STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195327	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gonzales Healthcare Center	905 West Cornerview Road Gonzales, LA 70737

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41876 Based on record reviews and interviews, the facility failed to: 1. Protect a resident's right to be free from physical abuse by Resident #239 for 1 (Resident #75) of 8 (Resident #11, Resident #37, Resident #43, Resident #47, Resident #75, Resident #239, Resident #20, and Resident #23) sampled residents investigated for abuse and neglect; 2. Protect a resident's right to be free from physical abuse by Resident #43 and Resident #47 for 2 (Resident #43 and Resident #47) of 8 (Resident #11, Resident #37, Resident #43, Resident #47, Resident #75, Resident #239, Resident #20, and Resident #23) sampled residents investigated for abuse and neglect; 3. Protect a resident's right to be free from verbal abuse and neglect by S11Certified Nursing Assistant (CNA) for 1 (Resident #37) of 8 (Resident #11, Resident #37, Resident #43, Resident #47, Resident #75, Resident #239, Resident #20, and Resident #23) sampled residents investigated for abuse and neglect; and, 4. Protect a resident's right to be free from neglect by S16CNA for 2 (Resident #20 and Resident #23) of 8 (Resident #11, Resident #37, Resident #43, Resident #47, Resident #75, Resident #239, Resident #20, and Resident #23) sampled residents investigated for abuse and neglect. Findings: Review of the facility's Abuse Prohibition Policy revised 01/01/2024 revealed, in part, neglect occurred when the facility was aware of services that a resident required but failed to provide them to the resident. Further review revealed abused occurred when the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain or mental anguish. 1. Review of Resident #75's record revealed, in part, he was admitted to the facility on [DATE]. Review of Resident #75's Progress Notes revealed, in part, a note written by S13Licensed Practical Nurse (LPN) dated 04/04/2024 indicated Resident #75 was hit on the arm by another resident. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/14/2024 at 11:54 a.m., S8Certified Nursing Assistant (CNA) indicated Resident #239 hit Resident #75's hand. In an interview on 05/14/2024 at 12:02 p.m., S13LPN indicated Resident #75 and Resident #239 were both in wheelchairs and Resident #75's wheelchair tapped the leg rest of Resident #239's wheelchair when passing Resident #239 in the dining room. S13LPN further indicated Resident #239 then hit Resident #75's hand. In an interview on 05/16/2024 at 1:45 p.m., S1Administrator indicated he reviewed the video surveillance footage which revealed Resident #239 hit Resident #75. S1Administrator confirmed Resident #239 physically abused Resident #75, and this should not have happened. 2. Resident #43 Review of Resident #43's record revealed, in part, an admitted [DATE] and had a diagnosis of late onset Alzheimer's disease. Review of Resident #43's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/24/2024 revealed, in part, Resident #43 had a Brief Interview for Mental Status (BIMS) of 6 which indicated her cognition was severely impaired. Further review revealed there was no documentation of having inappropriate behaviors. Review of Resident #43's Care Plan revealed she had the potential to be physically aggressive as evidenced by a witnessed incident on 04/10/2024 in which Resident #43 and Resident #47 were observed hitting each other in the dining room. In an interview on 05/15/2024 at 10:10 a.m., S9Certified Nursing Assistant (CNA) indicated Resident #43 and Resident #47 did not get along and were both verbally fussy with each other in the dining room. S9CNA indicated Resident #47 was moved away from Resident #43 frequently, but Resident #47 continued to go back towards Resident #43. In an interview on 05/16/2024 at 7:33 a.m., S7Licensed Practical Nurse (LPN) confirmed she witnessed Resident #43 and Resident #47 swinging at and hitting each other in the dining room when she was clocking in around 2:00 p.m. S7LPN further indicated she did not know why the fight started and did not see anyone else in the dining room who would have witnessed the cause of the fight. S7LPN also indicated Resident #47 was known to be aggressive with staff and other residents. In an interview on 05/16/2024 at 10:20 a.m., S1Administrator confirmed S7LPN witnessed Resident #43 and Resident #47 intentionally hit each other in the dining room. In an interview on 05/16/2024 at 11:12 a.m., S1Administrator confirmed no one witnessed the cause of the incident between Resident #43 and Resident #47, so there was no way to determine who was the aggressor or who was the victim. S1Adminitrator confirmed the fight between the above mentioned residents was intentional and was not accidental. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/16/2024 at 11:14 a.m., S4Corporate Clinical Specialist confirmed the fight between Resident #43 and Resident #47 was intentional. Resident #47 Review of Resident #47's record revealed, in part, an admitted [DATE]. Further review revealed, in part, Resident #47 had diagnoses of unspecified psychosis. Review of Resident #47's MDS with an ARD of 03/26/2024 revealed, in part, Resident #47 had a BIMS of 7 which indicated Resident #47's cognition was severely impaired. Review of Resident #47's Care Plan revealed, in part, Resident #47 had a behavioral problem, and on 04/10/2024, Resident #47 and Resident #43 were witnessed having a fight in the dining room. 3. Review of Resident #37's MDS (Minimum Data Sheet) with ARD (Assessment Reference Date) of 03/22/2024 revealed, in part, Resident #37 had a BIMS (Brief Interview Mental Status) score of 15 which indicated Resident #37 was cognitively intact. Further review revealed Resident #37 required extensive assistance of 1 person for bed mobility and toilet use, was frequently incontinent of urine, and was always incontinent of bowel. Review of Resident #37's care plan revealed, in part, Resident #37 had an Activities of Daily Living (ADLs) self-care deficit related to debility and weakness. In an interview on 05/15/2024 at 1:54 p.m., Resident #37 indicated in March 2024, she called for assistance and S11Certified Nursing Assistant (CNA) came into her room and told her good luck being changed and cancelled the call light. Resident #37 further indicated she called again for assistance, and did not receive assistance until the next shift. In an interview on 05/15/2024 at 2:07 p.m., S1Administrator indicated Resident #37 complained she waited too long to be changed towards the end of March 2024. S1Administrator further indicated he reviewed the call light log and discovered Resident #37 waited 95 minutes to be changed. S1Administrator further indicated Resident #37 was cognitive and he took her word for the comment of good luck being changed. S1Administrator further indicated S11CNA was terminated on 03/27/2024, after he substantiated Resident #37 was neglected and was verbally abused by S11CNA. S1Administer confirmed Resident #37 should not have been verbally abused nor neglected by S11CNA. 4. Review of the facility's reported incident revealed, in part, on 05/06/2024 Resident #20 and Resident #23 were identified by S14Certified Nursing Assistant (CNA) and S15Licensed Practical Nurse (LPN) to be heavily saturated with urine. Review also revealed Resident #20 alleged S16CNA had not assisted her all shift. Further review revealed the facility substantiated S16CNA neglected Resident #20 and Resident #23 on 05/06/2024. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #20's MDS with an ARD of 04/19/2024 revealed, in part, Resident #20 had a BIMS score of 12, which indicated Resident #20 had moderate cognitive impairment. Further review revealed Resident #20 was always incontinent of bowel and bladder and required total dependence on staff for toileting. Review of Resident #23's MDS with an ARD of 03/01/2024 revealed, in part, Resident #23 had a BIMS score of 5, which indicated Resident #23 had severe cognitive impairment. Further review revealed Resident #23 was always incontinent of bowel and bladder and required total dependence on staff for toileting. Review of the facility's Daily Assignment Sign In Sheet for 05/06/2024 revealed S16CNA was assigned Resident #20 and Resident #23 from 6:00 a.m. to 6:00 p.m. In an interview on 05/15/2024 at 2:35 p.m., S15LPN stated when she arrived to work on 05/06/2024, Resident #20's diaper, incontinence pad, and sheets were saturated with urine and feces. S15LPN stated Resident #20 informed her she was not changed all shift. S15LPN further indicated on 05/06/2024, Resident #23 was saturated with urine and full of feces in her wheelchair. S15LPN confirmed Resident #20 and Resident #23's appearance on 05/06/2024 was consistent with not being assisted all shift. Review of S15CNA's written statement revealed, in part, during rounds on 05/06/2024 S15CNA found Resident #23 in her wheelchair soiled with urine and feces. S15CNA was informed by Resident #23 that she had not been changed all day and could smell herself. S15CNA indicated Resident #20 in her bed with her shirt wet with urine and feces covering her sheets and incontinence pad. In an interview on 05/15/2024 at 4:49 p.m., Resident #20 stated there was a shift recently where she was not changed all shift. Resident #20 further indicated that she could not remember what day it occurred or which CNA was assigned to her. In an interview on 05/15/2024 at 4:50 p.m., Resident #23 state she did remember a shift where she did not get changed, but Resident #23 could not remember the day or the CNA assigned to her. In an interview on 05/16/2024 at 1:50 p.m., S1Administrator stated he was informed that Resident #20 and Resident #23 were left soiled on S16CNA's shift. S1Administrator stated he substantiated S16CNA neglected Resident #20 and Resident #23 from Resident #20's and Resident #23's allegations and S14CNA's and S15LPN's statements. S1Administator confirmed Resident #20 and Resident #23 required incontinence assistance from staff and did not receive it. In an interview on 05/16/2024 at 1:55 p.m., S2DON confirmed S16CNA leaving Resident #20 and Resident #23 soiled on 05/06/2024 was neglect. 45877 47327

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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** 47327 Based on record review and interviews, the facility failed to report an injury of unknown origin for 1 (Resident #43) of 8 (Resident #11, Resident #20, Resident #23, Resident #37, Resident #43, Resident #47, Resident #75, and Resident #239) sampled residents investigated for abuse. Findings: Review of Resident #43's record revealed an admitted [DATE] with diagnosis of Alzheimer's disease with late onset. Review of Resident #43's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/24/2024 revealed, in part, Resident #43 had a Brief Interview for Mental Status (BIMS) of 6 which indicated she was severely cognitively impaired. Further review revealed there were no documented behaviors. Review of Resident #43's Progress Notes revealed a nurse's note written on 04/19/2024 at 10:15 a.m. by S6Licensed Practical Nurse (LPN) that revealed S10Certfied Nursing Assistant (CNA) informed S6LPN that Resident #43's left cheek and left corner of her lip was swollen and red. In an interview on 05/15/2024 at 10:00 a.m., S6LPN stated on 04/19/2024 upon assessment of Resident #43, she noted her bottom lip was swollen and her left cheek was red. S6LPN further stated she notified Resident #43's primary care doctor and S2Director of Nursing. In an interview on 05/15/2024 at 12:10 p.m., S10Certfied Nursing Assistant (CNA) stated on 04/19/2024 she notified S6LPN Resident #43's cheek was red and her lip was swollen. S10CNA stated Resident #43 could not tell her if anything happened to her to receive a red cheek and swollen lip. In an interview on 05/16/2024 at 2:48 p.m., S1Administrator stated he was unaware of an incident that occurred on 4/19/2024 in which resident was found to have a red cheek and a swollen lip. In an interview on 05/16/2024 at 3:05 p.m., S2Director of Nursing (DON) stated she assessed Resident #43 on 04/19/2024 after she was notified by S6LPN but she did not document the assessment. S2DON stated Resident #43 was unsure of how she developed a red cheek and a swollen lip. S2DON confirmed there was no further investigation into how Resident #43 acquired a red cheek and swollen lip, nor did she report this information to S1Administrator. In an interview on 05/16/2024 at 3:45 p.m., S2DON stated she immediately went to assess the resident right after she read the note because her immediate thought was abuse. S2DON confirmed she did not have any documentation to support her assessment of the resident's lip and cheek. Based on interviews and Resident #43's record review there was no documentation indicating a report for an injury of unknown origin was made. Furthermore, facility failed to produce any documentation that indicated a report for an injury of unknown origin was made.

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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** 47327 Based on record reviews and interviews the facility failed to investigate an injury of unknown origin for 1 (Resident #43) of 8 (Resident #11, Resident #20, Resident #23, Resident #37, Resident #43, Resident #47, Resident #75, and Resident #239) sampled residents investigated for abuse. Findings: Review of Resident #43's record revealed an admitted [DATE] with diagnosis of Alzheimer's disease with late onset. Review of Resident #43's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/24/2024 revealed, in part, Resident #43 had a Brief Interview for Mental Status (BIMS) of 6 which indicated Resident #43's cognition was severely impaired. Review of Resident #43's Progress Notes revealed a nurse's note written on 04/19/2024 at 10:15 a.m. by S6Licensed Practical Nurse (LPN) that revealed S10Certfied Nursing Assistant (CNA) informed S6LPN that Resident #43's left cheek and the left corner of Resident #43's lip was swollen and red. In an interview on 05/15/2024 at 12:10 p.m., S10Certfied Nursing Assistant (CNA) stated on 04/19/2024 she notified S6LPN regarding Resident #43's red cheek and swollen lip. S10CNA stated Resident #43 was unable to explain what caused her red cheek and swollen lip. In an interview on 05/15/2024 at 10:00 a.m., S6LPN stated on 04/19/2024 she assessed Resident #43 and noted Resident #43's bottom lip was swollen and Resident #43's left cheek was red. S6LPN further stated she notified Resident #43's primary care doctor and S2Director of Nursing. In an interview on 05/16/2024 at 2:48 p.m., S1Administrator stated he was unaware of an incident that occurred on 4/19/2024 in which Resident #43 was found to have a red cheek and swollen lip. In an interview on 05/16/2024 at 3:05 p.m., S2Director of Nursing (DON) stated she assessed Resident #43 on 04/19/2024 after she was notified by S6LPN but did not document the assessment. S2DON stated Resident #43 was unable to explain what caused her red cheek and swollen lip. S2DON confirmed there was no further investigation into how Resident #43 acquired a red cheek and swollen lip, nor did she report this information to S1Administrator. In an interview on 05/16/2024 at 3:45 p.m., S2DON indicated, after reading the above mentioned nurse note, she assessed Resident #43 immediately because her immediate thought was abuse. S2DON confirmed she did not have any documentation to support her assessment of Resident #43's lip and cheek. Based on interviews and Resident #43's record review there was no documentation indicating an investigation for an injury of unknown origin was made. Furthermore, facility failed to produce any documentation that indicated an investigation for an injury of unknown origin was made.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 41876 Based on record reviews, observations, and interviews, the facility failed to administer a resident's tube feeding water flush as ordered for 1 (Resident #50) of 1 (Resident #50) sampled residents investigated for tube feeding. Findings: Review of Resident #50's Minimum Data Set with an Assessment Reference Date of 02/10/2024 revealed, in part, Resident #50 had dysphagia (difficulty swallowing) and required nutrition and hydration through a feeding tube. Review of Resident #50's May 2024 physician's orders revealed, in part, an order for Resident #50's tube feeding water flush at 150 milliliters (mL) every 6 hours. Review of Resident #50's tube feeding care plan revealed, in part, an intervention for staff to administer Resident #50's tube feeding flush at 150mL every 6 hours. Observation on 05/13/2024 at 10:15 a.m. revealed Resident #50's tube feeding pump was programmed to administer a water flush of 125mL every 4 hours. Observation on 05/14/2024 at 10:57 a.m. revealed Resident #50's tube feeding pump was programmed to administer a water flush of 125mL every 4 hours. Observation on 05/15/2024 at 11:20 a.m. revealed Resident #50's tube feeding pump was programmed to administer a water flush of 125mL every 4 hours. In an interview on 05/15/2024 at 2:27 p.m., S15Licensed Practical Nurse (LPN) indicated Resident #50 had a physician's order for tube feeding water flush of 150mL every 6 hours. Observation on 05/15/2024 at 2:33 p.m. revealed Resident #50's tube feeding pump was programmed to administer a water flush of 125mL every 4 hours. In an interview on 05/15/2024 at 2:34 p.m., S15LPN confirmed Resident #50's tube feeding pump was programmed to administer a water flush of 125mL every 4 hours. S15LPN confirmed Resident #50 was not getting the correct amount of tube feeding water flush. In an interview on 05/15/2024 at 4:09 p.m., S2Director of Nursing confirmed Resident #50's tube feeding water flush should be administered as ordered.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41876 Based on record reviews and interviews, the facility failed to ensure a resident did not have an order for administration of a psychotropic medication (drugs that affect one's mental state) on an as needed basis (PRN) without a physician's documentation of the specified duration of the order for 1 (Resident #46) of 5 (Resident #16, Resident #46, Resident #47, Resident #64, and Resident #82) sampled resident investigated for unnecessary medications. Findings: Review of Resident #46's admission record revealed, in part, Resident #46 was admitted to the facility on [DATE] with diagnoses of unspecified mood disorder and bipolar disorder (a serious mental illness characterized by extreme mood swings of extreme excitement or extreme depressive feelings). Review of Resident #46's May 2024 physician's orders revealed, in part, an order with a start date of 11/20/2023 for Lorazepam (a psychotropic medication used to treat anxiety) 0.5 milligrams (mg) by mouth every 12 hours as needed for anxiety related to bipolar disorder. Review of Resident #46's Pharmaceutical Consultant Report dated 11/28/2023 revealed, in part, a request by the consultant pharmacist for Resident #46's physician to address the order for Lorazepam 0.5mg every 12 hours as needed. Review revealed the consultant pharmacist documented a PRN order for a psychotropic medication was limited to 14 days and required the prescriber to evaluate the resident prior to extending the order. Further review revealed Resident #46's physician documented to continue the use of Resident #46's medications and wrote new admit no change at this time. Resident #46's Pharmaceutical Consultant Report was signed by Resident #46's physician on 12/05/2023. Review of Resident #46's Individual Resident Narcotic Record revealed, in part, documentation Lorazepam 0.5mg was administered to Resident #46 33 times since admission. In an interview on 05/16/2024 at 11:31 a.m., S6Licensed Practical Nurse confirmed Resident #46 had an order for Lorazepam 0.5mg to be administered PRN. There was no documented evidence and the facility did not present any documented evidence Resident #46 had a defined duration of the continued use of the psychotropic medication Lorazepam on a PRN basis after 14 days of the order date. In an interview on 05/16/2024 at 3:09 p.m., S2Director of Nursing confirmed she did not have any documentation from Resident #46's physician regarding the defined duration of Resident #46's PRN Lorazepam order.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17453 Based on observations, record reviews, and interviews the facility failed to administer a medication for hypertension as ordered by the physician for 1 (Resident #14) of 22 (Resident #11, Resident #14, Resident #16, Resident #21, Resident #37, Resident #43, Resident #46, Resident #47, Resident #48, Resident #50, Resident #52, Resident #54, Resident #57,Resident #62, Resident #64, Resident #69, Resident #75, Resident #82, Resident #87, Resident #88, Resident #239, and Resident #440) residents investigated in the sample. Findings: Review of the manufacturers prescribing information for Clonidine revealed, in part, application of a new system to a fresh skin site at weekly intervals continuously maintains therapeutic plasma concentrations of clonidine. If the patch is removed and not replaced with a new system, therapeutic plasma clonidine levels will persist for about 8 hours and then decline slowly over several days. Over this time period, blood pressure returns gradually to pretreatment levels. Resident #14 was admitted to the facility on [DATE] with a diagnosis of, in part, hypertension. Review of Resident #14's May 2024 Physician Orders revealed, in part, Clonidine HCL (hydrochloride) (a medication used to treat high blood pressure) apply 0.1 mg (milligram) transdermally (route of administration where active ingredients are delivered across the skin for systemic distribution) one time a day every Friday related to hypertension. Further review revealed, in part, change Clonidine HCL 0.1mg patch every Friday. Review of Resident #14's May 2024 electronic Medication Administration Record (eMAR) revealed, in part, S5Licensed Practical Nurse (LPN) documented administration of Resident #14's Clonidine 0.1mg patch on 05/10/2024. Observation of Resident #14 on 05/14/2024 at 9:00 a.m. revealed a patch was applied to Resident #14's right upper arm. Observation revealed the patch was dated 05/03/2024. In an interview on 05/14/2024 at 9:10 a.m., S5Licensed Practical Nurse (LPN) confirmed the patch on Resident #14's right upper arm was a Clonidine HCL 0.1mg patch and confirmed the patch was dated 05/03/2024. In an interview on 05/14/2024 at 11:49 a.m., S4Corporate Clinical Specialist and S13LPN confirmed Resident #14's patch on the upper right arm was dated 05/03/2024. S4Corporate Clinical Specialist and S13LPN further stated Resident #14 had no other patches applied on her body. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/16/2024 at 11:53 a.m., S5LPN indicated when she attempted to apply Resident #14's Clonidine HCL 0.1mg on 05/10/2024 the patch would not stick to Resident #14's chest. S5LPN indicated she did apply Resident#14's Clonidine HCL 0.1mg patch on 05/10/2024. S5LPN indicated she failed to remove Resident #14's Clonidine 0.1mg patch which was applied on 05/03/2024. S5LPN indicated she documented administration of Clonidine HCL 0.1mg on Resident #14's May 2024 eMAR on 05/10/2024. S5LPN indicated she did not notify Resident #14's physician of the failure to apply the Clonidine HCL 0.1mg patch until 05/14/2024. In an interview on 05/16/2024 at 12:15pm, S4Corporate Clinical Specialist indicated Resident #14's physician should have been immediately notified of the failure to apply Resident #14's Clonidine 0.1mg HCL patch on 05/10/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195327	A. Building B. Wing	05/16/2024

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 41876 Based on record reviews and interviews, the facility failed to obtain a resident's most recent hospice Plan of Care, recertification of terminal illness, and documentation of hospice services provided for 1 (Resident #50) of 1 (Resident #50) sampled resident reviewed for hospice. Findings: Review of Resident #50's Minimum Data Set with an Assessment Reference Date of 05/12/2024 revealed, in part, Resident #50 had diagnoses which included stroke, seizure disorder, and malnutrition. Further review revealed Resident #50 received hospice care while a resident in the facility. Review of Resident #50's May 2024 physician's orders revealed, in part, an order to admit Resident #50 to the Contracted Hospice Agency on 02/23/2022. Review of the facility's agreement with the Contracted Hospice Agency dated 02/04/2022 related to Resident #50's hospice services revealed, in part, the following: -The hospice interdisciplinary team, in consultation with the facility, shall review and revise Resident #50's individualized Plan of Care as frequently as Resident #50's condition required, but no less frequently than every 15 days; -All communication between the contracted hospice agency and the facility pertaining to the care and services of Resident #50 shall be documented in Resident #50's clinical record; and, -The facility shall be responsible for obtaining Resident #50's most recent hospice Plan of Care and recertification of terminal illness from the contracted hospice agency. Review of Resident #50's hospice binder revealed, in part, Resident #50's most recent Hospice Interdisciplinary Comprehensive Assessment and Plan of Care Update Report was dated 04/05/2024 for the certification period of 02/23/2024 through 04/22/2024. Review of Resident #50's hospice binder revealed, in part, the most recent recertification of terminal illness by the Contracted Hospice Agency's physician was signed on 02/12/2024 for the certification period of 02/23/2024 through 04/22/2024. Review of Resident #50's hospice binder revealed, in part, Resident #50's most recent contracted hospice agency's visit note documenting the delivery of hospice services was dated 04/08/2024. There was no documented evidence and the facility did not present any documented evidence of having any documentation of hospice services from the Contracted Hospice Agency since 04/09/2024. In an interview on 05/15/2024 at 11:18 a.m., Resident #50's Contracted Hospice Agency's Licensed Practical Nurse denied the facility attempted to obtain current hospice documentation from the Contracted Hospice Agency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195327	A. Building B. Wing	05/16/2024

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/15/2024 at 3:03 p.m., S2Director of Nursing (DON) confirmed Resident #50's hospice binder did not include any documentation since 04/09/2024. S2DON stated due to a change in staff. S2DON further indicated there was not a designated facility staff member to ensure Resident #50's hospice documentation was current.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46361 Based on record review, observations, and interviews, the facility failed to ensure a Certified Nursing Assistant (CNA) completed hand hygiene during incontinence and catheter care for 1 (Resident #57) of 1 (Resident #57) residents reviewed for catheter care. Findings: Review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, reviewed on 01/24/2024 revealed, in part, staff should perform hand hygiene before and after direct contact with residents, before moving from a contaminated body site to a clean body site during resident care, after contact with bodily fluids, and after removing gloves. Further review revealed the use of gloves does not replace hand washing/hand hygiene, and glove use along with routine hand hygiene was recognized as the best practice for preventing healthcare-associated infections. Review of Resident #57's Minimum Data Set with an Assessment Reference Date of 02/27/2024 revealed, in part, Resident #57 had a urinary catheter (a device that sits in the bladder and collects urine), was always incontinent of bowel, and had a urinary tract infection within the last 30 days. Review of Resident #57's progress note dated 03/22/2024 revealed, in part, Resident #57 had a urinary tract infection and was to receive 7 days of antibiotics for treatment. Observation on 05/15/2024 at 3:05 p.m. revealed S17CNA entered Resident #57's room and put on gloves without performing hand hygiene. S17CNA then removed Resident #57's soiled brief, wiped stool from Resident #57's buttocks, disposed of Resident #57's soiled brief, and then removed and discarded her gloves into the trash can. S17CNA did not complete hand hygiene, put on a new pair of gloves, and cleansed Resident #57's genitals and catheter tubing. Further observation revealed S17CNA discarded her gloves into the trash can and exited Resident #57's room without completing hand hygiene. In an interview on 05/16/2024 at 3:40 p.m., S17CNA confirmed she did not perform hand hygiene when she provided incontinence and catheter care to Resident #57 in the above documented observation, and should have. In an interview on 05/16/2024 at 12:29 p.m., S4Corporate Clinical Specialist confirmed S17CNA should have completed hand when she provided incontinence and catheter care to Resident #57 in the above documented observation.