STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195359	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Continuing Care Center	2301 Sterlington Road Monroe, LA 71203

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19098 Based on observations, record review and interviews the facility failed to assess a resident for self-administration of medications for 1 (#323) of 1 sampled residents. Findings: Review of the facility's Self -Administration of Medications policy and procedure dated 06/14/2006 revealed: A patient may self-administer medications if the patient is determined safe for the patient and other patients of the facility by the facility's interdisciplinary team. Procedure: An assessment for Self-Administration of Medications must be competed on each Patient requesting to self-administer medications and quarterly thereafter. An assessment for self-administration of Medications is kept with the Patient's medical record under the Assessment tab. If it has been determined the Patient is capable of self-administering his/her medications, a physician order must be obtained, a care plan formulated, and staff in-serviced. The nursing staff must interview the Patient on every shift to verify that all self-administered doses on the Patient's Medication Administration Record. If the shift interview indicates any question as to the continued safety of self-administration, then the nurse will initiate the re-assessment process outlined above. All medications for self-administration must be stored in a locked storage area in the Patients room. Narcotics must be under double lock. Review of the medical record for sampled resident #323 revealed an admitted [DATE] with diagnoses including acute respiratory failure, disorder of the lungs, hypertension and depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. (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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/30/2024 at 10:39 a.m., observation of resident #323's room revealed a bottle of Fluticasone Nasal (to treat allergies) spray 100 micrograms (mcg)/150 mcg in the room on the bedside table. Review of the label on the box revealed to administer 2 sprays. Resident #323 stated she sprays 2 in each nostril every day. On 10/01/2024 at 9:07 a.m., observation of resident #323's room revealed the Fluticasone nasal spray remained at the bedside. On 10/02/2024 at 7:54 a.m., observation of Resident #323's room revealed the Fluticasone nasal spray remained at the bedside. Review of the current physician orders for resident #323 revealed an order dated 09/19/2024 for Fluticasone Propionate 50 mcg/actuation nasal spray, suspension (2 sprays) both nostrils at bedtime. Further review of the record revealed there was no physician's order to allow resident #323 to keep the medication in the room at the bedside, and there was no assessment to determine if resident #323 was safe to have the medication in the room at the bedside to self administer. Observation of the bottle in the resident's room revealed the label from the pharmacy was from the hospital the resident was in prior to her admission to the nursing facility. Resident #323 said the hospital gave it to her and she actually took her own dose this morning. On 10/02/2024 at 11:20 a.m., an interview with S5Licensed Practical Nurse (LPN) revealed she was not aware resident #323 had the Fluticasone nasal spray in her room. S5LPN revealed there was a bottle on the mediation cart and she received the medication in the evening. S5LPN further revealed there was no order for resident #323 to have the medication at the bedside and there was no assessment for resident #323 to keep the medication at the bedside to self-administer the medication. On 10/02/2024 at 11:45 a.m., an interview with S2Director of Nursing (DON) revealed she was not aware the resident had the medication in her room. S2DON revealed if a resident had medications in their room and was self-administering the medication then they were supposed to have an assessment to self-administer medications.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on observation and interview, the facility failed to ensure the most recent state inspection results since the last annual survey were available for resident or family review. Findings: An observation upon entrance to the facility on [DATE] at 7:35 a.m. revealed the results of the last survey in the facility's survey binder was the last annual survey dated 09/13/2023. Further review of the survey binder revealed the last complaint survey results dated 08/16/2024 were not in the binder. An interview on 09/30/2024 at 7:40 a.m. with S2Director of Nursing (DON) confirmed the facility's survey binder did not have the most recent survey results for the complaint dated 08/16/2024.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 19098 Based on record reviews and interviews the facility failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet the resident's needs by not 1) having documentation of meal percentage intakes for 1 (#62) of 4 (#37, #43, #62, and #321) residents reviewed for nutrition. Also the failed practice was evidenced by not developing a care plan for 1 (#16) of 10 (#3, #16, #37, #40, #41, #58, #62, #221, #223, and #324) residents reviewed for Activities of Daily Living (ADL), and for 1 (#324) resident observed to have medications at the bedside. Findings: Review of the Self - Administration of Medications policy and procedure dated 06/14/2006 revealed: A patient may self-administer medications if the patient is determined safe for the patient and other patients of the facility by the facility's interdisciplinary team. Procedure: An assessment for Self-Administration of Medications must be completed on each patient requesting to self-administer medications and quarterly thereafter. An assessment for self-administration of Medications is kept with the patient's medical record under the Assessment tab. If it has been determined the patient is capable of self-administering his/her medications, a physician order must be obtained, a care plan formulated, and staff in-serviced. The nursing staff must interview the patient on every shift to verify that all self-administered doses on the patient's medication administration record. If the shift interview indicates any question as to the continued safety of self-administration, then the nurse will initiate the re-assessment process outlined above. All medications for self-administration must be stored in a locked storage area in the patient's room. Narcotics must be under double lock. Resident #323 On 09/30/2024 at 10:39 a.m., observation of resident #323's room revealed a bottle of Fluticasone Nasal spray 100 micrograms (mcg)/150mcg in the room on the bedside table. Review of the label on the box revealed to administer 2 sprays. Resident stated she sprays 2 in each nostril every day. On 10/01/2024 at 7:54 a.m. and 9:07 a.m., observations of resident #323's room revealed the Fluticasone nasal spray remained at the bedside. Review of the current Physician orders for resident #323 revealed an order dated 09/19/2024 for Fluticasone Propionate 50 mcg/actuation nasal spray, suspension (2 sprays) both nostrils at bedtime. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the record revealed no Physician's order to allow resident #323 to keep medication in the room at the bedside, and there was no assessment to determine if resident #323 was safe to have medication in the room at the bedside to self-administer. Further review of the record revealed there was no plan of care developed for the self-administration of medications for resident #323. On 10/02/2024 at 11:20 a.m., an interview with S5Licensed Practical Nurse (LPN) revealed she was not aware resident #323 had the Fluticasone nasal spray in her room. S5LPN said there was a bottle of the Fluticasone Nasal spray on the medication cart and resident #323 received the medication in the evening. Observation of the bottle of Fluticasone Nasal spray in the resident's room revealed the label from the pharmacy was from the hospital the resident was in prior to admission. Resident #323 said the hospital gave it to her and she actually took her own dose this morning. Interview on 10/02/2024 at 11:20 a.m. with S5LPN revealed she was not aware of the medication in resident #323's room. She confirmed there was no order for resident #323 to have the medication at the bedside and there was no assessment for resident #323 to keep the medication at bedside and self-administer the medication. On 10/02/2024 at 11:45 a.m., an interview with S2Director of Nursing (DON) revealed she was not aware the resident had the medication in her room. S2DON said if a resident has medications in their room and is self-administering the medication then they are supposed to have a self-medication assessment, a plan of care to self-administer medications and store the medications in a secured box. S2DON confirmed there was no plan of care developed for resident #323 to self- administer medications. 18118 Resident #62 Review of the medical record for resident #62 revealed an admitted [DATE] with diagnoses including encephalopathy, epilepsy, malignant neoplasm, protein calorie malnutrition, and dehydration. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #62's Brief Interview for Mental Status (BIMS) score was 99 which indicated that the resident was unable to complete the interview. Resident #62 was dependent on staff for activities of daily living. Review of the current care plan revealed resident #62 required extensive assistance with eating. Further review of the care plan revealed interventions were to allow the resident adequate time to eat, monitor his food intake at each meal, and to document the meal percentage consumed. Review of the resident #62's Activities of Daily Living (ADL) Verification Worksheet for daily meal intake percentages revealed there was no documented evidence of the breakfast, lunch and dinner meal percentage intakes on 09/10/2024, 09/14/2024, 09/15/2024 and 09/26/2024. Further review of the worksheet revealed no documented evidence of the breakfast and lunch meal percentage intakes on 09/12/2024, 09/21/2024 and 09/27/2024. On 10/01/2024 at 12:45 p.m., an interview with S2DON confirmed the meal intake percentages were incomplete for the month of September 2024 for resident #62. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	32231 Resident #16 Review of resident #16's medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, obstructive sleep apnea, acute and chronic respiratory failure with hypoxia, insomnia, altered mental status, and obesity. Review of the admission minimum data set assessment dated [DATE] revealed resident #16 had a BIMS score of 15. A score of 13-15 revealed resident #16 was cognitively intact with daily decision making skills. On 09/30/2024 at 11:30 a.m., an observation revealed resident #16's fingernails were dirty with grime observed underneath the nail beds of both hands. An interview with resident #16 revealed that the staff had not offered to clean her fingernails. Further observations of resident #16 on 10/01/2024 at 12:40 p.m. and 5:00 p.m., the resident continued to have dirty fingernails. During an interview on 10/02/2024 at 11:43 a.m., S1Administrator and S2Director of Nursing were notified of the above findings. On 10/02/2024 at 11:51 a.m., an observation revealed resident #16's fingernails remained dirty. S8Assistant Director of Nursing and S4Regional Director of Clinical Services were present during the observation and interview with resident #16. After the observation and interview was finished, S8Assistant Director of Nursing and S4Regional Director of Clinical Services both confirmed that resident #16's fingernails needed to be cleaned. On 10/02/2024 at 11:55 a.m., S9Certified Nursing Assistant was notified of the above findings. She revealed that she had given resident #16 a bath earlier that morning and that she was aware of the resident's fingernails being dirty. Review of the medical record revealed there was no documented evidence of a care plan being developed to address nail care for resident #16. On 10/02/2024 at 12:00 p.m., an interview with S4Regional Director of Clinical Services reviewed the electronic health record for resident #16. She confirmed there was no documented evidence of a care plan being developed to address the cleaning of the resident's fingernails.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on observations, record reviews, and interviews the facility failed to ensure a resident who is unable to carry out activities of daily living (ADL) received the necessary services to maintain good personal hygiene for 7 (#3, #16, #41, #45,#58, #62 and #221) of 11 (#3, #16, #37, #40, #41, #45, #58, #62, 221, #223, and #324) residents reviewed for Activities of Daily Living (ADL) care. The facility failed to ensure 1) residents' fingernails were kept clean and/or trimmed for #16, #41, #58 and #62, and 2) residents #3, #45 and #221 received baths as scheduled. Findings: Resident #62 Review of the medical record for resident #62 revealed an admitted [DATE] with diagnoses including encephalopathy, hypertension, epilepsy, atrial fibrillation, malignant neoplasm, protein calorie malnutrition, dehydration and chronic pain. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #62's Brief Interview for Mental Status (BIMS) score was 99 which indicated that the resident was unable to complete the interview. Resident #62 was dependent on staff for activities of daily living. On 09/30/2024 at 2:10 p.m., and 10/01/2024 at 9:52 a.m., observations of resident #62 revealed his fingernails were long and needed to be trimmed. On 10/01/2024 at 9:10 a.m., an interview with the S2Director of Nursing (DON) revealed the resident was dependent of staff for ADLs. On 10/01/2024 at 1:35 p.m. S2DON observed resident #62's fingernails, and S2DON confirmed resident #62's fingernails were long and needed to be trimmed. 19121 Resident #45 Review of resident #45's record revealed an admitted [DATE] with diagnosis of hypertension, heart disease, atrial fibrillation, urine retention, peripheral vascular disease, bilateral amputation of legs, sepsis, and neuropathic bladder. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS of 14 which indicates the resident is cognitively aware and able to make daily decisions. Further review of the MDS revealed the resident is dependent on staff for toileting, hygiene, shower/bathing, upper and lower body dressing, personal hygiene, and transfers. Interview on 09/30/2024 at 10:10 a.m. with resident #45 stated he does not get his baths three times a week and sometimes he goes a week without getting a bath. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the bath schedule effective 06/25/2024 revealed resident #45 should receive a bath on the evening shift on Tuesday, Thursday and Saturday. Review of the ADL verification worksheets dated 08/01/2024 through 09/30/2024 revealed no documented evidence that resident #45 received baths as scheduled for 13 days in August 2024 and 11 days in September 2024. Interview on 10/02/2024 at 7:20 a.m. with S12Certified Nursing Assistant (CNA) that works with resident #45 stated he was to receive baths on the evening shift on Tuesday, Thursday and Saturdays and she stated the resident does not refuse bathing. Interview on 10/02/2024 at 3:00 p.m. with S2DON confirmed that resident #45's documentation did not reflect him receiving baths on Tuesday, Thursdays and Saturdays in August and September 2024. 32231 Resident #16 Review of the resident #16's medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, obstructive sleep apnea, acute and chronic respiratory failure with hypoxia, insomnia, altered mental status, and obesity. Review of the admission minimum data set assessment dated [DATE] revealed resident #16 had a brief interview for mental score of 15. A score of 13-15 revealed resident #16 was cognitively intact with daily decision making skills. On 09/30/2024 at 11:30 a.m., an observation revealed resident #16 in her room, sitting up in her wheelchair, and visiting with her family member. Further observation revealed resident #16's fingernails were dirty with grime observed underneath the nail beds of both hands. An interview with resident #16 revealed that the staff had not offered to clean her fingernails. Further observations of resident #16 on 10/01/2024 at 12:40 p.m. and 5:00 p.m., the resident continued to have dirty fingernails. During an interview on 10/02/2024 at 11:43 a.m., S1Administrator and S2Director of Nursing were notified of the above findings. On 10/02/2024 at 11:51 a.m., an observation revealed resident #16 in her room, sitting up in her wheelchair positioned close to her bedside table where the resident's meal tray had been placed. Further observation revealed the resident's fingernails remained dirty. S8Assistant Director of Nursing and S4Regional Director of Clinical Services were present during the observation and interview with resident #16. After the observation and interview was finished, S8Assistant Director of Nursing and S4Regional Director of Clinical Services both confirmed that resident #16's fingernails needed to be cleaned. On 10/02/2024 at 11:55 a.m., S9Certified Nursing Assistant was notified of the above findings. She revealed that she had given resident #16 a bath earlier that morning and that she was aware of the resident's fingernails being dirty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #221 Review of the medical record revealed resident #221 was admitted to the facility on [DATE] and was discharged home on 07/30/2024. Resident #221's diagnoses included in part, cerebral infarction, essential (primary) hypertension, systolic and diastolic congestive heart failure, pain, dizziness, chronic obstructive pulmonary disease, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, facial weakness following cerebral infarction, encounter for surgical aftercare following surgery on the circulatory system, chronic pulmonary embolism, and chronic pulmonary embolism. Review of the discharge minimum data set assessment dated [DATE] revealed the resident required partial to moderate assistant with showering and bathing. Review of the medical record revealed resident #221 had a baseline care plan that revealed she required bathing support. Review of the Activities of Daily Living Verification Worksheet revealed there was no documented evidence of resident #221 having received a bath a total of twenty-two times from the dates of 07/08/2024 - 07/30/2024. On 10/02/2024 at 3:20 p.m., S1Administrator and S2Director of Nursing were notified of the findings noted above. S2Director of Nursing confirmed there was no documented evidence of resident #221 having received a bath for the 22 days. She further confirmed that there was no documented reason as to why the resident had not received a bath on those dates. 41829 Resident #58 Record review revealed resident #58 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia, dysphagia, essential hypertension, insomnia, anemia, constipation, chronic pain syndrome, and major depressive disorder. Review of quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 7 which indicated severe cognitive impairment. Further review revealed resident #58 required substantial/maximal assistance with eating, oral hygiene, toileting hygiene, shower/bathing, dressing upper and lower body, and personal hygiene. Review of active care plans revealed resident #58 had a self-care deficit and required extensive assistance with bathing, hygiene, dressing, grooming. An intervention listed was to clean and manicure fingernails as needed. Observations of resident #58, on 09/30/2024 at 10:00 a.m. and on 10/01/2024 at 8:35 a.m., revealed his fingernails on both hands were very long with a dark brown grimy substance under the fingernails on both hands. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/2024 at 12:05 p.m., an observation of resident #58 with S2Director of Nursing revealed resident #58's fingernails on both hands were very long with a dark brown grimy substance under the fingernails on both hands. S2DON confirmed resident #58's fingernails needed to be cleaned and trimmed. 43405 Resident #3 Review of resident #3's record revealed an admitted [DATE] with diagnoses including anxiety disorder, chronic kidney disease, other schizoaffective disorders, pain unspecified, unspecified dementia with behavioral disturbance, unstageable pressure ulcer of right heel, dysphagia, and long term use of opiate analgesics. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 14 indicating cognitively intact. Further review of the MDS revealed resident #3 dependent on staff for toileting hygiene, shower/bathing, upper and lower body dressing, personal hygiene, bed mobility, and transfers. Review of the Bath Schedule effective 06/25/2024 revealed resident #3 should be getting a bath on Monday, Wednesday, and Fridays on the evening shift. Review of the Activities of Daily Living Verification Worksheet for 08/01/2024-09/30/2024 revealed no documented evidence that resident #3 received baths as scheduled for 5 days in August 2024 and 8 days in September 2024. An interview on 10/02/2024 at 2:15 p.m. with S2DON confirmed that resident #3 did not have documentation of baths for 5 days in August 2024 and 8 days in September 2024. Resident #41 Review of resident #41's record revealed an admitted [DATE] with diagnoses including cerebral infarction, transient ischemic attack, unspecified convulsions, age related physical debility, chronic obstructive pulmonary disease, lobar pneumonia, and peripheral vascular disease. Review of resident #41's quarterly MDS dated [DATE] revealed a BIMS of 11 indicating moderate cognitive impairment. Further review of the MDS revealed resident #41 was dependent on staff for toileting, bathing, dressing, transfers, and personal hygiene. Observations of resident #41 on 09/30/2024 at 9:05 a.m. and 10/01/2024 at 4:25 p.m. revealed resident's fingernails on bilateral hands were long. An interview on 09/30/2024 at 9:05 a.m. with resident #41 revealed he's unable to trim his own fingernails. An interview on 10/01/2024 at 4:25 p.m. with resident #41 revealed he does not like his fingernails to be this long. Review of resident #41's careplan dated 11/22/2023 revealed ADL functions for resident included nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 10/02/2024 at 9:45 a.m. with S3Licensed Practical Nurse (LPN) revealed Certified Nurse Aids (CNA) on the hall are responsible for trimming resident #41's fingernails, and confirmed resident #41's were long and needed to be trimmed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 18118 Based on record review and interview, the facility failed to ensure that the resident environment remained as free of accident hazards as is possible by not completing an Accident/Incident report when a resident was found sitting on the floor for 1 (#62) of 3 (#51, #62, and #222) residents reviewed for falls. Findings: Review of the facility's Accident/Incidents Policy dated May 2016 revealed: 1 An Accident/Incident Report must be completed immediately upon facility staff becoming aware of the occurrence of an accident/incident (to include medication errors) involving a Patient and, if necessary, the Patient's Care Plan must be updated. Review of the facility's Fall Management Guidelines policy dated November 2022 revealed: 1. Definition Unintentional change in position coming to rest on the ground, floor or onto the next lower surface. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Review of the medical record for resident #62 revealed an admitted [DATE] with diagnoses including encephalopathy, hypertension, epilepsy, atrial fibrillation, malignant neoplasm, dehydration and chronic pain. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #62's Brief Interview for Mental Status (BIMS) score was 99 which indicated that the resident was unable to complete the interview. Review of the careplan with an effective date of 06/14/2024 revealed resident #62 was at risk for falls related to weakness. Review of the nurses' notes dated 06/27/2024 at 11:47 a.m. revealed resident #62 was sitting on the floor in his bedroom urinating. The nurse assisted the resident with getting dressed and cleaned his room. Review of the record revealed an Accident/Incident Report was not completed on 06/27/2024 when resident #62 was sitting on the floor. On 10/01/2024 at 12:45 p.m., an interview with S2Director of Nursing (DON) confirmed on 06/27/2024 at 11:47 a.m., when resident #62 was found sitting on the floor, the nurse should have completed an Accident/Incident report.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 19098 Based on observations, record review and interviews the facility failed to provide respiratory care consistent with professional standards of practice for 3 (#2, #323, and #325) of 3 (#2, #323, #325) residents sampled for respiratory care. The facility failed to ensure 1) Resident's oxygen concentrator filters were clean for (#2, #323) and 2) The resident's nebulizer equipment and tubing were dated and stored appropriately for (#323, #325). Findings: Resident #2 On 09/30/2024 at 3:16 p.m. observation of resident #2's oxygen concentrator revealed the filter on the back of the machine was dirty. Further observation of the oxygen administration revealed resident #2 received 2 liters per minute (lpm) per nasal cannula. Observation of the oxygen tubing revealed there was no date or initial on the humidification bottle or the oxygen tubing. On 10/01/2024 at 8:57 a.m. observation of the oxygen concentrator revealed the filter remained dirty. On 10/01/2024 at 11:58 a.m. observation of the oxygen concentrator with S2Director of Nursing (DON) confirmed the filter on the back of the machine was dirty. Resident #323 On 09/30/2024 at 10:33 a.m. observation of the oxygen concentrator for resident #323 revealed the filter on the back of the machine was dirty with dust and debris. Further observation of resident #323's room revealed the nebulizer mask and tubing was not dated or covered. On 10/01/2024 at 9:06 a.m. observation of the oxygen concentrator revealed the filter remained dirty with dust and debris and the nebulizer mask remained uncovered and was not dated. On 10/01/2024 11:30 a.m. observation of the oxygen concentrator revealed it remained dirty with dust and debris and the nebulizer mask remained uncovered and not dated. On 10/01/2024 11:35 a.m., an interview with S2DON confirmed the oxygen concentrator filter needed cleaning and the nebulizer mask should have been dated and covered. Resident #325 On 09/30/2024 at 12:07 p.m. observation of resident #325's room revealed the nebulizer pipe was not dated or covered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/01/2024 at 12:08 p.m. observation of resident #325's room revealed the nebulizer pipe was not dated or covered. On 10/1/2024 at 12:10p.m., an interview with S2DON confirmed the nebulizer pipe was not dated or covered.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18118 Based on record reviews, observations, and interviews, the facility failed to ensure residents were assessed for the risk of entrapment from bed rails and/or reviewed the risks and benefits of bed rails with the resident or resident's representative and/or obtain an informed consent prior to installation of bed rails for 5 (#9, #16, #31, #40, and #62) of 6 (#9, #16, #31, #40, #51, and #62) residents reviewed for accident hazards. Findings: Review of the facility's policy for Bed Safety and Bed Rails dated August 2022 revealed in part: Policy Statement Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rails is prohibited unless the criteria for use of bed rails have been met. 7. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following: a. Accident hazards: (1) The resident could attempt to climb over, around, between, or through the rails. Or over the foot board; and/or (2) A resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress. 8. Before using bed rails for any reason, the staff shall inform the resident or resident's representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent. a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons. Resident #62 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for resident #62 revealed an admitted [DATE] with diagnoses including encephalopathy, epilepsy, atrial fibrillation, malignant neoplasm, protein calorie malnutrition, dehydration and chronic pain. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed resident #62's Brief Interview for Mental Status (BIMS) score was 99 which indicated that the resident was unable to complete the interview. Resident #62 was dependent on staff for activities of daily living (ADLs). Review of the Assist Rail/Enabler Device informed consent dated 06/14/2024 revealed the consent was not signed by the resident or the resident's representative. On 09/30/2024 at 7:50 a.m.,10/01/2024 at 7:45 a.m., and on 10/02/2024 at 7:30 a.m., resident #62 was observed lying in the bed with quarter bed rails raised and locked on both sides of the bed. On 10/01/2024 at 12:45 p.m., an interview with S2Director of Nursing (DON) revealed the Assist Rail/Enabler Device informed consent for resident #62 was not signed by the resident or the resident's representative. Resident #31 Review of the medical record for resident #31 revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure with hypoxia, emphysema, cachexia, malformations of cerebral vessels, and anxiety. Review of the quarterly MDS assessment dated [DATE] revealed resident #31's BIMS score was 10 which indicated the resident had moderate cognitive impairment and required assistance with ADLs. Observations of resident #31 on 09/30/2024 at 10:27 a.m., 10/01/2024 at 9:00 a.m. and 3:20 p.m., and on 10/02/2024 at 9:15 a.m. revealed he was lying in the bed with quarter bed rails raised and locked on both sides of the bed. Review of the Assist Rail/Enabler Device informed consent dated 11/22/2023 revealed the consent was not signed by the resident or the resident's representative. On 10/01/2024 at 12:45 p.m., an interview with S2DON confirmed the Assist Rail/Enabler Device informed consent for resident #31 was not signed by the resident or the resident's representative. 32231 Resident #16 Review of the resident #16's medical record revealed she was admitted to the facility on [DATE] with diagnoses that included in part, obstructive sleep apnea, acute and chronic respiratory failure with hypoxia, insomnia, altered mental status, and obesity. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission minimum data set assessment dated [DATE] revealed resident #16 had a Brief Interview for Mental Status (BIMS) score of 15. A score of 13-15 revealed resident #16 was cognitively intact with daily decision making skills. On 09/30/2024 at 11:30 a.m., an observation revealed resident #16 in her room, sitting up in her wheelchair, and visiting with her family member. Further observation revealed resident #16 had one quarter bedrails, one to each side of her bed. Both bed rails were up and in a locked position. Further observations revealed that on 10/01/2024 at 12:40 p.m., 10/01/2024 at 5:00 p.m., and 10/02/2024 at 11:51 a.m., the bed rails remained up and in a locked position. Review of the Assist Rail/Enabler device informed consent document dated 09/20/2024 revealed the name of the device as an Assist Rail x1. Further review revealed there was no documented evidence of the consent form being signed by resident #16 and /or the resident's representative. On 10/01/2024 at approximately 3:15 p.m., S2DON was notified of the above findings. S2DON reviewed resident #16's medical record and confirmed the resident should have been assessed for having two bed rails and the consent was not signed by resident #16 and /or the resident's representative prior to the bed rails being place on the bed. Resident #40 Review of resident #40's medical record revealed she was admitted to the facility on [DATE] with diagnoses including in part, acute combined systolic (congestive) and diastolic (congestive) heart failure, chronic obstructive pulmonary disease, morbid (severe) obesity, functional quadriplegia, weakness, fall from bed, and pain in joints of left hand. Review of the annual minimum data set assessment dated [DATE] revealed resident #40 had a BIMS score of 15. A score of 13-15 revealed resident #40 was cognitively intact with daily decision making skills. On 09/30/24 12:13 p.m., an observation of resident #40 revealed the resident lying in bed. Further observation revealed one-half bed rails intact to each side of the resident's bed. Both bed rails were up and in a locked position. Further observation revealed that on 10/01/2024 at 12:25 p.m., resident #40 was lying in her bed with both of the bed rails up and in a locked position. Review of the medical record revealed there was no documented evidence of resident #40 being assessed for having two, one-half bed rails and no signed consent by resident #40/ representative prior to the bed rails being placed on the bed. On 10/03/2024 at approximately 3:20 p.m., S2DON was notified of the observations of resident #40 having one-half bed rails intact, one to each side of her bed and no documented evidence of resident #40 of a signed consent for the use of the bed rails. After a review of resident #40's medical record with S2Director of Nursing, she confirmed there was no documented evidence of an assessment being completed or a signed consent being obtained prior to the use of one-half bed rails for resident #40. 41829 Resident #9 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed resident # 9 was admitted to the facility 09/07/2012 with diagnoses that included gastrostomy status, unspecified intellectual disabilities, unspecified dementia, encephalopathy, angina pectoris unspecified, chronic pain syndrome, hyperlipidemia, gastro-esophageal reflux disease without esophagitis, constipation, unspecified glaucoma, and mild protein-calorie malnutrition. Review of quarterly MDS assessment dated [DATE] revealed a BIMS score of 13 which indicated resident #9 was cognitively intact. Resident #9 was dependent on staff for assistance with all Activities of Daily Living. On 09/30/2024 at 10:26 a.m., an observation of resident #9 revealed she was lying bed. The quarter bed rails on each side of the bed were in the upright position. On 10/01/2024 at 11:52 a.m., an observation of resident #9 revealed she was lying in bed. The quarter bed rails on each side of the bed were in the upright position. On 10/02/2024 at 9:10 a.m., an observation of resident #9 revealed she was lying in bed with the quarter bed rails on each side of the bed in the upright position. Review of active care plans revealed resident #9 required one person assistance with turning and repositioning in bed. An intervention listed included resident #9 used quarter assist rails x2 to assist with bed mobility and transfers. Further review of resident #9's medical record revealed there was no documented evidence of resident #9 being assessed for the use of bed rails or a consent for bed rails to be used. During an interview on 10/01/2024 at 3:08 p.m., with S2DON revealed there was no documentation that resident #9 was assessed for the use of bed rails. S2DON further revealed there was no documentation of a consent for bed rails to be used. S2DON confirmed resident #9 should have been assessed for bed rail use and a consent should have been obtained prior to the use of bedrails.

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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** 41829 Based on record review and interviews the facility failed to ensure each resident's medication regimen was free from unnecessary medications by failing to obtain a hemoglobin A1C and lipid panel for 1 (#49) of 5 (#3, #37, #43, #49, #51) residents reviewed for unnecessary medications. Findings: Record review revealed resident #49 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus with diabetic polyneuropathy, insomnia, anemia, essential hypertension, anxiety disorder, bipolar disorder, depression, arthritis, pain unspecified, unspecified dementia without behavioral disturbance, psychotic disturbance, and mood disturbance. Review of the Consultant Pharmacist Communication to Nursing letter dated 08/29/2024 revealed the following recommendation: I did not find any labs ordered routinely. Please verify we are monitoring labs (lithium, hemoglobin A1C, Complete Blood Count (CBC), Complete Metabolic Profile (CMP) and Lipid levels), if not please follow up with the prescriber to obtain orders. Further review of the letter revealed a verbal order per the Nurse Practitioner obtained by S2Director of Nursing (DON) dated 09/13/2024 at 12:30 p.m. for a hemoglobin A1C, CBC, and CMP every 3 months and lipid panel and lithium level every 6 months. Further record review revealed documentation resident #49 had the following lab completed on 09/19/2024: CBC with differential, CMP and lithium level. There was no documented evidence of a hemoglobin A1C or lipid profile being completed. On 10/02/2024 at 1:45 p.m. an interview with S2DON revealed she received a verbal order from the Nurse Practitioner on 09/13/2024 at 12:30 p.m. for resident #49 to have a hemoglobin A1C, CBC, and CMP every 3 months, and a lipid panel and lithium level every 6 months. S2DON revealed the hemoglobin A1C and lipid panel were not collected. S2DON confirmed the hemoglobin A1C and lipid panel should have been completed as ordered.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43405 Based on record reviews and interviews, the facility failed to ensure that each resident was free from unnecessary medication use for 5 (#3, #37, #43, #49, and #51) of 5 (#3, #37, #43, #49, and #51) residents sampled for unnecessary medication review. The physician/prescriber failed to provide a rationale for continuation of psychotropic medications. Findings: Resident #3 Review of resident #3's record revealed an admitted [DATE] with diagnoses including anxiety disorder, chronic kidney disease, other schizoaffective disorders, pain unspecified, unspecified dementia with behavioral disturbance, major depressive disorder, dysphagia, and long term use of opiate analgesics. Review of resident #3's September 2024 Physician's Orders revealed orders for the following psychotropic medications which require a gradual dose reduction (GDR): Seroquel, Buspirone, Lorazepam, Fluoxetine, and Haloperidol. Review of the Note to Attending Physician/Prescriber for resident #3 dated 05/27/2024 revealed the following: resident has been taking 2 antipsychotics- Seroquel 100 milligrams (mg) 4 times per day (qid) and Haloperidol 5 mg 3 times per day (tid)- which flags as a duplicate therapy. Please consider a slow GDR of Haloperidol to 2 mg tid to prevent an increase in risk of adverse effects. Further review of the note by the pharmacist revealed the physician marked disagree under physician response, but did not provide a rationale for continuing the psychotropic medications and not attempting a GDR. Review of the Note to Attending Physician/Prescriber for resident #3 dated 06/26/2024 revealed resident has been taking Buspar 15 mg 2 times per day (bid) and Ativan 2 mg tid for anxiety. Please review and consider a GDR to Ativan 1 mg tid and increase Buspar, if needed. Further review of the note by the pharmacist revealed the physician marked disagree under the physician response, but did not provide a rationale for continuing the psychotropic medications and not attempting a GDR. An interview on 10/02/2024 at 3:15 p.m. with S2Director of Nursing (DON) confirmed the physician did not provide a rationale for the continuation of psychotropic medications for resident #3 on the pharmacy letters dated 05/27/2024 or 06/26/2024. S2DON further confirmed that the physician/prescriber should have documented a rationale if they disagreed with the GDR. Resident #43: Review of resident #43's record revealed an admitted [DATE] with diagnoses including type 2 diabetes mellitus, mild protein calorie malnutrition, hypertension, hyperlipidemia, major depressive disorder, and anxiety disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #43's September 2024 Physician's Orders revealed orders for the following psychotropic medications which require a GDR: Wellbutrin XL, Mirtazapine, and Lexapro. Review of the Note to Attending Physician/Prescriber for resident #43 dated 04/26/2024 revealed the pharmacy consultant recommended a GDR for Mirtazepine 15 mg every (q) hour of sleep (hs) - 7.5 mg q hs then discontinue. Further review of the note by the pharmacist revealed the physician marked disagree under the physician response, but did not provide a rationale for continuing the psychotropic medication and not attempting a GDR. An interview on 10/02/2024 at 3:15 p.m. with S2DON confirmed the physician did not provide a rationale for the continuation of psychotropic medications for resident #3 on the pharmacy letter dated 04/26/2024. S2DON further confirmed that the physician/prescriber should have documented a rationale if they disagreed with the GDR. 19121 Resident #51 Review of the medical record for sampled resident #51 revealed an admitted [DATE] with diagnosis that include the following right hip fracture, hypertension, anxiety disorder, dementia, and vitamin deficiency. Review of resident #51's September 2024 Physician's orders revealed orders for the following psychotropic medications which require a GDR: Donepezil 10 mg once a day with a start date of 03/07/2023, Sertraline 100 mg once a day with a start date of 03/08/2023, and Klonopin 0.5 mg tablet at bed time with a start date of 04/12/2023. Review of the Note to Attending Physician/Prescriber for resident #51 dated 03/31/2024 revealed the following: Resident has been taking Sertraline 100 mg once a day for the past year. Please consider 75 mg each day. Further review of the note by the pharmacist revealed the physician marked disagree under the physician's response, but did not provide a rationale for continuing the psychotropic medication and not attempting a GDR. Review of the Note to Attending Physician/Prescriber for resident #51 dated 04/27/2024 revealed the resident has been taking Clonazepam 0.5 mg each day for anxiety and is due for a GDR/review. Please consider half a tablet. Further review of the note by the pharmacist revealed the physician marked disagree under the physician's response, but did not provide a rationale for continuing the anxiety medication and not attempting a GDR. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Note to Attending Physician/Prescriber for resident #51 dated 05/26/2024 revealed the following: Resident is currently taking Doxepin 10 mg once a day and is due for a GDR/review. Please consider PRN (as needed) for 14 days and then discontinue. Further review of the note by the pharmacist revealed the physician marked disagree under the physician's response, but did not provide a rationale for continuing the psychotropic medication and not attempting a GDR. Interview on 10/01/2024 at 3:05 p.m. with S2DON confirmed that the physician did not provide a rationale for the continuation of the psychotropic and anxiety medications for resident #51. S2DON further confirmed that the physician should have documented a rationale if he disagreed with the GDR. 32231 Resident #37 Review of the medical record revealed resident #37 was admitted to the facility on [DATE] with diagnoses including, hemiplegia and hemiparesis following other cerebrovascular disease affecting right dominant side and depression. Review of the September 2024 physician's orders revealed resident #37 was to receive the following psychotropic medications as follows: 12/04/2024; Aripiprazole 5 milligrams, one tablet by mouth, one time daily and Amitriptyline 10 milligrams every hours of sleep. Review of the Note to Attending Physician/Prescriber document dated 04/26/2024 revealed that resident #37 had been taking Amitriptyline 10 milligrams every hour of sleep and was due for a gradual dose reduction/review. Documentation further revealed to consider a gradual dose reduction to discontinue. Further review revealed the physician's response was documented as disagree. There was no documented rationale as to why the physician had disagreed to the gradual dose reduction for the psychotropic medication Amitriptyline. Review of the Note to attending physician/prescriber documents dated 02/29/2024, 05/23/2024 and 07/22/2024 a revealed that resident (referring to resident #37) was currently taking Aripiprazole 5 milligrams every day for anxiety which flagged as unnecessary use. Please review and consider a gradual dose reduction (2 milligrams every day for 7 days, then discontinue). Further review revealed the physician's response was documented as disagree. There was no documented rationale as to why the physician had disagreed to the gradual dose reduction for the psychotropic medication Amitriptyline. On 10/03/2024 at 9:16 a.m., S1Administrator and S2Director of Nursing were notified of there being no documented rationale as to why the psychotropic medication ordered for resident #37 had not been gradually reduced as noted by the pharmacist. 41829 Resident #49 Record review revealed resident #49 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus with diabetic polyneuropathy, insomnia, anemia, essential hypertension, anxiety disorder, bipolar disorder, depression, arthritis, pain unspecified, and unspecified dementia without behavioral disturbance, psychotic disturbance, and mood disturbance. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the active October 2024 physician orders included Seroquel 400 mg tablet give 2 tablets by mouth (po) every hour of sleep, Hydroxyzine Pamoate 25 mg capsule give one capsule BID, lithium carbonate 300 mg capsule give one capsule po BID, and Sertraline 50 mg tablet give one table po qd. Review of the September and October 2024 Electronic Medication Administration Record (EMAR) revealed resident #49 received medications as ordered by the physician. Review of the consultant pharmacist's Note to Attending Physician/Prescriber for resident #49 dated 04/26/2024 revealed the following: 1. Resident is currently taking Seroquel 500 mg qd for insomnia which flags as unnecessary use. Please review to determine if diagnoses needs updating. Also review to determine if dose needs to be divided to BID. 2. This resident is receiving Hydroxyzine for the control of anxiety. This antihistamine is rarely considered the agent of choice due to its strong anticholinergic properties. Please review and consider alternative. Further review of the note revealed the physician marked disagree under the physician's response, but did not provide a rationale for the clarification of the diagnosis used for Seroquel or for the continuation of Hydroxyzine. Review of the consultant pharmacist's Note to Attending Physician/Prescriber for resident #49 dated 05/27/2024 revealed the following: 1. Resident is currently taking Seroquel 800 mg qd. Please review to determine if dose needs to be divided to give BID. 2. This resident is receiving Hydroxyzine for control of anxiety. This antihistamine is rarely considered the agent of choice due to its strong anticholinergic and sedative properties. Please review and consider alternatives. Further review of the noted revealed the physician marked disagree under the physician's response, but did not provide a rationale for not giving Seroquel BID or for the continuation of Hydroxyzine. An interview on 10/02/2024 at 4:00 p.m. with S2Director of Nursing (DON) confirmed the physician did not provide a rationale for the continuation of the medications as ordered or a clarification of the diagnosis used for Seroquel. S2DON further confirmed the physician should have documented the rationale when disagreeing with the consultant pharmacist recommendations regarding the Hydroxyzine.

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	195359	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Continuing Care Center	2301 Sterlington Road Monroe, LA 71203

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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. 19098 Based on observations, record review and interviews the facility failed to securely store medications in a resident's room per the policy and procedure when self-administering medication for 1 (#323) of 1 (#323) residents self-administering medications. Findings: Resident #323 Review of the faclity's Self - Administration of Medications policy and procedure dated 06/14/2006 revealed: A patient may self-administer medications if the patient is determined safe for the patient and other patients of the facility by the facility's interdisciplinary team. Procedure: An assessment for Self-Administration of Medications must be competed on each patient requesting to self-administer medications and quarterly thereafter. An assessment for self-administration of medications is kept with the patient's medical record under the Assessment tab. If it has been determined the patient is capable of self-administering his/her medications, a physician order must be obtained, a care plan formulated, and staff in-serviced. The nursing staff must interview the patient on every shift to verify that all self-administered doses on the patient's Medication Administration Record. If the shift interview indicates any question as to the continued safety of self-administration, then the nurse will initiate the re-assessment process outlined above. All medications for self-administration must be stored in a locked storage area in the Patients room. Narcotics must be under double lock. On 09/30/2024 at 10:39 a.m. observation of resident #323's room revealed a bottle of Fluticasone Nasal (to treat allergies) spray 100 micrograms (mcg)/150 mcg in the room on the bedside table. Review of the label on the box revealed to administer 2 sprays. The resident stated she sprays 2 in each nostril every day. On 10/01/2024 at 9:07 a.m. observation of resident #323's room revealed the Fluticasone nasal spray remained at the bedside. On 10/02/2024 at 7:54 a.m. observation of resident #323's room revealed the Fluticasone nasal spray remained at the bedside. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the current physician orders for resident #323 revealed an order dated 09/19/2024 for Fluticasone Propionate 50 micrograms (mcg)/actuation nasal spray, suspension (2 sprays) both nostrils at bedtime. Further review of the record revealed there was no physician's order to allow resident #323 to keep the medication in the room at the bedside, and there was no assessment to determine if resident #323 was safe to have the medication in the room at the bedside to self-administer. On 10/02/2024 at 11:20 a.m., an interview with S5Licensed Practical Nurse (LPN) revealed she was not aware resident #323 had the Fluticasone nasal spray in her room. S5LPN revealed there was a bottle on the mediation cart and she received the medication in the evening. S5LPN further revealed there was no order for resident #323 to have the medication at the bedside and there was no assessment for resident #323 to keep the medication at bedside to self-administer the medication. Observation of the bottle of Fluticasone in the resident's room revealed the label was from the pharmacy from the hospital the resident was in prior to her admission to the nursing facility. Resident #323 said the hospital gave it to her and she actually took her own dose this morning. On 10/02/2024 at 11:45 a.m., an interview with S2Director of Nursing (DON) revealed she was not aware resident #323 had the medication in her room. S2DON revealed if a resident had medications in their room and was self-administering the medication then they are supposed to have an assessment to self-administer the medication and the medication must be stored securely.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19121 Based on observation, policy review and interviews the facility failed to implement policies and procedures for enhanced barrier precautions (EBP) for 4 (#7, #45, #321, #322,) of 4 (#7, #45, #321, #322) residents reviewed for enhanced barrier precautions. Findings: Review of the facility's Enhanced Barrier Precations (EBP) policy dated March 2024 revealed in part: EBP is an infection control intervention to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. Infections or colonization with a Centers for Disease Control and Prevention (CDC) targeted MDRO when Contact Precautions do not apply otherwise; or Chronic wounds (pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers) and/or indwelling medical devices (devices fully embedded in the body, ie central lines, hemodialysis catheters, urinary catheters, feeding tubes and trach tubes) even if the resident is not known to be infected or colonized with a CDC- targeted MDRO. EBP will be used for any resident who meet the above criteria. Procedures: 1. EBP is primarily intended to apply to care that occurs within a residents room where high contact resident care activities are performed (where there is extended contact with the resident and their environment). 2. EBP will be used when performing the following high contact resident care activities: Dressing, Bathing/showering, hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tube, tracheostomy, wound care (chronic): pressure ulcer, diabetic foot ulcer, unhealed surgical wounds, and venous stasis ulcers. 3. If splashes and sprays are anticipated during the high contact activity, face protections should be used in addition to the gown and gloves. 4. Outside resident room EBP should be followed when performing transfers or assisting during bathing in a shared/common shower room. 10. Residents who are on EBP will have signage placed outside their room to alert staff of those residents who require the use of EBP prior to providing high contact care activities. Resident #45 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record for sampled resident #45 revealed an admitted [DATE] with diagnoses of hypertension, heart disease, atrial fibrillation, urine retention, peripheral vascular disease, bilateral amputation of the legs, sepsis, and neuropathic bladder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed resident #45 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively aware and able to make daily decisions. Observation on 09/30/2024 at 10:10 a.m. of resident #45's door revealed no signs posted to ensure staff were aware the resident was on Enhanced Barrier Precautions procedures when providing care. Interview on 09/30/2024 at 10:15 a.m.with resident #45 revealed staff only wear gloves and do not wear gowns when they empty the foley catheter bag. Interview on 10/02/2024 at 7:20 a.m. with S12Certified Nursing Assistant (CNA) reported resident #45 was not on EBP. Interview on 10/02/2024 at 3:00 pm. with S2Director of Nursing (DON) confirmed resident #45 should be on enhanced barrier precautions due the resident having a foley catheter. S2DON further confirmed there should have been signage indicating EBP posted on resident #45's door. 19098 Resident #321 On 09/30/2024 during initial tour of the facility observation of resident #321's room revealed no indication resident #321 was on EBP. Review of the record for resident #321 revealed an admitted [DATE] with diagnoses of End Stage Renal Disease and had a hemodialysis line to the right groin area. Resident 322 On 09/30/2024 during initial tour observation of resident #322's room revealed no indication the resident had been placed on EBP. Review of the record revealed an admitted [DATE]. Further observation revealed resident #322 had tube feeding infusing. On 10/01/2024 at 11:15 a.m. observation of resident #321, and #322's door revealed there was no EBP signs posted. On 10/01/2024 at 11:20 a.m., an interview with S6MDS nurse revealed she had been given a list of residents to place EBP signage on the doors. S6MDS nurse confirmed there were no signs for EBP on resident #321 and #322's door. On 10/01/2024 at 11:45 a.m., an interview with S2DON revealed she was not aware the residents' rooms did not have EBP signs placed on the door when the residents were admitted . 32231 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7 On 09/30/2024 at 3:41 p.m., an observation revealed signs on the outside of resident #7's room door regarding enhanced barrier precautions and personal protective equipment use. Observation of one of the posted signs revealed that providers and staff must wear gloves and a gown for the following high-contact resident care activities which included device care or use for urinary catheters. During the observation, S13Certified Nursing Assistant was present and donning a pair of disposable gloves. She entered resident #7s room, walked to the bedside, and checked resident #7's brief. S13CNA then noted that resident #7's Foley catheter needed to be emptied. After she collected the urine, she disposed of the urine in the resident's bathroom, and left the room. S13CNA did not wear a gown when emptying the Foley catheter bag. After she exited the room, S13CNA revealed that she was told she only had to wear a pair of gloves and not a gown when caring for resident #7. On 10/03/2024 at 7:36 a.m., S1Administrator and S2Director of Nursing were notified of the above findings. S2Director of Nursing confirmed it was the nursing facility's policy for staff to the wear gloves and a gown when emptying a Foley catheter.