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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145039	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accolade Healthcare of Peoria	5600 Glen Elm Drive Peoria, IL 61614

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30899 Based on interview and record review the facility failed to notify the appropriate State Agency of a new diagnosis of bipolar disorder for one resident (R81) of four residents reviewed for Preadmission Screening in the sample of 59. Findings include: Current Physician's Order Summary Report indicates R81 was admitted to the facility on [DATE] with Primary Admission Diagnosis of Dementia with Other Behavioral Disturbance. R81's PASRR (Pre-Admission Screening and Resident Review) dated 11/14/22 indicates PASRR Level I Determination: No Level II required. There is no evidence of a PASRR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occurs or new information refutes these findings, a new screen must be submitted. R81's medical record diagnosis list indicates a diagnosis of Bipolar was added on 12/12/22 and Bipolar/Hypomanic added on 5/12/23. No documentation was found or presented to indicate another Pre-admission screen was completed after addition of Bipolar diagnosis on 12/12/22 and 5/12/23. On 9/6/24 at 1:45pm V1, Administrator confirmed the State Agency should have been notified to complete a new screening based on R81's new Bipolar diagnosis.

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

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34131 Based on observation, interview, and record review, the facility failed to revise care plans for six (R9, R22, R94, R110, R265, and R415) of 24 residents reviewed for care plan revision in a sample of 59. Findings include: Facility Care Planning, revised 6/24, documents Utilize the results of the comprehensive assessment to develop, revise and review resident's care plan. To provide a method for all staff to have needed information in caring for the residents. Each resident will have a plan of care to identify problems, needs and strengths that will identify how the team will provide care. Facility Dialysis Protocol, revised 9/23, documents The residents care plan will reflect their dialysis needs. 1. R9's medical record documents R9 has the following diagnoses: Depression and Paranoid Schizophrenia. R9's Physician Orders for September 2024 documents the following: Fluoxetine HCl/Hydrochloride Oral Capsule 20 MG/Milligram (Fluoxetine HCl) Give 2 capsule by mouth in the morning for depression related to Depression Unspecified; Quetiapine Fumarate Oral Tablet 300 MG (Quetiapine Fumarate) Give 350 mg by mouth at bedtime for Schizophrenia related to Paranoid Schizophrenia; and Olanzapine Oral Tablet 10 MG (Olanzapine) Give 1 tablet by mouth at bedtime related to Paranoid Schizophrenia. R9's current care plan has no documentation of nonpharmacological interventions for the above medications. On 9/6/24 at 12:02 PM, V9 Care Plan Coordinator verified there were no nonpharmacological interventions on R9's Care Plan and there should be. 2. R110's medical record documents R110 has the following diagnoses: Anxiety and Depression. R110's Physician Orders for September 2024 documents the following: Escitalopram Oxalate Oral Tablet 5 MG (Escitalopram Oxalate) Give 1 tablet by mouth in the morning for depression; Trazodone HCl Oral Tablet 100 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime for depression; and Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth three times a day related to Anxiety Disorder. R110's current care plan has no documentation of nonpharmacological interventions for the above medications. On 9/6/24 at 12:02 PM, V9 Care Plan Coordinator verified there were no nonpharmacological interventions on R110's Care Plan and there should be. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R265's medical record documents R265 has the following diagnoses: End Stage Renal Disease; and acquired absence of kidney. R265's current care plan has no documentation of who to contact for emergencies/complications; a target weight; an assessment and care of the right chest dialysis port; and resident specific dialysis orders on the care plan. On 9/3/24 at 10:05 AM, R265 had a right chest dialysis catheter port. At that same time, R265 stated I am on dialysis. On 9/6/24 at 12:02 PM, V9 Care plan Coordinator stated R265's Care Plan did not address complications, emergencies, target weight, nephrologist, or an assessment of the right chest catheter site. V9 also verified the care plan did not include resident specific dialysis orders. V9 stated R265's Care Plan, needs updated. 4. R94's medical record documents R94 has the following diagnoses: Ileostomy status. R94's Physician Orders for September 2024 documents the following: Ostomy: Monitor Colostomy, empty pouch when 1/3 full, change appliance every three to five days. On 9/04/24 at 2:55 PM, R94 stated I hope to get the colostomy reversed, and all stool comes out of the colostomy because I had to have my colon removed. R94's current care plan documents (R94) has constipation and ileostomy, with the interventions of Encourage resident to sit on toilet to evacuate bowels if possible. On 9/6/24 at 12:02 PM, V9 Care Plan Coordinator verified R94's care plan needed updated. 33970 5. R415's Physician Order Sheet dated September 2024 documents that she takes Buspirone 5 mg (milligram) three times a day for anxiety, Duloxetine 60 mg every morning for panic disorder, anxiety disorder, and Quetiapine Fumarate 25 mg twice daily for depression. R415's current care plan documents (R415) has a behavior problem of yelling out when no assistance is needed. The Interventions/Tasks for this focus area documents administer medications as ordered, allow choices within individuals decision making abilities and anticipate and meet the resident's needs. The care plan does not document what R415's decision making abilities are. The care plan does not have any other nonpharmacological interventions in place. R415's current care plan documents (R415) receives an antidepressant medication. The interventions/tasks for this focus area documents Administer antidepressant medications as ordered by physician. There were no nonpharmacological interventions listed. R415's current care plan documents (R415) takes anti-anxiety medications. The interventions/tasks for this focus area documents Administer anti-anxiety medications as ordered by the physician. There were no nonpharmacological interventions listed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/06/24 at 12:02 PM, V9/Care Plan Coordinator confirmed there aren't nonpharmacological interventions in place for R415. 30722 6. R22's Order Summary Report dated 09/04/24 documents R22 has diagnoses which include Unspecified Dementia, Unspecified Severity with other behavioral disturbance, Bipolar Disorder, Major Depressive Disorder and Delusional Disorders. R22's Order Summary Report documents an order for Quetiapine Fumarate 25 milligrams by mouth two times daily. R22's Care Plan last revised on 06/14/24 documents R22 receives antipsychotic medications Quetiapine related to Bipolar Disorder. Listed interventions include: 1) Administer Antipsychotic medications as ordered by physician. Observe for side effects and effectiveness every shift. 2) Discuss with physician, family regarding ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. 3) Observe/document/report as needed any adverse reactions of psychotropic medications. R22's Care Plan did not have any nonpharmacological interventions in place. On 09/06/24 at 12:02 PM V9/Care Plan Coordinator verified there are no nonpharmacological interventions in place for R22's behaviors.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34131 Based on observation, interview, and record review, the facility failed to observe, assess, and document on a colostomy for one (R94) of one resident reviewed for colostomies in a sample of 59. Findings include: R94's medical record documents R94 has the following diagnoses: Ileostomy status. R94's Physician Orders for September 2024 documents the following: Ostomy: Monitor Colostomy, empty pouch when 1/3 full, change appliance every three to five days. On 9/04/24 at 2:55 PM, R94 stated I hope to get the colostomy reversed. At that same time R94 pulled down her covers and showed surveyor colostomy. R94's medical record including the TAR/treatment administration record, MAR/Medication administration record, and nurses' notes have no documentation of monitoring, assessing, or changing R94's colostomy. On 9/06/24 at 11:11AM, V1 Administrator stated, I have no documentation to give you for (R94's) outputs from her colostomy. On 9/6/24 at 12:02PM, V9 Care Plan Coordinator verified R94's medical record had no routine documentation on R94's monitoring, assessing, or changing of her colostomy.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 34131 Based on observation, interview, and record review, the facility failed to have specific dialysis orders related to the type of dialyzer, flow rate, and length of time; nephrologist; target weights; and care of the dialysis port for one (R265) of two residents reviewed for dialysis in a sample of 59. Findings include: Facility Dialysis Protocol, revised 9/23, documents To provide guidance to the facility on how to care for the dialysis resident within the facility. All residents who need dialysis will be properly cares for within the facility. It is the responsibility of nursing to provide care for the dialysis resident. Nursing will monitor the access site for signs and symptoms of infection or bleeding at the site. The residents care plan will reflect their dialysis needs. R265's medical record documents R265 has the following diagnoses: End Stage Renal Disease; and acquired absence of kidney. R265's medical record has no dialysis orders, no nephrologist listed, no post dialysis target weight, or orders to cares for R265's dialysis port. On 9/3/24 at 10:05 AM, R265 had a right chest dialysis catheter port. At that same time, R265 stated I am on dialysis. On 9/4/24 at 11:15 AM, V10 LPN/Licensed Practical Nurse stated she was unsure who (R265's) nephrologist was, all nurses need to monitor the dialysis site and document, all residents on dialysis should have orders for dialysis in their chart and should have a target weight in the chart for residents on dialysis. On 9/4/24 at 2:10 PM, V11 RN/Registered Nurse in Dialysis stated they are contracted by the facility, facility does not have access to their records for specific resident orders for dialysis, expect the staff to observe and be aware of any concerns with residents dialysis access sites and call if any concerns, should know the nephrologist to contact in case of an emergency, and have their target weight for post dialysis.

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F 0758

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

30899

Based on observation, interview, and record review the facility failed to provide an appropriate indication for use of antipsychotic medications in seven residents (R22, R39, R70, R81, R102, R214, R415) with diagnosis of Dementia and failed to identify non-pharmacological interventions for two residents (R9, R110) receiving antidepressant medications of nine residents reviewed for unnecessary psychotropic medications in the sample of 59.

Findings include:

Facility Policy/Psychotropic Medications dated/revised 1/2024 documents:

Residents will only be given antipsychotic drugs when clinically indicated according to appropriate diagnosis and physician's order.

Duplicate Drug Therapy: Any drug therapy that duplicates a particular drug effect on the resident without any demonstrative therapeutic benefit. Any two or more drugs, whether from the same category or not, that have a sedative effect.

Antipsychotic Drug: A neuroleptic drug that is helpful in the treatment of psychosis and has a capacity to ameliorate thought disorders.

Psychotropic medications shall be used only after alternative methods have been tried unsuccessfully and only upon the written order of a physician and after informed consent has been received from the resident/representative.

The resident's care plan will include objectives for gradual dose reduction as well as alternative interventions to assist in gradual dose reduction.

1) Current Physician Order Summary Report indicates R39 has orders for Risperdal (antipsychotic) 0.25mg (milligrams) at bedtime related to Unspecified Dementia with Anxiety (order date 7/18/24).

R39's medical record indicates R39 has diagnoses of Dementia with Other Behavioral Disturbance and Anxiety with start date of 1/11/24.

Consent for Psychotropic Medications indicates consent was given on 7/18/24 to receive Risperdal for Dementia with behaviors.

Psychiatry Note dated 1/25/24 indicates Start Risperdal 0.5mg twice daily due to exhibits Dementia behaviors including physical and verbal aggression, refusal of care including refusal to get out of bed. Note indicates no audio/visual hallucinations, no symptoms of psychosis.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R39's Care Plan indicates (R39) receives an antipsychotic medication related to Dementia without behavioral disturbance. R39's Care Plan also indicates R39's behaviors related to Dementia are yelling out and arguing with staff, looking for her grandson; has potential to be physically aggressive with staff related to Dementia. On 9/3/24, 9/4/24 and 9/6/24 R39 was seen in the memory care unit participating in activities during lunch meals. On 9/6/24 at 11:35am V12, Memory Care Unit Director stated R39's only behaviors are being resistive to care at times and putting herself on the floor. 2) R70's medical record indicates R70 has diagnoses of Dementia, Moderate with Mood Disturbance dated 10/1/23 and Alzheimer's Disease dated 8/1/23. R70's Current Physician Order Summary Report indicates R70 has orders for Olanzapine (antipsychotic)2. 5mg twice daily for Dementia with Mood Disorder (date ordered 5/22/24). Consent for Psychotropic Medications indicates consent was given on 5/20/24 via telephone for R70 to receive Olanzapine. Consent does not include indication for use, diagnosis, or target behaviors. Psychiatry Note dated 8/8/24 indicates R70 continues to have sundowning behaviors almost daily, with behaviors starting around 4pm and sometimes continuing until 10pm. Note indicates no audio/visual hallucinations, no symptoms of psychosis or mania. Note indicates We will shift her Olanzapine today in hopes to better target her Dementia related behaviors and agitation. Note also indicates R70 receives the following psychotropic medications: Escitalopram and Mirtazapine (antidepressants) for Depression Melatonin for Insomnia, Depakote (Mood Stabilizer) for Mood. Current Care Plan indicates R70 receives antipsychotic medications related to Bipolar Disorder dated/revised 8/31/22. Care Plan indicates R70's behaviors are related to Dementia - packing belongings and going home, looking for a baby, interferes with other resident's care, looking for her sister and Physically aggressive to staff related to Dementia. On 9/3/24, 9/4/24 and 9/6/24 R70 was seen in the memory care unit participating in activities during lunch meals. On 9/3/24 and 9/6/24 V13, R70's Spouse stated he visits R70 every day and most of R70's behaviors are after he leaves for the day and R70 wants to go home. Behavior tracking 8/6/24 to 9/4/24 indicate R70's behaviors do not occur every day and are episodic. 3) Current Physician Order Summary Report indicates R81 has orders for Olanzapine (antipsychotic) 10mg in the evening and 5mg daily related to Bipolar Disorder (date ordered 5/10/24). Report also indicates R81 receives Haldol (antipsychotic) Decanoate injection 25mg weekly for Bipolar (order date 5/10/24). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R81's medical record indicates R81 has the following diagnoses: Dementia with other Behavioral Disturbance 12/9/22 (admit), Unspecified Psychosis 12/9/22. Bipolar 12/12/22 and Bipolar Hypomanic 5/12/23 Consent for Psychotropic Medication(s) dated 5/10/24 indicates consent was received for R81 to receive Haldol 25mg weekly and on 5/2/24 for R81 to receive Olanzapine 10mg at bedtime and 5mg daily for Bipolar Disorder. Psychiatry Note dated 8/13/24 indicates R81 is now receiving Hospice Care, does continue to wander the halls, but has not been overly intrusive. Note indicates no symptoms of psychosis or mania. R81's Care Plan indicates R81 receives antipsychotic medication related to Bipolar. Care Plan indicates R81's behaviors are related to Dementia - refuses labs, wanders, resisting care and aggressive with staff; hovers over residents while they eat, removes utensils from their hands; refuses medications, refuses to eat. and is verbally aggressive with staff related to Dementia. Care Plan does not identify behaviors related to Bipolar Disorder. On 9/3/24, 9/4/24 and 9/6/24 R81 was seen in the memory care unit either sleeping in her bed or wandering the halls. On 9/6/24 at 11:40am V12, Memory Care Director stated that R81's behaviors are mainly pacing (R81) is unable to actively participate in activities. 4) R102's Medical Record indicates R102 has the following diagnoses: Dementia without Behavioral Disturbance, Mood or Anxiety dated 4/23/24 (admit) and Disorganized Schizophrenia 4/23/24. Current Physicians Order Summary Report indicates R102 receives Seroquel (antipsychotic) 50mg at bedtime for Disorganized Schizophrenia (date ordered 7/4/24). Psychiatry Note dated 7/25/24 indicates on that date R102 was pleasant and in good spirits. Note indicates R102 continues to respond to internal stimuli but does so quietly and pleasantly. Note indicates there is no evidence of auditory nor visual hallucinations and no symptoms of psychosis or mania. No substance cravings for nicotine dependence. R102's Care Plan indicates R102 receives antipsychotic medication related to Disorganized Schizophrenia (revised 5/23/24) and that R102 has a behavior problem related to Disorganized Schizophrenia - has a habit of refusing showers when out of cigarettes. No other behaviors of Dementia or Schizophrenia were identified in R102's care plan. Consent for Psychotropic Medication(s) dated 7/4/24 indicates consent was given on that date to increase R102's Seroquel from 25mg to 50mg at bedtime. Consent does not indicate reason for increase, diagnoses, or target behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No progress notes were found or presented documenting the reason or justification for Seroquel ordered/increased on 7/4/24. On 9/3/24, 9/4/24 and 9/6/24 R81 was seen in the memory care unit in activities and during meals. On 9/6/24 at 11:40am V12, Memory Care Director stated that R102's behaviors are refusing showers when can't have a cigarette. I don't know of any other behaviors that (R102) has. 5) R214's Medical Record indicates R214 has the following diagnoses: Admitting Diagnosis: Dementia with Agitation/Psychotic Disturbance 8/20/24 Secondary Diagnosis: Bipolar Disorder 8/20/24 Current Physician Order Summary Report indicates R214 receives Haldol (antipsychotic) Injection 5mg every 8 hours as needed for agitation X 14 days (date ordered 8/29/24); Olanzapine (antipsychotic) 5mg daily for Bipolar Disorder date ordered 8/29/24; Quetiapine (antipsychotic) 50mg twice daily related to Bipolar Disorder date ordered 8/28/24 Psychiatry Note dated 8/22/24 indicates R214 is a new admit, combative, resisting care, hits, kicks, and fights. Note indicates R214 does not experience any psychotic symptoms, including auditory or visual hallucinations, no mania. Note indicates R214 has an underlying neurocognitive disorder that could be exacerbated by current medication regimen. Note indicates author of note recommends to add Olanzapine (as needed). Current Care Plan indicates R214 has Behavior of Resisting Cares and verbally and physically aggressive with staff related to Dementia, stands up from wheelchair without assist, makes inappropriate comments to staff - dated initiated 8/21/24/revised 8/28/24. No progress notes indicating circumstances/necessity of ordering multiple psychotropic medications for R214 including duplicate antipsychotic therapy were found or presented. No care plan was found or presented for any of R214's psychotropic/antipsychotic medications. On 9/3/24, 9/4/24 and 9/6/24 R214 was seen in the memory care unit in during meals and in her room with her spouse. On 9/4/24 at 10:30am V14, Spouse stated that R214 is confused and is resistive to care. V14 stated he was informed of the need for the (psychotropic) medications due to R214's behaviors. V14 stated he stays with R214 every day until about 630pm. On 9/6/24 at 11:50am V1, Administrator stated I agree there seems to be a lack of justification for these medications. We need to do better with this. 34131 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. R9's medical record documents R9 has the following diagnoses: Depression and Paranoid Schizophrenia. R9's Physician Orders for September 2024 documents the following: Fluoxetine HCl/Hydrochloride Oral Capsule 20 MG (Fluoxetine HCl) Give 2 capsule by mouth in the morning for depression related to Depression Unspecified; Quetiapine Fumarate Oral Tablet 300 MG (Quetiapine Fumarate) Give 350 mg by mouth at bedtime for schizophrenia related to Paranoid Schizophrenia; and Olanzapine Oral Tablet 10 MG (Olanzapine) Give 1 tablet by mouth at bedtime related to Paranoid Schizophrenia. R9's medical record has no documentation of nonpharmacological interventions and no identified indicators/behaviors for use for the above medications. On 9/6/24 at 12:02PM, V2 DON/Director of Nursing verified there were no nonpharmacological interventions and no identified indicators/behaviors for use for R9 and there should be. 7. R110's medical record documents R110 has the following diagnoses: Anxiety and Depression. R110's Physician Orders for September 2024 documents the following: Escitalopram Oxalate Oral Tablet 5 MG (Escitalopram Oxalate) Give 1 tablet by mouth in the morning for depression; Trazodone HCl Oral Tablet 100 MG (Trazodone HCl) Give 1 tablet by mouth at bedtime for depression; and Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth three times a day related to Anxiety Disorder. R110's medical record has no documentation of nonpharmacological interventions and no identified indicators/behaviors for use for the above medications. On 9/6/24 at 12:02PM, V2 DON verified there were no nonpharmacological interventions and no identified indicators/behaviors for use for R110 and there should be. 33970 8. R415's Physician Order Sheet dated September 2024 list diagnoses of disorientation, claustrophobia, unspecified dementia without behavioral disturbance, psychotic disturbance, anxiety disorder and panic disorder. R415's Physician Order Sheet dated September 2024 documents that R415 was started on Quetiapine Fumarate, an antipsychotic medication, for depression on 9/3/24. On 9/6/24 at 11:30AM V2 (Director of Nursing) stated An antipsychotic shouldn't have been ordered for depression. I need to educate our providers. (R145's) behaviors all seem to stem from her dementia and her anxiety. 30722 9. R22's Order Summary Report dated 09/04/24 documents R22 has diagnoses which include Unspecified Dementia, Unspecified Severity with other behavioral disturbance, Bipolar Disorder, Major Depressive Disorder and Delusional Disorders. (continued on next page)

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R22's Order Summary Report documents an order for Quetiapine Fumarate 25 milligrams by mouth two times daily. R22's Care plan last reviewed 08/12/24 documents R22 has been verbally aggressive towards staff related to dementia. R2 is/has potential to be physically aggressive towards staff related to dementia, R22 is resistive to care, refuses medications related to dementia. R22 has impaired cognitive function/dementia or impaired thought processes related to dementia, cerebrovascular accident. R22's Behavior Tracking Report documents R22 had four behaviors between 03/01/24 and 06/30/24 which include: 03/23/24 Mood Changes, 03/24/24 Compulsive, 04/26/24 Uncooperative, and 06/07/24 Uncooperative. On 09/03/24 at 10:53 AM, R22 was in her wheelchair near the dining room. R22 appeared calm while sitting and watching other people. On 09/03/24 at 1:10 PM, R22 was sitting in her wheelchair in her room. R22 was alert, confused and appeared calm. On 09/04/22 at 11:10 AM, R22 was in the hallway speaking with staff. R22 appeared calm and was asking about lunch time. On 09/06/22 at 11:32 AM, R22 was receiving cares. R22 was alert, confused and appeared to be in a pleasant mood while interacting with staff. On 09/06/22 at 11:32 AM, V5/CNA and V6/CNA stated they were not aware of R22 having behaviors. V5 stated R22 was a real nice lady. On 09/06/24 at 10:33 AM, V1 verified the facility Behavior Tracking Tool (undated) did not list R22 as having any behaviors between 07/03/24 and 09/03/24.

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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. 33970 Based on observation, interview, and record review, the facility failed to ensure medications were not left at a resident's bedside for one of 24 residents (R40) reviewed for medication storage in the sample of 59. Findings Include: The Facility's Administration of Medications policy dated 8/2023 documents Residents shall receive their medications on a timely basis in accordance with state and federal guidelines and within established facility policies. Self-administration of medications is permitted when approved by the interdisciplinary team, with a written order from the primary attending physician. On 9/6/24 at 9:30 AM, R40 was lying in bed with R40's bedside table over his bed. A clear medicine cup containing 11 pills was noted on R40's bedside table. The medication cup had been tipped over with approximately half of the pills spilled out onto the table. R40 stated, This is what some of the nurses do. R40 was not able to name his medicine or state which pill was what. R40's Medical Record did not contain any assessments or physician orders for self-administration of medications. On 9/6/24 at 10:00 AM, V3 (License Practical Nurse) verified V3 gave R40 his morning medications on 9/6/24. V3 verified V3 did not stay with R40 until all R40's medications were consumed but should have. On 9/6/24 at 10:05 AM, V2 (Director of Nursing) stated that the medicine in front of R40 would have been his morning medicine. R40's Medication Administration Record for September documents that R40's morning medicines on 9/6/24 would include: Escitalopram 20 mg (milligrams), Multivitamin 1 tablet, Omeprazole 40 mg, Vitamin B6 100 mg, Vitamin C 500 mg, Vitamin D 1 tablet, Zinc 1 tablet, Zyrtec 10 mg, Tylenol 650 mg, Bupropion ER (Extended Release) 100 mg, Buspar 5 mg, and Carbidopa-Levodopa 25-100 mg.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38805 Based on observation, record review, and interview, the facility failed to follow its policy to use facial hair beard restraints while in the kitchen, and failed to ensure food items were labeled with identification and dates. This failure has the potential to affect 121 residents who reside at the facility. Findings include: Facility's Hair Restraints Policy, Undated, documents: Guideline: Hair restraints shall be worn by all dining services staff when in food production area, dishwashing areas, or when serving food. 2. Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. Facility's Food Storage (Dry, Refrigerated, and Frozen) Policy, dated 2020, documents: Procedure: 1.a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. On 9/3/24 at 9:10am, V8 Dietary Aide washed dishes in the facility's kitchen; V8 did not have his facial hair beard covered. V8 Dietary Aide stated, I just know about the hairnet for head; I do not know if my beard is supposed to be covered. At this same time, V7 Dietary Manager stated that she was not sure what the facility policy was for staff covering their beards while in the kitchen. On 9/3/24 at 9:05am in the facility's Walk-In Freezer, one bag of frozen mixed vegetables was not labeled or dated; 11 medium sized plastic bags filled with hot dog buns and one plastic bag filled with sliced loaf bread were not labeled or dated. On 9/3/24 at 9:05am, V7 Dietary Manager stated, Anyone who opens the boxes or containers are responsible for labeling and dating the food. These items should have labels and dates. The facility's Long-Term Care Facility Application for Medicare and Medicaid (Centers for Medicare and Medicaid Services/CMS 671) form, dated 9/3/24, documents 122 residents reside in the facility.