STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146001	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care International	4815 South Western Ave Chicago, IL 60609

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on interview and record review, the facility failed to affirm the right of the resident to be free from physical abuse. This failure has affected 1 (R3) of 5 residents reviewed for abuse. Findings Include: On 6/11/24 at 11:03 AM, R4 speaks Spanish with little English, V23 (Housekeeper) assisted in interpreting to R4. R4 stated on 4/26/24, during the 3-11 shift R4 was in the dining room writing on a paper. R4 stated R3 bumped R3's wheelchair into R4's wheelchair. R4 denied hitting R3 in the back. On 6/11/24 at 11:37 AM, R3 stated R3 cannot remember what happened on 4/26/24. Surveyor asked if R3 feels safe in the facility? R3 stated R3 does not know. On 6/11/24 at 12:43 PM, V26 (Social Service Director) stated V26 has been on the 3rd floor in this facility for five years. V26 stated V26 was on vacation during the incident between R3 and R4, but V26 heard that there was a physical altercation between R3 and R4. Surveyor asked what intervention the facility put in place after the incident? V26 stated R4 was moved from 3rd floor to the 2nd floor. On 6/11/24 at 2:12 PM, V12 (Social Service Assistant) stated V12 did not witness the incident, but R4 hit R3 in the back. On 6/11/24 at 3:23 PM, V1 (Administrator) stated V1 was on religious holiday during the incident of 4/26/24, but V1 heard that R3 hit R4 in the back when V1 returned to the facility on [DATE]. On 6/12/24 at 10:59 AM, V31 (Licensed Practical Nurse/LPN) stated has been working in the facility for [AGE] years. V31 worked 3-11 shift on 4/26/24 the day of the incident, V31 did not witness the incident, but V31 assisted the nurse with the paperwork. V31 cannot remember the staff that told V31 that R4 hit R3 in the back when in the dining room. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 1:26 PM, V33 (Certified Nursing Assistant/CNA) stated has been in this facility for about 5 months. V33 worked 3-11 shift on 4/26/24 the day of the incident. V33 stated V33 was in the dining room, V33 witnessed R3 up in wheelchair, R3 bumped R3's wheelchair into R4's wheelchair. R4 then hit R3 in the back. V33 separated R3 and R4, V33 asked R4 why R4 hit R3? R4 stated I don't care. V33 transferred R4 to the nurse's station for one-on-one monitoring, the police came to the facility to take the report, and the ambulance came to pick up R4 to transport R4 to the hospital. On 6/12/24 at 2:50 PM, V13 (Assistant Director of Nursing/ADON) stated V13 has been working 2 years in this facility. V13 was called on the phone by V34 (3rd Floor Nurse Manager) and told that R4 hit R3 in the back. V13 conducted the investigation. On 6/13/24 at 11:41 AM, V34 (3rd Floor Nurse Manager) stated V34 was told by a CNA that R3 bumped R3's wheelchair into R4's wheelchair and R4 then hit R3 in the back. V34 asked R4 why R4 hit R3, R4 stated because R3 bumped into R4. V34 stated hitting is a form of physical abuse. On 6/13/24 at 12:44 PM, V35 (Registered Nurse/RN) stated V33 reported to V35 that R4 has hit R3. V35 separated R4 and R3, V35 asked R4 why R4 hit R3? R4 stated R4 did not care and R4 will do again. V35 called the physician and R4 was sent to the hospital for evaluation. And R4 was transferred to another floor. V2 (DON), V22 (LPN), V24 (CNA), V26 (Social Worker), V28 (CNA), V30 (Housekeeper), V34 (Nurse Manager), and V35 (RN) stated hitting is a form of physical abuse. Reviewed: Facility's Final Incident Report Form for physical abuse dated 4/26/24 documents in part: The nurse on the unit reported that R4 hit R3. Nurses progress note on 4/26/24 document in part: V33 was doing dining time when V33 witness a resident hit another resident. R4's Aggressive Behavior Assessment signed dated 11/24/23. Facility's Abuse Policy dated 10/24/22 document in part: This facility affirms the right of our residents to be free from abuse. Police report dated 4/26/24 document in part: Simple battery.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47304 Based on observation, interview and record review, the facility failed to ensure incontinence care was provided in a timely manner for 1 (R9) of 3 residents who needed assistance with toileting reviewed for improper nursing care. The findings include: R9's health record documented admitted on 9/17/2021 with diagnoses not limited to Hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side, Type 2 diabetes mellitus, Hyperlipidemia, Major depressive disorder, Unspecified atherosclerosis, Other seizures, Unspecified acute conjunctivitis left eye, Essential (primary) hypertension, Long term (current) use of anticoagulants, Personal history of other venous thrombosis and embolism, Gastro-esophageal reflux disease without esophagitis. On 6/12/24 at 11:09am Observed R9 lying on bed, alert, oriented x 3, verbally responsive. Stated he did a bowel movement and had called a little after 9am and staff stated to him that she still has other residents that she is taking care of. R9 said he has been waiting for 2 hours to be changed. At 11:11am Incontinence care observation conducted with V7 (Certified Nursing Assistant / CNA), R9 lying on bed, observed incontinence brief soiled with urine and feces. V7 provided Incontinence care. At 11:21am R9 said he always waited for at least 2 hours and at times almost 3 hours to be taking care of. He said he is always the last to be cared or changed. Stated this is the first time he was changed today from this shift (7am - 3 pm shift). R9 said it is the way staff is always doing it. He stated staff is not sufficient or short to take care of their needs. He always needs to wait for couple of hours to be changed. Stated he would ask the staff what taking them so long to care for him with no response from staff at times. R9 said staff will get to you when they got time, and it is taking too long. At 11:29am V7 (CNA) stated she has been working in the facility for 2 years. She said rounding should be done at least every 2 hours and as needed to assist resident with incontinence care. She said R9 had called earlier to be changed but not able to remember the exact time and she was not ready yet to attend to him as she was prioritizing to get up the fall risk residents and residents on get up list. She said was not able to get back with R9 until past 11am when she did the incontinence care with the surveyor, and it was the first time on this shift that R9 was provided with incontinence care. V7 stated she need to get up 3 fall risk residents and need to stop in between to do dining observation for at least 30 minutes. She said CNAs are rotating to do dining observation and at least 3x in a shift that they need to do it. Stated she can attend and do incontinence care for 2-3 residents in 30 minutes that she has been sitting in the dining room. She said they needed help with dining observation to attend and do incontinence care for residents in a timely manner. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 12:32pm V2 (Director of Nursing / DON) said started working in the facility as DON in September 2023. She said rounding is done every 2 hours and as needed to check if resident is clean and dry and provide incontinence care promptly so resident won't get infection, skin breakdown, irritation or odors. MDS (Minimum Data Set) dated 3/14/2024 showed R9's cognition was moderately impaired. He needed supervision / touching assistance with eating; Partial / moderate assistance with oral and personal hygiene, chair/bed and toilet transfer; Substantial / maximal assistance with toileting hygiene, shower / bathe self, upper body dressing; Dependent with lower body dressing. MDS showed R9 was frequently incontinent of bowel and bladder. Care plan dated 12/17/23 showed R9 have an ADL and functional ability for self-care and mobility performance deficit related to left side hemiplegia. Toilet use: R9 requires maximal assistance from staff for toileting. R9 have bowel and bladder incontinence related to limited mobility and require staff assistance. Facility's policy for incontinence care dated 4/20/21 documented in part: To prevent excoriation and skin breakdown, discomfort and maintain dignity. Incontinent resident will be checked periodically in accordance with the assessed incontinent episodes or approximately every 2 hours and provided perineal and genital care after each episode.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46342 Based on observation, interview and record review, the facility failed to provide a.) sufficient licensed nursing staff (Registered Nurse/Licensed Practical Nurse) on 5/10/24, b.) sufficient certified nursing assistants (CNA) on 05/12/24, c.) adequate staffing to ensure Activities of Daily Living (ADL) care provided to dependent resident who required assistance with bladder/bowel incontinence, d.) adequate staffing to ensure medication administration dispensed in a timely manner. This failure could potentially affect 207 residents residing in the facility as of census dated 6/11/24. Findings include: On 06/12/24 at 11:09 AM, R9 stated to another team surveyor that R9 had been waiting for two hours to be changed and that survey observed R9's incontinence brief to be soiled with urine and feces. R9 told the team surveyor that R9 had used R9's call light at 9:00 AM to alert staff that R9 had a bowel movement and needed to be changed. R9 stated R9 always has to wait for at least two hours and at times almost three hours to be taking care of. R9 stated staff is not sufficient to take care of R9's needs. On 06/11/24 at 11:10 AM, observed during initial unit tour V4 (Licensed Practical Nurse) passing medications on the 2nd floor unit. On 06/11/24 at 11:25 AM, V4 stated at times there is enough staffing at the facility and that fully staffed on the 2nd floor would be 3 nurses (RN-Registered Nurse or LPN-Licensed Practical Nurse) and 5 CNAs (Certified Nursing Assistants) but what is more typical of staffing on the 2nd floor is 2 nurses and 4-5 CNAs. V4 stated today there are 68 residents on the 2nd floor and V4 is one of two nurses covering the unit. V4 stated V4 is covering 34 residents today. V4 said, it is 11:36 AM right now and I'm still passing out 9 AM medications. V4 stated V4 still has to pass out 9 AM medications to ten residents. V4 stated if the Unit Nurse Manager was here today, V4 would tell the Unit Nurse Manager so the Unit Nurse Manager could help V4 get though the 9:00 AM medication pass but the Unit Nurse Manager is not working today so now V4 is just going to keep trying to get through them as quickly as V4 can.V4 stated by the time V4 finishes giving out all of the 9 AM medications V4 will be restarting right away on getting the 12 o'clock med passes administered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/11/24 at 11:50 AM, V5 (CNA) stated she is a CNA who usually works the 11pm-7am (night) shift. V5 stated on a good day there are three CNAs working the 11p-7a shift but typically there are only two CNAs working nights. V5 stated V5 worked last night and there were only two CNAs working so V5 had to take care of 34 residents. V5 stated V5 does her best to get to everyone eventually but it would be easier if there were more aides to help. At 12:35 PM, V5 stated V5 was scheduled to work on Mother's Day, 05/12/24 on the 11p-7a shift. V5 stated V5 arrived t 10:30 PM for the 11-7 shift and at that time there were 2 CNAs working the 3p-11p shift. V5 said, I don't know how many 3p-11p shift CNAs there were supposed to be on that day, but I think that shift was also short staff too. V5 stated on 05/12/24 there were 3 CNAs scheduled to work the 11p-7a shift on the 2nd floor but only V5 and another CNA showed up. V5 stated that at 12:00 AM, the other CNA V5 was working with, got pulled from the 2nd floor and sent to cover a different unit because they were short of staff on that unit. V5 stated when the scheduled changed and V5 was expected to be the only CNA working the 2nd floor unit covering 70-72 residents V5 stated V5 refused because V5 did not feel it was safe for the residents or realistic for V5 to get all that work done. V5 stated V5 refused to work alone and clocked out. On 06/11/24 at 2:53 PM, V11 (Staffing Coordinator) stated V11 is responsible for the nursing schedule including RN/LPN and CNAs. V11 stated the facility uses agency staff for nurses (RN/LPN), not CNAs. V11 stated the facility used to use agency staff to cover CNA shifts but the facility hired a number of CNAs, so the facility is now fully staffed with CNAs and no longer need to use agency for them. V11 stated when putting together the daily staffing schedule V11 follows the following guidelines: 1st, 2nd and 3rd floors for the (7a-3p) and (3p-11p) shift should each have 2-3 nurses per unit per shift and 4-5 CNAs per unit per shift and 1st, 2nd and 3rd floors for the (11p-7a) shift should each have 2 nurses per unit and 2-3 CNAs per unit. V11 stated total staff for the day by shift should be as follows: (7-3) shift should have 6-9 nurses and 12-15 CNAs, (3-11) shift should have 6-9 nurses and 12-15 CNAs and the (11-7) shift should have 6 nurses and 6-9 CNAs. V11 stated V11 tries to schedule to the higher number of the range but must least have the lower number of staff as the minimum to run the units. V11 stated it is important to make sure the units are adequately staff so the residents can be properly care for in all aspect including making sure residents receive their medications as ordered and that they receive the ADL care they need. V11 stated there has not been a situation wherein 1 nurse or 1 CNA was asked to work the floor by themselves. V11 stated V11 would not want this to happen and said, I don't want anyone to work like that. On 06/12/24 at 3:48 PM, V2 (Director of Nursing) stated V2 is trying to get the agency invoices requested by surveyor to prove when agency staff was working however V2 is not sure V2 is going to be able to provide them. V2 stated the only way the facility can prove the agency nurses worked a shift at the facility on a specific day is to check the MAR (Medication Administration Record). On 06/13/24 at 1:00 PM, V2 stated V2 was not able to find the MAR for V37 (Agency Nurse) listed on the (3p-11p) schedule for 5/10/24. V2 stated V37 was not there that shift because V37 did not sign in and V2 could not find V37's electronic signature on any of the MARs. V2 stated that (3-11) shift on 05/10/24 ran with 5 nurses instead of 6. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/12/24 at 3:00 PM, surveyor reviewed documents titled, Daily Schedule: International, Daily Assignment Sheets and Individual Timecard Reports with V11 from 05/10/24 (3p-11p) shift and 05/12/24 (7a-3p), (3p-11p) and (11p-7a) shifts. The documents showed the facility did not meet staffing numbers for RN/LPN coverage for the (3p-11p) shift on 05/10/24 because only a total of 5 nurses worked the (3p-11p) shift. The documents also showed that the facility did not meet staffing numbers for CNA coverage for the (7a-3p), (3p-11p) and (11p-7a) shift on 05/12/24 because only a total of 11 CNAs worked the (7a-3p) shift, 9 CNAs worked the (3p-11p shift) and 2 CNAs worked the (11p-7a) shift after 12:17 AM. On 05/13/24 at 1:18 PM, V2 stated V2 had heard there were not enough CNAs working on 05/12/24 over the (11p-7a) shift. V2 stated two CNAs to cover the building is not enough and not having enough coverage on the floor may cause a delay in treatment and prevent residents getting prompt care when they needed. V2 stated If there is less than the minimum number of staff working the staff may not be able to get to everyone. For example, everyone is supposed to be changed every 2 hours but if the facility does not have adequate staffing this time frame may be prolonged. V2 stated if this occurs V2's expectation is that the nurses would help the CNAs deliver ADLs care to residents. On 06/11/24 at 4:05 PM, V1 (Administrator) stated the facility uses staffing agencies for nursing staff (RN or LPN), not for CNAs. V1 stated some of the managers are RN/LPN and CNAs and they are expected to work the floor as needed if a nurse or CNA calls out. V1 stated V1 was not aware of any nursing staffing concerns. V1 stated having only one CNA or one nurse to work a unit alone would not be adequate staffing and that staffing is important so the facility can provide adequate care to the residents. On 6/11/24 at 11:20am Medication observation conducted with V3 (Licensed Practical Nurse / LPN) stated she is a wound nurse but was pulled to work on the floor due to short of nurses. At 11:25am Observed V3 prepared and administered the following medications to R7: 1. MVI with minerals 1 tablet 2. Spironolactone 25mg (milligrams) 1 tablet 3. Sertraline 50mg 1 tablet 4. Metoprolol succinate 5mg 1tablet 5. Aspirin 81mg 1 tablet R7's POS (Physician order sheet) and MAR (Medication administration record) documented above medications ordered time at 9am. At 11:33am V3 prepared and administered the following medications to R8: 1. Clopidogrel 75mg 1 tablet 2. Oxcarbazepine 600mg 1 tablet (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Vitamin D 125mcg equivalent to 5000iu 4. Aspirin 81mg 1 tablet 5. Senna concentrate geri kot 8.6mg 1 tablet 6. Iron tablet 325mg 1 tablet R8's POS and MAR documented above medications ordered time at 9am except for Ferrous Gluconate Oral Tablet 324MG ordered time at 8am. At 11:55 AM V3 prepared and administered the following medications to R6: 1. Iron tablet 325mg 1 tablet 2. Tamsulosin 0.4mg 1 capsule 3. Fluoxetine 20mg 3 capsules R6's POS and MAR documented above medications ordered time at 9am. Docusate Sodium Oral Liquid 100 MG/10ML Give 10 ml by mouth two times a day ordered time at 9am - WAS NOT GIVEN during medication administration observation. At 12:05pm V3 prepared and administered the following medications to R5: 1. Acetaminophen 325mg 2 tablets 2. Aspirin 81mg 1 tablet 3. Vitamin B12 500mcg (micrograms) 2 tablets 4. Gabapentin 100mg 1 capsule 5. Aripiprazole 5mg 1 tablet 6. Ezetimibe 10mg 1 tablet 7. Sertraline 50mg 1 tablet R5's POS and MAR documented above medications ordered time at 9am except for Gabapentin Capsule 100 MG scheduled at 8am - 4pm - 12mn and Acetaminophen Tablet 325 MG scheduled at 12mn - 4am - 8am - 12nn- 4pm - 8pm. At 12:10pm V3 stated I think I still have 8 more residents to give morning medications. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/13/24 at 12:32pm V2 (Director of Nursing / DON) said she started working in the facility as DON in September 2023. Stated nurses are supposed to follow physician order when giving medications and follow the 5 rights in giving medication (right resident, medication, right time, right dose, right route). She said medication should be given 1 hour before and 1 hour after the ordered time. V2 said if medication was given more than an hour the ordered time, it is considered late, not following doctor's order and it may counteract the medications especially if there is a medication scheduled in the next couple of hours. V2 said after giving medications nurses are expected to sign the eMAR (electronic medication administration record) to prove that medications were given. She said standard nursing practice, if it was not documented, it was not done or was not given. R2's MAR (medication administration record) showed Quetiapine 50mg on 5/10/24 scheduled at 9pm was not signed that medication was given. R4's MAR showed on 5/10/24 Hydralazine scheduled at 4pm, Keppra 500mg, Lopressor 50mg, Metformin 100mg, Insulin regular 8units scheduled at 5pm and Insulin Glargine 22 units scheduled at 9pm were not signed that medications were given. R5's medication audit report documented Acetaminophen 650mg and Gabapentin 100mg scheduled / ordered time at 8am was administered at 12:05pm and 12:07pm; Aspirin 81mg 1, Vitamin B12 500mcg, Aripiprazole 5mg, Ezetimibe 10mg, Sertraline 50mg scheduled time at 9am were given at 12:06pm, 12:07pm, 12:08pm 12:09pm. R5's MAR showed on 5/10/24 Gabapentin 100mg scheduled at 4pm; Acetaminophen 650mg scheduled at 4pm and 8pm; Atorvastatin 40mg scheduled time at 9pm were not signed that medications were given. R6 medication audit report documented Iron tablet 325mg, Fluoxetine 20mg and Tamsulosin 0.4mg scheduled time at 9am were given at 11:58am. R6's MAR showed on 5/10/24 Sennosides 8.6mg scheduled at 4:30pm; Docusate sodium 10ml scheduled at 6pm; Melatonin 3mg, Quetiapine 300mg scheduled at 8pm were not signed that medications were given. R7 medication audit report documented Metoprolol succinate 25mg, Aspirin 81mg, Spironolactone 25mg, Sertraline 50mg, MVI with minerals scheduled at 9am were given at 11:25am. R7's MAR showed on 5/10/24 Advair Diskus 500-50mcg/dose, Fluticasone HFA inhalation scheduled at 6pm; Simvastatin 20mg scheduled at 9pm were not signed that medications were given. R8 medication audit report documented Ferrous Gluconate 324MG ordered time at 8am was given at 11:52am; Senna 8.6mg, Clopidogrel 75mg, Aspirin 81mg, Vitamin D 125mcg, Oxcarbazepine 600mg scheduled time at 9am were given at 11:52am. R8's MAR showed on 5/10/24 Oxcarbazepine 600mg, Senna 8.6mg scheduled at 5pm; Lipitor 40mg scheduled at 9pm were not signed that medications were given. Facility's census report dated 06/11/24 showed total census of 207 residents. Facility provided document titled, Facility Assessment Tool which document the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1.) Requirement - Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents. 2.) Purpose - the purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. 3.) The following are estimated staffing needs only and may change based on census and the acuity of resident care required. a.) Licensed Nurses: RN, LPN, providing direct care. Total number of Licensed Nurses staffed per shift on average - Day Shift:8, Evening Shift: 8, Night Shift: 6 b.) CNA, Restorative Aides providing direct care. Total number of CNA's staffed per shift on average (includes Restorative Aides) Day Shift: 11, Evening Shift:11, Night Shift:9 Facility provided policy titled, Personnel Policy dated September 2015 which documented in part, 1.) Purpose - To define basic staffing requirements and patterns for all facility personnel. 2.) Policy - It is the policy of the facility to provide an adequate number of staff to successfully implement resident functions to meet resident needs. 3.) The facility operates in compliance with applicable federal, state, and local laws, regulations, and codes with accepted professional standards and principles that apply to professionals. 4.) Adequate staffing ratios by numbers and positions required to meet the needs of the residents will be maintained including the scheduling of relief staff during all vacation, holidays, and relief periods.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146001	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care International	4815 South Western Ave Chicago, IL 60609

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47304 Based on observation, interview, and record review, the facility failed to ensure that medications were given as ordered by the prescriber. This failure affected 6 (R2, R4, R5, R6, R7, R8) of 6 residents reviewed for improper nursing care. The findings include: R2's health record documented admitted on 1/20/2024 with diagnoses not limited to Unspecified sequelae of cerebral infarction, Encounter for palliative care, Dysphagia following other cerebrovascular, Occlusion and stenosis of right carotid artery, Acquired absence of left leg below knee, Atherosclerotic heart disease of native coronary artery, Non-st elevation (nstemi) myocardial infarction, Type 2 diabetes mellitus without complications, Essential (primary) hypertension, Unspecified dementia. R4's health record documented admitted on 11/28/2020 with diagnoses not limited to Other seizures, Type 2 diabetes mellitus without complications, Acute respiratory failure with hypoxia, Essential (primary) hypertension, Personal history of covid-19, Hypothyroidism, Anemia, Gastro-esophageal reflux disease without esophagitis. R5's health record documented admitted on 3/8/2022 with diagnoses not limited to Unspecified dementia, Unspecified severe protein-calorie malnutrition, Iron deficiency anemia, Pain, Depression, Acquired absence of right leg below knee, Acquired absence of left leg below knee, Schizophrenia. R6's health record documented admitted on 3/22/2024 with diagnoses not limited to Spinal stenosis cervical region, Dysphagia oropharyngeal phase, Flaccid neuropathic bladder, Schizoaffective disorder, Shortness of breath, Essential (primary) hypertension, Attention-deficit hyperactivity disorder, Unspecified dementia. R7's health record documented admitted on 2/18/2019 with diagnoses not limited to Chronic gout, Chronic respiratory failure with hypercapnia, Chronic combined systolic and diastolic heart failure, Malignant neoplasm of ascending colon, Chronic kidney disease, Hyperlipidemia, Chronic obstructive pulmonary disease, Cor pulmonale (chronic), Non-st elevation (nstemi) myocardial infarction, Personal history of other malignant neoplasm of large intestine, Essential (primary) hypertension. R8's health record documented admitted on 8/15/2019 with diagnoses not limited to Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery, Dysphagia oropharyngeal phase, Hemiplegia unspecified affecting right dominant side, Chronic respiratory failure, Chronic obstructive pulmonary disease, Other secondary hypertension, Vitamin d deficiency, Gastro-esophageal reflux disease without esophagitis, Other seizures, Unspecified dementia, Hyperlipidemia, Essential (primary) hypertension. On 6/11/24 at 11:20am Medication observation conducted with V3 (Licensed Practical Nurse / LPN) stated she is a wound nurse but was pulled to work on the floor due to short of nurses. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:25am Observed V3 prepared and administered the following medications to R7: 1. MVI with minerals 1 tablet 2. Spironolactone 25mg (milligrams) 1 tablet 3. Sertraline 50mg 1 tablet 4. Metoprolol succinate 5mg 1tablet 5. Aspirin 81mg 1 tablet R7's POS (Physician order sheet) and MAR (Medication administration record) documented above medications ordered time at 9am. At 11:33am V3 prepared and administered the following medications to R8: 1. Clopidogrel 75mg 1 tablet 2. Oxcarbazepine 600mg 1 tablet 3. Vitamin D 125mcg (micrograms) equivalent to 5000iu 4. Aspirin 81mg 1 tablet 5. Senna concentrate geri kot 8.6mg 1 tablet 6. Iron tablet 325mg 1 tablet R8's POS and MAR documented above medications ordered time at 9am except for Ferrous Gluconate Oral Tablet 324MG ordered time at 8am. At 11:55 AM V3 prepared and administered the following medications to R6: 1. Iron tablet 325mg 1 tablet 2. Tamsulosin 0.4mg 1 capsule 3. Fluoxetine 20mg 3 capsules R6's POS and MAR documented above medications ordered time at 9am. Docusate Sodium Oral Liquid 100 MG/10ML Give 10 ml by mouth two times a day ordered time at 9am - WAS NOT GIVEN during medication administration observation. At 12:05pm V3 prepared and administered the following medications to R5: 1. Acetaminophen 325mg 2 tablets (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Aspirin 81mg 1 tablet 3. Vitamin B12 500mcg 2 tablets 4. Gabapentin 100mg 1 capsule 5. Aripiprazole 5mg 1 tablet 6. Ezetimibe 10mg 1 tablet 7. Sertraline 50mg 1 tablet R5's POS and MAR documented above medications ordered time at 9am except for Gabapentin Capsule 100 MG scheduled at 8am - 4pm - 12mn and Acetaminophen Tablet 325 MG scheduled at 12mn - 4am - 8am - 12nn- 4pm - 8pm. At 12:10pm V3 stated I think I still have 8 more residents to give morning medications. On 6/13/24 at 12:32pm V2 (Director of Nursing / DON) said she started working in the facility as DON in September 2023. Stated nurses are supposed to follow physician order when giving medications and follow the 5 rights in giving medication (right resident, medication, right time, right dose, right route). She said medication should be given 1 hour before and 1 hour after the ordered time. V2 said if medication was given more than an hour the ordered time, it is considered late, not following doctor's order and it may counteract the medications especially if there is a medication scheduled in the next couple of hours. V2 said after giving medications nurses are expected to sign the eMAR (electronic medication administration record) to prove that medications were given. She said standard nursing practice, if it was not documented, it was not done or was not given. R2's MAR (medication administration record) showed Quetiapine 50mg on 5/10/24 scheduled at 9pm was not signed that medication was given. R4's MAR showed on 5/10/24 Hydralazine scheduled at 4pm, Keppra 500mg, Lopressor 50mg, Metformin 100mg, Insulin regular 8units scheduled at 5pm and Insulin Glargine 22 units scheduled at 9pm were not signed that medications were given. R5's medication audit report documented Acetaminophen 650mg and Gabapentin 100mg scheduled / ordered time at 8am was administered at 12:05pm and 12:07pm; Aspirin 81mg 1, Vitamin B12 500mcg, Aripiprazole 5mg, Ezetimibe 10mg, Sertraline 50mg scheduled time at 9am were given at 12:06pm, 12:07pm, 12:08pm 12:09pm. R5's MAR showed on 5/10/24 Gabapentin 100mg scheduled at 4pm; Acetaminophen 650mg scheduled at 4pm and 8pm; Atorvastatin 40mg scheduled time at 9pm were not signed that medications were given. R6 medication audit report documented Iron tablet 325mg, Fluoxetine 20mg and Tamsulosin 0.4mg scheduled time at 9am were given at 11:58am. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's MAR showed on 5/10/24 Sennosides 8.6mg scheduled at 4:30pm; Docusate sodium 10ml (milliliters) scheduled at 6pm; Melatonin 3mg, Quetiapine 300mgscheduled at 8pm were not signed that medications were given. R7 medication audit report documented Metoprolol succinate 25mg, Aspirin 81mg, Spironolactone 25mg, Sertraline 50mg, MVI with minerals scheduled at 9am were given at 11:25am. R7's MAR showed on 5/10/24 Advair Diskus 500-50mcg/dose, Fluticasone HFA inhalation scheduled at 6pm; Simvastatin 20mg scheduled at 9pm were not signed that medications were given. R8 medication audit report documented Ferrous Gluconate 324MG ordered time at 8am was given at 11:52am; Senna 8.6mg, Clopidogrel 75mg, Aspirin 81mg, Vitamin D 125mcg, Oxcarbazepine 600mg scheduled time at 9am were given at 11:52am. R8's MAR showed on 5/10/24 Oxcarbazepine 600mg, Senna 8.6mg scheduled at 5pm; Lipitor 40mg scheduled at 9pm were not signed that medications were given. Facility's medication administration policy and procedures (undated) documented in part: FIVE RIGHTS - right resident, right drug, right dose, right route and right time, are applied for each medication being administered. Medications are administered in accordance with written orders of the prescriber. Medications are administered within 1 hour before or after scheduled time, except before, with or after meal orders, which are administered based on mealtimes. The individual who administers the medication dose records the administration on the resident's MAR (Medication administration record) directly after the medication is given.