STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195426	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore Healthcare and Rehabilitation Center (the)	19110 Crowley-Eunice Hwy Crowley, LA 70526

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41824 Based on record review and interview, the facility failed to ensure the resident and/or resident's representative (RP) exercised the right to appropriately make informed decisions regarding the right to choose a provider of their preference for hospice services for 1 (#28) of 4 (#5, #7, #28, #42) residents investigated for hospice services in a final sample of 35 residents. Findings: Review of the facility's policy titled, Resident Rights and Quality of Life Policy and Procedure reviewed and approved by the facility on 08/22/2022 revealed in part: Resident's rights will be explained to the responsible party or legal guardian as appropriate. The resident has the right to .be informed in advance about care and treatment .freedom of choice of providers. Resident #28 Review of the resident's record revealed she was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE]. The resident's diagnoses included Heart failure, Chronic obstructive pulmonary disease (COPD), Respiratory failure, Presence of cardiac pacemaker, Dementia, and Cognitive communication deficit. Review of the resident's significant change MDS (Minimum Data Set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 7, indicating severe cognitive impairment. Further review of the resident's record revealed the resident received hospice services elected by the resident's daughter/RP with the facility's contracted hospice provider for a terminal diagnosis of COPD from 2/12/2024 until 5/29/2024. The resident was placed on palliative care with another hospice provider not contracted with the facility on 05/30/2024. Review of the resident's physician orders revealed: 02/12/2024 admit to (the facility's contracted hospice provider name) for a terminal diagnoses of COPD; 05/10/2024 d/c (discharge) from (the facility's contracted hospice provider name); (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/29/2024 consult with (hospice provider name of which the facility did not have an existing contract agreement). Review of the facility's grievances in the last 120 days revealed Resident #28's daughter/responsible party (RP) filed a complaint on 05/23/2024. Subject: Do not want (the facility's contracted hospice provider name) services. Review of the resident's grievance report dated 05/23/2024 revealed Resident #28's RP reported to S3SSD (Social Services Director) that she did not want (the facility's contracted hospice provider name) to follow-up with her mother's care when her mother returned to the facility. On 06/20/2024 at 9:45 a.m., a phone interview was conducted with Resident #28's RP who stated her mother had Dementia, was confused at times and was not able to answer appropriately nor make sound decisions for herself. She confirmed she made decisions on the resident's behalf including signing paperwork on the resident's behalf. She stated her mother had a decline in functioning and was ill therefore she elected to hospice services after consultation with the medical provider. The RP stated at the time she was made aware her mom was a hospice candidate, she initially met with an employee of the nursing home for consultation. She stated the nursing home only presented their contracted hospice provider. She was not informed of any other hospice agency providers nor that she had the right to choose the hospice provider of her choice. Because her mom needed the hospice services, she signed up to have the facility's contracted provider admit her mom to hospice. She stated the facility's contacted hospice provider staff rushed through the paperwork, did not explain anything to her fully, and also did not make her aware of the right to choose other providers. She was just told to sign all these papers with not fully understanding what any of the paperwork meant. The RP stated on 05/11/2024 around 4:15 p.m., she became dissatisfied with the hospice provider's nurse and revoked hospice services to allow her mother to be transfer to the ER evaluation and further treatment. It was then that a personal friend of hers informed her she had a right to choose which hospice provider she wanted. The RP expressed that she was upset finding this out from her friend and that had the nursing home informed her of rights she never would have elected to hospice from their contracted provider. She proceeded to file a grievance with S2DON (Director of Nursing) which led to the nursing home informing her at that she was able to obtain an individual contract with the hospice provider of her choice. The RP further stated that had she been aware of her rights, she would have researched other hospice providers before making a decision. Further review of Resident #28's record was conducted with review of the progress notes and social services notes for January 2024 - February 2024 which revealed in part: 02/08/2024 1:53 p.m., entry by S3SSD- Resident's RP has a conference with (the facility's contracted hospice provider name) on Monday. She will decide if she needs to be a hospice patient. 02/12/2024 entry by S3SSD- Resident #28 was admitted under (the facility's contracted hospice provider name) hospice services today. Further review of the notes failed to reveal any evidence the nursing home informed the resident's RP of her right to choose other hospice providers. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/20/2024 at 3:07 p.m., an interview was conducted with S3SSD who was the facility's designated staff to provide initial hospice education and set up hospice consults for the families. During her meeting with the family, she informs them they have a right to choose hospice providers and are provided information of other hospice providers available to them. She further stated the facility had an agreement with one hospice agency, but the resident/RP could choose another provider if they opted to do so. S3SSD stated she did not document the details of the family meetings and could not provide any evidence that the resident/RP was notified of the right to choose a provider of their choice. On 06/20/2024 at 3:48 p.m., an interview was conducted with S1ADM (Administrator) who stated the family/resident/RP should be informed of their right to choose a hospice provider upon the education consult with S3SSD. 06/20/2024 04:58 p.m., S2DON confirmed resident should be informed of right to choose hospice providers including being made aware of a list of companies in which to choose during their educational consult with S3SSD. She was informed there was no documented evidence in the records to show Resident #28's RP was informed of their right to choose a provider of their choice for hospice services.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49134 Based on record review and interview, the facility failed to ensure a Discharge Minimum Data Set (MDS) assessment was completed timely for 1(Resident #38) out of 35 sampled residents investigated. Findings: Resident #38 was admitted to the facility on [DATE] with diagnoses including Cord Compression, Aural Vertigo, Spinal Stenosis, Diabetes Mellitus, Hypertension, and Displaced Fracture of Right Femur. Review of Resident #38's medical record, revealed Resident #38 was admitted on [DATE] and discharged from the facility on 02/19/2024. Review of Resident #38's Discharge MDS assessment dated [DATE], revealed a transmission date of 06/20/2024. On 06/20/2024 at 12:30 p.m., an interview was conducted with S9MDSLPN. S9MDSLPN reviewed Resident #38's record and confirmed that an MDS discharge assessment should have been completed and transmitted within the 120 days after the resident was discharged from the facility and was not.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41824 Based on record review and interview, the facility failed to accurately code all applicable diagnoses on two consecutive comprehensive MDS (Minimum Data Set) assessments for 1 (#41) of 35 final sampled residents. Findings: Review of Resident #41's record revealed she was admitted to the facility on [DATE] with diagnoses including Dementia. Review of Resident #41's Psychiatric Evaluation by the psychiatrist dated 09/15/2020 revealed the resident was diagnosed with Depression, Dementia without behavior disturbances, and Schizoaffective Disorder. According to the resident's updated billing diagnosis code report, the resident's diagnoses of Dementia had a documented onset date of 09/11/2020; Schizoaffective Disorder had a documented onset date of 09/30/2020. Review of Section I-Active Diagnoses of the resident's admission MDS assessment dated [DATE] revealed the listed diagnoses of Non-Alzheimer's Dementia and Schizophrenia (Schizoaffective disorders) were unchecked. Review of Section I-Active Diagnoses of the resident's following quarterly MDS assessment dated [DATE] revealed the listed diagnoses of Schizophrenia (Schizoaffective disorders) was unchecked. On 06/18/2024 at 1:25 p.m., an interview and record review was conducted with S7RCE (Regional Clinical Educator). She explained that according to Resident #41's records, the resident was admitted to the nursing home on 09/11/2020. The resident was diagnosed with Schizoaffective Disorder on 09/15/2020 when the psychiatrist evaluated the resident and documented the diagnosis on 09/15/2020. On 06/18/2024 at 2:03 p.m., an interview and review of Resident #41's records was conducted with S10MDSLPN (Minimum Data Set, Licensed Practical Nurse). She reviewed the dates of the resident's diagnoses in comparison with the resident's admission MDS assessment dated [DATE] and the resident's subsequent quarterly MDS assessment dated [DATE]. S10MDSLPN confirmed the resident's admission assessment failed to include the resident's Dementia and Schizoaffective Disorder diagnoses. She further confirmed the following quarterly assessment dated [DATE] failed to include the resident's diagnosis of Schizoaffective Disorder. S10MDSLPN confirmed two of the resident's MDS assessments were inaccurate.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41824 Based on record review and interview, the facility failed to refer a resident with a newly evident serious mental disorder to the appropriate state designated authority for Level II PASARR (Pre-Admission Screening and Resident Review) evaluation and determination for 1 of 1 (#41) residents investigated for PASARR review in a final sample of 35 residents. Findings: Review of the facility's policy titled, Pre-Admission Screening and Resident Review (PASRR) Policy and Procedure reviewed and approved by the facility on 04/12/2023 revealed in part: The purpose of the policy was to ensure completion of Pre-Admission Screening and Resident Review Level II evaluations to assess the need for .and facilitation of behavioral health services. Policy: The facility is to review the resident diagnosis and medications upon admission and throughout the resident stay to determine if a Level II request for resident review is to be completed .2. Referring all residents with newly evident or possibly serious mental disorder .5. A resident review for Level II evaluation should be considered for the following residents: Residents with tier one diagnosis Schizophrenia .is to have a completed resident review form according to OBH (Office of Behavioral Health) guidance .The resident has a new mental health diagnosis, which will not normally resolve itself once the condition stabilizes. 6. Completed forms are to be filed/scanned in the resident chart. Review of Resident #41's record revealed she was admitted to the facility on [DATE]. Review of Resident #41's pre-admission Level I PASARR application dated 08/12/2020 revealed the resident was not diagnosed with a serious mental disorder prior to her nursing home admission. Review of Resident #41's Psychiatric Evaluation by the psychiatrist dated 09/15/2020 revealed resident was diagnosed with Depression, Dementia without behavior disturbances, and Schizoaffective Disorder. Review of Resident #41's updated billable diagnoses code report revealed the resident's diagnosis of Schizoaffective Disorder had an onset date of 09/30/2020. Review of the resident's physician orders for June 2024 revealed an order dated 01/23/2023 Risperidone 0. 25 mg (milligram) tab (tablet), 1 tab PO (by mouth) .look for target behaviors (getting in other resident's bed, eat my own scabs, refuse to get dressed, take water pitcher off nursing cart, take food out of trash, try to drink sanitizer, refuses to open mouth .dx (diagnosis) schizoaffective disorder. On 06/18/2024 at 8:45 a.m., an interview and review of Resident #41's PASARR records was conducted with S3SSD (Social Services Director). S3SSD stated Resident #41's pre-admission Level I PASARR was completed by the hospital the resident was admitted from on 8/12/2020. The nursing home received the Level I determination letter from the State (Form 142) on 09/10/2020 stating the resident did not qualify for Level II services. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/18/2024 at 1:25 p.m., an interview and record review was conducted with S7RCE (Regional Clinical Educator). She explained that according to Resident #41's records, the resident was admitted to the nursing home on 09/11/2020. The resident was diagnosed with Schizoaffective Disorder on 09/15/2020 when the psychiatrist evaluated the resident and documented the diagnosis on 09/15/2020. Another review of the resident's record failed to reveal evidence that a Level II request was submitted to OBH after the resident was diagnosed with Schizoaffective Disorder. On 06/18/2024 at 2:13 p.m., a review of the facility's PASARR policy and another review of Resident #41's record was conducted with S3SSD. S3SSD confirmed the resident was diagnosed with Schizoaffective Disorder on 09/15/2020 by the psychiatrist and with a documented onset date of 09/30/2020. She stated she was not sure if a Level II evaluation was sent at that time and confirmed according to the facility's policy, the paperwork should have been submitted to OBH. On 06/18/2024 at 4:59 p.m., a follow-up interview was conducted with S3SSD who stated she contacted OBH who informed her that due to the resident's newly identified Tier 1 diagnosis of Schizophrenia Disorder, the facility was required to submit a request for Level II since 2020. She further confirmed a Level II request had not been submitted for the resident and the resident currently required evaluation for services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41824 Based on observations, record review and interview, the facility failed to develop a comprehensive resident centered care plan for 1 (#324) of 35 final sampled residents by failing to develop nursing interventions to address edema to both lower extremities present upon Resident #324's nursing admission assessment. Findings: Review of the facility's policy titled, Care Plan Policy and Procedure reviewed and approved by the facility on 09/28/2023, read in part: a comprehensive person-center care plan will be completed .upon admission .and as needed. It is the policy of this facility to utilize an advanced care planning approach to review and determine patient centered care plans based on the following areas .active disease process .services furnished to attain or maintain the resident's highest practicable physician, mental, and psychosocial well-being; the resident individual goals. Review of Resident #324's record revealed she was admitted to the facility on [DATE] for skilled services. The resident had diagnoses including: Chronic Obstructive Pulmonary Disease (COPD), Chronic Diastolic Congestive Heart Failure (CHF), Atrial Fibrillation and Hypertensive Heart Disease with Heart Failure. Review of the resident's progress notes for June 2024 read in part: entry dated 06/04/2024 3:01 p.m., Resident admitted to facility .swelling noted to lower extremities. Swelling to left foot and leg greater than right. Pedal pulses difficult to palpate. entry dated 06/09/2024 11:55 p.m., swelling noted to BLE (bilateral lower extremities); Legs elevated. entry dated 06/09/2024 2:22 p.m., .+3 pitting edema to BLE. Review of the resident's eMAR (electronic Medication Administration Record) with physician orders for June 2024 revealed the following: 06/04/2024 Lasix 20 mg (milligrams) po (by mouth) daily for Hypertensive Heart Disease with Heart Failure; 06/07/2024 notify NP (nurse practitioner) of wt (weight) gain greater than 2lbs (pounds); 06/14/2024 increase Lasix to 40 mg po x3 days then resume 20mg po qd (every day) 06/10/2024 increase Lasix 40 mg x3 days then resume 20 mg q day wt mwf (Monday, Wednesday, Friday) notify if >2 # (pounds) gain (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the eMAR revealed the severity of the resident's pitting edema was assessed by nursing staff and graded (grade 1+ indicating 2 millimeters of depression that rebounds immediately; grade 2+ indicating 3-4 millimeters of depression that rebounds in 15 seconds or less; grade 3+ indicating 5-6 millimeters of depression that rebounds in 60 seconds; and grade 4+ indicating 8 millimeters of depression or deeper that rebounds in 2-3 minutes). The resident's edema was documented as follows: +1 on 06/05/2024 - 06/06/2024; +2 on 06/07/2024 -06/08/2024; +3 on 06/09/2024 and 06/10/2024; +2 on 06/11/2024; +3 on 06/12/2024 -06/13/2024; and +4 on 06/15/2024, 06/16/2024 and 06/17/2024. Review of the CNA (Certified Nursing Assistant) Fixed Task Care Plan, which listed resident specific tasks to be completed by the CNAs, failed to reveal a task to elevate the resident's legs. Further review of the resident's record revealed no documentation present that indicated staff elevated the resident's legs daily or implemented any interventions to address the edema. Review of the resident's comprehensive care plan failed to reveal a care plan was developed with interventions to address the resident's lower extremity edema. Review of the resident's AM5 MDS (Admission Minimum Data Set) assessment dated [DATE] revealed the resident had a BIMS (Brief Interview for Mental Status) score of 12, indicating the resident's cognition was moderately intact. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/17/2024 at 11:47 a.m., Resident #324 was observed sitting in her wheelchair inside her room wearing non-skid socks with her feet planted on the wheelchair foot rests. Closer observations revealed both of the resident's feet were swollen. The resident stated her feet and ankles were always swollen even prior to her admission into the facility. She stated the swelling worsened since she'd been in the facility, in part because she did not elevate her legs as she should. She stated to help with the edema, they increased her Lasix (a diuretic) which helped a little, but swelling to her legs increased again. She further stated the current swelling was more than she was used to having in the past. When asked what else besides Lasix the facility had tried to address her edema, the resident replied, nothing that she was aware of. The resident was asked if staff elevated her legs when she was in bed or when in her wheelchair and she stated no. She stated she would elevate her legs at home and it would help with the swelling. She tried to elevate them herself while in the facility, but sometimes she forgets to do so. She stated the swelling was a little worse today because she forgot to elevate her feet last night. The resident denied that the night nursing staff would elevate or assist her with elevating her legs at night when in bed. At this time, the resident's daughter/RP (responsible party) was visiting the resident and sitting at the bedside. The resident's RP confirmed the resident always had swelling to both feet and voiced concern making the statement, maybe if they would put some pillows to elevate her legs at night it would help. At this time observations of the resident's room did not reveal any positioning aides or extra pillows in the room. There was no special attachment to the wheelchair foot rests to elevate the legs or lift the feet higher. On 06/18/2024 at 9:54 a.m., an interview was conducted with Resident #324's nurse, S15LPN (Licensed Practical Nurse) who confirmed the resident currently had swelling to both lower extremities. S15LPN reviewed the resident's record and stated there were no orders or interventions to elevate the resident's legs. She further stated she was not aware of any other interventions that specifically addressed the resident's edema. On 06/18/2024 at 10:01 a.m., an interview was conducted with S6NP (Nurse Practitioner) who stated she was the resident's provider. S6NP stated the resident had COPD/CHF and chronic edema to the bilateral lower extremities upon admission to the facility. S6NP stated she and the physician had been titrating the resident's Lasix to decrease the resident's cardiac/respiratory congestion due to her heart condition. She stated the resident's edema was chronic and did not expect it to resolve due to her diagnoses. S6NP stated nursing staff should ensure the resident's legs were elevated due to the swelling, but she was not sure if elevating the legs were included in the resident's plan of care. On 06/18/2024 at 10:11 a.m., an interview was conducted with S10MDSLPN who stated she was responsible for Resident #324's care plan. She reviewed the comprehensive care plan in full and confirmed interventions were not developed to address the resident's bilateral lower extremities edema. She further confirmed the care plan did not indicate the resident had edema to both lower extremities. On 06/18/2024 at 10:14 a.m., an interview was conducted with Resident #324's CNAs (Certified Nursing Assistant), S13CNA and S14CNA who stated Resident #324 required limited assistance and could elevate her own legs. The CNAs further stated the resident knew she needed to elevate her own legs and that they were not required to remind, prompt, or ensure the resident elevated her legs. They were not told to elevate the resident's legs nor aware of any other interventions to address the resident's edema. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/18/2024 at 10:32 a.m., an interview was conducted with S2DON (Director of Nursing) who stated the nurses should use nursing judgement regarding when to elevate a resident's legs and was not sure if this needed to be documented in the care plan. S2DON stated the resident could elevate her legs herself, but confirmed staff were not instructed to monitor to ensure the resident's legs were elevated. A review of the resident's progress notes was conducted with S2DON at this time. S2DON confirmed the resident was assessed by the nurse upon admission on 06/04/2024, where the nurse who assessed the resident, documented the resident had edema to both lower extremities. She reviewed the resident's comprehensive care plan and confirmed the edema to the resident's lower extremities was not addressed. On 06/18/2024 at 11:07 a.m., an interview and review of resident #324's record was conducted with S2DON and S7RCE (Regional Clinical Educator) who reviewed the resident's admission assessment dated [DATE] and confirmed the resident was admitted with edema to both lower extremities. S7RCE stated based on the nurses' assessment, a physician's order was not needed for the facility to care plan the resident for nursing interventions to address the edema. S2DON and S7RCE confirmed a care plan was not developed to address the edema and that the intervention to elevate the resident's legs should have been implemented since the resident's admission.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44418 Based on observation, record review and interview, the facility failed to provide necessary care and services that is in accordance with professional standards of practice by failing to ensure oxygen was delivered at the ordered rate for 1 (#42) out of 3 (#12, #42, #71) resident reviewed for respiratory care out of a total sample of 35 residents. Findings: Resident #42 was admitted on [DATE], with diagnoses not limited to Chronic Respiratory failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Aphasia and Cognitive Communication Deficits. Review of the Resident #42's physician's orders for June 2024 revealed on 10/19/2023 an order for Oxygen (O2) at 2 L/NC (Liters per Nasal Cannula) continuous to relieve hypoxia; document oxygen saturation every shift. On 06/17/2024 at 9:18 a.m., an observation of resident lying in bed, with contractures to bilateral arms and hands, with O2 resting on resident's shoulder, a knot/kink in O2 tubing, midway between concentrator and end of nasal cannula tubing. On 06/17/2024 at 10:28 a.m., an observation of Resident #42 with S5LPN was conducted. S5LPN confirmed the O2 at 2 L/NC was in place to resident's nose. S5LPN then observed the N/C tubing and confirmed the oxygen tubing had a knot/kink in the tubing, midway between resident and concentrator. She removed the knot/kink from the tubing and confirmed the knot/kink was obstructing the oxygen flow.

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	195426	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44418 Based on observations and interviews, the facility failed to ensure medications were labeled to reflect medication adjustments as the physician ordered for 1 (#55) resident. The deficiency had the potential to affect a census of 69 residents. Findings: On 06/20/2024 a review of the facility's policy titled, Medication Storage with a last reviewed date of 09/28/2023, read in part, Policy: . 5. Medications will be labeled in accordance with currently accepted professional principles including expiration dated .Procedure: 1. Designated personnel will perform weekly and as needed review of medication storage areas and carts for compliance of policy Review of Resident #55's electronic health record revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part, Hypertensive Heart Disease with Heart Failure, Cognitive Communication Deficits and Unspecified Pain. On 06/20/2024, a review of Resident #55's Physician Orders for June 2024 revealed the following order: Order date: 05/17/2023, start date: 05/24/2023 - Tramadol ER (extended release) 100mg (milligrams) take one tablet by mouth (po) every 12 hours (Q12H) as needed (PRN) for pain. A review of Resident #55's individual narcotics record with a date of 05/2023 revealed medication/dosage/method of administration: Tramadol i (one) po Q12H PRN. Further review revealed on 05/26/2023 at 3:40 a.m., 06/01/2023 at 4:40 p.m., 06/05/2023 at 3:07 p.m., 09/15/2023 at 7:14 p.m., 09/16/2023 at 6:00 p.m., and 09/ /2023 quantity given was i. On 06/04/2023 and 07/28/2023 at 11:30 p.m., quantity given was ii (two). Further review of Resident #55's individual patient's narcotics record with a date of 12/26/2023 revealed medication/dosage/method of administration: Tramadol 50mg ii po Q12H PRN. On 03/13/2024 at 7:30 p.m., 03/22/2024 at 7:25 a.m., 05/17/2024 at 8:00 p.m., 05/28/2024, and 06/16/2024 at 5:30 a.m., quantity given was i. Review of Resident #55's Medication card with a date of 12/26/2023 was labeled: Tramadol HCL (Hydrochloride) tab 50mg; take one tablet by mouth every 12 hours as needed for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/20/2024 at 12:15 p.m., while conducting a CartB narcotic review with S8LPN (Licensed Practical Nurse), she confirmed the card dated 12/26/2023 for Resident #55's Tramadol read: Medication/Dosage/Method of Administration: Tramadol 50mg ii by mouth every 12 hours as needed. Amount received: 30. S8LPN also confirmed the resident was given ii Tramadol 50mg tablets for the following dates 03/16/2024 at 7:30 p.m., 03/22/2024 at 7:25 a.m., 05/17/2024 at 8:00 p.m., 05/28/2024 at 2:00 p.m. and 06/16/2024. The resident was given i Tramadol tablet on the following dates: 03/23/2024 at 7:37 a.m., 03/24/2024 at 8:33 a.m., 04/21/2024 at 8:00 p.m., 04/22/2024 at 6:00 p.m., 05/10/2024 at 10:39 a.m., 05/14/2024 at 6:00 a.m., and 05/24/2024 at 6:59 p.m. S8LPN confirmed the resident should have received ii tablets, to equal 100mg, each time the medication was administered. On 06/20/2024 at 3:30 p.m., an interview was conducted with S17RCS (Regional Clinical Specialist), she confirmed the physicians order for Resident #55 was changed on 05/17/2023 to Tramadol 100mg po Q12H po PRN for pain. S17RCS also, confirmed Resident #55 only received Tramadol 50mg on 05/26/2023 at 3:40 a.m., 06/01/2023 at 4:40 p.m., 06/05/2023 at 3:07 p.m., 09/15 at 7:14 p.m., 09/16 at 6:00 p.m., 03/23/2024 at 7:37 a.m., 03/24/2024 at 8:33 a.m., 04/21/2024 at 8:00 p.m., 04/22/2024 at 6:00 p.m., 05/10/2024 at 10:39 a.m., 05/14/2024 at 6:00 a.m., and 05/24/2024 at 6:59 p.m. S17RCS also confirmed the resident should have received Tramadol 100mg on those dates as the physician ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 44418 Based on interview, observations and record review the facility failed to ensure that pharmaceutical services provided to meet the needs of each resident were consistent with state and federal requirements and reflect current standards of practice as evidenced by failing to ensure medication was labeled as per physician orders for 1 (#20) resident. The deficiency had the potential to affect a census of 69 residents. Findings: Review of the facility's policy titled, Medication Administration-General Guidelines, read in part: Procedure: 1. Preparation: d. eight rights - right resident, right drug, right dose .A triple check of these rights is recommended at three steps in the process of preparation of medication administration: .3. Check #3: complete the preparation of the dose and re-verify the label against the MAR .e. prior to administration, the medication dosage schedule on the resident's electronic medication administration record (MAR) is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change on the direction or ., the physician's orders are checked for the correct dosage schedule. On 06/18/2024 at 8:37a.m., during an observation of medication administration to residents, Resident #20, S6LPN, observed the medication card for Potassium Chloride 20meq (Milliequivalents) was labeled take 1 &1/2 tablets (30meq) by mouth once now then resume 1 tablet by mouth once daily. S6LPN reviewed the EMR (Electronic Medical Record) physicians' orders and MAR (Medication Administration Record) and stated the physicians' orders and MAR read to give 20meq, give 2 tablets, confirming the medication card was labeled wrong. On 06/18/2024 at 09:10 a.m., a review of the physician orders and MAR was conducted with S6LPN, and S2DON (Director of Nursing). S6LPN confirmed the physician's order dated 05/17/2024 was for Potassium Chloride 20meq to give 2 tablets po (by mouth) daily, and the medication label on the card was incorrect. She also confirmed there was not another medication card with the correct label in the medication storage bin for the resident.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49134 Based on record review and interview, the facility failed to ensure accuracy of the documentation entered into the resident's record for 2 (#35, #71) residents in a final sample of 35 residents evidenced by: 1. inaccurately documenting a presence of a PEG (Percutaneous Endoscopic Gastrostomy) tube for Resident #35; 2. the nurse failing to document the correct reason as to why Resident #71 did not receive a scheduled medication, and another nurse failing to document that Resident #71 received an antibiotic injection immediately after administration per the facility's policy for medication administration. Findings: 1. Resident #35 Resident #35 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Urinary Incontinence, Edema, Depression, Anxiety Disorder, Congestive Heart Failure, Allergic Rhinitis, Insomnia, Restless Leg Syndrome, and Pain. A review of the physician's orders for Resident #35 revealed 03/04/2024: Regular Diet, Meat Finely Cut, no rice. Review of Resident #35's electronic records nursing progress notes revealed on 06/17/2024 at 5:45 a.m., residual check on PEG with 125cc (cubic centimeter) noted. On 06/17/2024 at 2:30 p.m., an interview was conducted with Resident #35, she stated she does not have a PEG tube. On 06/17/2024 at 2:45 p.m., an interview was conducted with S4LPN (Licensed Practical Nurse). S4LPN reviewed the resident's record and confirmed Resident #35 did not have a PEG tube. 06/17/2024 at 2:55 PM an interview was conducted with S2DON (Director of Nursing). S2DON reviewed the resident's record and confirmed Resident #35 did not have a PEG tube and that the nurse who documented incorrectly would need to retract that entry error. 41824 2. Resident #71 Review of the facility's policy titled, Medication Administration- General Guidelines reviewed and approved by the facility on 08/26/2022 revealed in part: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Documentation: a. The individual who administers the medication dose records the administration on the resident's eMAR (Electronic Medication Administration Record) directly after the medication is given .v. If a dose of regularly scheduled medication is withheld, refused, not available, or given a time other than the scheduled time (e.g. the resident is not in the facility at scheduled dose time .), the medication is documented as not given and an explanatory note is entered in the electronic document. Review of the resident's record revealed she was admitted to the facility on [DATE]. The resident's diagnoses included Urinary tract infection (UTI). Review of the resident's urine culture lab report revealed: collection date 06/06/2024; resulted and reviewed on 06/08/2024 .urine culture positive for Escherichia coli. Review of the resident's physician telephone orders for June 2024 revealed the following: 06/06/2024 Rocephin 1g (gram) IM (intramuscularly) QD (every day) x3 days pending C&S (urine culture and sensitivity) results. 06/08/2024 continue Rocephin 1g IM q (every) day for 4 more days. 06/13/2024 Rocephin 1 GM (gram) IM x3 days Review of the resident's eMAR for June 2024 revealed Ceftriaxone (Rocephin) 1 gm IM was marked as not administered 06/14/2024. On 06/18/2024 at 3:30 p.m., an interview was conducted with Resdient #71's nurse, S11LPN (Licensed Practical Nurse). She stated Resident #71 had a UTI and was prescribed the antibiotic Rocephin for treatment. She reviewed the resident's eMAR but could not find documentation that the resident received all 7 doses of the antibiotic as prescribed. On 06/18/2024 at 3:54 p.m., an interview and review of Resident #71's medication administration was reviewed with S7RCE (Regional Clinical Educator) who confirmed the resident did not receive a dose of Rocephin on 06/14/2024 as prescribed. Review of the medication administration history report revealed a note entered by S8LPN that read ceftriaxone 1gm vial give 3cc IM x 3 doses scheduled for 6/14/24 5:00 pm was not administered - other. cbg wnl (capillary blood glucose within normal limits) 6/14/24 5:31 p.m. S7RCE stated S8LPN charted in error and that the reason the resident did not receive the antibiotic was not accurately documented. S2DON (Director of Nursing) was present at this time and reviewed the resident's record in question. S2DON and S7RCE stated they were unsure if S8LPN administered the dose of Rocehpin and confirmed the resident's medication administration record was inaccurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/18/2024 at 4:21 p.m., an interview was conducted with S8LPLN who stated she did not administer Resident #71's dose of Rocephin on 06/14/2024 because the resident was transferred to the emergency room (ER) for evaluation. The resident did not return to the nursing home until after 6:00 p.m., after her shift ended. S8LPN reviewed the note she entered in the resident's medication administration record and confirmed she charted in error and did not enter the correct reason the resident did not receive the dose on her shift. S8LPN further reviewed the resident's record and progress notes and confirmed there was no documentation the resident received the dose of Rocephin upon return from the hospital. On 06/18/2024 at 4:31 p.m., S2DON stated Resident #71 returned from the hospital on 06/14/2024, but she was not sure of what time. A review of Resident #71's progress notes and skilled nursing notes for 06/14/2024 were conducted with S2DON and S7RCE which failed to reveal documentation of the exact time the resident returned from the hospital. Review of the resident's skilled notes revealed an assessment dated [DATE] at 9:37 p.m. There was no documentation the night nurse administered the dose of Rocephin on 06/14/2024. On 06/18/2024 at 4:51 p.m., S2DON and S7RCE stated S12LPN was Resident #71's nurse on the night shift on 06/14/2024. S12LPN reported to them that she administered Resident #71's dose of Rocephin on 06/14/2024 when the resident returned to the nursing home, but confirmed she failed to document it the resident's record. On 06/20/2024 at 9:11 a.m., a phone interview was conducted with S12LPN who stated she administered Resident #71's dose of Rocephin on 06/14/2024 upon the resident's return from the hospital. She stated that she failed to document the administration in the resident's record immediately after administering the drug to the resident per the facility's policy.