STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235400	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellspring Lutheran Services	1390 Maple Drive Fairview, MI 48621

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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 - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 Based on observation, interview, and record review the facility failed to 1) appropriately stage, 2) don personal protective equipment (PPE), 3) consult/involve physician for wound treatment, 4) provide aseptic wound care, 5) perform routine skin assessment, 6) provide accurate wound documentation and 7) implement interventions to prevent the development and worsening of a facility acquired pressure injury for two Residents (#2, #11) out of 2 residents reviewed for pressure ulcers. Findings include: Resident #2 (R2) Review of R2's medical record revealed admission to the facility on [DATE] with diagnoses including multiple sclerosis, diabetes mellitus, dependency on wheelchair, and major depression. Review of the 4/19/24 Minimum Data Set (MDS) assessment revealed she scored 9 out of 15 on the Brief Interview for Mental Status (BIMS) assessment indicating moderately impaired cognition. The MDS revealed she was at risk for pressure ulcer development and had no active/current pressure ulcers. On 7/9/24 at 8:15 AM, an observation was made of R2 in her room lying in her bed on her left side. R2 had a foam boarder dressing observed on the right posterior thigh. On 7/9/24 at 8:16 AM, an observation was made of Certified Nurse Aide (CNA) G and CNA F providing direct care to R2 in her room. CNA G and CNA F were changing linens and both CNAs and failed to don any personal protective equipment (PPE) such as gowns. On 7/9/24 at 8:17 AM, an interview was conducted with CNA G and was asked if she was required to wear a gown while providing direct care to R2 and replied, Not unless I am doing something with her catheter. CNA G was shown the sign hanging on the outer door of R2's room indicating R2 was on enhanced barrier precautions and if providing direct care such as changing linens then gloves and a gown were required to be worn by staff. On 7/9/24 at 8:18 AM, an interview was conducted with CNA F and was asked if she was required to wear a gown while providing direct care to R2 and replied, Oh gosh. I forgot. I should have been wearing a gown. On 7/9/24 at 1:00 PM, an observation was made of R2 sitting in her [brand name] specialized chair with flexible strapping surface, in the dining room, with her right hip directly up against the right side on her chair with a thin pad next to the arm of the chair. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 8:30 AM, an observation was made of R2 sitting in her [brand name] chair, in the TV room, with her right hip directly up against the right side on her chair with a thin pad next to the arm of the chair. Review of R2's physician order, dated 4/1/24, revealed Staff to wear gown and gloves (potentially additional PPE, if needed) during all high-contact resident care activities, prevention of transmission of multidrug-resistance organisms. Review of R2's physician order, dated 12/11/23, revealed Weekly skin sweep every day shift every Thu (Thursday). Review of R2's weekly skin assessment, dated 1/4/24, revealed alterations in skin integrity as follows: a.) Site: Left buttocks. Description: Chronic discoloration of the area, b.) Site: Other (specify). Description: Right arm - healing scratch, c.) Site: Abdomen. Description: Scratch to RLQ (right lower quadrant), d.) Site: Other (specify). Description: Healing bruise to RFA (right forearm), e.) Site: Right hand (back). Description: Fading bruise, f.) Site: Other (specify). Description: Fading bruise to L (left) wrist, g.) Site: Right toe(s). Description: MASD (moisture associated skin damage), and h.) Site: Chest. Description: Rt (right) chest blister, see TAR (treatment administration record). Review of R2's electronic medical record for weekly skin assessments from 1/4/24 through 7/4/24, revealed the lack of a weekly skin assessment on the following dates: 1/11/24, 2/1/24, 3/28/24, 4/11/24, 4/18/24, and 6/20/24. Review of physician order, dated 1/9/24, read in part, Skin prep to large fluid blister on right hip daily . Review of R2's weekly skin assessment, dated 1/18/24, revealed alterations in skin integrity as follows: a.) Site: Left buttocks. Description: Chronic discoloration of the area, b.) Site: Other (specify). Description: Right arm - healing scratch, c.) Site: Right iliac crest (front). Description: Blister, d.) Site: Other (specify). Description: Healing bruise to RFA (right forearm), (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e.) Site: Right toe(s). Description: MASD (moisture associated skin damage) between the great/2nd toes and 4th/5th toes. Blister to side of Great toe, and f.) Site: Chest. Description: Rt (right) chest blister, see TAR. Review of R2's wound assessment, dated 2/1/24, read in part, Wound type: Other. Site: Right trochanter (hip). Description: Open blister. Date of onset: 2/1/24. Depth in cm (centimeters): 0.2, wound measurements - length X width: 7.8 x 4.7, drainage: serosanguinous (blood and fluid mixed), drainage amount: light, wound edges: red .wound bed: granulation (new tissue), was care plan updated? Yes . Review of physician order, dated 2/1/24, read in part, Blister opened on right hip: skin prep peri (skin surrounding wound)-wound, apply calcium alginate (wound dressing type) to wound bed, cover with comfort foam .every day shift every other day. Review of R2's wound assessment, dated 2/19/24, read in part, Wound type: Other. Site: Right trochanter (hip). Description: Open blister. Date of onset: 2/1/24. Depth in cm: 0.2, wound measurements - length X width: 6.6 x 4.3 cm, drainage: serosanguinous, drainage amount: light, wound edges: red .wound bed: granulation, was care plan updated? Yes . Review of progress note, dated 2/19/24, read in part, .Blister measured as 4.5 x 2.4 x 0.6 cm. Edges unattached to wound base, yellow slough covering > 75 % (percent) of wound bed. Foul smelling. Surrounding skin red and hyperpigmented . Review of R2's wound assessment, dated 2/26/24, read in part, Wound type: Other. Site: Right trochanter (hip). Description: Open blister. Date of onset: 2/1/24. Depth in cm: 0.2, wound measurements - length X width: 6.4 x 4.2, drainage: serosanguinous, drainage amount: light, wound edges: red .wound bed: granulation, was care plan updated? Yes .Comments: Blister opened. Light Review of progress note, dated 2/29/24, read in part, .performed wound care to right hip. Blister measured as 4.5 cm x 2.4 x 0.6 cm. Edges unattached to wound base, yellow slough covering > 75% of wound bed. Foul smelling. Surrounding skin red and hyperpigmented . Review of R2's wound assessment, dated 3/4/24, read in part, Wound type: Other. Site: Right trochanter (hip). Description: Open blister. Date of onset: 2/1/24. Depth in cm: 0.2, wound measurements - length X width: 6 x 4.1, drainage: serosanguinous, drainage amount: light, wound edges: red .wound bed: slough, was care plan updated? Yes . Review of physician order, dated 3/6/24, read in part, Blister opened on right hip: skin prep peri-wound, apply Santyl (wound debriding agent) to wound bed, cover with comfort foam .every day shift day. Review of progress note, dated 3/7/24, read in part, .performed wound care to right hip. Decreased odor this week .applied Santyl to wound bed - nickel thick, covered with comfort foam . Review of progress note, dated 3/14/24, read in part, .Wound care to right hip performed. Dimensions 5 x 2.5 x 0.4 cm. Coordinated with facility nurse .update on wound care performed and wound assessment . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress note, dated 4/4/24, read in part, .All skin assessed and discussed with facility wound care nurse .purple discoloration of right trochanter, open wound on right iliac crest being treated .dimensions (4.5 x 2.5 x 0.3 cm) . Review of physician order, dated 4/8/24, read in part, Blister opened on right hip: skin prep peri-wound, apply iodosorb [dressing containing iodine] to wound bed, cover with comfort foam .every day shift day. Review of progress note, dated 4/11/24, read in part, .Right hip wound assessed. Secondary dressing from 4/10/24 saturated with drainage. Wound care to right hip performed. Dimensions 4.75 x 2.75 x 0.4 cm . Review of progress note, dated 4/17/24, read in part, .Blood glucose 517 . Review of progress note, dated 4/18/24, read in part, .Blood glucose 499 .obtain a .wound culture from Rt (right) hip and coccyx. After culture is completed, start resident on ciprofloxacin [antibiotic] 500 BID (two times daily) x 14 days . Review of progress note, dated 4/19/24, read in part, .Called to .verify antibiotic order and the order in the MAR (medication administration record) for cefalexin [antibiotic] 500 mg BID x 14 days in the correct order. Also notified that unable to obtain wound culture as wound bed is slough . Review of physician order, dated 4/19/24, read in part, Blister opened on right hip: skin prep peri-wound, apply Santyl (nickel thickness) to wound bed, cover with comfort foam .every day shift day. Review of physician progress note, dated 4/23/24, read in part, Patient is seen for wound to right hip, continues ATB (antibiotic) at this time . Review of progress note, dated 4/25/24, read in part, .She continues to have elevated blood sugars despite insulin changes. Facility nurses unable to obtain previously ordered wound culture as wound base is covered in slough .10 units insulin aspart (short acting insulin) administered x 1 at 12:33 PM for BS (blood sugar) = 479 by facility nurse. Recheck at 4:23 PM, BS = 472 . Review of progress note, dated 4/29/24 at 12:46 PM, read in part, Resident continues on ABT r/t (related to) wound infection. Upon assessment .Hypotensive (below normal blood pressure) with elevated HR (heart rate). Resident fatigued and declined am (morning) meal .concern for suspected sepsis r/t wound infection . order to hospital for further evaluation . Review of progress note, dated 4/29/24 at 9:23 PM, read in part, Resident returned from hospital emergency room visit .they gave her fluids and antihistamines and suggested we discontinue the cefalexin . Review of physician order, dated 4/29/24, read in part, Blister opened on right hip: cleanse wound with Dakin's [bleach preparation for wounds] solution, skin prep peri-wound, apply Santyl (nickel thickness) to wound bed, cover with comfort foam .every day shift. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Current wound care physician order, dated 5/28/24, read in part, Blister opened on right hip: cleanse wound with Dakin solution, skin prep peri-wound, pack wound with calcium alginate, cover with comfort foam .every day shift. Review of progress note, dated 6/13/24, read in part, .Wound care performed to right trochanter .wound base, dimensions and surrounding skin 3.4 x 2.5 x 1.3 cm . Review of progress note, dated 6/27/24, read in part, .has a chronic stage 3 PI (pressure injury) to her right trochanter . Review of physician notes, dated 1/31/24 through 7/10/24, revealed one physician note regarding R2's pressure injury on 4/23/24 and lacked any other notes. Review of R2's care plan, dated 5/1/2019, read in part, .Focus: I have a history of an alteration in my skin integrity .Goal: I will remain free from infection and areas will heal by next review (target date: 7/19/24) . Interventions .I have an air mattress on my bed to prevent skin breakdown while in bed (date initiated: 12/28/23). I need a weekly skin assessment to be completed by nurse (revision on: 6/6/18) . *Note: Most recent intervention last dated 12/28/23. On 7/10/24 at 12:15 PM, an observation was made of Registered Nurse (RN) C providing wound dressing change on R2's right lateral thigh area in her room. R2's pressure injury was a stage two with a granulated wound bed, and measured 2.2 x 2.1 x 0.9 cm. On 7/10/24 at approximately 3:00 PM, and interview was conducted with Occupational Therapist (OT) R and was asked if R2 had been re-evaluated by therapy for her [brand name] chair after acquiring the pressure injury on her right hip and replied, No. We were never told she had a new pressure injury. I was aware she had a sore on her coccyx. R2 should be assessed with a new pressure injury and I will have to get that approved now that she is on Hospice. On 7/10/24 at 5:00 PM, an interview was conducted with the Nursing Home Administrator/Director of Nursing (NHA/DON) and was asked about R2's pressure injury and replied, We did some research and thought it was a bullous pemphigoid (autoimmune blistering disorder) and asked the physician for a diagnosis because of the blister she developed, but he declined to give us the diagnosis. The NHA/DON was asked if the physician had seen R2's pressure injury initially and replied, I did go back in the notes and look, and he did observe it on 4/23/24 when he was here. He did not observe R2's pressure injury prior to that date. The NHA/DON confirmed no other physician notes were noted for R2's pressure injury. The NHA/DON was asked who determines and over sees the wound care treatment order decisions and replied, R2's wound care is a collaboration between our wound care nurse, the hospice nurse, and the physician. *Note: Progress notes for R2 lacked initial wound identification and physician notification. On 7/10/24 at 5:15 PM, an attempt was made to contact the medical director via telephone and no answer was made. On 7/10/24 at 5:16 PM, an attempt was made to contact the nurse practitioner via telephone and no answer was made. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 5:35 PM, an attempt was made to contact the hospice nurse via telephone and no answer was made. On 7/10/24 at 5:44 PM, an interview was conducted with hospice RN S and was asked about R2's wound and the care she provides and replied, I come to the facility to provide care to R2 and usually when I am here, I do the dressing change and assess her skin. RN S was asked if she was wound care certified and replied, No. RN S was asked if she communicated with the physician regarding wound care orders and replied, I discuss R2's wound needs with the facility wound care nurse and they discuss wound needs with the physician. RN S was asked to describe R2's wound initially and currently and replied, Well R2 was admitted to hospice services on 1/12/24. I do not see any wounds in the admitting notes. The first time the blister presented was 2/1/24, but after it opened up it had gotten much deeper than we anticipated. I think there was a pressure element. In my charting we discussed it with the wound nurse of the facility. It was open on a bony prominence, and we (hospice nurse and facility wound care nurse) staged it deeper stage two. On 4/15/24 is when I said that it had evolved to a stage two and at that time, we changed the order to Santyl. There was slough in the wound bed and we debrided the wound. R2 also has a super pubic catheter, and it was intermittently leaking. I think that is how the wound got infected, but she is also incontinent of stool. Her blood sugars were out of control. That wound looked yucky. She did get antibiotics. RN S was asked if the medical director had seen R2's wound and replied, I can give you dates when he did. I have it in my notes. It was either right before 4/20/24 or right after that. I can't find the exact date. I remember he wanted a wound culture, but we could not get a wound culture because the wound bed was all slough. Review of policy titled, Skin Management Facility Guidelines, dated January 2022, read in part, . Documentation should include: Location and staging of ulcer .The licensed nurse will complete a weekly skin assessment . Review of policy titled, Pressure Ulcer Preventive Measures Policy, dated January 2022, read in part, . Residents at risk for development of pressure ulcers receive interventions to reduce the risk of pressure ulcers .Residents identified at risk for pressure sore development will be inspected weekly for skin integrity . Documentation: On the care plan, document approaches and interventions to prevent pressure ulcers. Review of policy titled, Pressure Ulcer Treatment Policy, dated January 2022, read in part, .Resident with pressure ulcers receive necessary treatment and services to promote healing, prevent infection and reduce the likelihood of new ulcers developing .Contact the physician for treatment orders .Do not clean ulcer wound with cytotoxic [solutions causing tissue damage] skin cleaners or antiseptic agents (e.g. povidone iodine, iodophor, sodium hypochlorite solution [Dakin's solution] .protect pressure ulcers from exogenous sources of contamination (e.g. feces) .Documentation: 1. In the nurses notes, record periodically: Results of interventions, care being rendered, and adjustments to interventions. 2. Care plan: Who should provide care, how often, supplies and equipment needed, and how the care is undertaken . 40330 R 11 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R11's MDS assessment, dated 6/25/24, revealed R11 was admitted to the facility on [DATE] with diagnoses including cancer, heart failure, and on hospice care. The assessment revealed R11 was dependent for toileting and transfers and was frequently incontinent of bladder and bowel. The skin assessment showed R11 was admitted to the facility with two pressure injuries, one Stage 2 pressure ulcer, and one SDTI (Suspected Deep Tissue Injury). The BIMS assessment revealed a score of 11/15, which showed R11 had moderate cognitive impairment. During an interview on 7/08/24, it was confirmed by a facility wound care nurse, RN C, R11 was admitted with two pressure ulcers, a Stage 2 pressure ulcer on his buttocks, and a DTI (Deep Tissue Injury) on his left heel. RN C reported R11's wound on his buttocks was improving, and the DTI on his left heel remained unchanged, and clarified neither wound had signs of infection. RN C stated R11 wore pressure relieving boots on his bilateral heels to offload his heels and had an air mattress on his bed and chair. During an interview on 7/09/24 at 1:45 p.m., a second wound care nurse, RN B, was observed setting up supplies to treat R11's left heel wound (DTI) outside his room. RN B initially set up R11's wound care supplies on a treatment cart, which included a heel soaker pad, a waterproof foam heel cover in a plastic sleeve, saline wash, gauze pads, skin prep wipes, [brand name] bandage wrap, tape, and a paper measurement ruler. During an interview on 7/09/24 at approximately 1:49 p.m., R11 and his wife both agreed to the wound treatment, and for this Surveyor to observe the treatment by RN B of his left heel wound. During the observation on 7/09/24 at approximately 2:00 p.m., RN B was observed performing hand hygiene, donning gloves, and placed R 11's treatment supplies on his bedside table on two small brown paper towels from his bathroom. The bedside table was not sanitized prior to the observation, and contained a television remote, water container, and a pair of glasses next to the two paper towels of supplies. RN B next moved R11's wastebasket with clean gloved hands next to the bed and began removing R11's blanket from his lower bed and reached to remove R11's left pressure relieving boot. Surveyor asked RN B to stop briefly and privately let them know there was the potential for cross contamination by touching R11's bedding and heel boot prior to completing wound care after they had touched the wastebasket. RN B reported they understood the concern and removed their contaminated gloves, performed hand hygiene, and donned new gloves. RN B completed R11's wound care per physician orders and next removed the soiled supplies and garbage bags, while at the same time picking up a sealed, clean foam heel cup bandage with the same hand which touched the garbage and prepared to leave the room. Surveyor stopped RN B and noted they touched the unused clean heel cover pad clear plastic sheath and were cross contaminating the package as they were removing it from the room. RN B asked if she should put it back in the wound care cart, or leave it in R11's room, since it was dirty, and asked questions regarding how to prevent cross contamination from dirty to clean during wound care. It was also noted after the wound care treatment, RN B removed the two paper towels from R11's table and cleaned the table with water and a paper towel. Surveyor asked if this was a proper way to disinfect R11's table, and RN B stated, No. RN B returned and wiped R11's table with bleach wipes. During the observation, there were no further concerns observed during R11's wound care provision by RN B. The wound observation revealed a small dime-sized oval shaped closed wound on back of R11's heel, which was closed and purple and yellow in color, with irregular borders. There were no signs of infection or odor. R11 verbalized no pain or discomfort during the wound care treatment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After the observation, RN B acknowledged they understood all the concerns and stated this was a learning experience as they were newly wound care certified. RN B reported they did not have a supervisor or anyone providing oversight if they had questions, as they oversaw wound care in the facility along with RN C. During an interview on 7/09/24 at approximately 4:10 p.m., the Assistant Director of Nursing (ADON), RN A, was asked with RN B present if they were RN B's supervisor, and if they had been aware of the observed wound care infection control concerns related to RN B's provision of R11's wound care. ADON A clarified they were the Infection Preventionist nurse, and had been made aware of the infection control concerns by RN B on 7/09/24, and could address the concerns. ADON A reported they understood the concerns regarding the improper barrier, touching the wastebasket prior to wound care, not changing gloves from dirty to clean, and not cleaning R11's bedside table properly. ADON A explained the unused heel cup package was able to be sanitized without compromising the integrity of the heel protector bandage once it was contaminated by the dirty gloves. ADON A conveyed they would ensure use of a proper barrier for wound care and proper glove changes when indicated for facility wound care going forward. RN B reported their measurements on 7/09/24 showed the left heel wound was improving, which was confirmed in the facility wound care documentation. During an interview on 7/10/24 at approximately 6:00 p.m., the NHA/DON reported they had been made aware of the concerns related to infection control regarding the provision of wound care for R11 and acknowledged the concerns. Review of the policies received related to Pressure Ulcer Care and Skin Management did not include a procedure or process related to the provision of wound care infection control measures. Review of the CDC (Centers for Disease Control), Infection Control Assessment and Response (ICAR) tool for General Infection Prevention and Control (IPC) Across Settings, dated 1/27/23, revealed, Section 3: Observation Form - Wound Care: Observation 1: Prior to the start of the procedure, are clean supplies gathered and placed on a clean source in the room? Yes or No. Maintain separation between clean and soiled equipment to prevent cross-contamination Observation 7: Are gloves changed and hand hygiene performed when moving from dirty to clean tasks? Yes or No. Use an alcohol-based hand rub or wash with soap and water for the following clinical indications . e. Before moving from on a soiled body site to a clean body site on the same patient. f. Immediately after glove removal . Observation 8: Does HCP [Health Care Practitioner] maintain separation between clean and dirty supplies? Yes or No. Maintain separation between clean and soiled equipment to prevent cross contamination .During the procedure, separation should be maintained between clean and dirty supplies . (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45123 Based on observation, interview, and record review the facility failed to ensure that medication was administered appropriately, reconciled correctly, documented appropriately, and stored appropriately for one Resident (#20) out of 30 residents reviewed for pharmacy services. Findings include: Resident #20 (R20) On 7/9/24 at 9:25 AM, an observation was made of an unattended medication cup with two pills on top of R20's bedside table. R20 was not in her room at this time. This surveyor attempted to get the nurse working on the hall to bring this observation to their attention and conduct an interview, but they were unable to be located. On 7/9/24 at 9:28 AM, an interview was conducted with Registered Nurse D and was asked if they had seen RN H and replied, (RN H) is with another resident drawing blood for labs. On 7/9/24 at 9:30 AM, an interview was conducted with the Nursing Home Administrator/Director of Nursing (NHA/DON) and was asked to accompany this Surveyor to R20's room. The NHA/DON was directed to R20's room and the unattended medication cup. The Surveyor and the NHA/DON returned to her office and identified the two medications to be trazadone (antidepressant) 50 milligrams (mg) and cyclobenzaprine (muscle relaxant) 10 mg. The NHA/DON reviewed the Medication Administration Record (MAR) and trazadone was ordered to be given at 8:00 PM and the cyclobenzaprine was ordered as an as needed medication. The NHA/DON then stated that it must have been the night shift nurse yesterday evening (7/8/24) that left them in R20's room. Review of R20's MAR, dated July 2024, revealed that the last time the cyclobenzaprine was administered was on 7/7/24 at 8:13 AM. Review of R20's care plan, dated 7/2/24, lacked any care plan/desire to self-administer medications. Review of R20's physician orders, lacked an order to self-administer medications. Review of R20's progress notes, dated 7/8/24 through 7/9/24, lacked any documentation of a medication reconciliation for cyclobenzaprine by LPN E. Review of R20's MAR, dated July 2024, indicated the cyclobenzaprine was administered by LPN E on 7/8/24 at approximately 8:00 PM. On 7/9/24 at 9:38 AM, the NHA/DON and this Surveyor interviewed RN H regarding her morning medication pass. RN H replied that she did not give R20 a cyclobenzaprine and she had passed morning medication to R20 in her room. RN H stated that she did not see the medication cup on R20's bedside with the two pills in it during the time she was in R20's room performing morning medication pass. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235400	A. Building B. Wing	07/10/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/9/24 at approximately 10:30 AM, an interview was conducted with the NHA/DON and was asked if R20 had a safe self-administration medication assessment and replied, No. The NHA/DON was asked if medications should be left unattended at the bedside where other wandering residents had access and replied, No. The NHA/DON was asked to confirm that Licensed Practical Nurse (LPN) E had actually been the last nurse to dispense the medications to R20 on the evening of 7/8/24 and confirmed she would follow up with LPN E. On 7/10/24 at 9:00 AM, an interview was conducted with the NHA/DON and was asked if she was able to follow up with LPN E and replied, Yes. I came in at 5:30 AM today and asked her about the medications that were left in R20's room. The NHA/DON stated that LPN E had dispensed the two medications at approximately 8:00 PM on 7/8/24. LPN E initially dropped the cyclobenzaprine and had to dispense a second cyclobenzaprine, and then proceeded to R20's room to dispense both medications (trazadone and the cyclobenzaprine). After LPN E entered R20's room she heard another resident calling out for help and told R20 she would be right back and set the medications on her bedside table. LPN E then proceeded to assist a coworker in the resident's room that was calling out for help. When LPN E had finished assisting her coworker and the resident in another room she returned to her medication cart. LPN E had forgotten all about leaving R20 with the medication. The NHA/DON then stated that the medications should not have been left with R20 unattended, medication should have been signed out correctly, and reconciliation of the dropped medication should have been documented. Review of policy titled, Self-Administration of Medication, dated November 2017, read in part, .If a resident desires to participate in self-administration, the interdisciplinary team will assess the competence of the resident to participate, by completing a self-administration of medication assessment . Review of policy titled, Medication Pass Guidelines, dated September 2023, read in part, Purpose: To assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each resident by providing the administration of drugs in an accurate, safe, timely, and sanitary manner and to systemically distribute medications to residents in accordance with state and federal guidelines .Self-Administration - Residents are allowed to self-administer medications if deemed appropriate after being assessed by the Interdisciplinary Team and specifically authorized by the attending physician and in accordance with the guideline for self-administration of medication .Procedure .6. Observe that the resident swallows oral drugs. Do not leave medications with the resident to self-administer unless the resident is approved for self-administration of medication .Documentation: Record the name, dose, route, and time of medication on the Medication Administration Record .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. 49397 Based on observation, interview, and record review the facility failed to administer 6 of 32 medications accurately to two residents (#11 and #14) during medication pass, resulting in a medication error rate of 18. 75%. Findings include: Resident #14 (R14) During observation of medication administration on 7/9/24 at approximately 7:36 AM, Registered Nurse (RN) D dispensed five medications into medication cups for R14 and took them into R14's room. She proceeded to set them down next to R14's empty breakfast tray, stating she would take the tray and leave the medications. RN D proceeded to walk out and close the resident's door, prior to observing R14 taking her medications. Upon return to the medication cart, an interview was conducted with RN D asking if she often left medication with R14. RN D hesitated sighed, bowed her head and said No. On 7/9/24 at 7:55 AM, during a follow-up interview, R14 stated this was a daily occurrence. Review of the facility's Medication Pass Guidelines policy under procedure, number 6, read as follows: Observe that the resident swallows oral drugs. Do not leave medications with resident to self-administer unless the resident is approved for self-administration of the medication. On 7/9/24 at 9:37 AM, during an interview and record review, the Director of Nursing (DON) reviewed the EMR for R14 and confirmed R14 had not been approved for self-administration. Resident #11 (R11) On 7/9/24 RN D was observed donning a N95 mask to go into room where an aerosol medication had been dispensed per sign on door. RN D did not have a stethoscope to assess R11 post aerosol treatment. While conducting an interview with RN D post exiting R11's room, RN D stated she should assess R11 lungs prior to and after administering the aerosol medication. RN D acknowledged that she had not. Review of the facility's Nebulizer Therapy policy under procedure, number 15 read as follows: Assess therapy for efficacy by: Periodic observation of the amount and color of sputum produced during and immediately after a treatment. Monitoring the resident for adverse reactions such as tachycardia, sudden bronchospasm, nausea, and vomiting. Breath sounds before and after therapy. RN D did not complete number 15 of the Nebulizer Therapy policy.