STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165361	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Green Village Care Cen	100 Sixth Street Nevada, IA 50201

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886 Based on clinical record review and staff interviews, the facility failed to develop and implement a comprehensive person centered Care Plan for 1 of 14 residents reviewed for Care Plans (Resident #8). The facility reported a census of 47 residents. Findings include: Resident #8's Minimum Data Set (MDS) assessment dated [DATE] indicated they had symptoms of feeling down, depressed or hopeless for several days during the lookback period. The MDS included diagnoses of medically complex conditions and depression. The MDS reflected Resident #8 took an antidepressant during the lookback period. Resident #8's Medical Diagnoses reviewed on 11/14/24 listed diagnoses of major depressive disorder, recurrent, in partial remission. Resident #8's November 2024 Medication Administration Record (MAR) included the following orders: a. Bupropion HCl ER (antidepressant) oral tablet 150 milligrams (mg) related to Major Depressive Disorder b. Fluoxetine HCl (antidepressant) oral capsule 40 mg, related to Major Depressive Disorder c. Risperidone (antipsychotic) oral tablet 0.5 mg, two times daily, related to Major Depressive Disorder. Resident #8's Care Plan with a target date of 1/15/25, lacked information related to their mood or antipsychotic medications. During an interview on 11/14/24 at 8:00 AM, the MDS Coordinator explained they expected the Care Plan contain a Focus and Interventions for Resident #8's antidepressant medications, mood, and behaviors. The MDS Coordinator stated the Care Plan should include that, but verified it didn't. During an interview on 11/14/24 at 8:13 AM, the Administrator stated the facility didn't have a policy on Care Plans, as they followed standard practices.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46875 Based on clinical record review, staff interviews, and policy review the facility failed to revise a Care Plan for 1 of 15 residents reviewed (Residents #47). The facility reported a census of 47 residents. Findings include: Resident #47's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS identified Resident #47 required set up or clean up assistance with eating. Resident #47's MDS included diagnoses of hypertension (high blood pressure), traumatic brain injury, and dysphagia (difficulty with swallowing). The MDS documented Resident #47 received a mechanically altered diet that required a change in texture of food or liquids. A Physician diet order dated 7/22/24 directed staff to administer a mechanical soft diet with pureed meats with all solids cut into bite size pieces, only soft canned vegetables or fruit, no lettuce or cabbage unless pureed and honey consistency liquids. The Share Negotiated Risk Agreement dated 10/21/24 documented Resident #47 received a pureed diet with thickened liquids. Resident #47 requested to have a regular diet with no thickened liquids. The form indicated Resident #47 and the Power of Attorney (POA) knew he would have a risk for aspiration (food, liquid, or other material accidentally enters a person's airway or lungs) and death by not following the speech recommended diet. The form documented the final agreement as Resident #47 to receive a regular diet with regular consistency liquids per his request. Resident #47 signed the form, POA, facility Administrator on 10/21/24. The Physician documented a hand-written note on the form dated 10/24/24 that Resident #47 was at a very high risk of aspiration and rehospitalization . The Physician recommended to stay on speech recommended pureed diet and thickened liquids. The Care Plan Focus with a target date of 12/25/24 reflected Resident #47 had a potential for nutritional risk related to dysphagia (difficulty swallowing) and the need for a mechanical altered diet. The Care Plan Interventions directed staff to administer a mechanical soft diet with puree meats, lettuce, and cabbage. In addition, the Care Plan directed the staff to cut all of his food into bite sized pieces, serving only canned fruit/vegetables, and honey thickened liquids in a nosey cup (cup with a cut out allowing it to tip farther without hitting the face). The Care Plan lacked information related to the shared negotiated risk agreement. On 11/14/24 at 8:35 AM, the MDS Coordinator verified the Care Plan didn't address the Shared Negotiated Risk Agreement, but she would update the Care Plan. On 11/14/24 at 8:45 AM, the Nurse Consultant reported the facility didn't have a Care Plan policy. She stated the facility followed the standard nursing practice and the Resident Assessment Instrument (RAI) manual when updating the Care Plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886 Based on clinical record review, resident and staff interview, the facility failed to meet professional standards of quality for services provided during medication administration for 1 of 1 resident reviewed (Resident #51). The facility reported a census of 47 residents. Finding include: Resident #51's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of medically complex conditions, anemia (low iron levels in the blood), atrial fibrillation (abnormal heart rate), hypertension (high blood pressure), renal insufficiency (poor kidney function), diabetes mellitus, hyperlipidemia (elevated type of cholesterol), seizure disorder, respiratory failure and metabolic encephalopathy (brain dysfunction due to problems with the metabolism). The Incident Report - Medication Event dated 11/2/24 at 7:21 PM identified Resident #51 received another resident's (Resident #46) supper and hour of sleep (HS) medications. During an interview on 11/13/24 at 1:45 PM, the Administrator stated she completed an internal investigation regarding Resident #51's medication error. The Administrator provided a copy of the internal investigation. The Administrator stated Staff K, Certified Medication Assistant (CMA), who gave Resident #51 the incorrect medications no longer worked at the facility. She left the faciity on her own on the night of the incident. The Administrator explained Staff K was in training and only worked at the facility for a few days. Staff L, CMA, who trained her, still worked at the facility. They gave her a written disciplinary action, required her to take additional training on medication administration, and the Assistant Director of Nursing (ADON) conducted a medication audit. Staff L worked at the facility for approximately one year. During an interview on 11/14/24 at 10:25 AM, the Administrator stated Resident #51's medication error, identified a concern with the broken process of Staff L providing orientation to Staff K and her not knowing her training or following professional standards with the 5 rights. Staff L should have given the medications as she is the one who got them ready, or she should have gone into the room with Staff K to observe her give the medication. The Administrator stated they expected the right resident received the medication as prescribed. The Administrator stated they didn't have a policy for medication administration, as they followed professional standards. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 11:07 AM, Staff K, Certified Medical Assistant (CMA), explained it was only her second day in training at the facility and when Staff L, another CMA, trained her, they worked the 2 PM to 10 PM shift. Staff K stated she started the shift by observing Staff L pass medications. Around supper time Staff L started having Staff K give residents their medications. Staff L put the medications in the cup, then told Staff K to go and give it to the resident. She told Staff K who the resident was and where they were. Staff K stated because she didn't know the residents, she felt uncomfortable with this process as Staff L didn't go with her to give the medications. Staff K stated she gave some residents their medications while they were in the dining room. Staff L told her what color of hair they had and to find them based on their hair color, name, and where they sat. Staff K stated she got frustrated and concerned because she wasn't the one putting the medications in the container and she didn't know the residents. Staff K stated Staff L seemed frustrated with her because she kept asking questions. She added she didn't know the residents and Staff L didn't go with her. Staff K no longer worked at the facility as that was her last night at the facility. During an interview on 11/14/24 at 11:30 AM, Resident #51 and her husband recalled the night of 11/2/24 when Resident #51 received another resident's medication. A CMA, whom they never met before, came into the room then went up to Resident #51 and said she had her medications. The CMA didn't ask Resident #51 her name. Resident #51 said she asked the CMA what the medications were as she hadn't got medications that looked like that before. The CMA said she didn't know what the medications were. The CMA gave Resident #51 the medications with just water. Resident #51 said she had a hard time swallowing them as she usually got her medication with applesauce. Resident #51 said she started to gag on the medications and the CMA patted her on the back, then went to get her applesauce. The CMA came back to the room with the applesauce and then tried to give Resident #51's husband a cup of medications. Resident #51's husband said he told the CMA he wasn't a resident there and then she left the room. Resident #51 and her husband stated they feel the facility administration handled the incident well after finding out what happened. They said this never should have happened and said it is their policy for the person who signed out the medication be the person who gave the medication. During an interview on 11/14/24 at 12:00 PM, Staff L reported she trained Staff K on the night of 11/2/24. She added that night was Staff K's second night working at the facility. She trained Staff K the first night, and Staff K shadowed her that night. When asked to talk about the training process and how she trained Staff K, Staff L stated she didn't want to talk about it. She said she messed up, made a mistake, and learned a valuable lesson. She said she didn't follow the 6 rights and she should have. Staff L stated she gave Staff K medications to give to residents, without having Staff L put the medications in the cup herself and didn't go with her to ensure she gave the medication to the correct resident. Staff L stated she gave Staff K several resident medications that night, however couldn't give a specific number of residents she gave medication for Staff K to give. Staff L stated they were in the [NAME] hallway and she gave Staff K medication to at least one resident in the dining room, telling her what the resident looked like, but didn't go with her to give the resident the medication. Staff L stated she knew she didn't follow what she was supposed to follow and made a mistake. She said she put the medications for a resident in a cup with Staff K standing next to her, then gave the cup to Staff K. Staff L told her where to find the resident. Staff L stated she didn't feel like she needed to hold Staff K's hand. Staff L stated she didn't want to talk any further about the incident when asked what training she received before and after the incident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 12:30 PM, Staff M, CMA, recalled working the night of 11/2/24. She recalled Staff L trained Staff K and it was Staff K's second night in training. Staff M stated at one point in the evening, before and around super time, she and Staff L had their medication carts side by side by the beauty shop in the hallway. Staff M heard Staff K say she wasn't ready to put the medications in the cups herself or give them herself, as she wanted to observe more with Staff L. Staff M stated Staff L showed Staff K the Medication Administration Record (MAR) and Staff K stood next to Staff L, when Staff L put the medication in a cup for a resident. Staff M stated Staff L gave Staff K medications for residents while they were still in the dining room and wouldn't go with her to give the medication to the resident. However, Staff L gave Staff K a description of the resident and she saw their picture on the MAR. Staff L would write the name of the resident on the medication cup. Staff L also gave Staff K medication to give to residents in their room in the [NAME] hallway. Staff L told Staff K the name of the resident and their room number. Staff M heard Staff L talk to Staff K about Resident #46's medication, that she was in room [ROOM NUMBER], and married. Staff L didn't go with Staff K to room [ROOM NUMBER] to give Resident #46 her medication. Staff M heard about Staff K giving Resident #51 the medication meant for Resident #46.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on observation, interviews, record reviews and policy the facility failed to assess and treat a pressure ulcer for 2 of 2 residents observed with pressure ulcers (Residents #9 and #50). Resident #50 documentation indicated the facility found their pressure wound on 11/1/24. Interviews determined hospice found the pressure wound before that date. The facility, hospice staff, and Resident #50's family had a meeting before the facility documented the pressure ulcer. At the meeting, hospice reported the got an order for heel protectors for Resident #50. Resident #50's clinical record lacked documentation of the order. When the facility reported the concern to the physician, the directed to monitor the wound. Resident #50 reported she didn't like the boots because they made her feet hot. Resident #50's heel pressure ulcer declined and the facility failed to intervene to prevent the decline. Resident #9 had a pressure ulcer to their buttock. The nurse failed to provide clean technique while completing the wound treatment. The facility reported a census of 47 residents. Findings included: 1. Resident #50's Minimum Data Set (MDS) assessment dated [DATE] included diagnoses of anemia (low iron levels in the blood), atrial fibrillation (abnormal heart rate), hypertension, and demyelinating disease of the central nervous system (protective tissue surrounding special cells are damaged and disrupting the transmission of signals). The MDS indicated Resident #50 had a risk for a pressure ulcer, but didn't have one at the time of assessment. The Care Plan Focuses with a target date of 1/16/25 indicated: a. Resident #50 elected hospice services. The Interventions directed the following: i. Coordinate her care with hospice services to keep her as comfortable as possible. ii. May experience expected skin breakdown due to terminal disease process, poor nutrition, weight loss and decreased mobility, may be diagnosed with a Kennedy ulcer (occurs is some near final weeks of life) due to my terminal diagnosis. Skin issues are not expected to heal due to terminal disease process, poor nutrition, perfusion and decreased mobility. b. Resident #50 had a risk for alteration in skin integrity related to falls from terminal restlessness, altered skin integrity related to a terminal diagnosis of demyelinating disease, limited mobility and the use of a mechanical lift. Updated 11/8/24 Left calf medial aspect 4.0 by 2.0 centimeters (cm), left cheek bruising 5.0 by 5.0 cm extends down along left jawline, bruising is yellow and fading, and right medial heel measures 4.0 by 5.0 cm dark red center stage 2 pressure ulcer - hospice notified. Resident #50 had heel boots present but she often removed them. The Goal indicated Resident #50 would not develop skin alterations out of her disease process and skin impairment would heal without complications. The Interventions directed to use pillows/position devices as needed. The Skin Condition Note dated 11/1/24 indicated Staff E, Licensed Practical Nurse (LPN) completed Resident #50's weekly skin check, which revealed a right medial heel stage 2 pressure ulcer measuring 2.5 by 2.0 cm. The physician responded to continue to monitor. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Skin Condition Note dated 11/8/24 reflected Staff E completed the weekly skin check which revealed Resident #50's right heel stage 2 pressure ulcer measured 4.0 x 5.0 cm with a dark red center. Resident #50 remained on hospice level of care, heel boot present but she removed them often. Staff E placed a mepilex (dressing) to her right heel for protection and she alerted hospice to provide more. The Physician responded on 11/11/24 to continue to monitor. On 11/13/24 at 3:05 PM Staff C, Registered Nurse, reported they checked the Treatment Administration Record (TAR), and remarked it didn't have a treatment for Resident #50's right heel pressure ulcer. During an interview on 11/13/24 at 3:24 PM Resident #50's Power of Attorney (POA) voiced they had a meeting about two weeks before (10/30/24) with family, hospice, and the facility staff. They discussed the heel concern and hospice brought heel protectors. The POA reported she understood they had something new on order since Resident #50 wouldn't wear the heel protectors. On 11/13/24 at 3:25 PM Resident #50 acknowledged she didn't like to wear the heel protectors, as they made her feet hot. Resident #50 added that it would be nice if a doctor looked at her heel. She couldn't recall if it had a covered dressing or treatments. During an observation on 11/13/24 at 3:30 PM Staff C, Registered Nurse (RN), measured Resident #50's heel wound and reported it measured 1.5 by (x) 2.2 x 0.1 cm depth. They cleansed the wound and covered it with a mepilex dressing. Staff C said the TAR should include the heel boots, but it didn't. Staff C stated the previous Sunday they recalled the heel as dry with a darkened area, flat and reported the measurements in the skin book are much larger. They didn't appear accurate from their recalled comparison. Staff C explained the wound opened, they didn't have a treatment order and they should. During an interview on 11/14/24 at 1:35 PM Staff E stated they first saw the heel wound on 11/1/24. At that time, they measured, documented left medial heel, 2.5 x 2 cm stage 2, indicated the wound as open, notified the physician via fax, and alerted Staff D, Hospice RN, verbally. Staff E reported they didn't get any treatment orders and the Physician, directed to continue to monitor. Further interview, record review and discussion on 11/14/24 at 1:38 PM with LPN, Staff E included review of weekly skin record. LPN, Staff E acknowledged had measured the wound again on 11/8/24 noted increased size, stage II (two) measured 4.0 x 5.0 centimeters, dark red center, recorded placed mepilex (dressing) on for protection and alerted hospice to provide more direction. LPN, Staff E relayed, should not of staged the wound, is not qualified to do so as an LPN, relayed had staged as two since wound was open. Relayed updated Physician, Staff F and responded again to the updated measurements on 11/11/24 continue to monitor. During an interview on 11/14/24 at 3:00 PM, Staff D reported they documented in her hospice notes and acknowledged the following: a. On 10/29/24 suspected deep tissue injury, deep purple, obtained a physician order for the protective heel boots. b. On 10/31/24 met with family, the heel was intact, reddened, ensured a written order to the facility nurse for the heel protectors that didn't get transcribed to the TAR. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	c. On 11/11/24 obtained an order to cover wound with mepilex dressing, gave the order to the nursing facility staff, and again not transcribed to the TAR, and the order couldn't be located. d. On 11/12/24 measure the heel wound at 3 x 2.5 x .0.2 cm depth. e. On 11/14/24 at 3:05 PM, Staff D acknowledged the wound depth increased. They thought the facility should have transcribed the orders to the TAR. During an interview on 11/13/24 at 3:50 PM the Assistant Director of Nursing (ADON) acknowledged they only monitored the Stage 2 pressure ulcer weekly per the weekly skin book. The ADON verified Resident #50 had heel boots in her room, but no treatment orders. During an interview on 11/13/24 at 3:50 PM the Administrator acknowledged Resident #50 had a stage 2 pressure ulcer to her heel. They added the physician ordered to just monitor the wound and they wouldn't override a doctor's order. On 11/14/24 at 3:13 PM the ADON stated they have a process, when hospice got an order they give the written note to a facility nurse. Two nurses verify the order and add it to the electronic TAR. The ADON couldn't explain why the orders didn't get transcribed for the heel protectors or the mepilex dressing. The ADON expressed she trusted Staff D gave the orders to the facility nurse. The facility didn't provide a policy for pressure ulcer treatments. 2. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of heart disease, respiratory failure, metabolic encephalopathy (brain dysfunction due to problems with the metabolism) and depression. The MDS documented Resident #9 had a pressure ulcer. Resident #9 November 2024 TAR included an order dated 11/13/24 apply a Hydrofiber (soft, absorbent material that transforms into a gel on contact with wound fluid) with bordered foam dressing to change on Monday, Wednesday and Friday for skin healing. On 11/13/24 at 9:40 AM, observed Resident #9 lying on her side. Staff C explained they sanitized their hands, put on gloves, and removed the coccyx dressing. Staff C cleansed the coccyx wound with dermal (skin) cleanser, cut the hydro fiber, and placed it on the wound, labeled the dressing with a pen and applied it to Resident #9's coccyx. During the treatment, Staff C didn't complete hand hygiene between removing the old dressing and applying the ordered treatment. In an interview on 11/13/24 at 10:32 AM following Resident #9's coccyx wound treatment, Staff C reiterated the treatment process and verified they should have sanitized their hands before placing the new dressing on. In an interview on 11/13/24 at 3:00 PM the ADON acknowledged hand hygiene is standard practice after removing an old dressing, after taking off gloves, and prior to putting on gloves. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Infection Prevention and Control policy revised 7/31/24 instructed staff to perform hand hygiene before and after direct patient contact and after each situation that necessitates hand hygiene. To complete the hand hygiene, they will use an alcohol -based hand rub or hand washing for 20 seconds.

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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** 44972 Based on observation, record review, facility policy review, resident, and staff interview the facility failed to keep a resident's environment free from accidents and hazards by not storing the resident's smoking materials in a secured location for 1 of 1 resident reviewed for smoking (Resident #30). The facility reported a census of 47 residents. Findings include: Resident #30's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #30 used a wheelchair for mobility. The MDS further documented the resident had diagnoses to include diabetes, arthritis, Parkinson's disease, chronic obstructive pulmonary disease (COPD), and pulmonary fibrosis. Resident #30 reported shortness of breath with exertion and while lying flat. The MDS described Resident #30 as a current tobacco use. The Care Plan Focus with a target date of 12/26/24 indicated Resident #30 preferred to smoke. The Goal reflected Resident #30 would follow the facility guidelines for smoking in designated smoking areas and wouldn't sustain significant smoking related injuries. The Care Plan Interventions identified Resident #30 could exit and re enter the facility independently. They stored his smoking supplies at the nurse's station. If Resident #30 failed to let staff keep his smoking supplies at the nurse's station he could lose his smoking privileges. Resident #30 had a history of being non-compliant at times with the smoking practices outlined in the Care Plan. He would move the extinguishing receptacles and smoke beyond the boundaries of the designated smoking area. If staff observe those issues, they should intervene and ask him to comply. A Smoking assessment dated [DATE], indicated the facility educated Resident #50 about the risks of smoking. Resident #50 could light his cigarettes safely, hold the cigarette safely, put ashes in the ashtray, extinguish the cigarette safely, exhibited safety awareness when smoking, didn't have burn holes in clothing, and had no evidence of blisters or burns on his fingers. The facility approved his smoking privileges and allowed Resident #50 to smoke independently. He could exit and enter the facility independently. In addition, Resident #50 needed to store his smoking materials at the nurse's station, especially important because of oxygen in his room. Failure to keep the smoking supplies at the nurse's station may result in loss of his smoking privileges. On 11/13/24 at 10:20 AM, observed Resident #30 seated in his recliner in his room, remove his oxygen, ambulate to his motorized wheelchair, and put on his coat to go outside to smoke. Resident #30 independently exited the facility out the front door and located himself by the smoking receptacle. He removed a pack of cigarettes from his pocket in the front of his bib overalls. The pack of cigarettes contained several cigarettes and a lighter. Resident #30 removed 1 cigarette, the lighter, and safely lit the cigarette. He returned the pack of cigarettes back to the pocket in his bib overalls. He smoked the cigarette, ashed, extinguished, and placed the butt in the receptacle appropriately. Resident #30 re entered the building independently and returned to his room. Resident #30 didn't obtain his smoking materials from the nurse's station nor did he return them to the nurse's station after he finished smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/12/24 at 3:17 PM, Resident #30 reported he smoked 4 5 cigarettes per day and could smoke independently. He stated he either smoked out front or in the back of the facility, as both had smoking receptacles. He reported he used his motorized wheelchair to get to and from the smoking areas. He added he removed his oxygen in the room prior to going out to smoke. Resident #30 stated he kept his cigarettes and lighter in his possession. He reported the facility would like him to obtain and relinquish his smoking supplies to the nurse's station when he smoked but he felt he had to wait too long for the staff to get them so he rarely turned his supplies in. In an interview on 11/14/24 at 7:28 AM, Staff G, Certified Nursing Assistant (CNA), stated Resident #30 went to the nurse's station to get his smoking supplies and returned the smoking supplies to the nurse's station after he finished. Staff G stated Resident #30 didn't specifically ask her for the smoking supplies, he just asked whomever happened to be at the nurse's station at the time. Staff G stated Resident #30 did at times forget to turn in his smoking supplies. If the staff saw him come in without turning the supplies in, they stop him and ask him for them to return them to the nurse's station. In an interview on 11/14/24 at 7:33 AM, Staff H, Certified Medical Assistant (CMA), stated Resident #30 theoretically had to get his cigarettes and lighter from the nurse's station. She reported he didn't comply and kept his cigarettes on his person most of the time. Staff H stated the Director of Nursing (DON) and Administrator knew but Resident #30 was just non compliant most of the time. In an interview on 11/14/24 at 11:18 AM, Staff I, CNA, stated Resident #30 smoked independently and obtained his supplies from the nurse's station when he wanted to go out to smoke. Then he was to turn the smoking supplies back in after he finished smoking. Staff I stated she didn't know Resident #30 ever kept his cigarettes on him and didn't witnessed that behavior from him. In an interview on 11/14/24 at 1:07 PM, the Administrator stated any resident who smoked must have a Smoking Assessment completed. Resident #30 had to go to the nurse's station to obtain his cigarettes and lighter, then turn them back into the nurse's station when finished. They talked to Resident #30 about other options such as a lock box but he needed to store his smoking materials at the nurse's station at that time. In a facility provided policy titled Smoking Policy Notification with a revision date of September 2023 instructed the facility requested their cooperation in observing the facilities smoking policy, as it was a NON SMOKING facility. The authorized area(s) in the facility for permitted smoking is/are: The facility had no notations behind any of the above options.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46513 Based on clinical record review, policy review and staff interview, the physician failed to respond to gradual dose recommendations (GDR) for 1 of 5 residents reviewed (Residents #9). The facility reported a census of 47 residents. Findings included: 1. Resident #9's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of heart disease, respiratory failure, metabolic encephalopathy (brain dysfunction due to problems with the metabolism) and depression. The MDS documented Resident #9 received an antidepressant medication during the lookback period. The Care Plan Focus with a target date of 11/27/24 indicated Resident #9 used a psychotropic medication in the category of an antidepressant. The Intervention instructed to evaluate for GDR quarterly or as indicated. Resident #9's November 2024 Medication Administration Record (MAR) included the following psychotropic medications: a. Start date 3/25/24: Amitriptyline 25 milligrams (mg) tablet, by mouth one time a day for nerve pain. b. Start dated 3/26/24: Bupropion, 300 mg extended release 24-hour by mouth one time a day related to depression. The Pharmacy Review - GDR Request Psychotropic Medications dated 10/2/24 requested the provider access for possible GDR for amitriptyline 25 mg and Wellbutrin (bupropion) 300 mg. The physician responded they didn't agree with the recommendation and indicated they addressed this previously. Resident #9's clinical record lacked documentation of any other physician response to the GDR. On 11/14/24 at 2/26/24 PM the Administrator and the Assistant Director of Nursing (ADON) both acknowledged the facility should have documented a physician's response to pharmacy recommendations, but they couldn't locate the documents. The Medication Regimen Review policy, revised 8/16/24 directed the consultant pharmacist to review the medication regimen including psychotropic medication with considerations for dose reduction, potentially unnecessary medication usage, and required written communication intended for the attending physician. The facility would maintain the completed medication regimen consultation in the resident's clinical record. The facility is responsible for ensuring all clinical records are available for review.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48886 Based on clinical record review, resident interview, staff interviews and policy review, the facility failed to ensure residents are free of significant medication errors for 1 of 1 resident reviewed (Resident #51). During the orientation of one Certified Medication Aide (CMA), Staff K, the trainer gave the person in training resident's medications without ensuring they gave the medications to the correct resident. Due to it only being Staff K's second day of training she didn't know the residents and gave Resident #51, Resident #46's supper and hour of sleep medications (HS). The facility reported a census of 47 residents. Findings include: Resident #51's Minimum Data Set (MDS) assessment dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of medically complex conditions, anemia (low iron levels in the blood), atrial fibrillation (abnormal heart rate), hypertension (high blood pressure), renal insufficiency (poor kidney function), diabetes mellitus, hyperlipidemia (elevated type of cholesterol), seizure disorder, respiratory failure and metabolic encephalopathy (brain dysfunction due to problems with the metabolism). The Incident Report - Medication Event dated 11/2/24 at 7:21 PM identified Resident #51 received another resident's (Resident #46) supper and HS medications. Resident #46 November 2024 Medication Administration Record (MAR) reflected their supper and HS medications as: a. Donepezil HCl oral tablet, 10 milligrams (mg), related to mild cognitive impairment. b. Calcium Carbonate Vitamin D oral tablet with minerals, 600 800 mg unit, for bone health c. Potassium oral tablet, 99 mg, for nutritional supplement. During an interview on 11/13/24 at 1:45 PM, the Administrator stated she completed an internal investigation regarding the medication error with Resident #51. The Internal Investigation File included a progress note completed by Resident #51's primary care physician (PCP), dated 11/5/24. Under Chief Complaint/Nature of Presenting Problem section the PCP documented an acute visit to follow up on emergency department visit for hyperkalemia (elevated level of potassium in the blood). Under History of Present Illness, the PCP documented on 11/2/24 Resident #51 received a potassium supplement pill inadvertently (accidentally). She had mildly high potassium level in the hospital and this had been improving on labs. Her potassium level in the emergency department was 5.8, she received IV fluids and Lasix. When her potassium level normalized to 4.9, she discharge back to the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 2:30 PM, Staff J, Advanced Registered Nurse Practitioner (ARNP), stated she worked with Resident #51's PCP in the same office and is Resident #51's ARNP at the facility. Staff J recalled when Resident #51 received another resident's medication in error, which included a potassium pill. Resident #51 already had high potassium levels, they did have her go in for lab work the following morning to check her potassium levels, which were slightly elevated, however they cannot definitively say the slight elevation happened because of the medication error. Staff J stated Resident #51 went to the emergency room previously for elevated potassium and they treated her for this. Her levels are good now. Staff J described the resident as physically okay, she didn't have symptoms of high potassium, and didn't require additional medical treatment or admission to the hospital. Staff J stated the 3 medications Resident #51 received in error were a low risk medication error, and didn't place the resident at high risk or high level of harm or death. During an interview on 11/14/24 at 10:25 AM, the Administrator stated they expected the right resident received the medication as prescribed. The Administrator stated they didn't have a policy for medication administration, as they followed professional standards, but they did have a policy for following physician orders. During an interview on 11/14/24 at 11:07 AM, Staff K, Certified Medical Assistant (CMA) explained Staff K stated Staff L, CMA, put medications in a cup and told her to go give it to the lady in the room they were in before, the lady with the husband. Staff L didn't go with her, and stayed with the medication cart, she couldn't see down the hallway where Staff K was going. Staff K stated she went into the room where she thought she should go and gave the lady the medications. The lady (Resident #51) started choking a little, Staff K slapped her on the back to help her and she coughed up the pills. Staff K asked Resident #51 if she wanted some applesauce with the medications and she said yes. Staff K went back to the medication cart and got some applesauce. Staff L then gave her another cup of medications and said these are for the husband. Staff K went back to the room and gave Resident #51 the applesauce and she swallowed the medications. Staff K then told to Resident #51's husband she had his medications. He told her he wasn't a resident at this facility. Staff K realized at this point she was in the wrong room and just gave Resident #51 the wrong medication. She went to room [ROOM NUMBER] next door to Resident #51's room and gave the man in that room the medication that she just tried to give to Resident #51's husband. She stated she tried to find Staff L to tell her what happened but said she couldn't find her. Resident #51 later told the charge nurse what happened and the charge nurse came to talk to Staff K. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 11:30 AM, Resident #51 and her husband recalled the night of 11/2/24 when Resident #51 received another resident's medication. A CMA, whom they never met before, came into the room then went up to Resident #51 and said she had her medications. The CMA didn't ask Resident #51 her name. Resident #51 said she asked the CMA what the medications were as she hadn't got medications that looked like that before. The CMA said she didn't know what the medications were. The CMA gave Resident #51 the medications with just water. Resident #51 said she had a hard time swallowing them as she usually got her medication with applesauce. Resident #51 said she started to gag on the medications and the CMA patted her on the back, then went to get her applesauce. The CMA came back to the room with the applesauce and then tried to give Resident #51's husband a cup of medications. Resident #51's husband said he told the CMA he wasn't a resident there and then she left the room. Resident #51 and her husband stated they visited with their daughter at the time and their daughter said she thought Resident #51 just got the wrong medication. No one came to the room to talk to them about this and then approximately 30 minutes later the charge nurse came in to start the feeding tube. They told her they thought Resident #51 received the wrong medication. The charge nurse said it needed to be reported and looked concerned. They called the doctor's office and watched Resident #51 throughout the night. Resident #51 stated she didn't feel any side effects from receiving the wrong medications and felt okay. She went to the Emergency Department the next morning for a flush and they got her potassium down. During an interview on 11/14/24 at 12:00 PM, Staff L reported she trained Staff K on the night of 11/2/24. Staff L stated she put Resident #46's supper and hour of sleep (HS) medications into a cup and gave the cup to Staff K. She then told her to give Resident #46 the medication. She described Resident #46 as the one who was married and told her the room number. Staff K indicated she knew who Staff L was talking about. Staff L stated she didn't go with Staff K and couldn't see her from where she stood by the medication cart. Staff L stated she still stood by the medication cart when Staff K returned and said she needed applesauce. Staff L then gave Staff K a cup of medication that she prepared while Staff K was gone for her to take to Resident #46's husband, Resident #45. Staff L stated she didn't go with Staff K to give the medication. Staff L didn't recall talking to Staff K again that night. The Physician Orders policy, revised 8/16/24, instructed all resident medications must be in accordance to the licensed physician's orders. The facility shall ensure to follow physician orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44972 Based on observation and staff interview, the facility failed to discard expired stock medications to avoid compromising the integrity of the medications. The facility reported a census of 47 residents. Findings include: On 11/13/24 at 2:35 PM observed the medication room across from the nurses' station with Staff B, Licensed Practical Nurse (LPN). The room contained the following expired items: a. 1 unopened bottle of Rubbing Alcohol 70%, 16 fluid ounces with an expiration date of March 2024. b. 1 unopened box of Assure Prism Blood Glucose Monitoring System with an expiration date of 8/25/24 c. 2 unopened bottles of Geri Dryl (similar to Benadryl) Allergy Relief with an expiration date of September 2024. In an interview on 11/13/24 at 3:10 PM, the Assistant Director of Nursing (ADON) stated she didn't know if they had a facility policy related the prevention of expired stock medications in the medication storage area but she would implement one if they didn't. She stated she expected the staff to discard all expired medications, so the staff didn't use or give them to the residents. On 11/14/24 at 11:44 AM, the Administrator reported the facility didn't have a policy relating to expired medications.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 46875 Based on clinical record review, menu review, observations, staff interviews, and policy review the facility failed to provide residents food in a form to meet the needs of 2 of 6 residents (Resident #51 and #50). The facility reported a census of 47 residents. Findings include: A Physician diet order dated 10/24/24 for Resident #51 directed staff to administer a mechanical soft, ground meat diet. A Physician diet order dated 11/6/24 for Resident #50 directed staff to administer a mechanical soft texture diet. A facility menu titled Week 3 Wednesday documented the noon meal for a mechanical soft diet included a ground steak sandwich with grilled onion, potato salad with no raw vegetables, cooked broccoli cuts and maraschino cherry cake. On 11/13/24 at 11:20 AM, prior to the start of the noon meal service, observed the steam table didn't contain ground steak meat. The observation of the steak meat revealed various sizes of cut up meat. On 11/13/24 observations during the noon meal service revealed Staff A, Cook, prepared a steak sandwich with cut up meat for Resident #51. They served Resident #51 the non ground steak sandwich on a room tray. During the middle of the meal service, Staff A took several servings of the cut-up steak meat out of the steam table, grounded the meat using a robot coupe and returned the ground meat to the steam table. As the meal service continued, Staff A prepared and plated a steak sandwich with cut up meat (non ground) for Resident #50. Staff A placed it on a tray on the food cart. At 12:22 PM, the Dietary Manager intervened and stated she couldn't let the food trays leave the kitchen. She stated Resident #50's sandwich wasn't prepared with ground meat. Staff A removed Resident #50's plate from the food cart and acknowledged Resident #50's sandwich as prepared with cut up meat and not ground meat. Staff A prepared a new sandwich with ground meat for Resident #50. The Dietary Manager agreed if she didn't intervene Resident #50 would have received non ground meat. On 11/13/24 at 12:30 PM, the Dietary Manager reported she expected the staff to follow the menu and grind the meat as indicated on the menu. On 11/13/24 at 12:40 PM, Staff A reported she forgot to prepare the ground meat prior to the start of meal service. Staff A said when she prepared Resident #51's food tray she chopped up the food into small pieces in the pan before serving it. Staff A reported she made a mistake and overlooked the ground meat for Resident #50. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 12:45 PM, Resident #51 and her husband reported she had a sandwich with meat pieces for lunch. Resident #51's husband reported his wife shouldn't have a mechanically soft diet, as his wife could chew her meat with no problems. Resident #51 said she could chew her meat without difficulty. Resident #51's husband said he took his wife to a local restaurant the previous night and she ate chicken on the bone without difficulty. Resident #51 said she ate the chicken off the bone and didn't have any problems with chewing or swallowing. Resident #51 said she hasn't choked on her food. Resident #51 and her husband said a staff member comes to the room and provides supervision while she eats. Resident #51 and her husband said the meat was in smaller pieces that day for lunch. Resident #51 reported she ate all of her lunch, stating it was good and she had no difficulty swallowing or chewing. On 11/13/24 at 2:30 PM, the Dietary Manager provided a counseling form signed by Staff A on 11/13/24. The form indicated the problem was ensuring proper diets are prepared before meal service and to double check the correct diets are served. The form documented Human Resources would assign an online course to Staff A regarding proper food service procedures. The Altered Textured Diet Orders policy revised April 2012 instructed diet orders for residents requiring altered textures for chewing and swallowing problems, be written in a standardized language to specify the appropriate consistency of food and fluids to meet residents' safety, tolerance, and preferences.