STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155803	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamilton Pointe Health and Rehab	3800 Eli Place Newburgh, IN 47630

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38770 Based on observation, interview, and record review, the facility failed to ensure the privacy of residents was respected for 6 of 6 random observations and 1 of 1 insulin administrations observed. Staff did not knock on doors when entering, and left the door open when administering injections. (Resident D, Resident 45, Resident 37, Resident 6, Resident 7, Resident S, Resident 150) Findings include: 1. On 5/31/24 at 10:33 A.M., Registered Nurse (RN) 57 was observed to enter Resident 7's room without knocking. 2. On 5/31/24 at 10:35 A.M., RN 57 was observed to enter Resident S's room without knocking. 3. On 5/31/24 at 10:37 A.M., RN 57 was observed to enter Resident 150's room without knocking. 4. On 6/3/24 at 7:10 A.M., Qualified Medication Aide (QMA) 23 was observed to enter room [ROOM NUMBER] without knocking. From the hallway, QMA 23 was observed to administer two injections into Resident 45's abdomen. 5. On 6/3/24 at 7:16 A.M., QMA 23 was observed to enter Resident 37's room without knocking. 6. On 6/3/24 at 7:26 A.M., QMA 23 was observed to enter Resident D's room without knocking. 7. On 6/3/24 at 11:08 A.M., Licensed Practical Nurse (LPN) 19 was observed to administer an insulin injection to Resident 6. LPN 19 entered the room, raised the resident's shirt, and administered the insulin into the right side of the abdomen. LPN 19 did not shut the door or offer to shut the door, and did not pull the curtain. On 6/5/24 at 8:15 A.M., RN 31 indicated staff should provide privacy for residents by closing the door and/or shutting the curtains when administering injections. Staff should also knock on the door and announce who they are when entering the rooms. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/24 at 12:09 P.M., the Director of Nursing (DON) indicated there was not a formal policy for privacy, but provided a current non-dated Nurse Aide Procedure check-off form that indicated Knock and identify yourself before entering the resident's room. Wait for permission to enter the resident's room . Maintains resident's right to privacy . Close curtains, drapes, and doors . Maintains resident's right to privacy and dignity 3.1-3(a)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. 38770 Based on observation, interview, and record review, the facility failed to ensure residents who self administered medications were assessed for ability to self administer those medications for 4 of 4 random observations. Medications were observed in rooms where the resident lacked a self administration of medication assessment. (Resident 7, Resident S, Resident 150, Resident 6) Findings include: 1. On 5/30/24 at 9:39 A.M., Resident 7 was observed lying in bed with a box of throat lozenges lying at the foot of the bed. The box had a pharmacy label with the resident's name on it. On 5/31/24 at 9:41 A.M., Resident 7's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, depression, and psychotic disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/7/24, indicated a moderate cognitive impairment, and verbal behaviors directed toward others. Resident 7 required substantial to maximum assistance with transfers and bathing, and partial to moderate assistance with bed mobility. Current physician orders included, but were not limited to: Cepacol Sore Throat Mouth/Throat Lozenge (Menthol (Mouth-Throat)) Give 1 lozenge by mouth every hour as needed for for sore throat, dated 5/12/24. Resident 7 lacked an order related to having medications in room, or self administration of medications. Resident 7's clinical record lacked care plans related to having medications in room, or self administration of medications. Resident 7's clinical record lacked a self administration of medication assessment. On 5/31/24 at 10:33 A.M., Registered Nurse (RN) 57 was observed to enter Resident 7's room and identified the box of throat lozenges on the resident's bed as belonging to the resident. RN 57 indicated an order would have been needed to have the box in the room, left them in the room, and exited. At that time, RN 57 indicated he assumed Resident 7's morning medications had been found in the room as well, because that morning the resident had refused to take them, and RN 57 indicated he left them in the room for the resident to take when she wanted to. 2. On 5/30/24 at 9:11 A.M., Resident S's room was observed with a bottle of fluticasone propionate (nasal spray) on the nightstand, with a label that indicated it belonged to Resident S. On 5/31/24 at 9:07 A.M., Resident S's clinical record was reviewed. Diagnosis included, but were not limited to, renal failure. The most recent Admission MDS (Minimum Data Set) Assessment, dated 4/1/24, indicated no cognitive impairment, and no behaviors. Resident S required partial to moderate assistance with bathing and bed mobility, and substantial to maximal assistance with toileting and transfers. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/31/24 at 10:08 A.M., Resident S's room was observed with the bottle of nasal spray on the nightstand. Current physician orders included, but were not limited to: Fluticasone Propionate Nasal Suspension, 1 spray alternating nostrils one time a day for allergies, dated 5/21/24. Resident 46 lacked an order related to having medications in room, or self administration of medications. Resident S's clinical record lacked care plans related to having medications in room, or self administration of medications. Resident S's clinical record lacked a self administration of medication assessment. On 5/31/24 at 10:35 A.M., RN 57 indicated Resident S had an order to have the nasal spray in her room on a previous admission, but was unsure if there was a current order or not. At that time, RN 57 was observed to enter Resident S's room and acknowledge the nasal spray at bedside. RN 57 left the room, leaving the nasal spray. 3. On 5/30/24 at 10:16 A.M., Resident 150 was observed sitting in his room. On the nightstand an inhaler for spiolto respimat was observed. No label was observed on the inhaler. At that time, Resident 150 indicated he used the inhaler every morning. On 5/31/24 at 10:59 A.M., Resident 150's clinical record was reviewed. Diagnosis included, but were not limited to, shortness of breath and wheezing. The most recent Admission MDS (Minimum Data Set) Assessment, dated 5/23/24, indicated no cognitive impairment and no behaviors. Current physician orders included, but were not limited to: Acetaminophen (Tylenol) Oral Tablet (Acetaminophen) 650 mg (milligrams) by mouth every 6 hours as needed for pain dated 5/21/24. Resident 150's clinical record lacked a current order for a spiolto respimat inhaler. On 5/31/24 at 11:37 A.M., RN 57 was observed to enter Resident 150's room and located the spiolto respimat inhaler on the bed, and a bottle of unlabeled Tylenol in the nightstand drawer. At that time, RN 57 indicated the resident would have needed a self administration order to have the medications in his room, and was unsure if there was one. RN 57 left the room, leaving the medications in the room. Resident 150 lacked an order related to having medications in room, or self administration of medications. Resident 150's clinical record lacked care plans related to having medications in room, or self administration of medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 150's clinical record lacked a self administration of medication assessment. On 5/31/24 at 10:29 A.M., the Unit Manager indicated she was unsure what the policy was for medications in resident rooms, but would expect the staff to take them out of the rooms if observed. She indicated normally, the resident would have an order and assessment to self administer medications, and an order to keep at bedside. 48147 4. On 5/29/24 at 2:39 P.M., 2 2-oz (ounce) bottles of glucose shots were observed on Resident 6's bedside table. Resident 6 indicated she took the glucose shots when she felt like her blood sugar was low. On 5/30/24 at 2:24 P.M., 2 2-oz bottles of glucose shots were observed on Resident 6's bedside table. On 6/3/24 at 10:14 A.M., 2 2-oz bottles of glucose shots were observed on Resident 6's bedside table. On 5/30/24 at 2:31 P.M., Resident 6's clinical record was reviewed. Diagnosis included, but was not limited to, type 2 Diabetes Mellitus. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/28/24, indicated Resident 6 was cognitively intact, required setup assistance for eating, and received a hypoglycemic medication during the 7-day lookback period. Physician orders included, but were not limited to: Glucose Oral Solution (Glucose) - Give 30 ml (milliliters) by mouth every 8 hours as needed for blood glucose <70 may have up to three times daily, dated 2/1/24. The clinical record lacked a self-administration of medication evaluation. On 6/4/24 at 8:26 A.M., LPN (Licensed Practical Nurse) 19 indicated Resident 6 did not have a self-administration of medication order or evaluation for the glucose shots. On 6/4/24 at 2:54 P.M., the Regional Clinical Nurse indicated there was no self-administration of medication evaluation in Resident 6's clinical record. On 5/31/24 at 11:44 A.M., RN (Registered Nurse) 35 provided a current Resident Self-Administration of Medication policy, dated 11/1/23, that indicated A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely . The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record . The care plan must reflect resident self-administration and storage arrangements . 3.1-11(a)

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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** 48147 Based on interview and record review, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 2 of 5 residents reviewed for unnecessary medications. (Resident 6, Resident 7) Findings include: 1. On 5/30/24 at 2:31 P.M., Resident 6's clinical record was reviewed. Diagnosis included, but was not limited to, malignant neoplasm of descending colon. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/28/24, indicated Resident 6 was cognitively intact and did not receive an opioid during the 7-day lookback period. Physician orders included, but were not limited to: fentanyl (an opioid medication) patch 12 MCG/HR (micrograms per hour) - Apply 1 patch transdermally every 72 hours for pain and remove per schedule, dated 11/3/23. oxycodone-acetaminophen (an opioid medication) tablet 5-325 MG (milligrams) - Give 1 tablet by mouth three times a day for pain and give 1 tablet by mouth as needed for pain may have up to two additional doses daily. PRN (as needed) dose may not be within 2 hours of last routine dose, dated 1/12/24 and discontinued on 4/29/24. The April 2024 MAR (Medication Administration Record) indicated Resident 6 received oxycodone-acetaminophen three times daily on April 22, 23, 24, 25, 26, and 28 and two times on April 27. The April 2024 MAR indicated Resident 6 had a fentanyl patch placed on April 22, 25, and 28. On 6/4/24 at 1:11 P.M., MDS Coordinator 15 indicated that Resident 6's MDS dated [DATE] should have indicated the resident received opioids during the 7-day lookback period. On 6/4/24 at 1:11 P.M., MDS Coordinator 15 indicated the facility followed the RAI (Resident Assessment Instrument) Manual for guidance in coding MDS Assessments. 38770 2. On 5/31/24 at 9:41 A.M., Resident 7's clinical record was reviewed. Diagnosis included, but were not limited to, history of CVA (cerebrovascular accident). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/7/24, indicated a moderate cognitive impairment. Resident 7 was marked as not receiving an antiplatelet medication. Current physician orders included, but were not limited to: clopidogrel bisulfate (an antiplatelet) tablet 75 mg (milligram), give 1 tablet by mouth one time a day for preventative, history of CVA, dated 1/25/24 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 7's MAR (Medication Administration Record) for May 2024 indicated clopidogrel was administered in the 7-day look back period for the 5/7/24 Quarterly MDS Assessment. On 6/5/24 at 11:22 A.M., MDS Coordinator 89 indicated Resident 7's MDS on 5/7/24 was marked in error and should have indicated the resident received an antiplatelet. She indicated at that time that there was not a facility policy for MDS Assessments, and that the policy was to follow the RAI (Resident Assessment Instrument) manual.

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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. 48057 Based on interview and record review, the facility failed to ensure physician orders were followed for 2 of 2 residents reviewed for nutrition. (Resident 55 and Resident S) Findings include: 1. On 5/31/24 at 12:22 P.M., Resident 55's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and epilepsy. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/18/24, indicated Resident 55 was moderately cognitively intact, required setup assistance from staff for eating, had a feeding tube, had an unplanned weight loss, and was receiving a mechanically altered diet. Physician orders included, but were not limited to: Weekly weights for trending weight loss one time a day every Saturday for trending weight loss, dated 2/17/24. 2-Cal HN (liquid nutritional supplement) 300 mL (milliliters) bolus (administer full amount at once) four times a day, dated 5/23/24- current. 2-Cal HN 300 mL bolus four times a day, dated 5/2/24-5/23/24. Jevity 1.5 (liquid nutritional supplement) 300 mL bolus feeding four times a day before meals and at bedtime, dated 4/15/24-5/1/24. Jevity 1.5 (liquid nutritional supplement) 300 mL bolus feeding four times a day before meals and at bedtime, dated 2/29/24-4/15/24. Jevity one carton (237 mL) bolus feeding four times daily before meals and at bedtime, dated 7/27/23-2/29/24. Recorded weights for the last six months, that indicated a weight loss greater than 10% (10.65%), included: 12/1/23 124 pounds 6/2/24 110.8 pounds The following dates and times indicated the physician order for nutritional supplement was not administered during the last six months, and did not include a descriptive reasoning for the missed administration of nutritional supplement: 2/23/24 9 P.M. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/27/24 9 P.M. 3/3/24 9 P.M. 3/30/24 9 P.M. 4/3/24 9 P.M. 4/4/24 11 A.M. 4/13/24 9 P.M. 4/14/24 9 P.M. 4/15/24 11 A.M. 4/22/24 11 A.M., 5 P.M. 4/26/24 11 A.M. 5/7/24 bedtime 5/13/24 bedtime 5/20/24 bedtime 5/27/24 9 P.M. 6/4/24 1 P.M. On 6/5/24 at 1:12 P.M., the Director of Nursing provided a current policy titled Following Physician Orders, revised 4/24, and indicated Licensed healthcare personnel will consult and follow the physician/clinician order when performing any resident procedures. 38770 2. On 5/31/24 at 9:07 A.M., Resident S's clinical record was reviewed. Diagnosis included, but were not limited to, renal failure. The most recent Admission MDS (Minimum Data Set) Assessment, dated 4/1/24, indicated no cognitive impairment, and no behaviors. Resident S was receiving a therapeutic diet with no weight loss or gain. Current physician orders included, but were not limited to: Obtain weight daily **before dialysis** one time a day, notify physician of gain of more than 3 pounds in a day or 5 pounds in a week, dated 5/23/24. Discontinued physician orders included, but were not limited to: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain weight daily, one time a day, notify physician of gain of more than 3 pounds in a day or 5 pounds in a week, dated 5/22/24 through 5/22/24. Obtain weight daily, one time a day, notify physician of gain of more than 3 pounds in a day or 5 pounds in a week, dated 5/21/24 through 5/21/24. Obtain weight daily x 3 days, every day shift for 3 days, dated 5/21/24. Obtain weight daily in AM, one time a day, notify physician of gain of more than 3 pounds in 24 hours or > 5 pounds in 72 hours., dated 5/1/24 through 5/14/24. Obtain weight daily, one time a day, dated 4/30/24 through 4/30/24. Obtain weight one time a day, notify physician of gain of more than 3 pounds in 24 hours or 5 pounds in 72 hours, dated 4/27/24 through 4/29/24. Obtain weight every AM, one time a day, notify physician of gain of more than 3 pounds in 24 hours or 5 pounds in 72 hours, dated 4/7/24 through 4/24/24. Obtain weight one time a day, notify physician of gain of more than 3 pounds in 24 hours or 5 pounds in 72 hours, dated 3/29/24 through 4/6/24. A current dialysis care plan, initiated 5/21/24, included, but was not limited to, an intervention to weigh and get vital signs as ordered and as needed, also dated 5/21/24. Resident S was not in the facility on the following dates: 4/2/24 4/21/24 through 4/26/24 5/14/24 through 5/20/24 Resident S's clinical record lacked weights on the following dates from 3/28/24 through 5/31/24: 3/29/24 3/30/24 (recorded as 128.8, then crossed out 4/2/24 as error) 4/1/24 4/3/24 4/6/24 4/7/24 (recorded as 105.2, then crossed out 4/11/24 as re-weighed. No re-weigh documented) 4/8/24 (recorded as 104.8, then crossed out 4/11/24 as re-weighed. No re-weigh documented) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/12/24 4/16/24 4/18/24 (recorded as 122.2, then crossed out 5/9/24 as re-weighed. No re-weigh documented) 4/27/24 4/28/24 4/29/24 5/1/24 5/2/24 5/5/24 (recorded as 109.4, then crossed out 5/9/24 as re-weighed. No re-weigh documented) 5/7/24 5/8/24 5/9/24 5/13/24 5/25/24 5/26/24 (marked as n/a) 5/27/24 5/31/24 On 6/5/24 at 8:00 A.M., the Unit Manager indicated the dietician must have deleted Resident S's weights on 4/18/24 and 5/5/24 because those weights didn't match what the surrounding days had been. She indicated staff would discuss weights at morning meeting, and mark out the weights that were obtained that did not seem normal for that resident. On 6/5/24 at 11:05 A.M., the Director of Nursing (DON) indicated there was not a formal policy for following orders or care plans, but staff should be following interventions and orders as ordered. 3.1-35(b)(1)

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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** 48057 Based on interview and record review, the facility failed to provide care by thorough assessment of a resident prior to narcotic medication administration and implementation of a person centered care plan for the use of narcotics, and a care plan that reflected accurate resuscitative measures for 1 of 2 residents reviewed for expiration in the facility. (Resident P) Findings include: On [DATE] at 9:15 A.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, asthma and atrial fibrillation. The most recent quarterly MDS (Minimum Data Set) Assessment, dated [DATE], indicated Resident P was cognitively intact and was receiving opioid pain medication during the seven day lookback period. Physician orders included, but were not limited to: Do not resuscitate, dated [DATE]. Observe for side effects (Narcotic pain medication), dated [DATE]. Ipratropium-albuterol (medication to improve breathing) inhalation solution 0XXX,d+[DATE].5(3) mg/mL (milligram per milliter) one inhalation inhale orally every eight hours as needed, dated [DATE]. Norco (opioid pain medication) oral tablet ,d+[DATE] mg (Hydrocodone-Acetaminophen) Give one tablet by mouth three times a day for pain hold for sedation, dated [DATE]. Norco oral tablet ,d+[DATE] mg (Hydrocodone-Acetaminophen) Give one tablet by mouth every four hours as needed for pain, dated [DATE]. Resident P's clinical record included a signed document Titled Indiana Physician Orders for Scope of Treatment (POST), dated [DATE], and indicated Medical Interventions Comfort Measures (Allow Natural Death). Care plans included, but were not limited to: I have elected to be a full code, dated [DATE]. I have chronic breathing problems related to asthma; observe for increased shortness of breath, difficulty breathing, change in mental status , dated [DATE]. The clinical record lacked a care plan relating to narcotic pain medications and potential adverse side effects to monitor. On [DATE] at 9:15 A.M., Resident P's medication administration record was reviewed. Resident P narcotic sheet indicated on [DATE] Norco ,d+[DATE] mg was given at 6:35 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M., and 8:00 P.M. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated [DATE] at 5:16 P.M., indicated Resident was given a breathing treatment and oxygen saturation level had come back to 89% on 2L (liters). A progress note dated [DATE] at 6 P.M., indicated Resident P's family member had notified staff of the resident's symptoms. Vitals checked and oxygen saturation dropped to 68%. Resident was placed on 2L oxygen by nasal cannula. Resident declined going to the hospital. Staff set an acute visit for the following day. A progress note dated [DATE] at 7:17 P.M., indicated LPN 45 took bedtime medications to Resident P, and resident was unable to rouse or swallow medications. EMS and family were called, the Physician was notified through Telemedic. Ambulance arrived followed by the Fire Department. Blood glucose level had dropped, and an intravenous line was started by EMS in Resident P's left shin bone. At 8:08 P.M., Resident P stopped breathing. CPR (cardio-resuscitation) was not started. On [DATE] at 8:43 A.M., LPN 45 stated Resident P's oxygen level was at 68% prior to the breathing treatment of albuterol administered on [DATE] at 5:16 P.M. The Norco ,d+[DATE] tablet was signed out at 8:00 P.M., but should have been signed out at 7:17 P.M. with the other bedtime medications; Resident did not take any of the bedtime medications due to inability to swallow, the medications rolled out when a spoonful was placed in Resident P's mouth. Prior to 7:17 P.M., Resident P was completely alert and oriented, and having a full conversation. Resident P had no adverse signs, symptoms, or side effects other than nausea and respiratory changes. EMS (emergency medical services) and fire department arrived at the facility quickly; LPN 45 indicated she was not sure what Resident P's blood sugar was when EMS checked it, Resident was not a regular blood sugar check and did not receive insulin. Nurse indicated she probably should have revised charting and struck out the medications out for the eMAR (electronic medication administration record) to reflect the resident not taking the medications, but it was a chaotic night and staff were doing their best to get everyone caught up and the rest of the resident's taken care of. During an interview on [DATE] at 10:22 A.M., Regional Clinical Nurse 9 indicated in order for a nurse to recognize respiratory distress, it would have to be more than just low oxygen levels, and the resident did not have an order for oxygen but staff can administer oxygen in emergent situations without an order. During an interview on [DATE] at 11:38 A.M., Regional Clinical Nurse 9 indicated the care plan that indicated Resident P was a full code was inaccurate and should have indicated do not resuscitate, there was not a care plan related to pain medication side effects, and the facility did not have a policy relating to monitoring adverse side effects of narcotic pain medications. This citation relates to complaint IN00435563. 3XXX,d+[DATE](a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on observation, interview, and record review, the facility failed to ensure post fall assessments were completed and care plans were updated to prevent falls for 2 of 4 residents reviewed for accidents. (Resident 40, Resident 83) Findings include: 1. On 5/30/24 at 2:18 P.M., Resident 40 was observed in bed. There was one set of non-skid strips near her bed. On 5/30/24 at 1:26 P.M., Resident 40's clinical record was reviewed. Diagnoses included, but were not limited to, vascular dementia, fracture of fifth metacarpal bone right hand, and history of falling. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/16/24, indicated Resident 40 had moderate cognitive impairment, required supervision of staff for sit to stand transfers and toileting, partial to moderate assistance of staff for bathing, and had one fall with no injury since the prior assessment. A fall risk assessment, dated 3/15/24, indicated Resident 40 was at low risk for falls. A current falls care plan, revised 1/22/24, indicated the resident was at risk for falls. The interventions included, but were not limited to: I am going to wear proper footwear or non-slip footwear when I am up, dated 4/2/21 The clinical record indicated Resident 40 fell 7 times since 9/27/24. Fall 1 9/24/23 at 8:20 P.M. Fall was not witnessed. The resident indicated she fell while trying to transfer from the toilet to her chair. The resident had 3 small skin tears to her right lower extremity. Neurological assessments were completed. Intervention medication review and therapy referral was added to the care plan on 9/28/23. Fall 2 9/28/23 at 1:45 P.M. Fall was witnessed. The resident indicated she was picking something up off the floor. Intervention Give resident a reacher to retrieve things on the floor was added to the care plan on 9/29/23. Fall 3 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/23/23 at 7:45 A.M. Fall was unwitnessed. The resident indicated she lost her balance after using the toilet. Neurological assessments were completed. Intervention call don't fall sign placed in room was added to the care plan on 12/26/23. Fall 4 1/10/24 at 3:20 P.M. Fall was witnessed. The resident was attempting to self-transfer between her bed and her wheelchair. Intervention add non-skid strips next to bed was added to the care plan on 1/11/24. Fall 5 1/19/24 at 12:30 P.M. Fall was unwitnessed. The resident was attempting to self-transfer from her bed to her wheelchair. The resident broke her glasses in the fall and sustained a laceration to her right eye. The NP (Nurse Practitioner) was notified, and the resident was sent to the emergency room (ER) where she received sutures to her right eye and a fracture to her fifth metacarpal was identified. The resident returned to the facility at 7:29 P.M. on 1/19/24. Intervention Assist resident up in her wheelchair and down to the dining room for meals was added to the care plan on 1/22/24. Fall 6 2/6/24 at 4:00 P.M. Fall was witnessed. The resident indicated she fell while attempting to sit on her bed. Intervention New gripper socks added, add additional non-skid strips next to bed was added to the care plan on 2/7/24. Fall 7 5/9/24 at 12:35 P.M. Fall was unwitnessed. The resident attempted to self-transfer from her wheelchair to the toilet. Neurological assessments were incomplete. No neurological assessments were documented after 5/10/24 at 4:15 A.M. Intervention add cushion to secure to wheelchair with buckle/strap was added to the care plan on 5/10/24. 2. On 6/3/24 at 8:58 A.M., Resident 83's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side and muscle weakness. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 4/22/24, indicated Resident 83 had moderate cognitive impairment, required supervision for sit to stand transfers and partial to moderate assistance of staff for toileting and bathing, and had no falls since re-entry to the facility. A re-entry falls assessment, dated 4/15/24, indicated the resident was at high risk for falls. A falls care plan, revised 4/15/24, indicated the resident was at risk for falls related to weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes indicated the resident fell on [DATE] at 3:30 P.M. Fall was unwitnessed. The resident was found on the floor in his room with his head cupped in hand. The resident indicated he was attempting to go to the bathroom. A neurological assessment was completed on 4/12/24 at 3:30 P.M. and on 4/13/24 at 12:04 A.M. No other neurological assessments were documented. Intervention Add cupholder to wheelchair was added to the care plan on 4/15/24. Progress notes indicated the resident fell on [DATE] at 2:15 A.M. Fall was unwitnessed. The resident indicated he was attempting to go to the bathroom. No apparent injury was noted. The resident was sent to the emergency room (ER) for evaluation at 3:23 A.M. No neurological assessments were documented. An Interdisciplinary Team (IDT) note, dated 4/15/24 at 8:52 A.M., indicated the resident would be reassessed upon return from the hospital. A new intervention was not added to the care plan. On 6/4/24 at 9:20 A.M., the Director of Nursing (DON) indicated that when a resident fell , they were assessed for injuries and the risk management tool was filled out. Neurological assessments were completed per policy for any unwitnessed falls or suspected head injuries and documented in the electronic medical record (EMR). Staff could write their neurological assessments on paper, but then should transfer them into the EMR. IDT would review the fall and update the care plan with a new and relevant intervention after every fall. On 6/4/24 at 10:29 A.M., Medical Records employee provided a current Fall Investigation and Risk Evaluation policy, revised 6/22, that indicated Neuro checks if the fall was unwitnessed or an injury to the head is suspected or observed . Update the care plan with new intervention(s) . On 6/4/24 at 1:46 P.M., the DON provided a current Neurological Assessment Protocol policy, revised 12/21, that indicated Neurological assessments should be performed as follows for a 72 hour period: every 15 minutes x4, every 30 minutes x2, every 1 hour x2, every 4 hours x1, every 8 hours x8. 3.1-45(a)(2)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38770 Based on observation, interview, and record review, the facility failed to ensure pain management consistent with professional standards of practice, care plans, and the resident's goals and preferences were provided for 2 of 2 residents reviewed for pain management. A resident was not monitored for side effects of narcotic pain medication resulting in an overdose, pain medication was not given as prescribed, and a resident's preference for non-pharmacological pain relief was not honored. (Resident T, Resident 6) Findings include: 1. On 5/30/24 at 9:52 A.M., Resident T indicated she had arthritis and gout, and was in constant pain. She indicated she received medications for pain, but it did not help much. On 5/31/24 at 9:46 A.M., Resident T's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and leg pain. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/5/24, indicated no cognitive impairment, and no behaviors. Resident T required supervision with bed mobility and toileting, and partial to moderate assistance with bathing. Resident T received scheduled pain medications, and had experienced occasional moderate pain for the previous five days. Physician orders included, but were not limited to: Norco (Hydrocodone-Acetaminophen) (a narcotic pain medication) 10-325mg (milligram), give 1 tablet 5 times a day for pain, with instructions to use 5mg until the 10mg arrive, started 9/14/23 and discontinued 11/1/23. Norco 10-325mg, give 1 tablet 5 times a day for pain, with instructions to discontinue Norco 10mg when supply complete, started 11/1/24 and discontinued 11/2/23. Norco 5-325mg, give 2 tablets by mouth 5 times a day, with instructions to discontinue Norco 10/325 order when this supply completed, new order entered for 5/325 2 tabs 5 times a day, started 11/2/23 and discontinued 11/2/23. Norco 5-325mg, give 2 tablets by mouth 5 times a day, started 11/2/23 and discontinued 12/25/23. Norco 5-325mg, give 2 tablets by mouth 5 times a day, started 12/30/23 and discontinued 1/1/24. Norco 5-325mg, give 2 tablets as needed for pain 5 times a day, started 1/6/24 and discontinued 1/9/24. Norco 5-325mg, give 1 tablet as needed for pain 5 times a day, started 1/9/24 and discontinued 1/22/24. Norco 5-325mg every 12 hours as needed for pain, started 2/9/24 and discontinued 3/18/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxycodone (a narcotic pain medication) 5mg, give 1 tablet by mouth every 6 hours as needed for pain, started 3/28/24 and discontinued 4/22/24. Oxycodone 5mg, give 1 tablet every 4 hours as needed for pain, started 4/24/24 and discontinued 5/5/24. Oxycodone 5mg, give 1 tablet every 4 hours as needed for pain, started 5/12/24 and discontinued 5/15/24. Oxycodone 5mg, give 1 tablet by mouth every 4 hours as needed for pain, started 5/18/24 and currently an active physician order. Observe for side effects of narcotic pain medication every 12 hours for pain, dated 5/20/24. The original order for narcotic monitoring was dated 1/5/24. Resident T's MAR (Medication Administration Record) indicated when Norco 5-325mg was ordered to be given five times a day, it was to be given at 2:00 A.M., 9:00 A.M., 1:00 P.M., 5:00 P.M., and 9:00 P.M. A current risk for pain care plan, dated 7/7/21 and revised 6/19/23, indicated pain medication would be administered as ordered and requested, dated 7/7/21. A current opioid medication care plan, dated 11/14/22, indicated but was not limited to, the following interventions: To receive medication as prescribed, dated 11/14/22. Adequately monitor dose, duration and indication of use, dated 11/14/22. Assess pain, dated 11/14/22. Quarterly pain evaluations from 11/2023 through current included, but were not limited to, the following: 12/21/23 The evaluation was not complete. 1/5/24 The evaluation was not complete. 5/12/24 The evaluation was not complete. On 12/30/24, Resident T was sent to the hospital following an episode of altered mental status per family request. In the emergency room , the resident was minimally responsive to painful stimuli, and kept falling asleep. Because the resident was not able to protect her airway, she was intubated. The resident was administered Narcan (an opiate blocker) and rapidly improved, awoke and was communicating meaningfully. The resident was then admitted to the hospital on an infusion of Narcan. The admitting diagnosis was unintentional narcotic overdose and recent COVID infection, and the resident discharged back to the the facility on 1/5/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Narcotic sign out forms for Norco 5-325mg from 11/2023 to current were reviewed with the following dates and times one tablet was retrieved when the physician order was for two tablets: 11/11/23 at 2:00 A.M. 11/11/23 at 3:00 P.M. 11/11/23 at 8:00 P.M. 11/12/23 (unreadable time) 11/12/23 at 5:00 P.M. 11/12/23 at 8:00 P.M. 11/17/23 at 8:00 A.M. 11/17/23 at 1:00 P.M. 11/24/23 at 9:00 P.M. 12/23/23 at 8:00 A.M. Resident 31's clinical record lacked a reason why one tablet was given rather than the two tablets that were ordered. Narcotic sign out forms for Norco 5-325mg from 11/2023 to current included the following dates and times two tablets were retrieved when the physician order was for one tablet: 1/9/24 at 8:00 P.M. 1/15/24 (unreadable time) 1/16/24 at 8:00 P.M. 1/17/24 (unreadable time) 1/18/24 at 7:43 P.M. The Norco sign out forms indicated the following doses that were given within 2.5 hours of each other: 11/23/23 at 5:30 P.M. then again on 11/23/23 at 8:00 P.M. (two 5mg tablets with each administration). 11/30/23 at 10:30 A.M. then again on 11/30/23 at 1:00 P.M. (two 5mg tablets with each administration). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 2:06 P.M., the Director of Nursing (DON) indicated Resident T should have been monitored for narcotic side effects prior to the hospitalization on [DATE], but the monitoring was put into place in 1/2024. He further indicated he was unsure why staff was only giving Resident T one tablet of Norco when two were ordered. On 6/5/24 at 11:05 A.M., the DON indicated the facility did not have a policy specific to following orders, but the policy would be to follow physician orders. On 6/4/24 at 2:21 P.M., a current Medication Administration policy, dated 2/1/18, was provided and indicated Follow the six (6) rights of medication administration . right dose . right time . right documentation Medication(s) are to be administered no sooner than sixty (60) minutes prior and no later than sixty (60) minutes after scheduled time On 6/5/24 at 12:09 P.M., a current Medication Monitoring policy, dated 11/1/23, was provided and indicated This facility takes a collaborative, systematic approach to medication management, including the monitoring of medications for efficacy and adverse consequences. 48147 2. On 5/29/24 at 2:50 P.M., Resident 6 indicated she was in constant pain and took pain medication, but the facility would not let her have a heat pad or offer her an alternative like a warm washcloth or rice pack. A heat pad was what she used at home to help with arthritis pain, and it worked better than the pills for that pain. On 5/30/24 at 2:31 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of descending colon, anxiety disorder, and depression. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/28/24, indicated Resident 6 was cognitively intact, required setup assistance for eating, received scheduled and PRN (as needed) pain medication, and had no behaviors. A current opioid medication care plan, dated 4/12/24, included an intervention to participate in non-pharmacological approaches to pain reduction. A current acute pain care plan, dated 11/1/23, indicated the resident had all over pain complaints. Physician orders included, but were not limited to: fentanyl (an opioid pain medication) patch 12 MCG/HR (micrograms per hour) - Apply 1 patch transdermally every 72 hours for pain and remove per schedule, dated 11/3/23 Oxycodone-acetaminophen tablet 5-325 MG (milligrams) - Give 1 tablet by mouth three times a day for pain and give 1 tablet by mouth as needed for pain may have up to two additional doses daily. PRN dose may not be within 2 hours of last routine dose, dated 4/29/24 The most recent quarterly pain evaluation assessment, dated 5/1/24, indicated Resident 6 had pain at a level 5 (on a 1 to 10 pain scale). The assessment included a section to indicate methods of preferred pain relief, but it had not been completed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A behavior note, dated 5/22/23, indicated that staff had taken a heating pad away from the resident and reminded her that she had been told many times that she could not have a heating pad in her room. A progress note, dated 6/6/23 at 10:47 A.M., indicated the resident stated she had pain constantly. A progress note, dated 12/18/23 at 3:24 P.M., indicated the resident stated she had pain and the pain medication she was receiving was not enough. On 6/4/24 at 8:26 A.M., LPN (Licensed Practical Nurse) 19 indicated that Resident 6 received routine and PRN pain medication as well as a pain patch. The resident did not receive non-pharmacological pain interventions. She further indicated that therapy could provide thermal heat, but the resident would need a referral to therapy to be evaluated for that. On 6/4/24 at 11:04 A.M., the Therapy Supervisor indicated Resident 6 had been seen by therapy from May to June of 2023 where she was evaluated for hot and cold therapy and it was provided. She indicated that once residents are discharged from the therapy caseload, nurses can come get thermal pads with covers from therapy to use as long as there was a nursing order for it. On 6/4/24 at 11:10 A.M., RN (Registered Nurse) 35 indicated a resident needed a physician order for heat. On 6/5/24 at 9:01 A.M., the ADON (Assistant Director of Nursing) indicated there was no policy for heat use in therapy or as a non-pharmacological pain relief. Heating devices were not allowed in resident rooms because residents could get burned. Staff could use a washcloth heated with faucet water. Otherwise, the resident got referred to therapy. She was unsure how a resident could continue to receive heat as pain relief once discharged from the therapy caseload. She further indicated she would place a referral for Resident 6 to be evaluated by therapy for heat treatment. On 6/4/24 at 10:29 A.M., Medical Records employee provided a current Pain Management policy, dated 11/28/23, that indicated Non-pharmacological interventions will include but are not limited to .physical modalities (e.g. cold compress, warm shower/bath .). 3.1-37(a)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46758 Based on observation, record review, and interview, the facility failed to ensure accurately completed staff sheets were posted daily for 6 of 7 days during the survey. (5/28, 5/29, 5/30, 5/31, 6/3, 6/4) Findings include: On 5/28/24 at 2:08 P.M., a posted staffing sheet was observed sitting on a table across from the nurse's station. The sheet included, but was not limited to, the following information: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Assistant) Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for each shift. The sheet lacked a designation of actual shift hours worked for the part of the shift for LPN and CNA's 2 P.M. to 10 P.M. On 5/29/24 at 8:10 A.M., a posted staffing sheet was observed sitting on a table across from the nurse's station, The sheet included, but was not limited to, the following information: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse) and CNA (Certified Nursing Assistant). Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for each shift The sheet lacked a designation of actual shift hours worked for the part of the shift for CNA from 2:00 P.M. to 10:00 P.M. On 5/30/24 at 8:00 A.M., a posted staffing sheet was observed sitting on a table across from the nurse's station. The sheet included, but was not limited to, the following information: Shift hours for RN, LPN and CNA Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Actual hours worked of RN, LPN, and CNA for each shift The sheet lacked a designation of actual shift hours worked for the part of the shifts worked by RN from 6 A. M. to 2:00 P.M. and RN and CNA's for 2 P.M. to 10 P.M. On 5/31/24 at 8:05 A.M., a posted staffing sheet was observed sitting on a table across from the nurse's station. The sheet included, but was not limited to, the following information: Shift hours for RN, LPN and CNA Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for each shift The sheet lacked a designation of actual shift hours worked for the part of the shifts worked by CNA's from 2 P.M. to 10 P.M. On 6/3/24 at 8:05 A.M., a posted staffing sheet was observed sitting on a table across from the nurse's station. The sheet included, but was not limited to, the following information: Shift hours for RN, LPN and CNA. Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for each shift The sheet lacked a designation of actual shift hours worked for the part of the shifts worked by LPN's from 2 P.M. to 10 P.M. and CNA's 2 P.M. and 10 P.M. On 6/4/24 at 8:30 A.M., a posted staffing sheet was observed sitting on a table across from the nurse's station. The sheet included, but was not limited to, the following information: Shift hours for RN, LPN and CNA. Number of RN, LPN, and CNA for each shift Scheduled hours to work of RN, LPN, and CNA for each shift Actual hours worked of RN, LPN, and CNA for each shift The sheet lacked a designation of actual shift hours worked for the part of the shifts worked by LPN's on 2 P. M. to 10 P.M. and 6:00 A.M. and 6:00 P.M. and CNA's 2 P.M. and 10 P.M. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	On 6/4/24 at 1:30 P.M., the DON (Director of Nursing) presented the posted staffing sheets for 5/28, 5/29, 5/30, 5/31, 6/3, and 6/4/24. During an interview on 6/5/24 at 10:55 A.M., the DON indicated they were unaware of the making a designation of the actual hours worked of the half shifts posted on staffing sheets. On 6/5/24 at 11:04 A.M., the DON presented a current policy Posting Direct Care Daily Staffing Numbers revised 10/22. The policy indicated the facility will post on a daily basis prior to each shift, the number of nursing personnel responsible for providing direct care to the resident. The following information will be posted .the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift .

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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. 38770 Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of greater than 5 percent (%) for 2 of 3 residents (Resident 6, Resident 17) observed during medication pass. Three medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 12%. Findings include: 1. On 6/3/24 at 6:50 A.M., LPN 19 was observed to administer medications to Resident 17. LPN 19 put two chewable tablets of calcium carbonate 500mg (milligram) into the same medication cup as the other medications, and administered them all to the resident to swallow them. LPN 19 then removed a patch from the resident's back with bare hands, and applied a new patch (rivastigmine 4.6/24) also with bare hands. On 6/5/24 at 10:10 A.M., Resident 17's clinical record was reviewed. Diagnosis included, but were not limited to, dementia. Current physician orders included, but were not limited to: Calcium Carbonate tablet chewable 500mg, give 2 tablets by mouth one time a day, dated 11/3/23. Rivastigmime patch 24 hour 4.6/24, apply 1 patch transdermally one time a day, dated 1/30/24. 2. On 6/3/24 at 11:15 A.M., Licensed Practical Nurse (LPN) 19 was observed to administer an insulin injection for Resident 6. LPN 19 drew up 9U (units) of Admelog, went into the resident's room, and administered the injection into the right side of the abdomen. LPN 19 did not keep the needle in the skin for any length of time. Resident 6's clinical record was reviewed on 6/5/24 at 10:20 A.M. Diagnosis included, but were not limited to, diabetes. Current physician orders included, but were not limited to: Admelog injection solution, 8 units subcutaneously before meals for diabetes, dated 3/29/24. Admelog injection solution, inject as per sliding scale, dated 3/29/24. On 6/5/24 at 8:15 A.M., Registered Nurse (RN) 31 indicated insulin should be administered into the skin, waiting a few seconds before pulling the needle out to allow for absorption, and staff should wear gloves when taking off and administering medication patches. She further indicated staff should give chewable tablets separate from other oral pills so the resident can chew them as they should not be swallowed. On 6/4/24 at 2:21 P.M., a current Medication Administration policy, dated 2/1/18, was provided and indicated Follow the six (6) rights of medication administration . Right route . Apply gloves to remove old patch and apply new patch On 6/4/24 at 2:21 P.M., a current Insulin Administration policy, dated 12/21, was provided and indicated If using a syringe, keep the needle in the skin for count of five (5) seconds (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-48(c)(1)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48147 Based on observation, interview, and record review, the facility failed to ensure that food was served at palatable temperatures for 1 of 1 trays tested for temperature. (400 Hall) Finding includes: On 5/29/24 at 8:30 A.M., Resident 40 indicated the food was not hot all the time. On 5/29/24 at 2:40 P.M., Resident 6 indicated the food was cold and didn't taste good. On 5/30/24 at 10:47 A.M., Resident 31 indicated the food was not hot all the time. On 5/31/24 at 2:40 P.M., during a Resident Council meeting which consisted of 15 people, the following statement was made about the food temperatures: the food stayed on trays too long while coming down the halls (making the food cold by the time it reached the resident). On 6/3/24 at 10:44 A.M., [NAME] 28 checked the temperatures of the lunch food items that were on the holding table ready to be served. On 6/3/24 at 11:10 A.M., kitchen staff started plating the food. On 6/3/24 at 11:56 A.M., the lunch cart was delivered to the 400 hall and left in the hallway. Staff were not notified of its arrival. On 6/3/24 at 12:01 P.M., staff started distributing meals to rooms on the 400 hall. On 6/3/24 at 12:12 P.M., a test tray was obtained. Food temperatures for that meal were: carrots 116 F The food tasted lukewarm. On 6/3/24 at 12:24 P.M., the Dietary Manager indicated food should be between 120 to 135 F when served to residents. On 6/4/24 at 10:29 A.M., Medical Records provided a current Food Temperature Monitoring policy, revised 12/22, that indicated All hot food items must be . served at a temperature of at least 135 degrees F . Recommended temperatures on the serving line are higher for hot food and colder for cold food to allow for some changes during meal delivery and service time. 3.1-21(a)(2)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48147 Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions during 3 of 3 kitchen observations. Food was left open to air, expired food was not disposed of from the refrigerator, and gloves were not used according to professional standards. (Kitchen, Main Dining Room, [NAME] 21) Findings include: 1. On [DATE] at 8:15 A.M., the full kitchen tour with the Dietary Manager indicated the following: In the reach-in freezer, the following items were observed: Slice of orange melon open to air in a tray not labeled or dated 5 small ice cream containers tipped over with the lids half on and half off In the walk-in freezer, the following items were observed: 3 french fries were scattered on the shelves open to air 1 bag of mixed vegetables open to air In the walk-in refrigerator, the following items were observed: 1 broken egg in an egg crate with whole eggs Rice with a use by date of Sunday [DATE] 1 boiled egg on the floor Bag of grapes open to air with no label or date Container of boiled eggs in liquid open to air Cup of juice on the floor 4 small ice cream containers tipped over and melted in nectar orange bin In the dry pantry, the following items were observed: 8 packets of sugar, salt, and pepper on the floor On [DATE] at 10:41 A.M., the following items were observed in the walk-in refrigerator: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bacon on the floor standing water by the shelves holding bins containing thickened liquids 2. On [DATE] at 8:15 A.M., the following items were observed in the holding refrigerator in the main dining room: 2 chocolate milk containers with a use by date of ,d+[DATE] 2 fat free milk containers with a use by date of ,d+[DATE] 1 whole milk container with no use by date 3. On [DATE] at 10:02 A.M., [NAME] 21 was observed preparing pureed chicken. [NAME] 21 put on gloves, cleaned the preparation area, lifted the garbage lid, threw trash in the garage can, replaced the lid, and without changing gloves picked up the cooked chicken and placed it in the blender. On [DATE] at 8:15 A.M., the Dietary Manager indicated staff cleaned out the refrigerator daily. She removed the expired items from the refrigerator. On [DATE] at 10:29 A.M., Medical Records employee provided a current Leftovers policy, revised , d+[DATE], that indicated All food stored for later use shall be covered, labeled with the food name, and dated with the current date as well as a use by date, then stored appropriately (refrigerated or frozen if necessary) immediately . Leftovers that have not been properly stored will be discarded . On [DATE] at 10:29 A.M., Medical Records employee provided a current Glove Usage With Food Contact policy, revised ,d+[DATE], that indicated Gloves are just like hands. They are considered a food contact surface that can get contaminated or soiled. Anytime a contaminated surface is touched, the gloves must be changed . 3XXX,d+[DATE](i)(2) 3XXX,d+[DATE](i)(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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38770 Based on observation, interview and record review, the facility failed to ensure accurate documentation for 1 of 1 residents observed for a glucometer reading, and 1 of 3 residents reviewed for falls. A blood glucose was documented incorrectly, and post-fall assessments were not completed following a fall. (Resident 6, Resident 86) Findings include: 1. On 6/3/24 at 11:15 A.M., Licensed Practical Nurse (LPN) 19 was observed to perform a glucose reading on Resident 6. LPN 19 performed a fingerstick, and obtained a reading of 177. On 6/3/24 at 2:00 P.M., a blood sugar summary for Resident 6 was provided and indicated a blood sugar of 175 on 6/3/24 at 11:20 A.M. On 6/4/24 at 9:15 A.M., Registered Nurse (RN) 31 indicated blood sugar readings should be documented accurately. 46758 2. On 5/30/24 at 2:59 P.M., Resident 86's clinical record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following a cerebral infarction affecting right dominant side, aphasia following cerebral infarction, and muscle weakness. The current admitting MDS (Minimum Data Set) Assessment, dated 2/24/24, indicated the resident was mildly cognitively impaired, was dependent on transferring, dressing and toileting, and had no history of falls. Physician orders included but were not limited to nursing to assist with meals (opening items, set-up, cutting foods, placing silverware, etc.) before meals dated 3/7/24. The current care plan dated 2/23/24 indicated the resident needed assistance with ADL (Activities of Daily Living) related to right sided hemiparesis interventions included, but were not limited to, requiring the assistance of 2 with transfers, pivot transfer toward left side, and use gait belt and grip socks. Re-educate staff to always transfer residents toward left side. Progress note reviewed from 5/7/24 indicated Resident 86 had a fall in the shower. The Post-Fall Assessment started on 5/7/24 that was started on 8:00 A.M. indicated there was no charting at all on 5/7/24, no charting on 5/8 for second and third shifts, one missed assessment on second shift for 5/9. During an interview on 6/5/24 at 10:31 A.M., the Regional Nurse Consultant indicated all blanks should be filled on the fall assessment sheet. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/24 at 2:21 P.M., the Regional Nurse Consultant presented a current policy Documentation in Medical Record dated 1/30/23. The policy indicated each resident's medical record shall contain an accurate representation of the actual experiences and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation .Documentation shall be accurate, relevant, and complete .will be timely and in chronological order. 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 38770 Based on observation, interview, and record review, the facility failed to ensure a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection for 6 of 6 random observations. Resident care items were observed uncovered in bathrooms, and staff did not sanitize hands entering or exiting rooms with enhanced barrier precautions as indicated. (Resident 37, Resident D, Resident 7, Resident 46, Resident 20) Findings include: 1. On 5/30/24 at 9:38 A.M., Resident 7's bathroom was observed with four uncovered washbasins on the floor. On 6/5/24 at 8:30 A.M., the same was observed. 2. On 5/30/24 at 9:14 A.M., Resident 46's bathroom was observed with an uncovered washbasin in the sink. 3. On 5/30/24 at 10:10 A.M., Resident 20's bathroom was observed with an uncovered toothbrush on the back of the sink. On 6/5/24 at 8:29 A.M., the same was observed. 4. On 6/3/24 at 7:16 A.M., Qualified Medication Aide (QMA) 23 was observed to attempt to administer medications to Resident 37. QMA 23 entered and exited Resident 37's room without sanitizing or washing her hands. At that time, a sign was observed attached to the door that indicated enhanced barrier precautions, and that everyone must clean their hands, including before entering and when leaving the room. 5. On 6/3/24 at 7:26 A.M., QMA 23 was observed to enter Resident D's room with a blood pressure machine. QMA entered and exited the room without sanitizing or washing her hands. QMA 23 was observed to immediately enter the room a second time without performing hand hygiene. At that time, a sign was observed attached to the door that indicated enhanced barrier precautions, and that everyone must clean their hands, including before entering and when leaving the room. On 6/5/24 at 8:15 A.M., Registered Nurse (RN) 31 indicated when entering rooms on enhanced barrier precautions, staff should sanitize hands before entering and when leaving even if not providing direct contact with the resident. On 6/5/24 at 8:37 A.M., Certified Nurse Aide (CNA) 77 indicated the toothbrush in Resident 20's bathroom was uncovered because the staff were not provided with anything to cover them with. He indicated washbasins should be covered and not sitting directly on the floor. On 6/5/24 at 11:25 A.M., a current Enhanced Barrier Precautions policy, dated 3/26/24, indicated It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-18(b) 3.1-18(j) 3.1-18(l)

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46758 Based on observation, record review, and interview, the facility failed to provide an environment free of pests based on 8 (eight) random observations of gnats during the survey. (800 Nursing Hall, Kitchen, 300 Nursing Hall, Nurses Station, Dining Room, Resident room [ROOM NUMBER], ADON (Assist Director of Nursing) Office, and Nursing Manger Office) Findings include: 1. On 5/29/24 at 3:05 P.M., during a random observation a gnat was observed flying in a resident's room. 2. On 5/31/24 at 10:05 A.M. during a random observation gnats were observed flying in a Nursing Manager Office. 3. On 6/3/24 at 10:27 A.M., during a random observation in the ADON's office, several gnats were observed flying about in the room. 48147 4. On 5/29/24 at 9:16 A.M., Resident 84 indicated she had a problem with gnats in her room. At that time, gnats were observed in her room. 5. On 5/29/24 at 2:39 P.M., gnats were observed in Resident 6's room. 6. On 6/3/24 at 11:32 A.M., gnats were observed in the main dining room. 7. On 6/3/24 at 11:53 A.M., eight gnats were observed on the window of the 300 hall nurse station. 8. On 6/3/24 at 10:41 A.M., gnats were observed in the dry pantry in the kitchen. During an interview on 6/3/24 at 10:27 A.M., the ADON indicated over the weekend the fire department was at the facility over the weekend and flushed some pipes and thinks that the gnats were stirred up at this time. During an interview on 6/05/24 at 9:37 A.M., the DON (Director of Nursing) indicated they would not expect the facility to have pests. On 6/5/24 at 10:15 A.M., the Administrator provided a current policy Pest Control dated 3/7/23. The policy indicated .it is the policy of the facility to provide a safe .environment of care .maintain an effective pest control program .free of pest . 3.1-19(f)(4)