STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225284	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plymouth Harborside Healthcare	19 Obery Street Plymouth, MA 02360

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities 41106 Based on record review and interview, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASARR- screen to determine if a resident had an intellectual or developmental disability and/or serious mental illness (ID/DD/SMI) and needed further evaluation) for one Resident (#25), out of a total sample of 18 residents, who transferred to the facility in 2019. Findings include: Review of the MassHealth Nursing Facility Bulletin 169 titled Updates to Nursing Facility Regulations: preadmission screening and resident review (PASARR) for intellectual disability, developmental disability, and serious mental illness, dated June 2024, indicated but was not limited to the following: - Level II Evaluation. A comprehensive independent evaluation that is consistent with federal PASARR regulations at 42 CFR 483.134, and conducted on individuals that have positive Level I Screenings. The Level II Evaluation is a person-centered assessment taking into account all relevant information, including the individual's or individual's authorized representative's goals and preferences for the individual's care. It is required to ascertain: 1) whether the referred individual has ID/DD, SMI, or both; and 2) if so, whether community-based services, admission to a nursing facility or other setting is appropriate; and 3) if a nursing facility is appropriate, whether Specialized Services are required. - When an individual is transferred from one nursing facility (transferring facility) to another nursing facility (receiving facility), with or without an intervening hospital stay, the individual is not considered a new admission, and does not require preadmission screening (but may require a Resident Review, depending on the circumstances, such as a Significant Change). The transferring facility must ensure that it transfers all copies of the resident's PASARR paperwork, including the Level I Screening form and, if applicable, the Determination Notices and CERs, to the receiving facility. This transfer must be documented in the PASARR Portal. If the Level I Screening form is not available in the PASARR Portal, then the transferring facility must submit a new Level I Screening form via the PASARR Portal before transferring the individual. The receiving facility must not admit such an individual without receiving all PASARR-related documentation from the transferring facility. The receiving facility must inform the appropriate PASARR Authority within 48 hours of the transfer that the individual has been transferred to the receiving facility, in the same manner as described in Section 2.A.3, above. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #25 was admitted to the facility in July 2019 with diagnoses which included major depressive disorder, paranoid schizophrenia, and dementia with mood disturbances. Review of the Level I PASARR indicated but was not limited to the following: -Level II PASARR is indicated and must be completed before admission. Date of completion 7/31/12. Further review of the medical record indicated a Level II PASARR was not present in the medical record. During an interview on 10/22/24 at 5:12 P.M., the Director of Nursing (DON) said Resident #25 was a transfer from another facility. She said she could not find the Level II PASARR and will reach out to the previous facility to see if they have the completed Level II PASARR. The DON said she does not know if Resident #25 required any additional services for his/her mental illness. During an interview on 10/23/24 at 1:52 P.M., the DON said she called the MassHealth PASARR office, and they have no record of a Level II PASARR ever being completed. She said when Resident #25 transferred to this facility and did not have the Level II paperwork, they should have requested a Level II PASARR be completed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 42742 Based on document review and interview, the facility failed to ensure one Resident (#279) was provided a summary of their baseline care plan meeting, out of a total sample of 18 residents. Findings include: Review of the facility's policy titled Care Plans-Baseline, dated November 2017, indicated but was not limited to the following: -A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. -The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to: a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; and c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and any updated information based on the details of the comprehensive care plan, as necessary. Resident #279 was admitted to the facility in October 2024 and had diagnoses including atrial fibrillation, dementia, neuropathy (weakness, numbness, and pain from nerve damage), cerebrovascular accident (stroke), and coronary artery disease. Review of the Minimum Data Set (MDS) assessment, dated 10/17/24, indicated Resident #279 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13 out of 15. During an interview on 10/17/24 at 9:35 A.M., Resident #279 said he/she was new to the facility, about a week ago, but did not know what the plan of care was and did not receive a copy of anything. During an interview on 10/21/24 at 12:46 P.M., Resident #279 said he/she had still not received a copy of their baseline care plan since admission and only knew he/she was working with physical therapy. Review of the Admission 72-Hour Meeting Form, dated 10/15/24, indicated but was not limited to the following: -Attendees: Resident, Rehab/Therapy, and Social Services -Objective: To identify the patient/health care proxy (HCP)/family expectations of the care provided during the stay. Care will be based upon the patient's nursing and therapy goals. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Process: After the patient is admitted : (1.) It is recommended that the IDT (interdisciplinary team) meets with the patient/HCP/family within 72 hours. (2.) The Post Admission Conference Information obtained is used to determine the patient's goals for discharge. Further review of the form failed to indicate a copy of the baseline care plan was provided to the resident and/or resident representative. The section was not completed (box not checked). Review of the medical record failed to indicate documentation that a copy of the baseline care plan was provided to the resident and/or resident representative. During an interview on 10/22/24 at 1:14 P.M. with Unit Manager (UM) #1 and Social Worker (SW) #1, SW #1 said she had a meeting with the Resident but was not sure if she provided a copy of the baseline care plan to him/her. She said she doesn't usually check off the box on the form that indicates a copy was provided. SW #1 said she's only been at the facility for a very short time and is agency, so she wasn't sure who provides a copy of the baseline care plan to the residents. She said she just does the assessment form and does not write a separate note. UM #1 said a baseline care plan is completed within 48 hours of admission and a copy should be provided to the residents. SW #1 said there was no documentation to indicate the baseline care plan was provided. During an interview on 10/23/24 at 3:40 P.M., the Director of Nursing (DON) said the baseline care plan should be developed within 48 hours after admission and the resident or resident's representative should receive a copy of it.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48084 Based on observation, record review, and interview, the facility failed to ensure professional standards of practice were maintained during medication administration. Specifically, the facility failed to ensure three medications ordered by the physician were available and administered as ordered to one Resident (#66), out of a total of six residents observed during medication administration. Findings include: Review of the Massachusetts Board of Registration in Nursing Advisory Ruling 9324 titled Accepting, Transcribing, and Implementing Prescriber Orders, dated as last revised April 11, 2018, indicated but was not limited to the following: -It is the responsibility of the licensed nurse to ensure that there is a proper patient care order from a duly authorized prescriber prior to the administration of any prescription or non-prescription medication. -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers. -In any situation where an order is unclear, or a nurse questions the appropriateness, accuracy, or completeness of an order, the nurse may not implement the order until it is verified for accuracy with a duly authorized prescriber. Review of the facility's policy titled Administering Medications, dated as last revised 2/2020, indicated but was not limited to the following: -Medications are administered in a safe and timely manner, and as prescribed. -Medications are administered in accordance with prescriber's orders. -The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Resident #66 was admitted to the facility in October 2022 with diagnoses including wedge compression fracture and dementia. On 10/18/24 at 9:10 A.M., the surveyor observed Nurse #1 administer medications to Resident #66 which included but were not limited to the following: - High Potency Slow-Release Iron 45 milligrams (mg) of elemental iron equivalent to 142 mg of Ferrous Sulfate (one tab) - Fish Oil 1200 mg (one capsule) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Vitamin D3 25 micrograms (mcg) equivalent to 1000 international units (IU) (one tab) Review of the Physician's Orders for Resident #66 indicated but were not limited to the following: -Ferrous Sulfate tablet 325 mg give one tablet by mouth one time a day for supplementation (1/11/2023) -Fish Oil Oral Capsule 1000 mg give one capsule by mouth one time a day for supplement (1/13/2023) -Vitamin D3 125 mcg (5000 IU) give one tablet by mouth one time a day for supplement (5/29/24) During reconciliation of the medication administered and medications ordered it was determined that Nurse #1 failed to administer the correct medications as ordered by the provider. During an interview on 10/18/24 at 11:03 A.M., Nurse #1 said she administered the High Potency Slow-Release Iron 45 mg and the Fish Oil 1200 mg because that is all they have in the medication cart, so that is what he/she always gets. She said they are not the same as the orders, but it is all we have, so that is what was administered. Additionally, she said the Vitamin D3 order is for 125 mcg/5000 IU one tab and the highest dose available is 25 mcg/1000 IU, so that is what he/she always gets. She said there is not a 125 mcg/5000 IU tablet in the medication cart and the pharmacy doesn't send anything else so 25 mcg is what was administered not 125mcg as ordered. During an interview on 10/18/24 at 11:07 A.M., Unit Manager (UM) #1 said High Potency Slow-Release Iron 45mg is not the same as Ferrous Sulfate 325 mg, Fish Oil 1200 mg is not the same as Fish Oil 1000 mg, and Vitamin D3 25 mcg is not the same as Vitamin D3 125 mcg. He said all three medications administered were not what was ordered by the physician. He said the facility should have the correct doses or should order them if not in stock. Review of the medication storage room on 10/18/24 at 11:20 A.M. failed to indicate the correct medication was on hand. During an interview on 10/18/24 at 11:30 A.M., the Director of Nurses (DON) said those are all the wrong doses and medication errors. She said if the correct medication and/or dose is not available, then the nurse should notify the physician for a new order and/or request the correct medication/dose be obtained by the facility and not administer whatever is on hand. Refer to F759

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48084 Based on record review and interview, the facility failed to ensure a resident with a wound received necessary treatment and services to promote healing for one Resident (#32), out of a total sample of 18 residents. Specifically, the facility failed to address the wound physician's recommendations and accurately implement care and treatment of a non-pressure wound to the Resident's right first toe. Findings include: Review of the facility's policy titled Prevention and Management of Pressure Ulcers/Injuries, dated as last revised 8/2024, indicated but was not limited to the following: -Ensure a resident receives care consistent with professional standards of practice to prevent pressure ulcers and/or residents with pressure ulcer receive necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcer from developing. The facility failed to provide a policy for general skin care and/or non-pressure injuries. The Director of Nurses (DON) said the policy provided was the only skin policy they had. Review of the Service Agreement between the facility and the Wound Care Provider, dated 12/19/23, indicated but was not limited to the following: The facility agrees to support delivery of wound care services and commits to: -Provide a dedicated nurse to round and communicate with the Provider. -Inform the primary care provider of recommendations within 24 hours. -Discuss recommendations/wound care plan with the provider on day of rounds. Resident #32 was admitted to the facility in December 2021 with diagnoses which included heart disease and diabetes mellitus with neuropathy (nerve damage). Review of the Minimum Data Set (MDS) assessment, dated 8/2/24, indicated he/she scored 10 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating he/she had moderate cognitive impairment, was dependent for dressing and bathing, required assistance for turning, was at risk for pressure ulcer development, and had a lesion on his/her foot requiring a dressing. Review of the medical record indicated Resident #32 was followed by the Wound Doctor. Review of the Wound Evaluation and Management Summary, dated 7/24/24, indicated but was not limited to the following: -Focused Exam (site #6) non-pressure wound of the right first toe. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Duration greater than 264 days. -Wound measured 1 x 0.9 x 0.3 centimeters (cm), had moderate serous exudate (drainage), and had 30% thick adherent black necrotic eschar (dead tissue) and 15% thick adherent devitalized necrotic tissue. -Treatment Plan: Calcium Alginate (absorbent wound dressing to help with debridement) and Santyl (debriding ointment) once daily and wrap in kerlix. Review of the Physician's Orders indicated the following: -Right great first toe-Normal Saline wash, pat dry, apply calcium alginate, and cover with gauze roll every day shift. (7/24/24) The treatment order failed to include the Santyl ointment as recommended by the wound doctor. Review of the nursing and physician progress notes failed to indicate the physician declined the recommendation of the wound doctor. Review of the Wound Evaluation and Management Summary, dated 7/31/24, indicated but was not limited to the following: -Focused Exam (site #6) non-pressure wound of the right first toe. -Treatment Plan: Honey hydrogel sheet with border apply three times per week, cover with gauze roll. Review of the Physician's Orders indicated the following: -Right great first toe-Normal Saline wash, pat dry, apply Medhoney hydrogel and cover with gauze roll every day shift. (7/31/24) The treatment order failed to include the dressing change frequency as recommended by the wound doctor. Review of the nursing and physician progress notes failed to indicate the physician declined the recommendation of the wound doctor. Review of the Wound Evaluation and Management Summary, dated 8/7/24, indicated but was not limited to the following: -Focused Exam (site #6) non-pressure wound of the right first toe. -Treatment Plan: Honey hydrogel sheet with border apply three times per week, cover with gauze roll. Review of the Physician's Orders indicated the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Right great first toe-Normal Saline wash, pat dry, apply Medhoney hydrogel and cover with gauze roll every day shift. (7/31/24) The treatment order failed to include the dressing change frequency as recommended by the wound doctor. Review of the nursing and physician progress notes failed to indicate the physician declined the recommendation of the wound doctor. Review of the Wound Evaluation and Management Summary, dated 9/11/24, indicated but was not limited to the following: -Focused Exam (site #6) non-pressure wound of the right first toe. -Treatment Plan: alginate calcium once daily and cover with gauze roll. Review of the Physician's Orders indicated the following: -Right great first toe-Normal Saline wash, pat dry, apply Santyl and cover with gauze roll every day shift. (8/21/24) The treatment order failed to be discontinued and a new treatment initiated as recommended by the wound doctor. Review of the nursing and physician progress notes failed to indicate the physician declined the recommendation of the wound doctor. Review of the Wound Evaluation and Management Summary, dated 9/17/24, indicated but was not limited to the following: -Focused Exam (site #6) non-pressure wound of the right first toe. -Treatment Plan: (area left blank) Review of the Physician's Orders indicated the following: -Right great first toe-Normal Saline wash, pat dry, apply Santyl and cover with gauze roll every day shift. (8/21/24 Discontinue Date: 9/17/24) The previous treatment order was discontinued, and a new treatment was not implemented. Review of the nursing and physician progress notes failed to indicate the facility had reached out to the Wound Doctor to clarify treatment recommendations. Additionally, the notes failed to indicate the physician wanted the treatment discontinued and no treatment implemented for the wound. Review of the Wound Evaluation and Management Summary, dated 9/24/24, indicated but was not limited to the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Focused Exam (site #6) non-pressure wound of the right first toe. -Treatment Plan: Apply betadine once daily -Wound progress: not at goal. Review of the Physician's Orders indicated the following: -Right great first toe-Apply betadine once daily for 30 days to the right first toe. (9/25/24) During an interview on 10/18/24 at 3:50 P.M., Nurse #13 said she was new and not sure who did wound rounds, but Resident #32's wound is almost resolved and only gets betadine applied to it. During an interview on 10/23/24 at 2:51 P.M., Unit Manager (UM) #2 said the Staff Development Coordinator (SDC) does wound rounds and writes the orders. She did not know why these orders did not match the recommendations or why on 9/17/24 one treatment was discontinued and nothing else ordered. During an interview on 10/23/24 at 3:28 P.M., the SDC said she does wound rounds and writes the orders. She said the old physician would always say okay, but sometimes the new physician wants to do his own thing. She said if the physician wants something different than the recommendation there should be a note stating that. Additionally, the SDC said she did not know why the orders did not match the recommendation of the wound doctor or why on 9/17/24 one treatment was discontinued and nothing else ordered. She said it was hard to follow with the lack of documentation and that is part of the reason she had to take over wound rounds in September. During an interview on 10/23/24 at 4:30 P.M., the Director of Nurses (DON) said the orders should match the wound physician recommendations and if the physician wanted to do something different then there should be a progress note indicating such.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49425 Based on observations, interviews, and record review, the facility failed to ensure one Resident (#42), out of a total sample of 18 residents, received care and treatment to promote healing of pressure injuries. Specifically, the facility failed to accurately transcribe and implement orders for changes in treatments for the care of a stage four pressure ulcer injury (full thickness extending tissue loss that exposes bone, muscle, or tendon) to the left heel. Findings include: Review of the facility's policy titled Prevention and Management of Pressure Ulcers/Injuries, dated as last revised 8/2024, indicated but was not limited to the following: -Residents with pressure ulcer receive necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing -Conduct risk assessment upon admission, quarterly and with change in condition as warranted -Licensed nurse conducts a weekly skin evaluation -Develop the resident-centered care plan and interventions based on the risk factors identified, the condition of the skin, the resident's overall clinical condition Review of the wound clinic Services Agreement, dated March of 2015, indicated but was not limited to the following: Facility Responsibilities: -Provide a dedicated nurse to round and communicate with the Provider. -Inform the resident's primary care provider of Provider's recommendation within 24 hours. -Discuss recommendations/wound care plan with the Provider on the day of rounds. Review of the Massachusetts Board of Registration in Nursing Advisory Ruling 9324 titled Accepting, Transcribing, and Implementing Prescriber Orders, dated as last revised April 11, 2018, indicated but was not limited to the following: -It is the responsibility of the licensed nurse to ensure that there is a proper patient care order from a duly authorized prescriber prior to the administration of any prescription or non-prescription medication. -Nurse's Responsibility and Accountability: Licensed nurses accept, verify, transcribe, and implement orders from duly authorized prescribers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #42 was admitted to the facility in April 2024 with diagnoses including Type II diabetes mellitus with diabetic neuropathy (symptoms of numbness, weakness, and decreased sensation usually starting in feet/hands). Review of the Minimum Data Set (MDS) assessment, dated 7/24/24, indicated Resident #42 was cognitively intact as evidenced by a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS). Additionally, Resident #42 had skin treatments and was dependent on staff for assistance with bed mobility. Review of Resident #42's comprehensive care plan indicated but was not limited to the following: -Resident has a left heel pressure wound -Utilize wound MD for assessment -Notify MD/NP and obtain treatment Review of the medical record indicated Resident #42 was followed by a Wound Care Physician at the facility. Review of the Wound Evaluation and Management Summary, dated 9/17/24, indicated but was not limited to the following: -Stage 4 Pressure Wound of the Left Heel measured 0.2 x 0.3 x not measurable centimeters (cm) depth was not measurable due to presence of thick adherent black necrotic (dead) tissue. -Recommendation: Hydrocolloid sheet (thin) (a self-adhesive dressing that consists of two layers and is used to treat wounds with low to moderate amounts of drainage) apply three times per week for 30 days. -Discontinue: Gauze Island with border and Alginate Calcium dressing Review of the September 2024 Physician's Orders/Treatment Administration Record (TAR) indicated an order was implemented on 9/18/24 as follows: Left heel: Normal Saline (NS) wash, pat dry, apply hydrocolloid sheet, cover with gauze island dressing every day shift. The order failed to discontinue the gauze island with border dressing and continued to be changed daily instead of three times a week per the wound physician's recommendation. Review of the skin/wound note, dated 9/17/24, indicated Resident #42 was seen by the Wound MD, and orders were updated to reflect changes. Review of the nursing and physician progress notes failed to indicate the physician declined the recommendation of the wound physician. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Wound Evaluation and Management Summary, dated 9/24/24, indicated but was not limited to the following: -Stage 4 Pressure Wound of the Left Heel measured 0.3 x 0.5 x not measurable cm, depth was not measurable due to presence of thick adherent black necrotic tissue. -Recommendation: Hydrocolloid sheet (thin) apply three times per week for 23 days Review of the September 2024 Physician's Orders/TAR failed to indicate the order was obtained. The previous order for Hydrocolloid, cover with gauze island dressing change daily remained in effect. Review of the skin/wound note, dated 9/24/24, indicated Resident #42 was seen by Wound MD and orders were updated to reflect changes. Review of the nursing and physician progress notes failed to indicate the physician declined the recommendation of the wound physician. Review of the Wound Evaluation and Management Summary, dated 10/1/24, indicated but was not limited to the following: -Stage 4 Pressure Wound of the Left Heel measured 0.3 x 0.5 x not measurable cm, depth was not measurable due to presence of thick adherent black necrotic tissue. -Recommendation: Hydrocolloid sheet (thin) apply three times per week for 16 days Review of the October 2024 Physician's Orders/TAR indicated the order for left heel NS wash, pat dry, apply hydrocolloid sheet, cover with gauze island dressing every day shift was discontinued on 10/1/24. New order implemented on 10/1/24 for the following: Left heel, NS wash, pat dry, apply hydrocolloid sheet, cover with gauze island dressing, change every three days. The order failed to discontinue the gauze island with border dressing and continued to be changed every three days, instead of three times a week per the wound physician's recommendation. Review of the skin/wound note, dated 10/1/24, indicated Resident #42 was seen by Wound MD and orders were updated to reflect changes. Review of the nursing and physician progress notes failed to indicate the physician declined the recommendation of the wound physician. Review of the Wound Evaluation and Management Summary, dated 10/8/24, indicated but was not limited to the following: -Stage 4 Pressure Wound of the Left Heel measured 0.2 x 0.3 x 0.05 cm, with 100% granulation tissue. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Recommendation: Hydrocolloid sheet (thin) apply three times per week for 9 days Review of the October 2024 Physician's Orders/TAR failed to indicate the order was obtained. The previous order for Hydrocolloid, cover with gauze island dressing, change every three days remained in effect. Review of the skin/wound note, dated 10/8/24, indicated Resident #42 was seen by wound MD and orders were updated to reflect changes. Review of the nursing and physician progress notes failed to indicate the physician declined the recommendation of the wound physician. Review of the Wound Evaluation and Management Summary, dated 10/15/24, indicated but was not limited to the following: -Stage 4 Pressure Wound of the Left Heel measured 0.2 x 0.3 x not measurable cm, depth was not measurable due to presence of thick adherent black necrotic tissue. -Recommendation: Hydrocolloid sheet (thin) apply three times per week for 30 days Review of the October 2024 Physician's Orders/TAR failed to indicate the order was obtained. The previous order for Hydrocolloid, cover with gauze island dressing, change every three days remained in effect. Review of the skin/wound note, dated 10/15/24, indicated Resident #42 was seen by wound MD and no change in orders. Review of the nursing and physician progress notes failed to indicate the physician declined the recommendation of the wound physician. Further review of the October 2024 Physician's Orders/TAR indicated the treatment order had been discontinued on 10/21/24. New treatment order dated 10/21/24 for Resident #42's as follows: Left heel, NS wash, pat dry, apply hydrocolloid sheet, change every 3 days. During an interview on 10/17/24 at 2:43 P.M., Resident #42 said he/she developed the wound on his left heel at the facility. He/she said the wound doctor has been coming in to see him/her weekly. During an interview on 10/21/24 at 4:41 P.M., Unit Manager (UM) #1 said he completes rounds with the wound doctor and the wound nurse weekly. He said he removes the dressings, takes measurements of the wound, and replaces the dressings. UM#1 said the wound nurse receives the recommendations, notifies the physician, and updates the orders accordingly. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 10:26 A.M., the Wound Physician said he recommended the use of the hydrocolloid dressing to be applied three times a week. He said the dressing works best if it is not covered with another dressing. The Wound Physician said he is going to continue to recommend the hydrocolloid dressing for another week, and then re-assess the treatment recommendation at that time. During an interview on 10/22/24 at 1:47 P.M., the Wound Nurse said she rounds with the wound physician weekly. The wound doctor provides verbal recommendations and then sends them over to the facility electronically. She said she or Unit Manager #1 notifies the in-house provider of the recommendations. The Wound Nurse said she enters the orders into the chart and writes a skin/wound note. The Wound Nurse reviewed the recommendations from 9/17, 9/24, 10/1, 10/8, and 10/15 with the surveyor. She said she did notify the in-house physician of the recommendations, and she updated the treatment order. The Wound Nurse said the order in the chart does not match the wound physician's recommendations for those dates, because she entered the order incorrectly. During an interview on 10/22/24 at 2:12 P.M., UM #1 said he noticed yesterday that the order was incorrect, he notified the physician and changed the order to discontinue the gauze border dressing. UM #1 said he forgot to write a nursing note regarding updating the order, as he should have. The surveyor and UM #1 reviewed the order together, and UM #1 said the order is still incorrect, being completed every three days, instead of three times a week, per the wound physician's recommendation. During an interview on 10/22/24 at 2:18 P.M., the Director of Nursing (DON) said her expectations are for the wound physician's recommendations to be reviewed timely and transcribed correctly in the resident record. She said administering the wrong treatment is considered a medication error.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 42742 Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for the care of an indwelling suprapubic cystostomy catheter (surgical procedure that creates a connection between the bladder and the skin to drain urine) for one Resident (#24), out of a total sample of 18 residents. Specifically, the facility failed to ensure the Resident's urinary collection bag was kept below the level of the bladder and not in contact with the floor to help prevent catheter-related urinary tract infections and any related problems. Findings include: During an interview on 10/22/24 at 10:53 A.M., the Director of Nursing (DON) said the facility did not have a policy on Foley catheter care, only the insertion of. Review of Centers for Disease Control and Prevention (CDC) guidance titled Summary of Recommendations: Guideline for Prevention of Catheter-Associated Urinary Tract Infections, dated 3/25/24, indicated but was not limited to the following: III. Proper Techniques for Urinary Catheter Maintenance: -Keep the collection bag below the level of the bladder at all times. -Do not rest the bag on the floor. Resident #24 was readmitted to the facility in May 2024 and had diagnoses including neuromuscular dysfunction of the bladder, spastic hemiplegic cerebral palsy (type of cerebral palsy that causes a person to have involuntary muscle contractions and tightness on one side of their body), and infection and inflammatory reaction due to cystostomy catheter. Review of the Minimum Data Set (MDS) assessment, dated 7/19/24, indicated Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had an indwelling catheter. Review of current Physician's Orders indicated the following: -Ensure suprapubic catheter securement device is in place and catheter is secured on right leg every shift and prn (as needed), 6/25/24 -Suprapubic catheter 18 Fr (French), 10 cc (cubic centimeter) Foley catheter bag every shift, 1/16/24 Review of the Suprapubic Catheter care plan, initiated 3/25/22, indicated the following: -Keep drainage bag below level of bladder, 3/25/22 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Secure catheter, 3/25/22 During an observation with interview on 10/17/24 at 2:31 P.M., the surveyor observed Resident #24 sitting in a wheelchair in their room. A urinary catheter collection bag was observed hooked onto the waist band of the Resident's sweatpants draining yellow urine. The collection bag was not properly secured and was not hanging below the level of the Resident's bladder. Resident #24 said it was not supposed to be there, it was supposed to be below the seat of the wheelchair. Resident #24 said he/she had cerebral palsy, and a neurogenic bladder (bladder dysfunction caused by nervous system conditions) so he/she had a suprapubic catheter. During observations with an interview on 10/21/24 at 10:58 A.M. and 2:48 P.M., the surveyor observed Resident #24 sitting in a wheelchair in their room. A urinary catheter collection bag was observed hanging from a rod underneath the wheelchair draining yellow urine. The bag was in contact with the floor and had no barrier underneath potentially exposing it to environmental contaminants. Resident #24 said he/she had frequent urinary tract infections (UTIs) but denied any current symptoms or treatment. During an observation with interview on 10/21/24 at 3:40 P.M., the surveyor and Nurse #4 entered Resident #24's room and observed the Resident sitting in a wheelchair in their room. A urinary catheter collection bag was observed hanging from a rod underneath the wheelchair draining yellow urine. The bag was in contact with the floor and had no barrier underneath potentially exposing it to environmental contaminants. Nurse #4 said the Resident had a suprapubic catheter for urinary retention and the collection bag should not be in contact with the floor because where the drainage opening was, it could become contaminated and said the Resident could run over it with his/her wheelchair causing the bag to potentially rip. Nurse #4 said it should not have been hooked on his/her pants as it needed to be below the level of the bladder so urine could empty out of the bladder into it as efficiently as it should, or it could cause infection or bladder spasms which is one of the Resident's issues. During an interview on 10/22/24 at 1:43 P.M., Unit Manager (UM) #1 said the Resident had a neurogenic bladder and had a suprapubic catheter. He said the urinary collection bag should be positioned below the level of the bladder and should not have been resting on the floor or attached to the Resident's waist band. UM #1 said if the bag is above the bladder it puts the Resident at risk for UTIs and he/she is already at risk for UTIs. He said if it is on the floor, bacteria can get in or the Resident could run it over with his/her wheelchair and pull it out. During an interview on 10/23/24 at 3:18 P.M., the DON said the urinary collection bag should be below the level of the bladder and should not be in contact with the floor.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42742 Based on observation, interview, and record review, the facility failed to maintain the necessary respiratory care and services for one Resident (#57), out of a total sample of 18 residents. Specifically, the facility failed to maintain sanitary conditions of bilevel positive airway pressure (BiPAP - non-invasive breathing machine that helps people breathe when they're having trouble) mask and tubing and oxygen (O2) concentrator (medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen) equipment to help decrease the risk of potential contamination and exposure of infection to the resident. Findings include: Review of the facility's policy titled CPAP/BiPAP S/T/Support, revised January 2018, indicated but was not limited to the following: -CPAP (continuous positive airway pressure) and BiPAP can be used in conjunction with ventilation to improve oxygenation. -BiPAP delivers separate pressure settings for expiration (EPAP) and inspiration (IPAP). -CPAP/BiPAP may be appropriate for improving arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. During an interview on 10/22/24 at 12:02 P.M., the Director of Nursing (DON) said there was no policy for the care and storage of respiratory equipment, but staff follow professional standards of practice. Review of the PerfectO2 Series Oxygen Concentrator User Manual, revised November 2009, indicated but was not limited to the following: Section 6 - Maintenance -Note: At a minimum, preventive maintenance MUST be performed according to maintenance record guidelines. Cleaning the Cabinet Filter: -There is one cabinet filter located on the back of the cabinet. -Remove the filter and clean at least once a week depending on environmental conditions. -Clean the cabinet with a mild household cleaner and non-abrasive cloth or sponge. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #57 was admitted to the facility in June 2024 and had diagnoses including chronic obstructive pulmonary disease (COPD- group of lung diseases that block airflow and make it difficult to breathe), acute respiratory failure with hypercapnia (carbon dioxide retention), pulmonary hypertension, obstructive sleep apnea (OSA-sleep related breathing disorder), dependence on enabling machines and devices, dependence on supplemental Oxygen, and congestive heart failure. Review of the Minimum Data Set (MDS) assessment, dated 8/29/24, indicated Resident #57 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15, received oxygen therapy, and used a non-invasive mechanical ventilator. Review of current Physician's Orders indicated the following: -Administer Oxygen at 3 Liters (L)/minute (LPM) continuous via nasal cannula, every shift monitor, 6/13/24 -BiPAP: 14 cm (centimeters) H20 (inhalation); 6 cm H2O (exhalation) every evening and night shift, 6/13/24 On 10/17/24 at 9:31 A.M., the surveyor observed a BiPAP device resting on top of Resident #57's side table. The mask and tubing were resting on top of the device and were not stored in a plastic bag when not in use potentially exposing them to environmental contaminants. During an observation with interview on 10/17/24 at 11:44 A.M., the surveyor observed Resident #57 in a wheelchair in their room with nasal cannula (NC -device that delivers extra Oxygen through a tube and into your nose) tubing inserted into the Resident's nostrils with the other end attached to an O2 concentrator which was delivering 3 L of Oxygen. The exterior of the concentrator, including the rear filter storage cabinet, was laden with dust and debris. The rear filter was laden with dark brown matter. A BiPAP device was observed resting on top of Resident #57's side table. The mask and tubing were resting on top of the device and were not stored in a plastic bag when not in use potentially exposing them to environmental contaminants. Resident #57 said he/she used the BiPAP machine every night for OSA and used Oxygen for a tentative diagnosis of COPD and occasional shortness of breath. The Resident said he/she used Oxygen continuously during the day and with the BiPAP machine at night. On 10/21/24 at 11:14 A.M., the surveyor observed Resident #57 in a wheelchair in their room with NC tubing inserted into the Resident's nostrils with the other end attached to an O2 concentrator which was delivering 3 L of Oxygen. The exterior of the concentrator including the rear filter storage cabinet was laden with dust and debris. The rear filter was laden with dark brown matter. A BiPAP device was observed resting on top of Resident #57's side table. The mask and tubing were resting on top of the device and were not stored in a plastic bag when not in use potentially exposing them to environmental contaminants. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 10/21/24 at 3:56 P.M., the surveyor and Nurse #4 entered the Resident's room and observed Resident #57 in a wheelchair in their room with NC tubing inserted into the Resident's nostrils with the other end attached to an O2 concentrator which was delivering 3 L of Oxygen. The exterior of the concentrator including the rear filter storage cabinet was laden with dust and debris. The rear filter was laden with dark brown matter. A BiPAP device was observed resting on top of Resident #57's side table. The mask and tubing were resting on top of the device and were not stored in a plastic bag when not in use potentially exposing them to environmental contaminants. Nurse #4 said the Resident used BiPAP for OSA and said the mask/tubing should have been stored in a plastic bag when not in use. He said the O2 concentrator should be cleaned when dusty or dirty as needed. Nurse #4 said he saw some black/dark stains on the filter and said it's changed maybe every week but wasn't sure as he doesn't change them and wouldn't know how. During an interview on 10/21/24 at 4:09 P.M., the surveyor reviewed the medical record with Nurse #4 who said there was no order to clean the O2 concentrator, change the filter, or to store the respiratory equipment in a plastic bag when not in use. During an interview on 10/21/24 at 4:24 P.M., the surveyor reviewed the O2 concentrator with Unit Manager (UM) #1 who said it should have been wiped down and the filter cleaned weekly. He said the BiPAP equipment should have been stored in a plastic bag when not in use. During an interview on 10/23/24 at 3:55 P.M., the DON said the BiPAP equipment should be stored in a plastic bag when not in use and the O2 concentrator wiped down as needed. She said she wasn't sure how often the filter should be cleaned and wasn't sure of what the process was at the facility. The DON said there was no order for the filter to be changed but wasn't sure if there had to be as maintenance may do it. She said the expectation is that residents should have clean, safe, and operational respiratory equipment.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. 42742 Based on record review and interview, the facility failed to develop a person-centered plan of care accounting for the Resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization for one Resident (#24), with a history of trauma, out of a total sample of 18 residents. Findings include: Review of the facility's policy titled Trauma Informed Care, revised October 2019, included but was not limited to the following: -Policy: To guide staff in appropriate and compassionate care specific to individuals who have experienced trauma. -Trauma informed care is culturally sensitive and person-centered. -Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization. -Caregivers are taught strategies to help eliminate, mitigate, or sensitively address a resident's triggers. -Include trauma-informed care as part of the QAPI plan, so that needs, and problem areas are identified and addressed. Resident Care Strategies: -Reduce or eliminate unnecessary stimuli (noise, lighting, unwanted or sudden physical contact, etc.) as able. Resident #24 was readmitted to the facility in May 2024 and had diagnoses including spastic hemiplegic cerebral palsy (type of cerebral palsy that causes a person to have involuntary muscle contractions and tightness on one side of their body), anxiety disorder, bipolar disorder, and post-traumatic stress disorder (PTSD- occurs in some individuals who have encountered a shocking, scary, or dangerous situation). Review of the Minimum Data Set (MDS) assessment, dated 7/19/24, indicated Resident #24 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15 and had PTSD. Review of the Social Service Admission Assessment & Notes, dated 11/3/23, indicated but was not limited to the following: Psychosocial Well-Being/Trauma Informed Care: (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Psychiatric Diagnoses: PTSD, Bipolar, Anxiety Psychiatric/Psychological Services: -PRN (as needed) Trauma Informed Care: -Have you ever had an experience so upsetting that you think it changed you emotionally, spiritually, physically, or behaviorally? (symptoms of irritability, disturbed sleep, flashbacks, racing thoughts, memory difficulties, feeling emotionally numb, etc.) - yes -Do you think any of these problems bother you now? - yes -Would you be interested in discussing these problems? - yes -Resident feels uncomfortable around men and would not want a male therapist. -Trauma Informed Care Plan generated Review of the Trauma Informed care plan, initiated 11/8/23, indicated the following: -Resident has PTSD related to history of witnessing violence and being sexually and physically abused Goal: -Resident will have diminished risk for re-traumatization of past trauma through next review. Interventions: -Determine best coping strategies that has worked in the past to help the resident cope with traumatic event, 11/8/23 -Encourage resident to use a calm quiet area to foster positive self-reflection, 11/8/23 -Observe resident's sleep pattern and provide non-pharmacological interventions such as warm tea, soft music, or warm milk to aid with sleep, 11/8/23 -Refer the resident to psychiatric services for added psycho-social support, 11/8/23 Further review of the care plan indicated it was a template generated from the 11/3/23 Social Services evaluation. The care plan failed to include interventions that were person-centered to include the Resident's preferences and coping strategies to eliminate or mitigate triggers that may cause re-traumatization. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #24's Certified Nursing Assistant (CNA) Kardex (gives a brief overview of each resident to include activities, safety, eating/nutrition, resident care, bathing, behavior/mood, monitoring, and transferring) did not indicate Resident #24 had a history of trauma or identify any identified triggers or coping strategies. During an interview on 10/21/24 at 11:03 A.M., Resident #24 said he/she had PTSD and was seeing a female psychologist every week and that it could not be a male. Resident #24 said his/her triggers for PTSD included certain noises and smells that freak him/her out, babies crying, things like that. The Resident said when the ambulance door alarm goes off in the facility it's also a trigger. Resident #24 said no one at the facility asked him/her what his/her triggers were and would keep it to him/herself unless someone asks. The Resident said facility staff have not incorporated any of it in his/her plan of care that he/she knows of, and pain sets it off too, about what he did to us and did not feel his/her pain was being managed. During an interview on 10/21/24 at 3:46 P.M., Nurse #4 said he was assigned to the Resident and the Resident had no history like PTSD or bipolar disorder and was not sure if the Resident was being seen by psych services, but the Unit Manager (UM) might know. Nurse #4 said there weren't any triggers he was aware of that would upset the Resident other than pain. During an interview on 10/21/24 at 4:16 P.M., the surveyor reviewed the medical record with Nurse #4 who said Resident #24 had a history of PTSD and bipolar disorder but there was nowhere in the record where it identified any PTSD triggers. He said if there were, it would be carried over to the Medication Administration Record (MAR) where staff could monitor for specific PTSD related behaviors but there wasn't. Nurse #4 said there was no order to monitor PTSD related behaviors. During an interview on 10/22/24 at 12:00 P.M., CNA #5 said she was familiar with the Resident, but he/she had not any previous trauma that she knew of. During an interview on 10/22/24 at 12:08 P.M., CNA #6 said she was aware the Resident had a history of trauma but didn't know all the details or what triggers may re-traumatize the Resident. During an interview on 10/22/24 at 12:15 P.M., Nurse #2 said he was assigned to the Resident that day and was not aware of any history of trauma. Nurse #2 said the aides would know more as they spend more time with the Resident. During an interview with Social Worker (SW) #1 and UM #1 on 10/22/24 at 1:21 P.M., SW #1 said she started in August and is agency but said the Resident had a history of trauma, she thought sexual and physical abuse. UM #1 said the Resident doesn't like a male psychiatrist but other than that was not sure of any other triggers. SW #1 and UM #1 said they weren't aware of any other triggers, and none were documented on the care plan including the need for a female psychiatrist. SW #1 said the care plan was not person-centered to meet the Resident's trauma informed care needs and the goal was to try and prevent or mitigate triggers which could cause re-traumatization but didn't know what they were. SW #1 and UM #1 said there was a care planned intervention to determine what the Resident's coping strategies were, but they were not listed, and they didn't know what they were. SW #1 said she could read the psych notes to find out. UM #1 said they should have been listed on the care plan and said there was nothing in the record to monitor for PTSD symptoms but wasn't sure if they do that. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 9:34 A.M., Resident #24 said sometimes he/she gets flashbacks at night of him and calls out to staff but they don't respond sometimes. The Resident said he/she doesn't mind having a male nurse but there has to be a female present when providing wound care or personal hygiene though said there are a few male nurses that he/she feels comfortable with. The Resident said it's happened when it's just been a male nurse or aide and had to ask for a female to be present. Resident #24 said certain sounds also trigger his/her PTSD such as the ambulance door alarm because the sound of the alarm brings back memories for him/her. He/she said staff usually turn it off but there are times when it goes off for about half an hour which sets me off and wished staff were more diligent with this. The Resident said no one has asked him/her about his triggers until SW #1 did yesterday, after surveyor intervention. The Resident said he/she feels safe at the facility but doesn't feel staff are doing what they should to help him/her with his/her PTSD. Review of a Behavioral Health note, dated 9/18/24, indicated the Resident was having increased nightmares, two that were recurrent and brutal, based on incidents from the past that they wake him/her up at night and is disoriented, unable to turn a light on or take a drink of water or to do anything to orient him/herself. During an interview on 10/23/24 at 9:47 A.M., CNA #7 said he was assigned to the Resident this day and said the Resident had no history of trauma that he knew of and was getting ready to provide personal care to the Resident and that he would clean the front, then ask for assistance to clean the back. Resident #24 told the surveyor he was comfortable with CNA #7 providing personal care without a female present. During an observation with interview on 10/23/24 at 11:27 A.M., Resident #24 said he/she doesn't like to initiate conversation about his/her PTSD and hasn't said anything to anyone but would be okay talking about it if asked as he/she would like staff to know what triggers him/her, but no one has asked until yesterday. The Resident said he/she was comfortable speaking with the surveyor and SW #1 to help him/her and said the goal would be for staff to know what his/her triggers are so they can help prevent re-traumatization. Resident #24 said coping strategies included listening to music, writing, reading, painting, and 54321 (grounding exercise designed to manage acute stress and reduce anxiety). During an interview on 10/23/24 at 11:38 A.M., Nurse #5 said she was assigned to the Resident this day and knew the Resident had a history of trauma but didn't know the details. She said there were no triggers she was aware of. The surveyor and Nurse #5 reviewed the Resident's medical record. Nurse #5 said the Resident had a history of PTSD, anxiety, and bipolar disorder. She said she just started in August and did not know what the Resident's coping strategies were but knew he/she saw a counselor. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/23/24 at 3:20 P.M., the Director of Nursing (DON) said she would need to refer to the policy but said patients with PTSD would have a social services evaluation for trauma and a trauma informed care plan developed that should be person-centered and discussed at quarterly care plan meetings. She said the patient would also be referred to psych for ongoing support. The DON said the trauma informed care plan should include areas of the cause of the PTSD, the history of the resident, PTSD triggers and interventions specific to the resident. She said if a resident refuses services or does not wish to discuss their past trauma then that should be care planned as well as the resident has the right to decline services. The DON said she depends on the social services department to find out what the triggers are and individualize the care plan. She said she had only been at the facility since 10/3/24 and was not aware of any of this but said staff should have been aware of the Resident's history of trauma and potential triggers. She said the goal is for residents to be healthy physically, emotionally, and feel secure and to prevent or mitigate re-traumatization. She said staff should also have been aware of what the Resident's coping strategies were.

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F 0758 Level of Harm - Minimal harm or potential for actual harm 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. 48084 Based on record review and interview, the facility failed to ensure for one Resident (#65), out of five residents selected for unnecessary medication review, that their medication regimen was free from unnecessary psychotropic medications (drugs that affect the brain and nervous system including but not limited to antidepressants, antianxiety, antipsychotics, and sedatives). Specifically, the facility failed to ensure an as needed (PRN) psychotropic medication order for Ativan (anti-anxiety) was limited to 14 days unless the provider documented a rational to extend the PRN and the order was written for a specific longer duration. Findings include: Review of the facility's policy titled Psychotropic Medication, dated as last revised 7/2023, indicated but was not limited to the following: -Residents will not receive PRN doses of psychotropic medications unless that medication is necessary to treat a specific condition or diagnosis and that is documented in the clinical record. -The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rational for the order. The duration of the PRN order will be indicated in the order. -The Consultant Pharmacist reviews the appropriateness of the psychotropic medication order as part of each drug regimen review and monitors for appropriateness of psychotropic administration based on diagnosis, clinical indications, and prescribing guidelines. Review of the facility's policy titled Consultant Pharmacist Services Provider Requirements, dated 8/2020, indicated but was not limited to the following: -Consultant Pharmacist helps to identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical services. This includes providing oversight on regulatory compliance issues. -Reviewing the medication regimen of each resident at least monthly, incorporating federally mandated standards of care in addition to other applicable professional standard, and documenting the review and findings. -The facility has a process to ensure that findings are acted upon. Resident #65 was admitted to the facility in March 2024 with diagnoses which included depression, dementia, and anxiety. Review of the Minimum Data Set (MDS) assessment, dated 9/22/24, indicated he/she was taking anti-anxiety medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medial record indicated he/she was taking Ativan (anti-anxiety medication). Review of the Consultant Pharmacy Recommendations, dated 4/26/24, indicated Resident #65 was taking Lorazepam (Ativan) 0.5 milligrams (mg) as needed four times a day. Additionally, the recommendation indicated The Centers for Medicare and Medicaid Services (CMS) recently updated guidelines to include the following limitations on this medication: PRN orders for psychotropic medications are limited to 14 days. If the prescribing practitioner believes it is appropriate for the PRN order to be extended beyond 14 days, they must document their rationale in the resident's medical record and indicate the duration for the PRN order and give the order a specific stop date. PRN orders cannot be open-ended. The PRN medication must be reassessed at the end of that time frame for further need. Please review this PRN order and consider discontinuing if appropriate or document continued need for therapy and specify a stop date. Further review of the report indicated the physician reviewed the recommendation on 4/29/24 and indicated the following: marked other and wrote continue patient may be transitioned to comfort measures only (CMO) status will monitor. The recommendation was noted by nursing on 5/1/24. Review of the Physician's Orders for April and May 2024 indicated the following: -Ativan oral tablet 0.5 mg as needed for anxiety four times a day (Start Date: 4/16/24 Discontinue Date: 5/1/24) -Ativan oral tablet 0.5 mg as needed for anxiety four times a day, may have for extended time. (Start Date: 5/1/24) The order for PRN Ativan was rewritten on 5/1/24 and failed to indicate a stop date. Review of the Consultant Pharmacy Recommendations, dated 5/18/24, indicated Resident #65 was currently ordered Lorazepam (Ativan) 0.5 mg as needed four times a day, may have for an extended time. Additionally, the recommendation indicated order may continue for more than 14 days, however, you must specify reevaluation date (cannot be open ended) Please add a stop date. Further review of the report failed to indicate the physician had addressed the recommendation to add a stop date and the order remained in effect for greater than 14 days with no reevaluation/stop date. Review of the Medication Administration Record (MAR) for May and June 2024 indicated the following: -Resident #65 was administered Ativan 13 times. Further review indicated 11 of the 13 administrations were after the initial 14 days (between 5/15/24 and 5/31/24). -Resident #65 was administered Ativan three times between 6/1/24 and 6/5/24. The order was discontinued on 6/5/24 and scheduled twice daily. Review of physician's progress notes for May and June 2024 failed to indicate a rational and stop date for extending the PRN Ativan. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress note, dated 6/5/24, indicated Hospice recommended to discontinue PRN Ativan and start Ativan scheduled due to increased agitation. Nurse Practitioner (NP) approved recommendation. New order to start Ativan 0.5 mg twice daily. During an interview on 10/23/24 at 9:57 A.M., Nurse #7 said she did not know the process for addressing the pharmacy recommendation but said they should be in the medical record. During an interview on 10/23/24 at 9:59 A.M., Unit Manager (UM) #2 said after the recommendation is addressed, the order is written, the form goes back to the Director of Nurses (DON) and should be scanned into the medical record. During an interview on 10/23/24 at 10:32 A.M., the DON said she located the April recommendation and reached out to the pharmacist for the May recommendation because she could not locate it. The blank May recommendation was provided to the surveyor by the DON on 10/23/24 at 2:31 P.M. During an interview at that time the DON said she did not know if the recommendation had been addressed as she was not employed at the facility at that time and could not locate a pharmacy book or anything that the previous DON may have used to keep track of the recommendations. During an interview on 10/23/24 at 2:51 P.M., UM #1 said all psychotropic PRN meds must be limited to 14 days. Additionally, she said if the physician wants to extend it longer, they can if they document the reason and for how long, but it still needs a stop date. During an interview on 10/23/24 at 3:28 P.M., the Staff Development Coordinator (SDC) said PRN psychotropics must be limited to 14 days unless the physician wants it longer, and if that is the case they would need to document why they want it longer and for how long. She said the orders must have a stop date. During an interview on 10/23/24 at 4:28 P.M., the DON said PRN psychotropics are limited it 14 days. She said if the physician wants it longer, they must follow the regulation and this order was active for more than 14 days and did not have a stop date.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 48084 Based on observation, record review, and interview, the facility failed to maintain a medication error rate of less than 5%. Specifically, one of two nurses made three errors during the medication pass out of a total of 26 opportunities, resulting in a medication error rate of 11.54%. Findings include: Review of the facility's policy titled Administering Medications, dated as last revised 2/2020, indicated but was not limited to the following: -Medications are administered in a safe and timely manner, and as prescribed. -Medications are administered in accordance with prescriber's orders. -The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. Resident #66 was admitted to the facility in October 2022 with diagnoses including wedge compression fracture and dementia. On 10/18/24 at 9:10 A.M., the surveyor observed Nurse #1 administer medications to Resident #66 which included but were not limited to the following: - High Potency Slow-Release Iron 45 milligrams (mg) of elemental iron equivalent to 142 mg of Ferrous Sulfate (one tab) - Fish Oil 1200 mg (one capsule) - Vitamin D3 25 micrograms (mcg) equivalent to 1000 international units (IU) (one tab) Review of the Physician's Orders for Resident #66 indicated but were not limited to the following: -Ferrous Sulfate tablet 325 mg give one tablet by mouth one time a day for supplementation (1/11/2023) -Fish Oil Oral Capsule 1000 mg give one capsule by mouth one time a day for supplement (1/13/2023) -Vitamin D3 12 5mcg (5000 IU) give one tablet by mouth one time a day for supplement (5/29/24) During reconciliation of the medication administered and medications ordered it was determined that Nurse #1 failed to administer the correct medications as ordered by the provider. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/18/24 at 11:03 A.M., Nurse #1 said she administered the High Potency Slow-Release Iron 45 mg and the Fish Oil 1200 mg because that is all they have in the medication cart, so that is what he/she always gets. She said they are not the same as the orders, but it is all we have, so that is what was administered. Additionally, she said the Vitamin D3 order is for 125 mcg/5000 IU one tab and the highest dose available in the medication cart is 25 mcg/1000 IU, so that is what he/she always gets. She said there is not a 125 mcg/5000 IU tablet in the medication cart and the pharmacy doesn't send anything else, so 25 mcg is what was administered not 125 mcg as ordered. During an interview on 10/18/24 at 11:07 A.M., Unit Manager (UM) #1 said High Potency Slow-Release Iron 45 mg is not the same as Ferrous Sulfate 325mg, Fish Oil 1200 mg is not the same as Fish Oil 1000 mg, and Vitamin D3 25 mcg is not the same as Vitamin D3 125mcg. He said all three medications administered were not what was ordered by the physician. During an interview on 10/18/24 at 11:30 A.M., the Director of Nurses (DON) said those are all the wrong doses and are medication errors. She said if the correct medication and/or dose is not available the nurse should not administer whatever is on hand.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 42742 Based on observation, interview, and test tray results, the facility failed to serve food that was palatable and at appetizing temperatures for two out of two test trays conducted on two of two units. Findings include: Review of the facility's policy titled Trayline and Meal Delivery, revised June 2018, indicated but was not limited to the following: -Meals are assembled attractively based on the planned menu and resident diet orders, food allergens, and preferences; and delivered within established mealtimes in a manner to maintain palatability and food safety. On 10/18/24 at 1:30 P.M., the surveyor held a Resident Group meeting with 19 residents in attendance, five of which had the following food complaints: -food distribution is slow, the foods sits around in the cart and that is probably when it's not as hot -food sits on the unit -the food is not hot enough -the food is salty -the food is ice cold all the time. On 10/21/24 at 12:02 P.M., the surveyor requested a lunch test tray for the 1st Floor Unit (truck 4). The test tray was placed on the food truck at 12:16 P.M., left the kitchen, and arrived on the 1st Floor Unit at 12:17 P. M. The test tray was conducted at 12:24 P.M. with the Certified Dietary Manager (CDM) with the following results: -The milk registered at 45.1 degrees Fahrenheit (F) and was cool to taste -The chicken parmesan was 128.5 degrees F, lukewarm, tasted salty, rubbery texture -Pasta 125.4 degrees F, lukewarm -Ground chicken 122.9 degrees F, lukewarm -Pureed chicken 126.0 degrees F, lukewarm -Mashed potatoes 118.0 degrees F, lukewarm, bland tasting (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/22/24 at 7:33 A.M., the surveyor requested a breakfast tray for the 2nd Floor Unit (truck 2). The test tray was placed on the food truck at 7:41 A.M., left the kitchen, and arrived on the 2nd Floor Unit at 7:44 A.M. The test tray was conducted at 7:53 A.M. with the CDM with the following results: -The milk registered at 44.8 degrees F, cool to taste -Apple juice 50.6 degrees F, slightly cool -Scrambled eggs 121.0 degrees F, lukewarm, bland tasting -Waffle 94.8 degrees F, cold tasting, rubbery, required the use of a knife and fork with pulling motion to cut and sample -Ground meat sausage 98.0 degrees F, slightly warm, appetizing taste -Pureed bread 110.0 degrees F, lukewarm -Pureed eggs 101.7 degrees F, tasted cold and gritty in texture, no flavor The results of the test trays validated the residents' concerns of unpalatable food served at unappetizing food temperatures. During an interview on 10/22/24 at 8:05 A.M., the CDM said she agreed there was no taste to the scrambled eggs, the waffle was cold, the pureed bread did not taste hot, and said she agreed with the surveyor's findings regarding the pureed eggs. She said ideally cold temperatures, once the trays get to the unit, should be between 42.0 degrees F and 43.0 degrees F, realistically, and said overall the hot temperatures should have been between 125.0 degrees F and 135.0 degrees F once arriving to the units.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation and interview, the facility failed to follow professional standards of practice for food safety to prevent the potential of foodborne illness to residents who are at high risk. Specifically, the facility failed to: 1. Properly label and date food products stored in the walk-in refrigerator in the main kitchen and discard prepared food when past their use by date; 2. Ensure staff did not store personal food items in one of two resident nourishment kitchen refrigerators/freezers reviewed; and 3. Ensure staff performed proper hand hygiene when serving afternoon snacks to residents on the 2nd Floor Unit, blue hallway, and ensure the snack cart did not enter resident rooms. Findings include: Review of a facility document titled Label and Dating for Leftovers and Food Being Prepped for Later Use, undated, indicated but was not limited to the following: -Sandwich spreads must be marked with a 3-day discard. -Trays of drinks and plated desserts must be labeled with the date and meal they are for. -Meat pulled from the freezer must be dated with a date it was pulled and the date/meal that it's for. -Product that is prepared is good for 3 days and must be discarded on day 3. -Refer to the Food Storage Reference Guide for additional information regarding discard dates. Review of the facility's policy titled Food and Supply Storage, revised June 2018, indicated but was not limited to the following: Labeling and rotating food supply: -Food products that are opened and not completely used; transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and used by dates. -Store food removed from its original package in containers or food-grade storage bags intended for food that is durable, leak-proof, and able to be sealed or covered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Discard food that exceeds their use-by date or expiration date, is damaged, is spoiled, has the time and temperature danger zone requirements, or incorrectly stored such that it is unsafe, or its safety is uncertain. 1. On 10/17/24 at 8:11 A.M., the surveyor reviewed the main kitchen walk-in refrigerator and observed the following inside: -One 16.0 ounce (oz.) Polar Spring water bottle, approximately 1/4 full, not labeled -One 20 oz. blue Gatorade bottle, approximately 3/4 full, not labeled -One tray consisting of six plates of white cakelike desserts with brown drizzle and two bowls of a light brown textured item with whipped cream, not covered, not labeled with the food item, not dated when prepared or use by date -One tray of 13 covered glass bowls with unknown food substance, six bowls of diced fruit, uncovered, four bowls of pureed fruit, uncovered, tray not labeled with item description, date prepared, or use by date -Three isolated plastic cups with lids, one white liquid, one yellow liquid, one semi-opaque liquid, not labeled with item description, date prepared, or use by date -One loaf of pound cake stored in plastic wrapper, not labeled with item description, date illegible, no use by date -One square metal tin of salami wrapped in plastic wrap, labeled with preparation date of 10/3, use by date 10/10, not discarded by use by date -One large metal rectangular tin with individual large plastic bags of chicken breasts, one plastic bag ripped open, bag not sealed, contents inside potentially exposed to environmental contaminants -One tray of 24 plastic cups with lids, 23 semi-opaque liquids, one white liquid, not labeled with item descriptions, the preparation date, or use by date -One package of Swiss cheese slices, package opened, wrapped in saran wrap, not labeled with item description, date when opened, or use by date -Two turkey and cheese sandwiches on white bread, wrapped in saran wrap, preparation date 10/13, use by date 10/16, not discarded by use by date -One push rolling cart with one large rectangular metal tin on top with chopped broccoli inside, wrapped in saran wrap, not labeled with preparation date, or use by date -One square plastic container full of jelly, preparation date 10/10, use by date 10/14, not discarded by use by date -One square plastic container 1/4 full of applesauce, preparation date 10/10, use by date 10/14, not discarded by use by date (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One large plastic container of ham slices, preparation date 10/12, use by date 10/15, not discarded by use by date -One small plastic container of potato salad, preparation date 10/11, use by date 10/14, not discarded by use by date On 10/17/24 at 8:49 A.M., the surveyor reviewed the findings with the Certified Dietary Manager (CDM) who said the water and Gatorade bottles were for general resident use, were not labeled, but should have been. She said the trays of prepared foods and liquids including the isolated plastic cups should have been covered and labeled but weren't. She said the pound cake should have been labeled with the use by date but wasn't and was only good for one month, so she disposed of it. The CDM said the salami was no longer good and the chicken breast bag was not closed properly and was potentially exposed to the environment. She said it should have been sealed properly and would need to dispose of it. The CDM said the cheese package was not labeled properly once opened and the sandwiches were no longer good and disposed of them. She said the broccoli should have been labeled with the date when prepared and the use by date but wasn't, and the jelly, applesauce, and ham slices were no longer good and should have been disposed of. During an interview on 10/17/24 at 8:56 A.M., the CDM said food items when prepped are only good for three days and the cooks or dietary aides, whoever preps, are responsible for labeling the item with the item description, the date when opened/prepped, and labeled three days out as the use by date. She said the food is no longer good after that time. 2. On 10/22/24 at 6:33 A.M., the surveyor reviewed the 2nd Floor Unit nourishment kitchen and observed a plastic bag in the freezer with two large frozen items stored inside, contents unknown, wrapped in saran wrap, labeled with a first name only, no item description labeled, resident's full name and room number, preparation date, or use by date. During an interview on 10/2224 at 6:38 A.M., Nurse #3 said she had no idea what was in the plastic bag or who it belonged to. She said there were no residents on that unit with that first name. During an interview on 10/22/24 at 3:09 P.M., the CDM was made aware of the food items stored in the freezer and said it was a staff member's food. She said staff should not be storing personal food in the resident's refrigerators or freezers. 41106 3. Review of the facility policy titled Resident Meal Service and Dining, dated June 2018, indicated but was not limited to the following: -Appropriate hand hygiene is completed before distributing meals, after collecting soil dishware, and as needed during the mail service. Review of the facility's policy titled Hand Washing/Hand Hygiene, dated July 2024, indicated but was not limited to the following: -The facility considers hand hygiene the primary means to prevent the spread of infections. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All staff shall follow the hand washing hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. -Hand hygiene products and supplies (Sinks, soap, towels, alcohol-based hand rub etc.) shall be readily accessible and convenient for staff used to encourage compliance with hand hygiene policies. -Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively soap and water for the following situations: -Before and after eating or handling food -Before and after assisting a resident with meals On 10/17/24 at 2:19 P.M., the surveyor observed two Certified Nursing Assistants (CNAs) serving afternoon snacks on the second floor, blue hallway and made the following observations: -CNA #3 brought the snack cart into resident room [ROOM NUMBER] and assisted the resident in the A bed with choosing a snack. The resident picked a snack off the tray, handling multiple snacks before making his/her final selection. CNA #3 left the room without performing hand hygiene. -CNA #3 and CNA #4 then brought the snack cart into resident room [ROOM NUMBER] and offered snacks to both residents. CNA #3 or #4 did not perform hand hygiene. -CNA #3 brought the snack cart into resident room [ROOM NUMBER] and assisted the resident in the A bed (door) by uncovering the residents' hands form underneath the blanket. CNA #3 assisted the resident with choosing a snack and opened the snack for the resident. CNA #3 did not perform hand hygiene. -CNA #4 entered resident room [ROOM NUMBER] after CNA #3 served the resident in #203 A bed, and asked CNA #3 for a glass of juice. CNA #3 while still in room [ROOM NUMBER], handled the cups, poured a glass of juice, and handed it to CNA #4 who was leaving the room to serve to another resident not in room [ROOM NUMBER]. CNA #3 and CNA #4 did not perform hand hygiene. During an interview on 10/17/24 at 2:25 P.M., CNA #3 said she brings the whole cart of food into each resident's room to choose a snack because they change their minds. CNA #3 said she should be sanitizing her hands between each resident. CNA #4 agreed and said they should be sanitizing their hands and probably have a bottle of hand sanitizer on the cart. During an interview on 10/18/24 at 12:15 P.M., the Director of Nurses (DON) said the CNAs should not be bringing the whole cart of snacks into the resident rooms, it is an infection control issue. She said they should be performing hand sanitization in between each resident served.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 49425 Based on observation, document review, and interviews, the facility failed to maintain an infection prevention and control program with a complete system of surveillance to identify any trends of actual or potential infections, within the facility using their predetermined infection definition criteria. Findings include: Review of the facility's policy titled Surveillance for Infections, dated as revised July 2024, indicated but was not limited to the following: - The purpose of surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections to guide appropriate interventions and prevent future infections. - Criteria for infections are based on current standard definitions of infections. - In addition to collecting data on incidents of infections the surveillance system is designated to capture certain epidemiologically important data that may influence how overall surveillance data is interpreted, for example: surveillance data gathered for residents with a recent hospital stay. During an interview on 10/22/24 at 12:54 P.M., the Infection Preventionist (IP) said the facility uses the laboratory supplied surveillance sheet to document the surveillance of illnesses in the facility, and McGeer Criteria to identify and define whether an illness is an infection by the criteria protocol. Review of the McGeer Criteria for Infection, in use by the facility, indicated but was not limited to the following: Syndrome: Cellulitis (bacterial skin infection), soft tissue, or wound infection Must fulfill at least one criteria. 1. Pus at wound, skin, or soft tissue site 2. At least four of the following new or increasing sign or symptom: -Heat (warmth) at affected site, redness (erythema) at affected site, swelling at affected site, tenderness, or pain at affected site, serous (clear fluid) drainage at the affected site 3. At least one of the following: -Fever, leukocytosis (elevated white blood cell count), acute change in mental status, acute functional decline (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Syndrome: Urinary tract infection (UTI) without indwelling catheter Must fulfill both one and two criteria. 1. At least one of the following sign or symptoms: -Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate -Fever or leukocytosis (a high level of white blood cells), and one or more of the following: -Acute costovertebral angle pain or tenderness, suprapubic pain, gross hematuria, new or marked increase in incontinence, urgency, or frequency. -If no fever or leukocytosis, then two or more of the following: -Suprapubic pain, gross hematuria, new or marked increase in incontinence, urgency, and frequency. 2. At least one of the following microbiologic criteria - greater than or equal to 100,000 count of no more than two species of organisms in a voided urine sample, OR - greater than or equal to 50,000 count of any organism(s) in a specimen collected by an in-and-out catheterization Review of the laboratory surveillance sheet key in use by the facility: -Categories: Skin, Mucosal, Soft Tissue = S; Urinary tract = UTI; Urinary tract Catheter = UTC; Other = O -Count: Yes = Y; No = N Review of the facility provided surveillance listings indicated the following: July 2024: -14 out of 14 residents met McGeer Criteria for infection and 14 out of 14 residents were started on antibiotics. -Resident #12 Category: UTI; date of onset: 7/7/24; symptoms: Hx; results: Positive; count: Yes The surveillance listing for Resident #53 failed to indicate all criteria was met for this illness to be counted as an infection, and did not include any symptoms, making the surveillance sheet incomplete. August 2024 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11 out of 17 residents met McGeer criteria for infection and 17 out of 17 residents were started on antibiotics. September 2024 -11 out of 13 residents met McGeer criteria for infection and 13 out of 13 residents were started on antibiotics. -Resident #53 category: O; date of onset: 9/25/24; symptoms: redness, swelling; results: MD DX; count: Yes The surveillance listing for Resident #53 failed to indicate that all criteria was met for this illness to be counted as an infection, and never defined the other category, making the surveillance sheet inaccurate, incomplete, and undefined. Review of the McGeer criteria documents completed by the facility for Residents #12 and #53 indicated criteria was not met for an actual infection and the count of the infection inaccurate on the surveillance listing in accordance with the facility's use of McGeer criteria. During an interview on 10/22/24 at 1:18 P.M., the IP said she does not track any residents who have symptoms of an illness that do not require the use of an antibiotic. She said she would only track a gastrointestinal or COVID outbreak if warranted. The IP said she reviews the 24-hour nursing report and progress notes to see if any new antibiotics have been started and will track antibiotic use on the line listings. She said she is new to this position and was not educated on tracking and trending illnesses. The IP said for Residents #12 and #53, the McGeer criteria was filled out inaccurately and it should not have counted as an infection. She said she does not complete all the McGeer criteria documents. She said the nurse taking the order for the antibiotics completes the McGeer criteria in the chart. The IP said the symptoms did not meet the criteria to count the infection, although she did, and the surveillance was inaccurate. During an interview on 10/22/24 at 2:18 P.M., the Director of Nursing (DON) said her expectation is for the IP to track all illnesses to identify any trends in the facility. She said improvements are needed to ensure McGeer criteria is completed accurately, so they will have an accurate reflection of all infections within the facility.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 49425 Based on record review and interview, the facility failed to implement an antibiotic stewardship program which included antibiotic use protocols and monitoring of antibiotic use in accordance with the facility's antibiotic stewardship program. Findings include: Review of the facility's policy titled Antibiotic Stewardship Program, last revised 1/24, indicated but was not limited to the following: -The antibiotic stewardship program establishes antibiotic treatment recommendations to optimize antibiotic prescribing, monitoring, and communication of resident changes in condition(s) to improve resident outcomes related to antibiotic use. -Appropriate indications for use of antibiotics include Criteria met for clinical definition of active infection: McGeer Criteria (a set of guidelines used to help identify infections in long-term care facilities). -As part of the facility antibiotic stewardship program, clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee. -The infection preventionist, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. -At the conclusion of the review, the provider will be notified of the review findings. Review of the facility's policy titled Antibiotic Stewardship Review and surveillance of Antibiotic use and Outcomes, last revised 10/22, indicated but was not limited to the following: -Antibiotic usage and outcome data will be collected and documented -The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. -All clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee -The provider will be notified of the review findings. -All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 12:54 P.M., the Infection Preventionist (IP) said the facility uses the laboratory supplied surveillance sheet to document the surveillance of illnesses in the facility, and McGeer Criteria to identify and define whether an illness is an infection by the criteria protocol. Review of the facility surveillance sheets for July, August and September 2024 indicated but was not limited to the following: July: Resident #12 had a urinary issue with an onset date of 7/7/24, the surveillance indicated the issue did rise to the level of an infection, and Resident #12 was treated with an antibiotic for seven administrations. Review of the McGeer Criteria dated 7/9/24 for Resident #12 indicated the illness did not rise to the level of an infection, per the facility identified criteria, and the surveillance listing was inaccurate. Review of the progress notes, including physician and nurse practitioner notes for Resident #12 from 7/7/24 through 7/30/24, failed to indicate the provider was made aware of Resident #12's continued antibiotic use when the symptoms did not meet infection criteria. August: Resident #58 had a urinary issue with an onset date of 8/23/24 and had a catheter in place. The surveillance indicated the issue did not rise to the level of an infection as determined by the facility criteria, however an antibiotic was prescribed for seven days. Review of the progress notes, including physician and nurse practitioner notes for Resident #58 from 8/23/24 through 9/5/24 failed to indicate the provider was made aware of Resident #58's continued antibiotic use when the symptoms did not meet infection criteria. September: Resident #51 had a lower respiratory issue with an onset date of 9/17/24, the surveillance indicated the issue did not rise to the level of an infection as determined by the facility criteria, however an antibiotic was prescribed for five days. Review of the progress notes, including physician and nurse practitioner notes for Resident #51 from 9/17/24 through 10/22/24 failed to indicate the provider was made aware of Resident #51's continued antibiotic use when the symptoms did not meet infection criteria. During an interview on 10/22/24 at 1:18 P.M., the IP said, for Resident #12, she documented incorrectly on the surveillance listing, and she should have documented it did not count. She said when a resident is utilizing an antibiotic that does not meet criteria, she notifies the physician or nurse practitioner, and documents in a nursing note. The IP reviewed the nursing progress notes for Residents #12, #58 and #51 and could not locate any evidence the physician or NP were notified of the continued antibiotic usage. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 2:18 P.M., the Director of Nursing (DON) said her expectation is for the IP to notify the physician when an antibiotic is ordered that does not meet McGeer criteria, and document the notification and physician response in a nursing progress note.