STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195618	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 44269 Based on observation and interview, the facility failed to ensure the most recent survey results of the facility were posted in a place readily accessible to residents, family members, and legal representatives of residents. Findings: A review of the previous surveys conducted in the facility during the last 3 years revealed the following: Complaint survey had been conducted on 04/11/2023 and Recertification surveys had been conducted on 03/22/2023 and 02/23/2022. On 04/02/2024 at 10:58 a.m., an observation was made of a clear plastic file holder mounted to the wall outside of a closed office door near the facility's main entrance. A brown colored binder folder labeled LDH (Louisiana Department of Health) DHH (Department of Health and Hospitals) Licensing survey was observed inside the plastic file holder and inside the binder were survey results and plan of correction from the annual surveys conducted on 03/22/2023 and 02/23/2022. There was no evidence of the most recent survey results which was a complaint survey conducted on 04/11/2023. On 04/02/2024 at 1:05 p.m., S1ADM (Administrator) accompanied surveyor to the facility's designated area to post survey results, near the front entrance and The Director of Nurses Office. S1ADM stated the brown binder folder labeled LDH DHH Licensing survey was available for the public to review and contained the results from the most recent surveys. S1ADM confirmed the only survey results present in the binder were from the annual surveys conducted on 03/22/2023 and 02/23/2022. S1ADM further confirmed there was no results of the most recent survey, which was a complaint survey, conducted on 04/11/2023.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47965 Based on observation and interview, the facility failed to provide a homelike environment for 1 (#30) out of 2(#17, #30) residents investigated for environment, out of a total sample of 31 residents. Findings: Resident #30 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Acute Embolism and Thrombosis of Unspecified Deep Veins of Left Lower Extremity, and Moderate Protein Calorie Malnutrition. On 04/01/2024 at 9:15 a.m., an observation was made of Resident #30's bathroom. A copper colored stain was observed from the base of the left faucet into the left side of the bathroom sink. There was also a copper colored stain around the knob on the right base of the toilet spreading outward, and a large paint blister on the wall on the left side of the toilet. Further observation revealed a moderate build-up of dust on the vent in the ceiling of the bathroom. On 04/02/2024 at 3:31 p.m., a second observation was made of the resident's bathroom. The copper colored stains remained on the sink and toilet. The large paint blister and dust covered vent were also still present. On 04/02/2024 at 3:40 p.m., an interview and observation of the resident's bathroom was conducted with S9HMS (Housekeeping/Maintenance Supervisor). She confirmed the findings of the copper colored stain on the bathroom sink and around the knob on the right base of the toilet. She also confirmed the large paint blister on the wall beside the resident's toilet and dust build-up on the vent in the ceiling. S9HMS stated it was unacceptable and should not be like that.

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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** 17364 Based on observations, record reviews and interviews, the facility failed to develop a comprehensive plan of care for 2 (#13 and #17) out of 3 (#13, #15, #17) residents investigated for care planning out of a total sample of 31 residents, by failing to: 1. Address Resident #13 family's refusal for use of a proper positioning device. 2. Address Resident #17's limited range of motion. Findings: Resident #13. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnosis included Alzheimer's disease. Review of the resident's care plan revealed the resident used a wheelchair for mobility. On 04/01/24 9:45 a.m., the resident was observed slouched down in her high back wheelchair in the dining room. On 04/01/2024 at 11:57 a.m., S10CNA (Certified Nursing Assistant) began feeding the resident lunch at the dining room table. The resident was observed slouched down in her high back wheelchair while the CNA was feeding the resident. On 04/02/2024 at 8:20 a.m., the resident was observed in her high back wheelchair. The resident was observed positioned slouched down in the wheelchair at the dining room table. S11CNA was observed feeding the resident breakfast. An interview was conducted with S11CNA during this observation. She stated the resident was low and slouched down in the wheelchair. She stated that they try to sit her up higher but the resident continues to slide down in the wheelchair. On 04/02/2024 at 8:30 a.m., an interview was conducted with S2DON (Director of Nursing). She observed the resident sitting up in her high back wheelchair at the dining room table for breakfast. She stated that she was aware the resident sits low and slouched down in the high back wheelchair. She stated that the wheelchair was too big for the resident and that the resident's family insists that the resident sit in the high back wheelchair. On 04/02/2024 at 9:10 a.m., an interview was conducted with S4MDSC (Minimum Data Set Coordinator). She stated that the high back wheelchair was not the appropriate size for the resident but that the resident's family wants the resident to use it. Review of the resident's care plan revealed that there was no evidence the family insisted the oversized high back wheelchair be used for the resident. S4MDSC reviewed the resident's care plan and confirmed that the family insistence on using the oversized high back wheelchair was not in the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/2024 at 9:15 a.m., an interview was conducted with S2DON (Director of Nursing). She confirmed that the resident's family insistence on using the oversized high back wheelchair was not addressed in the care plan. 47965 Resident #17 Resident #17 was admitted to the facility on [DATE] with diagnoses including, but were not limited to, Parkinson's Disease, Muscle Weakness, Repeated Falls, and Contracture Right Hand. A review of Resident #17's quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 01/24/2024, revealed in section GG in part, Functional limitation in range of motion - upper extremity. Functional limitation in range of motion - lower extremity. A review of the resident's current plan of care revealed that she was not care planned for limited range of motion. On 04/02/2024 at 8:45 a.m., an observation was made of resident #17 in her bed. The resident's right hand was clenched in a fist without a hand roll. The resident was asked if she could open her hand and she attempted but was only able to move her right index finger. The resident stated she did not have a hand roll and no one came in to exercise her hand. On 04/02/2024 at 8:50 a.m., an interview was conducted with S19CNA (Certified Nursing Assistant). She stated that she has been working at the facility since July of 2023. She further stated that she has never seen a hand roll in the resident's hand. On 04/02/2024 at 2:58 p.m., an interview was conducted with S4MDSC (Minimum Data Set Coordinator). She confirmed that the resident was not care planned for limited range of motion, and should have been because the problem existed at the time the comprehensive care plan was completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 Based on record review, review of the facility's policy and procedure, and interviews, the facility failed to develop a comprehensive person-centered care plan within 7 days of the completion of the required comprehensive assessment MDS (Minimum Data Set) for 5 (Resident #4, 12, 16, 21, and 31) out of 5 (Resident #4, 12, 16, 21, and 31). The final sample size was 31. Findings: Resident #4 Review of Resident #4's record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Hepatitis A Without Hepatic Coma, Type 2 Diabetes Mellitus, Chronic Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease. Review of Resident #4's Annual MDS with an ARD (Assessment Reference Data) of 03/05/2024. Further review of Resident #4's EHR (Electronic Health Record) failed to reveal a compressive person-centered care plan. Resident #12 Review of Resident #12's record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Type 2 Diabetes Mellitus, Heart Failure, and Schizoaffective Disorder, and Acute Kidney Failure. Review of Resident #12's Annual MDS with an ARD of 02/21/2024. Further review of Resident #12's EHR failed to reveal a compressive person-centered care plan. Resident #16 Review of Resident #16's record revealed he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, and Anxiety Disorder. Review of Resident #16's Annual MDS with an ARD of 02/23/2024. Further review of Resident #16's EHR failed to reveal a compressive person-centered care plan. Resident #31 Review of Resident #31's record revealed she was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Depression, Chronic Pain Syndrome, and Hypertension. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #31's Annual MDS with an ARD of 03/15/2024. Further review of Resident #31's EHR failed to reveal a compressive person-centered care plan. 41868 Resident #21 Review of Resident #21's clinical record revealed she was admitted to the facility on [DATE] with diagnoses which included Depression, Spinal Stenosis, Tachycardia, Type 2 Diabetes Mellitus, Hypertension, Dementia, and Congestive Heart Failure. Review of Resident #21's Admission MDS assessment with an ARD of 03/01/2024, revealed a completion date of 03/05/2024. Further review of Resident #21's EHR failed to reveal a comprehensive person-centered care plan. On 04/02/2024 at 1:18 p.m., an interview was conducted with S4MDSC (Minimum Data Set Coordinator). S4MDSC confirmed that Resident #4, 12, 16, 21, and 31's comprehensive care plan was not developed and it supposed to be completed. She stated she has not had the time to develop the comprehensive care plans and is months behind.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17364 Based on record review and interview, the facility failed to ensure each resident with pressure ulcers received the necessary treatment and services to promote healing as evidenced by the staff failing to assess and provide treatment for an identified pressure ulcer for 1 (#13) out of 31 sampled residents. Findings: Resident #13. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnosis included Alzheimer's Disease. Review of the resident's Braden Risk assessment dated [DATE] revealed the resident was assessed as a high risk for pressure ulcer development. Review of the resident's weekly skin inspection on 01/15/2024 revealed the resident's skin was intact. Review of the resident's weekly skin inspection on 01/22/2024 revealed the resident's skin was not intact. Review of the resident's electronic clinical record revealed that there was no evidence that an assessment of a pressure ulcer or wound was done on 01/22/2024. Review of the resident's Wound Assessment note dated 01/25/2024 revealed a pressure ulcer was identified to left medial malleolus stage 3. It was documented as a new wound. Measurements were 2.90 cm (centimeter) x 2.10 cm x 0.10 cm. There was serosanguineous moderate drainage. The wound bed was noted with granulation tissue 70% and slough 30% and surrounding tissue pink with slight edema. On 04/02/2024 at 11:10 a.m., an interview was conducted with S3ADONIP (Assistant Director of Nursing Infection Preventionist). She stated that she identified the pressure ulcer to the resident's left medial malleolus on 01/22/2024. She confirmed that she could not provide evidence that an assessment of the pressure ulcer was done on 01/22/2024. S3ADONIP confirmed that an assessment of the pressure ulcer was done on 01/25/2024 and it was a stage 3, which was 3 days after it was identified by S3ADONIP. On 04/02/2024 at 12:25 p.m., an interview was conducted with S2DON (Director of Nursing). She stated that she does not remember if S3ADONIP informed her of the resident's stage 3 pressure ulcer on 01/22/2024. She confirmed that there was no evidence that an assessment of the pressure ulcer was done on 01/22/2024. S2DON stated that an assessment should have been done when the pressure ulcer was identified and not 3 days later.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17364 Based on observation, record review and interview, the facility failed to ensure each resident receives adequate supervision and assistance to prevent falls for 1 (#42) out of 2 (#40, #42) sampled residents investigated for falls out of a total sample of 31 residents. Findings: Resident #42. Review of the resident's electronic clinical record revealed the resident was admitted to the facility on [DATE]. The resident's diagnosis included Unspecified Dementia with other Behavioral Disturbance. Review of the resident's quarterly MDS (Minimum Data Set) dated 01/31/2024 revealed the resident's BIMS (Brief Interview Mental Status) score was 3 for severely impaired for cognition. Also, the quarterly MDS revealed the resident was coded for bed and chair alarm daily. Review of the resident's care plan revealed that it addressed falls. Bed and chair alarms were both interventions to prevent falls. On 04/02/2024 at 2:00 p.m., the resident was observed sitting up in wheelchair at dining room table. The resident was observed not to have a chair alarm attached to the wheelchair during this observation. On 04/02/2024 at 2:10 p.m., an interview was conducted with S12CNA (Certified Nursing Assistant). She stated the resident has had falls and that the chair alarm was used to help prevent the resident from having falls. She confirmed the resident did not have the chair alarm attached to the wheelchair during this observation. On 04/02/2024 at 2:15 p.m., an interview and observation was conducted with S13CNA. She stated the resident has had falls and that the chair alarm was used to help prevent the resident from having falls. She confirmed the resident did not have the chair alarm attached to the wheelchair during this observation. Review of the resident's progress note dated 01/06/2024 at 12:27 a.m. revealed, Writer summoned to resident's room. Resident found lying on left side with LE (lower extremity) flexed, pillow under LE and blanket underneath resident's head . When asked, resident reports that she was just trying to get out of the bed and ended up on the floor . Review of the resident's Incident Investigation dated 01/06/2024 at 12:27 a.m. revealed, Upon investigation, resident was in bed and rolled out found lying on left side . Alarm found to be malfunctioning and did not sound . Review of the resident's progress note dated 01/29/2024 at 7:57 a.m. revealed, Resident found on the floor on side of her bed. Resident present with skin tear to right forearm treated with basic first aid . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Incident Report dated 01/29/2024 at 7:05 a.m. revealed, Resident was discovered on the floor. Resident stated she was trying to go to the restroom. Resident present with a skin tear to the right forearm. There was no documentation the bed alarm was in place when resident was found on the floor. On 04/03/2024 at 9:05 a.m., an interview was conducted with S2DON (Director of Nursing). She reviewed the resident's investigation report for the fall that occurred on 1/6/2024 and confirmed that the resident's bed alarm was not functioning at the time of fall. On 04/03/2024 at 1:00 p.m., an interview was conducted with S3ADONIP (Assistant Director of Nursing Infection Preventionist). She reviewed the resident's investigation report for the fall that occurred on 01/29/2024 and confirmed that there was no evidence that the bed alarm was attached to the bed at the time of fall.

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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** 47540 Based on observations, record review and interviews the facility failed to properly store and label respiratory equipment for 2 (#9 and #16) out of 2 (#9 and #16) residents investigated for respiratory care. Findings: On 04/02/2024, a review of the facility's policy, Oxygen Administration, with a last reviewed date of 01/05/2024, revealed in part, the following, Policy: . All safety precautions and care of equipment shall be performed accord to recommended State and Federal guidelines and facility procedures. Prefilled humidifier bottles and nasal cannulas/mask will be changed every week and prn (as needed). All tubing and bottles are to be labeled each week when changed. When the tubing is not being used, it should be stored properly in a zip lock bag . Essential Points: There are multiple state and federal codes that address the storage, handling, and administration of oxygen. Procedures must be adhered to assure compliance with these codes . Resident #9 Review of Resident #9's health record revealed that he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Acute and Chronic Respiratory Failure With Hypoxia, Metabolic Encephalopathy, and Personal History of Malignant Neoplasm of Prostate. Review of Resident #9's most recent Annual Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) of 5, indicating his cognition was severely impaired. Section O: Special Treatments, Procedures and Programs checked for oxygen therapy. Review of Resident #9's physician's orders revealed an order dated 02/23/2024 that read, O2 (Oxygen) at 3 liters per NC (Nasal Cannula) PRN as needed below 90% and O2 sat (saturation) every shift keep O2 sat above 90% please on O2 PRN. Review of Resident #9's care plan revealed, at risk for SOB (Shortness of Breath) r/t (related to) Cancer, Respiratory Failure (receiving oxygen therapy prn). On 04/01/2024 at 8:50 a.m., an observation was conducted in Resident #9's room. Resident #9's oxygen tubing and humidifier was on the floor open to air and not labeled. On 04/01/2024 at 8:55 a.m., an observation and interview was conducted with S6LPN (Licensed Practical Nurse). S6LPN confirmed that Resident #9's oxygen tubing and humidifier was on the floor open to air and not labeled. She stated the oxygen tubing and humidifier should not be on the floor and should have been in a bag and labeled with the date. Resident #16 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's health record revealed that he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Other Specified Cough, Chronic Obstructive Pulmonary Disease, and Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina pectoris. Review of Resident #16's most recent Annual Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) of 9, indicating his cognition was moderately impaired. Section O: Special Treatments, Procedures and Programs checked for oxygen therapy. Review of Resident #16's physician's orders revealed an order dated 02/16/2024 that read, O2 (Oxygen) at 2. 5 liters/min (minute) via NC (Nasal Cannula) frequency continuous. Further review revealed an order dated 02/26/2024 that read, Xopenex nebulizer one vial TID (three times a day) for Chronic Obstructive Pulmonary Disease. On 04/01/2024 at 9:10 a.m., an observation and interview was conducted with Resident #16 in her room. A nebulizer with mouthpiece and tubing attached to the nebulizer machine was observed on the resident's dresser open to air and without a date. The resident stated the nurse gave him the nebulizer treatment and stored the nebulizer with mouthpiece and tubing on the dresser open to air. Resident #16's oxygen tubing and humidifier was in use and not labeled with the date. On 04/01/2024 at 9:15 a.m., an observation was made of S7CNA (Certified Nursing Assistant). S7CNA labeled Resident #16's oxygen tubing and humidifier. On 04/01/2024 at 9:20 a.m., an interview was conducted with S7CNA. S7CNA confirmed that Resident #16's oxygen tubing and humidifier was not labeled with the date. She also confirmed that his nebulizer with mouthpiece and tubing was open to air on his dresser and it should be in a bag and labeled. On 04/02/2024 at 3:20 p.m., an interview was conducted with S3ADONIP (Assistant Director of Nursing, Infection Preventionist). S3ADONIP confirmed Resident #9's oxygen tubing and humidifier should not have been on the floor and should be in a bag labeled with the date. She also confirmed Resident #16's nebulizer with mouthpiece and tubing should be stored in a bag labeled with the date and his oxygen tubing and humidifier should have been labeled with the date.

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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** 47965 Based on observations, interviews, and record reviews, the facility failed to ensure that medications and pharmaceutical services were provided to meet the needs of 2 (#25, #31) out of a total sample of 31 residents, by failing to: 1. Ensure that Resident #25's Plavix (blood thinner) was re-ordered and administered; 2. Maintain a system to account for the usage and reconciliation of all controlled medications. Findings: On 04/03/2024 at 10:30 a.m., a review of a policy titled Pharmacy Services-Ordering Medications with a revision date of 01/05/2024, revealed in part, Purpose: To ensure all medications are ordered in a timely manner. Policy .3. Drugs and Biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than five days prior to the last dosage being administered to ensure that refills are readily available. 1. Review of Resident #25's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses including, but were not limited to, Peripheral Vascular Disease, and Atherosclerosis of Native Arteries of Extremities with Intermittent Claudication, Bilateral Legs. A review of Resident #25's physician's orders revealed an order for Plavix 75 mg (milligram) one PO (by mouth) QOD (every other day). On 04/02/2024 at 7:38 a.m., an observation was made of S14LPN (Licensed Practical Nurse) during D1 (morning medication pass) on Hall W. She discovered that she did not have Plavix in her cart for Resident #25. S14LPN went to the medication storage room and returned without the Plavix. She stated that the medication was not in the resident's box so she called pharmacy to order it. On 04/03/2024 at 8:30 a.m., an observation was made with S16LPN of the medication cart on Hall W. Resident #25's stocked medications were reviewed with S16LPN, and the resident's Plavix was not in the cart. Further review revealed that the medication was not given on 04/02/2024. On 04/03/2024 at 8:35 a.m., an interview was conducted with S2DON (Director of Nursing) and S3ADONIP (Assistant Director of Nursing, Infection Preventionist). S3ADONIP stated that after the first pill was removed from the refill row on the blister packet, the nurse was responsible for pulling the re-order tab and faxing it to the pharmacy. She further stated that the pharmacy should refill the order the same day, and if the medication was not received, the nurse should conduct a follow-up phone call with the pharmacy and also notify administration. S2DON stated that the procedure was not followed because she was not made aware that Resident #25 had not received her Plavix. 2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195618	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Consolata Rehab and Wellness Center on the Teche	2319 East Main Street New Iberia, LA 70560

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/2024 at 12:40 p.m., an observation was made of the medication cart on Hall X with S17LPN and S18RN (Registered Nurse). A random narcotic check for Resident #31 revealed 76 Percocet (Oxycodone-Acetaminophen 10mg-325 mg tablet) pills in the blister pack and 77 on the narcotic reconciliation sheet. A review of the electronic medication administration (MAR) record revealed an order for oxycodone-acetaminophen 10mg-325 mg tablet: oral PRN (as needed) Q (every) 4 hours which was not signed as given. On 04/03/2024 at 12:40 p.m., an interview was conducted with S17LPN and S18RN. S17LPN confirmed the number of Percocet pills in the blister pack and the reconciliation sheet did not match, and stated she gave the medication to Resident #31 but had not reconciled the count. S18RN confirmed that the Percocet count and reconciliation sheet did not match. She also confirmed that the Percocet was not signed as given on the MAR. S18RN stated that the Percocet should have been reconciled on the narcotic sheet at the time it was given and also signed off on the MAR.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47540 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: 1. Failing to ensure medication was not left at Resident #31's bedside; 2. Failing to ensure medications were not left unattended on top of the medication cart; 3. Failing to ensure controlled medication was not taped back in the blister pack; 4. Failing to ensure medications were stored separately from food and labeled with the resident's name. Findings: On 04/02/2024, a review of the facility's policy, Medications Storage, with a last reviewed date of 01/05/2024, revealed in part, the following, Policy Statement: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: . 2. The nursing staff shall be responsible for maintaining medication storage . 9. Medications must be stored separately from food and must be labeled accordingly . On 04/02/2024, a review of the facility's policy, Administering Medications, with a last reviewed date of 01/05/2024, revealed in part, the following, Policy Interpretation and Implementation: . 19. No medications are kept on top of the cart . Resident #31 Review of Resident #31's health record revealed that he was admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Acute Sinusitis. Review of Resident #31's most recent Annual Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) of 15, indicating her cognition was intact. Review of Resident #31's physician's orders revealed an order dated 03/27/2024 that read, Flonase allergy 50 mcg (microgram) spray one spray each nostril QDAY (every day) X (for) 7 days. Review of Resident #31's health record revealed no documented evidence that Resident #31 requested to self-administer medications. Further review of Resident #31's health record revealed no evidence that the resident was assessed and care-planned to have medications at the bedside. (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/2024 at 8:55 a.m., an observation and interview was conducted in Resident #31's room. An observation was made of Flonase allergy spray on the resident's bedside table. Resident #31 stated the Flonase has been on my bedside table since last night. On 04/01/2024 at 9:00 a.m. an interview was conducted with S6LPN (Licensed Practical Nurse). S6LPN confirmed that there was Flonase allergy spray on Resident #31's bedside table that was left unattended, and it should have been securely stored after the resident used it. On 04/02/2024 at 3:15 p.m. an interview was conducted with S2DON (Director of Nursing). S2DON stated that Resident #31 could not self-administer her own medications. She confirmed that Flonase should not have been left unattended at her bedside and should have been stored appropriately by the nurse after administration. 47965 2. 04/02/2024 at 7:20 a.m., an observation was made of S14LPN during D1 (Morning med pass) on Hall W. She poured the following medications in a clear plastic medicine cup: Losartan Potassium 50 mg (milligram) one tablet; Zoloft 25 mg, one tablet; Buspar 10 mg, one tablet; Docusate calcium 240 mg one tablet; and Cinnamon 1000 mg two capsules She then discovered her narcotics binder was not on her cart and walked back to the nurses' station to retrieve it, leaving all the medications she had poured on top of the medication cart in Hall W unattended. On 04/02/2024 at 7:55 a.m., an interview was conducted with S14LPN. She confirmed that she had left the medications on top of the medication cart while she went to the nurses' station and stated that she should not have. 3. On 04/03/2024 at 12:40 p.m., an observation was conducted with S17LPN and S18RN (Registered nurse) on Hall X . A random narcotic check for Resident #67 revealed a Percocet tablet taped back in a punctured pill pocket of the blister pack. S17LPN and S18RN confirmed the pill pocket had been punctured and re-taped. S18RN stated that the medication was not supposed to be taped back in the blister pack. 4. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/2024 at 8:36 a.m., a tour was conducted of Room A with S3ADONIP (Assistant Director of Nursing, Infection Preventionist) and S2DON (Director of Nursing). An observation was made of the residents' supplement refrigerator. There were 2 snack pack puddings and 4 Nepro Therapeutic Shakes. S3ADONIP stated that the shakes and puddings were residents' supplements. The following items were noted on the shelves in the refrigerator and were not labeled to signify who they belonged to: an open box of Aztrazeneca (a medication) 1 16 oz (ounce) bottle unopened cola 1 polar pop drink cup 1 pepsi can 2 open bottles of pickles 1 container soup 2 plastic bags with food On 04/03/2024 at 8:36 a.m., an interview was conducted with S2ADON and S3ADONIP. They both confirmed the items in the refrigerator and stated that the supplement refrigerator should not contain medications. They also stated that the Aztrazeneca should have been labeled with the name of the resident it belonged to. They also agreed that the other food items should not be in the supplement refrigerator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47965 Based on observations and interviews, the facility failed to maintain an effective infection control and prevention program by failing to perform hand hygiene before preparing medications and after removing gloves after patient contact. This deficient practice had the potential to affect the 70 residents residing in the facility. Findings: On 04/03/2024, a review of the facility's policy titled Handwashing/Hand Hygiene with a revision date of 01/05/2024, revealed in part, Policy Statement. This facility considers hand hygiene the primary means to prevent the spread of infections .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections .7 .b. Before and after direct contact with residents; c. Before preparing or handling medications .m. after removing gloves. On 04/02/2024 at 7:52 a.m., S14LPN (Licensed Practical Nurse) was observed during D1. She donned a pair of gloves, drew up insulin and walked into Resident #25's room to administer the medication. S14LPN returned to the cart, removed her gloves and did not perform hand hygiene. She proceeded to pour medications. On 04/02/2024 at 7:55 a.m., an interview was conducted with S14LPN. She confirmed that she did not perform hand hygiene after removing her gloves. She stated that she should have performed hand hygiene after contact with the resident and removing her gloves. On 04/02/2024 at 8:02 a.m., an observation was made of S15LPN during morning D1 on Hall Y. She parked her medication cart in the hallway and removed a Hoyer lift that was parked in the hallway close to her cart. S15LPN returned to her cart and started to prepare medications before performing hand hygiene. On 04/02/2024 at 8:20 a.m., an interview was conducted with S15LPN. She confirmed that she did not perform hand hygiene before she started preparing medications and stated that she should have. On 04/02/2024 at 8:35 a.m., an interview was conducted with S3ADONIP (Assistant Director of Nursing, Infection Preventionist). She stated that she is responsible for infection control and prevention in the facility. S3ADONIP stated that hand hygiene should be performed before and after patient contact and before donning and after removing gloves.