STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235320	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lahser Hills Care Centre	25300 Lahser Rd Southfield, MI 48034

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation pertains to Intake MI00143763 Based on observation, interview and record review, the facility failed to treat a resident with dignity and respect for one (R19) of two residents reviewed for dignity. Findings include: On 4/29/24 at 9:24 AM, R19 was observed sitting in a geriatric chair (geri-chair) in the corner of the dining room eating breakfast along with ten other residents. R19 announced they had to go to the bathroom. Certified Nursing Assistant (CNA) D, from across the room told R19 they would have to wait until they were done eating before they could be taken to the bathroom. On 4/29/24 at 9:36 AM, R19 again announced they had to go to the bathroom. CNA D did not respond in any way to R19. On 4/29/24 at 9:38 AM, CNA D went over to R19, who was done eating their breakfast, and asked R19 why they had spilled their drink all over themselves as now she would have to change them. It was observed the table in front of R19 was wet along with R19's shirt, which also had food debris on it. On 4/29/24 at 9:41 AM, CNA D was observed to maneuver R19 in the geri-chair out of the corner of the dining room and pull R19 facing backwards through the dining room, to the end of the nurse station and down the hallway to the shower room. Review of the clinical record revealed R19 was admitted into the facility on [DATE] with diagnoses that included: dementia, schizoaffective disorder and major depressive disorder. According to a Brief Interview for Mental Status (BIMS) assessment dated [DATE], R19 had severely impaired cognition. Review of R19's Nutritional Preferences care plan included an intervention revised 4/15/24 that read in part, . supervision and assistance as needed. I tend to need 1:1 assistance near the end of my meal . On 5/1/24 at 10:06 AM, the Director of Nursing (DON) was interviewed and asked if it was appropriate to pull residents backwards in a geri-chair. The DON explained that residents should always be pushed so the resident is facing forward. When informed of the observations on 4/29/24, the DON had no explanation. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility document titled, Right of Resident in Michigan Nursing Facilities dated 11/28/16 read in part, .As a basic premise, all residents have the right to a dignified existence, self-determination, and communication with and and access to persons and services inside and outside of the facility .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review, the facility failed to ensure a level I Preadmission Screening (PAS)/Annual Resident Review (ARR) Mental Illness/Intellectual Disability/Related Conditions Identification was completed accurately and sent to local community mental health for a level II OBRA (Omnibus Budget Reconciliation Act of 1993) evaluation for one (R49) of one resident reviewed for PASARR's resulting in the potential for the resident to be excluded from receiving necessary care and services appropriate to meet their mental health and intellectual disability needs. Findings include: Review of the clinical record revealed R49 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: schizophrenia, adjustment disorder with mixed anxiety and depressed mood, psychotic disorder with delusions and hallucinations. According to the most recent comprehensive Minimum Data Set (MDS) assessment dated [DATE], section A1500 for Preadmission Screening and Resident Review (PASRR) was left blank. Review of R49's Level I Screening dated 12/27/23 revealed the form was marked as Hospital Exemption Discharge . SECTION II - Screening Criteria . 1.Yes The person has a current diagnoses of Mental Illness . 2. Yes The person has received treatment for Mental Illness . 3.Yes The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days . If any answer to items 1 - 6 in SECTION II is Yes, send ONE copy to the local Community Mental Health Services Program (CMHSP), with a copy of form DCH-3878 if an exemption is requested . Further review of the clinical record revealed there was no evidence that a Level I evaluation had been completed by the facility. On 5/1/24 at 10:08 AM, the Social Worker Director (SWD) was interviewed and asked why a Level I evaluation had not been completed in January 2024 for R49. The SWD explained the Level I had been overlooked. On 5/1/24 at 10:32 AM, the Administrator was asked for a policy on PASARR. The Administrator explained they did not have a policy but the facility followed the Federal Regulations regarding PASARR.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure medications were administered, documented, and stored according to professional standards of practice for four (R215, R11, R95, and R265) residents reviewed. Findings include: R215 On 5/1/24 at 10:00 AM, R215 was observed lying in bed. R215's Pain Management Physician (Physician 'L') was at R215's bedside. At that time, R215 reported he was experiencing severe pain to his right knee and he wanted to know what was causing the pain. R215 had Jackson Pratt drains extending from the side of both knees (two on the left side and one on the right side) that contained small amounts of brownish-pink opaque drainage and immobilizer devices applied to both legs. When asked by Licensed Practical Nurse (LPN) 'N' if she could remove the immobilizers to observe R215's skin, R215 reported he would not allow her to remove them until he received his pain medication because it would be too painful. R215 reported that after he received his pain medication and waited 30 minutes he would allow removal of the immobilizers and treatment to be done to his knees. On 5/1/24 at 10:07 AM, a review of R215's physician's orders revealed the following order: An active order with a start date of 4/30/24 for (Oxycodone [with] Acetaminophen (a schedule II controlled substance - a regulated drug due to the high potential for abuse and dependence - used to treat moderate to severe pain) 10-325 MG (milligrams). Give 1 tablet by mouth every 4 hours as needed for pain. A review of R215's Medication Administration Records (MAR) for April 2024 and May 2024 revealed as of 10:07 AM on 5/1/24, R215 had not received pain medication (Oxycodone with acetaminophen) since 10:07 PM on 4/30/24. There was no documentation on R215's May 2024 MAR that indicated he received any pain medication on that day. Further review of R215's clinical record revealed R215 was readmitted into the facility on [DATE] with a diagnosis of septic arthritis to the bilateral knees. A review of R215's Minimum Data Set (MDS) assessment dated [DATE] revealed R215 had intact cognition. On 5/1/24 at 11:04 AM, an interview was conducted with the wound care nurse (LPN 'O'). LPN 'O' reported R215 preferred his wound treatments to be completed first thing in the morning, but he refused to have her do the treatment to his knees due to pain on that morning. At that time, R215 reported LPN 'N' gave him his pain medication approximately 45 minutes prior and he would allow LPN 'O' to remove the knee immobilizers and administer treatment to his knees. LPN 'O' administered wound care to R215's bilateral knees. R215 verbalized significant pain during the treatments, was unable to talk through the pain, was tearful, braced himself using the bilateral enabler bars, grimaced, and yelled out. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/1/24 at approximately 12:00 PM, an interview was conducted with the Director of Nursing (DON). When queried about R215's pain during wound treatment, the DON explained Nurse Practitioner (NP) 'M' changed R215's pain medication regimen the previous day due to increased pain and that the order was for every four hours as needed. When queried as to why R215 had not received pain medication since 10:07 PM on 4/30/24, the DON reported he would look into it. On 5/1/24 at 12:19 PM, the DON provided a Individual Resident's Controlled Substance Record (a form used to ensure all controlled substances are accounted for) for R215 for the Oxycodone-acetaminophen and explained that on 5/1/24, R215 received one dose at 2:10 AM, one dose at 6:10 AM, and one dose at 10:13 AM based on the nurses' signatures and documentation that they pulled one tablet from R215's medication supply. When queried about the lack of documentation on the MAR that would have indicated the nurses administered the medication after they pulled it from the supply, the DON reported it should be documented on the MAR, but because the nurses documented they pulled the medication from the supply that was evidence it was administered to the resident. On 5/1/24 at 12:25 PM, the DON followed up and reported he interviewed R215 who said he received the pain medication from the midnight nurse. The DON reported the midnight nurse should have signed out on the MAR that she administered the medication after pulling it from the supply. On 5/1/24 at approximately 1:30 PM, the DON followed up and reported the midnight nurse (LPN 'P') added documentation to the MAR to indicate the Oxycodone-acetaminophen was administered at 2:10 AM and 6:10 AM. There was no documentation on the MAR that showed LPN 'N' administered the 10:13 AM dose (although R215 did verbally confirm he received it). The DON explained the nurses had 24 hours to go back and document administration of medications, including controlled substances. When queried about whether that process would allow for identification of diversion of drugs, the DON did not offer a response. A policy regarding controlled substances was requested. However, the policy received did not include procedures on administration of controlled substances, only ordering. On 5/1/24 at 12:23 PM, during a nursing skin assessment for R215, a packaged medication identified as Diltiazem 30 milligram (mg) one tablet was observed on R215' tray table next to ostomy supplies and beverage cups. The DON entered the room at which time this surveyor pointed to the medication. As the DON removed the packaged medication, R215 indicated the medication was left on the table last night by the nurse. 34275 R265 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/24 at approximately 9:29 AM, R265 was observed lying in bed. The resident was not able to answer any questions asked and appeared to be in a catatonic state. Three family members were also in the room. One identified themselves as the resident's guardian and a second family member reported that they were a licensed pharmacist. They reported that R265 was admitted to the facility on [DATE] for physical therapy and nursing care. The family members were asked as to the care provided by the facility. One of the family members indicated that they were disappointed that the facility was administering the drug Klonopin/Clonazepam (a drug classified as a psychotropic medication) three times per day to the resident. The family member noted that the resident had been on other psychotropic medication for some time but felt there was no need to add Klonopin as another scheduled medication. The family continued to express concerns with the facility and noted that they were going to find another facility that would better accommodate the resident. A review of R265's Hospital Transfer Record located in their electronic record noted medications that were recommended to be continued in SNF (skilled nursing facility). The drug Klonopin/Clonazepam was not noted in that section, but a handwritten note read Clonazepam/Klonopin .5 mg 3xd (three times per day) PRN (as needed). Continued review of R265's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: failure to thrive and unspecified dementia without behavioral disturbances. The resident's record noted that the resident was severely cognitively impaired. An order dated 4/24/24 documented, Klonopin oral tablet .5 MG/Controlled substance -give 1 tablet by mouth every 8 hours for panic disorder. A review of R265's Medication Administration Record (MAR) recorded that the resident received Klonopin . 5mg on 4/24/24 (2PM/10PM), 4/25/24 (6AM/2PM and 10PM), 4/26/24 (6AM/2PM and 10PM), 4/27/24 (6AM/2PM and 10PM), 4/28/24 (6AM/2PM and 10PM) and 4/29/24 (6AM). On 4/30/24 at approximately 8:14 AM, an interview was conducted with the DON. The DON was asked as to why R265 was placed on scheduled Klonopin three 3 times per day as opposed to the order noted in the Hospital records as PRN. The DON reported they would have to review the resident's records. The DON returned on 4/30/24 at approximately 8:49 AM and noted that the scheduled order for Klonopin appeared to be put in by Physician Q as scheduled and suggested contacting the physician. On 4/30/24 at approximately 3:25 PM, a phone interview was conducted with Physician Q. When asked about the scheduled Klonopin .5mg for R265, Physician Q reported that they remember receiving a call from nursing staff that the resident was exhibiting behavioral concerns when staff attempted to take their vitals. They noted that the order was supposed to be PRN and must have been put in wrong by the Nurse. Physician Q stated that the order sent to pharmacy would show that order was to be PRN. On 4/30/24 at approximately 3:49 PM, the DON was notified as to Physician Q's response. The DON was able to confirm that the order was noted as PRN and confirmed possibly Nurse R put the order in wrong. 39592 R11 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/24 at 9:58 AM, R11 was observed lying in bed. A medicine cup with four white tablets was observed on the three drawer bedside table. R11 was asked if they knew what medications were in the medicine cup. R11 explained they did not know. When asked how long the medications had been sitting there, R11 explained they did not know. Review of the clinical record revealed R11 was admitted into the facility on [DATE] with diagnoses that included: dementia, heart disease and hypertension. According to the MDS assessment dated [DATE], R11 had moderately impaired cognition and required the assistance of staff for activities of daily living (ADL's). On 5/1/24 at 10:05 AM, observation of R11's medications with LPN G revealed: Atorvastatin 10 mg (milligrams), a white tablet; Melatonin 5 mg, a white tablet; Metoprolol Succinate 25 mg, a white tablet; and Sennosides-Docusate Sodium 8.6-50 mg, a white tablet, were all ordered to be given at 9:00 PM. Review of R11's April 2024 MAR revealed all four medications, Atorvastatin, Melatonin, Metoprolol Succinate and Sennosides-Docusate Sodium were signed off as given on 4/28/24 at 9:00 PM. On 5/1/24 at 10:06 AM, the DON was interviewed and asked if nurses could leave medications at the bedside. The DON explained nurses should make sure resident took all medication before they were signed off as given. 49083 R95 On 4/29/24, a Clinical record review revealed R95 was admitted on [DATE] under Hospice Care services with a diagnosis of heart failure, end stage kidney disease, malnutrition, and chronic obstructive pulmonary disease (COPD). A Brief Interview for Mental Status (BIMS) score totaled 11 indicating R95 had moderate impaired cognition. On 4/29/24 at 10:14 AM, during the initial introduction to R95, an observation of the bedside table revealed a box containing a medication inhaler identified as Fluticasone-Salmeterol (a medication used to treat worsening of COPD). When asked if the medication was provided by the nurse, R95 replied it is kept on the table and it is taken by self whenever it is needed. On 4/29/24 at 4:28 PM, an observation with Registered Nurse (RN) K verified Fluticasone-Salmeterol Inhaler remained at R95's bedside. RN K reviewed the Electronic Medical Record (EMR) and confirmed there was no provider order for the medication to be self-administered and the medication should not be left at the bedside. On 4/29/24 at 4:39 PM, the Director of Nursing (DON) was informed a Fluticasone-Salmeterol Inhaler was observed at R95's bedside. The DON acknowledged resident medications that do not have self-administering orders are not to be left at a resident's bedside. Review of the facility Medication Administration Policy Section 7.1 01/21, stated .Residents are allowed to self-administer medications when specifically authorized by the prescriber, the nursing care center's Interdisciplinary Team (IDT), and in accordance with procedures for self-administration . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facilities Medication Administration Policy Section 7.1 01/21, stated: .Medications are administered as prescribed in accordance with good nursing principles and practices . A review of a facility policy titled, Medication Administration dated 1/2021, revealed, in part, the following: . The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medication .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to ensure continuous oxygen was provided per physician orders for one (R19) of one resident reviewed for oxygen therapy. Findings include: On 4/29/24 at 9:24 AM, R19 was observed sitting in a geriatric chair (geri-chair) in the corner of the dining room eating breakfast. An oxygen concentrator was observed next to R19 and nasal cannula tubing was connected to the concentrator providing oxygen to R19. On 4/29/24 at 9:41 AM, Certified Nursing Assistant (CNA) D was observed pulling R19 backward in the geri-chair in one hand while pulling the oxygen concentrator in the other hand from the dining room, down two hallways to a shower room. R19's nasal cannula tubing was still attached to the oxygen concentrator, no oxygen tank was observed. It should be noted, the oxygen concentrator had to be plugged in to work, it contained no battery power supply. Review of the clinical record revealed R19 was admitted into the facility on [DATE] with diagnoses that included: dementia, schizoaffective disorder and major depressive disorder. According to a Brief Interview for Mental Status (BIMS) assessment dated [DATE], R19 had severely impaired cognition. Review of R19's physician orders revealed an order for, O2 (oxygen) 2L (liters) every shift continuous. On 4/30/24 at 8:42 AM, R19 was observed sitting in a geri-chair in the corner of the dining room. The breakfast R19 was eating appeared to be mostly eaten. Licensed Practical Nurse (LPN) F was observed wheeling an oxygen concentrator into the dining room, plugging it in and attaching R19's nasal cannula tubing to it. No oxygen tank was observed to have been used before the oxygen concentrator was provided. On 4/30/24 at 8:47 AM, multiple oxygen tanks were observed at the nurse station on R19's unit. On 4/30/24 at 11:06 AM, R19 was observed sitting in a geri-chair in the common area. The wheel of the geri-chair was directly on the nasal cannula tubing, preventing oxygen from reaching R19 from the oxygen concentrator. On 4/30/24 at 11:10 AM, Licensed Practical Nurse (LPN) F was interviewed and asked why oxygen tanks were not utilized for residents on continuous oxygen therapy. LPN F explained they had tried using the oxygen tanks, but they would run out of oxygen quickly. On 5/1/24 at 9:30 AM, R19 was observed sitting in a geri-chair in the corner of the dining room eating breakfast. An oxygen tank was observed hanging from the back of the geri-chair. The nasal cannula tubing was observed completely wrapped around the oxygen tank, none of the tubing was attached to R19. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/1/24 at 10:06 AM, the Director of Nursing (DON) was interviewed and asked if a resident on continuous oxygen should be transported with an oxygen tank or concentrator. The DON explained oxygen tanks should be used when transporting residents. When informed oxygen tanks were not being used when transporting R19, the DON had no explanation. Review of a facility policy titled, Oxygen Administration revised 11/19/13 read in part, .Safely administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues . A Licensed Nurse will be responsible for the correct administration of oxygen to the resident but may delegate this task to another staff person trained and deemed competent in the use of oxygen . A reserve oxygen tank should e available on the unit to provide continuity of care .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** 32568 Based on observation, interview, and record review, the facility failed to ensure all controlled substances were accounted for and accurately documented for one (215) resident reviewed. Findings include: R215 On 5/1/24 at 10:00 AM, R215 was observed lying in bed. R215's Pain Management Physician (Physician 'L') was at R215's bedside. At that time, R215 reported he was experiencing severe pain to his right knee and he wanted to know what was causing the pain. R215 had Jackson Pratt drains extending from the side of both knees (two on the left side and one on the right side) that contained small amounts of brownish-pink opaque drainage and immobilizer devices applied to both legs. When asked by Licensed Practical Nurse (LPN) 'N' if she could remove the immobilizers to observe R215's skin, R215 reported he would not allow her to remove them until he received his pain medication because it would be too painful. R215 reported that after he received his pain medication and waited 30 minutes he would allow removal of the immobilizers and treatment to be done to his knees. On 5/1/24 at 10:07 AM, a review of R215's physician's orders revealed the following order: An active order with a start date of 4/30/24 for (Oxycodone [with] Acetaminophen (a schedule II controlled substance - a regulated drug due to the high potential for abuse and dependence - used to treat moderate to severe pain) 10-325 MG (milligrams). Give 1 tablet by mouth every 4 hours as needed for pain. A review of R215's Medication Administration Records (MAR) for April 2024 and May 2024 revealed as of 10:07 AM on 5/1/24, R215 had not received pain medication (Oxycodone with acetaminophen) since 10:07 PM on 4/30/24. There was no documentation on R215's May 2024 MAR that indicated he received any pain medication on that day. Further review of R215's clinical record revealed R215 was readmitted into the facility on [DATE] with a diagnosis of septic arthritis to the bilateral knees. A review of R215's Minimum Data Set (MDS) assessment dated [DATE] revealed R215 had intact cognition. On 5/1/24 at 11:04 AM, an interview was conducted with the wound care nurse (LPN 'O'). LPN 'O' reported R215 preferred his wound treatments to be completed first thing in the morning, but he refused to have her do the treatment to his knees due to pain on that morning. At that time, R215 reported LPN 'N' gave him his pain medication approximately 45 minutes prior and he would allow LPN 'O' to remove the knee immobilizers and administer treatment to his knees. LPN 'O' administered wound care to R215's bilateral knees. R215 verbalized significant pain during the treatments, was unable to talk through the pain, was tearful, braced himself using the bilateral enabler bars, grimaced, and yelled out. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/1/24 at approximately 12:00 PM, an interview was conducted with the Director of Nursing (DON). When queried about R215's pain during wound treatment, the DON explained Nurse Practitioner (NP) 'M' changed R215's pain medication regimen the previous day due to increased pain and that the order was for every four hours as needed. When queried as to why R215 had not received pain medication since 10:07 PM on 4/30/24, the DON reported he would look into it. On 5/1/24 at 12:19 PM, the DON provided a Individual Resident's Controlled Substance Record (a form used to ensure all controlled substances are accounted for) for R215 for the Oxycodone-acetaminophen and explained that on 5/1/24, R215 received one dose at 2:10 AM, one dose at 6:10 AM, and one dose at 10:13 AM based on the nurses' signatures and documentation that they pulled one tablet from R215's medication supply. When queried about the lack of documentation on the MAR that would have indicated the nurses administered the medication after they pulled it from the supply, the DON reported it should be documented on the MAR, but because the nurses documented they pulled the medication from the supply that was evidence it was administered to the resident. On 5/1/24 at 12:25 PM, the DON followed up and reported he interviewed R215 who said he received the pain medication from the midnight nurse. The DON reported the midnight nurse should have signed out on the MAR that she administered the medication after pulling it from the supply. On 5/1/24 at approximately 1:30 PM, the DON followed up and reported the midnight nurse (LPN 'P') added documentation to the MAR to indicate the Oxycodone-acetaminophen was administered at 2:10 AM and 6:10 AM. There was no documentation on the MAR that showed LPN 'N' administered the 10:13 AM dose (although R215 did verbally confirm he received it). The DON explained the nurses had 24 hours to go back and document administration of medications, including controlled substances. When queried about whether that process would allow for identification of diversion of drugs, the DON did not offer a response. A policy regarding controlled substances was requested. However, the policy received did not include procedures on administration of controlled substances, only ordering. A review of a facility policy titled, Medication Administration dated 1/2021, revealed, in part, the following: . The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medication .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on interview and record review, the facility failed to administer blood pressure medications according to physician ordered parameters for one (R59) of five residents reviewed for unnecessary medications, resulting in the resident receiving a medication used to treat low blood pressure when it was not needed. Findings include: A review of R59's clinical record revealed R59 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: hypertension (high blood pressure) and hypotension (low blood pressure). A review of a Pharmacy Recommendation progress note dated 12/14/23 revealed, The resident has an order for Midodrine 5mg PO (by mouth) BID (two times a day) (Hold for SBP >120). Please review administration record/hold orders with nursing staff with regards to compliance/accuracy, for medication safety. A review of a Pharmacy Recommendation progress note dated 4/18/24 revealed, The resident has order for Midodrine BID, with hold orders SBP >120. Please ensure the BP is being documented on the MAR along with each of these administrations . A review of R59's active physician's orders revealed the following: A discontinued order that was in place from 8/22/23 until 2/23/24 for Midodrine HCl .5 MG (milligrams). Give 1 tablet by mouth two times a day for low BP (blood pressure) hold for SBP (systolic blood pressure - top number) > (greater than) 120 mmHg (millimeters of mercury). An active order with a start date of 3/13/24 for Midodrine HCl .5 MG .1 tablet by mouth every morning and at bedtime for Hypotension. Hold for SBP greater than 120 . A review of R59's Medication Administration Records (MAR) revealed R59 received Midodrine outside of parameters (SBP greater than 120) on the following dates: January 2024 1/2/24 (5:00 PM dose) - 128/76 1/4/24 (5:00 PM dose) - 128/72 1/7/24 (8:00 AM dose) - 122/63 1/11/24 (5:00 PM dose) - 155/72 1/13/24 (8:00 AM dose) - 124/53 1/19/24 (8:00 AM dose) - 143/59 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/21/24 (8:00 AM dose) - 151/76 1/22/24 (5:00 PM dose) - 128/68 1/24/24 (8:00 AM dose) - 124/76 1/24/24 (5:00 PM dose) - 126/76 1/25/24 (5:00 PM dose) - 121/73 February 2024 2/1/24 (8:00 AM dose) - 126/59 2/11/24 (5:00 PM dose) - 123/62 2/12/24 (5:00 PM dose) - 123/77 2/14/24 (5:00 PM dose) - 121/72 2/17/24 (5:00 PM dose) - 122/85 2/20/24 (8:00 AM dose) - 125/64 A review of R59's March 2024 MAR revealed no documentation of R59's blood pressure. It was documented on the MAR that R59's morning dose of Midrodrine was held on 3/15/24, 3/30/24, and 3/31/24. However, no BP was documented on the MAR. A review of a progress note revealed R59's blood pressure was 118/60 which would have been within parameters to receive the medication (SBP was less than 120 mmHg). There was no documentation of R59's blood pressure on 3/30/24 and 3/31/24 to indicate why R59's Midodrine was held. There was no documented blood pressure in R59's clinical record to determine if R59's Midodrine should have been administered. A review of R59's April 2024 MAR revealed no documentation of R59's blood pressure at the time of Midodrine administration. It was documented on the MAR that R59's morning dose of Midrodrine was held on 4/3/24, 4/5/24, and 4/8/24. There was no progress note to indicate why the Midrodrine was held on 4/3/24 and 4/8/24. On 4/5/24, it was documented the Midrodrine was held when R59's blood pressure was 103/61 which was below the parameters for which it should have been held. There was no documented blood pressure in R59's clinical record to determine if R59's Midodrine should have been administered. On 4/30/24 at 8:15 AM, an interview was conducted with the Director of Nursing (DON). The DON reported nurses should administer medications according to physician ordered parameters. At that time R59's March 2024 and April 2024 MARs were reviewed with the DON. The DON reported there should be a space to document the blood pressure on the MAR to go along with the parameters ordered. The DON reviewed the vital's tab in the electronic medical record and the progress notes and confirmed R59's blood pressure was not documented. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Medication Administration dated 1/2021, revealed, in part, the following: . Medications are administered in accordance with written orders of the prescriber .Obtain and record any vital signs as necessary prior to medication administration .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to ensure a resident received psychotropic medication as ordered for one (R265) out of five residents reviewed for unnecessary medication. Finding include: On 4/29/24 at approximately 9:29 AM, R265 was observed lying in bed. The resident was not able to answer any questions asked and appeared to be in a catatonic state. Three family members were also in the room. One identified themselves as the resident's guardian and a second family member reported that they were a licensed pharmacist. They reported that R265 was admitted to the facility on [DATE] for physical therapy and nursing care. The family members were asked as to the care provided by the facility. One of the family members indicated that they were disappointed that the facility was administering the drug Klonopin/Clonazepam (a drug classified as a psychotropic medication) three times per day to the resident. The family member noted that the resident had been on other psychotropic medication for some time but felt there was no need to add Klonopin as another scheduled medication. The family continued to express concerns with the facility and noted that they were going to find another facility that would better accommodate the resident. A review of R265 Hospital Transfer Record located in their electronic record noted medications that were recommended to be continued in SNF (skilled nursing facility). The drug Klonopin/Clonazepam was not noted in that section, but a handwritten note read Clonazepam/Klonopin .5 mg 3xd (three times per day) PRN (as needed). Continued review of R265's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: failure to thrive and unspecified dementia without behavioral disturbances. The resident's record noted that the resident was severely cognitively impaired. An order dated 4/24/24 documented, Klonopin oral tablet .5 MG/Controlled substance -give 1 tablet by mouth every 8 hours for panic disorder. A review of R265's Medication Administration Record (MAR) recorded that the resident received Klonopin . 5mg on 4/24/24 (2PM/10PM), 4/25/24 (6AM/2PM and 10PM), 4/26/24 (6AM/2PM and 10PM), 4/27/24 (6AM/2PM and 10PM), 4/28/24 (6AM/2PM and 10PM) and 4/29/24 (6AM). On 4/30/24 at approximately 8:14 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked as to why R265 was placed on scheduled Klonopin three 3 times per day as opposed to the order noted in the Hospital records as PRN. The DON reported they would have to review the resident's records. The DON returned on 4/30/24 at approximately 8:49 AM and noted that the scheduled order for Klonopin appeared to be put in by Physician Q as scheduled and suggested contacting the physician. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/24 at approximately 3:25 PM, a phone interview was conducted with Physician Q. When asked about the scheduled Klonopin .5mg for R265, Physician Q reported that they remember receiving a call from nursing staff that the resident was exhibiting behavioral concerns when staff were attempting to take their vitals. They noted that the order was supposed to be PRN and must have been put in wrong by the Nurse. Physician Q stated that the order sent to pharmacy would show that order was to be PRN. On 4/30/24 at approximately 3:49 PM, the DON was notified as to Physician Q's response. The DON was able to confirm that the order was noted as PRN. When asked as to orders for psychotropic medications that are PRN, the DON reported with PRN medications we would have tried non-pharmacological interventions prior to administering the medications. A review of the facility policy titled, Controlled Substance Medication Orders documented, in part: Each controlled substance medication order is documented in the resident's medical record with the date, time and signature of the person receiving the prescription. The medication order is recorded on the physician order sheet .and recorded on the MAR .The prescription is faxed to the pharmacy by the prescriber or prescriber's agent .if this is not possible, the facility nurse on duty faxes the prescription to the pharmacy .the pharmacy prepares the medications based on the faxed copy .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49083 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent when total of two medication errors were observed for one resident (R54) out of four residents observed during medication administration for a total of 32 opportunities resulting in an error rate total of 6.25%. On 4/30/24 at 8:46 AM, a medication administration observation was conducted with Licensed Practical Nurse (LPN) I for R54. A prepackaged medication identified as Clopidogrel (Plavix, a medication that prevents the blood from clotting) 75 milligram (mg) was removed from the packaging, and placed into the medication cup. Further observation revealed LPN I removed a bottle from the medication cart and was identified as Aspirin Enteric Coated (EC) 81 mg, removed 1 tablet, and placed into the medication cup. LPN I was then observed providing the medications to R54 and verified oral administration. On 4/30/24, a medication reconciliation of the physicians' orders was conducted and revealed the Clopidogrel (Plavix) 75mg was ordered to be given at 7:00 PM and administration of the medication as observed around 9:00 AM was not documented. Further reconciliation revealed the Aspirin 81 mg was not ordered by the ordering provider as enteric coated. On 4/30/24 at 4:49 PM, The Director of Nursing (DON) was interviewed and informed of the medication reconciliation findings for R54. The DON acknowledged the errors and indicated notification of R54's physician would be contacted. Review of the facility policy titled Medication Administration General Guidelines Section 7.1 01/21, stated: . Prior to administration, review and confirm medication orders for each resident on the Medication Administration Record (MAR). Compare the medication and dosage schedule on the resident's MAR .Verify medication is correct three times .When pulling medication package from med cart, when dose is prepared, before dose is administered .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49083 Based on observation, interview, and record review, the facility failed to ensure safe and secure storage of medication from three of three medication carts reviewed to assure medications are inaccessible to unauthorized staff and residents. Findings Include: On 4/30/24 at 8:35 AM, a medication administration observation was conducted with Registered Nurse (RN) E. Medications were prepared from the medication cart identified as Second Floor Short Hall. After medications were prepared for a resident, RN E proceeded into the resident's room leaving the medication cart unlocked, unattended, and out of sight. Review of the facilities policy, Medication Administration General Guidelines Section 7.1, 01/21 stated: . The medication cart is kept closed and locked when out of sight of the medication nurse . On 4/30/24 at 9:19 AM, A medication administration observation was conducted with Licensed Practical Nurse (LPN) I from the medication cart identified as Second Floor Middle. LPN I recognized an ordered medication was not available in the cart and proceeded to walk away, leaving the cart with previously pulled medications on top of the cart. A second medication administration observation with LPN I was conducted. During medication preparation, LPN I dropped two medication pills onto the floor, then placed them on top of the cart. The two loose pills remained on top of the cart as LPN I walked away to administer medications. Upon return to the medication cart LPN I was queried if medications are to remain on top of the cart unattended. LPN I acknowledged both administrations of medications were left unattended and confirmed medications are not to be left and then disposed of the loose medications. Review of the facility policy, Medication Administration General Guidelines Section 7.1, 01/21 stated: .During administration of medications .No medications are kept on top of cart . On 4/30/24 at 9:40 AM, The medication cart identified as Second Floor Long Hall was inspected with Licensed Practical Nurse (LPN) J. When LPN J opened the drawer of the medication cart a blue plastic container labeled 2N-227-1 was observed to have an unidentifiable pink pill laying in the top left corner. When queried of the loose pill, LPN J acknowledged it was unidentifiable and disposed of it. Review of the facility policy Medication Storage Section 4.1, 01/21 stated: .Medications without secure closures are immediately removed and disposed of according to medication disposal . On 4/30/24 at 4:49 PM, The Director of Nursing (DON) was informed of the medication administration and storage observations. The DON acknowledged medications are not to remain unattended and medication carts are to be locked when not visible with the nurse. The DON acknowledged loose medications pills should not be in the medication carts.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 4/29/24 between 8:30 AM-9:05 AM, during an initial tour of the kitchen, with Dietary Manager S and Culinary Specialist T present in the kitchen, the following items were observed: The bulk flour bin was observed with no label identifying the contents inside. Culinary Specialist T stated that another staff member had just wiped it down, and the label must have come off. According to the 2017 FDA Food Code section 3-302.12 Food Storage Containers, Identified with Common Name of Food, Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD. The 2 bulk rice bins located next to the flour bin, were observed with dried on food splatter on the lid and on the outside surface of the bin. According to the 2017 FDA Food Code section 4-602.13 Nonfood-Contact Surface, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. The milk cooler was observed with pooling milk on the interior bottom surface, underneath the milk crates. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, .(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. The flooring in front of the stove was observed with a large spill of a white, granular substance. The flooring behind the trash can next to the coffee maker, was observed with a buildup of food debris. The flooring next to the spice rack was observed with a large pile of spilled thyme spices. The flooring in the dry storage room was observed with food debris underneath the racks. When queried about the cleaning of the floors, Dietary Manager S confirmed the food debris on the floor and stated staff is supposed to mop every night. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean.