

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195388	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2025
NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Franklin		STREET ADDRESS, CITY, STATE, ZIP CODE 1907 Chinaberry Street Franklin, LA 70538	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34608</p> <p>Based on record reviews, observations, and interviews, the facility failed to ensure residents identified as safe smokers maintained their rights to keep their smoking supplies and smoke at their leisure for 4 (Resident #40, Resident #51, Resident #90, and Resident #105) of 4 (Resident #40, Resident #51, Resident #90, and Resident #105) sampled residents reviewed for resident rights.</p> <p>Findings:</p> <p>Review of the facility's undated, Resident Smoking policy revealed, in part, residents who had independent smoking privileges are were permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession.</p> <p>Review of the facility's smoking policy revealed, in part, that the purpose was to establish guidelines for the facility's residents' safe smoking. Further review revealed residents who were identified as safe smokers were permitted to keep cigarettes and other smoking articles in their possession.</p> <p>Review of the facility's smoking hours revealed, in part, smoking times were at 8:30 a.m., 10:30 a.m., 1:00 p.m., 3:30 p.m., 6:30 p.m., and 8:30 p.m.</p> <p>Review of the facility's resident council meeting minutes dated 10/04/2024 at 2:00 p.m. revealed, in part, residents requested a meeting with S1Administrator regarding the change in the facility's smoking procedure.</p> <p>There was no documented evidence, and the facility was unable to present any documented evidence the facility responded to the residents' request.</p> <p>Review of the facility's safe smokers list revealed, in part, Resident #40, Resident #51, Resident #90, and Resident #105, were listed as a safe smokers.</p> <p>Observation on 01/6/2025 at 3:15 p.m., revealed a group of residents, which included Resident #40, Resident #51, Resident #90, and Resident #105, waiting for a staff member to give them their smoking material, and go outside with them to smoke at 3:30 p.m.</p> <p>Resident #40</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #40's Smoking Safety Screen dated 10/04/2024 revealed, in part, Resident #40 was assessed as being a safe smoker.</p> <p>In an interview on 01/6/2025 at 10:07 a.m., Resident #40 indicated the facility does not allow him to keep his cigarette and lighter, and does not allow him to smoke when he would like to smoke. Resident #40 further indicated he was not a child and the facility should allow him to keep his own smoking materials and should be allowed to smoke when he desires.</p> <p>Resident #51</p> <p>Review of Resident #51's Smoking Safety Screen dated 12/05/2024 revealed, in part, Resident #51 was assessed as being a safe smoker.</p> <p>In an interview on 01/06/2025 at 3:10 p.m., Resident #51 indicated he was a [AGE] year old veteran and was responsible enough to keep his own smoking materials. Resident #51 further indicated he did not appreciate being treated like a child.</p> <p>Resident #90</p> <p>Review of Resident #90's Smoking Safety Screen dated 01/03/2025 revealed, in part, Resident #90 was assessed as being a safe smoker.</p> <p>In an interview on 01/06/2025 at 10:10 a.m., Resident #90 indicated she was not happy about not being allowed to keep her smoking materials. Resident #90 further indicated she was grown and should be allowed to smoke when she wishes.</p> <p>Resident #105</p> <p>Review of Resident #105's Smoking Safety Screening dated 11/18/2024, revealed, in part, Resident #105 was assessed as being a safe smoker.</p> <p>Review of Resident #105's current Care Plan revealed, in part, Resident #105 was identified as a safe smoker with no restrictions. Further review revealed Resident #105 had a diagnosis of Major Depressive Disorder and Generalized Anxiety with an intervention which included to allow Resident #105 to make choices regarding her schedule.</p> <p>In an interview on 01/06/2025 at 10:05 a.m., Resident #105 indicated the smoking times were implemented a couple of months ago, and staff removed the resident's smoking supplies from their possession, locked them in a tackle box behind the nurse's station, and only passed them out to the residents at certain times. Resident #105 further indicated the smoking residents did not have a choice or proper notification of the new procedure. Resident #105 indicated this made her more anxious and was afraid to miss the smoking session so she came out early to ensure she did not miss the smoking session. Resident #105 indicated staff only allowed the smoking residents about 20 minutes to smoke. Resident #105 further indicated that she would prefer to have her smoking supplies in her possession. Resident #105 indicated staff issued two cigarettes per resident during the smoking session, and residents were not allowed to smoke more than two during this time. Resident #105 indicated she should be allowed to have as many of her cigarettes as she wanted to smoke because it was her personal property. Resident #105 indicated she should be able to smoke in the smoking area at her leisure.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>34608</p> <p>Based on record review and interviews, the facility failed to respond and maintain documented responses to the complaints voiced during the facility's resident council meetings for 3 of 3 resident council meeting minutes reviewed.</p> <p>Findings:</p> <p>Review of the facility's undated Grievance Policy and Procedure revealed, in part, the purpose of the policy was to ensure a resident's grievance would be followed up by prompt efforts to resolve the grievance of the resident. Further review of the policy revealed the resident council minute meetings were to be given to administration after completion of the meeting and the findings were to be documented and given to the administrator or designee for review.</p> <p>In interviews on 01/06/2025 at 10:00 a.m., during a meeting conducted with members of the resident council, Resident #40 indicated the facility does not respond to the resident council's concerns discussed in the monthly meetings. Resident # 71, Resident #90, and Resident #101 all agreed the facility did not follow-up with a responds to the concerns discussed during the resident council meetings.</p> <p>Review of the resident council's meeting minutes for the months of October, November, and December 2024 revealed, in part, there were no documented responses to the concerns discussed in the resident council meetings.</p> <p>Review of the facility's October 2024 resident council meeting minutes revealed, in part, the facility's residents requested to meet with S1Administrator regarding the smoking times.</p> <p>Review of the facility's November and December 2024 resident council meeting minutes revealed there was no documented response to the resident council above mentioned October 2024 request.</p> <p>In an interview on 01/6/2025 at 11:00 a.m., S10Assistant Activity Director indicated there was no documented responses to the residents' concerns discussed in the resident council meetings.</p> <p>In an interview on 01/6/2025 at 11:40 a.m., S9SocialWorker indicated she did not have any documented responses to the residents' concerns discussed in the resident council meetings.</p> <p>In an interview on 01/06/2025 at 3:35 p.m., S1Administrator indicated the facility did not have any documented evidence of the facility's response to the resident council concerns as required. S1Admnsitrator further indicated he was not notified the resident council requested to meet with him in October 2024, and he had not met with the resident council regarding their concerns.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877</p> <p>Based on interviews and record reviews, the facility failed to ensure a resident's physician was immediately notified of a resident's ear pain and drainage for 1 (Resident #43) of 3 (Resident #29, Resident #43, and Resident #79) residents investigated for pain.</p> <p>Findings:</p> <p>Review of Resident #43's record revealed, in part, Resident #43 was admitted to the facility on [DATE] with a diagnosis of otitis media (ear infection) of the right ear.</p> <p>Review of Resident #43's Minimum Data Set with an Assessment Reference Date of 10/07/2024 revealed Resident #43 had a Brief Interview Mental Status Score of 15 which indicated he was cognitively intact.</p> <p>In an interview on 01/06/2025 at 2:46 p.m., Resident #43 indicated he reported right ear pain and drainage to the nurse last week, but nothing has been done.</p> <p>In an interview on 01/07/2025 at 10:05 a.m., Resident #43 indicated he had not been seen by a physician, and had not received any information about his right ear complaints.</p> <p>In a telephone interview 01/07/2025 at 2:02 p.m., S16Licensed Practical Nurse (LPN) indicated Resident #43 complained to her of right ear pain and drainage over the weekend. S16LPN further confirmed that she did note minimal drainage to Resident #43's right ear. S16LPN further indicated she should have notified the doctor about Resident #43's ear, and should have.</p> <p>In an interview on 01/07/2025 at 2:05 p.m., S2Director of Nursing indicated if S16LPN felt like she should have notified the doctor, then she should have notified the doctor.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>17453</p> <p>Based on record reviews, and interviews, the facility failed to protect the resident's right to be free from resident to resident physical abuse for 1 (Resident #112) of 1 (Resident #112) sampled residents investigated for abuse.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Abuse Prevention and Prohibition revealed, in part, each resident has the right to be free from abuse. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends or other individuals. Abuse is defined as the willful infliction of injury with resulting physical harm, pain, or mental anguish. Resident abuse may include resident to resident abuse. Physical abuse may include an aggressive act, including inappropriate physical contact that is harmful or likely to cause injury or harm to a resident. Examples include hitting, slapping, pinching, biting, shoving, and kicking.</p> <p>Review of Resident #112's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/2024 revealed, in part, a Brief Interview for Mental Status score of 11, which indicated moderate cognitive impairment.</p> <p>Review of Resident #112's nurse's notes dated 11/28/2024 at 8:33 a.m. revealed, in part, Resident #112 walked to the dining room doorway. Resident #24 was standing at the dining room doorway and hit Resident #112 in the back of the head. Staff asked Resident #24 why he hit Resident #112 in the head, and he stated he could hit whoever he wanted.</p> <p>Review of Resident #112's nurse's notes dated 01/04/2025 at 8:45 a.m. revealed, in part, Resident #112 was involved in a physical altercation with Resident #174. Resident #112 was in the hallway when Resident #174 started the physical altercation. Resident #112 was in the corner and screamed for help. S7Certified Nursing Assistant (CNA) separated Resident #112 and Resident #174. Resident #112's lip was swollen and bleeding.</p> <p>In a telephone interview on 01/06/2025 at 11:32 a.m., S7CNA indicated she heard Resident #112 scream for help. S7CNA further indicated she observed Resident #112 and Resident #174 in the hallway and Resident #174 had pushed Resident #112 against the wall. S7CNA indicated Resident #112 was observed with blood on her lips.</p> <p>In a telephone interview on 01/06/2025 at 11:53 a.m., S6LPN indicated on 01/04/2025 she heard Resident #112 scream for help. S6LPN indicated Resident #112 and Resident #174 had to be separated. S6LPN further indicated Resident #112 had blood on her lips.</p> <p>In an interview on 01/06/2025 at 12:15 p.m., S2Director of Nursing (DON) confirmed she was aware of the above documented incidents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 01/06/2025 at 12:25 p.m., S1Administrator indicated the above documented incidents were resident to resident abuse.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>17453</p> <p>Based on interviews and record reviews, the facility failed to ensure allegations of physical abuse were reported to the Statewide Incident Management System (SIMS) for resident to resident physical abuse for 1 (Resident #112) of 1 (Resident #112) sampled residents investigated for abuse.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled Abuse Prevention and Prohibition revealed, in part,</p> <p>an alleged violation of abuse will be reported immediately, but not later then, 2 hours if the alleged violation involved abuse or resulted in serious bodily injury or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. The facility administrator or designee shall report or cause a report to be made to the mandated stated agency per reporting criteria within guidelines of notification of an alleged abuse. Administrator or designee will have 5 working days from the initial report of abuse to complete SIMS reporting according to DHH guidelines.</p> <p>Review of Resident #112's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/2024 revealed, in part, a Brief Interview for Mental Status score of 11, which indicated moderate cognitive impairment.</p> <p>Review of Resident #112's nurse's notes dated 11/28/2024 at 8:33 a.m. revealed, in part, Resident #112 walked to the dining room doorway. Resident #24 was standing at the dining room doorway and hit Resident #112 in the back of the head. Staff asked Resident #24 why he hit Resident #112 in the head, and he stated he could hit whoever he wanted.</p> <p>Review of Resident #112's nurse's notes dated 01/04/2025 at 8:45 a.m. revealed, in part, Resident #112 was involved in a physical altercation with Resident #174. Resident #112 was in the hallway when Resident #174 started the physical altercation. Resident #112 was in the corner and screamed for help. S7Certified Nursing Assistant (CNA) separated Resident #112 and Resident #174. Resident #112's lip was swollen and bleeding.</p> <p>In a telephone interview on 01/06/2025 at 11:32 a.m., S7CNA indicated she heard Resident #112 scream for help. S7CNA further indicated she observed Resident #112 and Resident #174 in the hallway and Resident #174 had pushed Resident #112 against the wall. S7CNA indicated Resident #112 was observed with blood on her lips.</p> <p>In a telephone interview on 01/06/2025 at 11:53 a.m., S6LPN indicated on 01/04/2025 she heard Resident #112 scream for help. S6LPN indicated Resident #112 and Resident #174 had to be separated. S6LPN further indicated Resident #112 had blood on her lips.</p> <p>In an interview on 01/06/2025 at 12:25 p.m., S1Administrator indicated the above documented incidents were resident to resident abuse. S1Administrator further indicated the incidents were not reported to the SIMS system, and should have been.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>17453</p> <p>Based on record reviews, observations, and interviews, the facility failed to administer a resident's oxygen per physician's orders for 1 (Resident #69) of 1 (Resident #69) sampled residents investigated for respiratory care.</p> <p>Findings:</p> <p>Review of the facility's undated policy titled oxygen administration policy and procedure revealed, in part, check physician's order for liter flow and method of administration.</p> <p>Review of Resident #69's January 2025 Physician's Orders revealed, in part, an order for oxygen 2 liters per minute (lpm) per nasal cannula (nc).</p> <p>Review of Resident #69's care plan revealed, in part, oxygen to be administered per physician orders.</p> <p>Observation on 01/05/2025 at 11:05 a.m. revealed Resident #69 received oxygen at 3lpm per nc via an oxygen concentrator.</p> <p>Observation on 01/06/2025 at 10:00 a.m. revealed Resident #69 received oxygen at 3lpm per nc via an oxygen concentrator.</p> <p>Observation on 01/07/2025 at 9:10 a.m. revealed Resident #69 received oxygen at 3lpm per nc via an oxygen concentrator.</p> <p>In an interview on 01/07/2025 at 10:38 a.m., S4Licensed Practical Nurse (LPN) confirmed Resident #69's physician order was for oxygen to be administered at 2lpm per nc via an oxygen concentrator, but it was delivered at 3lpm per nc via an oxygen concentrator.</p> <p>In an interview on 01/07/2025 at 10:43 a.m., S2Director of Nursing (DON) indicated Resident #69's oxygen should have been administered at 2lpm per nc via an oxygen concentrator as ordered by the physician.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877</p> <p>Based on interview and record review, the facility failed to fully assess a resident's pain for 1 (Resident #43) of 3 (Resident #29, Resident #42, and Resident #79) sampled residents investigated for pain.</p> <p>Findings:</p> <p>Review of the facility's undated Pain Management Policy and Procedure revealed in part, the nurse was to document in the clinical record the reason for pain, characteristics of pain, and pain management effectiveness.</p> <p>Review of Resident #43's record revealed he was admitted to the facility on [DATE] with a diagnosis of otitis media (ear infection) of the right ear.</p> <p>Review of Resident #43's Minimum Data Set with an Assessment Reference Date of 10/07/2024 revealed Resident #43 had a Brief Interview Mental Status Score of 15 which indicated he was cognitively intact.</p> <p>Review of Resident #43's Comprehensive Care Plan revealed he had a history of pain with a goal to verbalize decrease frequency/intensity of pain. Further review revealed an intervention to watch Resident #43 for worsening of pain and report symptoms to the physician.</p> <p>Review of Resident #43's January 2025, Physician's orders revealed, in part, an order for Tylenol (a medication used for pain) Oral Tablet 325 milligrams (Acetaminophen) Give 2 tablets by mouth every 4 hours as needed for sinus headache or general discomfort.</p> <p>Review of Resident #43's Electronic Medical Record revealed, in part, Tylenol was given at the following times:</p> <p>01/01/2025 at 9:19 a.m. for a pain rating of 6 with no documented evidence and the facility did not present any documented evidence for the reason for pain or characteristic of pain;</p> <p>01/02/2025 at 8:13 a.m. for a pain rating of 8 with no documented evidence and the facility did not present any documented evidence of the reason for pain or characteristic of pain;</p> <p>01/05/2025 at 7:35 p.m. for a pain rating of 8 for right side pain/earache; and,</p> <p>01/06/2025 at 7:58 a.m. for a pain rating of 8 with no documented evidence and the facility did not present any documented evidence of the reason for pain or characteristic of pain.</p> <p>In an interview on 01/06/2025 at 2:46 p.m., Resident #43 indicated he reported right ear pain and drainage to the nurse last week but nothing had been done.</p> <p>In an interview on 01/07/2025 at 10:05 a.m., Resident #43 indicated he still has not had a doctor come assess him or hear about any treatments for his complaints of right ear pain with drainage.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview 01/07/2025 at 02:02 p.m., S16Licensed Practical Nurse (LPN) indicated Resident #43 complained of right ear pain and drainage to her over the weekend. S16LPN further confirmed that she did note minimal drainage to Resident #43's right ear.</p> <p>In an interview on 01/07/2025 at 2:05 p.m., S2Director of Nursing could offer no explanation as to why staff had not assessed resident's ear pain and ear drainage, and why staff had not followed the facility's pain management policy and procedures as required.</p>		

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NAME OF PROVIDER OR SUPPLIER Legacy Nursing and Rehabilitation of Franklin		STREET ADDRESS, CITY, STATE, ZIP CODE 1907 Chinaberry Street Franklin, LA 70538	
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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>41461</p> <p>Based on observations and interview, the facility failed to ensure posted staffing information was accurate and/or current for 4 of 4 days of posted staffing information reviewed.</p> <p>Findings:</p> <p>Observation on 01/05/2025 at 8:50 a.m. revealed Staffing Disclosure Logs dated 01/04/2025, 01/05/2025, and 01/06/2025. Further observation revealed the Staffing Disclosure Logs did not have the facility name and/or the facility census.</p> <p>Observation on 01/07/2025 at 9:05 a.m. revealed the Staffing Disclosure Log dated 01/07/2025 did not include the facility name and/or the facility census.</p> <p>In an interview on 01/07/2025 at 12:13 p.m., S2Director of Nursing (DON) indicated the facility's name and daily census should have been documented on the posted Daily Staffing Disclosure Logs for 01/04/2025, 01/05/2025, 01/06/2025, and 01/07/2025.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>17453</p> <p>Based on record reviews, observation, and interviews, the facility failed to:</p> <ol style="list-style-type: none"> ensure medications were available for use for 1 (Resident #16) of 3 (Resident #16, Resident #51, and Resident #80) sampled residents reviewed for pharmacy services; and, maintain an accurate count of the disposition of controlled medications for 5 (Resident #51, Resident #54, Resident #72, Resident #73, and Resident #115) of 5 (Resident #51, Resident #54, Resident #72, Resident #73, and Resident #115) sampled residents who received controlled medications from Medication Cart a. <p>Findings:</p> <ol style="list-style-type: none"> <p>Resident #16</p> <p>Review of Resident #16's January 2025 physician's orders revealed, in part, Resident #16 had an order for Systane Balance Ophthalmic Solution (a medication used for dry eye) 1 drop in both eyes 4 times a day.</p> <p>Observation on 01/07/2025 at 9:05 a.m. revealed S8Agency Licensed Practical Nurse (LPN) did not administer Resident #16 her Systane Balance Ophthalmic Solution.</p> <p>In an interview on 01/06/2025 at 11:54 a.m., S8Agency LPN confirmed she did not administer Resident #16 her Systane Balance Ophthalmic solution. S8Agency LPN, further indicated Resident #16's Systane Balance Ophthalmic Solution was unavailable because it was on back order.</p> <p>In an interview on 01/06/2025 at 12:30 p.m., S3Assistant Director of Nursing indicated Resident #16's doctor should have been notified about her eye drops being on backorder so that a similar eye drop could have been ordered.</p> <p>Review of the facility's undated policy titled Narcotics Policy and Procedure revealed, in part, the total of each drug found in the controlled substance drawer shall be listed on the narcotic count sheet.</p> <p>On 01/07/2025 at 1:40 p.m. a reconciliation was completed of the controlled substances on Medication Cart a and the controlled substance binder for Medication Cart a and revealed, in part, the following:</p> <p>Resident#51</p> <p>(continued on next page)</p> 		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident #51's medication card for Alprazolam (a medication used to treat anxiety) 0.5 milligram (mg) revealed 36 pills remained on the medication card. Review of Resident #51's controlled medication administration record for Alprazolam 0.5mg revealed 37 pills remained on the medication card.</p> <p>Resident #54</p> <p>Review of Resident #54's medication card for Tramadol (a medication used to treat pain) 50mg revealed 46 pills remained on the medication card. Review of Resident #54's controlled medication administration record for Tramadol 50mg revealed 47 pills remained on the medication card.</p> <p>Resident #72</p> <p>Review of Resident #72's medication card for Clonazepam (a medication used to treat anxiety) 0.5mg revealed 17 pills remained on the medication card. Review of Resident #72's controlled medication administration record for Clonazepam 0.5mg revealed 18 pills remained on the medication card. Further review revealed Resident #72's medication card for Oxycodone/APAP Tablet (a medication used for pain) 7.5-325 revealed 30 pills remained on the medication card. Review of Resident #72's controlled medication administration record for Oxycodone/APAP Tablet 7.5-325 revealed 31 pills remained on the medication card.</p> <p>Resident #73</p> <p>Review of Resident #73's medication card for Tramadol (a medication used to treat pain) 50mg revealed 54 pills remained on the medication card. Review of Resident #73's controlled medication administration record for Tramadol 50mg revealed 53 pills remained on the medication card.</p> <p>Resident #115</p> <p>Review of Resident #115's medication card for Lorazepam (a medication used to treat anxiety) 0.5mg revealed 36 pills remained on the medication card. Review of Resident #115's controlled medication administration record for Lorazepam 0.5mg revealed 37 pills remained on the medication card.</p> <p>In an interview on 01/07/2025 at 1:40 p.m., S8Agency Licensed Practical Nurse (LPN) confirmed the above documented medications available on the medication cards did not match the count documented on the controlled medication administration record.</p> <p>In an interview on 01/07/2025 at 1:45 p.m., S1Director of Nursing (DON) indicated the number of pills available on the medication card and the number of pills documented on the controlled medication administration record should be the same.</p> <p>45877</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>45877</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on record reviews, observations, and interviews, the facility failed to ensure the medication error rate was not greater than 5% by having a medication 12.9% for 1 (Resident #16) of 3 (Resident #16, Resident #51, and Resident #80) sampled residents observed during medication administration.</p> <p>Findings:</p> <p>Review of the facility's undated Medication Pass Administration Policy and Procedure revealed, in part, medications shall be administered as ordered by the physician.</p> <p>Review of Resident #16's January 2025 physician's orders revealed, in part, Resident #16 had the following orders:</p> <p>Tolterodine Tartrate ER (a medication used for blood pressure) 2 milligrams (mg) give 1 capsule by mouth daily;</p> <p>Fetzima Capsule Extended Release 24 hour (a medication used for depression) 20 mg give 1 capsule by mouth with 40 mg capsule to equal 60 mg daily;</p> <p>Fetzima Capsule Extended Release 24 hour 40 mg give 1 capsule by mouth with 20 mg capsule to equal 60 mg daily;</p> <p>Systane Balance Ophthalmic Solution (a medication used for dry eye) 1 drop in both eyes 4 times a day; and,</p> <p>May crush medications except for enteric coated/time released medications</p> <p>Observation on 01/07/2025 at 8:59 a.m. revealed S8Agency Licensed Practical Nurse (LPN) opened 2 Fetzima Capsules and 1 Tolterodine Capsule and placed the medication inside of the capsules on top of pudding. S8Agency LPN then administered the medication with the pudding to Resident #16.</p> <p>Observation on 01/07/2025 at 9:05 a.m. revealed Resident #16 did not have her Systane Balance Ophthalmic Solution administered to her.</p> <p>In an interview on 01/06/2025 at 11:54 a.m., S8Agency LPN confirmed she opened Resident #16's Tolterodine Capsules and Fetzima Capsules and placed the medication that was inside the capsules on top of the pudding, and administered it to Resident #16. S8Agency LPN further indicated she did not know if the medications Tolterodine Capsule and Fetzima Capsule could be opened or not. S8Agency LPN, further indicated Resident #16's Systane Balance Ophthalmic Solution was on back order; therefore, she unable to administer the eye drops to Resident #16.</p> <p>In an interview on 01/06/2025 at 12:14 p.m., a Pharmacist, working at the pharmacy that fills Resident #16's medications, indicated Tolterodine and Fetzima capsules should not be opened, and should be taken whole.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There were 31 medication administration opportunities for error, with 4 observed errors for a medication administration error rate of 12.9%.</p> <p>In an interview on 01/07/2025 at 11:03 a.m., S2Director of Nursing confirmed the medication error rate should not have been over 5%.</p> <p>In an interview on 01/06/2025 at 12:30 p.m., S3Assistant Director of Nursing indicated Resident #16's doctor should have been notified about her eye drops being on backorder.</p>		