STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155274	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters of Rockport Skilled Nursing Facility, The	815 W Washington St Rockport, IN 47635

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 46416 Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 1 of 1 residents reviewed for self administering medications. A resident did not have a physician's order, care plan, or assessment to self administer medications. (Resident 29) Findings include: During an observation on 4/2/24 at 1:04 P.M., Resident 29 was observed laying in his bed asleep. On 4/3/24 at 8:50 A.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart disease, atrial fibrillation, edema, pain, morbid obesity, depression, and anxiety. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/2/24, indicated Resident 29's cognition was moderately impaired, a limited assist of 1 staff for bed mobility, transfers, toileting, and taking an opiod. Current Physician's Orders lacked an order for Resident 29 to self administer medications. The clinical record lacked a care plan related to self administering medications. The clinical record lacked a self administration medication assessment. Progress Notes included, but were not limited to, the following: On 12/17/23 at 2:55 P.M., Nursing Progress Note: . Res [resident] states he does not have any pain pills in his room and that he should have a whole drawer of them but we took them. Res said that we are taking his pills and giving them to other residents . On 12/17/23 at 4:15 P.M., Nursing Progress Note: . the resident has pain pills that were found earlier this week, in his room, prescribed by [name of nurse practitioner] . the facility does not have a written order for those pain pills . The resident becomes agitated . states he is withdrawing, will soon begin to puke, is having pain and exertion SOB . (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/23 at 5:21 P.M., Nursing Progress Note: . resident is presenting with s/s [signs/symptoms] of detoxing and is to be sent to the ER . On 12/17/23 at 7:00 P.M., Nursing Progress Note: . Spoke with resident regarding keeping medications at his bedside. Pt [patient] had provided 3 bottles of Prestiq [an antidepressant] earlier in the day to the nurse. Resent [sic] stated he had forgotten he had received the medication and had not taken any. Resident stated was unsure if he needed it. Resident denied having any other medications or pain pills at his bedside. Educated resident that any medication provided by [Doctor Name] needs to be given to nurse upon his return and resident voiced understanding . On 12/17/23 at 10:15 P.M., Nursing Progress Note: . questioned where the bottle of pain meds [medications] found came from. Notified of the ARNP [Advanced Registered Nurse Practitioner] who was listed on bottle and that there was 67 [pills left] . On 3/22/24 at 3:49 P.M., Nursing Progress Note: . Res [resident] had 45 QTY [quantity of pills] bottle of Haldol [antipyschotic] 5 mg in his room . During an interview on 4/4/24 at 1:58 P.M., the Director of Nursing (DON) indicated Resident 29 should not self administer his own medications. He received the medications from [Doctor's Name] who was not the one he saw at the facility. The Haldol was ordered for his nerves and he took one the one night. The DON indicated he did not admit to taking the pain pills from the bottle they found on 12/17/23, but they were not sure because they didn't know how many pills were in there to begin with. At that time, she indicated Resident 29 knew he shouldn't keep medications at bedside. She was unaware that he was still getting narcotic pain pills from the PCP (primary care provider). During an interview on 4/5/24 at 8:37 A.M., the Administrator indicated she and the Business Office Manager (BOM) went into Resident 29's room that morning and the resident ultimately admitted that he had another bottle of pain pills in his room at that time. She indicated he had them in a drawer. The bottle of Percocet (pain medications) was filled on 3/27/24 and the resident told her he took 4 pills a day from that bottle. On 4/5/24 at 11:00 A.M., a current nondated Self Administration of Medication Policy was provided by the DON and indicated . If the resident desires to self-administer medications, an assessment is conducted by an interdisciplinary team [IDT] . the results of the IDT assessment are recoded [sic] on the Medication Self-Administration Assessment Form . If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted . the medications provided to the resident for bedside storage are kept in the locked containers or a locked drawer . the facility nurse is responsible to account for every dose of medication the resident has taken . a physician order is obtained to self-administer medications if the above storage and skill assessment has been approved for the resident by the IDT. The order is recorded on the MAR [Medication Administration Record] . 3.1-11(a)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 45933 Based on interview and record review, the facility failed to ensure a bed hold policy was given to residents or resident representatives for 8 of 9 residents reviewed for hospitalization s. The bed hold form was not completed. There was no documentation of a resident or representative receiving a bed hold at the time of hospitalization . (Resident 17, Resident 30, Resident 29, Resident 8, Resident 19, Resident 21, Resident 10, Resident 7) Findings include: 1. On 4/2/24 at 8:44 A.M., Resident 7's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 1/14/24 and returned back to the facility from the hospital on 1/17/24. Resident 7's records lacked a bed hold policy. 2. On 4/2/24 at 11:55 A.M., Resident 17's clinical record was reviewed and indicated they were admitted from the facility to the hospital on 11/12/24 and returned back to the facility from the hospital on 11/14/24. Resident 17's records lacked a bed hold policy. 46416 3. On 4/4/24 at 1:36 P.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease and atrial fibrillation. The resident's clinical record indicated she was transferred to the hospital on 7/12/23 and 11/30/23. The clinical record lacked documentation that a bed hold policy was provided to the resident or resident representative. 4. On 4/4/24 at 11:04 A.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, heart failure and pneumonia. The resident's clinical record indicated she was transferred to the hospital on 1/26/24. The clinical record lacked documentation that a bed hold policy was provided to the resident or resident representative. 5. On 4/2/24 at 12:31 P.M., Resident 21's clinical record was reviewed. Diagnoses included, but were not limited to chronic obstructive pulmonary disease and anxiety. The resident's clinical record indicated she was transferred to the hospital 2/2/24 and 2/11/24. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record lacked documentation that a bed hold policy was provided to the resident or resident representative. 6. On 4/3/24 at 8:50 A.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and congestive heart disease. The resident's clinical record indicated he was transferred to the hospital on 12/17/23 and 12/23/24. The clinical record lacked documentation that a bed hold policy was provided to the resident or resident representative. 7. On 4/5/24 at 8:21 A.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure and renal failure. The resident's clinical record indicated he was transferred to the hospital on 12/26/23. The clinical record lacked documentation that a bed hold policy was provided to the resident or resident representative. 46882 8. On 4/2/24 at 1:26 P.M., Resident 10's clinical records were reviewed. Diagnosis included, but was not limited to, pathological fracture of right ankle, hypertensive encephalopathy, asthma, chronic obstructive pulmonary disease, pneumonia, seizures, and multiple myeloma. The most current Quarterly, State Optional MDS (Minimum Data Set) Assessment, dated 1/15/24, indicated Resident 10 was cognitively intact, required limited assistance of one with bed mobility and transfers, extensive assistance of 2 for toilet use and supervision for eating. Resident 10 was hospitalized from 10/26/23 thru 10/2723 for sepsis, and 12/5/23 thru 12/8/23 for aspiration pneumonia. The clinical records lacked bed hold paperwork or documentation that bed hold paperwork was given to Resident 10 when transferred to the hospital. During an interview on 4/4/24 at 2:40 P.M., ADON (Assistant Director of Nursing) indicated when a resident was transferred to the hospital, they were sent with bed hold policy, a transfer discharge record and copy of medication and MAR (Medication Administration Record) of medications given for the day, immunizations, allergies, diagnosis and pertinent lab and x-ray information if needed for the hospitalization , and always send DNR (Do Not Resuscitate) paperwork. This should be sent every time a resident was sent to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 at 11:54 A.M., an undated Bed Hold Policy was provided by the Business Office Manager which indicated, It is the policy of the facility to provide the Resident, Resident's family member and /or the Resident's legal representative, if applicable, in written form and/or by a telephone conservation prior to transfer to a hospital or prior to a Resident beginning therapeutic leave, for a duration of 24 hours or longer; certain information regarding the Resident's facility bed status and how the bed will be held. A copy of the Bed Hold policy given to the Resident, Resident's family member and/or the Resident's legal representative will be placed in the resident's record. This will be documented in the resident's record. 3.1-12(a)(25)(26)

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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** 46416 Based on interview and record review, the facility failed to ensure an accurate Minimum Data Set (MDS) Assessment was completed for 1 of 1 residents reviewed for activities of daily living, 1 of 1 residents reviewed for hospice services, and 1 of 5 residents reviewed for unnecessary medications. The MDS inaccurately indicated one resident received a hypoglycemic medication, one resident had a current diagnosis of pneumonia and septicemia, and one resident did not receive hospice services. (Resident 17, Resident 21, Resident 27) Findings include: 1. On 4/1/24 at 11:58 A.M., Resident 21 was observed sitting in her wheelchair eating lunch with her husband in the room who indicated the resident was on hospice care. On 4/2/24 at 12:31 P.M., Resident 21's clinical record was reviewed. Diagnoses included, but were not limited to chronic obstructive pulmonary disease and anxiety. The most recent Significant Change MDS Assessment, dated 2/26/24, indicated Resident 21's cognition was moderately impaired, was not receiving hospice care, and an extensive assist of 2 staff for bed mobility, transfers, and toileting. On 4/4/24 at 9:52 A.M., the MDS Coordinator indicated Resident 21 didn't have an order for hospice and that was why the hospice care was not listed on the 2/26/24 Significant Change MDS Assessment. During an interview on 4/5/24 at 12:03 PM., the Administrator indicated Resident 21 was admitted to hospice on 2/15/24 to the best of her knowledge, so hospice care should have been marked on the 2/26/24 Significant Change MDS Assessment. 45933 2. On 4/2/24 at 11:55 A.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease and depression. The Quarterly MDS on 11/19/23 failed to indicate that Resident 17 had pneumonia and septicemia. The most recent Quarterly MDS, dated [DATE], indicated Resident 17 had pneumonia and septicemia. A review of hospital records indicated Resident 17 was hospitalized with pneumonia and septicemia on 11/13/23. During an interview on 4/4/24 at 10:50 A.M., the MDS Coordinator indicated the Quarterly MDS on 11/19/23 should have indicated pneumonia and septicemia, and the MDS on 2/18/24 had pneumonia and septicemia marked in error. 3. On 4/3/24 at 8:19 A.M., Resident 27's clinical record was reviewed. Diagnoses included, but were not limited to, non-Alzheimer's dementia and depression. The most recent Annual MDS, dated [DATE], indicated Resident 27 received a hypoglycemic. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 27's clinical record lacked an order for a hypoglycemic. During an interview on 4/4/24 at 10:39 A.M., the MDS Coordinator indicated the hypoglycemic was triggered in error. At that time, she indicated their policy is to follow the RAI (Resident Assessment Instrument) manual. 3.1-31(i)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46416 Based on observation, interview and record review the facility failed to develop care plans for 3 of 5 residents reviewed for unnecessary medications and 1 of 1 reviewed for hospice. The facility failed to develop care plans for residents on an anticoagulant, diuretic, antidepressant, risk of opioid overdose, and a resident that received hospice services. (Resident 11, Resident 29, Resident 21) Findings includes: 1. On 4/3/24 at 8:50 A.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart disease, atrial fibrillation, edema, pain, morbid obesity, depression, and anxiety. The most recent Quarterly MDS Assessment, dated 1/2/24, indicated Resident 29's cognition was moderately impaired, a limited assist of 1 staff for bed mobility, transfers, toileting, and taking an opiod, antidepressant, anticoagulant, diuretic, and antiplatelet. Current Physician's Orders included, but were not limited to, the following: oxycodone-acetaminophen (Percocet-pain medication) 10-325 mg (milligram), give 1 tablet by mouth every hours as needed for pain, ordered 12/29/23 by the facility Nurse Practitioner (NP) fluoxetine HCl (hydrochloride) 20 mg (milligram) (antidepressant), give 1 capsule by mouth one time a day for depression, ordered 12/29/2023 apixaban 5 mg (anticoagulant), give 1 tablet by mouth two times a day for atrial fibrillation, ordered 12/29/2023 furosemide 40 mg (diuretic), give 1 tablet by mouth one time a day for edema, ordered 12/31/2023 metolazone 2.5 mg (diuretic), give 1 tablet by mouth one time a day for edema/HF (heart failure), ordered 12/29/2023 Aspirin 81 mg (antiplatelet), give 1 tablet by mouth one time a day for heart, ordered 12/29/2023 Resident 29's clinical record lacked a care plan for taking an antidepressant, anticoagulant, diuretic, antiplatelet, and risk for opiod overdose. 2. On 4/1/24 at 11:58 A.M., Resident 21 was observed sitting in her wheelchair eating lunch with her husband in the room who indicated the resident was on hospice care. On 4/2/24 at 12:31 P.M., Resident 21's clinical record was reviewed. Diagnoses included, but were not limited to chronic obstructive pulmonary disease and anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Significant Change MDS Assessment, dated 2/26/24, indicated Resident 21's cognition was moderately impaired, was not receiving hospice care, and an extensive assist of 2 staff for bed mobility, transfers, and toileting. The clinical record lacked a care plan related to hospice care. During an interview on 4/4/24 at 1:50 P.M., the Director of Nursing (DON) indicated the facility Nurse Practitioner (NP) was also the Medical Director of (hospice company). She was not sure when the order for hospice care was put into place for Resident 21 exactly, but the DON wouldn't expect the order to be in the clinical record under physician's orders but she would think a care plan related to hospice should be. During an interview on 4/5/24 at 8:17 A.M., Registered Nurse (RN) 5 indicated a resident receiving hospice care should have a physician's order and care plan for hospice in the electronic health record. During an interview on 4/5/24 at 12:03 PM., the Administrator indicated Resident 21 was admitted to hospice on 2/15/24. 46882 3. On 4/03/24 at 8:54 A.M., Resident 11's clinical records were reviewed. Diagnosis included, but were not limited to, atrial fibrillation, malignant neoplasm of sigmoid colon, supraventricular tachycardia, Alzheimer's disease, bipolar disorder, and anxiety disorder. The most current Annual, State Optional MDS (Minimum Data Set) Assessment, dated 3/6/24, indicated Resident 11 was cognitively moderately impaired, needed extensive assistance of two for bed mobility, transfers, and toilet use. Medications listed included antianxiety, antidepressant, anticoagulant, and diuretic. Physicians orders included, but were not limited to the following: lorazepam Oral Tablet 0.5 MG (milligram) Give 0.5 mg by mouth two times a day for anxiety/restlessness/behavior, dated 9/21/2023 Eliquis Oral Tablet 5 MG Give 1 tablet by mouth two times a day for atrial fibrillation, dated 11/28/2023 buspirone HCl (hydrochloride) Oral Tablet 10 MG Give 1 tablet by mouth two times a day for anxiety/depression, dated 1/20/2024 paroxetine HCl Tablet 40 MG Give 1 tablet by mouth one time a day for Antidepressant, dated 2/24/2022 furosemide Tablet 40 MG Give 40 mg by mouth two times a day for edema, dated 5/26/2022 Aldactone Tablet 25 MG Give 1 tablet by mouth one time a day for heart failure, dated 5/18/2022 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record for Resident 11 lacked a care plan for anticoagulant use. During an interview on 4/05/24 at 12:04 P.M., the DON (Director of Nursing) indicated clinical records should have care plans for residents on different medications including antipsychotics, antidepressants, diuretics and anticoagulants. On 4/4/24 at 11:54 A.M., a Baseline Care Plan Assessment/Comprehensive Care Plans Policy was provided which indicated .The Comprehensive Care Plan will further expand on the resident's risks, goals and interventions using the Person-Centered Plan of Care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs . 3.1-35(a) 3.1-35(b)(1)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. 45933 Based on interview and record review, the facility failed to ensure staff were completed with the CNA (Certified Nursing Aide) training program and evaluation within 4 months of their hire date for 5 of 5 staff that completed the CNA training program at the facility. The facility lacked information and supplies related to the CNA training program. Findings include: 1. A list of staff that had completed the CNA training program at the facility was provided by the Administrator on 4/2/24 at 11:30 A.M., and indicated the following: On 4/3/24 at 9:47 A.M., employee records were reviewed. Nurse Aide 41 had a start date of 3/23/23 and was not certified. Nurse Aide 43 had a start date of 6/21/23 and was not certified. Nurse Aide 45 had a start date of 8/14/21 and was not certified. Nurse Aide 51 had a start date 9/6/23 and was not certified. Nurse Aide 63 had a start date 6/21/23 and was not certified During an interview on 4/4/24 at 10:45 A.M., Nurse Aide (NA) 45 indicated she performed all CNA duties by herself, but did not take the test to be certified after the CNA class. During an interview on 4/4/24 1:01 P.M., the Administrator indicated that the 5 aides are technically still in training since they were unable to take the test and they should be certified before they worked on the unit by themselves. During an interview on 4/5/24 1:32 P.M., the Administrator indicated the most recent CNA class those students were in started on 7/5/23 and ended on 7/12/23. 46882 2. On 4/5/24 at 9:30 A.M., review of CNA Training Class information indicated the facility was no longer having CNA Training Classes due to the director of the program, the previous ADON (Assistant Director of Nursing) and the delegated instructor no longer worked at the facility. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility lacked an individual file for each of the five students who took the last CNA Training Class in July of 2023. The files lacked documentation of the actual time frames of the classroom portion of the course, documentation of any and all assessment tools (including tests and quizzes) utilized during the course, documentation of PPD (purified protein derivative) testing and physical exams, criminal background checks, documentation of actual time frames and activities during the clinical experience, completed RCP (Resident Care Procedures) assessment tool, copy of testing information, letter or certificate that was issued to the student. During an interview on 4/5/24 at 9:30 A.M., the DON (Director of Nursing) did not know where the supplies for the class were at that time. She indicated she knew they had a blood pressure cuff, pulse oximeter and thermometer. She indicated the room where classes were held was turned into a chapel so there were not any supplies in there. During an interview on 4/5/24 at 10:30 A.M., the Administrator indicated she knew there was a practice mannequin and a synthetic penis that was used for classes. She was not sure what or where the other supplies were located. On 4/4/24 at 1:50 P.M., the Administrator provided a CNA job description, revised April 1, 2023 that indicated, .Must have and maintain an active searchable Certified Nursing Assistant [sic] certification in accordance with the state . 3.1-14(b)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 38770 Based on observation and interview, the facility failed to ensure nurse staffing forms were posted in an area accessible to residents and visitors, or updated daily during 3 of 5 days of the survey. Findings include: On 4/1/24 at 8:40 A.M., posted nurse staffing forms were observed in the back hallway. At that time, all residents were located on the other side of the building. The forms were dated 3/18/24 and 3/19/24. On 4/3/24 at 10:00 A.M., the posted nurse staffing forms on the back hallway were dated 4/1/24 and 4/2/24. On 4/5/24 at 9:47 A.M., the posted nurse staffing forms on the back hallway were dated 4/3/24 and 4/4/24. On 4/5/24 at 9:48 A.M., the Administrator indicated the posted nurse staffing forms should be changed prior to the following shift, and by midnight for the next day. At that time, she indicated the back hallway was the only place the forms were posted, and were not located by the front door where visitors entered. On 4/5/24 at 11:00 A.M., a current Staffing Posting Requirement policy, dated 7/24/23, was provided and indicated .must post daily, at the beginning of each shift, the facility specific shift schedule for the 24 hour period . Data must be in a conspicuous prominent location; accessible to residents/visitors

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. 46416 Based on observation, interview, and record review, the facility failed to ensure staff had knowledge of and appropriate training for Narcan administration for 1 of 5 residents reviewed for unnecessary medications. Staff were not educated and inserviced on the use of Narcan ordered for resident with a history of substance abuse and overdose, the drug was not available for use in the facility. (Resident 29) Finding includes: During an observation on 4/2/24 at 1:04 P.M., Resident 29 was observed laying in his bed asleep. On 4/3/24 at 8:50 A.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart disease, atrial fibrillation, edema, pain, morbid obesity, depression, and anxiety. The most recent Quarterly MDS Assessment, dated 1/2/24, indicated Resident 29's cognition was moderately impaired, a limited assist of 1 staff for bed mobility, transfers, toileting and was taking an opiod. Physician's Orders included, but were not limited to, the following: oxycodone-acetaminophen (Percocet-pain medication) 10-325 mg (milligram), give 1 tablet by mouth every hours as needed for pain, ordered 12/29/23 by the facility Nurse Practitioner (NP) Narcan nasal liquid (medication that reverses opioid overdose) 4mg/0.1ml (milliliter), 1 spray in nostril every 2 minutes as needed for unresponsiveness may be used every 2-3 minutes until patient is responsive, ordered 12/29/23 A current Trauma Care Plan, dated 8/3/23, indicated I have experienced negative events in my lifetime, drug abuse, homeless, lost of spouse, daughter in prison, and included the following intervention: find things of comfort for resident, and encourage resident to use. Things of comfort include:, initiated 8/3/23 A current I have a history of drug abuse Care Plan, dated 8/2/23 included, but was not limited to the following intervention: currently not a problem-continue to monitor and provide positive reinforcement for non use, initiated 8/2/23 The clinical record lacked a care plan for the risk of opioid overdose. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/24 at 1:58 P.M., the Director of Nursing (DON) indicated they did not keep Narcan at the facility. During an interview on 4/5/24 at 8:08 A.M., Registered Nurse (RN) 5 indicated Narcan was kept in the Pixis. At that time, Narcan was not observed in the Pixis and she was unaware of where it was and indicated Narcan should be available because they have a few residents with it ordered, but they have not had inservices for it. On 4/5/24 at 11:00 A.M., a current nondated Director of Nursing Job Description was provided by the Administrator and indicated . The person holding this position is delegated the administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures to ensure that the highest degree of quality care is maintained at all times . Participates in developing, planning, conduction, and in-service training classes that provide instructions on how to do the job, and ensures a well-educated nursing service department .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46416 Based on interview and record review, the facility failed to maintain an complete, accurate clinical record for 1 of 5 residents reviewed for unnecessary medications. A narcotic pain medication was documented under the name of the Nurse Practitioner when it was ordered by an outside physician and the clinical record lacked documentation of destroying medications. (Resident 29) Finding includes: On 4/3/24 at 8:50 A.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart disease, atrial fibrillation, edema, pain, morbid obesity, depression, and anxiety. The most recent Quarterly MDS Assessment, dated 1/2/24, indicated Resident 29's cognition was moderately impaired, a limited assist of 1 staff for bed mobility, transfers, toileting and was taking an opiod and antidepressant but not an antipyschotic. Physician's Orders included, but were not limited to, the following: oxycodone-acetaminophen (Percocet-pain medication) 10-325 mg (milligram), give 1 tablet by mouth every hours as needed for pain, ordered 12/29/23 by the facility Nurse Practitioner (NP) Progress Notes included, but were not limited to, the following: On 12/17/23 at 2:55 P.M., Nursing Progress Note: . Res [resident] states he does not have any pain pills in his room and that he should have a whole drawer of them but we took them. Res said that we are taking his pills and giving them to other residents . On 12/17/23 at 4:15 P.M., Nursing Progress Note: . the resident has pain pills that were found earlier this week, in his room, prescribed by [name of nurse practitioner] . the facility does not have a written order for those pain pills . The resident becomes agitated . states he is withdrawing, will soon begin to puke, is having pain and exertion SOB . On 12/17/23 at 5:21 P.M., Nursing Progress Note: . resident is presenting with s/s [signs/symptoms] of detoxing and is to be sent to the ER . On 12/17/23 at 7:00 P.M., Nursing Progress Note: . Spoke with resident regarding keeping medications at his bedside. Pt [patient] had provided 3 bottles of Prestiq [an antidepressant] earlier in the day to the nurse. Resent [sic] stated he had forgotten he had received the medication and had not taken any. Resident stated was unsure if he needed it. Resident denied having any other medications or pain pills at his bedside. Educated resident that any medication provided by [Doctor Name] needs to be given to nurse upon his return and resident voiced understanding . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/17/23 at 10:15 P.M., Nursing Progress Note: . questioned where the bottle of pain meds [medications] found came from. Notified of the ARNP [Advanced Registered Nurse Practitioner] who was listed on bottle and that there was 67 [pills left] . On 3/22/24 at 3:49 P.M., Nursing Progress Note: . Res [resident] had 45 QTY [quantity of pills] bottle of Haldol [antipyschotic] 5 mg in his room . The progress notes lacked documentation of destroying the Percocet, Prestiq, and Haldol medications that were found. During an interview on 4/4/24 at 1:58 P.M., the Director of Nursing (DON) indicated the facility NP saw him there and wrote orders for medications, etc and then he went to his Primary Care Provider (PCP) and the PCP had also prescribed him medications they didn't know about. At that point, the Facility NP wouldn't order him more of the pain pills because the PCP was also ordering them. The DON indicated they talked to Resident 29 about only seeing one doctor and he couldn't decide if he was going to stay with the PCP or Facility Nurse Practitioner and went back and forth. The DON indicated she tried to get records from the PCP but she had not been successful. She indicated the resident still saw both providers. The PCP also ordered Haldol (an antipyschotic) for his nerves and he was also getting an injection in his stomach at his office for weight loss. At that time, she indicated neither of these were on his medication list so the pharmacist reviewing his medications was probably not aware he had 2 physicians or some of the medications he was getting. During an interview on 4/5/24 at 10:50 A.M., the DON indicated she was pretty sure the medications that were found were destroyed. During an interview on 4/5/24 at 10:55 A.M., Registered Nurse (RN) 3 indicated she was not sure who prescribed the pain medication in the medication cart. The physician's order in the electronic health record (EHR) indicated Facility NP but she was not certain because there was only room in the EHR to identify a couple providers and if a medication was ordered by a different provider, they would usually put additional directions under that prescription that would indicate who prescribed it, but there wasn't anything saying that. At that time, she indicated there should be documentation of destroying medications in the progress notes, especially the narcotic pain pills. During an interview on 4/5/24 at 10:05 A.M., the Facility NP indicated after Resident 29 was caught with the pain pills in his room that were not prescribed by her, she had the DON try to contact that prescriber and figure out what medications were being prescribed so they would have an accurate medication list, but the DON was unsuccessful. The Facility NP indicated that she spoke with Resident 29 and educated him on only having one provider and she was under the impression he wasn't going to see the other provider anymore. She was not aware that the current physician's order was active under her name but she was not writing the script for his Percocet. The DON was supposed to be working on that so the correct provider was listed. She indicated that she would expect the clinical record to be complete and accurate. On 4/5/24 at 11:00 A.M., a current nondated Controlled Substances policy was provided by the Administrator and indicated . The DON and Consultant Pharmacist are responsible for the control of Schedule II drugs. Both are responsible for periodically auditing the system and records to assure proper control is maintained . Records shall be maintained by authorized nursing personnel . A complete and accurate record of destroyed drugs will be maintained and signed by authorized personnel . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-50(a)(2) 3.1-25(s)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. 46416 Based on interview and record review, the facility failed to ensure adequate monitoring and supervision was done to keep a resident's drug regimen free from unnecessary drugs for 1 of 5 residents reviewed for unnecessary medications. A resident was getting narcotic pain medications from an outside physician. (Resident 29) Finding includes: On 4/3/24 at 8:50 A.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart disease, atrial fibrillation, edema, pain, morbid obesity, depression, and anxiety. The most recent Quarterly MDS Assessment, dated 1/2/24, indicated Resident 29's cognition was moderately impaired, a limited assist of 1 staff for bed mobility, transfers, toileting, and taking an opiod. Physician's Orders included, but were not limited to, the following: oxycodone-acetaminophen (Percocet-pain medication) 10-325 mg (milligram), give 1 tablet by mouth every hours as needed for pain, ordered 12/29/23 by the facility Nurse Practitioner (NP) The MARs (Medication Administration Record) were reviewed from September 2023 through March 2024 and indicated the resident did not take any Percocet in November 2023 or March 2024. Progress Notes included, but were not limited to, the following: On 12/17/23 at 2:55 P.M., Nursing Progress Note: . Res [resident] states he does not have any pain pills in his room and that he should have a whole drawer of them but we took them. Res said that we are taking his pills and giving them to other residents . On 12/17/23 at 4:15 P.M., Nursing Progress Note: . the resident has pain pills that were found earlier this week, in his room, prescribed by [name of nurse practitioner] . the facility does not have a written order for those pain pills . The resident becomes agitated . states he is withdrawing, will soon begin to puke, is having pain and exertion SOB . On 12/17/23 at 5:21 P.M., Nursing Progress Note: . resident is presenting with s/s [signs/symptoms] of detoxing and is to be sent to the ER . On 12/17/23 at 7:00 P.M., Nursing Progress Note: . Spoke with resident regarding keeping medications at his bedside. Pt [patient] had provided 3 bottles of Prestiq [an antidepressant] earlier in the day to the nurse. Resent [sic] stated he had forgotten he had received the medication and had not taken any. Resident stated was unsure if he needed it. Resident denied having any other medications or pain pills at his bedside. Educated resident that any medication provided by [Doctor Name] needs to be given to nurse upon his return and resident voiced understanding . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/23 at 10:15 P.M., Nursing Progress Note: . questioned where the bottle of pain meds [medications] found came from. Notified of the ARNP [Advanced Registered Nurse Practitioner] who was listed on bottle and that there was 67 [pills left] . On 3/22/24 at 3:49 P.M., Nursing Progress Note: . Res [resident] had 45 QTY [quantity of pills] bottle of Haldol [antipyschotic] 5 mg in his room . During an interview on 4/4/24 at 1:58 P.M., the Director of Nursing (DON) indicated the facility NP saw him there and wrote orders for medications, etc and then he went to his Primary Care Provider (PCP) and the PCP had also prescribed him medications they didn't know about. At that point, the Facility NP wouldn't order him more of the pain pills because the PCP was also ordering them. She was unaware that he was still getting narcotic pain pills from the PCP. The DON indicated they talked to Resident 29 about only seeing one doctor and he couldn't decide if he was going to stay with the PCP or Facility Nurse Practitioner and went back and forth. The DON indicated she tried to get records from the PCP but she had not been successful. She indicated the resident still saw both providers. The PCP also ordered Haldol (an antipyschotic) for his nerves and he was also getting an injection in his stomach at his office for weight loss. At that time, she indicated neither of these were on his medication list so the pharmacist reviewing his medications was probably not aware he had 2 physicians or some of the medications he was getting. During an interview on 4/5/24 at 10:55 A.M., Registered Nurse (RN) 3 indicated she was not sure who prescribed the pain medication in the medication cart. The physician's order in the electronic health record (EHR) indicated Facility NP but she was not certain because there was only room in the EHR to identify a couple providers and if a medication was ordered by a different provider, they would usually put additional directions under that prescription that would indicate who prescribed it, but there wasn't anything saying that. During an interview on 4/5/24 at 10:05 A.M., the Facility NP indicated after Resident 29 was caught with the pain pills in his room that were not prescribed by her, she had the DON try to contact that prescriber and figure out what medications were being prescribed so they would have an accurate medication list, but the DON was unsuccessful. The Facility NP indicated that she spoke with Resident 29 and educated him on only having one provider and she was under the impression he wasn't going to see the other provider anymore. She was unaware that he was still getting narcotic pain pills from the PCP. On 4/5/24 at 9:45 A.M., the Administrator indicated it would be their policy residents would not receive unnecessary medications. 3.1-48(a)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46416 Based on observation, interview, and record review, the facility failed to ensure proper storage and disposal of medications for 2 of 3 medications carts and 1 of 1 medication storage rooms observed. A bottle of medication in the medication cart was not labeled, expired medications and medications of discharged residents were observed in the medication storage room, and medication carts were observed unlocked. (Resident 86, Resident 87, Resident 21, Resident 88, Resident 33, Resident 11, Resident 5, Resident 2, Resident 22, Resident 8) Findings include: 1. During an observation of the East Hall Medication Cart on 4/5/24 at 8:20 A.M., there was a plastic pill container in the locked narcotic box with 2 tablets inside of it. The label of the container was observed with Resident 29's name, oxy-apap [Percocet] 10/325 mg [milligram], and dated 12-15-23. During an interview on 4/5/24 at 10:55 A.M., RN 3 indicated when a narcotic medication came in a bottle from the resident or pharmacy, the staff would put them into the plastic containers because they were numbered and easier to do narcotic counts. The label on the container should include the resident's name, date of birth, ordering physician, and directions for the medications. 38770 2. On 4/2/24 at 6:20 A.M., three medication carts were observed sitting together by the nurses station on East Hall without staff present. Two of the three carts were unlocked until the following times: The cart facing the nurses station was locked by Qualified Medication Aide (QMA) 37 at 6:39 A.M. The cart in the middle facing the hall was locked by Licensed Practical Nurse (LPN) 7 at 6:42 A.M. At that time, three residents were observed in the common area by the nurses station. 3. On 4/4/24 at 10:35 A.M., the middle medication cart on the East Hall was observed with a bottle of aspirin 81mg (milligrams) with no pharmacy label, and no other markings that indicated who it belonged to, dose to be given, physician name, or date opened. At that time, Registered Nurse (RN) 32 indicated there should have been a label on the bottle. 4. On 4/4/24 at 10:40 A.M., the medication storage room behind the nurses station was observed with the following medications sitting on a shelf: A bottle of metolazone 2.5mg, bumetanide 1mg, and gabapentin 100mg. The label on the bottles indicated they belonged to Resident 86. At that time, RN 32 indicated the resident was deceased . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A bottle of bupropion XL 300mg, gabapentin 400mg, furosemide 80mg, levsin 0.125mg, duloxetine 60mg, and metformin 1000mg. The label on the bottles indicated they belonged to Resident 87. At that time, RN 32 indicated the resident was deceased . A bottle of Miralax powder with a label that indicated it belonged to Resident 88. At that time, RN 32 indicated the resident was deceased . A bottle of pantopraz 40mg that expired 2/3/24. A foil pack of Zofran 4mg with 28 pills left. There was no label. A box of azithromycin with 4 pills remaining belonging to Resident 21. At that time, RN 32 indicated Resident 21 had come in with that medication, and when the pharmacy brought them in, the original leftovers were placed in the medication storage room. A card dated 3/7/24 that contained several boxes of loose pills with the name of Resident 33. A sheet that was attached to the card indicated the following medications: Aspirin 81mg Clopidrogel 75mg Eliquis 2.5mg Fluoxetine 10mg Bumetanide 2mg Potassium 20mEq (milliquivelants) Donepezil 5mg Ferrous Sulfate 325mg Vitamin D 5000U (units) Olanzapine 2.5mg RN 32 indicated Resident 33 was discharged . Two cards with Eliquis 5mg belonging to Resident 11. RN 32 indicated the resident was still in the facility. A card with donezepezil 10mg belonging to Resident 5. RN 32 indicated the resident was still in the facility. Two cards of guafenesin 600mg, two cards of garlic 1000mg, a box of albuterol, and a tube of zilactin-B gel 10% belonging to Resident 2. RN 32 indicated the resident was still in the facility. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Two individual packs of pantoprazole 40mg, and an individual pack of Calcium 600mg belonging to Resident 22. RN 32 indicated the resident was still in the facility. A black case with a bottle of armodafinil 250mg, a bottle of desvenlafaxine 50mg, a bottle of chlorthalidone 25mg, and a bottle of cyclobenzaprine 5mg belonging to Resident 8. RN 32 indicated the resident was still in the facility. At that time, RN 32 indicated nurses should be disposing of the medications in the medication storage room when they have time, and management would also dispose of them when there was time. She indicated night shift usually disposed of the medications, and policy was for two nurses to dispose of together. She indicated all of the medications in the storage room should have already been disposed of. On 4/5/24 at 11:00 A.M., the Administrator provided a discharge list from 2/1/24 through 4/5/24 that included the following: Resident 86 discharged to funeral home on 3/25/24. Resident 87 discharged to funeral home on 3/29/24. Resident 88 discharged to funeral home on 3/7/24. Resident 33 was discharged to home on 3/29/24. On 4/5/24 at 9:46 A.M., the Administrator indicated the medication carts should be locked at all times when a nurse is not in front of them. On 4/5/24 at 11:00 A.M., a current non-dated Medication Storage in the Facility policy was provided and indicated Medication rooms, carts, and medication supplies are locked or attended by person with authorized access . Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock. They will be disposed of according to drug disposal procedures . On 4/5/24 at 2:42 P.M., a current Prescription Labels policy, dated March 2023, was provided and indicated Medications are labeled in accordance with State and Federal laws as well as facility requirements 3.1-25(k) 3.1-25(m) 3.1-25(o) 3.1-25(p) 3.1-25(r)

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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. 46416 Based on interview and record review, the facility failed to ensure the food service department was directed by a supervisor competent in food service management and knowledgeable in sanitation standards and food handling for 1 of 1 dietary managers reviewed. The dietary manager was not certified. (Dietary Manager) Finding includes: On 4/1/24 at 8:53 A.M., the Dietary Manager's certification and/or qualifications were requested. Employee records were provided and indicated the Dietary Manager's start date was January of 2023. During an interview on 4/4/24 at 8:00 A.M., the Administrator indicated the Dietary Manager was not certified but was enrolled in a class that started in November of 2023 and a goal completion date of November of 2024. On 4/5/24 at 10:43 A.M., the Administrator indicated there was not a policy for the Dietary Manager position requirements, but provided a current Dietary Director Job Description, dated 1/29/24, as a policy which indicated . education/experience: . be a graduate of an accredited course in dietetic training, approved by the American Dietetic Association . must be registered as a Food Service Director in this state . 3.1-20(h)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46416 Based on observation and interview, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety for 2 of 2 observations of the kitchen. Foods were not labeled and open to air. Facial masks were adjusted with hands and food was prepped without sanitizing hands. Plate warmer lids and food containers were held against clothing. Bottom of shoe rested on shelf under table where food serving trays were stored. (Kitchen) Findings include: During the initial tour on 4/1/24 at 8:53 A.M., the following was observed in the kitchen: Refrigerator: Water was on the floor throughout an opened bag of pepperoni, not labeled an opened bag of roast beef meat, with 3/31 wrote on the bag in permanent marker 2 full bags of cabbage, with best if used by dates of 3/11/24 and 3/22/24 a full tray of individually wrapped green colored cake with white icing, not labeled a tray of dessert, not labeled Freezer: a ziploc bag of freezer burnt chicken thighs, with a preparation date of 9/20/23 a full tray of ice cream individually prepped and covered, not labeled Dry storage: an opened bag of elbow macaroni, with 3/21 wrote on the bag in permanent marker an opened bag of spiral pasta, not dated an open box of corn meal, with 7/19 wrote on the box in permanent marker an opened bag of pasta, open to air, not dated an opened gallon of soy sauce, not dated and without a readable manufacturer's expiration date an opened bottle of crystallized honey, not dated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a second observation on 4/3/24 at 10:52 A.M., the following was observed in the kitchen: Dry storage: an opened bag of elbow macaroni, with 3/21 wrote on the bag in permanent marker an opened bag of spiral pasta, not dated an open box of corn meal, with 7/19 wrote on the box in permanent marker an opened bag of pasta, open to air, not dated an opened gallon of soy sauce, not dated and without a readable manufacturer's expiration date During an observation on 4/3/24 at 10:19 A.M., Cook 9 and Dietary Aide 21 were wearing hairnets with hair sticking out at the napes of their necks and both temples while they were prepping food for lunch. During the same observation, Cook 9 pureed spaghetti sauce, put it in a bowl, covered it with foil, took her gloves off and put oven mitts on to grab food out, and put food back into the steamer. She washed dishes off, ran the dishwasher, grabbed the dishes from the dishwasher rack, and laid the top of the food processor with the mixer that touches the food on the table, then started pureeing green beans without washing her hands and using the mixer of the food processor that was laying on the table. During an observation on 4/3/24 at 11:24 A.M., Dietary Aide 21's mask slipped below her nose. She pulled it up with her left gloved hand then went to the freezer and carried covered, individual styrofoam bowls stacked up and leaning against her shirt with her masked chin holding the top one, and placed them on serving trays. During an observation on 4/3/24 at 11:31 A.M., Cook 9 adjusted her mask with her left gloved hand twice and proceeded to grab a plate to serve food on, holding it with her left thumb on top of the plate to hold it. During an observation on 4/3/24 at 11:37 A.M., Dietary Aide 21 held the top of the warmer plates with the inside against her shirt and placed them on top of the food plated on the tray before she put them into the serving cart. At that time, her left shoe was resting up on the bottom of the stainless steel table, on the shelf where the food trays were stored. During an interview on 4/1/24 at 9:15 A.M., the Dietary Manager indicated items should have a label with the date prepped and what it was if it was not in it's original container, meat should not be kept more then 3 months in the freezer, and food items should not be open to air. During an interview on 4/5/24 at 10:08 A.M., the Director of Nursing/Infection Preventionist (DON/IP) indicated after touching a mask with hands to adjust it, she would expect staff to use hand sanitizer or perform hand hygiene, the hairnets should cover all of the hair on all of the sides and back of the head, the food warmer top should never be placed against a shirt and then placed over food, food should not be carried against a shirt and held with their chin, touching the mask they were wearing. Food should be carried away from clothing, and staff should not place the bottom of their shoe on the surface where trays were kept. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/4/24 at 8:00 A.M., a current Food Safety and Sanitation Policy, dated April 2017, was provided by the Administrator and indicated . the facility will follow safe handling and storage of Potentially Hazardous food/Time/Temperature Control Safety (PHF/TCS) foods . foods will be stored, dated and labeled . On 4/4/24 at 8:00 A.M., a current Employee Health & Personal Hygiene Policy, dated April 2017, was provided by the Administrator and indicated Food service employees shall maintain good personal hygiene . 3.1-21(i)(2) 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45933 Based on observation, interview, and record review, the facility failed to properly prevent and contain COVID-19 to ensure infection control practices were followed for 1 of 2 residents reviewed for COVID-19. The facility failed to implement infection control practices for 1 of 2 residents during care and 1 random observation. A COVID-19 positive resident was observed sitting in the common area, and the physician was not notified of a resident's temperature status. Hand hygiene was not completed between dirty and clean tasks during perineal care. (Resident 11, Resident 26, Resident 27) Findings include: 1. During an observation of care on 4/4/24 at 10:43 A.M., CNA (Certified Nurse Aide) 27 and RN (Registered Nurse) 5 provided incontinence care on Resident 26. CNA 27 wiped Resident 26's peri area with 3 wipes and used her same gloved hands to place the clean brief on the bed. CNA 27 then placed her soiled gloves on Resident 26's right arm and right leg to assist her to roll over. CNA 27 removed 1 glove and placed a new glove on and wiped stool off of Resident 26's bottom. CNA 27 removed her gloves and failed to perform hand hygiene before she donned new gloves. After she donned new gloves, she placed the clean brief under the resident. During an interview on 4/5/24 at 10:08 A.M., the DON indicated hand hygiene should be performed and gloves should be changed between dirty and clean tasks. 38770 2. On 4/3/24 at 11:26 A.M., Resident 27's clinical record was reviewed. Diagnosis included, but was not limited to, Covid-19 (dated 3/30/24). Current physician orders included, but were not limited to: For COVID-19 + residents record temperature, pulse, respiration, blood pressure, and oxygen saturation every shift (report immediately any temperature 99.1 degrees or higher), dated 4/1/24. Resident 27's Medication Administration Record (MAR) for April 2024 indicated a temperature reading of 100 degrees on 4/2/24 day shift, and a temperature reading of 99.1 degrees on 4/2/24 evening shift. Resident 27's clinical record lacked notification to the physician related to the temperature readings on 4/2/24. On 4/5/24 at 2:30 P.M., the Director of Nursing (DON) and Administrator indicated notification to the physician related to the temperature readings could not be located. 46882 3. On 4/1/24 at 10:26 A.M., Resident 11 was observed sitting in a recliner in the common area next to the East hall nurse's station without a mask on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/24 at 11:28 A.M., Resident 11 was observed sitting in a recliner in the common area next to the East hall nurse's station without a mask on. On 4/1/24 at 11:55 A.M., Resident 11 was observed sitting in a recliner in the common area next to the East hall nurse's station coughing and without a mask on. On 4/4/24 at 2:15 P.M., Resident 11's call light was on. CNA 27 was observed going down the hall to get a gown (none in container outside of resident's room) and put it on, put on shield, but did not put on gloves before entering room. On 4/03/24 at 8:54 A.M., Resident 11's clinical records were reviewed. Diagnosis included, but were not limited to, Covid-19. The most current Annual, State Optional MDS (Minimum Data Set) Assessment, dated 3/6/24, indicated Resident 11 was cognitively moderately impaired, needed extensive assistance of two for bed mobility, transfers, and toilet use. Physician orders included, but were not limited to the following: COVID-19 Test as needed for COVID 19 Screening Laboratory, dated 3/29/2024 Transmission Based-Droplet Isolation every shift for Suspected w/ S&S (with signs and symptoms) or + (positive) COVID-19, dated 3/29/2024 Care Plan for COVID-19: I have been placed in droplet isolation due to positive COVID 19 test results Revision date 4/1/2024 Interventions: All services brought to the room. Date initiated: 4/2/24 Labs as ordered. Date initiated 4/2/24 Medications as ordered. Date initiated 4/1/24 Nursing Progress Note 3/29/2024 2:14 P.M. Note Text: resident [sic] tested positive for covid. family [sic] and hospice notified. vitals [sic] and neuros WDL [within defined limits]. waiting [sic] on hospice to call back to confirm if resident can have an antiviral. During an interview on 4/1/24 at 1:43 P.M., the Administrator indicated residents who were positive for Covid should be in isolation for 10 days. She indicated if Resident 11 was not in isolation, she should be. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/24 at 8:56 A.M., the ADON (Assistant Director of Nursing) indicated residents were placed in isolation as soon as they tested positive or started to show symptoms of Covid. During an interview on 4/4/24 1:43 P.M., the ADON indicated staff should wear a gown, gloves, N95 (Non-oil 95 percent efficiency) mask and shield if going into the room of resident with a positive Covid test. On 4/1/24 at 1:03 P.M., Post Public Health Emergency-Standard and Guidelines Policy, dated 5/16/23, indicated .Personal Protective Equipment [PPE]: HCP [Health Care Provider] who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection will follow Transmission Based Precautions and use a NIOSH [National Institute for Occupational Safety and Health] Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection .Duration of Transmission-Based Precautions for Residents with SARS-CoV-2 Infection: The following criteria will be used to determine when Transmission-Based Precautions can be discontinued for residents with SARS-CoV-2 .Symptom-based strategy: Residents with mild to moderate illness who are not immunocompromised: At least 10 days have passed since symptoms first appeared and At least 24 hours have passed since last fever without the use of fever-reducing medications and Symptoms have improved . On 4/4/24 at 1:50 P.M., a current, undated Gloves non- sterile policy was provided and indicated, .If for any reason there is a need to remove the gloves and reapply new gloves, Hand Hygiene must occur between the removal of the used pair of gloves and the application of the new pair of gloves. 3.1-18(b) 3.1-18(j) 3.1-18(l)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 38770 Based on interview and record review, the facility failed to employ a qualified Infection Preventionist. The full time Director of Nursing was also completing the Infection Preventionist duties. Finding includes: On 4/3/24 at 1:19 P.M., the Director of Nursing (DON) indicated she was the facility's appointed Infection Preventionist (IP). On 4/5/24 at 10:08 A.M., the DON indicated although she was a full time DON, about 8 hours had been spent earlier in the week on IP duties. At that time, she indicated the amount of hours dedicated to IP duties fluctuated depending on the amount of infections in the facility, and sometimes would stay over her usual hours. Hours spent on DON and IP specific duties were not documented. On 4/1/24 at 2:40 P.M., a current non-dated Infection Prevention and Control policy was provided and indicated There will be an appointed person to spearhead the Infection Prevention and Control Program. This person will be a licensed nurse, usually the DON or ADON [Assistant Director of Nursing] On 4/5/24 at 11:48 A.M., a current non-dated Infection Control job description was provided and indicated the Infection Preventionist reported to the DON.

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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. 38770 Based on interview and record review, the facility failed to ensure residents were informed of the benefits of influenza and pneumococcal vaccines, consents or refusals were obtained for vaccines, and vaccines were offered based on resident preference for 5 of 5 residents reviewed for vaccines. (Resident 1, Resident 15, Resident 3, Resident 23, Resident 26) Findings include: 1. On 4/2/24 at 7:59 A.M., Resident 1's clinical record was reviewed. Diagnosis included, but were not limited to, history of stroke and depression. The most recent Annual MDS (Minimum Data Set) Assessment, dated 3/12/24, indicated no cognitive impairment and no behaviors. A nurses note, dated 11/3/23 at 8:54 P.M., indicated Resident 1 received a flu shot with no adverse reactions. Resident 1's clinical record lacked a consent for the flu vaccine administered on 11/3/23. 2. On 4/2/24 at 9:54 A.M., Resident 15's clinical record was reviewed. Diagnosis included, but were not limited to, history of fracture and osteoarthritis. The most recent Quarterly MDS Assessment, dated 1/4/24, indicated no cognitive impairment and no behaviors. A current care plan for refusal of pneumococcal vaccines indicated to continue to offer vaccines yearly, dated 9/28/23. A pneumococcal vaccine consent form, dated 10/1/21, indicated a refusal of the vaccine per the resident's Power of Attorney (POA). Resident 15's clinical record lacked an offer for the pneumococcal vaccine since 10/1/21. Resident 15's clinical record indicated consent refused for the pneumococcal vaccine with no date for the refusal listed. 3. On 4/3/24 at 9:38 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but were not limited to, Multiple Sclerosis (MS). The most recent Quarterly MDS Assessment, dated 2/2/24, indicated a moderate cognitive impairment, and no behaviors. Resident 3's clinical record indicated the flu vaccine was administered on 11/3/23. A consent form for the flu vaccine, dated 11/2/23, indicated Resident 3's first initial and last name. The handwriting on the form matched another resident's consent form. On 4/5/24 at 8:53 A.M., Resident 3 indicated he did not sign the flu consent form, it was not his signature, and indicated someone else must have signed the form. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 3's clinical record indicated the pneumococcal vaccine was administered 5/4/23. The clinical record lacked a signed consent for the vaccine. 4. On 4/3/24 at 9:42 A.M., Resident 23's clinical record was reviewed. Diagnosis included, but were not limited to, hypertension. The most recent Quarterly MDS Assessment, dated 2/21/24, indicated a moderate cognitive impairment and no behaviors. A nurses note, dated 11/2/23, indicated resident did want the flu vaccine. Resident 23's clinical record indicated a flu vaccine was administered on 11/3/23 and a pneumococcal vaccine was administered on 5/4/23. Resident 23's clinical record lacked consent forms for the flu vaccine and pneumococcal vaccine. 5. On 4/3/24 at 9:46 A.M., Resident 26's clinical record was provided. Diagnosis included, but were not limited to, dementia and depression. The most recent Annual MDS Assessment, dated 3/27/24, indicated a moderate cognitive impairment and no behaviors. A nurses note, dated 11/3/23 at 8:55 P.M., indicated Resident 26 received a flu vaccine with no adverse reactions. Resident 26's clinical record lacked a consent form for the flu vaccine administered on 11/3/23. On 4/1/24 at 1:40 P.M., a current Influenza and Pneumococcal Immunization policy, dated 1/1/17, was provided and indicated Inform the resident and/or responsible party that they will need to sign the Immunization Consent or Refusal form 3.1-13(a)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 38770 Based on interview and record review, the facility failed to ensure residents were informed of the benefits of Covid vaccines, or consents and/or refusals were obtained for 4 of 5 residents reviewed for vaccines. (Resident 1, Resident 15, Resident 3, Resident 23) Findings include: 1. On 4/2/24 at 7:59 A.M., Resident 1's clinical record was reviewed. Diagnosis included, but were not limited to, history of stroke and depression. The most recent Annual MDS (Minimum Data Set) Assessment, dated 3/12/24, indicated no cognitive impairment and no behaviors. A Covid 2023-2024 Booster was administered on 11/27/23. Resident 1's clinical record lacked a signed consent form for the Covid vaccine administered on 11/27/23. 2. On 4/2/24 at 9:54 A.M., Resident 15's clinical record was reviewed. Diagnosis included, but were not limited to, history of fracture and osteoarthritis. The most recent Quarterly MDS Assessment, dated 1/4/24, indicated no cognitive impairment and no behaviors. A nurses note, dated 11/9/23, indicated Resident 26 denied wanting a Covid Booster. Resident 26's clinical record lacked a signed refusal for the Covid Booster offered on 11/9/23. 3. On 4/3/24 at 9:38 A.M., Resident 3's clinical record was reviewed. Diagnosis included, but were not limited to, Multiple Sclerosis (MS). The most recent Quarterly MDS Assessment, dated 2/2/24, indicated a moderate cognitive impairment, and no behaviors. A Covid 2023-2024 Booster was administered on 11/27/23. Resident 3's clinical record lacked a signed consent for the Covid Booster administered on 11/27/23. 4. On 4/3/24 at 9:42 A.M., Resident 23's clinical record was reviewed. Diagnosis included, but were not limited to, hypertension. The most recent Quarterly MDS Assessment, dated 2/21/24, indicated a moderate cognitive impairment and no behaviors. A Covid 2023-2024 Booster was administered 11/27/23. A consent form for the Covid Booster, dated 11/2/23, indicated Resident 23's first initial and last name. The handwriting on the form matched another resident's consent form's signature. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/5/24 at 8:57 A.M., Registered Nurse (RN) 5 indicated Resident 23 was not cognitively able to provide consent for vaccines, and staff should obtain any consents from her spouse. On 4/1/24 at 1:40 P.M., a current Covid-19 Vaccine policy, dated 10/5/23, was provided and indicated Providers should counsel COVID-19 vaccine recipients, parents, or guardians about expected local and systemic reactions The policy did not indicate when to obtain consent.

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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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45933 Based on interview and record review, the facility failed to provide at least 80 square feet (sq. ft) per resident in double occupancy rooms and 100 sq. ft. in single occupancy rooms. This was evidenced in 14 of 43 resident rooms in the facility. (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER]) Findings include: During an interview on 4/1/24 at 12:04 P.M., the Administrator indicated the facility had room size waivers. At that time, a list of rooms and sizes was provided and were as follows: 1. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 2. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 3. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 4. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 5. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 6. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 7. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 8. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 9. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 10. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 11. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 12. room [ROOM NUMBER]: 2 beds with 154.65 total sq. ft. SNF/NF and 77.32 sq. ft. per resident. 13. room [ROOM NUMBER]: 1 bed with 90.52 sq. ft. per resident, SNF/NF. 14. room [ROOM NUMBER]: 1 bed with 90.52 sq. ft. per resident, SNF/NF. 3.1-19(l)(2)