STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185388	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sam Swope Care Center	240 Masonic Home Drive Masonic Home, KY 40041

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview, record review, and review of the facility's policy, the facility failed to ensure a residents' right to formulate an advance directive were honored for one of four residents reviewed for advance directives out of 35 sampled residents (Resident (R) 85). R85 who was his own decision maker, requested and signed to be a full code status (life saving measures) upon admission to the facility; however, the facility inadvertently entered a Do Not Resuscitate (DNR) order which contradicted the resident's decision. Additionally, the facility allowed the resident's Power of Attorney (POA) to sign DNR documents instead of the resident signing his own code status forms. This failure placed the resident at risk for death in the event of a cardiac and/or respiratory failure. An Immediate Jeopardy was identified on [DATE] and was determined to exist on [DATE], in S483.10 F578: Request/Refuse/Discontinue; Formulate Advance Directives. The Administrator was notified on [DATE] at 3:57 PM of the Immediate Jeopardy. An acceptable Immediate Jeopardy Plan of Removal was provided on [DATE] at 12:55 PM and was validated on [DATE] at 10:55 PM. The Administrator was notified the Immediate Jeopardy was removed. After the removal of the Immediate Jeopardy, the deficiency remained at a scope and severity of a D. The findings include: Review of the facility's policy titled, Advance Directives, revised ,d+[DATE], revealed Advance directives will be respected in accordance with state law and facility policy .3. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative or resident representative in accordance with state and federal laws .7. In accordance with the State and Federal requirements, the legal representative may also have the right to refuse or forego treatment .a. Advance Directive-a written instruction, such as a living will or durable power of attorney for heath care, recognized by State law, relating to the provisions of health care when the individual is incapacitated .c. Durable Power of Attorney for Health Care (i.e., Medical Power of Attorney)-a document delegating authority to a legal representative to make health care decisions in case the individual delegating that authority subsequently becomes incapacitated .14. Nursing Services or designee will notify the Attending Physician as necessary of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Physician orders Process, revised ,d+[DATE] revealed .5. Code status for residents will [be] based upon the completed code status form signed by the resident or the resident representative or legal representative. Physician order will be obtained. 6. The physician or extender that gives a verbal order will be required to electronically sign the order in accordance with the most update [sic] federal and state regulation . Review of R85's undated Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet, tab revealed the resident was admitted to the facility [DATE] with diagnoses which included chest pain, asthma, hypercholesterolemia, hypertension, and coronary atherosclerosis of unspecified type of vessel, native or graft. Further review of R85's Face Sheet revealed the resident had a POA. Review of R85's Minimum Data Set (MDS), with an assessment reference date (ARD) of [DATE] and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. Review of R85's MDS, with an ARD of [DATE] and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 14 out of 15 which indicated the resident was cognitively intact. Review of R85's Directives for Code Status, dated [DATE] and provided by the facility revealed R85 chose to be a Full Code. R85 signed the document himself. Review of R85's Physician Verbal Order, dated [DATE] revealed an order of Do Not Resuscitate [DNR]. The order was entered by Licensed Practical Nurse Unit Manager (LPNUM) 1. During an interview on [DATE] at 3:39 PM, R85 stated if he was found unresponsive, he would want staff to start cardiopulmonary resuscitation (CPR) on him. During a subsequent interview on [DATE] at 4:20 PM, R85 told a Registered Nurse Surveyor he had signed a paper saying he wanted to be a full code. When asked what a full code meant, R85 stated if his heart stopped, or he stopped breathing, he wanted chest compressions to be done. During an interview on [DATE] at 4:29 PM, LPNUM1 reviewed R85's code status in the EMR and stated R85 was a DNR, so no CPR would be done. During an interview on [DATE] at 4:30 PM, LPN1 was asked what he would do if he found R85 unresponsive. LPN1 checked his assignment sheet which documented R85 as a DNR. The LPN then checked R85's physician order in the EMR which also reflected the code status of DNR. LPN1 stated CPR would not be done on R85. Review of the facility's untitled and undated assignment sheet provided by LPN1 revealed the document had R85 listed as a DNR. During an interview on [DATE] at 4:56 PM, Social Worker (SW) 1 stated R85 was his own decision maker. When asked what R85's code status was, SW1 stated she thought he was a DNR. When asked who should have signed the DNR paperwork, SW1 stated R85 or the POA should have. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 6:42 PM, POA 85 stated he signed DNR papers back in [DATE] because he did not want his brother to just lay there, so he thought it would be best to sign the DNR paperwork. Continued interview revealed the POA did not recall having a telephone conversation with a nurse regarding a decision to make the resident a DNR or full code. The POA stated approximately two years ago R85 became severely ill and R85 was a DNR; however, he had not had a conversation since then with his brother regarding code status and he did not know R85 wanted to be a full code. The POA also stated R85 could make his own decisions, and the facility should follow his brothers wishes. During an interview on [DATE] at 5:01 PM, the Social Service Director (SSD) stated she was not really familiar with R85 as he was not on her case load. The SSD stated R85 had a BIMS of 14 so she would assume he could make his own decisions. The SSD confirmed R85 signed a Directives for Code Status, document on [DATE] choosing to have a full code status. The SSD also confirmed a DNR was signed by POA1 on [DATE]. Review of R85's Directives for Code Status, dated [DATE] and provided by the facility revealed POA85 chose for R85 to be a DNR. POA85 signed the document and not R85 who was his own decision maker. During an interview on [DATE] at 5:28 PM, the Director of Nursing (DON) stated residents who had decision making capacity would make their own code status decision. The DON confirmed R85 signed to be a full code on [DATE]. The DON also confirmed a physician's order dated [DATE] which ordered R85 to be a DNR. When asked why the resident's decision to be a full code status and the physician's order contradicted each other, the DON stated it appeared the physician's order entered on [DATE] which ordered the resident to be a DNR was entered in error. During an interview on [DATE] at 10:24 AM, LPNUM1 confirmed she was the nurse who entered the physician's order for R85 to be a DNR. LPNUM1 stated she reviewed R85's Directives for Code Status, document dated [DATE] and seen the resident selected to be a full code. The LPNUM also stated when she put the electronic order in the EMR, it was a drop-down box and she erroneously selected DNR instead of Full Code. Continued interview revealed on [DATE] she called R85's POA in the presence of R85 to go over the resident's baseline care plan. During this conversation, she discussed R85's code status of DNR with the POA and the R85 per the physician's order on [DATE]. LPNUM1 stated neither R85 nor POA85 questioned the code status. The LPNUM further stated she let the resident and the POA know that paperwork (DNR form and EMS form) needed to be signed and the POA stated he would sign the paperwork the next time he was at the facility. During an interview on [DATE] at 4:48 PM, the Executive Director stated it was his expectation residents' wishes regarding code status would have been honored.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview, record review, and review of the facility's policy, the facility failed to report an allegation of abuse within two hours of the allegation for one of seven residents reviewed for abuse (Resident (R) 88) out of 35 sampled residents. On 06/28/2024 R88 reported an allegation of sexual abuse to the facility; however, the facility failed to report the allegation to the State Survey Agency (SSA) within the required two-hour time frame. R88 reported the allegation to the facility staff on 07/04/2024 at approximately 9:00 AM; however, the Administrator did not report the allegation to the SSA until 12:41 PM, which was outside of the required two-hour reporting timeframe. This failure placed the investigation of the allegation made by the resident at risk of being compromised. (Cross reference F610 and F842) The findings include: Review of the facility's policy titled, Abuse and Neglect Policy and Procedure, dated 10/2022 revealed The purpose of this policy is to attempt to prevent any type of abuse to residents through pre-employment and pre-admission screening, training of new staff and ongoing training for all staff, identification, investigation, protection, prevention, and reporting of abuse .Sexual Abuse .non-consensual sexual contact of any type with a resident .7. Training on reporting abuse .Reporting: 1. In accordance with the state and federal regulation all suspicions of abuse .will be reported. Reports will be made by the Administrator, or designee. Notification to the Department for Community Based Services, Office of Inspector General .will occur as indicated by the most current regulation of the community .c. Initial allegations involving .sexual abuse .are reported immediately, but not later than 2 hours after the allegation is made . 1. Review of the facility's investigation revealed on 07/04/2024 Resident [R88 was] admitted to the facility on [DATE] and stated that she was raped by a white woman on 06/27/2024 while at the hospital. She could not remember the name. During the interview with the DON [Director of Nursing], resident's cognition was alert and confused. Her current BIMS [Brief Interview for Mental Status Score] is a 7 [seven] [severely cognitively impaired]. [The] Resident did not exhibit any distress during the interview .DON when speaking to the resident's husband, he stated she was raped when she was [AGE] years old and fixated on the situation. The resident later stated it was a black woman. The resident alleged it happened prior to admission at the hospital. Other residents were interviewed, and body checks were completed on residents who were not cognitively intact. The facility reported timely. Unsubstantiated. The investigation revealed the facility documented the date and time the facility became aware of incident was 07/04/2024 at 11:15 AM and documented the Administrator was notified of the allegation on 07/04/2024 at 11:30 AM. Review of an email, dated 07/04/2024 at 12:41 PM, provided by the Administrator, revealed the subject line of the email was [R88's Name] initial report. The email was sent to the SSA. Review of R88's entire medical record revealed no documented evidence of the allegation made by R88. R88's medical record also lacked any documented evidence of immediate assessments made by nursing staff on R88 related to the allegation of sexual abuse. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R88's undated Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included dementia, psychotic disorder, and generalized anxiety disorder (GAD). Review of R88's admission Minimum Data Set (MDS), with and assessment reference date (ARD) of 06/06/2024 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a BIMS score of 11 out of 15 which indicated the resident was moderately cognitively impaired. Review of R88's Physical Therapy Treatment Encounter Note(s), electronically signed and dated 07/04/2024 at 12:07 PM, located in the resident's EMR under the Therapy tap revealed .During session, pt [R88] reported an incident that happened last Thursday evening. Social Services was called, and incident was reported to social worker . The note was electronically signed by Physical Therapy Assistant (PTA) 1. During an interview on 08/16/2024 at 2:50 PM, PTA1 stated at approximately 9:00 AM on 07/04/2024, R88 reported her bottom was sore and she had been raped by two black women. The PTA stated she immediately notified Social Worker (SW) 1. During an interview on 08/16/2024 at 3:05 PM, SW1 stated on 07/04/2024 between 9:00 AM and 9:15 AM she received a telephone call from PTA1 who reported R88 made an allegation of being raped. The SW stated when she received the call, she was almost to the facility and as soon as she arrived at the facility she went and interviewed R88. SW1 stated R88 reported the allegation occurred on Thursday. The SW stated she then asked the resident was it the current Thursday (07/04/2024) while she was at the facility or the prior Thursday when she was at the hospital; however, R88 was not able to tell her which Thursday the rape allegation occurred. When asked if she documented the interview with R88, SW1 stated she wrote it down on a scrap piece of paper; however, she threw the paper away and did not document the interview in the resident's medical record. Continued interview revealed she reported the allegation to the DON on 07/04/2024 at approximately 9:30 AM. During an interview on 08/16/2024 at 4:11 PM, the DON stated she was in the morning clinical meeting on 07/04/2024 when SW1 came and reported to her R88 was alleging she had been raped. The DON stated she immediately left the meeting and went and interviewed R88. When asked what R88 told her in her interview, the DON stated it was what was documented in her (DON) statement which was part of the facility's investigation. Continued interview revealed when asked what time the SW reported the allegation to her and what time she interviewed R88, the DON stated the clinical meeting started at 10:00 AM and ended at approximately 11:00 AM, so it was reported to her between 10:00 AM and 11:00 AM but could not give the exact time. The DON also stated she did not document the time she interviewed R88 about the allegations. During an interview on 08/16/2024 at 4:26 PM, the Administrator stated abuse allegations were to be reported to the SSA within two hours once the allegation was made. The Administrator stated the allegation was reported to him on 07/04/2024 at 11:30 AM. When asked what time the facility's staff became aware of the allegation, the Administrator stated, I don't have that in here [in his investigation]. When asked if he could definitively say the allegation was reported to the SSA timely, the Administrator stated, on my part yes. When the Administrator was informed the allegation was made by R88 to facility staff on 07/04/2024 at approximately 9:00 AM, the Administrator stated he was not aware there was an issue with the timeliness of the reported allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36898 Based on interview, record review, and review of the facility's policy, the facility failed to thoroughly investigate allegations of abuse for two of seven residents reviewed for abuse (Resident (R) 88 and R103) out of 35 sampled residents. R88 made an allegation of abuse on 07/04/2024 at approximately 9:00 AM. A facility staff member reported R103 was a victim of verbal abuse. (Cross Reference F842) The findings include: Review of the facility's policy titled, Abuse and Neglect Policy and Procedure, 10/2022 and provided by the facility revealed The purpose of this policy is to attempt to prevent any type of abuse to residents through investigation, protection, prevention .of abuse .Identification of Abuse: .2. The Administrator, or designee, will initiate an in-house investigation into any allegations and make appropriate determination related to the reporting of events to the .Office of Inspector General [State Survey Agency (SSA)] .Investigation: 1. The Administrator will be responsible for ensuring the facility's compliance with all applicable provisions .4. Information related to a report of abuse, will be obtained from persons with knowledge of the reported incident . 1. Review of R88's undated Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses which included dementia, psychotic disorder, and generalized anxiety disorder (GAD). During an interview on 08/16/2024 at 2:50 PM, Physical Therapy Assistant (PTA) 1 stated at approximately 9:00 AM on 07/04/2024, R88 reported her bottom was sore and she had been raped by two black women. The PTA stated she immediately notified Social Worker (SW) 1. During an interview on 08/16/2024 at 3:05 PM, SW1 stated on 07/04/2024 at approximately 9:00 AM, PTA1 called her and reported to her R88 made an allegation of sexual abuse. SW1 stated she was on her way to the facility at that time and arrived approximately five minutes later. SW1 also stated she immediately went and interviewed R88 who alleged she was raped. Continued interview revealed the SW finished interviewing R88 and then immediately reported this to the Director of Nursing (DON). Review of the facility's 5 Day Follow up/Final Report, of their internal investigation revealed no documented evidence SW1 was interviewed related to her interview with R88. Additionally, there was no documented evidence in the resident's medical record the resident was assessed by nursing staff. During an interview on 08/16/2024 at 4:26 PM with the Administrator, when asked if he interviewed SW1 or obtained a statement from SW1 since she was the first person to interview R88 after she made the allegation to PTA1 and if it could have been pertinent to his investigation since the resident could not tell the SW which Thursday the sexual abuse allegedly occurred, the Administrator stated he got what the resident was alleging through other interviews. When asked if it would have been important to know what the resident reported to SW1 during the social worker's interview including what time it was reported to her by PTA1, the Administrator stated, my role is once I am notified, I start the investigation [the Administrator avoided the specific question asked]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Cross Reference F609 and F842) 2. Review of R103's undated Face Sheet, located in the resident's EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE]. Review of R103's quarterly Minimum Data Set (MDS),with an assessment reference date of 04/29/2023 and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated the resident was moderately cognitively impaired. Review of the facility's 5 Day Follow up/Final Report, dated 08/21/2023 revealed on 08/17/2023 Licensed Practical Nurse (LPN) 4 reported CNA [Certified Nurse Aide] 8 and CNA9 were cursing in the dining room with resident [R103's Name] present .Staff interviews with no new findings, resident interviews no new findings, skin assessments with no new issues. After a thorough investigation, we are unable to substantiate the allegation of abuse . Review of a document titled, Verbal Statement from [LPN4's Name], dated 08/17/2023 with no interview time documented located in the facility's investigation revealed [R103's Name] asked me [LPN4] for some butter. I found the butter in the fridge and told the CNA [CNA8's Name], here was some butter. [R103's Name] became upset and began cursing. [CNA8's Name] then silently mouthed the word 'B***h' and then said some other things which I didn't hear. The other CNA, [CNA9's Name] jumps up, and her and resident were exchanging words. [CNA9] then said to [R103's Name] to get the [expletive] out of her face and back up,' he raised his cane and I [LPN4] got in between the resident and staff member to separate the situation. Review of a document titled, Verbal Statement via phone [CNA8's Name], dated 08/17/2023 with no interview time documented located in the facility's investigation provided by the facility revealed [R103's Name was asking for butter for his shrimp. I looked in the refrigerator and didn't see any. The nurse came over and found some butter. [R103's Name] started calling me a fu****g liar and I really didn't see the butter. He also told me I need to wear glasses, and I said I don't wear glasses and then I walked away. I did not curse [R103's Name]. Review of a document titled, Verbal Statement via phone [CNA9's Name], dated 08/17/2023 with no interview time documented located in the facility's investigation provided by the facility revealed [R103's Name] was upset and came at me. I kept telling him to 'back up,' he was calling me a 'fu****g liar' and was talking to [CNA8's Name] that way. He said he was going to hit me with his cane and the nurse came over and got him away. I never cussed him at all. I would never curse any residents Review of CNA9's document titled, Employee Counseling, dated 08/21/2023, located in the employee's personnel file provided by the facility revealed CNA9 was discharged (terminated) from her employment for . Unprofessional behavior in the workplace that is considered by management to be unacceptable . Review of CNA9's Payroll Activity/Change Form, dated 08/24/2023 and located in the CNA's employee personnel file provided by the facility revealed the CNA was terminated for Misconduct/Policy Violation and was not eligible for re-hire. It was documented that the last day CNA9 worked was 08/17/2023. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/16/2024 at 4:41 PM, when asked if he reviewed the facility's video surveillance which was located in the dining room where the alleged allegation occurred, the Administrator stated he did not recall if he reviewed it; however, if he had reviewed it, he would not have included it in his investigation if it was not pertinent. When asked would it had been helpful to review the video footage to validate or invalidate the event that was alleged, the Administrator stated sure. The Administrator also stated CNA9 was terminated for cussing in the dining room [during the alleged allegation] as it was unprofessional even though it was not towards a resident.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety 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** 36190 Based on interview, record review, and review of the facility's policy, the facility failed to develop and implement person centered comprehensive care plans for four of 35 sampled residents (Resident (R) 85, R90, R59, and R117). Upon admission to the facility, R85 chose his code status to be a full code; however, the resident's Care Plan contradicted his code status by having conflicting information when his care plan indicated he was a full code and had a do not resuscitate (DNR) code status. This placed the resident at risk for death in the event of cardiac and/or respiratory failure episode. An Immediate Jeopardy was identified at on [DATE] and was determined to exist on [DATE] at S483.21(b)(1) F656-Develop/Implement Comprehensive Care Plan. The Administrator was notified on [DATE] at 3:57 PM of the Immediate Jeopardy. An acceptable Immediate Jeopardy Plan of Removal was provided on [DATE] at 12:55 PM and was validated on [DATE] at 10:55 PM. The Administrator was notified the Immediate Jeopardy was removed. After the removal of the Immediate Jeopardy, the deficiency remained at a scope and severity of a D. Findings include: Review of the facility's policy dated ,d+[DATE] revised on ,d+[DATE], titled Care-Plans Comprehensive revealed The facility must develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Review of the Policy interpretation and implementation revealed The interdisciplinary Team, in coordination with the resident, his/her resident representative, develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS [Minimum Data Set] . Each resident's comprehensive care plan will include services that are to be furnished to maintain the resident's highest practical physical, mental, psychosocial wellbeing, including advance directive code status . Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plans . Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change . the interdisciplinary Team is responsible for the review and revision of care plans after each assessment, including comprehensive and quarterly assessments. 1. Review of R85's undated Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet, tab revealed the resident was admitted to the facility [DATE] with diagnoses which included chest pain, asthma, hypercholesterolemia, hypertension, and coronary atherosclerosis of unspecified type of vessel, native or graft. Further review of R85's Face Sheet revealed the resident had a Power of Attorney (POA). (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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R85's Minimum Data Set (MDS), with an assessment reference date (ARD) of [DATE] and located in the resident's EMR under the MDS tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. During an interview on [DATE] at 3:39 PM, R85 stated if he was found unresponsive, he would want staff to start cardiopulmonary resuscitation (CPR) on him. During a subsequent interview on [DATE] at 4:20 PM, R85 told a Registered Nurse Surveyor he had signed a paper saying he wanted to be a full code. Review of R85's Directives for Code Status, dated [DATE] and provided by the facility revealed R85 chose to be a Full Code. R85 signed the document himself. Review of R85's Physician Verbal Order, dated [DATE] revealed an order of Do Not Resuscitate [DNR]. The order was entered by Licensed Practical Nurse Unit Manager (LPNUM) 1. Review of R85's Comprehensive Care Plan, created and effective on [DATE] and last evaluated (updated) on [DATE], located in the resident's EMR under the Care Plan tab revealed a problem of . [R85's Name] advance directive: Full Code. The Care Plan had a goal of [R85's Name] wishes will be respected and honored. Interventions included .EMS DNR IN PLACE . which contradicted the residents wishes to be a full code and indicated EMS would not perform CPR in the event of a cardiac and/or respiratory event. During an interview on [DATE] at 10:24 AM, LPNUM1 confirmed she was the one who completed the code status section of R85's initial comprehensive care plan which reflected full code. The LPNUM stated she forgot that the resident had wanted to be a full code and when she went over the baseline care plan, she was looking at the ribbon of the EMR which indicated DNR based on the physician's order she entered on [DATE]. The LPNUM also confirmed the care plan indicated the resident was a full code; however, the care plan included DNR . as an intervention which contradicted each other. During an interview on [DATE] at 2:49 PM, the [NAME] President of Risk Management (VP) 1 confirmed the resident's care plan had a problem which indicated the resident was a full code but had an intervention which indicated the resident was a DNR. VP1 stated it was her expectation residents' care plans would have been reflective of person centered care which included residents' code status wishes. During an interview on [DATE] at 4:48 PM, the Executive Director stated it was his expectation resident's code status wishes be honored and followed. The Executive Director also stated it was his expectation care plans would be accurate and reflected the resident's preferences and care needs. (Cross Reference F578) 2. Review of the Face Sheet located in the EMR under the Profile tab revealed R117 was admitted to the facility on [DATE] with diagnoses of neoplasm (cancer) of the prostrate, injury of ureter, obstructive uropathy, and acute kidney failure. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R117's admission MDS located in the EMR under the MDS tab with an ARD of [DATE] revealed R117 had a BIMS of 15 out of 15 which indicated the resident was cognitively intact. Review of the MDS revealed R117 had an indwelling foley catheter. Review of R117's admission comprehensive Care Plan dated [DATE] located in the EMR under the Care Plan tab revealed a problem was not addressed for the use of the foley catheter. Review of R117's physician orders located in the EMR under the Orders tab with a date of ,d+[DATE] revealed an order for an 18 French (FR) with a 10 cubic centimeter (cc) balloon. The physician order further revealed R117 was to have catheter care done twice daily and urine output was to be documented. During an observation of R117 on [DATE] at 11:16 AM revealed the resident was lying in bed and had a foley catheter bag attached to the bedside. During an interview with R117 on [DATE] at 11:16 AM revealed he had prostate cancer and used the foley. During an interview on [DATE] at 1:12 PM with the MDS Coordinator (MDSC) confirmed she did not see a care plan in place for the foley catheter use and there should be. The MDSC further revealed the foley catheter should have an individual problem with individual interventions. The MDSC revealed the physician orders should have been on the Care Plan. The MDSC further revealed the Care Plan was utilized to provide staff with the knowledge of what needs to be done for the residents. The MDSC revealed she updated the care plans; however, the nurses should update the care plans too. The MDSC revealed the care plan was also carried over to the resident summary which went into the kiosk so that the Certified Nursing Assistants (CNAs) could see what care needed to be done. During an interview on [DATE] at 4:39 PM with the Director of Nursing (DON) revealed a foley catheter use should be care planned. The DON further revealed the staff would use the care plan as a guide for care of R117. During an interview on [DATE] at 5:18 PM with the Executive Director revealed the care plan should be updated according to the resident's needs. 3. Review of R90's quarterly MDS with an ARD of [DATE], located in the MDS tab of the EMR, revealed an admitted [DATE]. R90 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating R90's cognition was intact. R90's vision was severely impaired, received dialysis and chronic renal failure. Review of R90's Care Plan with an effective date of [DATE] to present, located in the EMR under the Care Plan tab, revealed R90 has the potential for complications related to hemodialysis for diagnosis of chronic renal failure and a goal Resident will remain free from complications related to renal dialysis, goal date [DATE]. An intervention included Monitor access area for redness or pain or signs of infection and report to MD [physician]. Review of R90's [DATE] Treatment Administration Record (TAR) located in the EMR under the Order tab revealed: Dialysis: Dialysis: Assess Access Site () Two Times Daily starting [DATE], order date: [DATE], Discontinued ([DATE]), Notes: Monitor Tunnel Catheter twice daily right chest, (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dialysis: Check for Thrill, Bruit, and Assess Site () Two Times Daily starting [DATE], order date: [DATE], Deleted-entry error, Notes: right chest tunnel cath. Order ID: 977651 has not been assigned administration times in the Date Range Specified, and Scheduled 3 times weekly Three Times Weekly starting [DATE], order date: [DATE], Notes: days of dialysis Monday, Wednesday, Friday at 6:30 AM . Review of R90's Dialysis Communication forms, dated [DATE], [DATE], and [DATE] located in the EMR under the Provider tab revealed no monitoring of R90's right chest tunnel catheter. Review of R90's notes, dated [DATE] to [DATE], located in the EMR under the Note tab revealed no documentation of R90's right chest tunnel catheter. During an interview on [DATE] at 9:46 AM, the Director of Nursing (DON) was asked where the implementation of R90's Care Plan related to the documentation for the monitoring of R90's right chest tunnel catheter was located. The DON reviewed the TAR in the EMR and stated she could not find a treatment order specifically for monitoring the catheter, just a general order for infection. The DON then pointed to a treatment order that had been discontinued for monitoring the Tunnel Catheter. The DON stated the treatment order had inadvertently been discontinued. The DON stated R90's access site had changed several times from her arm to her chest and confirmed the order must not have been reinstated. During an interview on [DATE] at 11:09 AM, Registered Nurse (RN)2 was asked if he checked R90's chest catheter after dialysis. RN2 stated, No, he only checked to ensure the port was covered because the dialysis center would check for bruit/thrill before they covered it. At 11:25 AM, the RN stated the old order was discontinued because R90's port sites changed from the arm to the chest. During an interview on [DATE] at 2:06 PM, the Executive Director was asked if he was aware of R90's access catheter for dialysis was not being implemented per the Care Plan. The Executive Director stated he was not aware. The Executive Director stated his expectation would be for staff to follow protocols, physician orders, and the Care Plan. During an observation and interview on [DATE] at 6:53 PM, R90 was asked if the nurse checked her access site on her right chest after dialysis. R90 stated, No, the nurse just checked her blood sugar. R90 then pointed to the bandaged area over her access site. 4. Review of R59's significant change MDS with an ARD date of [DATE], located in the MDS tab of the EMR, revealed an admitted [DATE]. R59 had a BIMS score of 15 out of 15 indicating R59's cognition was intact. The MDS indicated the resident received an anticoagulant (blood thinner), and had diagnoses of coronary artery disease, atrial fibrillation, and deep venous thrombosis. Review of R59's physician Orders located in the EMR under the Order tab, revealed warfarin 4 mg [milligram] tablet Every Day, dated [DATE] and warfarin 1 mg tablet Every Evening, dated [DATE]. The medication notes on the orders included side effects that should be monitored any signs of serious bleeding, including nosebleeds that happen often or don't stop, unusual pain/swelling/discomfort, unusual/easy bruising, prolonged bleeding from cuts or gums unusually heavy/prolonged menstrual flow, pink/dark urine, coughing up blood, vomit that is bloody or looks like coffee grounds, severe headache, dizziness/fainting, unusual tiredness/weakness, bloody/black/tarry stools, chest pain, shortness of breath, difficulty swallowing. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R59's Care Plan with an effective date of [DATE] to present, located in the EMR under the Care Plan tab, revealed no evidence of a Care Plan for the ordered warfarin Review of R59's [DATE] TAR located in the EMR under the Order tab revealed no evidence of monitoring for bleeding and other side effects. Review of R59's Notes dated [DATE] to [DATE], located in the EMR under the Note tab revealed no documentation of monitoring for warfarin potential side effects. During an interview on [DATE] at 7:31 AM, Licensed Practical Nurse (LPN)2 confirmed there was no care plan developed for R59's ordered warfarin or monitoring being completed except for laboratory tests. LPN2 stated her expectation would be for the warfarin to be care planned. LPN2 confirmed it was important to have a care plan for the use of an anticoagulant to ensure the resident was monitored for bleeding gums, stools, and when using the electric razor. During an interview on [DATE] at 4:38 PM, the DON stated she was not aware R59 did not have a Care Plan for the ordered warfarin, however; she stated the resident should have had one developed. During an interview on [DATE] at 2:09 PM, the Executive Director stated he was not aware of R59's anticoagulant not being care planned or that the resident was not monitored for bleeding, however, his expectation would be to care plan the medication, follow the care plan, monitor the medication for side effects, and follow the physician order and any protocols.

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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** 36190 Based on observation, interview, record review, and facility policy review, the facility failed to provide supervision to prevent a resident from wandering into other resident rooms for one (Resident (R) 68) of one sampled resident reviewed for wandering out of a total sample of 35. The findings include: Review of the facility policy titled Wander/Elopement Precautions Policy, updated 03/22, revealed It is the policy of the facility to provide the least restrictive environment for residents, while doing so attempt to implement inventions for those residents who are identified at risk of wandering /elopement to maintain safety. The policy did not address the intrusion of the privacy of others. Review of R68's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 06/22/2024, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE]. R68 had a Brief Interview for Mental Status (BIMS) score of one out of 15, indicating R68's cognition was severely impaired. Behaviors of wandering was marked behavior not exhibited. The question does the wandering significantly intrude on the privacy of activities of others? was left blank. The question how does resident's current behavior status, care rejection, or wandering compare to prior assessment? was answered Worse. R68 had a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, insomnia, and malnutrition. Review of R68's Care Plan with an effective date of 11/01/2022 to present, located in the EMR under the Care Plan tab revealed R68 has behavioral symptoms directed toward others: aggressive towards staff and refusing care, wandering into resident's rooms, taking items off nurse's cart, taking items out of other resident rooms, and laying in other resident's beds. The goal included R68 will have decreased behaviors within the next 30 days, goal date 09/27/2024. Review of R68's Progress Note dated 03/29/2024, located in the EMR under the Note tab revealed Resident noted to be entering other residents' rooms and sitting on their beds. When this nurse and the caregivers attempted to redirect resident, res [resident] noted to be resistant and inappropriate towards staff. This nurse educated on the importance of resident privacy and not entering their rooms and also educated on the importance of appropriate behavior towards staff, but education ineffective due to resident being confused and kept entering rooms. Review of R68's Progress Note dated 05/01/2024, located in the EMR under the Note tab revealed Res continues to wander the hallways, whispering to herself and entering other resident's rooms and laying down in their beds. This nurse has attempted to redirect her several times and re orient her but all attempts ineffective because her agitation has increased, and she has spent all morning walking incessantly and entering resident's room (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R68's Progress Note dated 05/03/24, located in the EMR under the Note tab revealed Res observed to keep wandering the hallways and whispering to herself. Three residents reached out to this nurse and complained because res entered to the three resident's rooms and laid down in their beds. This nurse has attempted to redirect her several times and re orient her but all attempts were ineffective. Res keeps spending all morning walking incessantly and entering resident's room. Review of R68's Behavior Note dated 06/08/2024, located in the EMR under the Note tab revealed Resident has continued to wander around the unit this shift. She has wandered into other Residents' rooms several times and other Residents have become very distressed and agitated, Nursing staff continues to redirect and distract with very little success . Review of R68's Behavior Notes dated 06/09/2024, located in the EMR under the Note tab revealed the Resident was observed to have taken a stick of deodorant from another Resident's room and was attempting to eat it. This Nurse was able to get deodorant away from R68 before she ate more than one bite . Resident was observed by Caregiver trying to pry an electrical outlet covering away from the wall, R68 was redirected but then began to remove the plated glass cover from the fire extinguisher cabinet less than an hour later. She was redirected again. Due to Resident's poor cognition, she is unable to understand these safety risks. Review of R68's Behavior Note dated 06/10/2024, located in the EMR under the Note tab revealed res found lying in another resident's bed sleeping. Res would not get out of bed for 2 hours despite staff's attempts . once in her own room and bed, res got back up out of bed and was wandering around her room and trying to come in the bathroom where this nurse and another res was at. During an observation on 08/13/2024 at 12:10 PM, R68 was observed walking down the hall pulling down the mesh stop sign attached across the doorway of room [ROOM NUMBER]. During an observation on 08/14/2024 at 5:35 PM, R68 was observed to stop at R37's room and the gate on the entry way prevented R68 from entering. R37 stated at this time this is why I have a gate. R37 told R68 to leave. R68 then turned into R68 suitemate's room. R68 was observed to pick up items in room [ROOM NUMBER]. During an observation on 08/14/2024 at 5:40 PM, R68 was observed walking in rooms [ROOM NUMBERS], which had a mesh stop sign across the entryway. R68 was observed bending down walking under the mesh stop sign. R68 then walked back into room [ROOM NUMBER] where another resident sat in her wheelchair. R68 picked up a tissue box from room [ROOM NUMBER] and left the room with the box. During an observation on 08/14/2024 at 5:42 PM, the unit was observed with mesh stop signs or a gate on the entry ways to rooms 265, 268, 269, 270, 271, 273, 276, and 278. During an observation on 08/16/2024 at 6:53 PM, R90 was in her room listening to music. R68 was observed at R90's doorway. R90 complained of R68 wandering into her room and how she found R68 in her bed one day. R90 stated she made her way to the hall and hollered down the hall to get R68 out of my room. R90 stated R68 would then return to her room after the nurse walked her out. R90 stated she has lost items like tissue paper, wipes, and condiments because R68 takes them. R90 stated she is blind and R68 will place things in a different spot than when she had it. R90 stated due to her sight she needs things to stay in the place where she knows they will be. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/15/2024 at 3:12 PM, Certified Nurse Aide (CNA)1 stated R68 did wander into other resident rooms, but R68 means no harm. CNA1 stated they occupy R68 with tasks, toys, a special apron to use with things on it for her to play with. CNA1 stated R68 needs a lot of redirections. CNA1 stated she understands R68's wandering into other resident's rooms was uncomfortable for the affected residents and some residents have mesh stop signs in the effect to keep R68 out of their rooms. During an interview on 08/16/2024 at 7:10 PM, CNA5 confirmed R68 wandered a lot in and out of other resident rooms and they redirect her or take her to her room, but it doesn't last long. During an interview on 08/14/2024 at 5:43 PM, Registered Nurse (RN)1 stated she was familiar with R68's behaviors of wandering into other resident rooms, but she wasn't aware of R68 walking under the mesh stop signs. RN1 stated F68 was redirected and offered diverting choices, but none of the interventions were effective. RN1 stated R68 wandered up and down both halls on the unit. During an interview on 08/15/2024 at 9:53 AM, the Director of Nursing (DON) was asked if she was aware of R68 wandered into other resident rooms. DON stated, Yes she was aware, but she thought the Fidget apron helped. DON states they tried to come up with activities to keep R68 occupied, such as redirecting her, and psychiatry had worked with her as well. The DON was informed of residents complaining of R68 wandering into their rooms, taking the mesh stop signs down, going under the mesh stop sign, and even getting in their bed. The DON acknowledged this was a problem. During a follow up interview on 08/16/2024 at 4:43 PM, the DON said her expectations for R68 was to redirect her, use diversion activities, snacks, fidget apron, and hydration. During an interview on 08/16/2024 at 2:09 PM, the Executive Director stated he was aware of R68 wandering into other resident rooms and their complaints. The Executive Director stated they were currently working on a resolution but in the meantime his expectation would be for staff to keep her occupied and redirect her out of other resident's space.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, record review, and facility policy review, the facility failed to monitor the tunnel catheter post dialysis for complications for one (Resident (R) 90) of one sampled resident reviewed for dialysis out of a sample of 35 residents. The deficient practice could lead to potential complications that could impact the quality of R90's hemodialysis. The findings include: Review of the facility's policy titled Instructions for Care of the Dialysis Catheter, dated 02/2023, revealed 3. Nursing will observe for signs of infection. Review of R90's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/26/2024, located in the MDS tab of the electronic medical record (EMR), revealed an admitted [DATE]. R90 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating R90's cognition was intact, and vision is severely impaired. R90 received dialysis and had chronic renal failure. Review of R90's Care Plan with an effective date of 03/29/2023 to present, located in the EMR under the Care Plan tab, revealed R90 has the potential for complications related to hemodialysis for diagnosis of chronic renal failure and a goal Resident will remain free from complications related to renal dialysis, goal date 10/02/2024. An intervention included Monitor access area for redness or pain or signs of infection and report to MD [physician]. Review of R90's August 2024 treatment administration record (TAR), located in the EMR under the Order tab revealed: Dialysis: Dialysis: Assess Access Site () Two Times Daily starting 03/30/2023, order date: 03/30/2023, Discontinued (09/18/2023), Notes: Monitor Tunnel Catheter twice daily right chest, Dialysis: Check for Thrill, Bruit, and Assess Site () Two Times Daily starting 03/30/2023, order date: 03/30/2023, Deleted-entry error, Notes: right chest tunnel cath. Order ID: 977651 has not been assigned administration times in the Date Range Specified, and Scheduled 3 times weekly Three Times Weekly starting 05/29/2023, order date: 05/29/2023, Notes: days of dialysis Monday, Wednesday, Friday at 0630 . Review of R90's Dialysis Communication forms, dated 08/14/2024, 08/12/2024, and 08/09/2024 located in the EMR under the Provider tab revealed no monitoring of R90's right chest tunnel catheter. Review of R90's Notes dated 08/01/2024 to 08/13/2024, located in the EMR under the Note tab revealed no documentation of monitoring of R90's right chest tunnel catheter. During an interview on 08/15/2024 at 6:13 PM, Licensed Practical Nurse (LPN)2 confirmed R90's treatment order for monitoring of the access catheter was discontinued. LPN2 thought it was because of so many changes of the site. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/16/2024 at 11:09 AM, Registered Nurse (RN)2 was asked if he checked R90's chest catheter after dialysis. RN2 stated, No, he only checked to ensure the port was covered because the dialysis center would check for bruit/thrill before they covered it. RN2 stated the old order was discontinued because R90's port sites changed from the arm to the chest. During an interview on 08/15/2024 at 9:46 AM, the Director of Nursing (DON) was asked where R90's dialysis access catheter was monitored per the Care Plan. The DON reviewed the Treatment Administration Record (TAR) in the EMR and stated she could not find a treatment order specifically monitoring the catheter, just a general one for infection. The DON stated the treatment order had inadvertently been discontinued because R90's access site had changed several times from her arm to her chest and confirmed the order must not have been reinstated. During an interview on 08/16/2024 at 2:06 PM, the Executive Director stated his expectation would be for staff to follow protocols, physician orders, and the care plan related to R90's tunnel catheter.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36190 Based on observation, interview, and record review, the facility failed to monitor for side effects of an anticoagulant (blood thinner) for one (Resident (R)59) of five residents reviewed for unnecessary drugs out of a total sample of 35 residents. The deficient practice could potentially result in unnoticed bleeding. The findings include: A policy for warfarin and/or anticoagulant medications was requested. The Director of Nursing (DON) and the [NAME] President of Risk Management stated they did not have a policy for coumadin/warfarin or for anticoagulant medications. Review of R59's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 06/21/2024, located in the MDS tab of the Electronic Medical Record (EMR), revealed an admitted [DATE]. R59 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R59's cognition was intact, received an anticoagulant, and diagnoses of coronary artery disease, atrial fibrillation, and deep venous thrombosis. Review of R59's physician Orders located in the EMR under the Order tab, revealed warfarin 4 mg [milligram] tablet Every 1 Day, dated 07/17/2024 and warfarin 1 mg tablet Every Evening, dated 08/05/2024. The medication notes on the orders included side effects that should be monitored any signs of serious bleeding, including nosebleeds that happen often or do not stop, unusual pain/swelling/discomfort, unusual/easy bruising, prolonged bleeding from cuts or gums unusually heavy/prolonged menstrual flow, pink/dark urine, coughing up blood, vomit that is bloody or looks like coffee grounds, severe headache, dizziness/fainting, unusual tiredness/weakness, bloody/black/tarry stools, chest pain, shortness of breath, difficulty swallowing. Review of R59's August 2024 Treatment Administration Record (TAR) located in the EMR under the Order tab revealed no documentation of monitoring for bleeding or other side effects for the use of the anticoagulant. Review of R59's Notes dated 06/15/2024 to 08/15/2024, located in the EMR under the Note tab revealed no documentation of monitoring warfarin side effects. During an interview on 08/16/2024 at 4:38 PM, the Director of Nursing (DON) said her expectation was for the resident to be monitored for bleeding and other side effects. During a follow up interview on 08/16/2024 at 8:45 PM, the DON confirmed there was no documentation for monitoring for bleeding nor were bleeding precautions in effect. During an interview on 08/16/2024 at 2:09 PM, the Executive Director stated he was not aware of R59's anticoagulant not being monitored for bleeding, but his expectation would be to monitor the medication for side effects, and follow the physician's orders and any protocols.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185388	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sam Swope Care Center	240 Masonic Home Drive Masonic Home, KY 40041

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15879 Based on observation, record review, interview, and review of the facility's policy, the facility failed to ensure all supplies in the medication room and crash carts were not expired for three out of the six medication rooms and three out of the six crash carts. This had the potential for the facility to use expired medications and supplies that could potentially not be effective. The findings include: Review of the facility's policy dated 05/2023, titled Crash Cart Stocking Protocol revealed the Director of Nursing or Nursing leadership provided Central supply a list of supplies needed for crash cart . Crash Carts are stocked by Central Supply and are covered until opened and used . Nursing staff verify daily crash has not been opened and if the crash cart is open the entire crash cart is re-stocked by Central Supply. Review of the facility's policy dated 09/2013 and revised on 04/2022, titled Medication Room Storage of Medications Policy revealed it is the policy of this facility that drugs are to be stored in a secure and orderly manner under proper temperature. During an observation and interview on 08/14/2024 at 1:47 PM with Licensed Practical Nurse (LPN)3, on the [NAME] unit medication room, revealed a tuberculin purified serum was not dated when it was opened and should be removed as it could have been opened past the 30 days. Observation further revealed five ifob test kits for occult stool had an expiration date of 06/30/2024. LPN3 stated since the test kits were outdated the assessment would not be accurate and could give false readings. LPN3 further stated the crash cart was checked each night by nursing and central supply has a check list that showed what the supplies should be. LPN3 stated central supply kept a log of when they checked the crash cart. Observation of the crash cart revealed connection tubing for the suction machine had an expiration date of 04/01/2023. LPN3 stated nursing should have been checking for expiration dates of the supplies on the crash cart. During an observation and interview on 08/14/2024 at 2:28 PM with LPN4, on the [NAME] unit medication room, revealed five athgrip tube securements (to hold IV catheters in place) had an expiration date of 07/31/2024. Observation further revealed four snap secure three way and temperature sensing foley securement device had an expiration date of 03/31/2024 and was expired. LPN4 stated they might not work as good as it should since it was expired, and she would not use them. Observation further revealed eleven packets of Immunological fecal occult blood (ifob) test kit for occult stool had an expiration date of 06/30/2024. LPN4 stated that since the test were expired it could give false readings. LPN4 revealed the crash cart was checked every night by nursing. Observation further revealed a suction tubing nonconductive connecting tube had an expiration date of 04/01/2023. Observation revealed two containers of sterile water had an expiration date of 05/25/2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/14/2024 at 2:30 PM with LPN4 revealed the crash cart was checked once a week by central supply or the nurse leader. LPN4 revealed she had not checked this crash cart, but she looked to make sure the blue tag and a suctioning machine were on the crash cart. LPN4 revealed the blue tag meant the crash cart was locked and everything that had been used was replaced. Interview with LPN4 further revealed the sterile water was used to suction the resident and sterile water should not be used if outdated. During an observation on 08/14/2024 at 3:00 PM with LPN2, on the [NAME] House hall, revealed a cath grip tube securement device was expired with an expiration date of 07/31/2024. Observation and interview with LPN2 further revealed a hydrocolloid medium device (to secure a catheter) was expired with a date of 12/31/2023. During an observation on 08/14/2024 at 3:15 PM further revealed the crash cart log showed it had been checked every night. Observation and interview with LPN2 revealed a suction kit was expired with a date of 08/01/2020, a nonconductive connecting tubing was expired with a date of 08/06/2023, and a portex nasopharyngeal airway tube was expired with a date of 11/2015. During an interview on 08/14/2024 at 3:15 PM with LPN2 she stated the nurses should make sure the cart was locked, a suction machine was available, and there was oxygen on the cart. LPN2 stated central supply should have checked there were supplies in the crash cart. LPN2 revealed nobody wanted to use something that was expired because it may malfunction and that could hurt the resident who needed it. During an interview on 08/16/2024 at 7:59 AM with Central Supply Worker stated they stocked the crash cart only if it had been opened. The Central Supply worker revealed they checked that the blue tag was still on the cart and that was all they checked. She stated they did not check inside the crash cart and had never thought about checking for expiration dates. During an interview on 08/16/2024 at 8:08 AM with the Director of Nursing (DON) she stated central supply stocked and audited the crash carts weekly. The nurses verified the tag had been sealed and not broken. Central supply had a supply list, and they should make sure all items were stocked and not expired. The DON revealed the crash cart should be opened weekly and checked for expired supplies and that all supplies were available. The DON revealed she did not know why there were expired supplies on the crash cart. The DON revealed if a supply was expired it may not function properly. During an interview on 08/16/2024 at 6:05 PM the Administrator confirmed the crash carts and medication rooms should be checked and audited for supplies that were not expired.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36898 Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents' medical records were complete, accurately documented, contained a record of residents' assessments, and staff documentation of medical and non-medical status including the care and services provided across all disciplines for one of seven residents reviewed for abuse (Resident (R) 88 out of 35 sampled residents). The findings include: Review of the facility policy, Resident Medical Record Process, dated 03/2024 revealed It is the policy of this facility that appropriate medical records be maintained/released for each resident in accordance with State and Federal regulation [483.70(i), 483.70(i)(2)(iv)] .Process . a. A medical record is maintained for each resident at this facility electronically. b. Medical record contains medical data that is reflective of the resident health care and care needs . 1. Review of R88's undated Face Sheet, located in the resident's electronic medical record (EMR) under the Face Sheet tab revealed the facility admitted the resident on 05/30/2024. Review of the facility's FRI dated 07/04/2024 revealed R88 made an allegation of sexual abuse (rape) to facility staff. Review of R88's entire medical record, including progress notes, nursing assessments, social service notes, etc., revealed no documented evidence of any information regarding R88 reporting the allegation of sexual abuse to the facility. During an interview on 08/16/2024 at 3:05 PM, Social Worker (SW) 1 stated she documented her interview with R88 on 07/04/2024 on a scrap piece of paper; however, after she verbally reported the allegation and interview with R88 to the Director of Nursing (DON), she threw away the scrap piece of paper. Continued interview with SW1 revealed it was the facility's practice not to document in any resident's medical record anything that could possibly be a reportable incident to the SSA unless the Administrator or the DON gave the ok to do so. When asked who told her this was the facility's process, SW1 stated she was given this direction by the Social Services Director (SSD). During an interview on 08/16/2024 at 3:19 PM, the SSD stated if any staff member, which included social service staff members, were told of any type of reportable incident, they (staff) were told to take the information to the Administrator or DON and not to document the concern in the resident's medical record. When asked why did SW1 not document her interview with the resident regarding the allegation of abuse in the resident's medical record, the SSD stated SW1 followed the practice of the facility. During an interview on 08/16/2024 at 4:26 PM, the Administrator stated it was his expectation residents' medical records be complete and accurate.