STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175494	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linn Community Nursing Home	612 Third St Linn, KS 66953

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32358 The facility had a census of 38 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 17 or his representative with written information regarding the facility bed hold policy when R17 transferred to the hospital. This placed the resident at risk of not being permitted to return and resume residence in the nursing facility. Findings included: - R17's Electronic Medical Record (EMR) documented R17 had diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid) and acute (condition characterized by a relatively sudden onset of symptoms that are usually severe) upper respiratory infection (infections of parts of the body involved in breathing, such as the sinuses, throat, airways or lungs). R17's Quarterly Minimum Data Set (MDS), dated [DATE], documented R17 had a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented the resident was dependent on staff for most activities of daily living (ADL). R17's Care Plan, revised 04/22/24, documented that staff put oxygen on R17 at night at two liters a minute via nasal cannula because R17 had trouble breathing when he laid flat. The Nurse's Note, dated 12/30/23 at 10:37 PM, documented R17 admitted to the hospital. A review of R17's clinical record lacked evidence the facility provided the resident or representative with the bed hold policy upon transfer to the hospital. On 06/03/24 at 11:56 AM, observation revealed R17 sat in a wheelchair at the west kitchenette counter, with no signs or symptoms of respiratory distress. On 06/05/24 at 08:07 AM, Administrative Nurse D stated she was responsible for providing the bed hold policy to residents when they transferred to the hospital. Administrative Nurse D verified the lack of evidence that R17 or his representative received the bed hold policy when R17 transferred to the hospital on 12/30/23. (continued on next page)

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

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Bed Hold Policy, revised 01/03/24, documented that before this facility transfers a resident to a hospital or the resident goes on therapeutic leave, the facility would provide written information to the resident and or resident representative that specifies the duration of the state bed-hold policy during which the resident is permitted to return and resume residency in the facility; the reserve bed payment policy in the state plan; the facility polices regarding bed-hold period, which is consistent with the law permitting the resident to return. The facility failed to provide R17 or his representative with the bed hold policy when R17 was transferred to the hospital. This placed the residents at risk of not being permitted to return and resume residence in the nursing facility.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 38 residents. The sample included 12 residents with one reviewed for discharge. Based on record review, and interview, the facility failed to complete a discharge summary for Resident (R) 39, which included a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) summary of the resident's stay in the facility. This placed the resident at risk of unidentified and unmet care needs. Findings included: - The Electronic Medical Record (EMR), documented R39 admitted to the facility on [DATE] and documented diagnoses of idiopathic peripheral neuropathy (no identifiable cause for weakness, numbness, and pain from nerve damage, usually in the hands and feet), enterocolitis (disease of the digestive tract) due to clostridium (C-diff: contagious bacteria characterized by foul-smelling frequent loose bowel movements), edema (swelling), vomiting, calculus (area of thickened and sometimes hardened skin that forms as a response to repeated friction, pressure, or other irritation) of kidney, anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), urinary tract infection, abdominal pain, and pain in the left leg. R39's Care Plan, dated 02/05/24, documented R39 wanted to return to live in the community. The Physician Order, dated 03/18/24, documented a phone order to discharge R39 back to her apartment with the same medication orders. The Progress Note dated 03/18/24 at 03:29 PM, documented R39 informed the nurse a family member was picking her up to take R39 to her apartment. The family member and R39 left the facility at 01:20 PM with medications and instructions. The Discharge Summary Course in Nursing Home documented R39 went home to her apartment. R39's EMR lacked a recapitulation of the resident's stay. On 06/05/24 at 08:00 AM, Administrative Nurse D verified the discharge summary lacked a recapitulation of R39's stay. The facility's Admission, Transfer and Discharge policy, dated 01/03/24, documented the clinical record documentation including the provision of and response to medical treatment and care, and changes in the resident's condition by the resident's chosen attending physician. The resident's functional status at the time of admission and at the time of discharge as well as progress notes that are reported at the time of observation and that describe significant changes in the resident's condition. The facility failed to develop a recapitulation of the resident's stay for R39. This placed the resident at risk for unidentified and unmet care needs.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 32358 The facility had a census of 38 residents. The sample included 12 residents, with four reviewed for accidents. Based on observation, record review, and interview the facility failed to ensure an environment free from accident hazards for cognitively impaired Resident (R) 35. On 05/23/24 at approximately 10:07 AM, Dietary Staff (DS) BB let R35 out the exit door by the main dining room, which led to the patio. DS BB then returned to dietary tasks without ensuring additional supervision for R35. The patio area contained a gate that was unlocked and R35 exited the patio area through the unlocked gate. At approximately 10:39 AM, Maintenance Staff U saw R35 on a bench by the front door reading a newspaper and when he went out the door, R35 walked back inside the facility. At approximately 01:12 PM, another resident asked DS BB to go outside, and DS BB stated they would have to check with the charge nurse to see if the resident could go outside. When DS BB asked the charge nurse, DS BB mentioned letting R35 outside earlier. The staff did not know R35 was outside of the facility without staff supervision until approximately 3.5 hours later. Staff found R35 in her room in her recliner, as R35 had made her way back to her room. The facility's failure to provide adequate supervision to ensure an environment free from accident hazards placed R35 in immediate jeopardy. The facility additionally failed to provide interventions for R12 to prevent falls. This placed R12 at risk for fall-related injury. Findings included: - R35's Electronic Medical Record (EMR) documented R35 had diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), dementia (a progressive mental disorder characterized by failing memory, and confusion), and a history of falling. R35's Quarterly Minimum Data Assessment, (MDS) revised 04/03/24 documented R35 had a Brief Interview of Mental Status (BIMS) score of nine, which indicated severe cognitive impairment. The MDS documented R35 used a walker for mobility and required supervision with ambulation. R35's Care Plan revised 04/22/24, instructed staff to make sure R35 had her walker with her when ambulating. The care plan documented R35 needed to focus on stabilizing herself when she stood up. R35 was unsafe when she walked by herself, and needed reminders for her safety, especially to use her walker. The care plan documented R35's wander/elopement risk assessment concluded she was at moderate risk due to being new to the facility and having poor short-term cognition. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility's Incident Report dated 05/23/24 documented Dietary Staff (DS) BB last saw R35 at 10:07 AM when she let R140 back in the facility and R35 went out the patio door behind him. DS BB told R35 she could not go outside without permission, however R35 continued outside. R35 exited the patio through an unlocked gate, then walked around on the sidewalk with her front-wheeled walker to the front door area of the facility at approximately 10:39 AM. R35 sat on a bench by the front door, and read the newspaper. The report documented Maintenance Staff (MS) U went out the front door and R35 grabbed the door before it closed and went into the facility. The report documented that at 01:12 PM R27 asked DS BB if she could go outside on the patio. DS BB went to the charge nurse to ask if R27 could go outside and mentioned to the charge nurse at that time that R35 was outside. The report noted the charge nurse immediately started looking for R35 and notified Administrative Staff E and Administrative Nurse D. Other staff were notified as well and staff searched for R35. At approximately 01:17 PM staff observed R35 in her room. Observation on 06/03/24 at 09:32 AM revealed an unlocked gait located at the end of a sidewalk, approximately 50 feet outside the dining room exit leading to the patio. The other gait was secured with a zip tie. The surveyor opened the unlocked gait, but the staff did not respond. During an interview on 06/03/24 at 09:32 AM, DS BB stated she let R35 go out on the patio on 05/23/24 because she thought it was safe. DS BB stated she did not know the gate was unlocked. During an interview on 06/03/24 at 09:51 AM, Administrative Nurse D verified the gate straight from the exit door to the patio was unlocked and stated it should be locked. Administrative Nurse D stated the patio gates do not alarm when they are opened and went on to say the facility was trying to get someone to come and put alarms on them. Administrative Nurse D verified the unlocked gate was the one R35 used to leave the building unsupervised on 05/23/24. The facility's Accident Prevention Policy, revised 05/06/24, documented that all staff members of the facility would ensure that each resident's environment remained as free from accident hazards as possible, and each resident would receive adequate supervision and assistive devices to prevent accidents. On 06/03/24 at 02:43 PM, the administrative staff were provided the IJ template and notified the facility's failure to provide a safe environment and supervision for R35 placed the resident in immediate jeopardy. The facility provided an acceptable plan for removal on 06/03/24 at 04:06 PM which included the following corrective actions: Updated Elopement and Elopement Risk Policies The facility started a sign-off sheet to include charge nurses' verification that a resident was able to go outside the facility without staff or a family member. Staff participated in an elopement drill on 05/28/24. R35's care plan was updated on 05/23/24. Initiated daily maintenance cheeks of the patio gates to make sure they are secured. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R35 received 15-minute checks. Updated R35's wander/elopement risk assessment which shows moderate risk for elopement. The surveyor verified the removal of the immediacy and implementation of the corrective actions while on site on 06/04/24 at 11:26 AM. The deficient practice remained at a D scope and severity. 37450 - R12's Electronic Medical Record (EMR), documented diagnoses of spinal stenosis (degenerative condition of the spine that could cause weakness and loss of use of extremities), cognitive-communication deficit, a need for assistance with personal care, restlessness, agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), pain, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and urinary tract infection. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R12 had moderately impaired cognition as assessed by staff. R12 had no delirium (sudden severe confusion, disorientation, and restlessness), psychosis (any major mental disorder characterized by gross impairment in reality perception), or exhibited behaviors. R12 had no functional range of motion impairment and did not use of mobility aids. R12 required substantial to maximal assistance with functional abilities and mobility. R12 was frequently incontinent of urine and bowel. R12 received scheduled pain medication and non-medication interventions for pain. The MDS further documented R12 had two or more falls with no injuries. The Fall Care Area Assessment (CAA), dated 02/07/24, documented R12 falls could be serious and could lead to death, and finding root causes could aid in prevention, and addressing the root causes with interventions would aid in reducing the risk for further occurrence and injuries associated with a fall. R12's Safety Care Plan dated 05/20/24 documented R12 was a high fall risk due to some of the medication R12 took, a fall history, and an unsteady gait. The Progress Note and Care Plan review revealed: On 06/22/23 at 10:35 PM, R12 had a fall with his knees on the floor and his upper body was leaning on his bed. The care plan instructed staff to leave the resident's door open. On 09/15/23 at 04:03 PM, staff assisted R12 with a chair in the dining room when R12's knee gave out. Staff broke the fall with R12 landing on a staff member's foot. The care plan documented R12 had a restorative program but may need more therapy. On 10/16/23 at 08:14 PM, the nurse was called to R12's room and found the resident lying on the floor with gripper socks on and the right foot with grippers on the top of the foot. R12 reported he reached for the wheelchair and the wheelchair rolled away from him. The care plan instructed staff to ensure gripper socks were worn correctly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 11/08/23 at 04:53 AM, R12 was wandering around the facility when he came through the front doors, near the office, tripped on the rug, and landed on the floor. The care plan lacked intervention related to the 11/08/23 fall. On 12/02/23 at 08:33 PM, a resident reported R12 was sitting on the floor of the dining room. The care plan lacked any intervention related to the 12/02/23 fall. On 01/18/24 at 02:08 PM, documented R12 had a fall and was lying on his right side next to a recliner. The care plan lacked any intervention related to the 01/18/24 fall. On 02/01/24 at 03:00 PM, R12 was watching a staff member at the bird cage when R12 crossed his leg and lost his balance. Staff attempted to stop R12's fall by grabbing R12's arms. The care plan intervention instructed staff to know R12 was incontinent, and that the resident's toileting plan had been adjusted. On 02/28/24 at 01:04 PM, documented R12 waved at a visitor, lost his balance, fell back against a wall, slid down, and landed on the floor. The care plan instructed staff R12 had fatigue and his gait and balance were more unstable. The physician had been notified with a request for acetaminophen to help with sleep. On 03/19/24 at 07:00 PM, R12 fell in the lobby and landed on his side. The care plan lacked any intervention related to the 03/19/24 fall. On 04/14/24 at 09:35 PM, R12 was found sitting on the floor in front of the dresser in his room. The care plan lacked any intervention related to the 04/14/24 fall. On 05/01/24 at 11:20 PM, R12 slid out of a wheelchair onto the floor. The care plan directed staff to ensure a gripper pad was in place on the wheelchair seat. On 06/03/24 at 09:05 AM, observation revealed R12 ambulated independently, without an assistive device, slightly leaning forward, arms hanging along his sides. Staff approached him and guided him to a chair in the commons area of the facility. On 06/04/24 at 08:31 AM, Certified Nurse Aide (CNA) O stated R12 wandered throughout the facility and staff tried to keep an eye on him, ensure he was wearing proper footwear, and maintain his toileting program. On 06/05/24 at 11:55 AM, Administrative Nurse D stated all resident falls should have care plan interventions to prevent further falls. Administrative Nurse D verified R12 lacked interventions for falls on 11/08/23, 12/02/23, 01/18/23, 02/01/24, 03/19/24, and 04/14/24. The facility's Fall Prevention Protocol, dated 05/07/24, documented that the effectiveness of the facility fall reduction program will be evaluated on a monthly basis by the Quality Assurance and Performance Improvement (QAPI) committee. Outcome indicators include the number of falls, the severity of fall-related injuries, and the effectiveness of implemented care plan interventions. The facility failed to adequately prevent R12's falls due to a lack of preventative interventions for five of 11 falls experienced which placed R12 at risk for injuries due to falling.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 38 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to assess Resident (R) 22 for trauma-informed care needs to eliminate or mitigate triggers that may cause re-traumatization of the resident. This placed R22 at risk for impaired quality of life. Findings included: - R22's Electronic Medical Record (EMR) documented diagnoses of hypertension (elevated blood pressure), mild cognitive impairment, muscle weakness, chronic pain, and dementia (progressive mental disorder characterized by failing memory, and confusion) with psychotic (any major mental disorder characterized by a gross impairment in reality perception) disturbance. R22's Quarterly Minimum Data Set (MDS), dated [DATE], documented R22 had intact cognition. R22 had no delirium (sudden severe confusion, disorientation, and restlessness), but did have delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and verbal behaviors directed toward others which occurred daily, and other behavioral symptoms not directed at others occurred four to six days of the observation period. R22 required set up or clean up assistance with functional abilities and mobility; the resident was always continent of urine and bowel. The MDS further documented R22 received non-medication interventions for pain and received a diuretic (medication used to promote the formation and excretion of urine). R22's Care Plan dated 04/24/24, documented the resident received a high-alert medication of valproate (antiepileptic drug), and olanzapine (antipsychotic). The Progress Note dated 04/24/24 at 09:08 AM, documented R22 left the facility and the receiving behavioral health unit was called with a report. The Progress Note dated 04/26/24 at 03:25 PM, documented R22 returned to the facility from the behavioral health unit. The Progress Note dated 05/16/24 at 03:09 PM, documented that staff discussed R22's conflict and name-calling of another resident in the dining room. R22's EMR lacked evidence the facility assessed R22 for a history of trauma to identify potential mental health needs. On 06/03/24 at 11:59 AM R22 finished lunch and independently returned to her room using a wheeled walker. On 06/04/24 at 12:45 PM, Certified Nurse Aide (CNA) O stated R22 continued to have behaviors following readmission to the facility. CNA O stated R22 could be unpredictable, but CNA O would try to talk to the resident or allow the resident time to calm down before approaching. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/05/24 at 11:15 AM, Administrative Nurse D stated she had not done a trauma assessment and said the assessment would have been done by social services. On 06/05/24 at 11:27 AM, Social Service X reported she had not completed a trauma-informed care assessment for R22, although she does ask residents about past traumas. Social Service X stated trauma-informed care should be included in the care plan, which would be helpful to staff to manage behavioral symptoms. The facility's Trauma Informed Care policy, dated 06/05/24, documented that the facility ensures that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of proactive and accounting for each resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Within forty-eight (48) hours of admission an initial screening for a history of trauma and determine if a resident has trauma-related symptoms. The facility failed to assess R22 for trauma-informed care needs to eliminate or mitigate triggers that may cause re-traumatization of the resident. This placed the resident at risk for unmet care emotional and psychosocial needs.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37450 The facility had a census of 38 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported an unapproved indication for use, the lack of target behaviors and side effect monitoring, and lack of patient-specific rationale describing why a gradual dose reduction (GDR) was contraindicated for the use of psychotropic (alters mood or thoughts) medications for Resident (R) 6, R13, R22, and R21. This placed the residents at risk for unnecessary medication side effects. Findings included: - R6's Electronic Medical Record (EMR), documented diagnoses of altered mental status, slurred speech, kidney failure, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R6's Quarterly Minimum Data Set (MDS), dated [DATE], documented R6 had severe cognitive impairment with no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by gross impairment in reality perception). R6 had behavioral symptoms not directed toward others, which occurred one to three days during the observation period. R6 was dependent on staff for functional abilities and mobility. The MDS further documented R6 received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), and opioid (a medication used to treat pain) medications. A GDR was documented as clinically contraindicated on 03/22/24. R6's Care Plan, dated 05/28/24, documented R6 received a high alert medication of divalproex (a mood stabilizer), Lexapro (an antidepressant), lorazepam (an antianxiety), Norco (medication used to treat pain), and olanzapine (an antipsychotic); staff was to monitor for adverse side effects. The care plan lacked resident-specific targeted behaviors and monitoring related side effects from the use of high-alert medications. The Physician Orders directed staff to administer the following: Divalproex Sodium Delayed-Release 250 milligrams (mg) tablet daily for disorientation 04/06/23 Lexapro 10 mg daily for anxiety disorder 03/05/22 Zyprexa 2.5 mg daily for altered mental status and anxiety disorder 04/06/23 Lorazepam 0.5 mg two times a day for anxiety disorder 03/04/22 The CP monthly medication regimen reviews (MRR) documented a recommendation for a GDR for Lexapro and Zyprexa on 02/28/24 and a GDR recommendation for lorazepam on 03/31/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Progress Note on 03/10/24 at 10:41 AM, documented R6 continued to holler out since waking in the morning. Scheduled medications were administered as ordered and R6 continued to holler out for mom at times, otherwise just hollered. The resident denied pain and when asked if he needed anything he would say no. The Progress Note on 03/22/24 at 03:05 PM, documented R6's physician declined the GDR for Lexapro and Zyprexa. The MRR reviewed from 05/31/23 through 05/31/24 lacked evidence the CP identified and reported the lack of side effects and targeted behaviors monitoring and lacked evidence the CP reported the unapproved indication and associated risks for Zyprexa. A review of R6's clinical record lacked evidence the physician documented the specific benefits versus the risks for R6's continuation of the antipsychotic medication. On 06/03/24 at 10:29 AM, observation revealed R6 sat in a Broda chair (special wheelchair with the ability to tilt and recline) dressed for the day. R6 had ongoing verbalizations and hollering that were not words. Licensed Nurse (LN) G administered the ordered medications without difficulties. LN G inquired if R6 wanted breakfast and the resident declined but accepted the offer of a glass of chocolate milk. On 06/04/24 at 02:46 PM, LN H reported physician orders in the EMR alerted staff to the type of medications the residents received with black box warnings. The EMR was specific with diagnoses but lacked specific targeted behaviors the resident exhibited. LN H reported the certified nurse aides (CNA) would alert the nurse of behaviors and the nurse would document in the progress notes. On 06/04/24 at 03:20 PM, Administrative Nurse D verified the use of psychotropic medication lacked specific targeted behaviors, symptom monitoring for adverse side effects, and lack of risk versus benefit statement by the physician. Administrative Nurse D verified she was aware of the unapproved indication related to the use of R6's antipsychotic medication, and said the consultant pharmacist had not included that in the monthly reviews. The facility's Consultant Pharmacist Services Provider Requirements, dated 06/05/24, documented the consultant pharmacist provides pharmaceutical care services, including but not limited to reviewing the medication regimen (drug regimen review) of each elder in the healthcare center at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the elder's clinical record. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing. The facility failed to ensure the CP identified and reported the lack of an approved indication for the use of an antipsychotic as well as inadequate monitoring and/or rationale for the continued use of psychotropic medications for R6. This placed R6 at risk of unnecessary psychotropic medications and related side effects. (continued on next page)

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	175494	A. Building B. Wing	06/05/2024

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R13's Electronic Medical Record (EMR) documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), pain, sleep disorder, heart failure, weakness, and major depressive disorder (major mood disorder which causes persistent feelings of sadness)with psychotic (any major mental disorder characterized by gross impairment in reality perception) features. R13's Quarterly Minimum Data Set (MDS), dated [DATE], documented R13 had intact cognition. R13 had no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by gross impairment in reality perception), and exhibited no behaviors. R13 required set up or clean up assistance with functional abilities and supervision or touch assistance with mobility. The MDS further documented the use of an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), a hypnotic (a class of medications used to induce sleep), diuretic (medication to promote the formation and excretion of urine), and opioid (a medication used to treat pain) medication. R13's Care Plan, dated 05/21/24, documented the use of high-alert medications including zolpidem (a hypnotic), duloxetine (an antidepressant), furosemide (a diuretic), Norco (medication to treat pain), trazodone (an antidepressant); staff were to monitor for adverse side effects. The care plan lacked resident-specific targeted behaviors and specific side effect monitoring with the use of high-alert medications. The Physician Orders directed staff to administer the following : Zolpidem 5 milligrams (mg) one time a day related to a sleep disorder 02/03/23 Duloxetine 60 mg one time a day for major depressive disorder, single episode, severe with psychotic features 12/13/23 Trazodone 100 mg one time a day related to a sleep disorder 02/03/23 Buspirone 5 mg two times a day for anxiety disorder 12/27/21 Depakote delayed release 250 mg two times a day for depression 02/29/24 The Progress Note dated 04/06/24 at 08:53 PM, documented R13 stood in the doorway of her room where another resident hollered and R13 stated to the other resident Oh shut up. On 04/24/24 the Pharmacy Recommendation requested the physician to consider a GDR for duloxetine, trazodone, buspirone, and a trial discontinuation of zolpidem. The physician declined the GDR and trial discontinuation of zolpidem. The physician declined the GDRs based on the listed reason that it would impair the resident's function or cause psychiatric instability by exacerbating an underlying condition or disorder. The denials did not record a patient-specific rationale describing why or how a GDR was likely to impair function or cause psychiatric instability in R13. The MRR reviewed from 05/31/23 through 05/31/24 lacked evidence the CP identified and reported the lack of side effects and targeted behaviors monitoring for R13's psychotropic medications. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/04/24 at 02:46 PM, LN H reported physician orders in the EMR alerted staff to the type of medications the residents received with black box warnings. The EMR was specific with diagnoses but lacked specific targeted behaviors the resident exhibited. LN H reported the certified nurse aides (CNA) would alert the nurses of behaviors and the nurse would document them in the progress notes. On 06/04/24 at 03:20 PM, Administrative Nurse D verified the lack of specific target behaviors and symptom monitoring for adverse side effects, as well as the lack of risk versus benefit statements by the physician. The facility's Consultant Pharmacist Services Provider Requirements, dated 06/05/24, documented the consultant pharmacist provides pharmaceutical care services, including but not limited to reviewing the medication regimen (drug regimen review) of each elder in the healthcare center at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the resident's clinical record. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing. The facility failed to ensure the CP identified and reported the inadequate monitoring and/or rationale for the continued use of psychotropic medications for R13. This placed R13 at risk of unnecessary psychotropic medications and related side effects. - R22's Electronic Medical Record (EMR) documented diagnoses of hypertension (elevated blood pressure), mild cognitive impairment, muscle weakness, chronic pain, and dementia (progressive mental disorder characterized by failing memory, and confusion) with psychotic (any major mental disorder characterized by gross impairment in reality perception) disturbance. R22's Quarterly Minimum Data Set (MDS), dated [DATE], documented R22 had intact cognition. R22 had no delirium (sudden severe confusion, disorientation, and restlessness), but did have delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and verbal behaviors directed toward others which occurred daily, and other behavioral symptoms not directed at others occurred four to six days of the observation period. R22 required set up or clean up assistance with functional abilities and mobility; the resident was always continent of urine and bowel. The MDS further documented R22 received non-medication interventions for pain and received a diuretic (medication used to promote the formation and excretion of urine). R22's Care Plan dated 04/24/24, documented high-alert medications of valproate and olanzapine. The Physician Orders directed staff to administer olanzapine (an antipsychotic) 2.5 milligrams (mg) two times a day related to dementia with psychotic disturbance. The Consultant Pharmacist Evaluation of Drug Regimen dated 04/30/24, noted an increase in olanzapine. The CP's evaluation lacked information regarding the unapproved indication for the use of the antipsychotic. On 06/04/24 at 12:45 PM, Certified Nurse Aide (CNA) O stated that R22 continued to have behaviors following readmission to the facility. CNA O stated R22 could be unpredictable, but CNA O would try to talk to the resident or allow the resident time to calm down before approaching. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/04/24 at 02:46 PM, LN H reported physician orders on the EMR alerted staff to the type of medications the residents received with black box warnings. The EMR was specific with diagnoses but lacked specific targeted behaviors the resident exhibited. LN H reported the certified nurse aides (CNA) would alert the nurses of behaviors and the nurse would document them in the progress notes. On 06/04/24 at 03:20 PM, Administrative Nurse D verified she was aware of the unapproved indication related to the use of R22's antipsychotic medication, and said the consultant pharmacist had not included that in the monthly reviews. The facility's Consultant Pharmacist Services Provider Requirements, dated 06/05/24, documented the consultant pharmacist provides pharmaceutical care services, including but not limited to reviewing the medication regimen (drug regimen review) of each elder in the healthcare center at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the elder's clinical record. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing. The facility failed to ensure the CP identified and reported the lack of an approved indication for the use of an antipsychotic for R22. This placed R22 at risk of unnecessary psychotropic medications and related side effects. 32358 - R21's Electronic Medical Record (EMR) documented that R21 had diagnoses of major depressive disorder (a major mood disorder that causes persistent feelings of sadness), Parkinson ' s disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and insomnia (inability to sleep). R21's Quarterly Minimum Data Set (MDS), dated [DATE], documented R21 had a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS documented R21 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) antidepressant (a class of medications used to treat mood disorders) and antianxiety medications during the observation period. R21's Care Plan, revised 04/22/24, documented R21 received Pristiq (a medication used to treat depression and instructed staff to monitor R21 for specific side effects. The care plan documented R21 received Seroquel (antipsychotic) for bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) and instructed staff to monitor R21 for specific side effects. The Physician Order, dated 10/11/23, instructed staff to administer R21 Seroquel extended-release (XR) tablet one time a day for behaviors. The Consultant Pharmacist's (CP) monthly medication regimen reviews (MRR) revealed the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/24/24 the CP recommended a GDR for Pristiq 50 milligrams (mg), Abilify 2 mg, and Seroquel 100 mg, daily. The physician declined the recommendations because the GDR was clinically contraindicated as indicated by the resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time would likely impair the individual's function or cause psychiatric insatiability by exacerbating an underlying medical condition or psychiatric disorder. A review of the MRR revealed the CP did not identify or report the inadequate monitoring for targeted behaviors for R21's psychotropic medications and or the unapproved indication for Seroquel. A review of R21's clinical record lacked evidence of targeted behavior monitoring related to R21's psychotropic medications. On 06/03/24 at 11:55 AM, observation revealed R21 sat in a wheelchair at the dining room table and visited politely with another resident at her table. On 06/04/24 at 03:20 PM, Administrative Nurse D verified the CP had not alerted the facility of the unapproved indication for Seroquel and/or specific targeted behaviors they should be monitoring for or the symptoms of adverse reactions for R21's psychotropic medications. The facility's CP Services Provider Requirements Policy, revised 06/05/24, documented the CP would communicate potential or actual problems detected related to medication therapy orders to the responsible physician and the director of nursing. The CP failed to identify and report the unapproved indication for use for R21's Seroquel and inadequate monitoring of targeted behaviors for R21's psychotropic medications. This placed the resident at risk for unnecessary psychotropic medications and related side effects.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37450 The facility had a census of 38 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 6, R13, R22, and R21 had approved indications and adequate monitoring for the use of psychotropic (alters mood or thought) medications. This placed the residents at risk of receiving unnecessary psychotropic medications. Findings included: - R6's Electronic Medical Record (EMR), documented diagnoses of altered mental status, slurred speech, kidney failure, anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). R6's Quarterly Minimum Data Set (MDS), dated [DATE], documented R6 had severe cognitive impairment with no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by gross impairment in reality perception). R6 had behavioral symptoms not directed toward others, which occurred one to three days during the observation period. R6 was dependent on staff for functional abilities and mobility. The MDS further documented R6 received an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality), antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), and opioid (a medication used to treat pain) medications. A GDR was documented as clinically contraindicated on 03/22/24. R6's Care Plan, dated 05/28/24, documented R6 received a high alert medication of divalproex (a mood stabilizer), Lexapro (an antidepressant), lorazepam (an antianxiety), Norco (medication used to treat pain), and olanzapine (an antipsychotic); staff was to monitor for adverse side effects. The care plan lacked resident-specific targeted behaviors and monitoring related side effects from the use of high-alert medications. The Physician Orders directed staff to administer the following: Divalproex Sodium Delayed-Release 250 milligrams (mg) tablet daily for disorientation 04/06/23 Lexapro 10 mg daily for anxiety disorder 03/05/22 Zyprexa 2.5 mg daily for altered mental status and anxiety disorder 04/06/23 Lorazepam 0.5 mg two times a day for anxiety disorder 03/04/22 The CP monthly medication regimen reviews (MRR) documented a recommendation for a GDR for Lexapro and Zyprexa on 02/28/24 and a GDR recommendation for lorazepam on 03/31/24. (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Progress Note on 03/10/24 at 10:41 AM, documented R6 continued to holler out since waking in the morning. Scheduled medications were administered as ordered and R6 continued to holler out for mom at times, otherwise just hollered. The resident denied pain and when asked if he needed anything he would say no. The Progress Note on 03/22/24 at 03:05 PM, documented R6's physician declined the GDR for Lexapro and Zyprexa. The MRR reviewed from 05/31/23 through 05/31/24 lacked evidence the CP identified and reported the lack of side effects and targeted behaviors monitoring and lacked evidence the CP reported the unapproved indication and associated risks for Zyprexa. A review of R6's clinical record lacked evidence the physician documented the specific benefits versus the risks for R6's continuation of the antipsychotic medication. On 06/03/24 at 10:29 AM, observation revealed R6 sat in a Broda chair (special wheelchair with the ability to tilt and recline) dressed for the day. R6 had ongoing verbalizations and hollering that were not words. Licensed Nurse (LN) G administered the ordered medications without difficulties. LN G inquired if R6 wanted breakfast and the resident declined but accepted the offer of a glass of chocolate milk. On 06/04/24 at 02:46 PM, LN H reported physician orders in the EMR alerted staff to the type of medications the residents received with black box warnings. The EMR was specific with diagnoses but lacked specific targeted behaviors the resident exhibited. LN H reported the certified nurse aides (CNA) would alert the nurse of behaviors and the nurse would document in the progress notes. On 06/04/24 at 03:20 PM, Administrative Nurse D verified the use of psychotropic medication lacked specific targeted behaviors, symptom monitoring for adverse side effects, and lack of risk versus benefit statement by the physician. Administrative Nurse D verified she was aware of the unapproved indication related to the use of R6's antipsychotic medication. The facility's Psychotropic Medication Use policy, dated 06/03/24, documented that the need for psychotropic medication will be monitored, as well as when the resident has received optional benefits from the medication and when the medication dose can be lowered or discontinued. The physician's order for a psychotropic drug will include both a qualifying diagnosis for the drug and a list of specific target behaviors that the staff will monitor during the drug administration. The continued use in accordance with current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric disorder or instability by exacerbating an underlying medical or psychiatric disorder: or the resident's target symptoms returned or worsened after the most recent GDR attempted dose reduction at that time would be likely to impair the resident. Licensed nurses will be aware of the potential side effects of psychotropic medications and report any side effects to the resident's attending physician. The facility failed to ensure R6 had an approved indication for the use of an antipsychotic as well as adequate monitoring and/or rationale for the continued use of psychotropic medications for R6. This placed R6 at risk of unnecessary psychotropic medications and related side effects. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/04/24 at 02:46 PM, LN H reported physician orders in the EMR alerted staff to the type of medications the residents received with black box warnings. The EMR was specific with diagnoses but lacked specific targeted behaviors the resident exhibited. LN H reported the certified nurse aides (CNA) would alert the nurses of behaviors and the nurse would document them in the progress notes. On 06/04/24 at 03:20 PM, Administrative Nurse D verified the lack of specific target behaviors and symptom monitoring for adverse side effects, as well as the lack of risk versus benefit statements by the physician. The facility's Psychotropic Medication Use policy, dated 06/03/24, documented that the need for psychotropic medication will be monitored, as well as when the resident has received optional benefits from the medication and when the medication dose can be lowered or discontinued. The physician's order for a psychotropic drug will include both a qualifying diagnosis for the drug and a list of specific target behaviors that the staff will monitor during the drug administration. The continued use in accordance with current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric disorder or instability by exacerbating an underlying medical or psychiatric disorder: or the resident's target symptoms returned or worsened after the most recent GDR attempted dose reduction at that time would be likely to impair the resident. Licensed nurses will be aware of the potential side effects of psychotropic medications and report any side effects to the resident's attending physician. The facility failed to ensure tR13 had adequate monitoring and/or rationale for the continued use of psychotropic medications. This placed R13 at risk of unnecessary psychotropic medications and related side effects. - R22's Electronic Medical Record (EMR) documented diagnoses of hypertension (elevated blood pressure), mild cognitive impairment, muscle weakness, chronic pain, and dementia (progressive mental disorder characterized by failing memory, and confusion) with psychotic (any major mental disorder characterized by gross impairment in reality perception) disturbance. R22's Quarterly Minimum Data Set (MDS), dated [DATE], documented R22 had intact cognition. R22 had no delirium (sudden severe confusion, disorientation, and restlessness), but did have delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue) and verbal behaviors directed toward others which occurred daily, and other behavioral symptoms not directed at others occurred four to six days of the observation period. R22 required set up or clean up assistance with functional abilities and mobility; the resident was always continent of urine and bowel. The MDS further documented R22 received non-medication interventions for pain and received a diuretic (medication used to promote the formation and excretion of urine). R22's Care Plan dated 04/24/24, documented high-alert medications of valproate and olanzapine. The Physician Orders directed staff to administer olanzapine (an antipsychotic) 2.5 milligrams (mg) two times a day related to dementia with psychotic disturbance. The Consultant Pharmacist Evaluation of Drug Regimen dated 04/30/24, noted an increase in olanzapine. The CP's evaluation lacked information regarding the unapproved indication for the use of the antipsychotic. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/04/24 at 12:45 PM, Certified Nurse Aide (CNA) O stated that R22 continued to have behaviors following readmission to the facility. CNA O stated R22 could be unpredictable, but CNA O would try to talk to the resident or allow the resident time to calm down before approaching. On 06/04/24 at 02:46 PM, LN H reported physician orders on the EMR alerted staff to the type of medications the residents received with black box warnings. The EMR was specific with diagnoses but lacked specific targeted behaviors the resident exhibited. LN H reported the certified nurse aides (CNA) would alert the nurses of behaviors and the nurse would document them in the progress notes. On 06/04/24 at 03:20 PM, Administrative Nurse D verified she was aware of the unapproved indication related to the use of R22's antipsychotic medication, and said the consultant pharmacist had not included that in the monthly reviews. The facility's Psychotropic Medication Use policy, dated 06/03/24, documented that the need for psychotropic medication will be monitored, as well as when the resident has received optional benefits from the medication and when the medication dose can be lowered or discontinued. The physician's order for a psychotropic drug will include both a qualifying diagnosis for the drug and a list of specific target behaviors that the staff will monitor during the drug administration. The continued use in accordance with current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric disorder or instability by exacerbating an underlying medical or psychiatric disorder: or the resident's target symptoms returned or worsened after the most recent GDR attempted dose reduction at that time would be likely to impair the resident. Licensed nurses will be aware of the potential side effects of psychotropic medications and report any side effects to the resident's attending physician. The facility failed to ensure R22 had an approved indication for the use of an antipsychotic. This placed R22 at risk of unnecessary psychotropic medications and related side effects. 32358 - R21's Electronic Medical Record (EMR) documented that R21 had diagnoses of major depressive disorder (a major mood disorder that causes persistent feelings of sadness), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and insomnia (inability to sleep). R21's Quarterly Minimum Data Set (MDS), dated [DATE], documented R21 had a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS documented that R21 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) antidepressant (a class of medications used to treat mood disorders) and antianxiety medications during the observation period. R21's Care Plan, revised 04/22/24, documented R21 received Pristiq (a medication used to treat depression and instructed staff to monitor R21 for specific side effects. The care plan documented R21 received Seroquel (antipsychotic) for bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods) and instructed staff to monitor R21 for specific side effects. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician Order, dated 10/11/23, instructed staff to administer R21 Seroquel extended-release (XR) tablet one time a day for behaviors. The Consultant Pharmacist's (CP) monthly medication regimen reviews (MRR) revealed the following: On 03/24/24 the CP recommended a GDR for Pristiq 50 milligrams (mg), Abilify 2 mg, and Seroquel 100 mg, daily. The physician declined the recommendations because the GDR was clinically contraindicated as indicated by the resident's target symptoms returned or worsened after the most recent GDR attempt within the facility and a GDR attempt at this time would likely impair the individual's function or cause psychiatric insatiability by exacerbating an underlying medical condition or psychiatric disorder. A review of the MRR revealed the CP did not identify or report the inadequate monitoring for targeted behaviors for R21's psychotropic medications and or the unapproved indication for Seroquel. A review of R21's clinical record lacked evidence of targeted behavior monitoring related to R21's psychotropic medications. On 06/03/24 at 11:55 AM, observation revealed R21 sat in a wheelchair at the dining room table and visited politely with another resident at her table. On 06/04/24 at 03:20 PM, Administrative Nurse D verified the CP had not alerted the facility of the unapproved indication for Seroquel and/or specific targeted behaviors they should be monitoring for or the symptoms of adverse reactions for R21's psychotropic medications. The facility's Psychotropic Medication Use policy, dated 06/03/24, documented that the need for psychotropic medication will be monitored, as well as when the resident has received optional benefits from the medication and when the medication dose can be lowered or discontinued. The physician's order for a psychotropic drug will include both a qualifying diagnosis for the drug and a list of specific target behaviors that the staff will monitor during the drug administration. The continued use in accordance with current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric disorder or instability by exacerbating an underlying medical or psychiatric disorder: or the resident's target symptoms returned or worsened after the most recent GDR attempted dose reduction at that time would be likely to impair the resident. Licensed nurses will be aware of the potential side effects of psychotropic medications and report any side effects to the resident's attending physician. The facility failed to ensure an approved indication for use for R21's Seroquel and adequate monitoring of targeted behaviors for R21's psychotropic medications. This placed the resident at risk for unnecessary psychotropic medications and related side effects.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 26768 The facility had a census of 38 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to store foods and ensure proper dishwashing in a manner to prevent food-borne illness. This placed the residents at risk for foodborne illness. Findings included: - On [DATE] at 09:22 AM, during the initial kitchen tour, observation revealed the following: The stainless-steel double-door refrigerator with a freezer on the bottom lacked a thermometer in the refrigerator section. The freezer section had seven opened, unsealed, unlabeled bags of frozen foods. The thermometer on the door shelf was not working. The walk-in freezer had boxes of homestyle portion chicken, frozen pasta, white shrimp, diced strawberries, and peach pies stored on the freezer floor. The white refrigerator in the hallway entry with a freezer in the top portion that had seven containers of an expired frozen product with a label that read Must be used by [DATE]. On [DATE] at 10:48 AM, observation in the facility kitchen revealed the walk-in freezer lacked an independent backup thermometer. The facility dishwashing machine used detergent pellets and sensors for heating and amounts of chemicals to disperse. The dishwashing logs documented the following: [DATE] through [DATE] temperatures ,d+[DATE] degrees F (Fahrenheit) with 200 parts per million (ppm) sanitizers. [DATE] through [DATE], no temperatures were recorded. [DATE], [DATE], and [DATE] the documentation lacked sanitizer or temperatures recorded. The facility's Weekly Water Temperature Log documented April kitchen water heater weekly checks, which measured ,d+[DATE] F, May checks measured ,d+[DATE] F, and June checks measured 118 F. On [DATE] at 09:22 AM, Dietary Staff DD verified the undated bags of frozen foods, the lack of an independent thermometer in cold storage, and the expired foods. Dietary Staff DD verified the boxes on the floor and stated the delivery came the day before and the employee could not lift so she was trying to get them put away today as she got time. Dietary Staff DD verified the expiration dates and stated the activity department put those in there and they should have been thrown away. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:21 AM, Dietary Staff CC verified staff should not store boxes of food on the freezer floor. Staff was to label and date food when opened, ensure working backup thermometers in each cold storage unit and dispose of expired foods. On [DATE] at 01:25 PM, Dietary Staff CC verified staff should have checked the temperature and chemical sanitation twice, daily. He verified the missing documentation and stated the dishwasher used chemical sanitation with low-temperature detergent. The facility's Dietary Purchases, Receipt, and Storage policy, dated [DATE], stated the Dining Services Manager was responsible for receiving and storing all food and supplies in a proper area. Ordering procedures require weekly inventories and there will be a complete inventory of all consumable items weekly by the Dining Services Manager. Staff would check refrigerators daily for any expired food and dispose of it daily. The facility failed to store foods and ensure proper dishwashing in a manner to prevent food-borne illness related to unsealed, undated bags of frozen food, food stored on the freezer floor, no backup thermometers for cold storage, and the dishwashing log lacked monitoring of chemical or temperatures for three days in [DATE]. This placed the residents at risk for foodborne illness.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 26768 The facility had a census of 38 residents. Based on interviews and record review, the facility failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by Legionella). This placed the residents in the facility at risk for infectious disease. Findings included: - The facility's Water Temperature Check Log documented checks of laundry, kitchen, common areas, and resident rooms weekly. The facility did not have documentation of Legionella preventative measures including identification of risk areas and actions taken to mitigate risk. During an interview on 06/04/24 at 03:10 PM, Maintenance Staff V verified the facility lacked a map of water distribution and dead-end or little-used faucets despite one whole resident hall was not used. Maintenance Staff V confirmed there was no documentation of disinfection of shower heads. During an interview on 06/04/24 at 03:13 PM the facility's Infection Control Preventionist CC verified the facility did not have the required documentation to show follow through with the water management plan to prevent Legionella or another waterborne pathogen. The facility's Water Management Policy, dated 01/17/24, stated the minimum standards included: suitable Legionella risk assessments. Description of building water systems. Identification of where Legionella could grow and spread. Action plan for preventing or controlling the risk. Implementation, management, monitoring, and recording of precautions to include regular inspections, microbiological monitoring, temperature checks, and flushing where appropriate. The facility failed to implement a water management program to manage waterborne pathogens placing the residents who reside in the facility at risk of contracting Legionella pneumonia.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768 The facility had a census of 38 residents. Based on the interview and record review, the facility failed to offer pneumococcal (type of bacterial infection) immunizations for four of the six residents sampled for immunizations: Residents (R) 13, R25, R12, and R24. This placed the residents at risk for complications related to pneumococcal pneumonia. Findings included: - R13's Electronic Health Record (EHR) documentation indicated R13 received one Pneumovax dose on 04/07/16. The facility lacked documentation R13 was offered or refused any further pneumococcal vaccinations. R13's Physician Order dated 03/26/21, directed staff to administer the pneumococcal vaccine per facility policy. R25's EHR documentation indicated R25 received one Pneumovax dose on 12/05/19. The facility lacked documentation R25 was offered or refused any further pneumococcal vaccinations. R25's EHR documented an admitting diagnosis of pneumonia and a Physician Order dated 02/23/22 that directed staff to administer the pneumococcal vaccine per facility policy. R12's EHR documentation indicated R12 received one Pneumovax dose on 09/24/19. The facility lacked documentation R12 was offered or refused any further pneumococcal vaccinations. R12's Physician Order dated 03/23/23, directed staff to administer the pneumococcal vaccine per facility policy. R24's EHR documentation indicated R24 received one Pneumovax dose on 11/19/15. The facility lacked documentation that R24 was offered or refused any further pneumococcal vaccinations. R24's Physician Order dated 08/10/21 directed staff to administer the pneumococcal vaccine per facility policy. During an interview on 06/04/24 at 01:14 PM, Administrative Nurse E verified four of the six reviewed residents had not received a second pneumonia immunization since admission to the facility and the facility had not screened the residents for eligibility for a second pnuemovax. During an interview on 06/04/24 at 03:00 PM, Administrative Nurse D stated the facility had not made a list of residents eligible to receive a second pneumococcal vaccination. She verified the residents reviewed were older than 65. She stated all the information was in their EHR. She stated the pharmacy would perform the vaccinations after they (the pharmacy) reviewed for eligible residents. During an interview on 06/05/24 at 09:42 AM, Administrative Nurse D verified the facility should have offered residents the physician-ordered pneumococcal vaccination according to facility policy. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Influenza and Pneumonia Immunization Policy dated 01/04/24, stated all current and newly admitted residents would be offered the Pneumovax injection as desired by the resident and approved by the primary care physician after investigation related to current immunization status. The Centers for Disease Control and Prevention (CDC) recommends two pneumococcal vaccines for all adults [AGE] years or older. PCV13 followed by a dose of PPSV23 at least one year later. If PPSV23 is done- a dose of PCV13 will be administered at least one year later. Each resident's immunization status would be determined, if possible, prior to vaccination and documented in the resident's clinical record. Prior to offering the vaccination each resident or their representative would receive current education regarding the benefits and potential side effects of the immunization. Pneumococcal vaccines are offered and administered by the county Health Department or the resident's physician. The clinical record would include the education provided and whether the vaccine was received or refused. The facility failed to offer R13, R25, R12, and R24 the physician ordered pneumococcal immunization. This placed the residents at risk for complications related to pneumococcal pneumonia.