STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Care Clifton	1190 E 2900 North Road Clifton, IL 60927

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41002 Based on interview and record review, the facility failed to accurately complete R15 and R54's comprehensive assessment. This failure affects two (R15, R54) of three residents reviewed for accuracy of assessments on the sample list of 36. Findings include: 1. R54's Minimum Data Set, dated dated dated [DATE], documents Section O0110 Special Treatments, Procedures and Programs. H1. Intravenous (IV) Medications R54 received while a resident. R54's Physician Order Sheet (POS) dated March, April, and May 2024 documents R54 has not been prescribed any Intravenous (IV) Medications. On 5/21/24 at 9:19AM, V2 (Director of Nursing) confirmed R54 has never received any Intravenous (IV) medications. V2 confirmed that the facility follows the Minimum Data Set (MDS) 3.0 User Resident Assessment Instrument (RAI) Manual for Long Term Care. 34201 2. R15's MDS (Minimum Data Set) dated 3/13/24 documents R15 is receiving hospice services. R15's Physician Orders Sheet dated March 2024 documents an order for Palliative Care, not hospice. R15's untitled document dated 3/15/24 from an outside care company documents R15 is receiving palliative care. On 5/20/2 at 8:30 AM, V2 (Director of Nursing) stated R15 is not on hospice but instead receiving palliative care and confirmed that R15's MDS is coded incorrectly.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to implement physician orders for laboratory results and withholding medication, and failed to assess, measure, and implement treatments for diabetic wounds for one (R31) of two residents reviewed for skin conditions in the sample list of 36. Findings include: On 5/19/24 at 9:37 AM, V7 (Licensed Practical Nurse/LPN) and V20 (LPN) administered treatments to R31's toe wounds. R31 had some toes that were previously amputated and there were dark black wounds to the left fourth toe and right second and third toes. On 5/19/24 at 9:55 AM, R31 stated R31 admitted with the toe wounds. R31's Care Plan dated 5/19/24 documents R31's diagnoses include Type 1 and Type 2 Diabetes Mellitus, Atherosclerosis of Coronary Artery Bypass Graft, Peripheral Vascular Disease, Chronic Kidney Disease, and Left Tibia Shaft Fracture. This care plan documents R31 has wounds to the left third and right fourth toes, and includes interventions to monitor for infection, administer treatments, and wound physician to follow as needed. R31's Admission Skin assessment dated [DATE] documents R31 admitted with casts to both legs/feet and does not document that R31 admitted with toe wounds. There are no documented assessments/measurements of R31's toe wounds until 4/19/24. R31's Wound Evaluation & Management Summary dated 4/19/24 and recorded by V23 (Wound Physician) documents R31's diabetic wounds of the left, proximal, dorsal second toe; left distal, dorsal second toe; and left, distal, dorsal fourth toe were resolved/healed. R31's Progress Notes dated 3/20/2024 at 8:21 AM and 4/22/24 at 8:45 AM, recorded by V25 (Nurse Practitioner) document R31 has areas of chronic necrosis on R31's toes. R31's Progress Note dated 4/26/24 at 8:50 AM and recorded by V25 documents R31 recently lost a toenail. R31's Progress Note dated 5/10/2024 at 8:50 AM recorded by V25 documents R31 has left and right tibia fractures with full length casts from mid-thigh to toes, R31's toes are necrotic, and R31 has a history of prior toe amputations. This note documents R31 has a history of hyperkalemia (high potassium level) secondary to chronic kidney disease and R31's potassium level was 5.4 (elevated) today. This note documents R31's Hemoglobin and Hematocrit was 9.7/30.5 (low), which is down from 10.7/34.1. This note documents orders for Complete Blood Count and Basic Metabolic Panel on 5/16/24 and to hold Lisinopril for five days. There is no documentation that these laboratory orders were implemented. R31's May 2024 Medication Administration Record documents R31's Lisinopril was only held for two days and not five days as ordered. R31's March and April 2024 Treatment Administration Records (TARs) do not document treatment orders for R31's diabetic wounds, besides an order dated 4/23/24-4/26/24 to cleanse the right fourth toe wound, apply triple antibiotic ointment, and cover with a dressing daily and as needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R31's Skin assessment dated [DATE] documents there was an open area to R31's right second toe and orders were initiated to cleanse the wound and cover with a dry dressing daily. R31's May 2024 TAR documents administrations of this treatment order 5/7/24-5/20/24. There are no descriptions of the wound bed/tissue or measurements of this wound in R31's medical record. R31's Wound Evaluation & Management Summary dated 5/17/24 and recorded by V23 (Wound Physician) documents R31's left fourth toe full thickness diabetic wound measured 0.3 centimeters (cm) long by 0.6 cm wide by no measurable depth. This summary documents R31's right third full thickness diabetic wound measured 1.5 cm by 1.5 cm by 0.1 cm. This summary documents these wounds were necrotic (dead tissue) and a treatment order for an oil emulsion dressing covered with an abdominal pad and gauze roll daily. R31's May TAR does not document that these treatment orders were implemented until 5/19/24, indicating R31's treatment was not administered on 5/18/24. This TAR does not document treatments for these wounds prior to 5/19/24. There are no other documented assessments or measurements of these wounds besides the resolution note by V23 on 4/19/24. On 5/19/24 at 9:35 AM V7 (LPN) stated R31 admitted with the wounds to the left and right toes, the wounds were scabbed and recently reopened. On 5/20/24 at 9:17 AM V2 (Director of Nursing/DON) stated V2 has been without an Assistant DON (ADON) for three months and without a wound nurse, so V2 has been handling things by herself. On 5/21/24 at 9:26 AM V2 stated R31 admitted with all of R31's toe wounds and they did not resolve/heal. V2 stated V23 documented the wounds were healed because V23 did not want to oversee R31's wound care anymore. V2 stated V23 has canceled some of V23's previously scheduled visits. V2 stated wound assessments should be documented weekly as skin assessments in the assessments section of the resident's electronic medical record (EMR). V2 stated V2 was responsible for documenting wound assessments prior to V3 (ADON who was hired late April 2024). V2 stated the floor nurses were administering wound treatments but were not doing the wound assessments. V2 stated V23 (Wound Physician) does not give V23's orders verbally when rounding and does not enter V23's progress notes into the resident's EMR until the day after V23's visit. V3 stated V3 entered V23's orders from 5/17/24 on 5/19/24 and confirmed R31's treatment was then missed on 5/18/24. V2 (DON) stated V25 (Nurse Practitioner) enters V25's orders into the resident's EMR and then usually notifies the nurses who then notify V2. V2 verified R31's laboratory orders were not completed as ordered on 5/16/24 and Lisinopril was not held for five days as ordered. On 5/21/24 at 11:10 AM V2 stated R31's physician was overseeing R31's wound care prior to V23, but V2 does not have any documentation to provide that the physician was aware or that treatment orders were not necessary. The facility's Pressure Injury and Skin Condition Assessment policy dated November 2023 documents Pressure Ulcers and other wounds such as diabetic, venous, and arterial, will have documented assessments and measurements at least weekly in the resident's medical record, including size, location, drainage, odor, stage, and wound description. This policy documents skin will be assessed upon admission/readmission, complete a wound assessment when there are wounds identified, and notify the physician when there are signs of skin problems. This policy documents physician notification will be documented in the resident's medical record and treatment orders will be initiated and recorded on the Treatment Administration Record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34201 Based on observation, interview and record review, the facility failed to complete a wound assessment for a pressure ulcer, follow physician orders for wound treatments, and monitor dressing to ensure they were intact for two of two residents (R15, R69) reviewed for pressure ulcers on the sample list of 36. Findings Include: 1. R69's Progress Notes dated 4/13/24 documents R69 was admitted to the facility from the hospital and has a stage 2 (pressure) wound to the coccyx. R69's medical record did not contain any wound assessments until 4/19/24, 6 days after admission. This wound assessment documents a stage 2 pressure ulcer to the sacrum measuring 2 cm (centimeters) by 0.5 cm by 0.1 cm. R69's May 2024 Physician Orders document the following Sacral Wound Treatment: apply a non-bordered foam dressing, cutting a donut out over wound, and secure it with tape twice a week. On 5/20/24 at 1:06 PM, V8 (Registered Nurse/RN) with V3 (Assistant Director of Nursing/ADON) entered R69's room to complete the wound treatment. V3 assisted R69 in pulling pants down to reveal a reddened sacrum that was not open and did not have the ordered foam dressing covering it. At this time, V3 stated that V23 (Wound Physician) had healed the wound out on 5/17/24 however still wanted the treatment completed for protection to the area. V8 applied the foam dressing to sacrum, without cutting a donut out over the wound/reddened area. V8 confirmed R69's dressing was not in place and stated I (V8) guess we need to check it daily to make sure it is in place. On 5/20/24 at 3:00 PM, V2 (Director of Nursing/DON) stated nurses should be assessing the wounds as soon as a wound is identified and then weekly thereafter. 2. R15's Progress Notes dated 5/11/24 documents a request for treatment was sent to V26 (Physician) for R15's stage one pressure ulcer on the coccyx. The only wound assessment form in R15's medical record is dated 5/17/24, 6 days after R15 acquired the pressure ulcer, and is blank. R15's May 2024 Physician Orders document the following orders: 5/19/24 - Sacral wound: Peri Wound Treatment: apply skin prep twice a week on shower days and PRN (as needed) for 30 days. 5/19/24 - Sacral Wound: Primary Dressing(s): non bordered foam, apply twice a week on shower days (Thursday and Sunday) and PRN for 30 days and secure with tape. 3/26/24 - Silver Sulfadiazine External Cream 1 %; Apply to sacrum topically one time a day. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 3:18 PM, V14 (RN) and V16 (Certified Nursing Assistant/CNA) entered R15's room to perform wound treatment. After performing hand hygiene and donning gloves, V16 pulled down R15's pant to reveal a stage 1 pressure ulcer to the sacrum, approximately 2 cm (centimeters) by 2 cm, that did not have the ordered foam dressing covering it. V14 cleansed the wound with wound cleanser and then applied Silver Sulfadiazine over the wound. After the treatment was completed, V14 stated V14 is not sure why the treatment order for skin prep and foam dressing did not show on the TAR (Treatment Administration Record) as needing completed and explained the Silver Sulfadiazine Cream is the only treatment that showed as needing completed. On 5/20/24 at 3:29 PM, V2 (DON) stated the Silver Sulfadiazine should have been discontinued on 5/17/24 when V3 (ADON) put the new treatment orders from V23 (Wound Physician) into the computer and it wasn't. On 5/20/24 at 3:43 PM, V10 (RN) confirmed V10 was R15's nurse on 5/19/24 when R15 was ordered to have the skin prep and foam dressing applied to the sacrum. V10 stated V10 did not apply the skin prep and foam but instead applied the silver Sulfadiazine cream. The facility's Pressure Injury and Skin Condition assessment dated [DATE] documents a wound assessment will be initiated and documented in the resident's chart when pressure and/or other ulcers are identified by the licensed nurse. A wound assessment for each identified open area will be completed and will include: site location, size, stage of pressure ulcer, odor, drainage, description, and date and initials of the individual performing the assessment. Dressings will be checked daily for placement, cleanliness, and signs and symptoms of infection.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 34201 Based on interview and record review, the facility failed to maintain and monitor adaptive devices to ensure proper functioning to prevent a fall for one of one resident (R53) reviewed for falls on the sample of 36. This failure resulted in R53's unsecured toilet seat riser sliding off the toilet when R53 was sitting and/or transferring onto the toilet, causing R53 to fall. R53 sustained a fractured finger and laceration requiring three sutures. Findings Include: R53's Fall Risk assessment dated [DATE] documents R53 is at risk for falls. R53's MDS (Minimum Data Set) dated 3/1/24 documents R53 has severe cognitive impairments. R53's Progress Notes document the following: 2/18/24 - CNA (Certified Nursing Assistant) heard R53 yelling. When CNA entered the room, R53 was sitting on the bathroom floor with dislodged toilet riser wedged between R53's torso and the toilet. R53 was bleeding from a laceration on the 5th finger. A hematoma was also noted on R53's left side of the forehead. R53 sent to the hospital. 2/18/24 - Hospital RN (Registered Nurse) called with report and states R53's pinky finger did show a fracture and the laceration required three sutures and glue for closure. 2/18/24 - returned to the facility with a splint to the left 5th finger and sutures. 2/22/24 - Laceration to the distal left 5th finger measuring 2.0 cm (centimeters) by 0.2 cm by 0.1 cm. Sutures intact. R53's Fall Investigation included a Falls Statement and Checklist dated 2/18/26 at by V12 (CNA) that documents it appears (R53) attempted to sit down and riser fell along with (R53). R53's Hospital ED (Emergency Department) Provider Note dated 2/18/24 documents R53 presented to the ED for evaluation after a fall. R53 is alert and oriented x 1 and does not follow commands. R53 has a partial avulsion to the skin and fat distal tuft of the left 5th finger {laceration} with exposure of muscle. Final Diagnoses: fall, initial encounter & open fracture of tuft of distal phalanx of finger. R53's X-ray dated 2/18/24 documents a displaced distal tuft fracture of the 5th digit with displacement measuring 2 mm (millimeters). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/21/24 at 9:07 AM, V2 (Director of Nursing) stated R53 self-transferred to the toilet which had a riser on it. The riser must not have been secured because R53 and riser both ended up on the floor. The riser was one that generally screwed onto the toilet. Our intervention was to remove those types of risers because that is how R53 got so banged up, due to being pinned between toilet and wall, and was trapped from the riser. On 5/21/24 at 9:24 AM, V11 (Maintenance Director) stated V11 never did checks on the facilities toilet seat risers to ensure they were secure. V11 explained R53's toilet seat riser was one with a front screw to secure it to the toilet itself and I (V11) just don't think it was screwed in all the way which allowed it to move and caused R53 to fall. The facility's Fall Prevention Program dated May 2022 documents the program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Malfunctioning equipment will be immediately reported to maintenance for repair or removed from service.

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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. 41002 Based on observation, interview, and record review the facility failed to initial and date oxygen, nebulizer, and humidification bottles, and failed to cover nebulizer for two (R41 and R70) of two residents reviewed for respiratory care on the sample list of 36. Findings Include: The facilities Oxygen and Respiratory Equipment-Changing/Cleaning Policy dated 3/2024 documents; Purpose: 1. Provide guidelines to employees for changing all disposable respiratory supplies. 2. To ensure the safety of residents by providing maintenance of all disposable respiratory supplies. 3. To minimize the risk of infection transmission. Procedure: 1. Handheld Nebulizer (HHN) and Mask, if applicable. A. The handheld nebulizer should be changed weekly and as needed (PRN). b. A clean plastic bag with zip loc or draw string, etc. will be provided with each new set up, and will be marked with the date the set up was changed. C. The aerosol machine will be cleaned monthly on the second shift using facility disinfectant and following manufacturer's directions. 2. Nasal Cannula. a. Nasal cannulas are to be changed once a week and as needed (PRN). b. Whenever possible, residents using a portable oxygen tank, will be switched to room oxygen concentrator while in their room. C. A clean plastic bag with a zip loc or draw string, etc. will be provided to store the cannula when it is not in use. It will be dated with the date the tubing was changed. 4. Oxygen humidifiers should be changed weekly or as needed and will be dated when changed. 1.) On 5/19/24 at 8:48AM, R70's oxygen was running at 3.0 liters per nasal cannula with an attached humidification bottle. Neither the tubing or humidification bottle were signed or dated. On 5/19/24 at 1:30pm, V2 (Director of Nursing) said R70's humidifier bottle and tubing should be dated, all oxygen tubing and humidifier bottles should be dated when changed. V2 confirmed that R70's humidifier bottle and tubing were not dated. R70's undated Face Sheet documents R70's diagnoses as Chronic Obstructive Pulmonary Disease (COPD), Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, Peripheral Vascular Disease, Acute and Chronic Respiratory Failure with Hypercapnia and Anxiety Disorder. R70's Physicians Order Sheet (POS) dated 4/24/24 documents an order for Oxygen at 2-5 liters/minute per nasal cannula to keep oxygen saturation above 90%, every shift related to Acute and Chronic Respiratory Failure with Hypercapnia, Change oxygen and humidifier bottle weekly and as needed, every shift Sunday. R70's Care Plan dated 5/13/24 documents R70 has altered respiratory status/difficulty breathing relate to Chronic Obstructive Pulmonary Disease (COPD). 40385 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) On 5/19/24 at 8:36 AM, R41's undated nebulizer mask, chamber, and tubing were uncovered and on the seat of R41's recliner. There was a plastic bag dated 4/21/24 on the recliner that contained the nebulizer tubing. R41 stated R41's nebulizer treatments are scheduled to be given as needed and R41's last nebulizer treatment was given three days ago. On 5/19/24 at 3:31 PM, V7 (Licensed Practical Nurse) stated usually night shift changes and dates the nebulizer mask and tubing weekly. V7 stated nebulizer mask/tubing should be stored in a bag when not in use. R41's Physician Order dated 12/31/23 documents to change oxygen and nebulizer tubing weekly and as needed. R41's May 2024 Medication Administration Record documents Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (milligrams per milliliters) inhale one application every six hours as needed for shortness of breath and this medication was last given on 5/15/24. On 5/20/24 at 2:30 PM, V2 (Director of Nursing) stated nebulizer mask/tubing should be stored in a plastic bag when clean and not in use, changed weekly, and the date should be labeled on the plastic bag.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to assess for the use of side rails, obtain consent for side rail use, and care plan side rail use for four (R7, R38, R41, R55) of four residents reviewed for side rails in the sample list of 36. Findings include: The facility's Side Rails/Bed Rails policy dated November 2023 documents bed rails are adjustable metal or plastic bars that range in a variety of types, shapes, and sizes. This policy documents the resident will be assessed for risk of entrapment and benefits of bed rails. This policy documents the assessment may consider the resident's medical diagnosis/conditions/symptoms/behaviors, size/weight, sleeping habits, medications, medical/surgical interventions, underlying medical conditions, existing delirium, self-toileting ability, cognition, communication, mobility, and risk for falls. This policies documents provide information such as the medical needs addressed, alternative interventions previously, and associated risk and benefits to obtain consent for side rail use from the resident or the resident's representative if applicable policy documents bed rails will be included as part of the resident's plan of care. 1.) On 5/19/24 at 1:05 PM, R7 was lying in bed and there was an upright side rail on the left side of R7's bed. On 5/20/24 at 9:40 AM, V22 (Certified Nursing Assistant/CNA) entered R7's room and transferred R7 from the bed to the wheelchair. R7 used the side rail to sit up on the side of the bed. V22 stated R7 uses the side rail to assist with turning and transfers, and it has been there for at least three months. R7's Minimum Data Set (MDS) dated [DATE] documents R7 has severe cognitive impairment and requires substantial/maximal staff assistance for turning in bed and transferring. R7's Care Plan revised 3/5/24 does not document side rail use. R7's Side Rail assessment dated [DATE] documents this is a quarterly review, side rails are not indicated at this time, and the risks and benefits of siderail use was verbally reviewed with R7. There are no side rail assessments after 7/6/23 documented in R7's electronic medical record (EMR). 2.) On 5/19/24 at 9:01 AM, R38 was lying in bed on an air mattress, and there were upright siderails on each side of R38's bed. On 5/20/24 at 11:35 AM, V22 (CNA) stated R38 uses the side rails to turn to the right side when in bed and the side rails are only upright when assisting with cares, otherwise the side rails are down (not engaged). R38's MDS dated [DATE] documents R38 has severe cognitive impairment and is dependent on staff for turning in bed, when moving from lying to sitting, and for transfers. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R38's Care Plan revised on 3/7/24 does not document side rail use. R38's Side Rail assessment dated [DATE] documents this is a quarterly review, side rails are not indicated at this time, and the risks and benefits of siderail use was verbally reviewed with R38. There are no side rail assessments after 7/13/23 documented in R38's EMR. 3.) On 5/19/24 at 8:43 AM, R41's bed had an upright side rail on each side. R41 stated the side rails are used to keep R41 from falling out of bed and are used when turning in bed. On 5/20/24 at 10:01 AM, V22 (CNA) stated R41 uses the side rails to turn in bed. R41's ongoing census report documents R41 admitted on [DATE]. R41's MDS dated [DATE] documents R41 is cognitively intact. There are no documented side rail assessments or consent for use in R41's EMR. R41's Care Plan revised 5/19/24 does not document side rail use. 4.) On 5/19/24 at 8:59 AM, R55 was lying in bed and R55's bed had an upright side rail on each side. R55 stated R55 uses the side rails to get in and out of bed. R55's MDS dated [DATE] documents R55 has severe cognitive impairment and requires substantial/maximal staff assistance for turning in bed and transferring. R55's Care Plan revised on 5/17/24 does not document side rail use. R55's Side Rail assessment dated [DATE] documents this is a quarterly review, side rails are not indicated at this time, and the risks and benefits of siderail use was verbally reviewed with R55. There are no side rail assessments after 7/7/23 documented in R38's EMR. On 5/20/24 at 1:15 PM, V2 (Director of Nursing) stated side rail assessments are completed quarterly and documented in the assessments section of the resident's EMR. V2 confirmed the assessments should document if side rails are used and appropriate. On 5/20/24 at 2:30 PM, V2 confirmed July 2023 was the last time side rail assessments were completed for R7, R38, and R55. V2 stated it is an EMR issue where the system is prompting the assessments as due in August (annually). On 5/21/24 at 9:45 AM, V2 stated the consent for side rail use is documented on the side rail assessments and confirmed R7's, R38's and R55's assessments document side rails are not indicated. V2 stated side rail assessments were completed quarterly regardless of if side rails are used and V2 is going to update the resident care plans to include side rails.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to identify and care plan specific targeted behaviors and nonpharmacological interventions, and complete psychotropic medication assessments for one (R31) of five residents reviewed for unnecessary medications in the sample list of 36. Findings include: 1.) R31's Minimum Data Set, dated dated dated [DATE] documents R31 has severe cognitive impairment. R31's Care Plan revised 5/17/24 documents R31 admitted on [DATE] and is resistive to cares due to nursing home adjustment. This care plan does not identify what specific cares R31 is resistive to and does not identify any other behaviors. This care plan documents R31 takes antipsychotic medication for psychotic disorder, antianxiety medication for antianxiety, and an antidepressant for depression, but does not identify specific targeted behaviors for the use of these medications. R31's Physician Order dated 5/17/24-5/31/24 documents to give Lorazepam (antianxiety) 0.5 milligrams (mg) by mouth every eight hours as needed (PRN) for anxiety/agitation. R31's Physician Order dated 3/26/24-4/4/24 document Olanzapine (antipsychotic) 5 mg give one tablet by mouth every 12 hours as needed for agitation and psychosis. R31's March 2024 Medication Administration Record (MAR) documents Olanzapine (antipsychotic) 5 mg was given on 3/28 and 3/31. R31's April and May 2024 MARs document Lorazepam (antianxiety) 0.5 mg PRN was given on 4/16, 4/18, 4/19, 4/20, 4/22, 5/17 and 5/19. These MARs document R31 received Lexapro (antidepressant) 5 mg daily from 4/11-5/2/24 and 10 mg daily starting 5/3/24, Mirtazapine (antidepressant) 15 mg daily for mood beginning on 3/27/24. R31's Behavior Monitoring and Interventions Report dated 2/29/24-5/20/24 document R31 has physical behaviors of grabbing/hitting/pushing others, verbal behaviors of accusing/cursing/screaming/anger/frustrated at others, making disruptive sounds, disrobing in public, repetitive movements, rummaging, throwing/smearing bodily waste, agitation, anxiety, delusions, hallucinations, and neglecting/refusing care. This behavior tracking is not personalized to identify R31's specific targeted behaviors and what nonpharmacological intervention to use to respond to each specific behavior. This tracking sheet lists generic interventions to remove from situation, provide calm environment, offer meaningful activity, reapproach, provide one to one, offer food, offer toileting, and provide comfort. R31's Behavior Monitoring and Intervention Report and nursing notes do not document specific behaviors and nonpharmacological interventions that were attempted prior to Lorazepam administrations on 4/19, 4/20, 4/22, 5/17, 5/19/24; and Olanzapine administrations on 3/28 and 3/31/24. R31's Psychotropic Medication Observation dated 5/19/24 documents this is a quarterly evaluation, and R31 has delusions, hallucinations, impaired social skills, memory impairment with abnormal thinking, and paranoia. This assessment documents R31's behaviors of noncompliance, anger, agitation, mood swings, restlessness, hostility, combative, and physically/verbally abusive or threatening; and does not document nonpharmacological interventions for R31's behaviors. There are no other documented psychotropic medication assessments in R31's medical record. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 9:08 AM, V21 (Certified Nursing Assistant/CNA) stated R31 cusses at the CNAs and has attitude towards the CNAs, but R31 has never been that way towards V21. V21 was asked what behavioral interventions are used to respond to R31's behaviors, and V21 stated R31 likes snacks. On 5/20/24 at 10:01 AM, V22 (CNA) stated R31's behaviors include yelling out help hello I need help, and R31 threatens to hit staff. V22 stated R31 plays in R31's feces and intentionally dumps R31's urinal. V22 stated R31 refuses to allow changing of clothing and incontinence briefs. V22 stated today R31 thought R31 was going to a wedding. V22 stated we try to just sit and talk with R31 when R31 is having behaviors, and R31 likes to go to therapy and enjoys drinking coffee. On 5/20/24 at 9:17 AM, V2 (Director of Nursing/DON) stated psychotropic medications are overseen by the Assistant DON (ADON), but V2 has not had an ADON for three months. V2 stated V2 has been doing audits to get caught up on quarterly psychotropic medication assessments. On 5/20/24 at 1:15 PM, V2 stated R31's behaviors include hallucinations, delusions, hitting staff, and refusing cares. V2 stated for a while we had staff going in pairs to provide R31's care. V2 confirmed R31's behavior tracking record is generic and does not identify R31's specific targeted behaviors and personalized nonpharmacological interventions to respond to R31's behaviors. V2 stated R31 likes basketball, so staff should offer to turn basketball on R31's television as a behavioral intervention. V2 stated psychotropic medication assessments should be done on admission and quarterly, and confirmed R31 did not have a psychotropic medication assessment prior to 5/19/24. V2 stated the nurses should document behaviors and interventions in the nursing notes when giving PRN (as needed) psychotropic medications. V2 confirmed behaviors and nonpharmacological interventions should be included in the resident's care plan. The Behavioral Health Services Program dated February 2024 documents behaviors, behavioral triggers, specific individualized behavioral interventions, and psychotropic medications including the specific targeted behavior for use should be included in the resident's care plan. This program documents to utilize the least restrictive interventions to respond to behaviors, document the interventions attempted, and evaluate the effectiveness of the intervention prior to using more restrictive/intrusive interventions including PRN ordered psychotropic medication administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40385 Based on observation, interview, and record review the facility failed to administer insulin per manufacturer's instructions and facility policy. There were 3 medication errors out of 33 opportunities, resulting in a 9.09% medication error rate. This failure affects three (R16, R32, R1) of six residents reviewed for medication administration in the sample list of 36. Findings include: The facility's Insulin Pen procedure dated March 2024 documents to apply a pen needle and prime the pen prior to each injection to remove air bubbles and ensure the needle is working. This procedure documents to prime the pen, turn the dial to 2 units and push the knob so that a drop of insulin appears, and this may need to be done more than once until a drop of insulin appears. 1.) The Fiasp (insulin) Highlights of Prescribing Information dated September 2017 documents Fiasp is a rapid acting insulin, to be given at the start of a meal or within 20 minutes of starting a meal, and it can cause hypoglycemia (low blood glucose). R16's Physician Order dated 4/18/24 documents to administer Fiasp FlexPen (insulin Aspart with Niacinamide) 100 units/milliliter (U/ML) subcutaneous four times daily based on the following sliding scale: 141 - 180 = 6U (units); 181 - 220 = 8U; 221 - 260 = 10U; 261 - 300 = 12U; 301 - 350 = 14U. On 5/20/24 at 10:40 AM, V8 (Registered Nurse) obtained R16's blood glucose level of 246. V8 administered Fiasp FlexPen 10 units into R16's right arm. V8 did not prime the insulin pen prior to administration and there was no food at R16's bedside. On 5/20/24 at 11:16 AM R16 was sitting in the dining room and R16's noon meal was not served until 11:23 AM (over 30 minutes after insulin administration). 2.) Humalog (Lispro) manufacturer's insert dated 6/15/2006 documents this insulin is rapid acting, it should be given within 15 minutes before a meal or immediately after a meal, and it can cause hypoglycemia. R32's Physician Order dated 4/26/24 documents Insulin Lispro peninjector 100 U/ML give 10 units subcutaneous before meals. R32's Physician Order dated 4/26/24 documents to administer Insulin Lispro peninjector four times daily based on the following sliding scale: 0 - 150 = 0; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10; 401 - 999 = 10 and call physician. On 5/20/24 at 10:53 AM, V8 obtained R32's blood glucose level of 267. V8 administered Lispro 16 units to R32's left arm. V8 did not prime the insulin pen prior to administration and there was no food at R32's bedside. The meal tray cart was brought to R32's hallway at 11:40 AM and R32's meal was served at 11:43 AM (50 minutes after insulin administration). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.) On 5/20/24 at 11:01 AM, V8 obtained R1's blood glucose level of 256 and administered Lispro 6 units into R1's abdomen. V8 did not prime the insulin pen prior to administration and there was no food at R1's bedside. The meal tray cart was brought to R1's hallway at 11:40 AM and R1's meal was served at 11:43 AM (42 minutes after insulin administration). On 5/20/24 at 2:30 PM, V2 (Director of Nursing) confirmed insulin pens should be primed prior to each administration. V2 stated residents should eat within 30 minutes of short acting insulin administration.

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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. 40385 Based on observation, interview, and record review the facility failed to ensure intravenous medications were accurately labeled for two (R22, R42) of six residents reviewed for medication administration in the sample list of 36. Findings include: The facility's Medication Administration Policy dated March 2024 documents medications must be administered as ordered including the right medication dosage, and labels that do not contain the correct order, resident name, or physician name need to be returned to the pharmacy for relabeling. The facility's Medication Storage policy dated March 2024 documents the medication name and quantity of additives should be included as part of the intravenous (IV) therapy label. 1.) R42's Physician Order dated 5/20/24 documents to administer a one-time IV micronutrient/hydration therapy of 500 milliliters (ml) 0.9% Normal Saline with vitamin/antioxidant additives (79 ml) including Glutamine 600 milligrams (mg), Arginine 300 mg, Lysine 150 mg, and Citrulline 250 mg to be given at a rate of 250 ml/hour (hr). On 5/20/24 at 11:51 AM, V24 (Registered Nurse) from (infusion company), started a peripheral IV line in R42's right arm and initiated R42's IV therapy medication at a rate of 250 ml/hour. The IV bag was premixed in 500 milliliter (ml) 0.9% Normal Saline and the IV bag label included Glutamine 150 mg, Arginine 500 mg, Lysine 250 mg, and Citrulline 250 mg, which did not match R42's IV therapy order. On 5/20/24 at 12:57 PM, V24 checked R42's IV which was still infusing. 2.) R22's Physician Order dated 5/20/24 documents to administer a one-time IV micronutrient/hydration therapy of 250 ml 0.9% Normal Saline with vitamin/antioxidant additives (79 ml) including Biotin 10 mg, Arginine 300 mg, Lysine 150 mg, and Citrulline 250 mg to be given at a rate of 250 ml/hr. On 5/20/24 at 12:06 PM, V24 started R22's peripheral IV line in R22's right arm and initiated R22's IV therapy medication at a rate of 250 ml/hr. The IV bag was premixed in 250 ml of 0.9% Normal Saline and the IV bag label included B7 (Biotin) 20 mg, Glutamine 150 mg, Arginine 500 mg, Lysine 250 mg and Citrulline 250 mg, which did not match R22's IV therapy order. On 5/20/24 at 2:00 PM, R22's IV bag was empty and V24 disconnected R22's IV. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 12:49 PM, V24 stated the infusion company provides an order form for each resident and the facility obtains the physician order. V24 stated the resident's Medication Administration Record is used to verify the IV therapy ordered. V24 confirmed R22's and R42's IV bag labels did not match the physician orders. V24 stated the infusion company recently changed the IV formulations and the old labels were used on R22's and R42's IV bags. V24 stated V24 mixed the IV bag at the infusion company and the dosages of the additives listed on the labels were based on the new formulary as listed in R22's and R42's orders.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41002 Based on observation, interview, and record review, the facility failed to employ a clinically qualified Director of Food and Nutrition Services. This failure has the potential to affect all 69 residents residing in the facility. Findings include: On 5/20/24 at 8:23am, V9 (Dietary Manager) was actively supervising dietary operations in the facility kitchen during resident meal preparations. V9 reported being the full-time manager of the facility food service and reported not being a clinically qualified Certified Dietary Manager or having the equivalent training. The Resident Census and Conditions of Residents report dated 5/19/24 documents 69 residents reside in the facility. Facility Assessment Tool dated 12/13/2022 documents: Part 3: Facility Resources Needed to Provide Competent Support and Care for our resident Population Every Day and During Emergencies. Position Dietitian or other clinically qualified nutrition professional to serve as the director of food and nutrition services. 1 Full Time Food Service Manager.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to maintain resident influenza and pneumococcal vaccination information and offer pneumococcal vaccines for four (R31, R7, R14, R54) of five residents reviewed for immunizations in the sample list of 36. Findings include: The facility's Influenza and Pneumococcal Immunization policy dated August 2023 documents education on the influenza will be given to the resident and resident representatives on admission and the vaccine will be administered once the consent for vaccination is signed. This policy documents residents and resident representatives will be given education on the pneumococcal vaccine and the vaccine will be offered in accordance with the CDC (Centers for Disease Control & Prevention) guidelines. This policy documents the influenza vaccine is offered October 1 through March 31. This policy documents influenza and pneumococcal vaccination refusals, education provided, and whether or not the vaccines were given will be documented in the resident's medical record. The CDC's Pneumococcal Vaccine Timing for Adults dated 3/15/23 documents the following for people age 65 or older: Give PCV20 (pneumococcal conjugate vaccine) or PCV15 followed by PPSV23 (pneumococcal polysaccharide vaccine) a year or more later for those who have not received any pneumococcal vaccines. For those who have only had the PPSV23, give PCV20 or PCV15 at least a year later. For those who have only had PCV13, give PCV20 or PPSV23 at least a year later. If both PCV13 and PPSV23 have been given, then give PCV20 at least 5 years after the last pneumococcal vaccine was given. 1.) R31's Minimum Data Set (MDS) dated [DATE] documents R31's pneumococcal vaccination is not up to date and R31 was not offered the vaccine. The immunization section of R31's electronic medical record (EMR) does not document influenza and pneumococcal vaccine information/history, and documents R31 is over age 65. There is no documentation in R31's medical record that R31 was offered the pneumococcal or influenza vaccines after admitting to the facility on [DATE]. 2.) R7's MDS dated [DATE] documents R7's pneumococcal vaccination is not up to date and R7 was offered and declined the vaccine. The immunization section of R7's EMR does not document pneumococcal vaccine history or that R7 refused the vaccine, and documents R7 is over age 65. There is no documentation in R7's EMR that R7 was offered the pneumococcal vaccine. 3.) R14's MDS dated [DATE] documents R14's pneumococcal vaccination status is not up to date and R14 was not offered the pneumococcal vaccine. The immunization section of R14's EMR does not document pneumococcal vaccination history, and documents R14 is over age 65. There is no documentation in R14's medical record that R14 was offered the pneumococcal vaccine. 4.) R54's MDS dated [DATE] documents R54's pneumococcal vaccination is not up to date and R54 was not offered since R54 is ineligible. The immunization section of R54's EMR does not document pneumococcal vaccine history or information. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/21/24 at 10:00 AM V2 (Director of Nursing/Infection Preventionist) stated resident vaccine information is received in the referral packet and is documented in the immunization section of the resident's EMR. V2 stated the facility has a pneumococcal vaccine clinic yearly, but one has not been offered recently. V2 reviewed R31's immunization information and confirmed there is no documentation of R31's influenza and pneumococcal vaccination status. V2 stated attempts were made to obtain R31's vaccine information from the assisted living facility where R31 previously resided, but no information was provided. V2 stated V2 was unsure of R31's influenza and pneumococcal vaccination status/history and confirmed R31 was not offered the pneumococcal vaccine. V2 stated R31 refused the influenza vaccine. V2 stated R7, R14, and R54 were not offered the pneumococcal vaccine and V2 was unsure of their pneumococcal vaccination status/history.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to assess side rails for risk of entrapment for four (R7, R38, R41, R55) of four residents reviewed for side rails in the sample list of 36. Findings include: 1.) On 5/19/24 at 1:05 PM, R7 was lying in bed and there was an upright side rail on the left side of R7's bed. On 5/20/24 at 9:40 AM, V22 (Certified Nursing Assistant/CNA) entered R7's room and transferred R7 from the bed to the wheelchair. R7 used the side rail to sit up on the side of the bed. V22 stated R7 uses the side rail to assist with turning and transfers, and it has been there for at least three months. R7's Minimum Data Set (MDS) dated [DATE] documents R7 has severe cognitive impairment and requires substantial/maximal staff assistance for turning in bed and transferring. 2.) On 5/19/24 at 9:01 AM, R38 was lying in bed on an air mattress, and there were upright siderails on each side of R38's bed. R38's MDS dated [DATE] documents R38 has severe cognitive impairment and is dependent on staff for turning in bed, when moving from lying to sitting, and for transfers. 3.) On 5/19/24 at 8:43 AM, R41's bed had an upright side rail (same type/size as R38's) on each side. R41 stated the side rails are used to keep R41 from falling out of bed and are used when turning in bed. R41's ongoing census report documents R41 admitted on [DATE]. R41's MDS dated [DATE] documents R41 is cognitively intact. 4.) On 5/19/24 at 8:59 AM, R55 was lying in bed and R55's bed had an upright side rail on each side. R55 stated R55 uses the side rails to get in and out of bed. R55's MDS dated [DATE] documents R55 has severe cognitive impairment and requires substantial/maximal staff assistance for turning in bed and transferring. There are no documented bed and rail assessments that assess/measure gaps for risk of entrapment for R7's, R38's, R41's and R55's side rails. On 5/20/24 at 2:30 PM, V2 (Director of Nursing) stated nursing and therapy staff do the bed rail assessments for risk of entrapment. V2 stated this is done by visually observing the resident's ability to utilize the side rail. V2 denied that any measurements are obtained to assess gaps for risk for entrapment and V2 stated V2 was unsure if this is done by therapy or maintenance staff. (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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/20/24 at 2:48 PM, V11 (Maintenance Director) stated maintenance staff do not assess side rail and bed gaps for risk of entrapment. On 5/21/24 at 8:10 AM, V19 Physical Therapy Assistant stated V19 installs side rails when V11 is busy, but V19 does not do any kind of assessment or measurement of bed and rail gaps to assess the risk for entrapment. The facility's Side Rails/Bed Rails policy dated November 2023 documents bed rails are adjustable metal or plastic bars that range in a variety of types, shapes, and sizes. This policy documents the resident will be assessed for risk of entrapment (getting caught/trapped/entangled within spaces in or about the bed rail) and ensure that bed rails are properly installed and maintained. This policy lists potential risks associated with bed rail use, including that a resident or body part could get caught between rails, within the rail, or between the bed rail and mattress; and potential risks can be exacerbated by improperly matching bed rails to bed frames and improper installation and maintenance. This policy documents to follow manufacturer's instructions to ensure the bed rail, bed frame and mattress are compatible, inspect and regularly check the mattress and bed rails for possible areas of entrapment, and ensure the rails are installed correctly. This policy documents the bed frame, rail, and mattress should not have gaps wide enough to entrap a resident's head or body. This policy documents gaps can be created from mattress compression/shifting and when using specialty mattresses such as an air mattress. The Guidance for Industry and FDA (Food and Drug Administration) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06 documents there are three body parts that are most at risk for entrapment, the head, the neck, and chest. This guidance documents 4 and 3/4 inches as the basis for dimensional limit for openings in the bed system to avoid head entrapment, 2 and 3/8 inches as the basis for dimensional limit to avoid neck entrapment, and dimensions of greater than 12 and 1/2 inches to avoid chest entrapment. This guidance documents there are seven zones where entrapment can occur, which includes within the rail, under the rail, between the rail and mattress, and between the rail and head or foot boards of the bed.