STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115562	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Holly Hill, LLC	413 Pendleton Place Valdosta, GA 31602

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49681 Based on observations, resident and staff interviews, and record reviews, the facility failed to provide care in a manner that maintained or enhanced residents' rights, dignity, and respect. Specifically, the facility failed to ensure that dependent residents were cleaned promptly when needed after eating, and failed to ensure the call light was in reach, for one of 14 residents (R) (R70). Findings included: Record review revealed R70 was admitted with diagnoses of but not limited to unspecified injury of the head, aneurysm of the heart, muscle weakness, unsteadiness on feet, dysphagia oropharyngeal phase, abnormal posture, and other abnormalities of gait and mobility. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C-Brief Interview for Mental Status (BIMS) score of 13 indicating little to no cognitive impairment. Section GG-ADL assistance needed included but not limited to, showers/baths, transfers, assist with setting up for feeding and cleaning as needed. Review of the care plan revealed a goal that R70 will be free from the negative consequences of vision loss as evidenced by remaining physically safe and participating in social and self-care activities. Assist with toileting and transfers PRN (as needed). Place call light within reach. Problem: Impaired Physical Mobility/Deconditioning related to COPD (Chronic Obstructive Pulmonary Disease), convulsions, cerebral infarction, PE (pulmonary embolism), and low back pain. ADL (Activities of Daily Living) needs will be met, and his independence potential maximized within the constraints of his illnesses through the next review. Long-term target date 11/30/2024. Review of menus revealed that breakfast was scheduled to be served to all residents from 7:30 am to 8:00 am. Observation on 11/18/2024 at 10:30 am revealed R70 in bed asleep. He did not respond when surveyor knocked on the door. The call light was on the floor and out of reach for R70. Observation on 11/19/2024 from 9:57 am to 11:20 am revealed R70 was in bed, the call light was on the floor, and he had breakfast food on his face and clothes. CNA (Certified Nursing Assistant) CC walked by and spoke to R70 but did not clean him or check to see if his call light was in reach. Interview at that time with R70 revealed he was visually impaired. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation at 11:20 am CNA CC cleaned the resident from the food on his face, picked up the call light from the floor, gave him a bed bath and changed his clothing. This observation revealed R70 had food on his face and clothing since breakfast earlier that morning. Resident revealed was unaware of food being all over him due to vision loss. Interview on 11/19/2024 at 4:08 pm, MDS Coordinator AA revealed that residents with vision or hearing loss should have a call light accessible and staff ensured the call light was accessible by checking on residents often. Interview further revealed that residents with vision loss should be assisted with eating, should be cleaned after eating because food is often everywhere and sometimes their clothes needed changing. Interview on 11/19/2024 at 4:12 pm Licensed Practical Nurse (LPN) ZZ revealed that when residents are visually impaired the CNA and nurses should follow the care plan and ensure interventions are being followed. Staff should check every hour or as needed to ensure the residents have their call light, assist with eating if needed, and clean the resident up after they finish eating. Interview on 11/19/2024 at 4:19 pm the Director of Health Services (DHS) revealed that nursing staff should follow interventions in the care plan for residents, especially for residents who are hearing and visually impaired and dependent for ADL. She also revealed that some interventions needed updating.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, resident and staff interviews, record reviews, and review of the facility's policies titled, Self-Administration of Medications by Patients/Residents and Bedside Storage of Medications, the facility failed to ensure unauthorized medications were not stored at the bedside for three of 32 residents (R) (R58, R19, and R67) reviewed. The deficient practice had the potential to allow unauthorized access of unsecured medications to residents and visitors. Findings included: Review of the facility's undated policy titled Self-Administration of Medications by Patients/Residents documented, .Each patient/resident who desires to self-administer medication is permitted to do so if the healthcare center's Licensed Nurse and physician have determined that the practice would be safe for the patient /resident and other patients/residents of the healthcare center. If the Licensed nurse determines the patient /resident or family member to be capable of self -administration of medications, the attending physician must write an order to that effect that includes the specific medications based off of the Self-Administration Medication Observation. Review of the facility's policy titled Bedside Storage of Medications reviewed 7/2/2024 documented, Policy Statement: It is the policy of (name of facility) Pharmacy Services that bedside medication storage is permitted for sublingual and inhaled emergency medications and other medications. For patients/residents 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 healthcare centers Interdisciplinary Patient/Resident Assessment team . Scope . Procedure: 1. A written order for the bedside storage of medication is placed in the patient/resident medical record. 1. Record review of R58's medical record revealed diagnoses of but not limited to chronic kidney disease stage 3, hypertension, cerebral infarction, and cognitive functions following cerebral infarction. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 indicating little to no cognitive impairment. Review of R58's self-administration evaluation/assessment form titled Self-Administration assessment dated [DATE] revealed R58 was assessed to administer only eyedrops and albuterol at the bedside. Observation on 11/17/2024 at 3:03 pm with Certified Med Tech VV revealed the following prescription medications labeled with the resident name inside R58's room: One bottle of nasal spray (mometasone furoate nasal spray 50 mcg (microgram) dosage) and Advair Diskus (fluticasone propionate-salmeterol) blister device 250-50 mcg/dose (micrograms per dose) amount. The CMA VV confirmed the unauthorized medications and removed the medications from R58's room. Review of R58's Physician Order Form dated November 2024 and November 2024 Medication Administration Record (MAR) listed Advair Diskus fluticasone propion-salmeterol blister device 250-50 mcg/dosage amount as one of the medications for the nurse to administer. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/18/2024 at 11:33 am the Director of Health Services (DHS) and Unit Manager, both staff confirmed being unaware that R58 had unauthorized prescription medications in her room. They revealed that R58 was authorized to only self-administered albuterol and eye drops. The DHS revealed the risk would be that other residents could come in contact with the medications. 50524 2. Review of R19's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognition) BIMS score of 14 which indicated little to no cognitive impairment. Review of the facility's documents revealed no evidence of physician's orders for self-administration of medication for R19. Review of the facility's documents revealed no evidence of Self-Assessment for Medication Administration for R19. Observation and interview on 11/17/2024 at 2:11 pm revealed R19 lying in bed in his room. There were 23 bottles of medications on R19's bedside table. R19 revealed he took his own vitamins which were on the table next to his bed. R19 revealed he preferred the [specific name] brand, and he took the medications whenever he wanted to. He revealed the nurses and other staff were aware of the medications being on his bedside table and they were aware he took them. 3. Review of the Electronic Medical Records (EMR) revealed R67 was admitted with a diagnosis of but not limited to chest pain. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognition) BIMS score of 14 which indicated little to no cognitive impairment. Section I (Active Diagnoses) listed Cardiorespiratory Conditions. Review of the care plan dated 4/13/2023 documented, Category: Pain- has potential for pain related to (r/t): history of (h/o) chest pain. Goal: will be comfortable as measured by his/family goals through next review. Approach: Complete Pain Observation on admission and as needed (PRN), administer any pain medications/interventions per physician's orders, monitor effectiveness of pain medication/intervention, provide any comfort measures, report to physician if he does not experience reduction or relief of pain after receiving prescribed interventions. Review of Physician's Orders dated 4/12/2023 included nitroglycerin tablet, sublingual; 0.4 milligram (mg); sublingual, take 1 tablet sublingually every 5 minutes x (times) 3 as needed for chest pain. As Needed PRN 1, PRN 2, PRN 3. Review of facility's documents revealed no evidence of physician's orders for self-administration of medication for R67. Review of facility's documents revealed no evidence of Self-Assessment for Medication Administration for R67. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 11/18/2024 at 8:37 am revealed R67 sitting on his bed in his room. He revealed he had a bottle of nitroglycerin tablets on his bedside table, and he took the tablets whenever he had chest pain. He stated he had them there because the nurses took too long to come and give the tablet to him. He revealed the nurses knew he had the medication. R67 further revealed he would bring the medication with him outside whenever his family came to visit him, and he took the nitroglycerin tablet if he had chest pain. Interview on 11/18/2024 at 9:57 am Licensed Practical Nurse (LPN) KK confirmed the bottle of nitroglycerin was at resident's bedside. She confirmed there was no physician's orders for self-administration of medication for R67. She further stated R67 was not to have the nitroglycerin at his bedside to take on his own. Interview on 11/18/2024 at 11:35am with Director of Health Services (DHS) revealed R19 was not supposed to have medication at the bedside. She revealed if residents had medications at their bedside and were self-administering medications, they were to have a self-assessment done by the Interdisciplinary Team (IDT) to see if the resident was alert and mentally and physically able to self-administer medications. She also stated R19 needed an order to self-administer medication, and he did not have an order nor a self-assessment to self-administer medication. The DHS revealed staff needed to know if and when R19 was taking the medication in order to monitor it. She revealed the outcome if residents took their own medications without proper assessment and monitoring could result in medication adverse effects and harm to the residents. Interview on 11/19/2024 at 5:35 pm with Certified Nursing Assistant (CNA) HH revealed medications should not be at the resident's bedside and she would call the nurse to tell her that there was medication at the resident's bedside. Interview on 11/19/2024 at 5:45 pm with Licensed Practical Nurse (LPN) II revealed residents should not have medication at their bedside. She revealed the resident could overdose on the medications when they take it whenever they wanted to or took more than the prescribed dosage, and the nurse did not know about it. She revealed the medication could also interfere with medications the nurse was giving them and that could cause adverse reactions for the resident.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, resident and staff interviews, and record reviews, the facility failed to accommodate the needs of two of 8 residents (R) (R66 and R70) reviewed for accommodation of needs. Specifically, the facility failed to provide a morbid obese resident (R) (R66) with a bed that would accommodate her size; and the facility failed to ensure (R70), who was visually impaired, had a call light within reach. Findings included: A facility policy on accommodation of needs was requested but not provided. 1. Record review of the medical record revealed R66 had diagnoses of but not limited to obesity class 3, vascular dementia, cerebral vascular accidents (CVA) with left side paralysis, hemiplegia and hemiparesis following cerebral infarction. Review of R66's Quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed a Brief Interview for Mental Status (BIMS) score of 14 which indicated little to no cognitive impairment. R66's weight was assessed as 276 lbs (pounds), assessed as one-person assist with bed mobility and mechanical lift for transfer. Observation on 11/17/2024 at 1:56 pm revealed R66 lying centered in bed. Continued observation revealed the bed mattress was too narrow, not wide enough to provide space for turning on each side. Interview at that time, R66 revealed being afraid of falling on the floor when the Certified Nursing Assistant (CNA) staff rolled her on her side during incontinence care and bed baths. R66 revealed most of the time there was only one staff member assisting her. She revealed that the CNA's often tell her that she needed a bigger bed and would call another CNA to position themselves on the other side to prevent R66 from rolling off the bed. R66 revealed expressing her fears to the CNA's and a licensed nursing staff. Interview on 11/19/2024 at 2:00 pm (at the time of observation of R66's bed), the Therapy Director/Physical Therapist (PT) confirmed that based on observation of R66's body size/ measurement/alignment lying flat and centered in the bed, there was not enough space on both sides of the mattress. PT further revealed that without having guard from another staff on the opposite side of the bed, R66 was at risk of falling. She revealed she would do a referral for the facility Occupational Therapist to re-assess R66 for bed mobility because R66 was discharged from therapy. Interview on 11/18/2024 at 11:38 pm, the Director of Health Services (DHS) and Unit Manager both confirmed that R66 could use a larger bed. Both staff revealed that in the past R66 was in a larger bed. Unit Manager reported being unable to recall as to why the resident's bed was changed to a smaller bed. DHS reported that R66's bed could be extended, and a larger mattress could be provided. Interview on 11/19/2024 at 3:45 pm, the Administrator revealed that R66's bed was extended today and R66 had a wider mattress to fit the new bed extension width. The Administrator revealed being unaware that the bed was too small and recalled in the past R66 was in a larger bed due to her weight size. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49681 2. Record review revealed R70 was admitted with diagnoses of but not limited to unspecified injury of the head, aneurysm of the heart, muscle weakness, unsteadiness on feet, dysphagia oropharyngeal phase, abnormal posture, and other abnormalities of gait and mobility. Review of the Quarterly MDS assessment dated [DATE] Section C assessed R70 a BIMS score of 13 indicating little to no cognitive impairment. Section GG ADL assistance-comb hair, showers/ baths, transfers, assist with setting up for feeding and cleaning as needed. Review of the care Plan revealed a goal that R70 will be free from the negative consequences of vision loss as evidenced by remaining physically safe and participating in social & self-care activities. Assist with toileting and transfers PRN (as needed). Place call light within reach. Problem: Impaired Physical Mobility/Deconditioning related to COPD (Chronic Obstructive Pulmonary Disease), convulsions, cerebral infarction, PE (pulmonary embolism), and low back pain. R70 ADL needs will be met, and his independence potential maximized within the constraints of his illnesses through the next review. Long-term target date 11/30/2024. Review of menus revealed that the facility had scheduled breakfast to be served to all residents from 7:30 am to 8:00 am. Observation on 11/18/2024 at 10:30 am revealed R70 in bed asleep. He did not respond when surveyor knocked on the door. The call light was on the floor and out of reach for R70. Observation on 11/19/2024 from 9:57 am to 11:20 am revealed R70 was in bed, the call light was on the floor, and he had breakfast food on his face and clothes. CNA (Certified Nursing Assistant) CC walked by and spoke to R70 but did not clean him or check to see if his call light was in reach. Interview at that time with R70 revealed he was visually impaired. Observation on 11/19/2024 at 11:20 am CNA CC cleaned the resident and picked the call light up from off the floor, gave him a bed bath and changed his clothing. Observation revealed it took over 60 minutes for staff to clean R70's face and clothing from food that he had from breakfast. Resident was unaware of food being all over him due to vision loss. Interview on 11/19/2024 at 4:08 pm, MDS Coordinator AA revealed that residents with vision or hearing loss should have a call light accessible and staff ensured the call light was accessible by checking on residents often. Interview further revealed that residents with vision loss should be assisted with eating, should be cleaned after eating because food is often everywhere and sometimes their clothes needed changing. Interview on 11/19/2024 at 4:12 pm, Licensed Practical Nurse (LPN) ZZ revealed that when residents are visually impaired the CNA and nurse staff should follow the care plan and ensure interventions are being followed. Staff should check every hour or as needed to ensure the residents have access to call lights, assist with eating if needed, and clean the resident up after they finish eating. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/19/2024 at 4:19 pm the Director of Health Services (DHS) revealed that nursing staff should follow interventions in the care plan for residents, especially for residents who are hearing and visually impaired and dependent for ADL. She also revealed that some interventions needed updating.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on resident and staff interviews, record review, review of the facility's Admission Packet, and review of the facility's policy titled, Advance Directive policy, the facility failed to provide residents and or their representatives written information regarding the right to accept or refuse medical or surgical treatment for three of 33 residents (R) (R45, R58, and R4) reviewed. This failure denied the residents and/or representatives the opportunity to have choices and preferences with their health care and formulating an Advance Directive. Findings included: Review of the facility's Advance Directive policy dated 11/6/17 revealed, Prior to, or upon Admission, the patient/resident and/or their responsible party will be asked about the existence of any advance directives. The Advance Directive Checklist, which is in the Georgia Admission Packet, will be completed. Review of the facility's Admission Packet revealed it did not contain language that pertained to the facility's provision of written information about the resident/representative's right to accept or refuse medical or surgical treatment. 1. R45 was admitted to the facility with diagnoses of but not limited to Alzheimer's Disease with late onset, metabolic encephalopathy, and type two diabetes mellitus with diabetic neuropathy. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R45's cognition was undetermined due to a Brief Interview for Mental Status (BIMS) score of 99, indicating the interview was unable to be completed. 36377 2. R58 was admitted to the facility with diagnoses of but not limited to chronic kidney disease stage 3 and cerebral infarction. Review of the Annual MDS assessment dated [DATE] assessed a BIMS score of 15 which indicated little to no cognitive impairment. Review of R58's November 2024 Physician Order Form dated November 2024 revealed an order for full code status. Review of R58's Advance Directive form dated 11/17/2021 documented that R58 signed the Advance Directive at the time of admission. Continued review of the Advance Directive form, and the resident's medical record revealed no written documentation or evidence to show a form, or discussion being provided to the resident/responsible party regarding a choice to accept or refuse surgical treatment. 50171 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R4 was admitted to the facility with diagnoses of but not limited to viral pneumonia, cerebrovascular disease, unilateral primary osteoarthritis, muscle weakness (generalized), abnormal posture, rhinovirus, chronic encephalopathy, lack of coordination, abnormalities of gait and mobility, Type 2 diabetes mellitus without complications, atherosclerosis of native arteries of extremities, bilateral legs. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed a BIMS score of 15, indicating little to no cognitive impairment. Interview on 11/20/2024 at 11:27 am with the facility's Social Worker and Senior Nurse Consultant confirmed no evidence was found to support the residents, R45, R58, R4, and/or any other resident/representative had been provided written information related to their right to accept or refuse medical or surgical treatment, on or after admission to the facility. Interview on 11/20/2024 at 11:50 am with the Regional Corporate Admissions Coordinator revealed the facility used the documents that are included in the admission packet and admitted she was not familiar with an advanced directive checklist that included the right to consent or deny medical or surgical treatment.

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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** 49675 Based on observation and interview, the facility failed to maintain a safe, clean, comfortable, and homelike environment on one of five halls (100 hall). Specifically, the facility failed to ensure the toilet base and caulking was not stained dark brown in one shared bathroom between rooms 102, 104, and in room [ROOM NUMBER] and room [ROOM NUMBER]; failed to ensure light fixtures above resident's beds were not rusty brown colored and wall trim was not sticking out toward residents' bed in room [ROOM NUMBER]. The deficient practice caused an unsafe and unsanitary environment and had the potential to place residents at risk for avoidable injury or illness, and a diminished quality of life. Findings included: Observations on 11/17/2024 at 3:42 pm, 11/18/2024 at 2:36 pm, and 11/19/2024 at 8:30 am revealed the bathroom toilet base and caulking that is shared between rooms [ROOM NUMBERS] to be stained dark brown. Observations on 11/17/2024 at 2:45 pm, 11/18/2024 at 2:36 pm, and 11/19/2024 at 11:07 am in room [ROOM NUMBER] revealed the light fixtures above residents beds to be white with rusty brown colored spots, the toilet caulking and base to be stained brown, and the plastic trim that is placed on the middle of the wall that is the length of the wall, was pulled off the wall and sticking out toward the resident's bed. Observations on 11/17/2024 at 1:15 pm, 11/18/2024 at 2:38 pm and 11/19/2024 at 11:12 am revealed the bathroom toilet base and caulking of room [ROOM NUMBER] to be stained brown. Observation and rounding on 11/20/2024 at 3:12 pm with the Maintenance Director confirmed the toilet bases and caulking to be stained dark brown in the bathroom shared between room [ROOM NUMBER] and 104 and the toilets in rooms [ROOM NUMBERS]. The light fixtures above the residents' rooms in room [ROOM NUMBER] were rust covered, and the plastic trim in room [ROOM NUMBER] is pulling away from the wall sticking out toward the resident's bed. The Maintenance Director revealed it was his intentions to fix, repair, or replace all the identified concerns.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, resident and staff interviews, record reviews, and review of the facility's policy titled, Care Plans, the facility failed to develop and implement a care plan for five residents (R) (R58, R77, R47, R29, and R338) out of 32 reviewed. Specifically, they failed to create and implement a care plan for R58 for self-administration of medication, and for R47 for oxygen use. The facility failed to follow the care plan for resident R47 reviewed for nutrition related to obtaining admission and weekly weights; and they failed to follow the care plan for three residents (R77, R29, R338) receiving oxygen therapy and ensure the oxygen flow rate for each resident was followed based on physician order. Findings included: Review of the facility's policy titled, Care Plan dated 7/27/2023 revealed, Admission Comprehensive Plan of Care 2. A comprehensive person-centered care plan will be developed by the interdisciplinary team for each patient /resident within seven days after the completion of the comprehensive assessments. The care plan serves as instructions for the patient's care and provides continuity of care by all partners. Short and concise instructions, which can be understood by all partners. 1. Record review of the medical record revealed R58 had diagnoses of but not limited to chronic kidney disease stage 3, hypo-osmolality and hyponatremia, chronic kidney disease stage 3 and anemia in chronic kidney disease. Review of R58's Physician Order Form (POF) dated November 2024 listed an order for albuterol and eyedrops. Review of resident form titled Self-Administration assessment dated [DATE] revealed R58 was assessed to self-administer eyedrop and albuterol. Review of R58 's care plan revealed no care plan to support resident assessment and authorization to self-administer medications. 2. Record review of R77's medical record revealed an admitted [DATE] with diagnoses of but not limited to chronic respiratory failure and paroxysmal atrial fibrillation. Review of the Admission MDS assessment dated [DATE] assessed a BIMS score of 11 which indicated moderate cognitive impairment and was assessed for oxygen use. Review of R77's orders included an order dated 10/15/2024 for administering oxygen therapy at 2 LPM (liters per minutes) via (by) nasal cannula continuous every shift. Review of R77's care plan created 7/31/2024 identified/documented a problem, Oxygen use related to asthma, chronic respiratory failure. Interventions included oxygen as ordered/needed. (continued on next page)

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	115562	A. Building B. Wing	11/20/2024

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/17/24 from 2:05 pm until 3:33 pm, and again at 5:01 pm revealed R77 receiving oxygen therapy from an oxygen concentrator via nasal cannula (NC) at 3 liters with no humidifier bottle attached. Interview on 11/20/2024 at 1:49 pm, the MDS Coordinator AA confirmed his expectation that nursing staff follow the care plan for weights for R47. He reported being unaware that the care plan was not being followed. MDS Coordinator reported being unaware that R58 was assessed to self-administer medications. He stated that R58's medical record should include a care plan to address self-administering of medications. He reported being unaware that R77 was not receiving oxygen per physician order, and that his expectation that residents' care plans were being followed. 50169 3. Record review for R47 revealed an admitted [DATE] with diagnoses of but not limited to pneumonia, asthma, dysphagia oral phase, surgical aftercare, and cognitive communication deficit. Review of Admission MDS assessment dated [DATE] revealed Section C-Cognition included BIMS score of 13 suggesting little to no cognitive impairment; Section O-Special treatments included oxygen. Review of physician orders included order dated 10/21/2024, Oxygen at 2 LPM via NC continuous. Every shift, days, nights; Change respiratory circuit/supplies weekly once a day on Monday nights; change respiratory circuit/supplies; as needed PRN. Record review revealed there was no care plan for oxygen use and no individualized interventions to address the monitoring. Review of R47's care plan created 8/6/2024 identified/documented, Problem: nutrition and/or hydration risk related to acute kidney failure and dysphagia. Interventions included weigh and monitor results on admission, then weekly x 4 weeks (for four weeks) or until stable. Record review revealed R47 was weighed on 10/21/2024 by facility staff. Continued review revealed no other weights were recorded consecutively for four weeks after admission to monitor R47's weight. Observation on 11/17/2024 at 5:07 pm, on 11/19/2024 at 9:35 am and at 12:37 pm revealed R47 was lying in bed receiving oxygen via nasal canula. Interview during observations R47 revealed she had received oxygen since she had been in the facility. Interview on 11/19/24 at 2:00 pm, the Registered Dietician (RD) revealed that weights should be completed weekly for four weeks after admission to monitor nutrition risks, and at least monthly to monitor for weight loss. The RD revealed being unaware that R47 was not being weighed and followed for the first four weeks after their admission to facility and admission weight. Interview on 11/20/2024 at 11:10 am Unit Manager DD revealed it was the nurses' responsibility, as well as the Minimum Data Set (MDS) Coordinator to make sure that care plans were updated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/20/2024 at 1:25 pm MDS Coordinator AA, revealed different departments are responsible for completing the resident's care plan and MDS checked as needed to make sure all information had been entered or updated. He confirmed that R47 did not have a care plan for oxygen and the risk to a resident not being care planned correctly would be that the resident would not receive the proper care. 49675 4. Review of the medical record for R29 revealed she was admitted to the facility on [DATE] with acute kidney failure, type two diabetes mellitus with diabetic chronic kidney disease, and hypertensive heart disease with heart failure. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 15, indicating little to no cognitive impairment. Section O, special treatment (included oxygen) reported none. Review of the physician orders revealed an order for oxygen dated 7/25/2024, oxygen at 2 LPM via nasal cannula continuous. Review of the care plan initiated revised on 9/9/2024, revealed that resident has diagnosis of acute respiratory failure with hypercapnia. Oxygen as needed and ordered. Oxygen saturations as needed and ordered. Observations on 11/17/2024 at 1:06 pm and 4:58 pm revealed R29 receiving oxygen at a rate of 3 liters. Interview on 11/18/2024 at 11:20 am with Registered Nurse (RN) DD verified the physician order for oxygen at a rate of 2 liters. She looked at picture the surveyor captured and verified the oxygen was set on the wrong oxygen rate. She stated it was the nurse's responsibility to check daily to make sure the flow rate is correct. Interview on 11/20/2024 at 10:05 am with the Director of Health Services (DHS) revealed her expectations were for nurses to follow orders and for charge nurses to check oxygen rates. She expected all oxygen rates to be set on the prescribed rate by the physician. Interview on 11/20/24 at 1:42 pm with MDS Coordinator AA revealed the Interdisciplinary team (IDT) oversaw development of the care plan. He revealed his expectations were that staff follow the care plan, update it accordingly, and administer oxygen per orders. He revealed all staff including Certified Nursing Assistants (CNA's) should review care plans and physician orders to ensure each resident who was on oxygen therapy had the correct flow rate. 50171 5. Review of the clinical record revealed R338 was admitted to the facility with diagnoses of but not limited to unspecified fracture of T11-T12 collapsed vertebra, muscle weakness unsteadiness on feet, abnormal posture, pain, unspecified, reduced mobility, low back pain, neuromuscular dysfunction of bladder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R338's most recent MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated little to no cognitive impairment. Section O revealed the resident required oxygen therapy. Review of the Physician orders revealed an order for oxygen at 3 liters per minute (LPM) per nasal cannula (NC) at 9pm with a start date of 11/1/2024. Observation on 11/17/2024 at 2:12 pm revealed R338 lying in bed receiving oxygen therapy via NC set at 2. 5/LPM. Observation on 11/18/2024 at 9:30 am revealed R338 lying in bed receiving oxygen therapy via NC set at 2/LPM. Rounding on 11/18/2024 at 3:16 pm with RN DD confirmed the LPM should be set on 3/LPM and not 2. 5/LPM. She adjusted the rate to 3/LPM. LPN revealed her expectations were that she and other nurses follow physician orders. Interview on 11/20/2024 at 11:10 am with RN DD revealed that it was the nurse's responsibility, as well as the MDS Coordinator to make sure that the care plan was updated. Interview on 11/20/2024 at 1:25 pm with MDS Coordinator AA revealed different departments are responsible for completing the resident's care plan. He revealed that MDS would get an email from the hospital with resident changes and MDS checked the care plan as needed to make sure all information was entered or updated. MDS coordinator AA confirmed that R338 did not have a care plan for oxygen use and that the risk to a resident not being care planned correctly would be that the resident would not receive proper care.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50524 Based on observations, staff interviews, and record reviews, the facility failed to apply splints as ordered for one of 10 residents (R) (R56) receiving splints. This deficient practice had the potential to cause worsening of R56's contractures and a diminished quality of life. Findings included: Review of Electronic Medical Records (EMR) revealed R56 was admitted on [DATE] with diagnoses of but not limited to unilateral primary osteoarthritis, contractures of left hand, contracture of right hand, contracture of right elbow, contracture of left elbow, contracture of right shoulder, muscle weakness (generalized). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Section C (Cognition) documented no Brief Interview for Mental Status (BIMS) score, as cognitive skills for daily decision making as severely impaired; Section I (Active Diagnosis) Muscle weakness (generalized); Section O (Special Treatments) range of motion (passive) and splint or brace assistance; Section GG (Functional Abilities) upper extremity impairment, lower extremity impairment. Review of the care plan dated 8/23/2024 included but not limited to, application of elbow extension, elbow orthosis, hand palm guard orthosis, hand cone orthosis, hand carrot orthosis, resting hand orthosis application for four-to-five-hour wear tolerance daily as tolerated with skin inspection following removal for redness, edema, and pain daily from 7:00 am to 11:00 pm, or twice a day from 7:00 am to 7:00 pm and 7:00 pm to 7:00 am; requires BUE PROM (bilateral upper extremity Passive Range of Motion) in all planes daily as tolerated to minimize risk of further contracture. Review of Orders dated 8/23/2024 included but not limited to Restorative: Apply R Elbow extension orthosis and B hand Palm Guard Orthosis to R (right) Elbow and B hand joints for four-to-five-hour wear tolerance daily as tolerated with skin inspection following removal for redness, edema, and pain. Observation on 11/17/2024 at 3:00 pm, on 11/18/2024 at 11:00 am and 4:00 pm, on 11/19/2024 at 10:00 am and 2:00 pm, and on 11/20/2024 at 9:00 am revealed R56 lying in bed. Resident had contractures of both hands. No splints were seen on resident at any observation. Interview on 11/20/2024 at 9:07 am with Certified Nursing Assistant (CNA) JJ revealed R56 was to have splints for his hand contractures and confirmed R56 was not wearing splints for his hands and right elbow. She looked for the splints in the drawers of the resident's bedside table and in the resident's dresser drawers, she was unable to locate R56's splints. Interview on 11/20/2024 at 9:10 am Licensed Practical Nurse (LPN) KK revealed R56 had a brace for each hand which were to be applied for four to five hours every day. She confirmed R56 did not have splints on since the survey dates 11/17/2024 through 11/20/2024. She revealed the Certified Nursing Assistants (CNA) was to apply the splints and check them off on their documentation. She revealed if the splints were not applied the contractures would get worse and also cause skin break down. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/20/2024 at 9:14 am CNA LL revealed she had worked with the facility for three years and was assigned to R56 for this shift. She revealed she only had one resident this shift who had contractures and it was a resident on another hall. She confirmed R56 had contractures and she did not put the splints on this shift. Interview on 11/20/2024 at 9:48 am Director of Health Services (DHS) revealed her expectations were for the CNAs and nurses to apply the splints as ordered by the Physical Therapist (PT)/Occupational Therapist (OT) and doctor's orders. She revealed the outcome if the splints were not applied as ordered would be worsening of the contractures. Interview on 11/20/2024 at 9:59 pm with the PT Assistant MM and PT NN revealed R56 was discharged from therapy. They stated whenever a resident was to have a splint, they educated the CNAs about it because the CNAs were the ones to apply the splints. Interview on 11/20/2024 at 10:03 pm with the OT OO revealed R56 was discharged from therapy and the CNAs were to apply the splints as directed from the verbal education they received.

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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** 49675 Based on observations, resident and staff interviews, record review, and review of the facility's policy titled, Oxygen Administration, the facility failed to ensure two of 33 residents (R) (R59 and R82) reviewed were free from accident hazards. Specifically, the facility failed to ensure R59 was free from exposure to harmful chemicals and R82 was free from exposure to a free-standing oxygen tank. Findings included: A facility policy for accidents and hazards was requested, however, the facility advised they did not have a policy. Review of the facility's policy titled, Oxygen Administration revised 8/2/2023 documented, .8. Racks or cart is required for stabilization of E-tanks when in use or in storage. 1. Review of R59's medical record revealed the resident was admitted with diagnoses of but not limited to type two diabetes mellitus with diabetic neuropathy, anemia, muscle weakness (generalized). Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed a Brief Interview for Mental Status (BIMS) score of 15 which indicated little to no cognitive impairment. Observation on 11/17/2024 at 1:15 pm revealed a bottle of [brand name] bleach sitting above the bathroom sink. Interview and rounding on 11/17/2024 at 1:17 pm with Registered Nurse (RN) FF verified the Clorox bleach was in R59's bathroom and confirmed chemicals such as bleach should never be stored in a resident's bathroom. Interview on 11/20/2024 at 10:03 am with the Director of Health Services (DHS) revealed that bleach nor any other chemical should be in a resident's room. She revealed it is against the facility's policy for residents to have bleach or any other hazardous chemical in rooms. She revealed training and education will be completed. 50524 2. Review of Electronic Medical Records (EMR) revealed R82 was admitted with a diagnosis of but not limited to chronic respiratory failure with hypercapnia. Review of Admission MDS assessment dated [DATE] documented Section C (Cognition) BIMS score of 15 which indicated little to no cognitive impairment, Section I (Active Diagnosis) debility, cardiorespiratory conditions, respiratory failure, Section J (Health Conditions) shortness of breath or trouble breathing with exertion. Shortness of breath or trouble breathing when sitting at rest, shortness of breath or trouble breathing when lying flat. (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 care plan dated 9/6/2024 included Oxygen, use related to morbid obesity, chronic resp (respiratory) failure. Goal: Maximize oxygen level and maintain optimal breathing. Approach: Oxygen as ordered. Review of Physician's orders dated 9/5/2024 included, but not limited to oxygen at 4 liters per minute (LPM) via (by) nasal cannula (NC) continuous every shift day, evenings, nights. Observation on 11/17/2024 at 2:01 pm revealed a free-standing oxygen tank in the corner of R82's room which was not in a rack or cart. Interview on 11/17/202 at 2:20 pm with R82 revealed the oxygen tank had been in the corner of his room for maybe a few weeks because no one had taken an oxygen tank in his room recently. Interview on 11/17/2024 at 5:11 pm the DHS confirmed the oxygen tank was in R82's room and was not in a cradle/caddy (cart or rack). She stated oxygen tanks should not be free-standing; they should be in a cradle because they can be dangerous if they fall over. She revealed her expectations were for the staff to ensure that the oxygen tanks were secured in a cradle. She stated the outcome if the oxygen tanks were not secured would be they could be projectiles and they could harm the resident and cause death. Interview on 11/17/2024 at 5:26 pm with Licensed Practical Nurse (LPN) PP revealed the oxygen tank needed to be in a holder. If it was not in a holder, it could explode if it fell over. She confirmed the resident could be hurt or get killed if the tank exploded. Interview on 11/19/2024 at 5:35 pm with Certified Nursing Assistant (CNA) HH revealed she worked at the facility for [AGE] years, oxygen tanks should be in a carrier or on the back of the wheelchair. She revealed the tank could fall and explode and harm the resident's if it was not secured in a holder. Interview on 11/19/2024 at 5:45 pm with LPN II revealed she worked at the facility for a year and a half. She revealed oxygen tanks should be kept in a roller carrier because they could fall over and hurt the resident if it is not secured. She revealed if the tank fell on the resident, it could damage the part of the body it falls on, or if it exploded it would hurt the resident even worse.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on observations, staff interview, and record reviews, the facility failed to ensure that one of four residents' (R) (R39)'s catheter tubing was not coiled and correctly positioned to prevent obstruction of urinary flow out of four residents with a catheter. This deficient practice had the potential to put residents at risk for complications related to their urinary health with the possibility of urinary tract infections. Findings included: Record review of the medical record revealed R39 admitted with diagnoses of but not limited to urinary retention and neurogenic bladder. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed a Brief Interview for Mental Status (BIMS) score of 15 that indicated little to no cognitive impairment. MDS also assessed for catheter use. Review of the November 2024 Physician Order Form (POF) and Medication Administration Record (MAR) included the following order dated 6/23/2023, Suprapubic cath: 16Fr/10 bulb (16 French 10 bulb) every shift, every day, evening, night. R39's care plan created 2/28/2020 included instructions to keep drainage bag below level of bladder. Observations on 11/17/2024 at 1:34 pm to 2:55 pm, revealed R39 lying in bed with an attached catheter. Continued observation revealed the catheter tubing was coiled and hung on a dresser knob which was positioned directly across from the resident's bed. The positioning of the catheter and tubing resulted in the catheter being positioned at the height of the bed instead of positioned below the bladder. Interview with R39 at the time of the observation, R39 revealed that staff placed the bag there. Observation on 11/17/2024 at 2:58 pm with Certified Med Tech (CMA) VV and the Wound Nurse of R39 lying in bed with an attached catheter drainage bag revealed the bag was hanging on the resident's bedside drawer handle resulting in the drainage bag being at waist height. CMA VV placed a dignity bag on the catheter bag and hung the bag on the dresser knob. When asked why the bag was placed on the knob, CMA VV reported her reason for hanging the bag on the dresser knob was based on R39's preferences. CMA VV exited the room leaving the catheter drainage bag hung on the dresser knob. CMA VV reported that she was never instructed to how to hang the catheter bag. Interview at the time of observation inside R39's room with the Director of Health Services (DHS) and the Unit Manager, on 11/18/2024 at 1:30 pm, revealed R39's catheter bag and tubing were hung on dresser drawer knob above the level of the bladder and at the height of the resident bed. The DHS confirmed the drainage bag was too high and repositioned the bag below the bladder. She revealed her expectation was that staff positioned the bag correctly.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36377 Based on staff interviews, record reviews, and review of the facility's policy titled, Nutritional Screening and Assessments/Food Preferences, the facility failed to provide evidence that nutrition assessments were completed by the Registered Dietitian (RD) for two of 32 residents (R) (R47 and R77) reviewed. This deficient practice had the potential to place the residents at risk of nutrition problems and weight loss. Findings included: Review of the facility's policy titled Nutritional Screening and Assessments/Food Preferences dated 3/28/2024 documented, .It is the policy of the facility for each patient/resident to receive an initial nutritional screening and comprehensive nutritional assessment upon admission. Food preferences are obtained for each patients /resident upon admission and annually to assure food choices and preferences are granted. Assessments must be completed within 14 days of admission. 1. Record review for R47 revealed an admitted [DATE] with diagnoses of but not limited to dysphagia oral phase, hypertension, and acute kidney failure. Review of Physician orders revealed that R47 was prescribed a diet for NAS (No Added Sugar), mechanical soft with special instruction chopped meat in gravy. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated little to no cognitive impairment. Record review revealed that there was no nutrition assessment completed for R47 by the Registered Dietician until 11/18/2024. Review of R47's care plan created 8/6/2024 included, risk for nutrition and/or hydration risk related to acute kidney failure, dysphagia, and pneumonia. 2. Record review of R77's medical record revealed an admitted [DATE] with the following diagnoses but not limited atrial fibrillation, chronic obstructive pulmonary disease, and end stage renal disease (ESRD). Review of the Admission MDS assessment dated [DATE] assessed a BIMS score of 11, which indicated moderate cognitive impairment, and was assessed for oxygen use. Review of R77's diet order consisted of CCHO/NAS (controlled carbohydrate/no added salt) special instructions no bananas, no tomatoes, no potatoes, no oranges 1000 ml/24 hr (1000 milliliters in 24 hours) fluid restriction, nursing 280 ml:7a-7p 160 ml 7p-7a 120 ml, Dietary 720 ml: Breakfast 240 ml, lunch 240 ml, dinner 240 ml. Record review revealed that R77's nutrition assessment was not completed by the Registered Dietician until 8/5/2024. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/19/2024 at 2:15 pm with the Registered Dietician (RD) confirmed that R47's nutrition assessment was not completed until 11/18/2024 during the survey; and that R77's nutrition assessment was not completed until 8/5/2024. The RD reported having a system in place to keep track of all assessments, and that both residents' assessments were addressed after she identified the error. Interview on 11/10/2024 at 5:19 pm, the Administrator and Director of Health Services (DHS) revealed being unaware that R47 and R77's nutrition assessments were not completed in a timely manner based on the company policy. Administrator reported her expectation that all nutrition assessments were completed in a timely.

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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** 50171 Based on observation, staff interviews, record reviews, and review of the facility's policy titled, Oxygen Administration, the facility failed to follow Physician Order's for four of 11 residents (R) (R338, R77, R29, and R34) reviewed for receiving oxygen. The deficient practice increased the risk of respiratory complications and infections for the residents receiving respiratory care and treatment. Findings included: Review of the policy titled Oxygen Administration revised 8/2/2023 revealed, .Policy Statement: It is the policy of the facility to provide oxygen safely and accurately to appropriate patients/residents. Oxygen will be administered by licensed personnel only when ordered by the physician, PA or NP. The physician order may be written PRN for comfort/dyspnea or may specify the number of liters, method of administration and length of time the oxygen is to be administered. 1. Review of the Electronic Medical Record (EMR) revealed R338 admitted to the facility with diagnoses of but not limited to unspecified fracture of T11-T12 sequela, collapsed vertebra, muscle weakness (generalized), unsteadiness on feet, abnormal posture, pain, reduced mobility, low back pain, neuromuscular dysfunction of bladder. Review of the most recent Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated little to no cognitive impairment. Section O revealed the resident required oxygen therapy. Review of the Physician orders revealed an order for oxygen at 3 liters per minute (LPM) per nasal cannula (NC) at 9pm with a start date of 11/1/2024. Observation on 11/17/2024 at 2:12 pm revealed R338 lying in bed receiving oxygen therapy via NC set at 2. 5/LPM. Observation on 11/18/2024 at 9:30 am revealed R338 lying in bed receiving oxygen therapy via NC set at 2/LPM. Rounding on 11/18/2024 at 3:16 pm with Registered Nurse (RN) DD confirmed the LPM for R338 should be set on 3/LPM and not 2.5/LPM. She adjusted the rate to 3/LPM. RN DD revealed her expectations were that she and other nurses follow physician orders. Interview on 11/18/2024 at 4:15 pm with the Director of Health Services (DHS) revealed it was her expectation that nursing staff check oxygen concentrators every shift to ensure they are set on the prescribed rate of LPM. 36377 2. Review of the EMR revealed R77 had diagnoses of but not limited to chronic respiratory failure whether with hypoxia or hypercapnia, and paroxysmal atrial fibrillation. (continued on next page)

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	115562	A. Building B. Wing	11/20/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission MDS assessment dated [DATE] assessed a BIMS score of 11 which indicated moderate cognitive impairment and was assessed for oxygen use. Review of November 2024 Physician Order Form (POF) revealed an order dated 10/15/2024 for Oxygen at 2 LPM via NC continuous daily. Observation on 11/17/202 starting at 2:05 pm until l3:33 pm, and again at 5:00 pm revealed R77 receiving oxygen therapy by NC at 3 liters from the oxygen concentrator. A closer observation revealed no humidifier bottle attached to the oxygen concentrator. Interview 11/19/2024 at 11:01 am, the DHS and Unit Manager were notified by photos that R77 was receiving oxygen therapy at 3 liters instead of 2 liters by nasal cannula from her oxygen concentrator. Both staff confirmed through photos that R77's oxygen setting was set on 3 liters instead of 2 liters and that this was a deficient practice. The DHS confirmed that R77's O2 should be set on 2 liters per physician order instead of 3 liters. Unit Manager revealed that R77 had no history of changing the oxygen setting on the oxygen concentrator. Both staff revealed that the licensed nursing staff were responsible for monitoring residents' O2 Sat (oxygen saturation). 49675 3. Review of the EMR revealed R29 was admitted to the facility with diagnoses of but not limited to acute kidney failure, type two diabetes mellitus with diabetic chronic kidney disease, and hypertensive heart disease with heart failure. Review of the Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15, indicating little to no cognitive impairment. Section O (Special treatments which included oxygen therapy) reported, none. Review of the physician orders revealed an order for oxygen dated 7/25/2024, oxygen at 2 LPM via nasal cannula continuous. Observations on 11/17/2024 at 1:06 pm and 4:58 pm revealed R29 received oxygen at a rate of 3 liters. The tubing nor the humidifier bottle was dated. Observations on 11/18/2024 at 2:36 pm and11/19/2024 at 11:07 am revealed R29 received oxygen with the humidifier bottle not dated. Interview on 11/18/2024 at 11:20 am with RN DD verified the physician order for oxygen at a rate of 2 liters. She looked at picture the surveyor captured and verified the oxygen was set on the wrong oxygen rate. She revealed it was the nurse's responsibility to check daily to make sure the flow rate was correct. Interview further revealed the facility did not date tubing or humidifiers, however the resident's tubing was dated for 11/17/2024 and she was unsure who dated the tubing. Interview on 11/20/2024 at 10:05 am with the DHS revealed her expectations were for nurses to follow orders and for charge nurses to check oxygen rates. She expected all oxygen rates to be set on the rate prescribed by the physician. The DHS revealed it was not the facility's policy to label or date tubing or the humidifiers for residents receiving oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50524 4. Review of the EMR revealed R34 was admitted to the facility with diagnosis of but not limited to Chronic Obstructive Pulmonary Disease (COPD). Review of the Annual MDS assessment dated [DATE] documented Section C (Cognition) BIMS score of 14 which indicated little to no cognitive impairment; Section I (Active Diagnoses) included asthma, COPD, respiratory failure; Section J (Health Conditions) included shortness of breath or trouble breathing when lying flat. Review of care plan dated 10/27/2023 included, Oxygen use related to aspiration, COPD, pneumonia, terminal illness. Goal: Maintain optimal breathing and oxygen level within constraints of terminal diagnosis through next 90 days. Approach: Notify medical doctor (MD) of any changes. Maximize oxygen level through next 90 days, oxygen as needed/ordered. Oxygen saturations as needed/ordered. Review of Physician's orders dated 03/12/2024 included but not limited to Oxygen: Change respiratory circuit/supplies weekly once a day on Sunday (Sun) nights. Oxygen: Oxygen at 2 LPM via nasal cannula to keep oxygen (O2) saturation (Sats) > (above) 95% (percent) every shift day, evening, night. Oxygen: Change respiratory circuit/supplies as needed (PRN), ipratropium-albuterol solution for nebulization; 0.5 milligram (mg)-3 mg (2.5 mg base)/3 milliliter (mL); amount (amt): 1 vial; inhalation every 6 hours PRN. Interview on 11/17/2024 at 11:25 am with the DHS revealed the oxygen masks were to be stored in bags when not in use. She revealed her expectations were for the staff to place oxygen masks in bags and the tubing changed and labelled weekly. She stated if this was not done the outcome would be an infection control issue where the residents could get infections from the masks being placed on dirty surfaces. Interview on 11/19/2024 at 5:35 pm with Certified Nursing Assistant (CNA) HH stated she worked at the facility for [AGE] years and confirmed oxygen face masks should be kept in bags when not in use. Interview on 11/19/2024 at 5:45pm with Licensed Practical Nurse (LPN) II she stated oxygen masks are to be covered in bags when they are not been used. If oxygen masks were not kept in bags or covered, they can cause infection to the residents. Interview on 11/21/2024 at 5:00 pm with the Infection Preventionist revealed she stated her expectations were for oxygen masks to be covered or placed in bags when not in use. She stated if oxygen equipment were placed on dirty surfaces when not in use and they are not in bags or covered, infection can be spread to the residents.

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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. 50524 Based on observations and staff interviews, the facility failed to lock one of five medication carts when not in use, failed to remove expired medication from the medication cart, and failed to place open dates on insulin and glucometer strips. This deficient practice had the potential to cause unauthorized persons to access medications and cause complications from expired and undated medication use. The facility's census was 83. Findings included: Review of facility's documents revealed no evidence of a policy for medication carts, expired or no open date for medications. The policy was requested from the facility related to medication carts, expired medication, and no open date for medications but no policy was provided. Observation on 11/17/2024 at 5:20 pm revealed medication cart was not locked on the 200 long hallway. Observation on 11/18/24 at 5:20 pm during review of medication cart 2 Short Hall cart revealed there was one bottle of Bisacodyl 5 mg (milligram) tablets which had expiration date 9/2024 on the bottle. Observation on 11/18/2024 at 5:39 pm during review of medication cart 300 Hall Cart revealed there were containers of medication which were not labelled with open dates and included one bottle of insulin, and one bottle of glucometer strips. Observation on 11/19/2024 at 4:30 pm during review of medication cart 2 Long Hall Cart revealed there were containers of medication which were not labelled with open dates including one bottle of eyedrops. Interview on 11/17/2024 at 5:22 pm with Licensed Practical Nurse (LPN) PP confirmed the medication cart was not locked. She revealed the cart could not be locked since the previous week. She revealed she was informed by the UM (Unit Manager) that she could place it against the wall with the drawers facing the wall when not in use because it could not be locked. She stated she placed it close to the nurses' station but agreed that she could not monitor it from the nurses' station because it was not in full sight. LPN PP further stated if a resident got to open the drawers and got access to the medications, it would be a risk to the resident for allergic reactions or death if they took the wrong medication and in excess quantity. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/17/2024 at 5:42 pm the Director of Health Services (DHS) revealed she was not aware the medication cart was not closing since last week. She revealed nobody should leave medication carts unlocked, and her expectations were for the nurses to lock the medication carts when not administering medications or when leaving the cart unattended. She revealed the cart had narcotics and other medications and the outcome if the cart was left unattended would be that residents had access to the medications. She revealed this could cause harm to the residents and it could lead to the residents' death. Interview on 11/18/2024 at 5:18 pm with Registered Nurse (RN) QQ confirmed the bottle of Bisacodyl 5 mg tablets medication was expired. RN QQ revealed if the medications were expired, the medications would lose their effectiveness and would not be beneficial to the residents. Interview on 11/18/2024 at 5:25 pm with the DHS revealed her expectations were for staff to remove expired medications from the medication carts. She revealed the outcome to the residents if medications are expired would be the medications would not be effective in their treatment and the residents could have an adverse reaction from the medication. Interview on 11/18/2024 at 5:45 pm with the DHS revealed her expectation was for the nurses to put open dates on the medication containers. She revealed placing the open dates on glucometer strips and insulin was important for diabetic management, and the outcome would be, it would obscure diabetic readings if the staff were not efficiently managing the open dates on insulin and glucometer strips containers. Interview on 11/19/2024 at 11:56 am Licensed Practical Nurse (LPN) KK confirmed there were no open dates on medication containers in the medication cart. She revealed there should be open dates on the medication containers, and she also confirmed she did not write the open date on one of the medication bottles.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49675 Based on observations, staff interviews, and review of the facility's policy titled, Dietary Partner Hygiene and Dress Code, the facility failed to ensure hair nets were worn by dietary staff. Specifically, beard guards were not used by male dietary staff during preparation of meals. This had the potential to affect 80 out of 83 residents who received an oral diet. Findings included: 1. Review of the facility's policy titled Dietary Partner Hygiene and Dress Code dated 11/10/2020 revealed, Scope: This applies to all dietary partners, and any person (s) who handles and serves food employed by [NAME] Health. Hygiene: 2. Hair is covered with hair net and or cap. Facial hair is completely covered with a hair net or beard guard. Dining observation on 11/19/2024 at 12:32 pm revealed the Dietary Manager (DM) prepping trays and serving trays to residents in the main dining room. He was not wearing a beard cover. Interview on 11/20/2024 at 4:25 pm the DM revealed hairnets and beard coverings should always be used while preparing food in the kitchen. He revealed he was unsure about the policy regarding wearing beard guards while prepping trays in the dining room or serving trays. He confirmed he did not wear a beard guard on 11/19/2024. Interview on 11/20/2024 at 4:53 pm with the Director of Health Services (DHS) revealed her expectations were that all staff including the DM wear hair nets and beard coverings while serving food. She revealed there was a risk of contamination of food if beard is not covered. Interview on 11/20/2024 at 5:00 pm with the Infection Preventionist (IP) revealed that all staff prepping or serving trays should have beard coverings and hair nets on. She revealed if staff fail to cover hair, it poses a threat of contamination. 50524

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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. 36377 Based on observations and staff interviews, the facility failed to ensure that staff's personal food items were not stored in one of one medication storage rooms. The deficient practice had the potential to increase the probability of contamination of medication and storage supplies located in the storage room area. Findings included: Review of facility's documents revealed no evidence of policy regarding medication room and storage. The policy was requested from the facility, and none was provided. Observation on 11/18/2024 at 4:30 pm during review of the medication room revealed personal food items in the medication room. Foods observed on a shelf in a cupboard next to medical supplies included a pack of hot dog buns, mustard and ketchup. The DHS (Director of Health Services) was present throughout the review of the medication room. Interview on 11/18/2024 at 4:45 pm with the DHS confirmed the personal food items were in the medication room, and she revealed her expectations were for the staff not to put personal food items in the medication room. The DHS further revealed the medication room was for the residents' medication and supplies so when there were personal food items in the medication room, the outcome would be contamination and compromise of the medication and supplies. Interview on 11/18/2024 at 5:45 pm with Licensed Practical Nurse (LPN) II revealed food items must not be in the medication room, and the medication room was for the residents' medications and supplies. She further revealed if food items were in the medication room, it was unsanitary and it would cause contamination of the medications and supplies and possible infection to residents. Interview on 11/20/2024 at 5:00 pm with the Infection Preventionist (IP) revealed food items were not to be kept in the medication room because food items could cause bacterial growth that would contaminate the medications in the medication room.