STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225679	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Megansett Nursing & Rehabilitation	209 County Road Box 408 N Falmouth, MA 02556

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 41106 Based on observation, interview, and record review, the facility failed to treat the Resident's clothing items with respect. Specifically, the facility failed to label the Resident's clothing to ensure prompt return of the clean laundry, for one Resident (#35), out of a total sample of 17 residents. Findings include: Review of the facility's policy titled Personal Property, undated, included but was not limited to the following: -The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. -The facility will promptly investigate any complaints of misappropriation or mistreatment of resident's property. Resident #35 was admitted to the facility in April 2024 with diagnoses including: cellulitis (infection of skin) of the left leg, muscle weakness, and difficulty in walking. Review of the Minimum Data Set (MDS) assessment, dated 5/4/24, indicated that Resident #35 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 15 out of 15. Further review indicated Resident #35 required substantial to maximum assistance for upper body dressing and was dependent for lower body dressing. During an interview on 5/21/24 at 4:30 P.M., Resident #35 said all his/her clothes have been down in the laundry for at least a week and he/she has no clean clothes. Resident #35 said he/she has been wearing the same clothes for days. On 5/21/24 at 4:35 P.M., the surveyor, with Resident #35's permission, observed the closet and dresser, the closet had no clothes and the dresser had multiple unlabeled new white boxer shorts and pairs of socks. The surveyor observed Resident #35 to be wearing khaki shorts and gray top. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 10:28 A.M., Resident #35 said they finally brought back some of his/her clothes. Resident #35 was observed wearing the same clothes he/she was wearing on 5/21/24. Resident #35 said he/she had complained to the Aides (Certified nursing assistants-CNAs) multiple times about the missing clothing and nothing was done. On 5/23/24 at 10:30 A.M., the surveyor, with Resident #35's permission, observed the closet and dresser. There were three pairs of shorts and one shirt hanging in the closet and two shirts in the dresser. The clothes were not labeled with the Resident's name. On 5/23/24 at 10:35 A.M., the Director of Laundry came into Resident #35's room and looked at the clothes hanging in the closet and the dresser and said the clothes were not labeled and should have been. During an interview on 5/23/24 at 10:43 A.M., in the laundry room the Director of Laundry said all resident's clothes come down in a bin in the morning, they are washed and hung on the rack, and then delivered to the residents the following morning. The surveyor observed laundry personnel completing the process and when a garment was not labeled, it was brought to the back room and hung on a separate rack. The Director of Laundry said all residents' dirty clothes are put in one bin on the unit, so if they are not labeled, we have no idea whose clothes they are until someone comes looking for them. The surveyor viewed the back room and there were two racks of unlabeled resident clothing. He said laundry staff, or the nurses are supposed to label all the residents' clothing. During an interview on 5/23/24 at 10:58 A.M., Nurse #6 said laundry has been a problem for a long time, the clothes go down, but they don't come back for a long time. She said the families get really frustrated and you end up having to bring them down to the basement to look on the rack for the missing clothes. During an interview on 5/23/24 at 11:05 A.M., Unit Manager #1 said laundry has been a problem, the clothes go down and they take a while to come back. She said Resident #35's clothes were delivered by his/her Assisted Living Facility and she personally gave the clothes to laundry staff in a bag to be labeled. During an interview on 5/23/24 at 11:16 A.M., with the Director of Laundry and Unit Manager #1 present, Unit Manager #1 said Resident #35's clothes were given to laundry staff for labeling. The Director of Laundry said he doesn't know why the staff didn't label them; it delays the clothes getting back to the Resident.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 31830 Based on Minimum Data Set (MDS) assessment review and staff interview, the facility failed to encode and electronically transmit MDS data to the Centers for Medicare and Medicaid Services (CMS) processing system, for one Resident (#19), out of one resident assessment reviewed. Findings include: A discharge MDS is required any time a resident is discharged from the facility. Facilities are required to encode and transmit (submitted and accepted into the QIES ASAP system) the MDS electronically no later than 14 calendar days after the MDS completion date. Resident #19 was admitted to the facility in December 2023 with diagnoses which included chronic kidney disease and urinary tract infection. The Resident was discharged from the facility on 1/9/24. Review of the MDS assessment indicated a discharge MDS had not been transmitted to CMS. During an interview on 5/24/24 at 1:05 P.M., the MDS Nurse said the discharge MDS assessment had not been submitted to the CMS processing system within 14 days as required.

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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. 42742 Based on observation, interview, record review, and policy review, the facility failed to follow professional standards of practice for three Residents (#27, #216, and #35), out of a total sample of 17 residents. Specifically, the facility failed: 1. For Resident #27, to ensure medications were administered under direct supervision and not left at the bedside; 2. For Resident #216, to ensure medications were administered under direct supervision and not left at the bedside; and 3. For Resident #35, to ensure medications were administered in accordance with physician's orders. Findings include: Review of the facility's policy titled Administering Medications, dated December 2023, indicated but was not limited to the following: -Medications are administered in accordance with prescriber orders, including any required time frame. -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. -Residents may self-administer their own medications only if the attending physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. Review of Lippincott Nursing Procedures, 8th edition. [Philadelphia: Wolters Kluwer, [2019], indicated but was not limited to the following: Safe Medication Administration Practices, General: -To promote a culture of safety and prevent medication errors, nurses must adhere to the five rights of medication administration; identify the right patient by using at least two patient-specific identifiers; select the right medication; administer the right dose; administer the medication at the right time; and administer the medication by the right route. -Address concerns about the order with the practitioner, pharmacist, or your supervisor if needed. -Document all medications administered in the patient's medication administration record (MAR) or treatment administration record (TAR) including the medication strength, dose, route of administration, and date and time of administration. If a medication wasn't administered, document the reason why, and interventions taken, practitioner notification, and the patient's response to interventions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Handle medications brought by the patient from home as directed by your facility. 1. Resident #27 was admitted to the facility in September 2023 and had diagnoses including venous thrombosis and embolism, major depressive disorder, chronic kidney disease, congestive heart failure, atrial fibrillation, chronic obstructive pulmonary disease (COPD) (group of lung diseases that block airflow and make it difficult to breathe), hyperlipidemia, anxiety, neuropathy, gastro-esophageal reflux disease (GERD), and asthma. Review of the Minimum Data Set (MDS) assessment, dated 5/19/24, indicated Resident #27 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. During an observation with interview on 5/21/24 at 10:56 A.M., the surveyor observed a plastic medication cup on top of the Resident's overbed tray table with approximately 15 various whole pills inside. A nurse was not present in the room or in the immediate vicinity. Resident #27 said there were 17 pills inside the cup and forgot to take them that morning. Resident #27 said the nurse left them there for him/her to take, per his/her preference, and said, I think they're my nine o'clock pills. Review of current Physician's Orders indicated the following 9:00 A.M. scheduled medications: -Eliquis oral tablet (anticoagulant), give 2.5 milligrams (mg) by mouth, two times a day related to atrial fibrillation, 11/9/23 -Sertraline HCL (antidepressant) oral tablet 25 mg, give 3 tablets by mouth (total dose 75 mg) one time a day for depression, 9/12/23 -Lasix (furosemide) (diuretic) oral table 40 mg, give 1 tablet by mouth one time a day related to acute on chronic diastolic (congestive) heart failure, 10/10/23 -Amiodarone HCL (antiarrhythmic) oral tablet, give 200 mg by mouth one time a day related to atrial fibrillation, 9/29/23 -Aspirin 81 mg oral table chewable, give 1 tablet by mouth in the morning for blood thinner, 3/15/23 -Clopidogrel Bisulfate (Plavix) (blood thinner) oral tablet 75 mg, give 1 tablet by mouth one time a day related to hyperlipidemia, 11/18/23 -Colace Capsule (docusate sodium) (stool softener) 100 mg, give 1 capsule by mouth two times a day for constipation, 9/10/23 -Depakote (divalproex sodium) (anticonvulsant and treats mood disorder) tablet delayed release 125 mg, give 1 tablet by mouth one time a day for diagnosis of mood disorder, 3/15/23 -diltiazem HCL (calcium channel blocker) oral tablet 120 mg, give 1 tablet by mouth two times a day related to atrial fibrillation, 9/28/23 -gabapentin oral capsule 100 mg, give 1 capsule by mouth three times a day for neuropathy, 10/9/23 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-iron (Ferrous Sulfate) tablet 325 mg (65 Fe) mg, give 1 tablet by mouth one time a day for supplement for iron deficiency, 9/10/23 -Magnesium oral capsule 400 mg, give 1 capsule by mouth one time a day related to COPD with acute exacerbation: chronic respiratory failure with hypoxia, 8/15/23 -Multivitamin oral tablet, give 1 tablet by mouth one time a day related to muscle weakness, 8/14/23 -pantoprazole sodium tablet delayed release 40 mg, give 1 tablet by mouth in the morning for GERD, 11/27/21 -Potassium Chloride ER oral tablet extended release, give 10 milliequivalent (mEq) by mouth one time a day for supplement, heart failure, 10/27/23 -theophylline (bronchodilator) ER tablet extended release 12-hour 300 mg, give 0.5 mg tablet by mouth one time a day for antiasthmatic and bronchodilator agents, total dose 150 mg, 10/12/21 Review of the May 2024 Medication Administration Record (MAR) indicated the above 5/21/24 medications were prepared and documented as being administered by Nurse #1. During an observation with interview on 5/22/24 at 4:13 P.M., the surveyor observed a plastic medication cup on top of the Resident's overbed tray table with one whole capsule inside. The Resident said it was gabapentin for tingles in his/her feet. No nurse was present inside the room or in the immediate vicinity. The Resident said it was his/her 2:00 P.M. medication and Nurse #6 left it with him/her to take on his/her own. Review of current Physician's Orders indicated the following: -gabapentin oral capsule 100 mg, give 1 capsule by mouth three times a day for neuropathy, 10/9/23 Review of the May 2024 MAR indicated the 5/22/24 2:00 P.M. gabapentin medication was prepared and documented as being administered by Nurse #6. Nurse #6 was not available for interview. Review of Resident #27's most recent Self-Administration of Medications assessment, dated 5/14/24, indicated the Resident was not approved for self-administration of medications and was not approved to keep medications at the bedside. During an interview on 5/23/24 at 11:22 A.M., Nurse #1 said Resident #27 was very independent and took their pills on his/her own. Nurse #1 said she left the pills with the Resident on 5/21/24 to take them on his/her own. Nurse #1 said the policy is to stay with the patient until all the medications are taken unless approved to self-administer them. She said she should have stayed with Resident #27 as the Resident was not approved to take them on his/her own. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 11:33 A.M., the Staff Development Coordinator (SDC) said the 5/14/24 self-administration evaluation indicated Resident #27 was not approved to self-administer medications. She said Nurse #1 should have stayed with the Resident until all the medications were administered. During an interview with the Administrator and SDC on 5/23/24 at 3:48 P.M., the SDC said the nurses should have stayed with Resident #27 to ensure the medications were all taken. She said if an assessment approves of self-administration, then the order would follow and, if approved, be specific for the types of medications that are approved for self-administration, but this was not the case for this Resident. 2. Resident #216 was admitted to the facility in May 2024 and had diagnoses including diabetes mellitus type II, hypertension, and GERD. Review of the MDS assessment, dated 5/9/24, indicated Resident #216 was cognitively intact as evidenced by a BIMS score of 15 out of 15. During an observation with interview on 5/21/24 at 9:27 A.M., the surveyor observed a plastic medication cup on top of the Resident's overbed tray table with three whole small white round tablets, one whole large white oval tablet, one whole yellow round tablet, and one whole green round tablet inside (six tablets total). No nurse was present inside the room or in the immediate vicinity. Resident #216 said nursing staff usually leave them with him/her to take by his/herself and preferred it that way. Review of current Physician's Orders indicated the following 8:00 A.M. and 9:00 A.M. scheduled medications: -desmopressin acetate (antidiuretic) oral tablet 0.2 mg, give 1 tablet by mouth two times a day for diabetes mellitus, 5/4/24 -Ferrous sulfate oral tablet 325 mg (65 Fe) mg, give 1 tablet by mouth one time a day for anemia, 5/4/24 -hydrocortisone oral tablet (steroid) 10 mg, give 1 tablet by mouth two times a day for colitis, 5/4/24 -metformin HCl (antidiabetic) oral tablet 1000 mg, give 1 tablet by mouth one time a day for diabetes mellitus, 5/4/24 -pantoprazole sodium oral tablet delayed release 40 mg, give 1 tablet by mouth two times a day for GERD, 5/4/24 Review of the May 2024 MAR indicated the above 5/21/24 medications were prepared and documented as being administered by Unit Manager (UM) #1. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on 5/23/24 at 8:35 A.M., the surveyor observed Resident #216 sitting at the side of the bed eating his/her breakfast meal. A plastic medication cup was observed on top of the Resident's overbed tray table with 1 whole large white oval tablet, 2 whole small white round tablets, 1 whole small green round tablet, and 1 whole small yellow round tablet inside (5 tablets total). No nurse was present inside the room or in the immediate vicinity. Resident #216 said UM #1 left them there for him/her to take on his/her own because he/she liked to take them after breakfast. Review of Resident #216's medical record failed to indicate a consent/request to self-administer medications, a completed admission Self-Administration of Medications assessment, or a physician's order to self-administer medications. During an interview on 5/23/24 at 10:40 A.M., UM #1 said she brought the Resident their pills that morning then left the room because the Resident had his/her hand out. UM #1 said she should have stayed with the Resident to ensure all the pills were swallowed. She said she assumed he/she took them, so she left the room. UM #1 said residents who wish to self-administer need to be assessed to determine if they know what the pills are, which is which, what they're for, when they need to take them, side effects if they miss them, and if they're able to swallow them safely. At 10:44 A.M., the surveyor reviewed Resident #216's medical record with UM #1 who said there was no consent or assessment completed upon admission to self-administer medications and no physician's order for it, but there should be if the Resident wished to self-administer. During an interview with the Administrator and SDC on 5/23/24 at 3:48 P.M., the SDC said the nurses should have stayed with Resident #216 to ensure the medications were all taken. She said if an assessment approves of self-administration, then the order would follow and, if approved, be specific for the types of medications that are approved for self-administration, but this was not the case for this Resident. 3. Resident #35 was admitted to the facility in April 2024 and had diagnoses including aortic valve disorder, transient ischemic attack (TIA), and cerebral infarction. On 5/23/24 at 9:00 A.M., the surveyor observed Nurse #4 prepare Resident #35's 9:00 A.M. medications as follows: 9:00 A.M. - Nurse #4 opened an over-the-counter (OTC) bottle of chewable aspirin 81 mg from the top drawer of her medication cart and added one whole tablet into a medication cup along with nine other medication tablets. Nurse #4 did not separate the chewable aspirin from the rest. Nurse #4 said the order wasn't for an enteric coated tablet as indicated on the label of a different OTC bottle she had first looked at, just a regular aspirin, so she gave a chewable tablet instead. 9:17 A.M. - Nurse #4 administered the medications to the Resident. Resident #35 swallowed all the tablets whole except for a Tums tablet which had been separated from the rest and chewed. Resident #35 swallowed the chewable aspirin whole. Review of current Physician's Orders indicated the following: -aspirin low dose oral tablet delayed release 81 mg, give 1 tablet by mouth one time a day for analgesics, 4/28/24 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 9:31 A.M., the surveyor reviewed the physician's orders with Nurse #4 who said the order was for a delayed release aspirin tablet. She said the Resident would have swallowed a delayed release tablet whole and, if given a chewable tablet instead, then the Resident should have chewed it, not swallowed it. She said the other aspirin bottle said enteric coated, not delayed release, so she gave the chewable instead. Nurse #4 said she should have clarified the order with the physician prior to giving the chewable tablet, which was an immediate release, not a delayed release tablet per physician's orders. During an interview with the Administrator and SDC on 5/23/24 at 3:32 P.M., the SDC said medications should be administered per physician's orders and if clarification was needed, then the nurse should have asked the physician. The SDC said medications should be administered per the 5 rights: right medication, right dose, right time, right patient, and right route.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, interview, document review, and policy review, the facility failed to ensure an accurate account of all controlled medications was maintained. Specifically, the facility failed to ensure an accurate account of lorazepam (Ativan) (schedule IV-controlled drug with low potential for abuse, treats anxiety) oral concentrate was maintained in the controlled substance accountability record book, as required. Findings include: Review of the facility's policy titled Controlled Substances, undated, indicated but was not limited to the following: -The facility shall comply with all laws, regulations, and other requirements related to the handling, storage, disposal, and documentation of Schedule II and other controlled substances. -Controlled substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must verify that correct amount is received. -If the count is correct, an individual resident-controlled substance record must be made for each resident who will be receiving a controlled substance. -Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services/designee. Review of the facility's policy titled Discontinued Medications, undated, indicated but was not limited to the following: -Staff shall destroy discontinued medications or shall return them to the dispensing pharmacy in accordance with facility policy. During the 2nd floor medication storage room review on [DATE] at 7:57 A.M. with Unit Manager (UM) #2, the surveyor observed a locked metal box stored inside the medication refrigerator on the upper shelf. Contents were heard inside. UM #2 said it was a narcotic box, but she didn't think there was anything stored inside of it and was unable to open it for surveyor review. Nurse #3 was present and was also unable to open the box. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 8:12 A.M., the Staff Development Coordinator (SDC) arrived at the medication storage room and opened the narcotic box alongside UM #2. Stored inside was one opened bottle of lorazepam (Ativan) oral concentrate 2 milligram (mg)/milliliter (ml), 30 ml, stored inside its packaging box. A pharmacy label for Resident #1A was affixed to the packaging box. The SDC and UM #2 said the Resident had expired a while ago and didn't know the lorazepam was still stored in the box. The surveyor reviewed the controlled substance accountability record book, page 143, for Resident #1A's lorazepam 2 mg/ml oral concentrate with the SDC who said the book was not transcribed properly. She said there was a page change, and the medication did not follow so there was no account for the medication since [DATE], therefore, they didn't know the drug was still in the box. The SDC said the nurse who was responsible for carrying over the medication to another page no longer worked at the facility and the other nursing signature documented was illegible. The SDC said Resident #1A's liquid Ativan should have been accounted for then destroyed when the Resident expired but wasn't. During an interview on [DATE] at 3:51 PM., the SDC said on [DATE] Resident #1A's liquid Ativan was discontinued and the Resident was started on PO (by mouth) Ativan. She said the same day the Resident had been transferred to another room, switched nurses, and had a different narcotic book record. She said the liquid Ativan got lost in transition, but the discontinued date should have been transcribed in the narcotic book and the medication destroyed. She said the last dose was given on [DATE]. The SDC said there was not an accurate account of all controlled substances maintained in the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42742 Based on observation, interview, and policy review, the facility failed to ensure staff stored all drugs and biologicals used in the facility in accordance with currently accepted professional principles. Specifically, the facility failed: 1. For Resident #27, to ensure a bottle of Echinacea Complex (used for healthy immune function) tablets, Breztri Aerosphere inhaler, albuterol inhaler, and nasal spray bottle were stored in the medication cart and not left at the bedside; and 2. To ensure a schedule-IV controlled substance medication was maintained in a separately locked, permanently affixed compartment. Findings include: Review of the facility's policy titled Storage of Medications, revised [DATE], indicated but was not limited to the following: -Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. -The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Review of the facility's policy titled Administering Medications, dated [DATE], indicated but was not limited to the following: -Medications are administered in accordance with prescriber orders, including any required time frame. -Residents may self-administer their own medications only if the attending physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. 1. Resident #27 was admitted to the facility in [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD) (group of lung diseases that block airflow and make it difficult to breathe). Review of the Minimum Data Set (MDS) assessment, dated [DATE], indicated Resident #27 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 14 out of 15. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225679	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Megansett Nursing & Rehabilitation	209 County Road Box 408 N Falmouth, MA 02556

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation with interview on [DATE] at 10:56 A.M., the surveyor observed one large bottle of Echinacea Complex, 100 tablets, stored inside a wire container that was visible on the floor next to his/her bed. Resident #27 said it was his/hers from home and took one tablet in the morning and one tablet in the evening. On [DATE] at 11:07 A.M., the surveyor observed the following: -One large bottle of Echinacea Complex, 100 tablets, stored inside a wire container that was visible on the floor next to Resident #27's bed -One Bretztri Aerosphere (budesonide/glycopyrrolate/formoterol fumarate) aerosol inhaler, 160 micrograms (mcg)/9 mcg/4.8 mcg per inhalation with 110 inhalations remaining, stored on the Resident's overbed tray table. The inhaler was not stored in the packaging box. -One albuterol sulfate inhaler, 90 mcg/inhalation with 160 inhalations remaining stored on the Resident's overbed tray table. The inhaler was not stored in the packaging box. -One bottle of saline nasal spray, 1.5 fluid ounces, seal broken, stored on the Resident's overbed tray table. During an interview on [DATE] at 11:07 A.M., Resident #27 said he/she took the medications on their own and preferred it that way. The Resident said he/she used the Bretztri inhaler twice a day and the Albuterol as needed for COPD and asthma. The Resident said he/she had last used the Albuterol the day before and said staff knew. Resident #27 said the saline nasal spray was for a dry nose from the weather and the Oxygen and the nurses gave it to him/her a month or so ago. Review of current Physician's Orders indicated the following: -albuterol sulfate (bronchodilator) HFA aerosol solution 108 (90 base) mcg/act, 2 puff inhale orally every 4 hours as needed for shortness of breath or wheezing, [DATE] -Bretztri Aerosphere aerosol (budesomide-glycopyrrol-fumoterol), [DATE].8 mcg/act, 2 puffs inhale orally two times a day for COPD, use spacer, rinse mouth after each use, [DATE] Further review of physician's orders failed to indicate an order for the Echinacea tablets or saline nasal spray and failed to indicate an order for Resident #27 to store the medications at the bedside. Review of Resident #27's most recent Self-Administration of Medications assessment, dated [DATE], indicated the Resident was not approved for self-administration of medications and was not approved to store medications at the bedside. During an interview on [DATE] at 11:22 A.M., Nurse #1 said the Resident was very independent and takes medications on his/her own. She said she was aware the Resident kept inhalers in the room but was not aware of the bottle of Echinacea. Unit Manager (UM) #2 said there wasn't an order to keep medications at the bedside but should be if the Resident was approved to do so. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:33 A.M., the Staff Development Coordinator (SDC) said the [DATE] self-administration evaluation indicated Resident #27 was not approved to self-administer medications or keep medications at the bedside. She said there wasn't an order to store medications at the Resident's bedside. UM #2 said the Resident goes out of the facility with friends and sometimes purchases his/her own medications without telling staff. 2. During the 2nd floor medication storage room review on [DATE] at 7:57 A.M. with Unit Manager (UM) #2, the surveyor observed a locked metal box stored inside the medication refrigerator on the upper shelf. There was no lock on the refrigerator and the surveyor was able to easily remove the box from the refrigerator. The box was not permanently affixed to the shelf. Contents were heard inside. UM #2 said it was a narcotic box, but she didn't think there was anything stored inside of it and was unable to open it for surveyor review. Nurse #3 was present and was also unable to open the box. During an interview on [DATE] at 8:12 A.M., the Staff Development Coordinator (SDC) arrived at the medication storage room and opened the narcotic box alongside UM #2. Stored inside was one opened bottle of lorazepam (Ativan) oral concentrate 2 milligram (mg)/milliliter (ml), 30 ml, stored inside its packaging box. A pharmacy label for Resident #1A was affixed to the packaging box. The SDC and UM #2 said the Resident had expired a while ago and didn't know the lorazepam was still stored in the box. The SDC said the narcotic box should have been permanently affixed inside the medication refrigerator or the idea would be to have a locked refrigerator but there was no lock on it. The SDC said Resident #1A's liquid Ativan should have been accounted for then destroyed when the Resident expired but wasn't.

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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. 41106 Based on observation, policy review, and interview, the facility failed to follow their policy and professional standards of practice for food safety and sanitation to prevent the potential spread of foodborne illness to residents who are at high risk. Specifically, the facility failed to ensure that one of two resident kitchenette refrigerators maintained a safe temperature of below 41 degrees Fahrenheit (F). Findings include: Review of the facility's policy titled Food Receiving and Storage, undated, indicated but was not limited to the following: -Food shall be received and stored in a manner that complies with safe federal handling practices. -Food items and snacks kept on the nursing units must be maintained as indicated below: -All food items to be kept below 41 F must be placed in the refrigerator located at the nurse's station and labeled with a use by date. -Refrigerators must have working thermometers and be monitored for temperature according to state specific guidelines. Review of the 2022 Food Code by the U.S. Food and Drug Administration (FDA), revised 1/2023, indicated but was not limited to the following: FDA continues to recommend that food establishments limit the cold storage of time/temperature control for safety foods, ready-to-eat foods to a maximum temperature of 41 F. On 5/22/24 at 11:32 A.M., the surveyor observed the second-floor resident kitchenette and observed the internal temperature of the refrigerator to be 48 F. On 5/22/24 at 3:32 P.M., the surveyor and Food Service Manager (FSM) observed the second-floor resident kitchenette and made the following observations: -Internal temperature of the refrigerator was observed to be 45 F. -Internal temperature of carton of milk in the lower right drawer was 50.4 F. -Internal temperature of can of ginger ale on the second shelf was 48.2 F. During an interview on 5/22/24 at 3:35 P.M., the FSM said the refrigerator must be below 41 F and the product inside maintained below 41 F.