STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195556	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Retirement & Rehab Ctr, L L C	635 Schley Street Mansfield, LA 71052

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 40193 Based on record review and interview, the facility failed to transmit within 7 days after a completed resident's assessment for 1 (#118) resident out of 31 sampled residents reviewed. Findings: Review of Resident #118's medical records revealed an admitted [DATE] with the following diagnoses, including in part: hypertensive heart disease without heart failure, obesity/unspecified, anemia/unspecified, and insomnia/unspecified. Review of Resident #118's MDS (Minimum Data Set) assessment dated [DATE] revealed the status was in progress. During an interview on 02/19/2025 at 9:30 a.m. S4 MDS acknowledged Resident #118's MDS assessment dated [DATE] was completed but had not been transmitted and it should have been.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39897 Based on record review and interview the facility failed to ensure resident's assessments accurately reflected the resident's status during the observation period for 3 (#5, #21, #50) of 18 (#5, #15, #21, #22, #24, #28, #35, #38, #41, #43, #49, #50, #58, #63, #66, #67, #118, #119) residents reviewed for assessment. The facility failed to ensure the MDS (Minimum Data Set) were coded accurately for restraints and use of bedrails. Findings: Resident #5 Review of Resident #5's medical record revealed an admitted [DATE] with diagnoses that include in part, major depressive disorder, anxiety disorder, pain and paranoid schizophrenia. Review of Resident 5's physician orders revealed an order dated 7/27/2024: 1/4 side rails up times 2 to assist with bed mobility Review of the Resident #5's MDS dated [DATE] revealed Resident #5 had a BIMS (Brief interview for mental status) score of 6 out of 15 indicating severely impaired mental cognition. Further review revealed Resident #5 was impaired on one side to upper and lower extremities and required extensive 1 person physical assistance for bed mobility. Review of Resident #5's MDS indicated bed rails were not in use. Resident #21 Review of Resident #21's medical record revealed an admitted [DATE] with diagnoses that include in part, transient cerebral ischemic attack, malignant neoplasm of unspecified site of right female breast, rheumatoid arthritis, and history of falling. Review of Resident 21's physician orders revealed an order dated 7/27/2024: 1/4 rails to aide in bed mobility. Review of Resident #21's quarterly MDS dated [DATE] revealed Resident #21 had a BIMS score of 11 out of 15 indicating moderate cognitive impairment. Further review revealed Resident #21 was dependent for toileting, and hygiene. Review of Resident #21's MDS indicated bed rails were not in use. Resident #50 Review of Resident #50's medical record revealed an admitted [DATE] with diagnoses that include in part parkinsonism, schizoaffective disorder, dementia-severe with agitation, major depressive disorder and chronic kidney disease stage 3B. Review of Resident #50's physician orders revealed an order dated 12/30/2024: enablers times 2 to aide in bed mobility and safety. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #50's annual MDS dated [DATE] revealed Resident #50 had a BIMS score of 10 out of 15 indicating moderate cognitive impairment. Further review revealed Resident #50 required limited 1 person assistance with bed mobility and transfers with substantial maximum assistance with toileting. Review of Resident #50's MDS indicated bed rails were not in use. During an interview on 02/19/2025 at 11:40 a.m. S4MDS reviewed Resident #5, Resident #21 and Resident #50's physician orders and MDS assessments for restraints and verified it did not include the use of bedrails and should have.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on record review and interview, the facility failed to develop and implement a baseline care plan within 48 hours of admission for 1 (#119) resident out of 31 sampled residents reviewed. Findings: Review of Resident #119's medical records revealed an admitted [DATE] with the following diagnoses, including in part: unspecified protein-calorie malnutrition, generalized anxiety disorder, undifferentiated schizophrenia, unspecified dementia with agitation, anorexia, other specified extrapyramidal and movement disorders, major depressive disorder/recurrent/moderate, impulsive disorder/unspecified, and gastrostomy status. Review of Resident #119's medical record failed to reveal a baseline care plan was completed on admission. During an interview on 02/19/2025 at 9:30 a.m. S4 MDS (Minimum Data Set) acknowledged Resident #119 did not have a baseline care plan developed on admission and should have.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40193 Based on record reviews and interview, the facility failed to develop a comprehensive person- centered care plan to meet the resident's medical, nursing and mental and psychosocial needs for 2 (#28, #118) out of 31 sampled residents reviewed. Findings: Resident #28 Review of Resident #28's medical records revealed an admitted [DATE] with the following diagnoses, including in part: chronic obstructive pulmonary disease/unspecified, type 2 diabetes mellitus without complications, acquired absence of left leg below knee, peripheral vascular disease/unspecified, unspecified lack of coordination, personal history of other venous thrombosis and embolism, transient ischemic attach (TIA), cerebral infarction without residual deficits and unspecified abnormalities of gait and mobility. Review of Resident #28's comprehensive care plan failed to include problems and approaches for oxygen therapy, type 2 diabetes mellitus, hypertension,activities of daily living self-care deficit, impaired mobility/amputation, anticoagulant therapy, unsafe smoker and diuretic use. During an interview on 02/19/2025 at 9:30 a.m. S4 MDS acknowledged Resident #28's comprehensive care plan did not include oxygen therapy, type 2 diabetes mellitus, hypertension, activities of daily living self-care deficit, impaired mobility/amputation, anticoagulant therapy, unsafe smoker and diuretic use and should have. Resident 118 Review of Resident #118's medical records revealed an admitted [DATE] with the following diagnoses, including in part: hypertensive heart disease without heart failure, obesity/unspecified, anemia/unspecified, and insomnia/unspecified. Review of Resident #118's comprehensive care plan failed to problem and approaches for include nutrition, hypertension, insomnia and anemia. During an interview on 02/19/2025 at 9:30 a.m. S4 MDS (Minimum Data Set) acknowledged Resident #118's comprehensive care plan was not complete and did not include nutrition, hypertension, insomnia and anemia and should have.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36665 Based on record review, observations, and interviews the facility failed to ensure a resident who is unable to carry out ADLs (activities of daily living) received the necessary services to maintain good grooming and personal hygiene for 2 (#43, #63) of 5 (#28, #38, #43, #63, #119) residents reviewed for activities of daily living. The facility failed to ensure residents received nail care. Findings: Review of the facility's Nail Care Policy (un-dated) provided by S2 DON on 02/19/2025 revealed the following: The purpose of this policy is to provide guidelines for the provision of care to a resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines: 1. Routine cleaning and inspection of nails will be provided during activities of daily living care on an ongoing basis. 2. Routine nail care, to include trimming and filing, will be provided by nurse on a regular schedule per care plan unless contraindicated. Nail care will be provided between scheduled occasions as the need arises. 3. Principles of Nail care: a. Nails should be kept smooth to avoid skin injury b. Only licensed nurses shall trim or file fingernails of residents with diabetes. Toenails of residents with diabetes or circulation problems should only be filed only. c. If a resident has a toe infection, diabetes mellitus, neurologic disorders, renal failure, or PVD (peripheral vascular disease), toenail trimming should be performed by a physician or practitioner. Resident #43 Review of Resident #43's medical record revealed an admitted [DATE] with a diagnosis of but not limited to cerebrovascular disease affecting left non-dominant, heart failure, epilepsy, chronic atrial fibrillation, and end stage renal disease. Review of Resident #43's MDS (Minimum Data Set) revealed resident #43 was assessed to have a BIMS (Brief Interview Mental Status) score of 11 indicating moderately impaired cognition. Further review revealed resident #43 was assessed to be dependent and required assistance to complete bathing, dressing/grooming, and using the toilet. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #43's Comprehensive Care Plan revealed the following: Imapired Physical Mobility related to a diagnosis cerebrovascular accident with left sided hemiplegia: resident requires extensive assistance with bed mobility and dressing/grooming tasks. Observation on 02/17/2025 at 11:30 a.m. with S2 DON revealed Resident #43's fingernails had a brown colored substance underneath the nails and protruded past the nail bed on both hands. During an interview on 02/17/2025 at 11:30 a.m. in the presence of S2 DON, Resident #43 answered, Yes when asked do you want your fingernails trimmed? During an interview on 02/18/2025 at 2:00 p.m. S2 DON confirmed resident #43's fingernails should have been trimmed. Resident #63 Review of Resident # 63's medical record revealed an admitted [DATE] with diagnoses of but not limited to wedge compression fracture of T5-T6 vertebra, subsequent encounter for fracture with routine healing, need for assistance with personal care, unspecified lack of coordination, and generalized muscle weakness. Review of Resident #63's Quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Review of Resident #63's Comprehensive Care Plan revealed Resident #63 had impaired mobility with interventions to assist with ADL's as needed. Observation on 02/17/2025 at 9:30 a.m. revealed Resident #63's toenails were long and had grown over the nail bed. During an interview on 02/17/2025 at 9:30 a.m. Resident #63 reported she did not like her toe nails that long. Observation of Resident #63's toenails with S5 LPN on 02/18/2025 at 3:45 p.m. revealed Resident #63's toe nails were long and grown over the nail bed. During an interview on 02/18/2025 at 3:45 p.m. S5 LPN confirmed Resident #63's toe nails were long and needed to be trimmed. 36921

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36921 Based on record reviews, observations, and interviews, the facility failed to ensure 1 (#49) of 1 resident reviewed for limited range of motion received treatment and care in accordance with professional standards of practice by failing to follow physician orders for a palm protector for Resident #49's right contracted hand, accurately assess Resident #49's limitation in range of motion and for refusals of care and services and ensure Resident #49's fingernails were trimmed. Findings: Review of Resident #49's face sheet revealed an initial admitted [DATE] and a re-entry admitted [DATE] with the following diagnoses but not limited to end stage renal disease, hypertensive heart disease without heart failure, and major depressive disorder. Review of Resident #49's February 2025 physician orders dated 11/05/2024 for palm protector to right hand as tolerated and to monitor skin integrity to right hand every day for signs and symptoms of status change related to palm protector use; one time a day for prevention. Review of Resident #49's Quarterly MDS (Minimum Data Sets) dated 12/28/2024 revealed a BIMS (Brief Interview of Mental Status) of 11 out of 15 indicating moderately impaired cognition. Review of Resident #49's Quarterly MDS failed to reveal Resident #49 rejected care. Further review of Resident #49's Quarterly MDS revealed Resident #49 had no limitation in range of motion to upper and lower extremities. Review of Resident #49's care plan revealed the Resident #49 has limited physical mobility with a goal to remain free of complications related to immobility, including contractures and was at risk for impaired skin integrity related to history of skin breakdown, altered cognition, decreased mobility and poor circulation with interventions to monitor skin integrity every day related to usage of right hand palm protector; palm protector to right hand as tolerated. Further review of Resident #49's medical record failed to reveal refusal of care or attempts of wearing the palm protector to the right hand. Observation of signage above Resident #49's bed revealed: Put my palm protector on right hand. Observation on 02/17/2025 at 3:00 P.M. failed to reveal the palm protector on Resident #49's contracted right hand. Observation on 02/18/2025 at 3:45 P.M. with S5 LPN (Licensed Practical Nurse) failed to reveal the palm protector on Resident #49's contracted right hand. Further observation revealed S5 LPN attempted to open Resident #49's tightly closed hand to assess his palm revealed Resident #49 grimaced and said ouch. Observation when S5 LPN slightly opened Resident #49's hand revealed discolored, thick and long fingernails had grown over the nail bed. During an interview on 02/18/2025 at 3:45 P.M. Resident #49 reported he did not wear the palm protector on his right palm. Resident #49 further reported he did not know where the palm protector was. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/18/2025 at 3:45 P.M. S5 LPN reported Resident #49 wears the palm protector sometimes and refuses sometimes, but was unable to recall the last time Resident #49 actually wore the palm protector. S5 LPN was unable to locate Resident #49's palm protector. S5 LPN reported Resident #49's care plan should be updated after MDS reviewed the nurses daily charting and morning meetings to see how often Resident #49 refused care/palm protector. S5 LPN acknowledged Resident #49's fingernails were long and had grown over the nail bed and could cause skin breakdown in Resident #49's contracted hand.

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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** 40193 Based on observations, interviews and record reviews the facility failed to provide residents necessary respiratory care and services in accordance with accepted professional standards of practice for 1 (#28) out of 1 (#28) residents reviewed for respiratory care. The facility failed to ensure oxygen concentrator filter was cleaned weekly. Findings: Review of Facility's Respiratory Equipment - Infection Control Guidelines dated June 2024 revealed: Oxygen concentrators, nebulizers, suction machines. The nursing department is responsible for all the following except: 3. Housekeeping will be responsible to clean oxygen concentrator filters weekly. Oxygen concentrators: 4. Rinse filters from oxygen concentrators weekly in water. Squeeze dry and return to use. Review of Resident #28 medical records revealed an admitted [DATE] with the following diagnoses, including in part: chronic obstructive pulmonary disease (COPD)/unspecified. Review of Resident #28 Physician's orders revealed an order dated 01/20/2025 for O2 (oxygen) at 2 liters/NC (nasal cannula) PRN (as needed) shortness of breath or O2 sat (saturation) < 90% every 1 hours related to chronic obstructive pulmonary disease/unspecified. Observation on 02/17/2025 at 8:30 a.m. revealed Resident #28 wearing continuous oxygen at 2 liters per minute via nasal cannula. Further observation revealed oxygen concentrator filter with moderate amount of fluffy gray particles. Observation on 02/17/2025 at 2:45 p.m. revealed Resident #28 wearing continuous oxygen via nasal cannula. Further observation revealed oxygen concentrator filter with moderate amount of fluffy gray particles Observation on 02/18/2025 at 9:20 a.m. revealed Resident #28 lying asleep in bed wearing continuous oxygen via nasal cannula. Further observation revealed oxygen concentrator filter with moderate amount of fluffy gray particles. During an interview on 02/18/2025 at 9:30 a.m. S3 LPN (Licensed Practical Nurse) acknowledged Resident #28's oxygen concentrator filter was dirty and should have been cleaned. During an interview on 02/18/2025 at 9:30 a.m. S2 DON (Director of Nursing) acknowledged Resident #28's oxygen concentrator filter was dirty.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36665 Based on observations, record review and interviews the facility failed to ensure correct use and maintenance of bed rails by ensuring residents were accurately assessed for the risk of entrapment from bed rails and an informed consent was obtained from resident or resident representative prior to installation for 2 (#43, #63) of 5 (#5, #21, #41, #43, #63) residents reviewed for bed rails. Findings: Review of the facility's Bed Rail policy (undated) revealed the following: If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails including but not limited to the following elements: a. assess the resident for risk for entrapment from bed rails prior to installation b. review risk an benefits of bed rails with the resident size and weight c. the facility must document in the residents care plan specific interventions and services for use of a bed rail. Resident #43 Review of Resident #43's medical record revealed an admitted [DATE] with a diagnosis of but not limited to cerebrovascular disease affecting left non-dominant, heart failure, epilepsy, chronic atrial fibrillation, and end stage renal disease. Review of Resident #43's MDS (Minimum Data Set) revealed resident #43 was assessed to have a BIMS (Brief Interview Mental Status) score of 11 indicating moderately impaired cognition. Further review revealed Resident #43 was assessed to be dependent and required two person assistance with bed mobility. Observation on 02/17/2025 at 8:30 a.m. revealed Resident #43 had bilateral bed rails on his bed. Observation on 02/18/2025 at 4:00 p.m. revealed Resident #43 in bed with both bed rails up. Review of Resident #43's Comprehensive Care Plan failed to reveal a problem with interventions specific for bed rail use. Review of Resident #43's Medical Record failed to reveal a signed consent for bed rail use. Resident #63 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident # 63's medical record revealed an admitted [DATE] with diagnoses of but not limited to wedge compression fracture of T5-T6 vertebra, subsequent encounter for fracture with routine healing, need for assistance with personal care, unspecified lack of coordination, and generalized muscle weakness. Review of Resident #63's Quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Further review revealed Resident #63 was assessed to require 1/4 (quarter) side rails up times two to assist with bed mobility. Observation on 02/17/2025 at 9:30 a.m. revealed Resident #63 had raised quarter side rails to both sides of the bed. Review of Resident #63's Comprehensive Care Plan failed to reveal a problem with interventions specific for quarter side rail use. Review of Resident #63's medical record failed to reveal a signed consent for the use of quarter side rails. Further review of Resident #63's medical record failed to reveal an assessment for risk for entrapment was done prior to installation of quarter side rails. During an interview on 02/19/2025 at 9:45 a.m. S2 DON (Director of Nurses) confirmed resident #43 and Resident #63's care plan did not a problem with interventions specific for bedrail use and did not have a signed consent for bed rail use. S2 DON also confirmed Resident #63 did not have a risk for entrapment assessment done prior to installation of bed rails. 36921 39897

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 36921 Based on record reviews, observations and interviews, the facility failed to ensure nursing staff provided nursing services to assure residents maintained the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by individual plans of care. The facility failed to ensure medication was administered prior to documentation of medication for Resident #24 and proper storage of medication for Resident #26. Findings: Resident #24 Observation of medication administration on 02/17/2025 at 3:38 P.M. revealed S3 LPN (License Practical Nurse) administered Sucralfate 1gm to Resident #24. Review of Resident #24's EMAR (electronic medication administration record) revealed S3 LPN signed off on 4:30 P.M. administration of 8 units of Humalog (Insulin Lispro) per sliding scale. During an interview on 02/17/2025 at 3:50 P.M. S3 LPN reported she had not administered Humalog (Insulin Lispro) to Resident #24 that was due at 4:30 P.M. S3 LPN reported Resident #24's blood sugar was 310 when checked earlier. S3 LPN further reported Resident #24 would require 8 units of Humalog (Insulin Lispro) that would be administered closer to meal time. During an interview on 02/19/2025 at 11:40 A.M. S2 DON (Director of Nursing) confirmed medications should not be documented in the EMAR (Electronic Medication Administration Record) until they are actually given. Resident #26 Observation of medication administration on 02/18/2025 at 8:45 A.M. with S5 LPN revealed Resident # 26's Fluticasone-Salmeterol Inhaler Aerosol 115-21 MCG (microgram) medication was not available on the medication cart. Further observation revealed Fluticasone-Salmeterol Inhaler Aerosol 115-21 MCG was in Resident #26's room. During an interview on 02/28/2025 at 8:45 A.M. S5 LPN confirmed Fluticasone-Salmeterol Inhaler Aerosol 115-21 MCG should be stored on the medication cart and not in Resident #26's room. During an interview on 02/19/2025 at 11:40 AM S2 DON reported Resident # 26 did not have an order for self-administration of Fluticasone-Salmeterol Inhaler Aerosol 115-21 MCG and should not have been kept in Resident # 26's room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195556	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desoto Retirement & Rehab Ctr, L L C	635 Schley Street Mansfield, LA 71052

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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 36921 Based on record review, observations and intreviews, the facility failed to provide current pharmaceutical services to meet the needs of each resident as evidenced by having expired medications available for resident use on 2 of 2 medication carts in the facility. Findings: Review of facility's policy for Medications - Administering (not dated) revealed: Policy statement: Medications shall be administered in a safe and timely manner, and as prescribed. Expiration/Beyond Use Dates: 9. The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. Observation of the Medication Cart 1 for Hall 1 on 02/17/2025 at 10:15 A.M. with S5 LPN (Licensed Practical Nurse) revealed Vitamin D 25 mcg (microgram) had a best used by date of 01/2025. During an interview on 02/17/2025 at 10:15 A.M. S5 LPN confirmed Vitamin D 25 mcg was expired and should not have been available on the medication cart for usage. Observation of the Medication Cart for Hall 2 on 02/17/2025 at 10:25 A.M. with S3 LPN revealed Vitamin D 25 mcg had a best used by date of 01/2025. During an interview on 02/17/2025 at 10:25 A.M. S3 LPN confirmed Vitamin D 25 mcg was expired and should not have been available on the medication cart for usage. During an interview on 02/19/2025 at 1:45 P.M. S2 DON (Director of Nursing) reported the facility medication carts should have been checked at the end of each month and expired medications should have been discarded.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36921 Based on record reviews, observations and interviews, the facility failed to ensure staff practices were consistent with current infection control principles and practices to prevent infection and cross contamination. The facility failed to ensure (1) incontinence care was provided in a sanitary manner for Resident #62 that was observed for incontinence, and (2) proper storage of patient equipment Findings: Review of facility's Incontinence Care policy (undated) revealed: Equipment and Supplies: 2. wash basin; wash clothes 3. Incontinent brief (disposable or cloth) 4. non-drying soap and water and/or incontinence spray cleaner (periwash) 6. plastic bag for soled linen Steps in Procedure: 3. Fill the wash basin with warm water. (Note: If a premixed solution is used, run warm water over the container to assure that the solution is warm). 5. Place plastic bag within reach to hold soiled linen and laundry. 11. Place disposable items into special waste container. 13. Remove gloves and discard into appropriate receptacle. 15. wash hands 1. Review of Resident #62's face sheet revealed an admitted [DATE] with unspecified macular degeneration, and hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side. Review of Admission MDS (Minimum Data Sets) dated 11/25/2024 revealed a BIMS (Brief Interview of Mental Status) of 10 out of 15 indicating moderately impaired cognition. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #62's baseline care plan revealed Resident #62 required extensive assistance to total assistant with grooming and hygiene. Observation of incontinence care on 02/19/2025 at 9:36 A.M. revealed S6 CNA (Certified Nurse Assistant) performed incontinence care on Resident #62. Further observation revealed before S6 CNA entered Resident #62's room she stopped by the linen cart and retrieved three towels and a draw pad used to protect the bed during incontinent episodes. S6 CNA then put on gloves and placed one small bath towel, and draw pad on Resident #62's over bed table along with Resident #62's personal items that were already on the over bed table. S6 CNA went into Resident #62's bathroom to wet the towels and apply soap. S6 CNA then placed the two wet towels on Resident #62's over bed table. S6 CNA performed perineal care to Resident #62 with one of the wet towels then dried the perineal area and placed the used towel on Resident #62's over bed table. S6 CNA then proceeded to clean the perineal area with the second wet towel and placed the used towel on Resident #62's over bed table. S6 CNA assisted Resident #62 in turning to his right side. S6 CNA then removed Resident #62's incontinence brief and placed the used incontinence brief on the floor. S6 CNA then reused the towels that were placed on Resident #62's over bed table that were used to clean Resident #62's perineal area to clean Resident #62's buttocks and rectal area. After cleaning Resident #62's buttocks and rectal area and removing the dirty incontinence brief and draw pad, S6 CNA placed the dirty incontinence brief, draw pad and towels that were used during incontinent care on the floor. S6 CNA then placed a clean incontinence brief on Resident #62 and a clean draw pad under Resident #62. Further observation revealed S6 CNA then lowered Resident #62's bed using bed remote, pulled the string to turn off the lights over Resident #62's bed, pulled the curtain, opened the door touching the door knob with the same gloves that were used to provide incontinence care to Resident #62. During an interview on 02/19/2025 at 2:44 P.M. S2 DON (Director od Nursing) reported dirty incontinence briefs and dirty linen should not have been placed on Resident #62's overbed table or on the floor. During an interview on 02/19/2025 at 2:58 P.M. S7 LPN (Licensed Practical Nurse)/CNA Instructor reported S6 CNA should have used a water basin to provide incontinence care. S7 LPN/CNA Instructor reported dirty linen used during incontinence care should have been placed in a trash bag or pillow case. S7 LPN/CNA Instructor reported S6 CNA should have changed gloves at appropriate times during and after incontinence care before touching Resident #62's personal items to prevent cross contamination. 2. Observation on 02/17/2025 at 9:00 A.M. of the secured unit revealed a water cooler with ice used for resident drinking was stored in an occupied resident's room. During an interview on 02/17/2025 at 9:15 A.M. S8 CNA confirmed the water cooler with ice was stored in an occupied resident's room at this time. S8 CNA reported there is no where else to store the water cooler on the secured unit. During an interview on 02/19/2025 at 3:50 PM S2 DON reported there were 19 residents on the locked unit. S2 DON further reported the water cooler with ice for residents on the secured unit should be stored on the hallway and not in a resident's room.