| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 215017 | A. Building<br>B. Wing | 04/22/2024 |

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| Autumn Lake Healthcare at Long View | 3332 Main Street<br>Manchester, MD 21102 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>45139<br><br>Based on observation and interview, it was determined that the facility failed to maintain a resident's dignity by standing over a seated resident while assisting them at meals. This was evident for 1 resident ( #19) in 1 out of 2 dining areas in the facility observed during a survey.<br><br>The findings include:<br><br>On 4/9/24 at 12:23 PM, an observation of the first-floor dining area was made by 2 surveyors. Observation revealed that Staff #9 was standing over Resident # 19 while assisting them with meals.<br><br>On 4/09/24 at 12:24 PM, a brief interview with the facility Dietician Staff #15, was completed in the first-floor dining area. Staff #15 confirmed the observation of Staff # 9 standing over Resident #19 while assisting them to eat. Staff # 15 reported that the facility policy requires staff to sit while assisting residents at meals.<br><br>On 04/19/24 at 1:54 PM, the above concerns were discussed with NHA, Director of Nursing, and Regional Director of Nursing. No additional information was provided.<br><br>On 4/22/24 at 12:21 PM, during an interview with Staff #15, she reported that she had a conversation with Staff #9 and that Staff # 9 understood it was not the facility policy to stand while assisting a resident with meals |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>45139<br><br>Based on interview, and pertinent documentation review, it was determined that the facility failed to communicate to staff that a resident had dentures and failed to take reasonable precautions to prevent a resident's dentures from getting lost. This was evident for 1 Resident (Resident #77) out of 3 residents investigated for personal property, during a survey. The findings include:<br><br>On 4/10/24, a review of records revealed Resident #77 was a long-term resident of the facility.<br><br>On 4/10/24 at 8:20 AM, Resident #77's family member was interviewed. During the interview s/he reported that Resident #77 had dentures when s/he was admitted to the facility, but the dentures were lost during the residents stay.<br><br>On 4/16/24 at 1:40 PM, a review of Admission/Readmit Screener document, dated 6/16 23, revealed that the resident was admitted to the facility with partial lower dentures that s/he wore only when eating. Further review of the document revealed that Resident #77 required the facility staff to assist him/her with both setup and clean up assistance when performing oral hygiene.<br><br>On 4/16/24 at 1:46 PM, review of the Minimum Date Set (MDS) section GG dated 6/21/23, revealed a section titled oral hygiene: the ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with use of equipment, was reviewed. Further review revealed that Resident #77 required supervision or touching assistance to perform this task.<br><br>The Minimum Data Set (MDS) is part of the process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.<br><br>Setup or clean-up assistance means the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. When supervision or touching assistance is required, the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.<br><br>On 4/16/24, review of Resident # 77's care plan failed to reveal documentation that the resident had dentures.<br><br>On 04/16/24 at 2:29 PM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) failed to provide GNA documentation in TASKS, that the resident had dentures and needed the care provided with the dentures. |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>49409<br><br>Based on staff interviews and the review of the facility records, it was determined that the facility failed to monitor and prevent the misappropriation of resident property. This was evident for 1 ( Resident #153) out of 16 residents reviewed for abuse during the annual survey.<br><br>The findings include:<br><br>Resident #153 was readmitted to the facility and received long-term care for more than three years. Part of the resident's care was pain management. There was an order to receive Oxycodone 10mg three times a day during the month of May 2023. The facility reported an incident of missing medication (Oxycodone) on 05/12/2023.<br><br>On 04/17/24 at 10:23 AM, a review of the facility's report on the incident revealed that the narcotic medication<br><br>(Oxycodone) card with 30 pills was received from the Pharmacy on 05/08/23 and that on 5/11/23 it was discovered that this card, with approximately 23 remaining pills, was missing. A review of Nurses' statements, interviews, resident interviews, review of medication administration records (MAR) and narcotic records indicated that the agency Nurses counted narcotics incorrectly during 3-11 and 11-7 shifts on 05/10/23. Nurses were educated regarding the standard procedure for medication custody handoff.<br><br>On the afternoon of 4/17/23, surveyor observed the Controlled Substance card count logs for 3 nursing units. The log had columns for the date, time, cards (the medications are kept in punch cards) added during the shift (with sub-columns for # the cards, resident name, and med/dose), cards removed during the shift (with sub column for # of cards, resident name and med/dose); off going nurse's signature; oncoming nurse's signature; the number of cards present; and count correct (yes or no).<br><br>On 4/17/24 at 2:42 PM, the surveyor observed the Controlled Substance card count log for Unit 2-B. A review of the 2-B log revealed the most recent documentation was on 4/16/24. The row for 3 PM revealed signatures for the off-going and oncoming nurses, 19 cards, and a correct count. On the row for 4/16/24 at 11 p.m., there was a signature for the outgoing nurse, but the area for the oncoming night nurse was noted to be blank. However, there was documentation that the number of cards was 19, and the count was correct. No documentation was found to indicate that a count was completed on 4/17/24.<br><br>On 4/17/24 at 2:43 PM, the surveyor's interview with a Registered Nurse (Staff #30) revealed that the nurses complete a narcotic count at the start of a shift and then we sign count is correct. She confirmed that she did the count this morning with no identified problems, reporting that it was counted with an off-going nurse this morning. When shown the Controlled Substance card count log, the nurse reported, It doesn't look like we signed this book.<br><br>On 04/17/24, at 2:54 PM., a review of the 1-A unit narcotic count log revealed that the day Nurse, (Staff # 31), had already signed as the offgoing nurse at 3 PM .; the area for the oncoming nurse was noted to be blank.<br><br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of the 1-A unit narcotic count log failed to reveal a signature for the 4/15/24 7 am off-going nurse.<br><br>On 04/17/24 at 2:54 pm, the Director of Nursing (DON) confirmed that the medication cart for unit 1-A had not yet been turned over to the oncoming Nurse. The DON also acknowledged the concern of pre-signing the count by stating, ' because they already signed this [indicating the off-going nurse signature]'. The surveyor then reviewed the concern found in the 2-b unit with the DON, who indicated that the concern would be addressed.<br><br>On 4/17/24 at 3:24 PM, surveyors interviewed Nurse (Staff #31), who stated that I am supposed to sign when I count [is completed]; it is just a bad habit; now I know to sign when the next shift comes in. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>48470<br><br>Based on records review and interviews, the facility failed to provide the resident and/or resident's representative with the notice of transfer in writing as soon as practicable. This was evident for 2 (Resident #86, #85) of 4 residents reviewed for hospitalization .<br><br>The findings include:<br><br>1) Resident #86 was admitted to the facility in 2023. The resident's medical record indicated that s/he was recently sent to the hospital for an evaluation due to a change in condition.<br><br>On 4/11/24 at 11:26 AM, the change in condition/concurrent review form for Resident #86, initiated by Licensed Practical Nurse (LPN Staff #37) with an effective date of 4/7/24 at 12:30 AM, was reviewed and revealed section P (Documentation provided for residents/resident representatives) with 5 items for the staff to mark. The first 2 items were listed under THE FOLLOWING ITEMS MUST BE GIVEN TO RESIDENT UPON HOSPITAL TRANSFER, where item 1. Documents Given to Resident, had an area for reason for transfer/discharge that was blank, and item 2. Resident is their own responsible party had the area marked as no. The next 3 items were listed under THE FOLLOWING ITEMS MUST BE GIVEN TO RESIDENT REPRESENTATIVE UPON HOSPITAL TRANSFER, where item 3. Resident Representative Present had the area marked as no, item 4. If the Resident Representative was not present was it sent to the Responsible Party? had the area marked as yes, but item 5. Documents given to Resident Representative had an area for reason for transfer/discharge that was blank as well.<br><br>On 4/16/24 at 12:25 PM, the Director of Nursing (DON) was interviewed, and she reported that, after an order from the provider is received to send a resident to the hospital, the nurses would then call the family or resident representatives (RP) to give verbal notifications, then the admissions staff would follow up and send the written notifications to the family or RP.<br><br>Later at 1:18 PM, the Admissions Director (Staff #38) was interviewed about the recent transfer of Resident #86. Staff #38 reported that she sent the transfer notification via email to the RP and would give the surveyor a printout of the email as evidence. After the surveyor reviewed the printed email correspondence, there was no evidence that a written notice of transfer was sent to the residents RP. The emails consisted of Staff #38 informing the RP on how much it would cost to hold the resident's room. The concern was discussed with Staff #38 that per regulation, a written notice of transfer must be provided to residents and/or RP, and as their facility's policy stated, A copy of the resident's bed hold and notice of transfer will be mailed to the resident's representative on the next business day by business office manager or designee. Staff #38 stated, The notice of transfer I think is given by nursing and confirmed that she was the only one in the facility who goes over the bed hold policy with the resident's family or RP after hospital transfers, but indicated that she only completed the bed hold section and not the notice of transfer.<br><br>The DON was again interviewed on the same day at 1:42 PM. She verified the facility's policy and confirmed that Staff #38 was responsible for contacting the family or RP when residents are transferred.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/22/24 at 10:25 AM, the concern was reviewed with the Nursing Home Administrator, Infection Preventionist Nurse, DON, and Regional DON that there was no evidence that a written notice of transfer was provided to the resident and/or the RP after the resident transfer.<br><br>48259<br><br>2) In an interview with Resident #85's representative, on 4/9/24 at 11:58 AM, s/he stated that the resident had been hospitalized over a month ago.<br><br>A medical record review on 4/9/24 at 12:58 PM revealed that Resident #85 was admitted to the facility in September 2023 with diagnoses that included Dementia.<br><br>A subsequent record review on 4/15/24 at 3:17 PM revealed nurse's documentation that Resident #85 was noted with an increased swelling to their neck and an episode of vomiting. The attending provider was notified and ordered to send the resident to the emergency room for evaluation.<br><br>Further review of the nurse's note showed that Resident #85's representative agreed to the hospital transfer. However, there was no evidence in Resident #85's medical record that a written notice of the transfer was given to the resident/resident representative.<br><br>In an interview on 4/15/24 at 3:33 PM with Licensed Practical Nurse (LPN Staff #39), she reported that she only notifies a resident representative of a hospital transfer via phone and not in writing.<br><br>In a subsequent interview on 4/15/24 at 3:53 PM, the Director of Nursing reported that the nurses handed a hospital transfer packet, that included the transfer notice, to the emergency staff but not to the Resident. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>48470<br><br>Based on records review and interviews, the facility failed to provide the resident and the resident's representative with the notice of bed-hold policy in writing. This was evident for 2 (Resident #86, #85) of 4 residents reviewed for hospitalization . The findings include:<br><br>1) Resident #86 was admitted to the facility in 2023. The resident's medical record indicated that s/he was recently sent to the hospital for evaluation due to a change in condition.<br><br>On 4/11/24 at 11:26 AM, the change in condition/concurrent review form for Resident #86, initiated by Licensed Practical Nurse (LPN Staff #37) with an effective date of 4/7/24 at 12:30 AM, was reviewed and revealed section P (Documentation provided for residents/resident representatives) indicated that the bed hold policy was provided to the resident and the resident representative.<br><br>Later at 1:18 PM, the Admissions Director (Staff #38) was interviewed about the recent transfer of Resident #86. Staff #38 reported that she sent the bed hold policy via email to the RP and would give the surveyor a printout of the email as evidence. The email correspondence consisted of Staff #38 informing the RP on how much it would cost to hold the resident's room. Staff #38 was specifically asked if the bed-hold policy was attached to the email and she replied, I don't think so, I think I just went over it over the phone. The concern was discussed with Staff #38 that per regulation, the bed-hold policy must be provided to residents and RP in writing, and as their facility's policy stated, A copy of the resident's bed hold and notice of transfer will be mailed to the resident's representative on the next business day by business office manager or designee. Staff #38 acknowledged the concern and confirmed that she is the only one in the facility who goes over the bed hold policy with the resident's family or RP after being transferred.<br><br>The Director of Nursing (DON) was interviewed on the same day at 1:42 PM. She verified the facility's policy and confirmed that Staff #38 is the one who follows up with the family or RP when residents are transferred.<br><br>On 4/22/24 at 10:25 AM, the concern was reviewed with the Nursing Home Administrator, Infection Preventionist Nurse, DON, and Regional DON that there was no credible evidence that the bed-hold policy was provided in writing to the resident and the RP after the resident transfer.<br><br>Cross Reference F623<br><br>48259<br><br>2) The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions.<br><br>An interview with Resident #85's representative on 4/9/24 at 11:58 AM revealed that the resident had been hospitalized over a month ago for an infection.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A medical record review on 4/15/24 at 3:17 PM revealed an MDS assessment, dated 11/18/23, that documented Resident #85 had severe cognitive impairment.<br><br>Further review revealed nurse's documentation on 2/13/24 that Resident #85 was noted with an increased swelling to the neck and an episode of vomiting. The attending provider was notified and ordered to send the resident to the emergency room for evaluation.<br><br>A continued review of the nurse's documentation dated 2/13/24 showed that the bed hold policy was reviewed with Resident #85's representative. However, there was no evidence in Resident #85's medical record that shows when the copy of the bed hold policy was mailed to the Resident's representative.<br><br>During an interview on 4/15/24 at 3:40 PM, Licensed Practical Nurse (LPN Staff #40), reported that, during a transfer of a resident to the hospital, she would hand a packet that included a copy of the bed hold policy to the resident unless they were cognitively impaired, if that's the case, then she would hand it over to the emergency medical team.<br><br>In a subsequent interview on 4/15/24 at 4:12 PM with the Admissions Director (Staff #38), she reported that she calls residents' representatives the day after hospitalization and reviews the bed hold policy with them. Staff #38 added that she sends the bed hold policy to the resident representatives via email. However, she could not provide documentation that a copy of the facility's bed hold policy was emailed to Resident #85's representative. |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>48259<br><br>Based on record review and interviews, it was determined that the facility failed to complete Quarterly Minimum Data Set (MDS) assessments for residents within the regulatory time frames to facilitate appropriate care planning and maintain the current assessment record. This was evident for 4 (#70, #52, #83, #85) of 68 residents reviewed during the recertification survey.<br><br>The findings include:<br><br>The MDS is a federally mandated assessment tool that nursing home staff use to gather information on each resident's strengths and needs. The information collected drives resident care planning decisions.<br><br>The Quarterly assessment must be completed within 92 days of the MDS Completion Date of the last quarterly MDS assessment. It must also be completed no later than 14 days after the ARD, which is the ARD + 14 days.<br><br>The last day of this observation period is the Assessment Reference Date (ARD). This is the end date of the observation period and provides a common reference point for all team members participating in the assessment. In completing sections of the MDS that require observations of a resident over specified periods such as 7, 14, or 30 days, the ARD is the common endpoint of these look back periods.<br><br>1) The following quarterly MDS assessments were not completed within the regulatory timeframe based on their most recent quarterly or annual MDS assessment.<br><br>1a) A review of Resident #70's Quarterly MDS assessment with ARD 2/14/23 showed that it was due on 2/28/23; however, it was completed and signed in section Z0500B on 3/28/23, 42 days after the ARD.<br><br>1b) 1c) A review of Resident #52's Quarterly MDS assessment with ARD 12/19/23 showed that it was due on 1/2/24; however, it was completed and signed in section Z0500B on 1/8/24, 20 days after the ARD.<br><br>Further record review noted another Quarterly MDS assessment with ARD 1/17/24 for Resident #52 that was due to be completed on 1/31/24. However, it was completed and signed in section Z0500B on 2/8/24, 22 days after the ARD.<br><br>1c) A review of Resident #83's Quarterly MDS assessment with ARD 2/15/24 showed that it was due on 2/29/24. However, it was completed and signed in section Z0500B on 3/5/24, 19 days after the ARD.<br><br>1d) A review of Resident #85's Quarterly MDS assessment with ARD 2/27/24 showed that it was due on 3/12/24. However, it was completed and signed in section Z0500B on 3/14/24, 16 days after the ARD.<br><br>In an interview on 4/19/24 at 8:55 AM, staff #5, the MDS coordinator, confirmed that all the MDSs were late. She added she would pay more attention going forward to avoid them being late. |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>37276<br><br>Based on medical record review and staff interview, it was determined that the facility staff failed to complete, within 14 days, a Significant Change in Status Minimum Data Set (MDS) Assessment. This was evident for 1 (#4) of 1 residents reviewed for hospice during the survey.<br><br>The findings include:<br><br>The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strengths and needs. Information collected drives resident care planning decisions. MDS assessments must be accurate to ensure each resident receives the necessary care.<br><br>A significant change means a major decline or improvement in a resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions that have an impact on more than one area of the residents' health status. When there is a major decline or lack of improvement in a resident's status, a MDS Significant Change in Status Assessment (SCSA) should be completed within 24 days.<br><br>On 4/17/24 at 9:01 AM, a review of Resident #4's medical record revealed the resident was admitted to the facility in January 2023 with multiple diagnoses, including cerebral infarction (stroke), high blood pressure, diabetes, and dementia with behavioral disturbance.<br><br>Review of Resident #4's progress notes revealed that, on 10/25/23 at 5:58 PM, in a physician's progress note, the Physician's Assistant (PA) documented that the resident presented with a failure to thrive (state of decline that is multifactorial and may be caused by chronic concurrent diseases). The PA documented Resident #4 continued with signs of decline due to decreased intake by mouth, ongoing lethargy, and decreased verbal response. The PA documented, that due to the resident's ongoing decline, hospice was discussed with the resident's Power of Attorney (POA), who was in agreement with a hospice consult, and a hospice consult would be obtained.<br><br>On 10/26/23 at 7:24 PM, in a physician's progress note, the PA documented that Resident #4 was diagnosed as having a failure to thrive, and hospice had been discussed with the family and a hospice consult was pending.<br><br>On 11/9/23 at 3:43 PM, in a physician's progress note, the PA documented thatResident #4 was noted with a severe decline last month and the resident had not returned to baseline.<br><br>Continued review of Resident #4's medical record revealed a 11/12/23 order to admit the resident to hospice related to cerebrovascular disease, weight loss, and dysphagia (difficulty in swallowing).<br><br>On 11/12/23 at 6:16 PM, in a nurses note, the nurse documented the resident was admitted to hospice related to cerebrovascular disease, weight loss and dysphagia<br><br>On 11/13/23 at 4:16 PM, in a physician's progress note, the physician documented that Resident #4 was admitted under hospice care and services over the weekend.<br><br>(continued on next page) |

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| | 215017 | A. Building<br>B. Wing | 04/22/2024 |

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| Autumn Lake Healthcare at Long View | 3332 Main Street<br>Manchester, MD 21102 |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #4's MDS assessments revealed a quarterly MDS with an assessment reference date (ARD) of 10/25/23 and annual an MDS with an ARD of 1/23/24 had been completed for the resident. Continued review of the medical record failed to reveal evidence that, following Resident #4's significant change and admission to hospice, a Significant Change in Status Assessment (SCSA) had been completed.<br><br>On 4/17/24 at 12:15 PM, during an interview, MDS Nurse/Registered Nurse (RN Staff #5), was made aware of the above concern. While reviewing the resident's medical record, Staff #5 indicated that when a resident was admitted to hospice, she would automatically complete a significant change MDS assessment within 14 days. Staff #5 confirmed that a SCSA had not been completed for Resident #4 following the resident's significant change and his/her admission to hospice, with no further explanation given at that time. |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assure that each resident's assessment is updated at least once every 3 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259<br><br>Based on record review and staff interviews, it was determined that the facility failed to complete comprehensive Minimum Data Set (MDS) assessments within the regulatory time frames to facilitate appropriate care planning and maintain current and accurate assessment records. This was evident for 7 (#29, #52, #72, #11, #96, #92, #37) of 68 residents reviewed during the recertification survey.<br><br>The findings include:<br><br>The MDS is a federally mandated assessment tool that nursing home staff use to gather information on each resident's strengths and needs. The information collected drives resident care planning decisions.<br><br>The Admission MDS assessment is a comprehensive assessment for new residents and, under some circumstances, returning residents. It must be completed by the end of day 14, counting the date of admission to the facility as day 1.<br><br>The Annual MDS assessment is a comprehensive assessment for a resident that must be completed annually (at least every 366 days) unless a Significant Change in Assessment has been completed since the most recent comprehensive assessment.<br><br>Completion of the Comprehensive Annual MDS assessment, including the Care Area Assessments (CAA), must be completed no later than 14 days after the Assessment Reference Date (ARD).<br><br>The last day of this observation period is the Assessment Reference Date (ARD). This is the end date of the observation period and provides a common reference point for all team members participating in the assessment. In completing sections of the MDS that require observations of a resident over specified periods such as 7, 14, or 30 days, the ARD is the common endpoint of these look back periods.<br><br>1a) A review on 4/18/24 at 12:33 PM, of Resident #29's Annual MDS assessment with ARD 2/22/24 showed that it was due on 3/7/24; however, it was completed and signed in section V0200B2 on 3/14/24, 21 days after the ARD.<br><br>1b) A review on 4/18/24 at 3:29 PM of Resident #52's Annual MDS assessment with ARD 3/12/24 showed that it was due on 3/26/24; however, it was completed and signed in sections V0200B2 and Z0500B on 3/28/24, 16 days after the ARD and was 2 days late.<br><br>1c) A review on 4/19/24 at 9:55 AM of Resident #72's Admission MDS assessment with ARD 2/26/24 revealed that Resident #72 was admitted to the facility on [DATE]. Further review of the MDS assessment found that the admission MDS assessment was due on 3/4/24. However, it was completed and signed in sections V0200B2 and Z0500B on 3/6/24, day 16, after Resident #72's admission to the facility and was 2 days late.<br><br>(continued on next page) |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1d) A review on 4/19/24 at 10:05 AM of Resident #11's Admission MDS assessment with ARD 3/12/24 revealed that Resident #11 was admitted to the facility on [DATE]. Continued review of the MDS assessment noted that it was due on 3/19/24. However, it was completed and signed in sections Z0500B on 3/24/24 and V0200B2 on 3/29/24, ten days late.<br><br>1e) A review on 4/19/24 at 10:15 AM of Resident #96's Admission MDS assessment with ARD 3/28/24 contained an admitted [DATE]. Further review of Resident #96's MDS assessment found that it had to be completed on 4/4/24. However, it was completed and signed in section V0200B2 on 4/8/24, 18 days after Resident #96's admission to the facility and was 4 days late.<br><br>1f) A review on 4/19/24 at 10:55 AM of Resident #92's Admission MDS assessment with ARD 3/31/24 noted that Resident #92 was admitted to the facility on [DATE]. A continued review showed that the Admission MDS for Resident #92 had to be completed on 4/7/24. However, it was completed and signed in sections Z0500B on 4/12/24 and V0200B2 on 4/17/24, 24 days after Resident #92's admission to the facility and ten days late.<br><br>1g) A review on 4/19/24 at 11:15 AM of Resident #37's admission MDS assessment dated [DATE] noted that Resident #37 was admitted to the facility on [DATE], meaning the admission MDS had to be completed on 1/24/24. However, further review showed that Resident #37's MDS was completed and signed in sections V0200B2 and Z0500B on 1/29/24, 19 days after Resident #37's admission to the facility and five days late.<br><br>In an interview with the MDS Coordinator (Staff #5) on 4/17/24 at 12:23 PM, she stated that an Admission MDS needed to be completed on or before the 14th day of a resident's admission to the facility.<br><br>In a subsequent interview on 4/19/24 at 3:35 PM with Staff#5, she reported that she completed some of the sections of the MDSs. However, it was dependent on the corporate MDS person to sign them as complete. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>37276<br><br>Based on medical record review and staff interview it was determined that facility staff failed to develop and implement comprehensive, person-centered care plans, with measurable goals and non-pharmacological approaches. This was evident for 2 (#4, #64) of 6 residents reviewed for unnecessary medications.<br><br>The findings include:<br><br>A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.<br><br>The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status.<br><br>1) On 4/16/24 at 2:51 PM, a review of Resident #4's medical record revealed the resident currently resided in the facility following his/her admission in January 2023 for long term care and had multiple medical diagnosis including depression, anxiety disorder, and dementia with behavioral disturbance.<br><br>Review of Resident #4's April 2024 Medication Administration Record (MAR) revealed the resident received psychotropic medications. There was a 10/24/23 order for Duloxetine (antidepressant) 1 capsule by mouth one time a day related to depression that was documented as given every day from 4/1/24 to 4/16/24, and a 12/19/23 order for Seroquel (Quetiapine Fumarate) (antipsychotic) by mouth at bedtime for agitation/anxiety related to dementia in other diseases classified elsewhere that was documented as given every night from 4/1/24 to 4/15/24.<br><br>A review of Resident #4's MDS revealed a quarterly MDS with an assessment reference date (ARD) of 10/25/23 that documented Resident #4 BIMS summary score was 6, indicating the resident had severe cognitive impairment, and the resident received antidepressants and antipsychotics during the MDS look back period. Resident #4's annual MDS with an ARD of 1/23/24 documented the resident's BIMS summary score was 4, the resident had diagnosis of anxiety, depression, and dementia and Resident #4 received antidepressants and antipsychotics on a routine basis during the look back period.<br><br>1a) Review of Resident #4's care plans revealed a care plan with the focus, Mental Health Diagnosis, initiated on 1/17/23 with the goal, [Resident #4] has diagnosis of depression, will use [his/her] coping mechanisms to manage [his/her] diagnosis within the next 90 days, that had the interventions, 1) Administer medications as ordered. Monitor/document for side effects and effectiveness, 2) Consult [name of provider] psych as needed, and 3) Resident is very social, visits with family and attends activities.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The care plan was not comprehensive, or resident centered and failed to identify resident specific behaviors for which an antidepressant had been prescribed. The care plan goal was not measurable, with no indication what coping measures the cognitively impaired resident was expected to use to manage his/her depression. The interventions did not include non-pharmacological interventions or actions to help with Resident #4's depression or address the resident's potential behaviors for which an antidepressant had been prescribed<br><br>1b) Resident #4 had a care plan, [Resident #4] takes Seroquel for dementia with behavioral disturbance, initiated on 10/18/23 with the goal, will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment x 90 days, that had the interventions, 1) Administer medications as ordered. Monitor/document for side effects and effectiveness, 2) Consult with pharmacy, MD to consider dosage reduction when clinically appropriate, 3) Discuss with MD, family re ongoing need for use of medication 4) Educate family/caregivers about risks, benefits and the side effects and/or toxic symptoms, 5) Monitor/record occurrence for target behavior symptoms -delusions/hallucinations and document per facility protocol, 6) Monitor/record/report to MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation's, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person7), and Psych consult as clinically indicated<br><br>The care plan was not comprehensive, or resident centered. The goal addressed general antipsychotic drug related complications and did not address the resident's behaviors for which the medication had been prescribed. The interventions identified target behavior symptoms to be monitored, however the care plan failed to include non-pharmacological interventions or actions to help with Resident #4's behavior<br><br>Continued review of the resident's care plans failed to reveal evidence that a comprehensive care plan, with resident specific, measurable goals and individualized, non-pharmacological interventions had been developed to address Resident #4's behaviors for which psychotropic medications had been prescribed.<br><br>On 4/16/24 at 2:31 PM, the above findings were discussed with the Director of Nursing (DON), and she acknowledged the concerns at that time.<br><br>On 4/19/24 at 10:27 AM, during an interview, the concerns with Resident #4's Mental Health Diagnosis care plan were discussed with Social Services Director, (SSD). At that time, the SSD indicated she understood the concerns and had spoken with the DON about the concerns with the care plan.<br><br>2) On 4/18/24 at 3:11 PM, a review of Resident #64's medical record revealed the resident was admitted to the facility in March 2023 with multiple diagnosis, including depression, anxiety, and dementia with behavioral disturbance and currently resided in the facility for long term care.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #64's April 2024 MAR revealed the resident received psychotropic medications. There was a 11/2/23 order for Escitalopram (Lexapro) (antidepressant) by mouth one time a day related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, a 3/10/23 order for Olanzapine (Zyprexa) (antipsychotic) by mouth in the evening related to unspecified dementia, unspecified severity, with other behavioral disturbance and a 1/24/24 order for Remeron (Mirtazapine) (antidepressant) Give 0.5 tablet by mouth in the evening for failure to thrive (a state of decline that is multifactorial and may be caused by chronic concurrent diseases and functional impairments).<br><br>A review of Resident #64's MDS revealed a quarterly MDS with an ARD of 11/28/23 that documented Resident #64's BIMS summary score was 1, the resident had diagnoses of dementia, anxiety and depression and Resident #64 received antipsychotic and antidepressant medications in the MDS look back period. Resident #64's annual MDS with an ARD of 2/28/24 that documented Resident #64's BIMS summary score was 99, indicating the resident was unable to complete the BIMS, the resident had diagnoses of dementia, anxiety, and depression, and received antipsychotic and antidepressant medications in the MDS look back period.<br><br>2a) Review of Resident #64's care plans revealed a care plan with the focus, Mental Health Diagnosis, initiated on 3/13/23, with the goal, [Resident #64] has diagnosis of Depression and Anxiety; [s/he] will use [his/her] coping mechanisms to manage [his/her] diagnosis within the next 90 days, that had the interventions, 1) Administer medications as ordered. Monitor/document for side effects and effectiveness, 2) Arrange for psych consult, follow up as indicated, and Quarterly completion of PHQ-9 assessments<br><br>The care plan was not comprehensive, or resident centered and failed to identify the resident's specific behaviors for which an antidepressant had been prescribed. The care plan goal was not measurable, with no indication what the coping mechanisms the cognitively impaired resident was to use to manage his/her depression and anxiety. The interventions did not include non-pharmacological interventions to assist Resident 64# manage his/her potential behaviors for which an antidepressant had been prescribed.<br><br>On 4/19/24 at 10:27 AM, during an interview, the concerns with Resident #64's Mental Health Diagnosis care plan were discussed with Social Services Director, (SSD). At that time, the SSD stated s/he understood.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2b) Continued review of the resident's care plans revealed a care plan, [Resident #64] takes Olanzapine for dementia with behavioral disturbance, delusions, hallucinations, pacing, with the goal, will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment, that had the interventions1) Administer medications as ordered. Monitor/document for side effects and effectiveness, 2) Consult with pharmacy, MD to consider dosage reduction when clinically appropriate, 3) Discuss with MD, family re ongoing need for use of medication, 4) Educate family/caregivers about risks, benefits and the side effects and/or toxic symptoms, 5) Monitor/record occurrence for target behavior symptoms pacing delusions, hallucinations and document per facility protocol, 6) Monitor/record/report to MD prn side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation's, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person, 7) NPI such as activities of interest, quiet space, snack/drink, soft music, rest period, etc. during episodes of increased anxiety/agitation. Date Initiated: 4/17/24, and 8) Psych consult as clinically indicated<br><br>The care plan goal addressed the side effects of psychotropic medications, however, the care plan failed to have a resident specific, measurable goal that addressed the behaviors for which the medication had been prescribed. Also, the care plan failed to include non-pharmacological interventions prior to 4/17/24.<br><br>In addition, further review of Resident #64's care plans failed to reveal a care plan had been developed that addressed the resident's use of Remeron for the indication of failure to thrive.<br><br>On 4/19/24 at 11:36 AM, during an interview, when made aware of the concerns with the development of comprehensive care plans, the DON acknowledged the concerns and indicated she understood. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>48470<br><br>Based on resident and staff interviews and medical records review it was determined the facility 1) failed to include residents in the development of the care plan and invite to the care plan meeting, 2) failed to ensure participation in the care planning process by required interdisciplinary team members, and 3) failed to evaluate and update a care plan. This was evident for 3 (Resident #43, #1, #46) of 5 residents reviewed for care planning, and 2 (Resident #4, #64) of 6 residents reviewed for unnecessary medications.<br><br>The findings include:<br><br>1) Resident #43 has been residing in a private room at the facility since admission in late 2023. On 4/9/24 at 11:33 AM, Resident #43 was interviewed and reported that s/he had not participated in a care plan meeting. The resident stated, I get a printout of what was discussed. They don't do it in my room. And indicated that it was because s/he was bedbound.<br><br>On 4/11/24 at 9:07AM, the Social Services Director (SSD) was interviewed, and she explained her process in conducting care plan meetings. Invitations are sent by mail or email and scheduled every 90 days unless the resident has had a significant change in their health status. The SSD also reported that care plan meetings are held downstairs in the activities room and documents in her care plan notes for those who attended the meeting. The SSD stated, If a resident is bed bound, I usually give them an update about what happened in the meeting.<br><br>On the same day at 9:31 AM, Resident #43's progress notes written by the SSD with reference dates of 12/5/23, and 3/5/24 for the last 2 care plan meetings were reviewed and both indicated that an overview of the meetings would be provided to the resident at bedside as the resident is not able to attend due to being bedbound.<br><br>Later at 1:23 pm, a review of the care plan meeting invitation letters provided by the SSD revealed all were addressed to the RP only. Furthermore, texts from the letters stated but not limited to, this is a fifteen-minute meeting scheduled for the purpose of discussing what the staff is doing to meet the needs of individual residents. We want to know your concern/complaints and other issues that are not a part of the plan of care. However, we are not able to do so at this meeting. Please respect residents, families and staff who are waiting for their appointments. An appointment will be arranged to discuss these issues when it is convenient for you and sufficient time is available. This meeting will be held on (date and time). In the event you are unable to make it to the care plan meeting, feel free to request a conference call or if you would like an overview of the meeting, please contact (Name of MDS nurse) or (Name of MDS nurse) to set that up.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 4/11/24 at 3:31 PM, the SSD was again interviewed about care plan meetings in the presence of the Nursing Home Administrator (NHA). The SSD reported that she prints the care plan meetings scheduled for the day and goes in resident rooms and invites them verbally. The SSD indicated that invitation letters are generated by the front desk based on when comprehensive assessments are done and goes to the residents and/or the RP, and that she follows up with the resident on the morning of the meeting to check if they are attending or not. The concerns were discussed with the SSD and NHA that there was no credible evidence that Resident #43 was invited to the care plan meetings, and care plan meetings can be rescheduled based on the resident and/or RP availability.<br><br>At the time of survey exit on 4/22/24 at 2 PM, no further information or documentation was provided to the surveyor.<br><br>49409<br><br>2) Resident #1 has been at the facility for more than two years, receiving long-term care. The resident was diagnosed with multiple medical conditions and receiving treatment. Resident is alert and oriented, able to communicate.<br><br>On 04/10/24 at 09:59 AM, the Resident was interviewed and stated, There is no care plan meeting that I know. If they had a meeting, my son would have come.<br><br>On 04/15/24 at 02:25 PM, reviewed the progress notes for the care plan meeting, sign-in sheets for the care plan meeting, and invitation letters that were sent to the family to attend the care plan meeting. The sign-in sheets for the care plan meeting do not have the resident's or family's signatures.<br><br>A review of the interdisciplinary team (IDT) care plan notes dated: 08/23/22, 11/22/22, 02/28/23, 05/30/23, 06/06/23, 08/24/23, 02/20/24, and 04/02/24 was completed. None of the notes revealed that the resident or family was present or invited to attend care plans.<br><br>Further review of the Medical record failed to reveal documentation addressing why neither the resident nor the family were involved in the IDT meetings.<br><br>On 04/16/24 at 2:40 PM, during an interview with the Social Services Director (SSD), the surveyor asked about the family's signatures when they attended the care plan meeting. SSD stated that they do sign the care plan attendance sheet when they attend meetings. The surveyor shared that the copies given by the facility consist of eight care plan meetings held on 08/23/22, 11/22/22, 02/28/23, 05/30/23, 06/06/23, 08/24/23, 02/20/24, 04/02,/24. None of the care plan notes or attendance sign-in sheets revealed that the resident or resident's family was present for the meetings.<br><br>The SSD also repoted that the facility informs the residents verbally on the day of the care plan meeting only if they are alert and oriented. If the residents don't have the capacity (residents who are deemed not capable of making healthcare decisions by two physicians), the facility does not invite them to the meeting but sends letters to the family. Resident families rarely return the signed slip from the invitation sent from the facility; sometimes, they just show up to the meeting. The surveyor asked if the SSD makes phone calls to follow up with the family after sending the invitation letter, and if family members don't respond or show up at the meetings, SSD said, NO.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 37276<br><br>3) A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care. Resident and resident representative participation in care planning can be accomplished in many forms such as holding care planning conferences (meetings) at a time the resident representative is available to participate, holding conference calls or video conferencing.<br><br>The MDS (Minimum Data Set) is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Following the assessment, care plans should be reviewed along with an evaluation of the resident's progress or lack of progress towards meeting his/her goals, and the care plan updated based on the needs of the resident or in response to current interventions.<br><br>On 4/9/24 at 11:51 AM, during an interview, when asked if the resident was invited to care plan (CP) meetings and participated in the development of his/her care plan, Resident #46 stated s/he could not recall being invited to or attending a care plan meeting.<br><br>On 4/11/24 at 9:07 AM, an interview was conducted with the Social Service Director (SSD), with the Nursing Home Administrator (NHA) in attendance. During the interview, the SSD stated that CP invitation letters were formulated by the front desk receptionist according to the care plan schedule and sent to a resident's family member by mail or an email. The SSD stated when the resident's family member was not present at the meeting and/or the resident declined to attend the meeting, their absence would be documented in the resident's medical record. The SSD also stated that residents who could not get out of bed did not attend their care plan meeting, and after the meeting, the SSD usually would go to the resident's room to share the update, give them a copy of the care plan, and she would document this in the resident's medical record. When asked if CP meetings were ever held in a resident's room, the SSD indicated that care plan meetings were never held in a resident's room, and she had never received a request from a resident to have a CP meeting in his/her room. The SSD stated that, when necessary, on admission, they would go to a resident's room for their CP meeting.<br><br>On 4/11/24 at 3:33 PM, during an interview, the SSD stated that CP meeting invitation letters were given to alert and oriented residents, and, on the morning of the CP meeting, the SSD would go to the resident's room and invite the resident to the meeting. When asked how the CP invitation letter was provided to the resident, the SSD indicated that she did not know who gave the resident the letter, and she only followed up with the resident on the day of the CP meeting.<br><br>Review of Resident #46's medical record failed to reveal documentation to indicate Resident #46 was invited to his/her care plan meetings, or that the resident was given the opportunity to participate in the development of his/her care plans. Review of Care Plan Meeting attendance signature sheets for Resident #46's CP meetings held on 5/24/23, 8/24/23, 11/16/23 and 2/22/24 failed to reveal no signatures of Resident #46 to indicate the resident attended the meeting. In addition, there was no documentation to indicate a Geriatric Nursing Assistant (GNA) attended any of the CP meetings, and there was no evidence that on 5/25/23 and 2/22/24, a food and nutrition services staff member had attended the meetings.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Continued review of Resident #46's medical record, revealed the resident had an indwelling urinary catheter (commonly called a Foley) (sterile tube inserted into the bladder to drain urine). Review of Resident #46's care plans revealed a care plan with the focus, [Resident #46] has an indwelling catheter related to Pyocystis (severe lower urinary tract infection (UTI) resulting from the collection of infected debris within the bladder) and obstructive uropathy (urinary tract disorder that occurs due to obstructed urinary flow). Goal is to remove once infection is cleared and bladder function may be restored, has been closely followed by urology-HX MRSA (Methicillin-resistant Staphylococcus aureus) (type of staph bacterial infection that is resistant to many antibiotics) - urine that was initiated on 9/5/22, with the goal, [Resident #46 will be/remain free from catheter-related trauma through next 90 days.<br><br>On 8/3/22 at 9:30 AM in a urology encounter note, the urologist documented Resident #46 had a cystoscopy (examination of the bladder and urethra using a cystoscope, inserted into the urethra (tube through which urine leaves the body) which was positive for Pyocystis and signs of incomplete bladder emptying, and a foley catheter was placed. On 1/24/23, in a urology consultant report, the practitioner documented Resident #46 had incomplete bladder emptying and foley catheter placement. On 6/21/23, in a urology consultant report, the practitioner documented Resident #46 had vesicoureteral reflux (abnormal flow of urine from your bladder back up the tubes (ureters) that connect the kidneys to the bladder), dysfunction of the bladder and small capacity and foley catheter replaced. Continued review of Resident #46's medical record failed to reveal documentation to indicate Resident #46 continued to have Pyocystis. The facility staff failed to revise the care plan once the resident's infection was cleared, and update the care plan with the resident's current clinical indication for the catheter.<br><br>On 4/12/24 at 1:40 PM, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were made aware of the concerns with Resident #46's indwelling catheter care plan and the DON & ADON acknowledged the concern at that time.<br><br>4) On 4/16/24 at 2:51 PM, a review of Resident #4's medical record revealed a quarterly MDS with an assessment reference date (ARD) of 10/25/23 and annual assessment with an ARD of 1/23/24.<br><br>Review of Resident #4's care plans revealed a care plan, with the focus, Mental Health Diagnosis, initiated on 1/17/23 with the goal, [Resident #4] has diagnosis of depression, will use [his/her] coping mechanisms to manage [his/her] diagnosis within the next 90 days, that had the interventions, 1) Administer medications as ordered. Monitor/document for side effects and effectiveness, 2) Consult [name of provider] psych as needed, and 3) Resident is very social, visits with family and attends activities.<br><br>Further review of Resident #4's medical record revealed, on 11/2/23 at 4:42 PM in a care plan note with the focus, Mental Health Diagnosis, the Social Worker (SW) documented Resident #4 had a diagnosis of depression and was on psychotropic medication at that time. The SW wrote the resident's PHQ-9 (patient depression questionnaire) ranged from minimal to mild depression, the family visited often, and psych was involved. There was no documentation found to indicate the care plan was reviewed for Resident #4's progress or lack of progress towards meeting his/her goals and the resident's potential response to the interventions had been evaluated.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/1/24 at 10:21 AM, in a care plan note with the focus, Mental Health Diagnosis, the SW indicated that a care plan meeting was held, that Resident #4 had a diagnosis of anxiety and depression, his/her PHQ-9 (patient depression questionnaire) score was 0; and the resident was followed by psych. There was no documentation found to indicate the care plan was reviewed for Resident #4's progress or lack of progress towards meeting his/her goals and the resident's potential response to the interventions had been evaluated.<br><br>5) On 4/18/24 at 3:11 PM, a review of Resident #64's medical record a quarterly MDS assessment with an ARD of 11/28/23 and annual assessment with an ARD of 2/28/24.<br><br>Resident #64's care plans revealed a care plan with the focus, Mental Health Diagnosis, initiated on 3/13/23, with the goal, [Resident #64] has diagnosis of Depression and Anxiety; [s/he] will use [his/her] coping mechanisms to manage [his/her] diagnosis within the next 90 days, that had the interventions, 1) Administer medications as ordered. Monitor/document for side effects and effectiveness, 2) Arrange for psych consult, follow up as indicated, and Quarterly completion of PHQ-9 assessments<br><br>On 12/8/23 at 11:24 AM, in a care plan note with the focus, Mental Health Diagnosis, the SW documented Resident #64 had diagnosis of depression and anxiety, that was not on psychotropic medications. PHQ-0 was minimal depression, the resident was seen by psych, and the resident was usually smiling and social. There was no documentation found to indicate the care plan was reviewed for Resident #64's progress or lack of progress towards meeting his/her goals or the resident's potential response to the interventions had been evaluated,<br><br>On 3/8/24 at 9:39 AM, in a care plan note with the focus, Mental Health Diagnosis, the SW documented Resident #64 had diagnosis of depression and anxiety, the resident was taking psychotropic medications, his/her was PHQ-9 was 0 to Minimal Depression, and the resident was very active on the unit. There was no documentation found to indicate the care plan was reviewed for Resident #64's progress or lack of progress towards meeting his/her goals or the resident's potential response to the interventions had been evaluated.<br><br>On 4/19/24 at 10:27 AM, during an interview, the concerns the evaluation of Resident #4 and Resident #64's Mental Health Diagnosis care plan were discussed with Staff #4, Social Services Director, (SSD) and the SSD acknowledged the concerns at that time. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45139<br><br>Based on pertinent document review and interviews, it was determined that the facility failed to document that incontinent care was provided to a dependent resident. This was evident for 1 (resident # 298) out of 2 residents, reviewed for neglect during a survey.<br><br>The findings include:<br><br>Review of intake # MD00176574 revealed a concern that Resident #298, a long-term care resident, was not receiving appropriate incontinent care.<br><br>On 4/18/24 at 6:17 AM, review of the quarterly Minimum Date Set (MDS) dated [DATE] section G0400, revealed that resident #298 was dependent on the staff for toileting hygiene. Further review of section H under urinary continence revealed that Resident #298 was documented as being always incontinent.<br><br>The Minimum Data Set (MDS) is part of the process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems.<br><br>On 4/19/24, review of Geriatric Nursing Assistant (GNA) task documentation failed to reveal documentation that Resident #298 received bowel and bladder incontinent care on the following dates.<br><br>9/4/24 day shift 7:00 AM - 3:00 PM<br><br>9/4/24 evening shift 3:00 PM -2300 PM<br><br>9/5/24 day shift 7:00 AM - 3:00 PM<br><br>9/6/24 evening shift 3:00 PM -2300 PM<br><br>9/7/24 day shift 7:00 AM - 3:00 PM<br><br>On 4/11/24 at 4:21 PM, GNA #33 was interviewed. During the interview, GNA #33 reported that she documents throughout the shift when she completes her resident care. In addition, she reported that, if she does not have time to document care when it is completed, she would document at the end of her shift.<br><br>On 4/19/24 at 9:44 AM, the above concern was discussed with the Administrator. The Administrator was unable to provide any additional documentation that incontinent care was provided for the dates and shifts listed above, prior to the end of the survey. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>49409<br><br>Based on interviews, and medical records review, it was determined that the facility failed to provide treatment and care in accordance with professional standards of practice. This was evident for 1 (Resident #1) out of 4 residents who were reviewed for hospitalization during the annual survey.<br><br>The findings include:<br><br>Resident #1 has been at the facility for more than two years. The resident was diagnosed with Diabetes Mellitus along with other medical conditions.<br><br>On 04/10/24 at 10:03 AM, an interview revealed that the resident was sent to the hospital about a month ago. The resident also reported that s/he was not getting insulin before going to the hospital but was now receiving it.<br><br>On 04/12/24 at 11:24 AM, a record review confirmed the resident's report that s/he was not receiving insulin prior to the recent hospitalization . Further review revealed that, on 02/14/24 at 1:08 PM, the facility received a lab report revealing a glucose level of 328 mg/dl.<br><br>Provider #3 saw the Resident on the same day, 02/14/24, at 1:47 p.m. A review of the 02/14/24 progress notes revealed the chief complaint was bleeding. The provider's encounter notes do not address elevated Glucose levels. The nurses progress note, dated 02/14/24 at 5 PM, did not acknowledge elevated glucose levels.<br><br>Further review of the medical record revealed that two encounter notes were written by the primary care nurse practitioner on 03/04/24. The provider's progress notes written at 2:24 pm revealed, Review of pt's labs: [NAME] blood cell count (WBC) has been chronically elevated >11 since 11/2023. No symptoms of Infection. On the same day, 03/04/24, at 3:39 pm, Resident #1seen by the provider for an annual wellness visit. Neither of these notes acknowledged or addressed the glucose level of 328mg/dl.<br><br>The nurses' progress notes from 3/6/24 at 12:18 PM revealed a critical glucose level of 455 mg/dl, MD was made aware, and no new orders. The normal range of blood glucose levels (per laboratory used by the facility) was 70 - 100 mg/dl.<br><br>On 04/17/24 at 11:48 AM, an interview was conducted with the primary care physician. The physician reported that they would follow the resident's diabetes with an A1C (The A1C test, also known as the hemoglobin A1C or HbA1c test, is a simple blood test that measures your average blood sugar levels over the past 3 months) and based on those results, the resident was well-controlled in December ( HgA1c - 6. 7mg/dl). The Provider also reported that the resident was having issues with chronically elevated white blood cell counts and bleeding. Regarding the elevated blood sugars, the physician reported that he felt that whatever was making the white blood cell count go up, was also causing the elevated blood sugar.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of the medical record revealed that the resident was seen by the primary care NP (Staff #41) on 03/08/24 at 1:12 PM. A review of the note for this visit revealed that the Provider's progress notes did not address the increased Glucose level of 445 mg/dL.<br><br>Furthermore, on 03/11/24 at 8:44 PM, the nurse's progress notes revealed that the resident had been sent to the hospital. Blood sugar checked prior to transfer was reading HIGH. If the Glucometer displays high, it means the blood glucose level exceeds 500 - 600 mg/dl (the manufacturer guide gives the range). Review of hospital records confirmed that resident's glucose level was >600 on the day of the admission. Further review of the medical record revealed the resident's Hgb A1C was found be 12 during the hospitalization , indicating an average elevated glucose level over the previous 3 months.<br><br>Resident was in hospital from 03/11/24 to 03/17/24. The resident was started on insulin while in the hospital and continues to receive insulin and an oral hypoglycemic (medication to lower blood sugar) daily. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>48470<br><br>Based on records review and interviews, it was determined that the facility failed to ensure that a resident's drug regimen was free from unnecessary drugs and failed to notify a resident's attending provider of when a medication was not given. This was evident for 3 (Resident #198, #4, #85) of 6 residents reviewed for unnecessary medications and 1 (#85) of 68 residents reviewed during hte recertification survey.<br><br>The findings include:<br><br>1) Resident #198 was admitted to the facility in 2023 and was sent to the emergency room after 7 days for a change in condition. On 4/12/24 at 12:50 PM, Resident #198's progress notes were reviewed and revealed a note documented by Licensed Practical Nurse (LPN Staff #35) on 7/24/23 at 8:30 PM that indicated she had administered medication for an acute onset of pain.<br><br>On the same day at 1:20 PM, Residents #198's medical records were reviewed and revealed pain management orders including:<br><br>a) Oxycodone HCl Oral Tablet 5 MG, give 1 tablet by mouth every 4 hours as needed for pain scale 5-10 related to a left femur fracture.<br><br>Oxycodone is a potent opioid that can be useful when used judiciously for pain. The immediate-release formulation of oxycodone is FDA approved for the management of acute or chronic moderate to severe pain, for which the use of opioid medication is deemed appropriate and for which other pain management strategies are insufficient. The most common side effects include constipation, dizziness, headache, nausea, and somnolence.<br><br>b) Non-Pharmacological Interventions (NPI) attempted prior to administering any prn pain med. as needed Document the number that corresponds to the Non-Pharmacological Interventions attempted: 1.Warm beverage offered 2. Repositioned 3. Soft music played 4. Lights dimmed 5. Other (document in a progress note) 6. Resident refused NPI.<br><br>The orders were reviewed along with the medication administration record and revealed that on 7/24/23, Staff #35 administered the Oxycodone at 3:15 PM for a pain score of 5/10 and documented that it was ineffective. Further review of Resident #198's medical record failed to reveal evidence that non-pharmacological interventions were attempted prior to administering the Oxycodone.<br><br>In an interview with the Director of Nursing (DON) on 4/15/24 at 3:38PM, she reported her expectation with nurses when residents complained of pain and stated, We also have NPI's. Here, we always offer that first then we check for pain medication orders. The concern was discussed with the DON that, after reviewing Resident #198's medical record, there was no evidence that non-pharmacological interventions were attempted prior to administering the pain medication. The DON acknowledged the concern.<br><br>37276<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2) A Lidocaine (local anesthetic) patch, when applied topically (to the skin), helps reduce pain by causing a temporary loss of feeling in the area where the patch was applied. Depending on the Lidocaine patch product, the patch may be left on the skin for up to 8 or 12 hours. According to MedlinePlus a division of the National Institutes of Health (NIH), Lidocaine 4% patches can be applied up to 3 times daily and for no more than 8 hours per application. Applying too many patches or topical systems or leaving them on for too long may cause serious side effects.<br><br>On 4/16/24 at 2:06 PM, a review of Resident #4's medical record was conducted. Review of Resident #4's April 2024 MAR revealed a 3/19/24 order for Lidocaine HCl External Patch 4 % (Lidocaine HCl), apply to left shoulder topically one time a day for left shoulder pain. Apply to left shoulder on in the morning and remove at night. The MAR documented the Lidocaine patch was applied Upon (upon rising) every day for 16 days in April, however there was no documentation found in the April MAR to indicate the Lidocaine patch was removed from the resident every night as ordered.<br><br>The concerns with failing to document when the lidocaine patch was removed after it was applied to Resident #4 were discussed with the Director of Nursing (DON) on 4/16/21 at 2:30 PM and the DON acknowledged the concerns at that time.<br><br>48259<br><br>3) Blood pressure (BP) is often written as an upper and lower number. Systolic blood pressure is the upper number. It measures the pressure in the arteries during heart muscle contraction. Diastolic BP is the lower number. It measures the pressure in the arteries when the Heart rests between beats.<br><br>Medical record review, on 4/9/24 at 12:58 PM, found that Resident #85 was admitted to the facility in September 2023 with diagnoses including Tachycardia (rapid heartbeat) and Dementia.<br><br>Further record review revealed that an attending provider documented, on 3/1/24, that Resident #85 continued to have Tachycardia. The provider recommended the use of a low-dose antihypertensive medication to manage the condition.<br><br>A continued review of the provider's note of 3/1/24 showed a statement that indicated the resident had experienced low BP readings in the past on a high dose of anti-hypertensive medication. The statement read, There is concern as patient was on higher doses of metoprolol during her hospitalization to cause low BP readings and increased confusion. Therefore, we will start low-dose and add hold parameters.<br><br>A subsequent record review on 4/9/24 at 2:08 PM found an attending provider's order dated 3/1/24 for an antihypertensive medication to be administered twice daily to Resident #85. The order had parameters to hold (not to give) the medication for a systolic BP less than 100, or a diastolic BP less than 60, or a heart rate less than 60 per minute.<br><br>A review of Resident #85's medication administration records for March 1 through April 9, 2024, was completed on 04/09/24 at 12:58 PM. The review found that Resident #85's antihypertensive medication was administered on 3/12/24 for a BP reading 132/55 and on 4/2/24 for a BP reading of 106/59. The medication was given despite the attending provider's order to hold it for DBP less than 60.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A continued review noted that the medication was held five times in March and once in April. However, there was no documentary evidence that Resident #85's attending provider was made aware of the low BP readings or low heart rate on 3/3/24, 3/12/24, 3/19/24, 3/24/24, 3/30/24, and 4/4/23.<br><br>During an interview, on 4/11/24 at 10:00 AM, staff #28, a licensed practical nurse, stated that she would notify an attending provider if she held any medication due to parameters because there might need to be an adjustment (dosage change) to the medication.<br><br>In a subsequent interview, on 4/11/24 at 10:23 AM, staff #29, the attending provider, stated that a low BP was considered a change in condition and that she wanted to be notified if a resident's BP was low and their medication was held by the nurses.<br><br>During an interview, on 4/11/24 at 12:45 PM, the director of nursing (DON) stated that she expected the nurses to notify the attending provider if the resident's condition was acute. The DON added that the nurses did not have to notify the attending provider if the resident's condition was chronic.<br><br>This meant that the nurses needed to notify the attending provider, because Resident #85's treatment with antihypertensive medication was newly started on 3/1/24 and within 2 days, on 3/3/24, the medication had to be withheld due to low BP reading. However, the review failed to show any evidence that the attending provider was made aware. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>49409<br><br>Based on resident interviews, staff interviews, and medical record reviews, it was determined that the facility failed to implement individualized, non-pharmacological approaches to care prior to the use of psychotropics. This was evident for 1 (Resident #1) out of 1 resident reviewed for mood and behavior.<br><br>The findings include:<br><br>Resident #1 has been at the facility for more than two years, receiving long-term care. The resident was diagnosed with multiple medical conditions.<br><br>On 04/11/24 at 11:45 AM, a medical record review revealed that the resident was seen by a psychiatric provider on 12/10/23, who stated that the Resident denied having Anxiety or depression. A review of Nurses' progress notes from 03/22/24 to 03/31/24 revealed no documentation of the resident being awake at night.<br><br>On 3/25/24 at 1:00 PM, the Nurse Practitioner's (NP Staff #41)) progress notes stated that the resident was more interactive than what I'm used to though staff reports that the resident was at [his/her] baseline. On 03/31/24 at 3:25 AM, Nurse progress notes stated, slept well, call light within reach.<br><br>Review of activity assessments from 03/21/24, 12/31/23, and 11/06/23 revealed that the resident's preferred activities were: enjoys participation in large and small groups, 1:1 activity, Crafts, Music, gospel Music, talking to people, Bingo, and puzzles. Activity care plan notes on 02/03/34 stated, current leisurely pursuit patterns include spending an increased amount of time in [his/her] room and preferring in-room visits over group activities. Activity care plan notes from 04/02/24 documented reviewed with IDT this date. The resident has been enjoying independent leisurely pursuits in her room, including watching TV and receiving one-on-one and in-room visits from staff and visitors.<br><br>The resident was seen by the primary NP on 04/01/24 at 3:40 PM. The NP documented no increased nervousness or depression. During my visit, the patient was sleepy. Staff report that the patient has been sleeping during the day and is up all night. Trial Trazadone, sleep log x 7 days.<br><br>On 04/01/24, a new order was placed: trazodone HCl Oral Tablet 50 MG, Give 1 tablet by mouth at bedtime for insomnia.<br><br>Prior to initiating the TRAZADONE medication (Anti Deppresant) for insomnia, no evidence of trying non-pharmacological interventions and or sleep logs review was found.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 04/01/24 at 9 PM, nurse's progress notes indicated, The resident was awake during the evening and fell asleep at 8 PM On 04/02/24 at 07:52 PM Nurses' progress notes: The resident was awake most of the shift On 04/03/24 at 03:54 PM, Nurse progress notes: The resident was asleep at the beginning of the shift and then awake for the remainder of the day shift on 04/04/24 at 2:58 PM, Nurses progress notes; stated Awake throughout shift.<br><br>On 04/12/24 at 10:53 AM, the Nurse Practitioner's progress notes indicated, Pt was seen to f/u on (Diabetes) DM and insomnia. Pt placed on trazodone on 4/1 for reports of insomnia. Sleep log reviewed. Noted that pt is sleeping through the night. The resident occasionally wakes up around 5 am and would go back to sleep an hour later.<br><br>On 04/15/24 at 04:05 PM, surveyor reviewed with the Director of Nursing (DON) & Assistant Director of Nursing (ADON) the concern regarding no non-pharmacological interventions prior to initiating the use of psychotropics (Trazadone). The DON stated that she would check and bring in any additional information if available to support the implementation of non-pharmacological interventions. As of time of survey exit on 4/22/24, no additional documentation was provided regarding this concern. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>37276<br><br>Based on observations and interviews, it was determined that the facility failed to properly store medication as evidenced by failing to discard expired medications and failing to date medications when opened. This was evident for 3 or 3 medication carts observed during the survey.<br><br>The findings include:<br><br>1) On 4/19/24 at approximately 2:55 PM, an observation of a medication cart on Unit 1A revealed an open bottle of Promethazine DM Oral solution that was labeled with Resident #3's name, a 1/2/24 opened date and a manufacturer expiration date of 1/24. The facility failed to discard the bottle of Promethazine when it expired in January 2024.<br><br>Also, in the Unit 1A medication cart, there was a Trelegy Ellipta inhaler that was labeled with Resident #80's name and the opened date was 2/27/24. According to the manufacturer's instructions, Trelegy Ellipta inhaler should be discarded after the foil tray is opened or when the counter reads 0, whichever comes first. The Trelegy inhaler should have been discarded on 4/9/24, which was 6 weeks after opening.<br><br>On 4/19/24 at 3:22 PM, At that time, Registered Nurse (RN Staff #8) confirmed the medications were expired and discarded them appropriately.<br><br>2) On 4/19/24 at 3:28 PM, an observation of a medication cart on Unit 1B revealed a bottle of Olopatadine (Patanol) eye drops labeled with Resident #54's name and the opened date was 2/6/24. According to the manufacturer's instructions, Olopatadine eye drops should be discarded 4 weeks after opening. It should have been discarded six weeks after 1/13/24.<br><br>On 4/19/24 at 3:46 PM, Licensed Practical Nurse (LPN Staff #11) confirmed the findings, indicated the expired eye drops would be discarded appropriately, and replacement eye drops for the resident would be ordered from the pharmacy.<br><br>3) On 4/19/24 at 3:51 PM, an observation of a medication cart on Unit 2B revealed an opened Fluticasone Propionate and Salmeterol inhalation powder (Advair Diskus) inhaler labeled with Resident #57's name that was not labeled with the date when opened. According to the manufacturer's instructions the inhaler should be discarded 1 month after opening the foil pouch or when the counter reads 0, whichever comes first. Because the inhaler was not labeled when opened, there was no way to know whether the medication had expired.<br><br>Also, in the 2B medication cart, there was an opened Fluticasone Propionate and Salmeterol (Advair) Inhaler labeled with Resident 81's name and the date opened was 2/24/24. The facility failed to discard the medication 1 month after opening as per manufacturer's instructions.<br><br>At that time, LPN Staff #25 who had been present, confirmed the findings and indicated the inhalers would be discarded appropriately.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/22/24 at 12:52 PM, the above concerns with failing to discard expired medications and failing to date medications when opened were discussed with the Director of Nursing (DON) and she acknowledged the concerns at that time. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>48259<br><br>Based on records review and staff interviews, it was determined that the facility failed to keep complete and accurate medical records. This was evident for 1 (Resident #16) of 16 residents reviewed for abuse, and 1 (Resident #64) of 6 residents reviewed for unnecessary medications.<br><br>The findings include:<br><br>1) The Minimum Data Set (MDS) is a federally mandated assessment tool used by nursing home staff to gather information on each Resident's strengths and needs. Information collected drives resident care planning decisions.<br><br>On 4/10/24 at 9:58 AM, a medical record review showed that Resident #16 was admitted to the facility in March 2022. Continued review revealed an MDS assessment, dated 3/8/22, that documented Resident #16 used hearing aids.<br><br>On the same day at 10:20 AM, a record review for Resident #16 revealed an order summary report for April 2024 that contained an attending provider's order, initiated on 6/12/2022, for the Nurse to apply hearings aids upon rising and remove at HS. To be locked in treatment cart when not in use for safekeeping every day and evening shift (HS - at bedtime).<br><br>Further review completed on 4/10/2024 at 1:30 PM, of Resident #16's treatment administration record (TAR) for February 1 through April 10, 24, revealed that this order was signed off daily by the nurses, except on 2/13/24, 2/17/24, 3/1/24 and 3/5/24.<br><br>An observation of Resident #16 on 4/10/2024 at 11:58 AM, revealed the resident was lying in bed awake and was not wearing the hearing aids.<br><br>A subsequent observation was made of Resident #16 on 4/11/24 at 1:34 PM, sitting in a chair by the bedside and having no hearing aids in his/her ears.<br><br>An interview with Resident #16's son on 4/11/24 at 1:40 PM, He reported that Resident #16 had not used the hearing aids for several months.<br><br>During an interview with Geriatric Nurse Aid (GNA Staff #34) on 4/11/24 at 1:50 PM, she reported that she had never seen Resident #16 wearing a hearing aid since she started working with the resident.<br><br>During a subsequent interview on 4/11/24 at 1:59 PM, registered nurse (RN Staff #30) confirmed that Resident #16 had not been wearing the hearing aids for several months. Staff #30 could not provide a rationale for why the nurses had consistently documented that the resident was wearing hearing aids, but stated that she would talk to the attending provider and have the order discontinued.<br><br>37276<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2) Review of Resident #64's April 2024 medication administration record (MAR) revealed a 11/2/23 order for Escitalopram Oxalate (Lexapro) Give by mouth one time a day related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.<br><br>Review of Resident #64's medical record revealed on 1/26/24, in an encounter note, the Certified Registered Nurse Practitioner (CRNP) documented Resident #64's assessment and diagnosis included anxiety disorder, unspecified, continue Lexapro, and depression, continue Lexapro. On 2/19/24, in an encounter note, the CRNP documented Resident #64's assessment and diagnosis included anxiety disorder, unspecified, continue Lexapro; psych following, and depression, continue Lexapro; psych following.<br><br>On 4/19/24 at 11:36 AM, the Director of Nurses was made aware of the concern with the indication for use of Escitalopram as transcribed in his/her MAR, and the DON acknowledged the concern at that time. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48259<br><br>Based on observations, records review, and interviews, it was determined that the facility failed to replace and store a nebulizer mask in a sanitary manner to prevent the spread of infection, failed to post notification requiring the use of personal protective equipment (PPE), and failed to wear the proper PPE prior to entering a room which required enhanced barrier precautions (EBH). This was evident for 2 (Resident #28, #38) of 3 residents reviewed for respiratory care and 2 (Resident #85, #1) random observations during the survey.<br><br>The findings include:<br><br>1) A nebulizer is a small machine that turns liquid medicine into a mist to be inhaled through a mouthpiece or mask and enters the lungs directly. After use, the mask or mouthpiece is washed with mild soap, rinsed under running water, dried on paper, and kept in a sealable plastic bag.<br><br>During a tour of the 2nd-floor unit on 4/9/24 at 10:46 AM, Resident #28 was observed lying in bed and wearing oxygen through nasal cannula tubing attached to an oxygen concentrator set at 2L(Liters). A nebulizer mask, dated 3/9/24, was also observed lying bare on a nightstand with no covering.<br><br>A medical record review completed on 4/9/24 at 10:55 AM for Resident #28 found an order summary report for April 2024 that contained an attending provider's order initiated on 10/6/23 for Budesonide Inhalation Suspension via nebulizer three times a day for COPD (COPD is a chronic inflammatory lung disease that obstructs airflow from the lungs).<br><br>In an interview on 4/9/24 at 11:20 AM with staff #36, she confirmed that the date on the nebulizer tubing and mask for Resident #28 was 3/9/24. Staff #36 said the mask should have been changed and that she would change the tubing and mask immediately after the surveyor's intervention.<br><br>In a subsequent interview with the director of nursing (DON) on 4/10/24 at 2:54 PM, she said the nebulizer mask and tubing were expected to be changed weekly and placed in a bag.<br><br>In an interview on 4/11/24 at 1:17 PM with the DON, she stated an audit was done on all the units regarding nebulizer masks and tubing, and training was provided to the nurses after the surveyor's intervention.<br><br>45139<br><br>On 4/9/24 at 3:00 PM, review of records revealed that Resident #38 was a long-term resident of the facility. Further review revealed the resident was in isolation and an order was in place for contact/droplet precautions every shift for a COVID-19 diagnosis.<br><br>Contact and droplet precaution, Personal protective equipment (PPE) are recommended for healthcare workers before entering the room of suspected or confirmed COVID-19 patients. The required PPE include mask, eye protection, long sleeve gown and gloves.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3) On 4/12/24 at11:40 PM, an observation was made of Resident #38's room. The observation revealed that Resident #38's room had 2 doors that allowed access to the room from the hallway. The first door opened to the resident's main room and the second door opened to the resident's bathroom. Further observation revealed a sign on the first door, directing staff and visitors to the personal protective equipment (PPE) that must be worn before entering the room. Further observation failed to reveal any sign on the second door.<br><br>On 4/12/24 at 12:42 PM, a second observation confirmed that there were 2 doors that had access to Resident #38's room and only one door had a sign indicating what PPE must be worn. Observation revealed that when the second door was open it provided unobstructed access to Resident #38's room.<br><br>On 4/12/24 at 12:43 PM, an observation was made with the facility's Infection Preventionist (Staff # 26) of the second door to Resident #38's room. Staff #26 confirmed that there was no sign on the second door and that the door should be locked. After attempting to lock the door, staff # 26 reported that the door was unable to be locked.<br><br>Staff # 26 reported that she would get a lock on the door and put up the appropriate signs indicating what PPE must be worn before entering.<br><br>On 4/12/24 at 12:46 PM, the surveyor discussed the above concern with the Director of Nursing. The DON reported that a plan to put up the appropriate signs and apply a lock on the second door had already been started.<br><br>On 4/17/24 at approximately 5:57 AM, observation was made of nurse LPN Staff # 27 entering Resident #85 room without a gown on. Further observation revealed an enhanced barrier precaution (EBP) sign on the door.<br><br>Enhanced Barrier Precautions can be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: Wounds or indwelling medical devices, examples of indwelling medical devices include central line, urinary catheter, feeding tube, and tracheostomy/ventilator. Enhanced barrier precautions include the use of gown and gloves, when providing care.<br><br>On 4/17/24 at 6:04 AM, during a brief interview with Staff #27, she reported that she had provided care for Resident #85. She reported that she gave the resident some medicine and provided a bolus for the G-tube. When the surveyor asked the nurse if the resident was on EPH, the nurse did not respond.<br><br>A G tube is a tube inserted through the wall of the abdomen directly into the stomach. It allows air and fluid to leave the stomach and can be used to give drugs and liquids, including liquid food.<br><br>On 4/17/24 at 6:50 AM, review of orders for Resident #85 revealed an order dated 11/20/23 for Enhanced Barrier Precautions to be maintained at all times, G tube every shift. Continued review of the order revealed an order dated 11/17/24, Flush PEG tube with 30 ML of H2O before and after each med pass every shift.<br><br>(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) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/17/24 at 7: 22 AM, during an interview with Infection preventionists Staff #26, she reported that it is best practice to wear gown and gloves when accessing a medical device such as a G-tube. 4) On 4/18/24 at 4:09 AM, an observation was made of GNA #16. Observation revealed GNA #16 entered Resident #1's room. The observation failed to reveal that the GNA wore a gown. Further observation revealed an Enhanced Barrier Precaution sign on the door.<br><br>4) On 4/18/24 at 4:14 AM, during a brief interview with GNA # 16, she reported that she provided incontinent care to resident #1. She reported that she put on the PPE (gloves) prior to providing care to the resident. In addition, she reported that she knew when she needed to wear a gown by a sign on the door for EBP. She reported that several of the doors on her unit have EBP signs, but room [ROOM NUMBER] was not one of them.<br><br>On 4/18/24 at 4:17 AM, GNA # 16 and surveyor made an observation of the door to room [ROOM NUMBER]. GNA #16 confirmed there was an EBP sign on the door.<br><br>On 4/18/24 at 4:18 AM, during a brief interview, GNA #16 reported that she had not seen the sign and she should have worn a gown when providing incontinent care.<br><br>On 4/18/24 at 6:33 AM, during an interview with the Infection Preventionists Staff #26, she reported that when Resident #1 first arrived, they were not on EBP. The resident recently acquired an open wound and was then put on EBP, and the sign was put on the resident door. |