| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195424 | A. Building<br>B. Wing | 05/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lexington House | 16 Heyman Lane<br>Alexandria, LA 71303 |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, interview and record review, the facility failed to ensure a resident received reasonable accommodation of needs by failing to ensure the call light was accessible by a resident for 1 (Resident #7) of 41 sampled residents.<br><br>Findings:<br><br>On 05/21/2025, Review of facility policy titled, Call Light/Bell, with revision date of 01/2024, revealed in part .<br><br>Purpose: To provide the resident a means of communication with staff members. To provide staff members a means of summoning assistance when they are with the resident.<br><br>Process: Ensure resident has call light in reach when in resident room . Leave the resident comfortable. Place the call light within the resident's reach before leaving the room .<br><br>Resident #7<br><br>Review of Resident #7's electronic medical record revealed an admission date of 06/10/2022 with diagnoses that included: Type 2 Diabetes Mellitus with Hyperglycemia, Protein Calorie Malnutrition, Alzheimer's, Essential Primary Hypertension, Schizophrenia, Tachycardia, Edema, unspecified Dementia, severe with other behavior disturbances, History of Urinary Tract Infections (UTIs).<br><br>Review of Resident #7's Quarterly MDS with ARD of 02/20/2025, revealed a BIMS Score of 3, indicating severe cognitive impairment. Resident #7 required total care and extensive assistance for bed mobility.<br><br>Review of Resident #7's Care Plan revealed in part . Resident #7 had a high risk for falls related to decreased mobility, weakness, severe cognitive impairment, and poor safety awareness. Interventions included in part . place call light within reach.<br><br>On 05/19/2025 at 09:35 a.m. Observation revealed Resident #7 lying in bed. Resident #7 was noninterviewable. Call light was observed on the floor next to Resident #7's bed. Resident #7 could not reach the call light.<br><br>On 05/20/2025 at 11:39 a.m. Observation revealed Resident #7 lying in bed awake and alert. Call light was observed on the floor next to Resident #7's bed. Resident #7 could not reach the call light.<br><br>(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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 05/20/2025 at 03:15 p.m. Observation revealed Resident #7 lying in bed awake and alert. Resident #7 was calm with no abnormal behaviors. Call light was observed on the floor next to Resident #7's bed. Resident #7 could not reach the call light.<br><br>On 05/20/2025 at 03:16 p.m. S14 LPN accompanied surveyor to Resident #7's room. S14 LPN confirmed the call light was not accessible to the resident and should have been.<br><br>On 05/20/25 at 03:20 p.m. above findings discussed with S1 Corp RN. S1 Corp RN acknowledged above findings and confirmed Resident #7's call light should have been within reach. |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>Based on record review and interview, the facility failed to ensure the SNF ABN Form CMS-10055 (Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage Form CMS-10055) was provided to the resident and/or the resident's responsible party prior to the discontinuation of Medicare Part A services for 2 (#34 and #61) of 2 residents reviewed for Beneficiary Notification who required the notification.<br><br>Findings:<br><br>Resident #34<br><br>Review of Resident #34's clinical record revealed the resident was being discharged from Physical and Occupational Therapy on 05/08/2025 due to non-compliance or refusal to participate in therapy with benefit days remaining.<br><br>In an interview on 05/21/2025 at 4:00 p.m., S16 Accounts Manager reported Resident #34 was discharged from Skilled Services due to refusing to participate in therapy but remained in the facility. S16 Accounts Manager confirmed a SNF ABN, Form CMS-10055 was not provided to the resident or their responsible party prior to discharge from skilled services because she was unaware of the form or that it needed to be sent.<br><br>Resident #61<br><br>Review of Resident #61's SNF Beneficiary Notification Review form revealed Resident #61 was discharged from Medicare Part A services when benefit days were not exhausted. Further review revealed a SNF ABN, Form CMS-10055 was not provided to the resident or their RP prior to discharge from the services.<br><br>In an interview on 05/21/2025 at 4:10 p.m., S17 MDS stated Resident #61 was discharged from therapy because she was not cognitively able to participate in therapy.<br><br>In an interview on 05/21/2025 at 4:15 p.m., S16 Accounts Manager confirmed Resident #61 remained in the facility with benefit days remaining. S16 Accounts Manager confirmed she did not send the SNF ABN Form CMS-10055 to Resident #61 or her RP because she was unaware of the form or that it needed to be sent prior to discharge from skilled services. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Based on observation, record review and interview, the facility failed to ensure the person-centered care plans were developed and implemented for 2 (#25 and #90) of 41 sampled residents. The facility failed to:<br><br>1.<br><br>Ensure Resident #25 did not have a cigarette and lighter in his/her possession, as care planned; and<br><br>2.<br><br>Ensure a care plan was developed timely for Resident #90 to address her known history of eating non-food items.<br><br>Findings:<br><br>Resident #25<br><br>Review of facility policy titled Smoking Policies and Regulation with a revision date of 10/2024, revealed in part . Cigarette lighters and matches are not permitted in a resident's room and will be kept at the nurses' stations. The facility will provide lighting devices and will light cigarettes upon request in designated areas set aside for smoking.<br><br>Review of the electronic health record for Resident #25 revealed an original admit date of 11/06/2015 with a re-entry date of 10/23/2024 with diagnoses which included: Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Diabetes, Hemiplegia and Hemiparesis following CVA of right dominate side, and Hypertensive Heart Disease without Heart Failure.<br><br>The Quarterly MDS with an ARD of 04/08/2025, revealed Resident #25 has a BIMS score of 11, which indicated moderate cognitive impairment.<br><br>Review of care plan initiated 06/29/2024 revealed Resident #25 was at risk for complications related to nicotine dependence (smoking). Resident #25 is a safe smoker. Interventions included: Cigarettes and smoking supplies are kept by nurses, Resident #25 is able to smoke at her reasonable request, and Resident #25 is to return all smoking supplies back to staff after each smoking session.<br><br>Interview on 05/20/2025 at 2:37 p.m., Resident #25 revealed cigarettes are kept in a pouch on her wheelchair. Observed one pack of cigarettes and one lighter in resident's wheelchair pouch.<br><br>Interview on 05/20/2025 at 2:46 p.m., S5 LPN revealed Resident #25 is a safe smoker. S5 LPN confirmed cigarettes and smoking supplies are stored at the nurses' station. S5 LPN confirmed Resident #25 should not have a lighter and pack of cigarettes in her wheelchair pouch.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 05/20/2025 at 2:52 p.m., S12 CNA confirmed Resident #25 keeps smoking supplies in her wheelchair pouch regularly.<br><br>Interview on 05/20/2025 at 3:15 p.m., S2 DON and S1 Corp RN confirmed smoking supplies should be kept at the nurses' station and were not.<br><br>Resident #90<br><br>Review of Resident #90's electronic health record revealed an admission date of 05/13/2024 with pertinent diagnoses that included: Type 2 Diabetes Mellitus with other Specified Complication, Generalized Muscle Weakness, Cognitive Communication Deficit, Chronic Kidney Disease stage 1, Senile Degeneration of Brain, Severe Unspecified Dementia with other Behavioral Disturbance, Hypothyroidism, Iron Deficiency Anemia, Chronic or Unspecified Gastric Ulcer with Hemorrhage.<br><br>Review of Resident #90's Significant Change MDS with ARD of 04/15/2025 revealed Resident #90 had a BIMS score of 4, indicating severe cognition impairment. Resident #90 required a mechanically altered diet and partial to moderate assistance with eating.<br><br>Review of Resident #90's electronic health record progress notes revealed in part .<br><br>Progress note dated 05/05/2025 at 08:58 a.m. created by S5 LPN on 05/21/2025 08:59 a.m.<br><br>Resident #90 noted sitting at dining room table chewing on her straw, staff able to redirect Resident #90 attention at this time and S15 MD notified of behaviors with no new orders at this time. Resident #90 does have occasionals when she will chew on non-food items. Able to remove items from view at this time .<br><br>Progress note dated 04/16/2025 1:16 p.m. created by S5 LPN revealed in part .<br><br>Resident was seen by S15 MD discuss with MD about Resident #90 restless behaviors and paranoid behaviors. Resident has anxiety behaviors. Resident #90 will eat plastics, paper, will tear up different items, along with lap tray. Orders are to restart Risperdal 0.5mg bid .<br><br>Review of Resident #90's current care plan on 05/20/2025 revealed Resident #90 was not care planned for the resident's behavior of eating non-food items.<br><br>On 05/21/25 08:53 a.m., an observation revealed Resident #90 in bed positioned on her right side with head of bed elevated. Resident #90 was awake, alert, and observed to be chewing with string like material coming from her mouth. Resident #90 was observed holding a bib with several holes that had been bitten or chewed. Resident #90 was noninterviewable. Surveyor immediately requested S5 LPN come to Resident #90's bedside and notified S5 LPN of surveyor observation. S5 LPN immediately removed bib from Resident #90. S5 LPN requested Resident #90 open her mouth and spit out material. Resident #90 did not follow command to open mouth and spit out material. S5 LPN applied gloves and performed finger sweep of Resident #90's mouth. S5 LPN confirmed eggs and small pieces of cloth material were removed from Resident #90's mouth. S5 LPN stated Resident #90 did have a history of chewing on non-food items.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 05/21/2025 at 02:02 p.m., a review of Resident #90's electronic health record care plan revealed a care focus area was created by S13 MDS on 05/21/2025 and read in part . Focus: The resident has a behavior problem: resident eats/chews on nonfood items such as bibs, paper towel, blankets, sheets, magazines, tissues/napkins, etc.<br><br>Goals: The resident will have fewer episodes of eating nonfood items by review date.<br><br>Interventions: Labs as ordered, notify MD as indicated, observe behavior episodes as needed, redirect behaviors, offer food items in place, redirect for a potentially difficult situation.<br><br>On 05/21/2025 at 02:30 p.m., an interview was conducted with S13 MDS. S13 MDS stated Resident #90 was care planned for behavior problem of eating nonfood items on 04/18/2025. S13 MDS stated Resident #90's electronic health record revealed a created date of 05/21/2025 because S13 MDS revised the care plan on 05/21/2025. Surveyor questioned what part of care plan was revised on 05/21/2025. S13 MDS stated nothing was revised, she was just looking at it.<br><br>On 05/21/2025 at 03:28 p.m. Resident #90's care plan with a start date of 04/15/2025 and completion date of 04/24/2025 was reviewed with S13 MDS. S13 MDS confirmed Care Plan Focus: The resident has a behavior problem: resident eats/chews on nonfood items such as bibs, paper towel, blankets, sheets, magazines, tissues/napkins, etc. was not present in the care plan reviewed for those dates. S13 MDS confirmed if care plan focus was initiated on 04/18/2025, it should have been in the care plan reviewed for those dates and was not. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Resident #11<br><br>Review of Resident #11's medical record revealed an admit date of 02/28/2012 and a readmission date of 01/16/2023 with diagnoses that included in part .Chronic Respiratory Failure with Hypoxia, Dysphagia, Cognitive Communication Deficit, Stage 3 Chronic Kidney Disease and Pressure Ulcer of Sacral Region, Stage 3.<br><br>Review of Resident #11's Significant Change MDS with an ARD of 05/01/2025 revealed a BIMS was not conducted because the resident was rarely or never understood. Further review revealed Resident #11 was dependent on staff with eating, toileting hygiene, rolling left and right, sitting to lying, and chair/bed to chair transferring.<br><br>Review of Resident #11's current physician's orders revealed the following:<br><br>05/03/2025: Clean Stage 3 to sacrum with wound cleanser, pat dry, apply Santyl ointment to wound, and cover with a dermadress dressing every day until healed.<br><br>Review of Resident #11's current care plan revealed the resident had a Stage 3 pressure ulcer to sacrum dated 03/27/2025. Interventions included: Administer treatments as ordered and observe for effectiveness as needed; Weekly treatment documentation to include measurement of each skin breakdown's width, length, and depth, type of tissue and exudate.<br><br>Review of Resident #11's 04/2025 TAR (Treatment Administration Record) revealed Resident #11 had an order dated 03/28/2025 to Clean Stage 3 pressure ulcer to sacrum with wound cleanser, pat dry, apply Santyl ointment to wound and cover with a dermadress dressing every other day. Review of the TAR revealed wound care was not provided as ordered on 04/01/2025, 04/03/2025, 04/07/2025, 04/09/2025, 04/11/2025, 04/13/2025, 04/19/2025, 04/21/2025, 04/23/2025, 04/25/2025, and 04/27/2025. Further review revealed this wound care order was only completed 4 days in April 2025.<br><br>Review of Resident #11's 05/2025 TAR revealed Resident #11's wound care orders for Stage 3 Sacral pressure ulcer were changed on 05/03/2025 to every day. Review of the TAR revealed wound care was not provided on 05/03/2025, 05/04/2025, 05/07/2025, 05/10/2025, and 05/11/2025.<br><br>In an interview on 05/21/2025 at 10:50 a.m., S2 DON acknowledged wound care was not documented as completed each day as ordered, on Resident #11's 04/2025 and 05/2025 TARs and should have been.<br>Resident #109<br><br>Review of Resident #109's medical record revealed an admit date of 11/15/2024 with the following diagnoses in part . Type 2 Diabetes Mellitus, Encounter for Orthopedic Aftercare following Surgical Amputation, Acquired Absence of Left Leg Below Knee, Peripheral Vascular Disease, and Non Pressure Chronic Ulcer of Right Foot.<br><br>Review of Resident #109's Quarterly MDS with ARD of 02/21/2025 revealed Resident had a BIMS of 15 (Cognition Intact).<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 109's current plan of care revealed Resident had diabetic foot ulcer to right great toe. Interventions included: Treatment as ordered. Refer to eTAR.<br><br>Review of Resident #109's Active Physician's Orders read in part .<br><br>Clean diabetic ulcer to right tip of great toe with normal saline, pat dry, apply dermacol, then apply bordered dressing every day shift until healed.<br><br>Clean MASD to bilateral buttock with normal saline, pat dry, apply nystatin powder 10000unit/gm every day and every evening shift until healed.<br><br>Review of Resident #109's 04/2025 eTAR on 05/20/2025 at 11:30 a.m. revealed there was no evidence of a completed wound care for order of: Clean diabetic ulcer to right tip of great toe with normal saline, pat dry, apply dermacol, then apply bordered dressing every day shift until healed on 04/11/2025 and 04/18/2025. There was no evidence of completed wound care for order of: Clean MASD to bilateral buttock with normal saline, pat dry, apply nystatin powder 10000unit/gm every day and every evening shift until healed on 04/02/2025, 04/04/2025, 04/07/2025, 04/08/2025, 04/09/2025, 04/10/2025, 04/11/2025, 04/15/2025, 04/17/2025, and 04/18/2025.<br><br>Review of Resident #109's 05/2025 eTAR on 05/20/2025 at 11:30 a.m. revealed there was no evidence of a completed wound care for order of: Clean MASD to bilateral buttock with normal saline, pat dry, apply nystatin powder 10000unit/gm every day and every evening shift until healed on 05/01/2025, 05/02/2025, 05/06/2025, 05/09/2025, 05/12/2025, 05/13/2025, 05/14/2025, 05/15/2025, and 05/16/2025.<br><br>Interview on 05/21/2025 at 10:50 a.m., with S2 DON acknowledged wound care was not documented as completed each day as ordered, on Resident #109's April 2025 and May 2025 eTARs and should have been.<br><br>Based on observation, record review, and interview the facility failed to provide care and services that met professional standards of quality by failing to ensure Physician's Orders were implemented. The facility failed to provide wound care as ordered for 3 (#6, #11, and #109) of 3 residents reviewed for skin and pressure ulcers. Total sample size was 41. Findings:<br><br>Review of the facility's policy titled Prevention and Treatment of Skin Issues dated 11/2023 read in part . It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care. Treatment of Skin Issues: If a resident is admitted with or there is a new development of a skin issue, the following procedures are to be implemented. Notify Physician/NP and obtain treatment orders communicating facility wound care protocols for consideration. Notify Supervisor/DON as assigned. Initiate Weekly Wound Documentation in the Wound Assessment Manager (WAM electronic documentation) which will include: type of wound, location, date, stage (pressure ulcers only) length, width and depth; wound base description, wound edge description and if present: drainage, odor, undermining, and/or tunneling. Document on any changes or concerns in the resident's medical record.<br><br>Resident #6<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #6's medical record revealed an admit date of 02/05/2020 with the following diagnoses in part . Chronic Respiratory Failure with Hypoxia; Chronic Obstructive Pulmonary Disease; Parkinson's Disease without Dyskinesia; Localized Edema; and Dementia.<br><br>Review of Resident #6's Quarterly MDS with ARD of 05/30/2025 revealed Resident had a BIMS of 5 (Severe Cognitive Impairment).<br><br>Review of Resident 6's current plan of care revealed Resident had a skin tear and bruises related to fragile hemorrhagic skin, picks, and scratches. Interventions included: if skin tear occurs, treat per facility protocol and notify physician and family. Monitor/document location, size and treatment of skin tear.<br><br>Review of Resident #6's Active Physician's Orders read in part .<br><br>Clean open lesion to right eyebrow with normal saline, pat dry, apply triple antibiotic ointment to wound and cover with Band-Aid daily until healed.<br><br>Review of Resident # 6's 05/2025 eTAR on 05/20/2025 revealed there was no evidence of an order to complete wound care to the open lesion to right eyebrow.<br><br>Observation on 05/19/2025 at 10:02 a.m. of Resident #6 revealed she had a hematoma to upper right eyebrow with an undated Band-Aid in place. Resident #6 had dried blood over her right eyebrow.<br><br>Observation on 05/20/2025 at 08:06 a.m. of Resident #6 revealed she had dried blood over her right eyebrow with undated Band-Aid in place.<br><br>Observation on 05/20/2025 at 11:33 a.m. of Resident #6 revealed she had dried blood over her right eyebrow with undated Band-Aid in place.<br><br>Interview on 05/20/2025 at 11:47 a.m. with S5 LPN revealed Resident #6 had skin cancer on several areas of her body. S5 LPN stated that Resident #6 picked at right upper eyebrow causing skin tear and bleeding, so it was covered with a Band-Aid. S5 LPN confirmed the treatment to Resident #6's right eyebrow area should be performed daily and the dressing should have a date on it, but it did not. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services that assured accurate acquiring, receiving, dispensing and/or administration of medications to meet the needs of each resident. The facility had a total census of 115 residents.<br><br>The facility failed to:<br><br>1.<br><br>Ensure an accurate account for controlled medications was completed at the time of administering narcotics on 1 (Cart 4) of 4 (Cart 1, Cart 2, Cart 3, and Cart 4) medication carts for Resident #28; and<br><br>2.<br><br>Ensure proper nursing procedures and documentation were completed at the time of wasting/destroying narcotics on 1 (Cart 1) of 4 (Cart 1, Cart 2, Cart 3, and Cart 4) medication carts for Resident #1<br><br>Findings:<br><br>Review of a facility policy on [DATE] at 11:54 a.m. titled, Destruction of Unused, Expired or Discontinued Medications revised on 10/2019 revealed the following in part .1. Unused or discontinued non-controlled medications are to be destroyed by the Director of Nursing (DON) or designee and another licensed nurse.<br><br>Review of a facility policy on [DATE] at 4:15 p.m. titled, Administration of Medications revised on 03/2025 revealed the following in part .Purpose: To administer medications in accordance with best practice.14. Document all applicable information in the clinical record.<br><br>1.<br><br>On [DATE] at 10:20 a.m., a controlled medications reconciliation was conducted with S3 LPN of Cart 4. At the time of the medication reconciliation, review of Resident #28's document titled, Individual Resident Narcotic Inventory Count for Clonazepam 0.5mg tablets revealed a total count of 60 tablets remaining. Observation of Resident #28's Clonazepam 0.5mg narcotic blister package revealed a total count of 59 tablets remaining. S3 LPN confirmed he administered one Clonazepam tablet this morning as ordered and failed to document timely in Resident #28's clinical record, but should have.<br><br>2.<br><br>(continued on next page) |

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|---|---|---|---|
| | 195424 | A. Building<br>B. Wing | 05/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lexington House | 16 Heyman Lane<br>Alexandria, LA 71303 |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] at 10:38 a.m., a controlled medications reconciliation was conducted with S4 LPN of Cart 1. At the time of medication reconciliation, review of Resident #1's document titled, Individual Resident Narcotic Inventory Count for Oxycodone/Acetaminophen 5mg/325mg tablets revealed two entries on [DATE] at 9:00 p. m. where two tablets were documented as wasted/dropped on floor by a nurse. Further review of the document revealed no evidence of a destruction witness signature for neither of the two waste entries. S4 LPN confirmed there should had been a witness/second signature when Resident #1's Oxycodone/Acetaminophen tablets were wasted on [DATE], but there was not.<br><br>In an interview and record review on [DATE] at 11:00 a.m., S1 Corp RN and S2 DON revealed all floor nurses were aware they should document narcotics in the clinical record as soon as the narcotic is administered to the resident. S2 DON confirmed S3 LPN should have documented timely on Resident #28's clinical record upon administration of the Clonazepam tablet, but had not. S2 DON revealed all floor nurses were aware they must have a witness/second signature when wasting narcotic medications and properly document in the clinical record. S2 DON confirmed the nurse failed to follow proper nursing procedures for wasting Resident #1's narcotic medications. S2 DON confirmed there should have been a witness/second signature when Resident #1's Oxycodone/Acetaminophen tablets were wasted/destroyed on [DATE] on both occasions, but there was not. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>Based on observations and interviews, the facility failed to ensure recipes for pureed diets were followed during meal preparation. This failed practice had the potential to affect 12 residents (#6, #11, # 36, #37, #46, #53, #58, #69, #71, #76, #85, and #101) who received pureed diets.<br><br>Findings:<br><br>Review of the Facility's lunch menu for 05/19/2025 revealed, in part .Barbeque ribs, macaroni and cheese, peas, green salad, and a roll.<br><br>An observation on 05/19/2025 at 09:45 a.m. revealed a pan of pureed meat in the kitchen. S8 Dietary aide revealed meat was pureed prior to observation. S8 Dietary aide was observed pouring an unknown amount of peas in the electric food processor. S8 Dietary aide was observed not measuring portions or following the pureed recipe. Interview with S8 Dietary aide at that time revealed he eyeballs portions based on the pan he uses for pureed foods. S8 Dietary aide confirmed he does not follow recipes or measure portions when preparing pureed foods.<br><br>Interview on 05/19/2025 at 09:47 a.m., S7 Dietary Manager confirmed S8 Dietary aide did not measure or follow pureed recipe and should have. S7 Dietary manger revealed S8 Dietary Aide had not followed pureed recipes in the past resulting in disciplinary action.<br><br>Interview on 05/19/2025 at 10:00 a.m., S9 Dietician confirmed if pureed recipes are not followed, required nutritional contents may not be accurate. |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.<br><br>Based on record review, observation, and interview the facility failed to provide fluids sufficient to maintain adequate hydration. The facility failed to provide a water pitcher or any fluid for hydration at the bedside to 1 (Resident #37) of 41 sampled residents.<br><br>Findings:<br><br>On 05/21/2025, Review of facility policy titled, Hydration Provision of Fluids for Residents, with a revision date of 05/2018, revealed in part .<br><br>Policy: The facility ensures that all residents receive sufficient amounts of fluids based on individual needs to maintain proper hydration and health.<br><br>Procedure: The Director of Food and Nutrition Services/consultant assesses fluid needs based on the following guidelines . A minimum of 2000cc's (cubic centimeter) per day while on antibiotic therapy for UTI .<br><br>.The nursing assistants offer fluids every 2 hours to residents, unless restricted .A water pitcher with water and ice is placed by the bedside of all residents unless contraindicated (NPO (nothing by mouth), Fluid Restriction, etc.).<br><br>Resident #37<br><br>Review of Resident # 37's electronic medical record revealed an initial admission date of 06/15/2015 and a re-entry admission date of 08/10/2018 with diagnoses that included: Alzheimer's, Mild Protein- Calorie Malnutrition, Non Pressure chronic Ulcer of left ankle limited to break down of skin, Peripheral Vascular Disease, Anxiety disorder, Dysphagia, unspecified, Primary Generalized Osteoarthritis, History of Urinary Tract Infections.<br><br>Review of Resident #37's Quarterly MDS with ARD of 03/19/2025, revealed Resident #37 was rarely/never understood with severely impaired cognition. Resident #37 required supervision or touching assistance with eating.<br><br>Review of Residents #37's 05/2025 orders revealed in part .<br><br>09/18/2024: Doxycycline Hyclate Oral Tablet 100 mg (milligram) Give 1 tablet by mouth every 12 hours related to Non-pressure Chronic Ulcer to Left Ankle indefinitely.<br><br>05/16/2025: Macrodantin Oral Capsule 50mg Give 1 capsule by mouth one time a day related to history of UTI (Urinary Tract Infection) indefinitely.<br><br>05/09/2025: Ertapenem sodium injection solution 1 GM (gram) Inject 1 gram intramuscularly in the afternoon R/T (related to) UTI for 5 days. (Discontinued 05/14/25)<br><br>06/13/2024: Probiotic Oral Capsule give 1 capsule by mouth two times a day for R/T Prophylactic ABT (antibiotic).<br><br>(continued on next page) |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #37's Care Plan with an initiation date of 06/01/2024 revealed in part . 05/05/2025 Resident #37 was receiving antibiotic therapy r/t UTI/Sepsis. 05/09/2025 IM (intramuscular) antibiotic therapy for 5 days and oral antibiotic therapy BID (two times daily) for 5 days r/t UTI. Interventions included in part . Encourage fluids.<br><br>Resident #37 had alteration in elimination r/t difficult stool and or loose stool. Interventions included in part . Encourage to drink all fluids on meal trays and fluids offered between meals.<br><br>On 05/19/2025 at 10:05 a.m. Observation revealed Resident #37 sitting up in wheelchair in room. Resident #37 was awake, alert, and confused. Resident #37 was noninterviewable. No observation of a water pitcher or any other fluid for hydration at Resident #37's bedside.<br><br>On 05/20/2025 at 08:31 a.m. Observation revealed Resident #37 sitting up in wheelchair in room awake and alert. Resident #37's speech was garbled and unintelligible. No observation of a water pitcher or any other fluid for hydration at Resident #37's bedside.<br><br>On 05/20/2025 at 02:09 p.m. Observation reveals Resident #37 lying in bed resting with eyes closed. No water pitcher observed at the bedside.<br><br>On 05/20/2025 at 02:27 p.m. review of Resident #37's electronic health record Facility Task: Offer Fluid Every 2 Hours While Awake with review dates of 05/16/2025- 05/20/2025 revealed in part .<br><br>05/16/2025 fluids offered: 1:11 p.m. and 3:48 p.m.<br><br>05/17/2025 fluids offered: 12:00 a.m., 07:39 a.m., 4:05 p.m., and 11:29 p.m.<br><br>05/18/2025 fluids offered: 07:37 a.m. and 4:44 p.m.<br><br>05/19/2025 fluids offered 06:06 a.m., 07:23 a.m., 6:54 p.m.<br><br>05/20/2025 fluids offered 07:25 a.m.<br><br>On 05/21/2025 at 08:40 a.m. Observation reveals Resident #37 sitting up in wheelchair in room. Resident #37 was awake and alert. Resident #37 lips appeared dry. No observation of a water pitcher or any other fluid for hydration at Resident #37's bedside.<br><br>On 05/21/2025 at 09:06 a.m. interview conducted with S12 CNA. S12 CNA revealed she was assigned to Resident #37's hall and familiar with Resident #37. S12 CNA stated Resident #37 required total care with the exception of feeding. S12 CNA states Resident #37 did drink well when offered fluids. S12 CNA confirmed all residents should have water pitcher at the bedside, unless they had restrictions. S12 CNA unable to recall if Resident #37 had restrictions.<br><br>On 05/21/2025 at 09:08 a.m. S12 CNA accompanied surveyor to bedside. S12 CNA confirmed Resident #37 did not have a water pitcher at the bedside and should have one.<br><br>On 05/21/2025 at 09:15 a.m. interview with S5 LPN revealed Resident #37 could drink from a cup independently once staff poured water into cup from water pitcher. S5 LPN confirmed Resident #37 did not have any fluid restrictions and should have water pitcher at the bedside.<br><br>(continued on next page) |

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| F 0807<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 05/21/2025 at 09:25 a.m. interview conducted with S1 Corp RN and S2 DON to discuss above findings. S1 Corp RN and S2 DON acknowledged Resident #37 did not have a water pitcher at the bedside on multiple observations and should have. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to maintain a clean and sanitary kitchen to prevent the likelihood of foodborne illnesses and failed to store, prepare, and serve food in accordance with professional standards for food service safety. The deficient practice had the potential to effect all of the residents who received meals from the kitchen. There were 115 residents who resided in the facility.<br><br>The facility failed to ensure:<br><br>1. Food items in the pantry were labeled with an open date;<br><br>2. Staff were wearing hair restraints including beard restraints to prevent hair from contacting food;<br><br>3. Maintenance of a clean and sanitary kitchen at all times; and<br><br>4. Dishes were sanitized appropriately.<br><br>Findings:<br><br>1. Observation on 05/19/2025 at 8:40 a.m. of the facility pantry revealed one undated, open bag of penne pasta. S7 Dietary Manager confirmed open food in pantry should be labeled with an open date and was not.<br><br>2. Observation on 05/19/2025 at 8:40 a.m. revealed S8 Dietary Aide had long facial hair with no use of a beard restraint. S8 Dietary Aide confirmed he was supposed to wear a beard restraint but stated the facility was currently out. Interview on 05/19/2025 at 8:45 a.m. with S7 Dietary Manager confirmed S8 Dietary Aide should have been wearing a beard restraint while preparing food and was not. S7 Dietary Manager then provided S8 Dietary Aide with a beard restraint.<br><br>3. On 05/19/2025 at 8:40 a.m. during the initial kitchen observation revealed unsanitary air conditioner vents covered in a black substance. S7 Dietary Manager revealed air conditioner vents are cleaned every few months but was unsure the last time they were cleaned. S7 Dietary Manager confirmed that air conditioner vents in the kitchen were unsanitary and needed cleaning. Interview on 05/21/25 at 9:30 a.m. with S10 Maintenance confirmed air conditioner vents in the kitchen were unsanitary and needed to be cleaned.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. On 05/19/2025 at 9:00 a.m. during the initial kitchen observation revealed S8 Dietary Aide failed to sanitize dishes appropriately when utilizing the 3 compartment sink. Sanitation strip was non-reactive x 2 attempts by S8 Dietary Aide. Observed sanitation hose in the 2nd compartment sink. Interview with S8 Dietary Aide revealed sanitization hose should be in the 3rd compartment of the sink (sanitization compartment) and was not. S8 Dietary Aide then moved sanitization hose to 3rd compartment of the sink. S7 Dietary Manager confirmed sanitation strip was non-reactive x 2 attempts. S7 Dietary Manager confirmed chemical sanitizer was not mixed to the proper concentration. Interview with S8 Dietary Aide revealed sanitization for the 3 compartment sink should be monitored three times a day and recorded in a sanitation log. S8 Dietary Aide confirmed he did not check water temperature or sanitization this morning prior to utilizing the 3 compartment sink. Interview with S7 Dietary Manager confirmed chemical sanitizer and temperatures for the 3 compartment sink should be monitored three times a day and recorded in the appropriate log. S7 Dietary Manager was not able to provide a temperature/chemical sanitization log.<br><br>On 05/19/2025 at 9:00 a.m., a review of Dishwasher Temperature Logs dated 12/2024-05/2025 revealed missing temperature logs for multiple dates. |