STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245454	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Health Care Center	109 Court Avenue South Sandstone, MN 55072

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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 47263 Based on interview and document review, the facility failed to maintain a surety bond (a written agreement to guarantee payment of another company's obligation under a separate contract) to protect the account balance of the resident trust fund. This had the potential to affect 23 of 41 residents at the facility who had a trust account managed by the facility. Findings include: During an interview on 2/12/25 at 9:35 a.m., the office manager (who was responsible for the resident trust funds) pulled up the total balance for the resident trust which was 9,254.77 dollars. The office manager was unable to locate a copy of the surety bond and indicated they would need to follow-up with the corporate office. On 2/13/25 at 10:52 a.m. the administrator stated the corporate office was going to send a copy of the surety bond. On 2/14 /25 at 1:58 p.m., the administrator e-mailed a copy of a document entitled Erisa Dishonesty Bond Edition of 10/1/17, Spring Valley Mutual Insurance Company. The bond indicated it covered employees insured by the employee benefit plans. The document did not include coverage for residents with trust accounts. An additional request for a copy of the surety bond specific to the resident trust accounts was made and additional documents were not received. The facility policy Handling of Resident Finances and Property dated 8/2021, identified the facility must ensure any party responsible for holding or managing residents' personal funds is bonded or obtained insurance in sufficient amounts to specially cover losses of resident funds and provides proof of the bond or insurance.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47263 Based on interview and document review the facility failed to ensure the right to weekend mail delivery occurred for 5 of 5 residents (R2, R3, R19, R28, R36) who were reviewed for weekend mail delivery. This deficient practice had the potential to impact all 41 residents who resided at the facility. Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R2 was cognitively intact. R3's quarterly MDS assessment dated [DATE], indicated R3 was moderately cognitively impaired. R19's quarterly MDS assessment dated [DATE], indicated R3 was moderately cognitively impaired. R28's quarterly MDS assessment dated [DATE], indicated R28 was moderately cognitively impaired. R36's quarterly MDS assessment dated [DATE], indicated R2 was cognitively intact. During a group interview on 2/11/25 at 10:11 a.m., the following was said: --- R2 confirmed mail was delivered to the facility on the weekend and indicated packages from delivery places like UPS were also delivered to the facility on weekends. R2 went on to say mail and packages did not get delivered to them on the weekends. ---R28 stated it depended on who was working if they got their mail. It seemed like some staff didn't know they were supposed to deliver resident mail. ---R2 stated they ordered things on-line, and they did not get their packages or personal mail on the weekend. Instead of being delivered the packages just sat on the chairs by the door all weekend long. ---R28, R3, R19, and R36, confirmed residents did not always get their packages and/or mail delivered to them on the weekend. During an interview on 2/13/25 at 8:27 a.m., the social worker stated the facility did get mail delivery on Saturdays and they believed it was the activities staff that were responsible for mail delivery on the weekends. During an interview on 2/13/25 at 11:31 a.m., activities aid (AA-B) stated resident mail got delivered to the main office. AA-B indicated one of their responsibilities was to deliver resident mail. They checked for and delivered resident mail that was located on the activity director's desk in their department only. AA-B confirmed they did not go and get newly delivered resident mail on the weekends from the office, they only delivered resident mail that was already on the director's desk when they worked on the weekend. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 2/13/25 at 11:33 a.m., Activities Aid (AA-A) stated during the week mail was delivered to the office where it was sorted and then delivered to the activities department for delivery to residents. AA-A stated on weekends, they only delivered mail that was already in the activities department. When mail and packages were delivered to the facility on the weekends, they got put in the office. AA-A confirmed they did not go into the office and get resident mail or packages on Saturdays or Sundays, instead they left the mail for the office manager to sort on Monday. During an interview on 2/13/25 at 11:48 a.m., the activities director (AD) on Saturdays, staff should go through the mail and make sure magazines, packages, cards and personal stuff got passed out to residents. AD confirmed residents were not consistently getting their mail delivered to them on the weekend as they should, and indicated they planned to rework things to ensure this happened consistently going forward. The facility policy Resident Mail dated 12/2023, directed mail will be delivered to residents within 24 hours unopened, and unread including magazines and newspapers, unless assistance is requested by the resident or resident representative.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48109 Based on observation, interview, and record review, the facility failed to ensure provider orders for medication parameters were followed for 1 of 5 residents (R18) reviewed for unnecessary medications. In addition, the facility failed to ensure provider orders for a fluid restriction and daily weights were followed for 1 of 2 (R142) residents reviewed for hydration. Findings include: R18's admission Minimum Data Set (MDS) dated [DATE], identified moderately impaired cognition and diagnoses of hypertension (high blood pressure) and repeated falls. R18's care plan dated 2/3/25, identified potential for drug interactions and adverse effects related to the use of multiple medications, and listed interventions to administer medications as ordered and observe for effectiveness and adverse side effects. R18's provider orders contained an order for furosemide (a medication used to help rid the body of water) 20 mg to be given one time per day for hypertension and to hold the medication if R18's systolic blood pressure (SBP, the top number of a blood pressure which represents the pressure in the arteries when the heart beats) was below 110. Review of R18's medication administration record (MAR) revealed furosemide was administered to R18 on 2/5/25 when her SBP was 94, and on 2/7/25 when her SBP was 90. During an interview on 2/13/25 at 7:55 a.m., assistant director of nursing, registered nurse (RN)-A stated she would expect the provider order was followed and if it wasn't it needed to be followed up with the provider. RN-A stated the risk for R18 receiving this medication when the SBP was below 110 could be even lower blood pressure and more electrolyte imbalance. During an interview on 2/13/25 at 11:43 a.m., the director of nursing (DON) stated she would expect the order would be followed, and not following the order could put R18 at risk for even lower blood pressure and possibly becoming dehydrated. R142's admission record identified an admitted [DATE] and diagnoses of heart failure, stomach cancer, anemia, and hypertension. R142's care plan dated 2/3/25, didn't contain information regarding a fluid restriction. R142's provider orders dated 2/4/25, identified orders for: -furosemide (a medication used to help rid the body of water) 20 milligrams (mg) daily -spironolactone (a medication used to help rid the body of water) 50 mg daily -fluid restriction of 64 ounces (oz) daily, with 46 oz from dietary and 18 oz from nursing with medications. Document the amount of fluids given from nursing every shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 2/6/25 a nursing order for daily weight monitoring related to a diagnosis of ascites (the accumulation of extra fluid around the abdomen). During a review on 2/10/25, it was noted R142's medication administration record (MAR) for February 2025 didn't reflect R142's weight was taken and recorded in the record for 2/9, 2/10, 2/11 or 2/12. Review of R142's progress notes identified a note from 2/7/25 indicating a nurse's order was placed to weigh R142 daily due to a diagnosis of ascites. The notes didn't reflect any refusals from R142 to have his weight taken. During an interview on 2/10/25 at 5:45 p.m., R142 was complaining to an unknown nursing assistant (NA) that he had asked for water this morning but hadn't gotten any. The NA explained to R142 he was on a fluid restriction and only got two eight ounces (oz) glasses of water from nursing staff, which was on his over-the-bed table. During an interview on 2/11/25 at 10:59 a.m., R142 was looking at a large pitcher of water that was brought to him this morning, he didn't know who brought it. R142 picked up the pitcher and said it was full, and then said, isn't that stupid, yesterday I could only get a little glass of water and now I get this, R142 shook his head and stated he didn't understand. R142 also had a 20 oz bottle of orange soda which he said he had brought here himself; the bottle was about half gone. During an observation on 2/11/25 at 1:57 p.m., R142 was sleeping in his room. The bottle of orange soda was two-thirds empty. During an interview on 2/11/25 at 3:30 p.m., nursing assistant (NA)-A stated staff looked at the Kardex (a care plan summary) or care plan to know how to care for residents, and if it weren't clear she would ask the supervisor. NA-A stated she knew R142 had a fluid restriction because she heard about it, but it wasn't on his Kardex. During an interview on 2/11/25 at 3:42 p.m., an assistant director of nursing, RN-A confirmed the Kardex for R142 didn't contain a fluid restriction. RN-A explained any RN in management could update the care plan, which would flow to the Kardex, but she wasn't sure if it was a nursing or dietary responsibility. RN-A stated it would be important to follow fluid restrictions because R142 could get fluid overload. During an interview on 2/12/25 at 11:20 a.m., NA-B stated they could look at the Kardex to know how to care for the residents. NA-B wasn't aware of any residents with a fluid restriction. NA-B stated dietary had slips that came out with the trays and indicated if there was a special diet, allergies, or special equipment needed. NA-B stated the NAs were responsible for getting the weekly and daily weights done in the morning before breakfast. During an interview on 2/12/25 at 11:30 a.m., NA-C stated they could look at the care plan to know how to care for the residents. NA-C wasn't aware of any resident with a fluid restriction. NA-C looked at R142's Kardex and confirmed there was a 64 oz fluid restriction. NA-C stated they hadn't weighed R142 today, LPN-B had weighed him. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/25 at 12:34 p.m., LPN-B stated the NAs were responsible for getting resident's weight, but she had weighed him today. LPN-B confirmed R142 had an order for daily weights, and she had weighed him yesterday and today, but hadn't documented it yet. LPN-B stated it would be important to take his daily weight because he had ascites and was at risk for retaining fluid. During an interview on 2/13/25 at 11:32 a.m., the DON stated daily weights needed to be completed, and it would be important for R142 because he had ascites and too much fluid could lead to complications. The DON would also expect fluid restrictions be on the Kardex. A policy, Medication Guidelines - Long Term Care dated 2/2025, identified its purpose was to ensure the accurate storage and safe and effective administration of medications by qualified personnel. The medication administration guidelines indicated provider orders would be followed, and medications would be given following the six rights of medication administration, including the right resident, drug, dose, route, time and documentation.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview and document review the facility failed to ensure aspiration precautions were followed for 1 of 2 residents (R24) reviewed for accidents. Findings include: R24's quarterly Minimum Data Set (MDS) dated [DATE], identified R24 had diagnoses which included cerebral infarction (stroke), dysphagia (difficulty swallowing foods or fluids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage). R24's MDS identified R24 had no rejections of care and was cognitively intact. R24's kardex as of 2/11/25, identified Special Instructions : No straws (per speech therapy). R24's order review report identified tube feeding diet, no straws per speech therapy dated 3/26/24. On 2/11/25 at 2:49 p.m., R24 was seated in the recliner and on a bedside table next to the chair was a large plastic cup with a straw in the cup. On 2/11/25 at 2:55 p.m., R24 stated they always had a straw in the water cup. On 2/11/25 at 2:57 p.m., registered nurse (RN)- A reviewed R24's orders and verified R24 was not supposed to have straws per speech therapy and per her current orders. RN-A stated the nursing assistants would know not to give R24 a straw with her water based on the kardex. RN-A verified the use of a straw would increase the risk for aspiration. A policy on aspiration precautions was requested but not provided.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview, and document review, the facility failed to ensure oxygen was administered as ordered for 1 of 1 residents (R11) reviewed for oxygen therapy. Findings include: R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 had diagnoses which included treatment for palliative care, anxiety disorder, chronic obstructive pulmonary disease (COPD[a group of lung disease that block airflow and make it difficult to breathe]), macular degeneration (an eye disorder that causes vision loss), and paroxysmal atrial fibrillation (a type of irregular heartbeat where the heart's upper chambers [atria] beat rapidly and irregularly for a short period of time). R11's MDS identified R11 was moderately cognitively intact and used oxygen. R11's care plan initiated on 11/4/24, identified R11 had an alteration in respiratory status related to a diagnosis of COPD with use of oxygen. Interventions included to administer oxygen as order by medical provider (MD). R11's active orders current as of 2/13/25, identified R11 had an order for oxygen at two liters per nasal cannula at bedtime related to COPD. R11's treatment record for the past three months identified R11 had oxygen flowing at 3 liters per minute on the following dates: 1/1/25 1/2/25 12/17/24 12/20/24 12/21/24 12/22/24 12/23/24 12/24/24 12/25/24 12/26/24 12/27/24 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/28/24 12/29/24 12/30/24 12/31/24 A review of the past three months of progress notes did not include any notes on increased oxygen needs or communication to the MD about an increased need for oxygen. On 2/10/25 at 5:20 p.m., R11's oxygen flow meter was at 2.5 liters per min (LPM). On 2/11/25 at 3:16 p.m., licensed practical nurse (LPN)-A verified R11's oxygen was at 2.5 LPM and said it should have been at 2 LPM. LPN-A stated it works opposite if the LPM are set too high and the resident might start retaining carbon dioxide which could lead to respiratory failure. LPN-A stated R11 had recently been using her oxygen during the day and not just at night. During an interview on 2/13/25 at 7:54 a.m., the director of nursing (DON) stated she would expect staff to check a resident's oxygen flow meter daily to ensure it was at the correct LPM and to document oxygen saturations daily. The DON verified it was important to follow the MD's orders especially with residents with COPD because a higher flow rate could contribute to breathing difficulties. The Oxygen Administration - Long Term Care policy dated 2/2024, identified a provider order was needed for oxygen administration. The policy identified the order should be verified to ensure the amount of liter flow, method of administration and duration of therapy.

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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 42587

Based on observation, interview, and document review, the facility failed to ensure use of an as-needed (i.e., PRN) psychotropic medication was limited to a 14-day period and/or re-evaluated by the provider to ensure ongoing need and efficacy of the medication for 1 of 5 residents (R11) reviewed for unnecessary medication use.

Findings include:

R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 had diagnoses which included treatment for palliative care, anxiety disorder, chronic obstructive pulmonary disease (COPD [a group of lung diseases that block airflow and make it difficult to breathe]), macular degeneration (an eye disorder that causes vision loss), and paroxysmal atrial fibrillation (a type of irregular heartbeat where the heart's upper chambers [atria] beat rapidly and irregularly for a short period of time). R11's MDS identified R11 was moderately cognitively intact and had no behaviors or rejections of care. R11's MDS identified R11 used scheduled and PRN pain medications, used anti-anxiety, anti-depressant, and opioid medications during the review period.

On 2/11/25 at 10:33 a.m., R11 was seated on her bed wearing oxygen at two liters per minute, the television was on she was finishing her breakfast and said she would like something other than boiled eggs all the time. No other concerns.

R11's active orders as of 2/13/25, identified the following order:

lorazepam oral tablet 0.5 milligrams (mg) give 0.5 mg by mouth every two hours as needed for anxiety/dyspnea orders valid through end of life.

A review of the monthly pharmacy reviews identified the following:

11/12/24, Pharmacist Recommendations to Providers: Order - lorazepam 0.5 mg every two hours PRN. PRN orders for psychotropic drugs anti-psychotic, anti-depressant, anti-anxiety, and hypnotics are limited to 14 days. If believe that it is appropriate for the PRN order to be extended beyond 14 days, should document the rationale in the resident's medical record and indicate the duration for the PRN order. No response from the physician was received.

12/10/24, Medical Director summary from the pharmacist. PRN psychoactive (non-anti-psychotics) without end date. Lorazepam 0.5 mg every two hours PRN. Rationale/indication for requiring PRN order past 14 days. No response was received.

2/7/25, Pharmacist Recommendations to Providers: Order - lorazepam 0.5 mg every two hours PRN. PRN orders for psychotropic drugs anti-psychotic, anti-depressant, anti-anxiety, and hypnotics are limited to 14 days. If believe that it is appropriate for the PRN order to be extended beyond 14 days, should document the rationale in the resident's medical record and indicate the duration for the PRN order. No response from the physician was received.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospice Order date 2/5/25, start lorazepam 0.5 mg one tab oral every two hours PRN for anxiety/dyspnea. Order valid through end of life. During an interview on 2/11/25 at 11:27 a.m., hospice registered nurse (RN)-C stated they were told it was okay to write orders for lorazepam until end of life, then stated there was current discussion about the need for a stop date. During an interview on 2/13/25 at 7:54 a.m., the director of nursing (DON) stated PRN lorazepam should only be ordered for 14 days, the DON added for hospice residents the order could be ordered for up to six months. The DON was not sure if the medical director had talked with the hospice physician about a stop date for R11's PRN lorazepam. During an interview on 2/13/25 at 9:35 a.m., consultant pharmacist (CP)-C stated he requested a stop date in November for R11 and received no response. The request was re-issued in December and now again in February. CP-C stated this was discussed at the quality meeting on 1/7/25 and believed the medical director had reached out to the hospice medical doctor regarding this concern. Psychotropic Medication Management - Long Term Care dated 10/2023, identified the following; As needed orders for psychotropic drugs (with the exception of anti-psychotics, see below) are limited to 14 days. Unless, the attending physician or prescribing practitioner believes that it is appropriate for the as needed order to be extended beyond 14 days in which case he/she should document their rationale in the resident's medical record and indicate the duration of the as needed order.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview and document review, the facility failed to ensure that temperature-controlled medications were properly stored for 6 of 6 residents (R10, R14, R17, R1, R19, R6) and any resident needing medications from the pharmacy-provided emergency kit, stock vaccine, and tuberculin testing medication. Findings include: R10's quarterly Minimum Data Set (MDS) dated [DATE], identified R10 had diagnoses which included multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), diabetes mellitus, and hyperlipidemia. R14's quarterly MDS dated [DATE], identified R14 had diagnoses which included, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), hypertension, diabetes mellitus, hyperlipidemia, arthritis, and dementia. R17's admission MDS dated [DATE], identified R17 had diagnoses which included hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting left non-dominant side, hypertension, gastric esophageal reflux disease (GERD), diabetes mellitus, and arthritis. R1's annual MDS dated [DATE], identified R1 had diagnoses which included seizures, GERD, thyroid disease, arthritis, aphasia (a language disorder that affects a person's ability to understand, produce, or use language due to damage to the brain areas responsible for language processing), anxiety, and depression. R19's quarterly MDS dated [DATE], identified R19 had diagnoses which included hemiplegia affecting left non-dominant side, nicotine dependence, hypertension, diabetes mellitus, and depression. R6's quarterly MDS dated [DATE], identified R6 had diagnoses which included, heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), anemia, hypertension, and seizures. On 2/12/25 at 2:27 p.m., during a tour of station three's medication room with registered nurse (RN)-B the medication refrigerator temperature log was noted to have temperatures recorded that were out of range. RN-D entered the room and verified the morning temperature at 6:30 a.m., was 48 degrees Fahrenheit (F) and at 1:40 p.m., the temperature was 53 degrees F. RN-D stated the refrigerator contained insulins, neurontin, vaccines, and other medications. RN-D stated she had adjusted the temperatures but did not notify anyone. RN-B stated they would obtain a list of medications in the refrigerator. On 2/12/25 at 2:41 a.m., maintenance (M)-A arrived and stated the dial must have been turned the wrong direction, the inside back wall of the refrigerator was wet with water droplets. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sandstone Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 109 Court Avenue South Sandstone, MN 55072	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of station three's medication refrigerator temperature record identified the refrigerator was supposed to be checked twice a day. The readings should be reviewed weekly for out-of-range temperatures or temperature trends. The safe range was identified as 36 degrees F to 46 degrees F. October 2024 revealed the following dates out of the safe range: 10/3/24 6:46 a.m., 47 F 10/8/24 6:45 a.m., 35 F and 2:00 p.m., 35 F 10/9/24 6:45 a.m., 47 F and 3:05 p.m., 47 F 10/10/24 6:00 p.m., 35 F 10/14/24 2:20 p.m., 47 F 10/16/24 2:22 p.m., 47 F 10/18/24 6:30 a.m., 35 F 10/20/24 3:00 p.m., 28 F 10/21/24 1:00 a.m., 47 F 10/26/24 2:15 p.m. 35 F 10/27/24 6:30 a.m., 47 F and 3:40 p.m., 47 F 10/28/24 6:30 a.m., 47 F 10/30/24 6:30 a.m., 35 F November 2024 revealed the temperature was out of the safe range five times. December 2024 revealed the temperature was out of the safe range twice. January 2025 revealed the temperature was out of the safe range ten times. February 2025 revealed the following dates out of the safe range: 2/8/25 8:00 p.m., 48 F 2/10/25 8:30 p.m., 48 F 2/11/25 6:30 a.m., 48 F and 1:40 p.m., 53 F. An inventory revealed the following medications were stored in station three's medication refrigerator: (continued on next page)

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	245454	A. Building B. Wing	02/13/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	liquid gabapentin 90 milliliter and 20 milliliter bottles (used to treat seizures and pain caused by shingles) for R1 Trulicity six pens (a once weekly injectable medication that treats type 2 diabetes) for R14, R10, R19 Semglee (long acting man-made insulin used to control high blood sugars) for R10 Copaxone 17 syringes (a medication used to treat relapsing remitting multiple sclerosis) for R10 Novolog one pen (type of insulin used to treat diabetes) for R17 Lantus seven pens (a type of insulin used to treat diabetes) for R14 Arexvy kit one dose (active immunization for the prevention of lower respiratory tract disease caused by the respiratory syncytial virus (RSV) for R6 Arexvy kit 20 doses stock Aplisol one bottle stock (used for intradermal administration as an aid in the diagnosis of tuberculosis) refrigerated emergency kit: promethazine suppositories four (used to treat nausea) Lantus one pen Novolog one pen Manufacturer's information for the following medications was as follows: liquid gabapentin dated 4/2012, identified the medication should be stored between 36 degrees and 46 degrees F. Trulicity dated 11/2024, identified the medication should be stored between 36 degrees and 46 degrees F. Semglee dated 11/2023, identified the medication should be stored between 36 degrees and 46 degrees F. Copaxone dated 1/2025, identified the medication should be stored between 36 degrees and 46 degrees F. promethazine suppositories no date, identified the medication should be stored between 36 degrees and 46 degrees F. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Novolog dated 3/2023, identified the medication should be stored between 36 degrees and 46 degrees F. Lantus dated 11/2018, identified the medication should be stored between 36 degrees and 46 degrees F. Arexvy dated 2025, identified the medication should be stored between 36 degrees and 46 degrees F. Aplisol dated 11/2013, identified the medication should be stored between 36 degrees and 46 degrees F. During an interview on 2/13/25 at 7:56 a.m., the director of nursing (DON) stated she would expect staff to notify maintenance if the medication refrigerator was out of the temperature range. The DON stated it was important to keep the refrigerator in range so the medications stored in the refrigerator did not lose their effectiveness. During an interview on 2/13/25 at 9:53 a.m., the consultant pharmacist (CP)-C stated staff were supposed to check the medication refrigerators twice a day if they were storing vaccines and stated 50 degrees F was too warm. CP-C stated he would expect the facility to call the pharmacy the medications came from and to adjust the temperature and check every one to two hours to see if the temperature returned to a safe range. CP-C stated it was a concern for the viability of medications if the refrigerator had been out of the safe range for months. CP-C stated the medications should have been treated like they had been at room temperature and dated as opened for the date the refrigerator was out of the safe temperature range. On 2/13/25 at 10:33 a.m., during an interview, M-A stated he could not recall being notified that the medication refrigerators were out of the safe range. M-A stated he checked the medication refrigerators monthly. On 2/13/25 at 10:40 a.m., with RN-B during a tour of station two the medication room temperature log did not show any temperatures out of the safe range, the temperature in the refrigerator was 39 degrees F. On 2/13/25 at 10:48 a.m., RN-B stated she would expect staff to alert someone in upper management or maintenance if the temperatures in the medication refrigerators were out of range. On 2/13/25 at 11:02 a.m., the administrator stated she would expect staff to correct temperatures in the medication refrigerator that were out of range, then re-check the temperature and involve maintenance if needed. The administrator stated medications needed to be kept in a specific range to make sure they remained usable. Medication Guidelines - Long Term Care dated 2/2025, identified Medication requiring refrigeration must be stored in the refrigerator located in the medication room and kept within standard temperature parameters based on Centers for Disease Control (CDC) recommendations.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42587 Based on observation, interview and document review the facility failed to ensure alcohol based hand sanitizer was in use in the hand hygiene dispensers throughout the facility. In addition, the facility failed to ensure oxygen tubing was changed timely for 1 of 1 resident (R11) reviewed for oxygen therapy. Findings include: On 2/10/25 at approximately 2:15 p.m., during resident screenings the hand sanitizer dispensed from the hallway wall dispenser and the dispensers in resident rooms felt watery and was odorless. On 2/11/25 at 2:03 p.m., housekeeper (H)-A stated housekeeping was in charge of refilling the hand hygiene dispensers. When the hand sanitizer fluid was no longer visible in the side window of the dispenser, they would open the dispenser, remove the container and take it to a locked room where the container would be refilled. H-A opened the dispenser and showed the refillable bottle in the dispenser, the bottle was undated. On 2/12/25 at 9:26 a.m., H-B stated Ecolab had stopped making the product they were using foam in cans so Ecolab provided a new product. H-B stated it felt watery and the nursing assistants (NAs) didn't like it so the facility also had Purell hand sanitizer in pump bottles and [NAME] hand sanitizer in pocket size bottles. The Ecolab product was in all resident rooms and in the hallway dispensers. The product was benzalkonium chloride 0.89 % and water. H-B stated the bottles in the dispenser should have been dated when they were first filled. H-B stated the dispensers were re-filled when the product was no longer visible in the side window. The product was in a locked room, staff would attach the refillable bottle and press a button, the machine would automatically dispense the product and water in a pre-programmed ratio. During an interview on 2/12/25 at 3:26 p.m., registered nurse (RN)-A reviewed the information on benzalkonium chloride 0.89% and verified this was the product the facility was using and that the product was a non-alcohol based hand sanitizer. RN-A thought it had been in use about one and one half years. RN-A could not verify if nursing had been involved in the change in the hand sanitizer product. During an interview on 2/12/25 at 3:43 p.m., the administrator stated she learned today that the hand sanitizer product was not alcohol based. During an interview on 2/13/25 at 7:53 a.m., the director of nursing (DON) stated hand sanitizer products needed to be alcohol based and until yesterday she was not aware that the product in the hand sanitizer dispensers was not alcohol based. During an interview on 2/13/25 at 9:25 a.m., Ecolab representative stated the hand sanitizer was not alcohol based and said it was quaternary based product. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ecolab product specification document for concentrated foam hand sanitizer dated 2015, identified the product was benzalkonium chloride. The product was concentrated and was to be diluted in a 10 to 1 ratio. Page two of the document dated 6/5/20, identified the following: To help reduce the risk of infection, the US Centers for Disease Control (CDC) and the World Health Organization (WHO) are recommending that standard practices to reduce exposure to and transmission of a range of illnesses be followed. These practices include reinforcing good personal hygiene by performing proper handwashing with soap and water or using an alcohol-based hand sanitizer if soap and water are not available. The Centers for Disease Control (CDC) Handsanitizer guidelines and recommendations dated 3/12/24, identified the following: Hand Sanitizer Guidelines and Recommendations Key points Washing hands with soap and water is the best way to get rid of germs in most situations. If soap and water are unavailable, use a hand sanitizer with at least 60% alcohol to clean your hands. You can tell if the sanitizer contains at least 60% alcohol by checking the product label. Handwashing/Hand Hygiene policy dated 1/2023, identified the facility would use an alcohol-based hand rub containing at least 62 % alcohol. R11 R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 had diagnoses which included treatment for palliative care, anxiety disorder, chronic obstructive pulmonary disease (COPD[a group of lung disease that block airflow and make it difficult to breathe]), macular degeneration (an eye disorder that causes vision loss), and paroxysmal atrial fibrillation (a type of irregular heartbeat where the heart's upper chambers [atria] beat rapidly and irregularly for a short period of time). R11's MDS identified R11 was moderately cognitively intact and used oxygen. R11's care plan initiated on 11/4/24, identified R11 had an alteration in respiratory status related to a diagnosis of COPD with use of oxygen. Interventions included to administer oxygen as order by medical provider (MD). R11's care plan did not include directing staff to change oxygen tubing. R11's active orders current as of 2/13/25, identified R11 had an order for oxygen at two liters per nasal cannula at bedtime related to COPD. A review of R11's treatment record for December 2024, January 2025, and February 2025, did not identify oxygen tubing changes. On 2/10/25 at 5:20 p.m., R11's oxygen tubing that she was using and was connected to the oxygen concentrator and the oxygen tubing connected to the oxygen tank on her wheelchair were both dated 2/2. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/11/25 at 3:16 p.m., licensed practical nurse (LPN)-A checked R11's oxygen tubing and verified it was dated 2/2, and stated the tubing should be changed weekly. On 2/13/25 at 7:54 a.m., the director of nursing (DON) stated oxygen tubing is expected to be changed weekly to minimize the risk for infection. Oxygen Administration - Long Term Care dated 2/2024, identified under infection control Nasal cannulas, mask , or mouth pieces are to be replaced weekly and as needed.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 42587 Based on observation, interview, and document review the facility failed to ensure resident call lights were within reach from the bathroom floor in multi-resident bathrooms for 3 of 3 residents (R24, R11, R30) reviewed for call light accessibility. Findings include: On 2/10/25 at 1:58 p.m., R24's shared bathroom call light was checked to see if it worked and if it was accessible from the floor. The call light was a white cord that was looped and attached to a hook approximately four feet from the floor. On 2/10/25 at 5:24 p.m., R11's shared bathroom call light was checked to see if it was in working order and if it was accessible from the floor. The call light cord was approximately 10 inches from the floor. On 2/10/25 at 6:42 p.m., R30's bathroom call light was checked to see if it was in working order and for accessibility from the floor. The call light was approximately 14 inches from the floor. On 2/12/25 at 9:10 a.m., maintenance (M)-A checked R11's bathroom call light and removed it from the hook in the wall and measured. When the call light was freed from the hook in the wall the bottom of the cord was 18 inches from the floor. M-A stated it makes sense that the call lights should be able to be reached from the floor. On 2/12/25 at 9:11 a.m., R11 stated the call light had always been hooked to the wall, she stated she did not ask for it to be looped and hooked to the wall. On 2/12/25 at 9:17 a.m., R11's bathroom call light was measured by M-A and found to be 18 inches from the floor. On 2/12/25 at 9:19 a.m., R30's bathroom call light was measured by M-A and found to be 17 inches from the floor. During an interview on 2/13/25 at 10:56 a.m., the administrator stated if a resident fell in the bathroom and the call light cord reached almost to the floor they would have a better chance to reach the call light. A policy on call lights was requested but not provided.