

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER Patterson Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 910 Lia St Patterson, LA 70392	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>48855</p> <p>Based on observation, interview, record review, and facility policy review, it was determined the facility failed to assess a resident for self-administration of a medication for 1 (Resident #25) of 2 residents observed for accidents/hazards.</p> <p>Findings included:</p> <p>Review of the facility's policy titled, Medication Administration, dated 07/08/2024, revealed resident may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.</p> <p>Review of Resident #25's Quarterly Minimum Data Set with an Assessment Reference Date of 10/03/2024 revealed, in part, Resident #25 had a Brief Interview of Mental Status score of 15, which indicated Resident #25 was cognitively intact.</p> <p>Review of Resident #25's December 2024 Physician's Orders revealed an order dated 01/21/2023 for Flonase Sensimist Nasal Suspension (a nasal spray used to treat stuffy/itchy nose, and sneezing) 1 spray in each nostril one time a day for allergic rhinitis (inflammation in the nose). Further review revealed no evidence Resident #25 had a physician's order to self-administer medications.</p> <p>Review of Resident #25's Care Plan revealed, in part, no evidence Resident #25 had been care planned to address the self-administration of medications.</p> <p>Observation on 12/09/2024 at 10:29 AM, revealed Resident #25 had a bottle of Flonase Sensimist Nasal Suspension at her bedside.</p> <p>In an interview on 12/09/2024 at 10:29 AM, Resident #25 indicated she had an order for Flonase nasal spray to be administered daily, but she had been self-administering the nasal spray as needed. Resident #25 further indicated the last time she self-administered the nasal spray was one day last week.</p> <p>In an interview on 12/10/2024 at 3:53 PM, S5Licensed Practical Nurse (LPN) indicated Resident #25's should not have been self-administering nasal spray.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 12/10/2024 4:30 PM, S15Minimum Data Set (MDS) Coordinator indicated Resident #25 did not have a physician's order or was care planned for self-administration of medications.</p> <p>In an interview on 12/10/2024 at 4:30 PM, S20Clinical Nurse Specialist indicated Resident #25 should not have been self-administering nasal spray.</p> <p>In an interview on 12/10/2024 at 4:23 PM, S2Director of Nursing (DON) indicated Resident #25 did not have a physician's order for self-administration of medications, and was not care planned for self-administration of medications. S2DON confirmed Resident #25 should not have been self-administering nasal spray.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>46361</p> <p>Based on observations and interviews, it was determined the facility failed to ensure shower rooms were maintained in a safe and sanitary manner for 2 (shower room y and shower room z) of 3 shower rooms reviewed for physical environment.</p> <p>Findings included:</p> <p>Review of Resident #82's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/2024 revealed, in part, Resident #82 had a Brief Interview of Mental Status (BIMS) score of 12, which indicated Resident #82 was moderately impaired.</p> <p>Observation of shower room y on 12/10/2024 at 8:50 AM revealed shower stalls were in use and had an unknown black/brown substance on the surface and around the edges of the shower tiles.</p> <p>Observation of shower room z on 12/10/2024 at 8:55 AM revealed 3 shower stalls were in use and had an unknown black/brown substance on the surface and around the edges of the shower tiles.</p> <p>In an interview on 12/10/2024 at 9:06 AM, S14Housekeeping Manager indicated the housekeeper assigned to the hall was responsible for cleaning the shower room on that hall.</p> <p>In an interview on 12/10/2024 at 9:20 AM, S17Housekeeper indicated she was responsible for cleaning shower room z. S17Housekeeper confirmed the shower stalls in shower room z had a black/brown unknown substance on the tiles and should have been cleaned.</p> <p>In an interview on 12/10/2024 at 9:30 AM, Resident #82 indicated the facility's shower rooms were not kept clean by the housekeeping staff. Resident #82 further indicated he showered in the front left stall of shower room z a couple of days ago and noticed mildew along the surface and cracks of the tiles.</p> <p>In an interview on 12/10/2024 at 9:40 AM, S14Housekeeping Manager indicated the shower stalls in shower room y and shower room z were not clean and should not have a black/brown unknown substance on the surface of the shower stalls.</p> <p>Observation on 12/10/2024 at 10:11 AM, of shower room y revealed a sharps container mounted to the wall which was overflowing and had 3 used shaving razors on top of the sharps container. Further review revealed a red/brown substance had dripped down the lid of the sharps container.</p> <p>During an interview on 12/10/2024 at 10:14 AM, S19License Practical Nurse (LPN) indicated she did not know who was responsible for replacing the full sharps container located in shower room y. S19LPN further indicated the used shaving razors overflowing from the sharps container was definitely not, safe or sanitary.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/10/2024 at 10:18 AM, S3Assistant Director of Nursing (ADON) indicated the sharps container located in shower room y should not have been overflowing with used shaving razors.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877</p> <p>Based on record review and interview, it was determined that the facility failed to implement recommendations from the Office of Behavioral Health (OBH) for a resident with a mental health diagnosis for 1 (Resident #39) of 2 sampled residents reviewed for Pre-admission Screening and Resident Review (PASARR).</p> <p>Findings included:</p> <p>Review of Resident #39's Electronic Medical Record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses, in part, of anxiety disorder, depression, and schizophrenia.</p> <p>Review of Resident #39's Level II PASARR with an authority period of 04/09/2024 through 04/08/2025 revealed Resident #39 was referred to OBH for recommendations of psychiatric treatment.</p> <p>Review of Resident #39's OBH's recommendations dated 04/09/2024 revealed, in part, a recommendation for a comprehensive psychiatric evaluation.</p> <p>Review of Resident #39's EMR revealed no documented evidence, and the facility did not present any documented evidence that Resident #39 had a comprehensive psychiatric evaluation completed.</p> <p>In an interview on 12/11/2024 at 10:10 AM, S20Corporate Clinical Specialist confirmed Resident #39 did not have a comprehensive psychiatric evaluation completed as recommended by OBH.</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>48855</p> <p>Based observations, interviews, record reviews, facility document review, and facility policy review, it was determined that the facility failed to ensure a resident was involved in the development and revision of the resident's Comprehensive Care Plan for 1 (Resident 58) of 2 residents reviewed for involvement in their Comprehensive Care Plan.</p> <p>Findings included:</p> <p>Review of a facility policy titled, Care Plans, Comprehensive Person-Centered, last reviewed November 2024, indicated the care planning process would facilitate resident and/or representative involvement. The interdisciplinary team must review and update the care plan when there was a significant change in the resident's condition, when the desired outcomes are not met, when the resident was readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS assessment.</p> <p>Review of Resident #58's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/03/2024 revealed, in part, Resident #58 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #58 was cognitively intact.</p> <p>Review of the facility's document indicated Resident #58 had an annual MDS assessment review dated 05/12/2024, quarterly MDS assessment review dated 08/12/2024, an entry MDS assessment review dated 09/25/2024, and a quarterly MDS assessment review dated 10/03/2024.</p> <p>In an interview on 12/09/2024 at 11:07AM, Resident #58 indicated he had not participated in and was not notified of his care plan meetings during the time of the above mentioned assessments.</p> <p>In an interview on 12/10/2024 at 9:23AM, S19Social Worker (S19SW) indicated Resident #58 was his own responsible party.</p> <p>In an interview on 12/11/2024 at 11:55AM, S19SW indicated she had no documented evidence, and the facility could not produce any documented evidence that Resident #58 participated in and/or was notified of his care plan meetings for the above mentioned care plan assessments.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48855</p> <p>Based on observation, interviews, and record review, facility document review, and facility policy review, it was determined the facility failed to provide nail care to a dependent resident for 1 (Resident #76) of 5 residents reviewed for activities of daily living (ADL).</p> <p>Findings included:</p> <p>Review of the facility's Admission Record revealed the facility admitted Resident #76 on 10/27/2023 with diagnosis that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) followed by a cerebral infarction affecting Resident #76's right dominant side.</p> <p>Review of Resident #76's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/03/2024 revealed Resident #76 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #76 was cognitively intact. Further review revealed Resident #76 required supervision and assistance with personal hygiene.</p> <p>Review of Resident #76's Care Plan initiated on 11/06/2024 revealed Resident #76 had an ADL self-care performance difficulty related to hemiplegia and required assistance and supervision with personal hygiene.</p> <p>Review of the facility's policy titled Care of Fingernails/Toenails last revised February 2018 revealed, nail care included daily cleaning, regular trimming, and the documentation thereof should be in the resident's medical record.</p> <p>Observation on 12/09/2024 at 9:44 AM revealed Resident #76 had half inch long nails to his left ring and middle fingers and one fourth inch long nails to all fingers on his right hand.</p> <p>Observation on 12/10/2024 at 9:04 AM revealed Resident #76 had half inch long nails to his left ring and middle fingers and on fourth inch long nails to all fingers on his right hand.</p> <p>There was no documented evidence, and the facility could not produce any documented evidence Resident #76 was provided nail care.</p> <p>In an interview on 12/10/2024 at 9:05 AM, Resident #76 indicated he had asked staff to trim his nails, but staff had not trimmed his nails. Resident #76 further indicated he was bothered that his fingernails on both his hands were long.</p> <p>In an interview on 12/10/2024 at 9:12 AM, S2Director of Nursing (DON) indicated Resident #76's nails should have been trimmed by staff when resident #76 requested nail care.</p> <p>In an interview on 12/10/2024 at 9:33 AM, S3Assistant Director of Nursing (ADON) indicated staff should have trimmed Resident #76's when requested nail care.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48855</p> <p>Based on observations, interviews, record reviews, and facility document review, it was determined the facility failed to ensure a resident that was cognitively impaired and had a high risk of falls had appropriate interventions to prevent future falls for 1 (Resident #12) of 2 residents reviewed for accidents.</p> <p>Findings included:</p> <p>The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/30/2024 revealed, in part, Resident #12 was admitted to the facility on [DATE], had a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #12 had moderate cognitive impairment, and was dependent on staff for toileting transfers. Further review revealed, prior to admission, Resident #12 had a previous history of falls and one fall which resulted in a fracture.</p> <p>Review of Resident #12's NSG: Morse Fall Scale Evaluation - V1 dated 09/25/2024 revealed Resident #12 had a previous history of falls, used a wheelchair, and overestimated and often forgot his limitations. Further review revealed Resident #12's score was 55, which indicated Resident #12 was a high risk for falls.</p> <p>Review of the facility's incident report titled Incident by Incident Type revealed, in part, Resident #12 had fall without injury on 09/25/2024, fall with injury on 10/23/2024 and 11/22/2024, and an unwitnessed fall on 12/09/2024.</p> <p>Review of Resident #12's Care Plan revealed, in part, Resident #12 had a risk for falls related to abnormal gait, muscle weakness, and a previous fall which resulted in a fracture.</p> <p>Further review revealed the following dated staff interventions:</p> <ul style="list-style-type: none"> -On 09/25/2024, educate Resident #12 to call for assistance with transfers; -On 10/01/2024, encourage Resident #12 to use the call bell system; -On 10/23/2024, educate Resident #12 to call for assistance with bed mobility and transfers; -On 11/22/2024, re-educate Resident #12 to call for assistance when needing an adult brief and bed linen change; and, -On 12/09/2024, re-educate Resident #12 on the importance of calling for assistance with transfers and demonstrate the proper use of the facility's call bell system. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/11/2024 at 3:30PM, S15Minimum Data Set Coordinator (MDSC) indicated Resident #12 was cognitively impaired, and to educate and re-educate Resident #12 to use the call bell system for assistance, were not appropriate interventions for a resident with cognitive impairment. S15MDS further indicated Resident #12's fall care plan interventions should have been updated with new appropriate interventions.</p> <p>In an interview on 12/11/2024 at 3:55PM, S16Licensed Practical Nurse (LPN) indicated Resident #12 was admitted from another facility with a history of frequent falls. S16LPN further indicated to use the call bell system was not an appropriate fall care plan intervention for Resident #12 because of his cognitive impairment.</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>45877</p> <p>Based on observations, record reviews, interviews, and facility policy it was determined that the facility failed to develop a plan of care for 1 (Resident #287) of 1 residents investigated for oxygen use.</p> <p>Findings included:</p> <p>Observation on 12/09/2024 at 9:39 AM revealed Resident #287 received oxygen at 3 liters per minute (LPM) per nasal cannula (NC).</p> <p>Observation on 12/10/2024 at 8:40 AM revealed Resident #287 received oxygen at 3 LPM humidified per NC.</p> <p>Observation on 12/10/2024 at 8:40 AM revealed Resident #287 received oxygen at to 3LPM humidified per NC.</p> <p>Observation on 12/11/2024 at 11:56 AM revealed Resident #287 received oxygen at 2 LPM humidified per NC.</p> <p>Review of Resident #287's Physician's Orders revealed no documented evidence of an order for oxygen.</p> <p>Review of Resident #287's Altered Respiratory Status Care Plan initiated on 12/13/2022 and last revised on 04/08/2024 revealed, in part, no intervention for oxygen use was initiated.</p> <p>In an interview on 12/11/2024 at 11:58 AM, S18Licensed Practical Nurse confirmed Resident #287 was being administered oxygen.</p> <p>Review of the facility's Oxygen Administration policy (revised 2024) revealed, in part, the first step of oxygen administration was to verify that there was a physician's order for this procedure.</p> <p>In an interview on 12/11/2024 at 12:15 PM, S2Director of Nursing confirmed Resident #287 did not have an order for oxygen and he should have .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48855</p> <p>Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure only licensed personnel administered medications for 1 (Resident #25) of 27 residents observed during initial pool.</p> <p>Findings included:</p> <p>Review of the facility's policy titled, Medication Administration, dated 07/08/2024, revealed only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.</p> <p>Review of Resident #25's December 2024 Physician Orders, revealed, in part, an order dated 12/09/2021 for Resident #25's antifungal powder to be administered to Resident #25's lower abdominal skin fold, to skin folds on Resident #25's sides, and behind Resident #25's knees daily and as needed until resolved.</p> <p>Observation on 12/09/2024 at 10:21 AM revealed S21Certified Nursing Assistant (CNA) removed a bottle of antifungal powder from Resident #25's bedside table. S21CNA then applied the antifungal powder under Resident #25's right breast.</p> <p>Review of Resident #25's bottle of antifungal powder revealed the active ingredient was miconazole ntrate 2.0% (a medication used to treat fungal infections of the skin).</p> <p>In an interview on 12/09/2024 at 10:21 AM, Resident #25 stated the facility's CNAs had been applying Resident #25's antifungal powder under her right breast as needed.</p> <p>In an interview on 12/10/2024 at 4:20 PM, S21CNA indicated she had been applying Resident #25's antifungal powder under Resident #25's right breast daily as needed. S21CNA further indicated she was not aware the antifungal powder contained medication and she should not have been applying it.</p> <p>In an interview 12/10/2024 at 4:35 PM, S2Director of Nursing (DON) indicated S21CNA should not have applied antifungal powder to Resident #25.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45877</p> <p>Based on record reviews and interviews, it was determined that the facility failed to monitor for the effectiveness and potential side effects of hypnotics, antidepressants, anti-anxiety medications, antipsychotics, and opioids for 1 (Resident #4) of 5 residents reviewed for unnecessary medications.</p> <p>Findings identified:</p> <p>Resident #4's Electronic Medical Record (EMR) revealed, in part, Resident #4 was admitted to the facility on [DATE] with diagnoses, in part, of unspecified dementia, anxiety disorder, depression, restlessness and agitation</p> <p>Review of Resident #4's November 2024 and December 2024 Physician's Orders revealed the following orders:</p> <ul style="list-style-type: none"> - Haloperidol lactate (a medication used to treat psychosis) oral concentrate 2 milligrams (mg)/milliliter (ml), give 0.5 mls by mouth two times a day related to restlessness and agitation beginning on 11/13/2024 - Trazodone hydrochloride (a medication used to treat depression and/or anxiety) 50 mg oral tablet, give 2 tablets by mouth at bedtime for insomnia beginning 11/04/2024 - Morphine sulfate (a medication used to treat pain) oral solution 20 mg/5 ml, give 0.5 mls every 2 hours as needed for shortness of breath related to chronic obstructive pulmonary disease with a start date of 10/17/2024 - Lorazepam (a medication used to treat anxiety) oral tablet 0.5 mg, give 1 tablet by mouth every 6 hours as needed for anxiety disorder beginning on 10/17/2024 - Zolof (a medication used to treat depression) 25 mg tablet, give 25 mg by mouth 1 time a day related to depression beginning on 10/18/2024 <p>Review of Resident #4's November 2024 and December 2024 Electronic Medication Administration Record revealed no documented evidence and the facility failed to present any documented evidence Resident #4 was monitored for the effectiveness and possible side effects of the previous mentioned medications.</p> <p>Review of Resident #4's Electronic Medical Record did not reveal any documented evidence and the facility was unable to present any documented evidence Resident #4 was monitored for the effectiveness and possible side effects of the previous mentioned medications.</p> <p>In an interview on 12/11/2024 at 3:08 PM, S2Director of Nursing confirmed Resident #4 was not monitored for the effectiveness and possible side effects of the previous mentioned medications and should have been.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/11/2024 at 3:50 PM, S20Corporate Clinical Specialist confirmed Resident #4 was not monitored for the effectiveness and possible side effects of the previous mentioned medications and should have been.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22609</p> <p>45877</p> <p>Based on observation and interview, it was facility determined the facility failed to ensure the following:</p> <ol style="list-style-type: none"> 1. An insulin pen was not used past the expired open date [DATE]; 2. an open medication on a blister pack was not taped to secure it inside the pack for 1 medication cart (medication cart a) of 2 medication carts reviewed; and, 3. The facility's medication refrigerator stored medication at the proper temperature for 1 medication refrigerator c of 1 medication refrigerators observed. <p>Findings included:</p> <ol style="list-style-type: none"> 1. <p>Observation of medication cart a on [DATE] at 8:50AM, revealed a medication insulin pen, Solastor (a medication used to lower blood sugar) pen with an open date of [DATE]. Observation further revealed a medication card with Hydrocodone-Acetaminophen ,d+[DATE] milligrams (mg). Further observation revealed pill #19 on the Hydrocodone-Acetaminophen ,d+[DATE] mg had been opened then secured in the medication card with a piece of tape.</p> <p>In an interview on [DATE] at 8:54 AM, S13Licensed Practical Nurse (LPN) indicated insulin pens should be discarded 28 days after opening and confirmed the previous mentioned insulin pen should have been discarded. S13LPN further indicated tape should not be placed on opened pills on medication cards.</p> <p>In an interview on [DATE] at 11:12 AM, S2Director of Nursing (DON) confirmed insulin pens should be discarded after 28 days of opening. S2DON further confirmed medication should not be placed back into the medication card and secured with tape after it was opened.</p> 2. <p>Observation on [DATE] at 4:10 PM of the medication room b revealed the medication refrigerator's c temperature was 50 degrees Fahrenheit. Observation on the outside side of the refrigerator revealed a Daily Temperature Log. Further observation of medication refrigerator e revealed the refrigerator contained insulins (a medication used to lower blood sugar) and influenza vaccines.</p> <p>Review of the Daily Temperature Log for medication refrigerator e revealed documentation of a refrigerated storage temperature range from ,d+[DATE] degrees Fahrenheit.</p> <p>(continued on next page)</p> 		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the influenza vaccine's package information revealed, in part, the influenza vaccine should be stored at a temperature between 36 to 46 degrees Fahrenheit.</p> <p>In an interview on [DATE] at 4:10 PM, S3Assistant Director of Nursing indicated the temperature to store the insulin and influenza medications were not stored at the proper temperature.</p> <p>In an interview on [DATE] at 4:42 PM, S2DON indicated the temperature in the refrigerator should not be over 45 degrees Fahrenheit.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>48855</p> <p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on observations, interviews, record review, and facility document review, it was determined that the facility failed to follow the facility's lunch menu and ensure the substitution to the menu was approved by the facility's dietician for 6 (Resident #22, Resident #23, Resident #34, Resident #47, Resident #50, and Resident #61) of 6 residents lunch meal tickets observed for dining.</p> <p>Findings included:</p> <p>Observation on 12/09/2024 at 12:10 PM revealed the posted menu in the facility's dining room revealed a baked pork chop, broccoli and cauliflower, a dinner roll, and a frosted cake would be served for lunch.</p> <p>Review of the facility's approved menu for 12/09/2024 revealed beef roast, mashed potatoes, broccoli and cauliflower with cheese, dinner roll, and a frosted cake.</p> <p>Observation on 12/09/2024 at 12:10 PM revealed Resident #22's, Resident #23's, Resident #34's, Resident #47's, Resident #50's, and Resident #61's 12/09/2024 lunch meal served was baked pork chop, mashed potatoes, broccoli and cauliflower, and a frosted cake. Further review revealed the meal served to Resident #22, Resident #23, Resident #34, Resident #47, Resident #50, and Resident #61 was not the meal advertised on the lunch menu.</p> <p>In an interview on 12/09/2024 at 12:05 PM, Resident #22 indicated the chopped meat on her ordered mechanical soft diet ticket was not a pork chop as indicated on the posted menu in the facility's dining room. Resident #22 further indicated the broccoli and cauliflower did not have any cheese.</p> <p>In an interview on 12/09/2024 at 12:07 PM, S22Dietary Manager (S22DM) indicated she substituted the beef roast with a grilled pork chop, and S23Cook did not add cheese to the broccoli and cauliflower. S22Dietary Manager further indicated she did not get the lunch menu revision approved by the facility's dietician on 12/09/2024.</p> <p>In an interview on 12/09/2024 at 1:04 PM, S24Registered Dietician (S24RD) indicated she should have been made aware of the 12/09/2024 lunch menu revision, and the revision should have been recorded and approved the day the revision was made to the menu.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48855</p> <p>Based on interviews and observations, it was determined that the facility failed to:</p> <ol style="list-style-type: none"> 1. Ensure the facility's hood fan was kept clean and sanitary; 2. Ensure the facility's double fryer was kept clean and sanitary; 3. Ensure stored foods in the facility's cooler were properly contained and had an open date for 1 (cooler d) of 2 coolers observed; 4. Ensure a dietary cook wore a proper hair restraint during food handling and preparation; and, 5. Ensure Auto-Chlor test strips were not expired. <p>Findings included:</p> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> Observation on [DATE] at 8:28 AM revealed the facility's hood fan had an unknown white and orange/red substance on the outside surface of the hood fan. In an interview on [DATE] at 10:14 AM, S1Administrator indicated the facility's hood fan should not have an unknown white and orange/red substance on the outside surface and should have been kept in a sanitary manner. 2. <ul style="list-style-type: none"> Observation on [DATE] at 10:15 AM revealed the facility's double fryer had a white substance on the outside of the fryer; and an unknown brown substance on the back ledge of the fryer. In an interview on [DATE] at 10:16 AM, S1Administrator indicated the facility's double fryer should not have had an unknown white substance on the outside and an unknown substance on the back ledge and should have been kept clean and in a sanitary manner. 3. <ul style="list-style-type: none"> Observation on [DATE] at 8:30 AM of cooler d revealed: <ul style="list-style-type: none"> -a bag of frozen fish with no open date; -a bag of sliced turkey, not contained, open to air, and with no open date; and, -a bag of shredded lettuce, not contained, open to air, and with no open date. <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on [DATE] at 8:30 AM, S22Dietary Manager (DM) indicated the bag of frozen fish in cooler d should have had an open date, the bag of sliced turkey in cooler d should have been contained and had an open date, and the bag of shredded lettuce in cooler d should have been contained and had an open date.</p> <p>4.</p> <p>Observation on [DATE] at 8:30 AM revealed S23Cook was prepping lunch in the facility's kitchen without a hair restraint covering his beard.</p> <p>In an interview on [DATE] at 8:31 AM, S22DM indicated S23Cook should have worn a proper hair restraint to cover his beard while he handled and prepped food.</p> <p>5.</p> <p>Observation on [DATE] at 11:55 AM revealed the facility's Auto-Chlor test strips for the facility's dishware and the facility's 3 compartment sanitization sink had an expiration date of ,d+[DATE].</p> <p>In an interview on [DATE] at 11:55AM, S22DM indicated the facility's Auto-Chlor test strips were expired and should not have been.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>22609</p> <p>Based on observations and interviews, it was determined the facility failed to maintain an effective infection prevention and control program by:</p> <ol style="list-style-type: none"> not performing hand hygiene while administering medications for 1 (Resident #1) of 2 residents observed during medication administration; and, failing to cover a resident's urinal for 1 (Resident #3) of 32 residents observed during the initial pool. <p>Findings included:</p> <ol style="list-style-type: none"> <p>Review of the facility's Handwashing-Hand Hygiene Policy and Procedures policy last revised in 2020 revealed hand hygiene during medication administration was achieved by use of an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water before preparing or handling medications.</p> <p>Observation on 12/09/2024 at 8:40 AM revealed Resident #1 asked S13Licensed Practical Nurse (LPN) to cut their Tylenol, cranberry, and Carafate (a medication used for gastric reflux) tablets in half. Further observation revealed S13LPN took the medication cup from Resident #1 and walked to her medication cart. Observation then revealed S13LPN removed keys from her pocket, unlocked her medication cart, and removed the pill cutter from the medication cart. Observation revealed S13LPN removed the above mentioned pills from the medication cup with her ungloved hand, cut the medications in half, and then placed the medications back into the medication cup without performing hand hygiene. Observation revealed S13LPN administered the medications to Resident #1.</p> <p>In an interview on 12/09/2024 at 8:44 AM, S13LPN confirmed she did not perform hand hygiene before she cut Resident #1's medications in half, and she should have.</p> <p>In an interview on 12/09/2024 at 11:12 AM, S2Director of Nursing confirmed hand hygiene should be performed before administering medications to residents.</p> <p>Observation of Resident #3's bathroom on 12/11/2024 at 9:30 AM revealed Resident #3's urinal was hanging on the hand rail, which was not contained to prevent the spread of infection.</p> <p>In an interview on 12/11/2024 at 9:32 AM, S12Certified Nursing Assistant (CNA) confirmed Resident #3's urinal was not in a plastic bag but should have been.</p> <p>In an interview on 12/11/2024 at 9:45 AM, S2Director of Nursing indicated Resident #3's urinal should have been contained in a plastic bag for infection control compliance.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>45877</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>45877</p> <p>Based on record reviews, observations, and interviews, it was determined the facility failed to ensure a functional call bell system was available for 1 (Resident #18) of 32 sampled residents.</p> <p>Findings included:</p> <p>Review of Resident #18's Minimum Data Set (Minimum Data Sheet) with an Assessment Reference Date (ARD) of 11/15/2024 revealed, in part, Resident #18 required assistance with activities of daily living.</p> <p>Review of Resident #18's Care Plan initiated on 06/12/2019 and last revised on 12/09/2024 revealed Resident #18 had a self-care deficit with an intervention to encourage Resident #18 to use the call bell to call for assistance.</p> <p>Observation on 12/10/2024 at 8:50 AM revealed Resident #18's call light was wrapped around the bed's side rail and not plugged into the wall.</p> <p>Observation on 12/10/2024 at 4:30 PM revealed Resident #18's call light was wrapped around the bed's side rail and not plugged into the wall.</p> <p>Observation on 12/11/2024 at 8:50 AM, revealed Resident #18's call light was wrapped around the bed's side rail and not plugged into the wall.</p> <p>In an interview on 12/11/2024 at 9:05 AM, S5Licensed Practical Nurse (LPN) confirmed Resident #18's call light was not plugged into the wall. S5LPN further indicated Resident #18's call light should be plugged into the wall in order for the call system to function and have it available for use.</p> <p>In an interview on 12/11/2024 at 9:08 AM, S11Certified Nursing Assistant (CNA) indicated Resident #18 knew how to use the call light. S11CNA confirmed Resident #18's call light was wrapped around his bed's side rail and not plugged into the wall. S11CNA further confirmed Resident #18's call light must be plugged into the wall to be functional.</p> <p>In an interview on 12/11/2024 at 9:10 AM, S3Assistant Director of Nursing (ADON) indicated Resident #18's call light should not be wrapped around the side rail of his bed. S3ADON further indicated Resident #18's call light should be plugged into the wall.</p> <p>In an interview on 12/11/2024 at 9:12 AM, S2Director of Nursing confirmed Resident #18's call light should be plugged into the wall.</p>		