

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235599	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/13/2025
NAME OF PROVIDER OR SUPPLIER  Carriage House Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  2394 Midland Rd Bay City, MI 48706	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471</b></p> <p>Based on interview and record review, the facility failed to ensure the CMS 802 (form utilized by the facility to list all current residents and to note pertinent care categories) was accurate for three residents (#48 #49 and #93) of 10 residents reviewed for matrix accuracy.</p> <p>Findings include:</p> <p>Resident #48:</p> <p>Upon entrance on 3/11/2025, review was conducted of the CMS 802. The 802 indicated, Resident #48 was being administered an antibiotic due to a current UTI (Urinary Tract Infection).</p> <p>On 3/12/2025 at 9:00 AM, a review was conducted of Resident #48's clinical record and it indicated the resident admitted to the facility on [DATE] with diagnoses that included, Cerebral Infarction, Vascular Dementia, Anxiety, Major Depressive Disorder and Hypertension. Further review yielded the following results:</p> <p>March 2025 MAR (Medication Administration Record):</p> <p>Indicated Resident #48 was not currently prescribed an antibiotic.</p> <p>February 2025 MAR:</p> <p>Bactrim Tablet - Give 1 tablet by mouth two times a day for infection for 14 days. Started on 2/12/2025 and ended on 2/26/2025.</p> <p>Resident #93:</p> <p>Upon entrance on 3/11/2025, CMS 802. The 802 indicated Resident #93 was being administered an antibiotic due to a current UTI (Urinary Tract Infection) for infection indicated at M (multidrug-resistant Organism).</p> <p>On 3/12/2025 at 9:15 AM, a review was conducted of Resident of Resident #93's clinical records and it indicated he was admitted to the facility on [DATE] with diagnoses that included Anxiety, Schizoaffective, Thyroid Disorder, Hyperlipidemia and Heart Failure. Further review of the record yielded the following:</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>February MAR:</p> <p>Macrobid Oral Capsule 100 MG (milligrams) give 1 capsule by mouth two times a day for 14 days. Started on 2/16/2025 and ended on 3/1/2025.</p> <p>On 3/12/2025 at 2:15 PM, Infection Preventionist B was queried if Resident #93 is currently being treated with an antibiotic for an UTI. Preventionist B stated not currently as the resident completed her treatment on 2/26/2025.</p> <p>Preventionist B was further queried if Resident #93 currently has a UTI, and she stated he does not as he finished his course of treatment on 3/1/2025. She was asked how this information is updated for facility usage, and it was explained they go over it in morning meeting but also she emails an updated list at least weekly of current infections with antibiotic usage.</p> <p>On 3/15/2025 at 3:15 PM, an interview was conducted with MDS (Minimum Data Set) Coordinator E regarding accuracy of CMS 802. Coordinator E stated the 802 is a real-time depiction of resident care categories. Coordinator E was queried if Residents #48 and #93 currently have UTI's and are being treated with antibiotics and he stated they are not. He reported Resident #93's treatment ended last week and Resident #48 at the end of February. He stated it was an oversight on his part as he completes the 802 manually.</p> <p>22927</p> <p>Resident #49:</p> <p>On 3/11/2025 the survey team received the CMS-802 Resident Matrix form from the facility as an accurate resident assessment overview of residents residing within the facility during the annual survey. The form was hand signed and dated.</p> <p>Observation and interview on 03/11/25 at 09:24 AM with Resident #49 revealed some confusion. Licensed Practical Nurse M came into the resident room and stated that the resident #49 he goes to (local) hemodialysis on Tuesday/Thursday/Saturday schedule. LPN M was able to show the state surveyor Resident #49's right chest hemodialysis catheter with a white bandage dressing with no date. LPN M stated that Resident #49 was dressed and ready to go to his hemodialysis treatment and had a pick-up time of 9:45 AM per order.</p> <p>Record review on 03/12/25 at 10:30 AM of the facility-provided CMS-802 form signed and dated 3/11/2025 by Registered Nurse E did not identify the Dialysis therapy for Resident #49.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/13/25 at 12:24 PM, Registered Nurse (RN) E MDS (Minimum Data Set) assessment nurse revealed that the nurse reviews the resident admission orders for the residents as part of the assessment. Record review of the CMS-802 form by RN E stated that was his signature and date on the CMS-802 form. RN E revealed that the Interdisciplinary Team (IDT) team meets every morning and to discuss residents' diagnoses and any changes. The MD nurses enter the assessment changes manually each Monday of the week and go into (electronic medical record) and run a report on new admits, diagnosis, orders, specialty (UTI/Antibiotics) and update that on the assessment. Record review of Resident #49's CMS-802 dialysis category was blank, Why? RN E stated that's a good question. The Infection Control nurse hands out a sheet with dialysis/hospice residents that is reviewed, I don't have an answer. I probably missed the box. Resident #49 was admitted in February 2025. It didn't transfer over to the CMS-802 form because of the update button. It messes with all residents' assessments. It was just missed.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37668</p> <p>Based on interview and record review, the facility failed to ensure licensed nursing staff competency for medication administration for one resident (Resident #21) of one resident reviewed, resulting in medication administration without a Health Care Provider's order and inappropriate medication administration per professional standards of practice.</p> <p>Findings include:</p> <p>Resident #21:</p> <p>Record review revealed Resident #21 was originally admitted to the facility on [DATE] with diagnoses which included Coronary Artery Disease (CAD), depression, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required supervision to moderate assistance with bathing, dressing and transfers.</p> <p>On 3/12/25 at 7:39 AM, an interview was completed with Resident #21 in their room. When queried regarding their care in the facility, Resident #21 stated, The care is getting worse. Resident #21 was asked what was getting worse and revealed they had a bad experience with a nurse during the prior night. When asked what happened, Resident #21 revealed a new nurse (LPN R) was working. Resident #21 stated, (LPN R) comes in here and sits the pills down. There were two pills in there and they looked like they were for my bladder. (LPN R) didn't explain it, just left them there. Resident #21 then stated, I went out (to the nurses' station) this morning and found out. When asked what they meant, Resident #21 revealed they did not take the pills they did not recognize that the nurse left in their room and took the pills to the nurses' station to find out what the pills were. When queried if the nurse left any other medications in their room, Resident #21 revealed the only medications they did not take were the ones they did not recognize. With further inquiry, Resident #21 revealed they were told the pills they did not recognize were for gas when they took them to the nurses' station. Resident #21 stated, I guess they ran out of the correct pills. When queried what happened when they went to the nurses' station to ask what the medication was, Resident #21 replied, (LPN R) was madder than hell and threw the pills out. Resident #21 stated, They aren't supposed to leave the pills on the table. When asked how they knew LPN R was mad, Resident #21 stated, (LPN R) was rude to me. (LPN R) told me, go back to your room, I ain't going to listen to you anymore. When asked how that made them feel, LPN R revealed they were upset and angry. LPN R stated, Who the hell does (LPN R) think they are. Don't treat me like that. Resident #21 continued, I can't understand why they have such a problem with the people on third shift. When asked if they had other concerns, LPN R then stated, I had cream in here and the (Certified Nursing Assistant [CNA]) threw it out last night. Resident #21 was asked what kind of cream they had and why the CNA threw it out, Resident #21 indicated it was a cream for the skin irritation under their breasts and revealed the staff told them they had to throw the cream away because the State is here.</p> <p>.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was completed with Unit Manager LPN H on 3/12/25 at 8:13 AM. When queried regarding Resident #21, LPN H revealed the Resident had expressed care concerns related to night shift staff and medications to them that morning. LPN H was asked about LPN R and revealed the nurse was new to the facility. When queried regarding the medications, LPN H stated, (LPN R) gave (Resident #21) Tums (Active ingredient: calcium carbonate- neutralizes stomach acid and reduces heartburn/indigestion. Used to treat heartburn and acid reflux) and not Simethicone (Active ingredient: dimethicone- breaks down gas bubbles in the stomach, reduces gas, bloating, and abdominal discomfort). When queried how they knew LPN R administered Tums and not Simethicone, LPN H revealed they spoke to LPN R after Resident #21 verbalized their concerns to them this morning. When queried if they asked LPN R why they gave the Resident Tums and not Simethicone and revealed LPN R told them they were unable to locate the Simethicone. With further inquiry, LPN H revealed simethicone is located in the facility medication storage room and in each medication cart.</p> <p>A review of Resident #21's Health Care Provider (HCP) orders and Medication Administration Record (MAR) revealed the Resident did not have an order for Tums. The Resident did have an order for Simethicone. Resident #21 also had an order for Milk of Magnesia (medication used to treat constipation, upset stomach, and heartburn).</p> <p>Review of progress note documentation in Resident #21's Electronic Medical Record (EMR) revealed no related progress note documentation from the night shift on 3/11/25 to 3/12/25.</p> <p>On 3/12/25 at 8:25 AM, LPN H called LPN R and placed the phone on speaker. A phone interview was completed at this time. When asked what occurred with Resident #21's Simethicone, LPN R stated, I couldn't find it, so I gave (Resident #21) Tums. When queried if the Resident brought the medication to the nurses' station later in the shift, LPN R stated, (Resident #21) came up (to nurses' station) and was upset because the CNA took the things out of their room and threw them away because the State was here. When asked if they understood they were speaking to a Surveyor, LPN R confirmed they did. LPN R was then asked why they gave the Resident Tums if the order was for Simethicone, LPN R stated, I gave it to (Resident #21) with their other pills and they came back out with the Tums and said what are these. I told (Resident #21) I explained it to you. LPN R was stopped and asked if they were saying they left the Resident's medications in the room and stated, No.</p> <p>When asked if the only medication they administered to Resident #21 was the Tums, LPN R replied they Resident had other medications. LPN R was then asked if the Resident brought all the medications out the nurses' station and indicated they only brought the Tums. LPN R was asked again how the Resident brought the medication to the nurses' station if they administered them in the room and did not respond. When asked if they left the medications in Resident #21's room for them to take, LPN R confirmed they did. When asked why they left Resident #21's medications at their bedside for them to take, LPN R stated, I figure she is cognitive enough to take them by themselves. When asked if Resident #21 had a medication self-administration assessment, LPN R responded they did not know. When queried what the facility policy/procedure is regarding medication self-administration, LPN R verbalized they did not know. When asked, Unit Manager LPN H informed LPN R that nursing staff are to administer and stay with residents during medication administration and not leave medications at residents' bedsides.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When queried why they administered Tums and not Simethicone to Resident #21, LPN R revealed they could not find Simethicone in the medication cart. When queried if they asked another nurse for assistance in locating the medication in a different area or medication cart, LPN R replied, No. When asked if they reviewed Resident #21's MAR to see if they had orders for any other medications which may assist with complaints of gas and stated, No. When queried if Resident #21 had a Healthcare Provider order for Tums, LPN R stated, No. When asked if they contacted the Resident's Healthcare Provider to inform them of the situation and obtain an order, LPN R verbalized they did not. When asked why they administered Tums instead of simethicone, without a Healthcare Provider order, LPN R replied, I just thought it would be easier. When asked if it is within their scope of practice to administer medications without a healthcare provider order, LPN R stated, No. LPN R was then asked where they documented administration of the Tums and revealed they did not chart it. When queried what they told Resident #21 when they came to the nurses' station regarding the medication, LPN R replied, I told (Resident #21) there was no problem with meds. When asked if the Resident was upset, LPN R confirmed they were. When queried why they told Resident #21 there was not a problem with the medications when there was, LPN R did not provide an explanation. After the phone call was completed, LPN H was asked if they had any additional comments and stated, I got nothing.</p> <p>A review of LPN R's Human Resource (HR) and education/training records revealed they completed medication administration training and competency at the facility</p> <p>An interview was completed with the Director of Nursing (DON) on 3/13/25 at 1:52 PM. When queried regarding LPN R administrating Tums to Resident #21 without a HCP order and leaving the medications at the Resident's bedside, the DON stated, We don't give meds without orders here.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38471</p> <p>Based on interview and record review the facility failed to effectively monitor four residents (#60, #76 #85, #276) of five residents reviewed for unnecessary medications. Resulting in, Residents # #60, #85 and #276) being administered medications without the proper indications for usage and Resident #76 being administered a prophylactic antibiotic without risk versus benefit analysis.</p> <p>Findings Include:</p> <p>Resident #60:</p> <p>On 3/12/2025 at 8:40 AM, a review was conducted of Resident #60's records, and it indicated the resident initially admitted to the facility on [DATE] with diagnoses that included, Acute and Chronic Respiratory Failure with Hypoxia, Anxiety Disorder, Atrial Fibrillation and Major Depressive Disorder. Resident #60 can make her needs known to facility staff and is her own person. Further review yielded the following:</p> <p>Physician Orders:</p> <p>Risperidone Tablet 0.5 MG (milligram) Give 1 tablet by mouth one time a day related to Major Depressive Disorder. Ordered on 2/25/2025</p> <p>Risperidone Tablet 0.5 MG Give 1 tablet by mouth one time a day for antipsychotics. Ordered on 2/22/2025 and discontinued on 2/24/2025.</p> <p>While Resident #60 does have a diagnosis of Major Depressive Disorder that is not a proper indication of usage for Risperidone nor is stating the class the medication appropriate.</p> <p>Psychiatric Note dated 2/5/2025</p> <p>Chief complaint: Psychosis, Anxiety .She is noted to be prescribed Risperdal for reported hallucinations previously experienced .</p> <p>Resident #256:</p> <p>On 3/12/2025 a review was conducted of Resident #256's medical records and it indicated she admitted to the facility on [DATE] with diagnoses that included, Peripheral Vascular Disease, Atrial Fibrillation, Pulmonary Hypertension and Metabolic Encephalopathy. Resident #256 can make her needs known to facility staff. Further review of the records yielded the following:</p> <p>Physician Orders:</p> <p>Ramelteon Oral Tablet 8 MG (Ramelteon) Give 1 tablet by mouth in the evening for sleep. Ordered on 3/10/2025.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Aripiprazole Oral Tablet 5 MG Give 2 tablet by mouth one time a day for antipsychotic/antimanic. Ordered on 3/10/2025.</p> <p>It is unknown why Resident #256 was prescribed a hypnotic and antipsychotic when she does not have any mental health or sleep disorder diagnoses.</p> <p>Review was conducted of the signed consent for Abilify and Ramelteon and they did not indicate which specific condition was being treated for the administration of medications.</p> <p>On 3/13/2025 at 8:30 AM, Social Worker Director N was queried regarding Resident #60's Risperidone administration for Major Depressive Disorder and was asked if this was an appropriate indication of use. Social Worker N stated it was not, review was completed of chart and found there was a diagnosis of psychosis listed in a recent psychiatric evaluation that did not integrate into the residents' diagnoses list.</p> <p>Social Worker Director N was further queried regarding Resident #256's antipsychotic and hypnotic usage without proper indications and after review of the record reported it appear that when the resident was in the hospital, she was diagnosed with hospital acquired delirium and prescribed both medications but again the diagnoses were not integrated into her clinical record.</p> <p>22927</p> <p>Resident #76:</p> <p>In an interview on 03/11/25 at 11:43 AM, Resident #76 while she was seated up in a high back wheelchair in the resident's room was asked about illness/infections by the surveyor. Resident #76 stated, It was for my pee, I couldn't go to the bathroom very well.</p> <p>In a record review on 03/11/25 at 11:52 AM of Resident #76's Medication Administration Record (MAR) for January 2025, Resident #76 received the antibiotic medication every morning at 7:00 AM from 1/9/2025 through 2/28/2025.</p> <p>An interview and record review on 03/12/25 at 02:52 PM with Registered Nurse/Infection Control Preventionist B revealed Resident #76 was admitted on [DATE] with the antibiotic Cephalexin 250mg one capsule by mouth one time a day for Urinary Tract Infection (UTI) Prophylaxis (recurrent UTI). RN B revealed Resident #76 was on antibiotic because she has a history of re-current Urinary Tract infections (UTI). Resident #76 went to Hospital on 1/1/25 till 1/8/25 for metabolic encephalopathy and recurrent UTI's and came back to the facility on an antibiotic. On 2/24/2025, Resident #76 acquired an in-house acquired UTI with Proteus Mirabilis and Cephalexin. On 2/28/2025 Resident #76 was started on Cephalexin 250mg twice daily was started and then stopped on 3/5/25. Resident #76 was started on Cephalexin 250mg one capsule by mouth one time a day for Urinary Tract Infection (UTI) Prophylaxis (recurrent UTI's). prophylactic antibiotic. The state surveyor inquired about a Risk vs Benefit statement for prophylaxis antibiotic therapy? RN B performed a Record review of Resident #76's electronic medical record and revealed there to be no Risk vs benefit by the physician for prophylactic antibiotic usage. RN B did not find Risk vs benefit by the physician for prophylaxis use from December 2024 through March 2025. None were found. RN B stated that Yes we should have gotten a risk vs benefits from our physician prior to use.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the facility 'Antibiotic Stewardship- Orders for antibiotics' policy, dated 9/2024, revealed antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program and in conjunction with the facility's general policy for medication utilization and prescribing: (4.) Empirical (based on experience; determined from experimental data, as opposed to theoretical. [NAME]-Keen, Encyclopedia &amp; Dictionary of Medicine, Nursing, &amp; Allied Health, 7th edition, page 584.) use of an antibiotic based on clinical criteria of suspected sepsis may be appropriate. The staff and practitioner will document the specific criteria that support the suspicion in the resident's clinical record.</p> <p>Resident #85:</p> <p>Observation on 3/11/2025 around 10:00 AM, during the initial screening process of the annual survey, revealed that Resident #85 was lying in bed with oxygen at 2-liter nasal cannula. Resident #85 opened her eye to her name and did not respond to questions about her care.</p> <p>Record review on 03/12/25 at 12:32 PM of Resident #85's medical diagnosis list revealed admitted : Dementia, severe, with psychotic disturbance; unspecified dementia, severe with anxiety; other mixed anxiety disorders; alcohol dependence with alcohol-induced persisting dementia; cognitive communication deficit . Record review of Resident #85's March 2025 Medication Administration Record (MAR) revealed antipsychotic medication Olanzapine (Zyprexa) 2.5mg give one tablet by mouth two times a day related to unspecified dementia, severe with psychotic disturbance started on 3/9/2025.</p> <p>In an interview on 03/12/25 at 01:43 PM, Social Worker N revealed that Resident #85 was on Zyprexa (antipsychotic) 10mg daily, and the facility lowered the dose down to 5mg daily currently, it's only been since the 3/9/25. The Xanax (anxiolytic) 0.25mg at HS, ordered on 8/30/24, was a 0.5mg dose, and was lowered to a 0.25mg dose.</p> <p>Record review on 03/12/25 at 01:53 PM with Social Worker N of Resident #85's Zyprexa antipsychotic medication consent listed dementia with behavioral features. Improve functionality, reduce adverse behaviors. The proposed course of the medication is: Prolonged treatment. There were no behaviors identified on the consent. What are the behaviors? Social Worker N stated it is the wrong diagnosis, and It was signed by 2 nurses.</p> <p>In an interview and record review on 03/12/25 at 2:01 PM, Registered Nurse (RN) G stated I did get consents for Zyprexa and Xanax for Resident #85. I believe it was her guardian. On 2/27/2025 it was not a new order; we were updating paperwork. No, I did not write a note that I contacted the DPOA. I called to let guardian know that we were changing the paperwork, due to new CMS guidelines. What behaviors are you treating? not on the consent form. RN G stated I was just helping out; she's not my resident. Record review of Resident #85's physician order record states psychotic disturbance? what disturbance? hallucinations, delusions, what? RN G stated I don't know. No, I did not document the call for phone consent either. Record review of the consent form noted 'Also document Obtained Phone Consent in Nurse's Notes. This was not done. Record review of Progress notes with no note for consents.</p>		

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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.			
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>22927</p> <p>Based on observation, interview and record review, the facility failed to ensure proper administration of medication for one resident (Resident #83), resulting in Resident #83 receiving levothyroxine (thyroid hormone replacement) with med pass supplement and other medications.</p> <p>Findings include:</p> <p>Record review of facility 'Medication Administration' policy dated 1/25, revealed medication are administered in a safe and timely manner, and as prescribed. (7.) Medications are administered within (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). (8.) If a dosage is believed to be inappropriate or excessive for resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility Medical Director to discuss concerns. (22.) The individual administering the medication initials the resident's EMAR (Electronic Medication Administration Record) after giving each medication and before administering the next ones. (24.) The nurse must ensure residents consume medications before leaving the resident.</p> <p>Resident #83:</p> <p>Observation and interview on 03/12/25 at 07:03 AM with Registered Nurse (RN) I of Resident #83</p> <p>blood sugar check, revealed a blood sugar level of 69. N I provided cranberry juice to resident. RN I prepared Resident #83's oral medications of: Med pass 120ml, cholecalciferol tablet 1000-unit x 2 tablets, levothyroxine 137mcq, Lasix 40mg, glipizide 10mg, metoprolol 25mg, potassium chloride ER 20meq, xifaxan 550mg, Zyprexa 2.5mg, lactulose solution 10gm/ml, give 30ml. Resident #83 was observed to take the medications after the Med pass solution and lactulose solutions.</p> <p>Record review of Resident #83's March 2025 Medication Administration Record (MAR) revealed Registered Nurse I signed out 7:00 AM medication administration for 3/12/2025 including levothyroxine thyroid hormone therapy medication with the 7:00 AM supplements and medications.</p> <p>Record review on 03/12/25 at 10:25 AM of Resident #83's March 2025 Medication Administration Record (MAR) revealed that on 3/13/2025 Resident #83 received levothyroxine 137mcq medication which was signed out as administered with other medications and supplements.</p> <p>In an interview and record review on 03/13/25 at 10:43 AM, Licensed Practical Nurse (LPN) manager H revealed that Breakfast is served at 8:00 AM to 8:15 AM. The state surveyor inquired of Resident #83's thyroid medication orders; on Monday 3/10/2025 levothyroxine on Monday was at 5:00AM given with no food and on an empty stomach. LPN H reviewed Resident #83's levothyroxine was given at 7:00 AM on 3/12/2025 with other medications and supplements. On 3/13/2025 again levothyroxine was given at 7:00 AM. The state surveyor inquired who entered the medication order on 3/11/2025? Record review with LPN H of the orders revealed that LPN H had put the order in for 7:00 AM. LPN H stated that she knew better and that the medication should have been scheduled to be administered at 5:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/13/25 at 11:10 AM, Registered Nurse (RN) Unit manager F revealed that the medication levothyroxine is administered, at 5:00 AM because it is to be given on and empty stomach and before other medications.</p> <p>Record review of 'Nursing 2017 Drug Handbook' page 875, revealed levothyroxine oral medication administration recommended to be given at the same time each day on an empty stomach, preferable 1 hour before breakfast. Interactions noted oral antidiabetics may alter glucose level.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>22927</p> <p>Based on observation, interview and record review, the facility: (1.) Failed to ensure proper labeling of medications in 3 of 3 medication carts, (2.) Failed to ensure properly secure/lock 1 treatment cart with medical supplies and prescription creams/ointments, and (3.) Failed to ensure proper completion of medication refrigerator temperature log, resulting in opened and undated medications.</p> <p>Findings include:</p> <p>Record review of facility 'Storage of Medications' policy dated 1/25, revealed the facility stores all drugs and biologicals in a safe, secure, and orderly manner. (5.) Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or for destroyed. (8.) Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use.</p> <p>Record review of facility 'Medication Administration' policy dated 1/25, revealed medication are administered in a safe and timely manner, and as prescribed. (12.) The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.</p> <p>Observation and interview on 03/11/25 at 09:57 AM with Registered Nurse (RN) K offthe 600-unit medication Cart #6 revealed one loose white oval tablet found in the second drawer. Resident #53 had a multi-dose bottle of Dorzolamide 2% eye drops, opened and not dated on the bottle. RN K could not say when the bottle was opened. Resident #37's multi-dose Fiasp flex touch insulin pen, open date 3/7/2025, with no expiration date on insulin pen.</p> <p>Observation and interview on 03/12/25 at 06:20 AM with Licensed Practical Nurse (LPN) P corporate Clinical support of the 400-unit medication Cart #4, revealed she had medications setting out on the top of the medication cart. Observation of Resident #32 Ventolin multi-dose inhaler with box lid missing revealed that there was no open date on the inhaler device or box. Resident #73 Timolol 0.25% ophthalmic eye drop multi-dose bottle, and box had no date when opened. Resident #73 had a second bottle of Timolol 0.25% ophthalmic solution 1 drop right eye daily was also opened with no date on bottle or box. Resident #95 medication Flonase nasal spray 50mcg per spray multi-dose bottle opened with no date on bottle or box.</p> <p>Observation and interview on 03/12/25 at 06:34 AM with Licensed Practical Nurse (LPN) L on 500-unit medication Cart #5, revealed Resident #18 eye drop medication latanoprost 0.005% ophthalmic solution had no date on the open multi-dose bottle or box and the top drawer of the medication cart had a black tablet loose in the drawer tray. LPN L stated that he thought the black tablet was iron.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 03/12/25 at 06:41 AM with Licensed Practical Nurse (LPN) L of the Medication room on the 500/600 unit revealed the refrigerator to have for Resident #91 a bottle of Lorazepam intensol oral concentrate 2mg/ml, give 0.5mg via peg tube. The multi-dose bottle of Lorazepam intensol oral concentrate was not dated and open with 14 ml left the bottle of 30 ml. No date on bottle or the box. Record review of the 'Control Substance Record' form for Lorazepam 2mg/ml concentrate noted first use on 7/1/- and on 8/15/- documented the bottle spilled in the refrigerator, and on 10/28/24 the line was signed out and then crossed out.</p> <p>Observation and interview on 03/12/25 at 06:45 AM with Licensed Practical Nurse (LPN) H of the 500/600 medication room refrigerator of Resident #91's Lorazepam intensol oral concentrate 2mg/ml, reviewed the control substance sign-out sheet and the crossed-out dosing and medication spill revealed that the sheet should not have had cross outs, that's not how to waste a narcotic.</p> <p>Observation and interview on 03/13/25 at 09:42 AM with Registered Nurse (RN) Q of the 100/200 medication room revealed an electronic Med bank dispenser with fingerprint style. RN Q revealed that with narcotics, it takes 2 nurses. Review of the medication refrigerator temperature log revealed that the day shift for 3/12/2025 was not documented. RN Q stated that she has not documented or checked the refrigerator for today. Review of refrigerator temperature noted a manual dial thermometer noted on the second shelf of the refrigerator. observation of medication within the refrigerator noted multiple multi-dose insulin pens, eye drops and other medications that require refrigeration.</p> <p>Record review of the facility 'Temperature Log' form undated revealed: (1.) Record the current controlled room temperature twice daily. (3.) Refrigerator temperature must be between 36 degrees Fahrenheit and 46 degrees Fahrenheit.</p> <p>Record review of the 100/200-unit medication refrigerator temperature logs revealed:</p> <p>April 2024: noted 19 shifts failed to document/check the refrigerator temperature. On 4/28/24 and on 4/30/24 staff documented below the recommended temp.</p> <p>May 2024: noted 22 shifts failed to document/check the refrigerator temperature.</p> <p>June 2024: noted 19 shifts failed to document/check the refrigerator temperature.</p> <p>July 2024: noted 25 shifts failed to document/check the refrigerator temperature.</p> <p>August 2024: noted 24 shifts failed to document/check the refrigerator temperature.</p> <p>December 2024: noted 22 shifts failed to document/check the refrigerator temperature.</p> <p>February 2025: noted 18 shifts failed to document/check the refrigerator temperature.</p> <p>March 2025: noted 1 shift failed to document/check the refrigerator temperature.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 03/13/25 at 11:13 AM, Registered Nurse F unit manager reviewed the 100/200 medication refrigerator temperature logs which revealed multiple empty/blank check spots. RN F stated the facility replaced the thermometer and we have replaced the refrigerator, if the temperature is not in range staff are to notify the unit manager or Infection Control Preventionist, it's an infection control issue.</p> <p>Record review of facility 'Refrigerator Temperature Monitoring for Medications' policy, dated 1/2025, revealed the purpose was to ensure that medications stored in refridgerators are kept at appropriate temperature to maintain thier stability, potency, and effectiveness, in compliance with healthcare regulations and best practices.</p> <p>37668</p> <p>On 3/11/25 at 2:36 PM, the treatment cart outside of Unit Five and Six nurses' station was observed unlocked and unattended by staff. Four staff were observed walking past the treatment cart. The staff did not address the cart was unlocked.</p> <p>On 3/11/25 at 2:44 PM, Unit Manager Licensed Practical Nurse (LPN) H was requested to come to the treatment cart. When asked if the treatment cart was unlocked, LPN H confirmed. Upon opening the cart, topical prescription medications as well as stock medications were contained in the cart. When queried if the cart is supposed to be locked, LPN H stated, Yes.</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39059</p> <p>Based on observation, interview and record review, the facility failed to follow care plan interventions for dining for one resident (Resident #8) out of five residents reviewed for dining, resulting in a lack of assistive devices provided.</p> <p>Findings include:</p> <p>Resident #8:</p> <p>On 3/11/25, at 11:45 AM, Resident #8 was sitting up in their bed with their lunch meal. A review of Resident #8's meal ticket on their tray revealed the resident required a Scoop plate (a dining aid plate with a non-slip suction with a high rim) and a Kennedy cup (a dining aid cup with a J shaped handle and is spill proof). Resident #8 was drinking their cranberry juice from a small plastic juice glass. Their meal was housed on a white plate. There was no Scoop plate provided. The Kennedy cup was empty.</p> <p>On 3/12/25, at 9:00 AM, a record review of Resident #8's electronic medical record revealed an admission on 12/16/2024 with diagnoses that revealed Amnesia, Anorexia, and Seizures. Resident #8 required assistance with Activities of Daily Living.</p> <p>A review of the most recent Minimal Data Set assessment (MDS) Date 1/7/2025 revealed a Brief Interview of Mental Status result of 07 which revealed severely impaired cognition.</p> <p>A review of the I have a nutritional problem care plan Date Initiated: 12/03/2024 revealed Goal I will maintain adequate nutritional and hydration status . Interventions Adaptive Equipment: -[NAME] cups -scoop plate Date Initiated: 12/04/2024 .</p> <p>A review of the NUTRITIONAL EVALUATION Effective Date: 03/10/2025 revealed . Weight: 139.5 Date: 03/04/2025 Usual body weight 145 . ADAPTIVE EQUIPMENT Is any adaptive dining equipment used? . The Yes was check marked.</p> <p>On 3/12/25, at 12:08 PM, Resident #8 was sitting up in their bed with their lunch meal. There was no Scoop plate provided nor a Kennedy cup. There was one small plastic glass of cranberry juice.</p> <p>On 3/13/25, at 12:19 PM, Resident #8 was sitting up in their bed with their lunch meal. The Kennedy cup provided on the tray was tipped upside down and empty. The meal was provided on a Scoop plate. The Scoop side of the plate was at 12 O'clock and not closest to the resident. There was a small plastic juice glass of cranberry juice.</p> <p>On 3/13/25, at 12:23 PM, CNA C entered Resident #8's room and was asked why the Kennedy cup was tipped upside down and empty. As CNA C explained that the resident didn't like to use it.</p> <p>On 3/13/25, at 12:29 PM, the Director of Nursing (DON) was alerted Resident #8 was not provided the assistive devices listed on their care plan.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39059</p> <p>Based on observation, interview and record review, the facility failed to transport clean linen and store gloves in a sanitary manner, resulting in contamination of linen and Personal Protective Equipment (gloves).</p> <p>Findings include:</p> <p>On 3/11/25, at 10:05 AM, an observation of room [ROOM NUMBER] revealed a box of clear gloves on top of the counter. There were gray gloves piled on top of the box of clear gloves. The gray gloves were not covered and some were flopped over the box touching the top of the counter. The resident offered yes, the staff use the gloves.</p> <p>On 3/11/25, at 4:18 PM, an observation of CNA O in the 200 hallway was conducted. CNA O was carrying a pile of clean linens with their left arm. The pile of linen was resting on their uniform top. The linen was uncovered.</p> <p>On 3/11/25, at 4:19 PM, CNA O was asked if that was how they normally carried clean linen and CNA O offered, No. CNA O was asked what the facility expectation was for transporting clean linen and CNA O moved their left arm out away from their body.</p> <p>On 3/12/25, at 7:45 AM, a further observation of room [ROOM NUMBER] revealed the pile of gray gloves remained. It appeared the pile of gray gloves was less than the day prior.</p> <p>On 3/12/25, at 8:27 AM, an observation along with the Director of Nursing (DON) of gloves in room [ROOM NUMBER] was conducted. The DON was asked if the gloves are supposed to be stored exposed and the DON offered, No, they're not supposed to be. The resident offered that they do see the staff use the gray gloves.</p> <p>On 3/13/25, at 10:30 AM, Infection Control Nurse A was alerted of the observations of the glove storage and CNA O with the clean linen touching their uniform. IC Nurse A offered, I heard about that.</p>