeding for all six feeders. During an interview on 2/19/2025 at 2:15 pm, CNA #5 stated when staff were in the dining room assisting residents, they were only allowed to feed one resident at a time. She indicated if she saw that there was a resident sitting off to the side without a meal, she would excuse herself briefly from the table and inquire where the other resident's meal was and would get them their food, even if the resident who was waiting needed to be assisted as well. She stated she would put their food in front of the resident and give them some verbal cues to get them started until she could get someone to assist them or finish what she was doing so that she could help them herself. During an interview on 2/19/2025 at 2:55 pm, CNA #6 stated staff in the dining room were only allowed to feed one resident at a time due to the choking hazard. She stated staff needed to be paying attention to the resident they were helping. She indicated if she saw that a resident was without food and not sitting at a table, she would find the nurse and ask why the resident was not eating and would try to find someone to assist the resident until she was available to help them herself. She stated, No one should sit there and watch everyone else eat. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/2025 at 1:39 pm, the Director of Nursing (DON) stated she expected residents to be treated with dignity at all times, including during the dining process. She stated the facility would address the reason residents were sitting to the side and watching others eat and, That is not a right process, and we will make it right. During an interview on 2/20/2025 at 1:46 pm, the Administrator stated her expectation was that everyone would have a specific time to eat, and no one would be secluded and have to sit and watch others eat. She stated she expected residents to be treated with dignity during the dining process and at all times. 2. Review of the Admission Record revealed R262 admitted with diagnosis that included but not limited to diabetes mellitus without complications. Review of the Admission Minimum Data Set (MDS) was not yet completed and available for review at the time of the survey. Review of R262's Care Plan included a problem, initiated 2/17/2025, that indicated the resident had a diagnosis of diabetes mellitus. Interventions directed staff to check blood glucose levels per physician's orders (initiated 2/18/2025). Review of R262's Order Summary Report with active orders as of 2/19/2025 revealed a physician's order dated 1/31/2025 to check the resident's blood glucose two times a day. During an observation of the medication administration pass on 2/18/2025 at 9:08 am, Registered Nurse (RN) #7 placed R262's morning medications into a medication cup and gathered blood glucose testing supplies and a glass of water for the resident. R262 was ambulating in the hallway with a therapist to the therapy gym. RN #7 followed the resident and therapist into the therapy gym and, after R262 was seated on a stationary bike, RN #7 handed the resident the medication cup and glass of water. As the resident was swallowing the medications, RN #7 grabbed a bedside table in the therapy gym and placed the blood glucose testing supplies on the table. Once R262 finished taking the oral medications, the nurse performed a fingerstick blood glucose test, obtaining a blood sample from the resident's finger, then told the resident the result was 191 in the presence of other residents and staff in the therapy gym. During an interview on 2/19/2025 at 2:29 pm, LPN #4 stated the place to obtain a blood sugar was in the resident's room, privately. She stated if the blood sugar testing occurred in the dining room or therapy gym, this would be a privacy issue and a violation of a basic resident right. During an interview on 2/19/2025 at 2:59 pm, RN #8 stated the appropriate place to obtain a blood sugar was in the privacy of the resident's room. She stated the only time it would be appropriate to obtain a blood sugar in a public place like the dining room or the therapy gym was in the case of an emergency. During an interview on 2/19/2025 at 3:10 pm, LPN #9 stated the appropriate place to obtain a blood sugar was in the resident's room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/2025 at 10:05 am, the Director of Nursing (DON) stated the appropriate place to check a resident's blood glucose was in the resident's room, not in a public area like the therapy gym. During a follow-up interview on 2/20/2025 at 1:30 pm, the DON stated her expectation was for the nurses to follow facility policies for passing medications and for dignity issues related to appropriate places to do blood sugar checks. During an interview on 2/20/2025 at 9:10 am, the Administrator stated her expectation was that the nurses pass medications per policy and ensure the dignity of the facility's residents in the process.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 28193 Based on observation, staff interviews, record review, and review of the facility's policy titled Administering Oral Medications, the facility failed to ensure care and services were provided in accordance with accepted professional standards for one out of three Residents (R) (R55) observed during medication administration. Specifically, Registered Nurse (RN) (RN#7) withheld R55's physician-ordered medications without consulting with the physician for an order to do so. Findings include: Review of the facility's policy titled, Administering Oral Medications, copyrighted in 2001, under the section titled Purpose revealed, The purpose of this procedure is to provide guidelines for the safe administration of oral medications. The policy did not address withholding ordered medications. Review of the facility's policy titled, Medication Holds revised 4/2007, under the Policy Statement revealed, Temporary medication holds may be ordered by the resident's attending physician. Review of the Admission Record revealed, R55 admitted to the facility with diagnoses that included but not limited to essential (primary) hypertension, unspecified atrial fibrillation, and unspecified heart disease. Review of R55's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/6/2025, revealed Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Review of R55's Care Plan included a problem, initiated 2/4/2025, that indicated the resident had hypertension. Interventions directed staff to give antihypertensive medications as ordered and monitor for effectiveness and side effects such as orthostatic hypotension and increased heart rate (tachycardia). Review of R55's Order Summary Report with active orders as of 2/19/2025 indicated the resident had the following physician's orders: - amlodipine besylate-valsartan oral tablet 5-320 milligrams (mg), one tablet by mouth once daily for hypertension (ordered 12/31/2024 to start 1/1/2025). - Cardizem extended-release 24-hour coated beads 180 mg, one tablet by mouth once daily for atrial fibrillation (ordered 12/31/2024 to start 1/1/2025). Neither order included parameters for withholding the medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of a medication administration pass on 2/18/2025 at 8:27 am, Registered Nurse (RN) #7 checked Resident #55's blood pressure and pulse. The blood pressure result was 107/61 and the pulse was 48 beats per minute. RN #7 decided to hold the amlodipine besylate-valsartan 5-320 mg and the Cardizem extended-release 180 mg, due to the resident's blood pressure reading. She documented on the Medication Administration Record (MAR) that she was holding the medications and destroyed the medications in solution on the medication cart. RN #7 then returned to R55's room and administered the remaining medications to the resident with a glass of water. Review of R55's Medication Administration Record for February 2025 revealed RN #7 had documented her initials and, 04 for the Cardizem and amlodipine besylate-valsartan. The Chart Codes on the MAR revealed 04 indicated, vital sign outside of parameter. Review of R55's Progress Notes revealed that as of 2/19/2025 at 9:19 am, RN #7 had not documented notifying the resident's physician of the decision to withhold the resident's ordered medications or to obtain orders for parameters for withholding the medications. During an interview on 2/19/2025 at 9:44 am, RN #7 stated she did not notify the physician about withholding a medication until there was a pattern of like three days. She stated she withheld the medications for R55 because she knew the resident and how the resident's blood pressure changed, but she did not call the physician. During an interview on 2/19/2025 at 2:29 pm, Licensed Practical Nurse (LPN) #4 stated all orders for blood pressure medications should include parameters for withholding the medication. She indicated if there were no parameters, she would contact the physician before administering the medication to discuss whether or not to withhold it. During an interview on 2/19/2025 at 2:59 pm, RN #8 stated if there were no parameters for withholding a medication in the order, she would use her nursing judgement to hold the medication, would document it on the electronic MAR (eMAR), and would call the physician to notify them of the rationale for holding the medication and to ask for parameters to add to the order for the future. During an interview on 2/19/2025 at 3:10 pm, LPN #9 stated if there were no parameters in a blood pressure medication order, she would use nursing judgement to hold the medication, would document it on the eMAR, and then would call the physician to notify them and ask for parameters. During an interview on 2/19/2025 at 10:05 am, the Director of Nursing (DON) stated the nurses used nursing judgement for withholding blood pressure medications and would obtain parameters from the physician on as-needed (PRN) blood pressure medications. She stated the facility's policies did not specify what blood pressure parameters to use, but she would consider a systolic blood pressure less than 90 or a diastolic blood pressure less than 50 to be low. She stated, Every nurse could have a different idea of what is low, I guess. During a subsequent interview on 2/20/2025 at 1:30 pm, the DON stated her expectation was for the nurses to follow the policy for passing medications and to follow through with physician notification if they were going to hold a medication. During an interview on 2/20/2025 at 1:45 pm, the Administrator stated her expectation was for the nurses to pass medication per policy and per regulation. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/2025 at 9:10 am, the Medical Director (MD) stated his opinion on blood pressure parameters was that it should be determined on an individual basis and with nursing judgment. He stated he preferred that blood pressure medications have parameters that are set based on the induvial resident and not a standing order. He indicated he would expect a nurse to hold a blood pressure medication and notify him each time it was necessary and, if there was a pattern, he would look at altering the medication regimen.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 28193 Based on observations, staff interviews, record review, and review of the facility's policies titled, Medication Holds and Administering Oral Medications, the facility failed to ensure the medication error rate was less than 5% for two out of Residents (R) (R55 and R29) of three residents observed during medication administration. Observation of medication administration revealed 4 medication errors out of 31 opportunities, which resulted in a medication error rate of 12.9 %. Findings include: Review of the facility's policy titled, Medication Holds, revised 4/2007, revealed under Policy Statement, Temporary medication holds may be ordered by the resident's attending physician. Review of the facility's policy titled, Administering Oral Medications, copyrighted in 2001, revealed under Purpose, The purpose of this procedure is to provide guidelines for the safe administration of oral medications. The policy revealed under Steps in the Procedure, . 9. Prepare the correct dose of medication: Remove the cap from the bottle and place cap upside down on the work surface. Hold the medication cup at eye level and use your thumb to mark the desired level on the cup. Fill to the bottom of the meniscus at the desired level. Place cup on a level surface and read the poured amount at eye level to check accuracy. 1. Review of the Admission Record revealed R55 had a medical history that included diagnoses of essential hypertension, atrial fibrillation, and heart disease. Review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/6/2025, revealed R55 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Review of R55's Care Plan included a problem, initiated 2/4/2025, that indicated the resident had hypertension. Interventions directed staff to give antihypertensive medications as ordered and monitor for effectiveness and side effects such as orthostatic hypotension and increased heart rate (tachycardia). Review of R55's Order Summary Report with active orders as of 2/19/2025 indicated the resident had the following physician's orders: - amlodipine besylate-valsartan oral tablet 5-320 milligrams (mg), one tablet by mouth once daily for hypertension (ordered 12/31/2024 to start 1/1/2025). - Cardizem extended-release 24-hour coated beads 180 mg, one tablet by mouth once daily for atrial fibrillation (ordered 12/31/2024 to start 1/1/2025). Neither order included parameters for withholding the medication. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of a medication administration pass on 2/18/2025 at 8:27 AM, Registered Nurse (RN) #7 checked R55's blood pressure and pulse. The blood pressure result was 107/61 and the pulse was 48 beats per minute. RN #7 pulled R55's prepackaged medications from the cart, opened the packets of medication, and poured them all of them into a medication cup together. After entering the resident's room, RN #7 decided to hold the amlodipine besylate-valsartan 5-320 mg and the Cardizem extended-release 180 mg, due to the resident's blood pressure reading. Returning to the medication cart, she removed the amlodipine besylate-valsartan and the Cardizem from the medication cup. She documented on the Medication Administration Record (MAR) that she was holding the medications, then destroyed the medications in a solution on the medication cart. RN #7 then returned to R55's room and administered the remaining medications to the resident with a glass of water. Further review of R55's medical record revealed the physician's orders for amlodipine besylate-valsartan 5-320 mg and Cardizem extended-release 180 mg did not include parameters for withholding the medications. Additionally, there was no documentation as of 2/19/2025 at 9:19 AM to indicate RN #7 contacted the physician to obtain an order to withhold the medications on 2/18/2025. This resulted in two medication errors. During an interview on 2/19/2025 at 9:44 AM, RN #7 stated, The ability to hold a medication is based on the type of medication it is and nursing judgement. She stated she did not notify the physician about holding a medication until there was a pattern of like three days. RN #7 stated she held the blood pressure medications for R55's because she knew the resident and how their blood pressure changed. She stated the facility did not have standing orders for parameters on when to hold medications or when to notify the physician. During an interview on 2/20/2025 at 1:30 PM, the Director of Nursing (DON) stated her expectation was for the nurses to follow the policy for passing medications and to follow through with physician notification if they were going to hold a medication. During an interview on 2/20/2025 at 9:10 AM, the Medical Director (MD) stated he would expect a nurse to hold a blood pressure medication and notify him each time it was necessary and, if there was a pattern, he would look at altering the medication regimen. 2. Review of the Admission Record revealed the facility admitted R29 on 1/10/2020. According to the Admission Record, the resident had a medical history that included diagnoses of anxiety and cognitive communication deficit. Review of the Significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/4/2024, revealed R29 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident required a wheelchair for locomotion and total assistance with all activities of daily living (ADLs). Review of R29's Care Plan included a problem, initiated 12/20/2021, that indicated the resident had Crohn's disease with an alteration in gastrointestinal status. Interventions directed staff to give medications as ordered. Review of R29's Order Summary Report with active orders as of 2/19/2025 revealed the following physician's orders: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- cholecalciferol tablet 1000 units, one tablet by mouth once daily for supplement (ordered 01/27/2025). - polyethylene glycol 3350 kit, 17 grams by mouth once daily related to constipation (ordered 6/1/2021). During an observation of medication administration on 2/18/2025 at 8:54 AM, RN #7 prepared R29's medications. She poured the polyethylene glycol powder into the cap of the bottle and did not measure it on a flat surface before pouring it into a cup of water and stirring it up. As RN #7 finished preparing the medications, the resident's significant other walked by, and the nurse reminded them to bring in more calcium 1000-unit tablets because they were out. She stated there was none to give for this medication pass. The nurse counted five tablets and one gel cap in the medication cup prior to administration, for a total of six medications. According to R29's MAR, there should have been six tablets and one gel cap in the medication cup. The ordered cholecalciferol tablet (calcium 1000-unit tablet) was omitted. During an interview on 2/19/2025 at 10:05 AM, the DON stated medications that were poured and needed to be measured should be prepared on a flat surface and at eye level to make sure the level of medication poured was accurate. During a subsequent interview on 2/20/2025 at 1:30 PM, the DON stated she expected the nurses to follow the policy for passing medications and for the medication error rate to be below the percentage necessary to keep from getting a citation. During an interview on 2/20/2025 at 1:45 PM, the Administrator stated her expectation was for the nurses to pass medications per policy and regulation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 28193 Based on observations, staff interviews, record review, and review of the facility's policy titled, Administering Oral Medications, the facility failed to ensure medications were accurately labeled for one out of three Residents (R) (R55) observed during medication administration. Findings include: Review of the facility's policy titled, Administering Oral Medications, copyrighted in 2001, revealed under Purpose, The purpose of this procedure is to provide guidelines for the safe administration of oral medications. Under Steps in the Procedure, . 6. Check the label on the medication and confirm the medication name and dose with the MAR [Medication Administration Record]. Review of the Admission Record revealed R55 had a medical history that included diagnoses of essential hypertension, atrial fibrillation, and heart disease. Review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/6/2025, revealed R55 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Review of R55's Care Plan included a problem, initiated 2/4/2025, that indicated the resident had hypertension. Interventions directed staff to give antihypertensive medications as ordered and monitor for effectiveness and side effects such as orthostatic hypotension and increased heart rate (tachycardia). Review of R55's Order Summary Report with active orders as of 2/19/2025 indicated the resident had the following physician's orders: - amlodipine besylate-valsartan oral tablet 5-320 milligrams (mg), one tablet by mouth once daily for hypertension (ordered 12/31/2024 to start 1/1/2025). - Cardizem extended-release 24-hour coated beads 180 mg, one tablet by mouth once daily for atrial fibrillation (ordered 12/31/2024 to start 1/1/2025). (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of a medication administration pass on 2/18/2025 at 8:27 AM, Registered Nurse (RN) #7 checked Resident #55's blood pressure and pulse. The blood pressure result was 107/61 and the pulse was 48 beats per minute. RN #7 pulled R55's prepackaged medications from the cart, opened the packets of medication, and poured them all of them into a medication cup together. After entering the resident's room, RN #7 decided to hold the amlodipine besylate-valsartan 5-320 mg and the Cardizem extended-release 180 mg, due to the resident's blood pressure reading. Returning to the medication cart, she attempted to remove the amlodipine besylate-valsartan 5-320 mg tablet and the Cardizem extended-release 180 mg tablet from the medication cup and stated she needed to pull a strip of tomorrow's medications from the cart to see which pill the Cardizem was, because the descriptions from the pharmacy on the medication packets did not always match the medications that were in the packages. She stated sometimes the manufacturers changed the appearance of the medications, and the pharmacy did not update the medication packets to match what the medications looked like. She indicated this made it difficult for the nurses to know which medications they were giving without looking them up on their phones. RN #7 removed the two medications from the cup and destroyed them. During an interview on 2/19/2025 at 10:05 AM, the Director of Nursing (DON) stated the nurses had sealers so that a tablet could be sealed off in a corner of the packets and not come out of the packet with the rest of the medications. She stated being able to seal off a medication would require the description on the outside of the packet to be correct. The DON stated the pharmacist was currently at the facility and would look at R55's medications with the surveyor. During an interview on 2/19/2025 at 10:17 AM, the Pharmacist was observed reviewing R55's medication package for the morning medication pass. She stated the amlodipine besylate-valsartan had the wrong description on the outside of the packet. She stated the medication in the package was large and brown with an L-299 on it, and the description on the outside of the packet indicated it was white and oval with P-576 on the tablet. The pharmacist stated it was a pharmacy error and that she would need to take it to her supervisors to find out what had happened. She stated the error should have been caught in the pharmacy's quality assurance (QA) process and should not have made it to the facility. She indicated at times, the manufacturers changed the appearance of a medication, but there had to be a way to ensure the description of the medication was changed in the system as well. She stated when there were medication description errors, a resident could receive a medication they were not supposed to get, since the nurse could not verify the medication. Copies of the front and back of R55's medication packaging and the actual medications inside were provided for review. The medications were lined up inside the packaging according to a list on the front of the package to show the discrepancy between the medication description and the appearance of the medication inside. The packaging indicated the amlodipine besylate-valsartan description was OVL/WHT/P-576 [oval/white/P-576]. The medication inside was a dark, football-shaped medication with L-299 stamped on the tablet. During a subsequent interview on 2/19/2025 at 11:15 AM, the pharmacist stated she had talked to her supervisor about the problem with the identifier description not matching the pills inside of the packet. She stated she was given a sticker to put on R55's medication cycle going forward that identified the amlodipine besylate-valsartan's changed description. The pharmacist stated, We are going to have to look at the process going forward and have some things to change so that this does not happen again to anyone else and cause a significant medication error. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115524	A. Building B. Wing	02/20/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/2025 at 1:30 PM, the DON stated her expectation was for the nurses to follow the policy for passing medications. During an interview on 2/20/2025 at 1:45 PM, the Administrator stated her expectation was for the nurses to pass medication per policy and per regulation.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 28193 Based on observations, staff interviews, record review, and review of the facility's policy titled, Infection Prevention and Control Program, the facility failed to ensure infection control practices to prevent the potential spread of infection were maintained during medication administration for residents receiving medications from one of four medication carts observed. The failed practice affected one out of three Residents (R) (R55) observed during medication pass and one out of one (R262) observed receiving a blood glucose check. Specifically, the nurse attempted to remove medications from a medication cup with an ungloved fingernail for R55, placed a glucometer on a bedside table without disinfecting the table or placing a barrier for R262, failed to promptly replace an overflowing sharps container on the medication cart, and had an open personal beverage sitting on top of the cart uncovered throughout the medication pass. These failures had the potential of exposing residents to infections. Findings include: A facility policy titled, Infection Prevention and Control Program, revised 12/2023, indicated under Policy Statement, An infection prevention and control program (IPCP) is established and maintained to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Section 7. indicated, Important facets of infection prevention include: . 3. educating staff and ensuring that they adhere to proper techniques and procedures. 1. During an observation of medication administration on 2/18/2025 at 8:20 AM, Registered Nurse (RN) #7 was preparing to pass medications. She had an open can of flavored seltzer water sitting on top of the cart uncovered in an ice bath for the duration of the medication pass. The sharps container attached to the right side of the cart was filled past the designated full line, with lancets and needles visible above the protective flap. During an observation of medication administration on 2/18/2025 at 9:08 AM, RN #7 performed a blood glucose test on R262, then returned to the medication cart and disposed of the lancet in the sharps container, stating her sharps container was way too full and should have been changed out. During an observation of the medication cart on 2/19/2025 at 9:52 AM, the sharps container remained overfilled and had not been changed out, even after being acknowledged by RN #7 at 9:08 AM. During an interview on 2/19/2025 at 10:05 AM, the Director of Nursing (DON) was informed of the surveyor's observations of the sharps container on the medication cart being overfilled. During an observation of the medication cart on 2/19/2025 at 3:07 PM, the sharps container remained overfilled. During an observation of the medication cart on 2/20/2025 at 3:00 PM, the sharps container remained overfilled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/2025 at 1:30 PM, the DON stated her expectation was for the nurses to follow the policy for passing medications, including infection control practices. During an interview on 2/20/2025 at 1:45 PM, the Administrator stated her expectation was that the nurses pass medications per policy and per regulation while following infection control practices. During an interview on 2/20/2025 at 9:10 AM, the Medical Director (MD) stated he was made aware of multiple infection control issues during the medication pass that were not acceptable, and the facility would have to in-service the nurses on those items. 2. Review of R55's Order Summary Report with active orders as of 2/19/2025 indicated the resident had the following physician's orders: - amlodipine besylate-valsartan oral tablet 5-320 milligrams (mg), one tablet by mouth once daily for hypertension (ordered 12/31/2024 to start 1/1/2025). - Cardizem extended-release 24-hour coated beads 180 mg, one tablet by mouth once daily for atrial fibrillation (ordered 12/31/2024 to start 1/1/2025). During an observation of medication administration on 2/18/2025 at 8:27 AM, RN #7 decided to withhold two of R55's medications (amlodipine-besylate valsartan and Cardizem) after placing them in a medication cup with the resident's other scheduled medications. At the resident's bedside, without gloves on, RN #7 began using her fingernail to dig around in the medication cup to retrieve the two medications. She was able to recognize one of the medications and had to return to the cart to read the description of each medication on the packaging to identify the second medication to be removed. RN #7 removed the second blood pressure medication with her bare hand as well, destroyed the two medications, and then administered the remaining medications to R55. During an interview on 2/19/2025 at 2:29 PM, Licensed Practical Nurse (LPN) #4 stated if she needed to remove a medication from a medication cup with more than one medication in it, she would put on a pair of gloves, remove the medication, and destroy it. During an interview on 2/19/2025 at 2:59 PM, RN #8 stated if she needed to remove a pill from a medication cup with multiple pills in it, she would put on a pair of gloves, identify the pill, and remove it from the cup with a gloved finger, or she would use a medicine spoon to retrieve it and then destroy the medication. During an interview on 2/19/2025 at 3:10 PM, LPN #9 stated if she needed to remove a pill from a medication cup with multiple pills in it, she would use a medicine spoon to retrieve it and then destroy the medication. 3. Review of R262's Order Summary Report, dated 2/19/2025, revealed an order to check the resident's blood glucose twice daily. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of medication administration on 2/18/2025 at 9:08 AM, RN #7 prepared R262's morning medications and gathered the blood glucose testing supplies and a glass of water. R262 was ambulating in the hallway with a therapist to the therapy gym. RN #7 followed the resident and therapist into the therapy gym. After R262 was seated on a stationary bike, RN #7 grabbed a bedside table in the therapy gym and, without disinfecting it or placing a barrier on the table, placed the glucometer directly on the tabletop, then proceeded with the blood glucose test. The nurse disinfected the glucometer upon returning to the cart.