STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265198	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines Adult Care Center	1900 S Jamison Kirksville, MO 63501

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 25232 Based on observation, interview, record review, and policy review, the facility failed to ensure residents who self-administered medications had a self-administration of medications assessment, a physician's order, and a care plan completed for two of two residents (Resident (R) 4 and R44) reviewed for self-administration of medications out of a total sample of 22 residents. Failure to assess and care plan residents for self-administration of medications increases the potential of medication errors for residents. Findings include: Review of the facility's policy titled, Self-Administration of Medications, revised 02/2021, indicated, Resident have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation: 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident .3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status .8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. 1. Review of R4's Face Sheet, located under the Profile tab in the Electronic Medical Record (EMR) indicated that R4 was admitted to the facility with diagnoses which included allergic rhinitis. During observation on 10/08/24 at 10:20 AM of R4's room a white box with a bottle of nasal spray inside was observed on the resident's bedside table. The label read Azelastine Hydrochloride Nasal Spray (this medication is used for seasonal allergies). R4 said that she took one spray each nostril in the morning and at night. R4 said that the facility knew she had them because the facility just re-ordered her a new bottle. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/25/24 and located in the resident's EMR under the MDS tab indicated the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. Review R4's Physician Orders, dated 09/01/23, provided by the facility indicated Azelastine HCl Nasal Solution 0.1 % (Azelastine HCl) 137 micrograms (mcg) in each nostril two times a day for allergic rhinitis, may keep at bedside. Review of R4's EMR under the Assessments tab revealed no documented evidence that the resident had been assessed for self-administration of medication. Review of R4's Care Plan, located under the Care Plan tab in the EMR indicated no evidence of a self-administration of medication care plan. Observation on 10/10/24 at 8:30 AM and 10:08 AM of R4's room revealed a box with nasal spray on R4's over the bed table. During an observation and interview on 10/10/24 at 10:20 AM, Licensed Practical Nurse (LPN) 3, confirmed that R4 had nasal spray next to her bed. LPN3 stated she was unsure if R4 had been assessed for self-administration of medication. Continued interview revealed that the LPN3 was not sure if residents should be care planned if they self-administered their medications. During an interview on 10/10/24 at 11:25 AM, the Director of Nursing (DON) confirmed for a resident to self-administer medications, the resident required a physician's order, assessment, care plan for self-administration, and a way to lock up the medication. The DON confirmed R4 was not assessed for self-administration of medication and was not care planned for self-administration of medication. 2. Review of R44's Face Sheet, located under the Profile tab of the EMR indicated R44 was admitted to the facility with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). Observation of medication administration on 10/09/24 at 8:27 AM, Certified Medication Technician (CMT) 6 gathered R44's morning medication and went into R44's room with Advair hydrofluoroalkane (HFA) inhaler (this is an inhaler to help breathing) and a vital sign machine. Once inside R44's room, CMT6 handed the inhaler to R44 and took R44's vital signs. The CMT left the room prior to observing R44 administer the inhaler medication. After two minutes, CMT6 returned to R44's room, handed R44 her other medication, and asked R44 if she administered her inhaler medication. R44 said yes and handed the inhaler back to CMT6. Review of R44's quarterly MDS with an ARD of 07/21/24 and located under the MDS tab in the EMR revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R44's Physician Orders, dated 02/05/24 and located under the Orders tab in the EMR, indicated, Advair HFA Inhalation Aerosol 115-21 MCG/Asthma Control Test (ACT) (Fluticasone-Salmeterol), two puffs inhale orally two times a day related to COPD. Continued review of R44's Physician Orders revealed no documented evidence of an order for R44 to self-administer any medications. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R44's EMR under Assessments tab indicated no documented evidence that the resident had been assessed for self-administration of medications. Review of R44's Care Plan, located under the Care Plan tab in the EMR indicated no evidence of self-administration of medication care plan. During an interview on 10/10/24 at 11:15 AM, the Nursing Supervisor (NS) confirmed R44 did not have a physician's order, was not assessed for self-administration of medications, and the resident' care plan did not reflect self-administration of medications. During an interview on 10/10/24 at 11:25 AM, the DON confirmed R44 was not assessed to determine if the resident was able to safely self-administer medications, the resident was not ordered by their physician to self-administer their medications, and the resident's care plan did not reflect self-administration of medication.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 11599 Based on interview, record review, and policy review, the facility failed to have a grievance procedure with an identified person to lead investigations, a system to inform residents of their right to file a grievance, and documentation to show the results of grievance investigations for six of six residents (Resident (R) 1, R21, R28, R38, R48, and R56) interviewed in the resident group interview. The failure had the potential to affect all residents who resided at the facility to be informed of their right to file a grievance and for the facility to resolve any grievance the residents may have. Findings include: Review of the facility's undated policy titled, Grievance Policy, indicated, Objective of Grievance Policy: The objective of the grievance policy is to ensure the facility makes prompt efforts to resolve grievances a resident may have. The intent of the grievance process is to support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost clothing, or violation of rights) and to assure that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident appropriately apprised of its progress toward resolution. The grievance policy will be reviewed on an annual basis or more frequently and will be integrated into the facility Quality Assurance and Performance Improvement Program (QAPI) .Procedure: A. The facility will promote the grievance process throughout the organization .B. Grievance Official: The facility will train and designate an individual who is responsible for: a. Overseeing the grievance process in conjunction with facility administration, b. Receive and track all grievances through to their conclusion .f. Complete written grievance resolutions/decisions to the resident involved .C. Resident and Resident Representative Notification: The facility will inform residents orally and in writing of their right to make complaints and grievances and the process to do so during admission, readmission and the care planning process .E. A grievance concern can be expressed orally to the grievance official or facility staff or in writing using a grievance form which will be located adjacent to the bill of rights posting located throughout the facility at each nursing station and outside the social service office. F. Grievances may be given to any staff member who will forward the grievance to the grievance office, or they may file the grievances anonymously in the designated box located outside the nursing administration office. G. Response: Any employee of this facility who receives a complaint shall immediately attempt to resolve the complaint within their role and authority .H. Resolution. The grievance official will complete a written response within seven working days to the resident or resident representative .I. The grievance officer will maintain a log of all grievances for a period of three years .J. QAPI: The facility will track, trend, and analyze the grievance process and findings for trends, performance gaps and opportunities for individual education, system, and systemic improvement." During the initial observational tour of the facility on 10/08/24 between 9:30 AM-11:30 AM, there were no grievance forms observed on any of the facility's four neighborhoods. There was a black box observed on the wall, labeled grievance, after entering through the main door of the facility. Further observations on 10/09/24 at 7:45 AM, 10/10/24 at 7:30 AM, and 10/11/24 at 7:45 AM revealed there were no grievance forms observed in the different neighborhoods and/or next to the grievance box which was on the wall after entering the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 10/08/24 at 2:09 PM, the Administrator was asked to provide the grievance log for the previous six months for review. The Administrator denied having such a log or having documentation of grievance investigations or their results. The Administrator said, We all attend the monthly resident council meetings and handle concerns immediately. We just hired a QA (Quality Assurance) staff member to handle the grievance process. A Resident Group interview was held on 10/10/24 at 11:00 AM with six alert and oriented residents chosen by the facility (Resident (R) 1, R21, R28, R38, R48, and R56) who regularly attended the monthly Resident Council meetings. The residents were asked if they knew how to file a grievance. None of the six residents knew of a process to file a grievance. None of the residents knew of the newly hired QA staff member. Review of six months of Resident Council meeting minutes revealed no discussions about grievances, the right to file a grievance, or the right to have a conclusion to the grievance investigation. During an interview on 10/11/24 at 7:52 AM, the QA staff member said she was New to position, just over a month. The QA denied having received prior grievance concerns, upon hire, for investigation or anything new since being hired to investigate. During an interview on 10/11/24 at 1:30 PM, the MDSC indicated if a resident and/or family expressed a concern during a care conference, then she took notes and informed either the DON or the Administrator and sometimes both. The MDSC stated she would go to the department that the concern was about and let them know. The MDSC confirmed she did not write any concerns identified down on the facility's grievance form. 25232

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 25232 Based on record review, interview, and policy review, the facility failed to ensure that three of five employee files (Certified Nursing Assistant (CNA) 6, CNA7, and CNA1) reviewed had a background check prior to hire. This had the potential to have staff hired that have an unknown history of abuse. Findings include: Review of facility's undated policy titled, New Employee Background Check Policy, indicated, To ensure the safety and well-being of residents by conducting thorough background checks on all prospective employees, contractors, and volunteers before they are hired or engaged by the facility .Procedure: 1. Initiating Background Checks: Human Resources (HR) will request a criminal background check for all prospective employees using the appropriate state and federal systems .2. Reviewing Background Check Results: Upon receipt of the background check results, HR will review the information to determine if the prospective employee is eligible for hire. If the background check reveals disqualifying information, HR will ensure the individual does not have contact with residents. 1. Review of Certified Nursing Assistant (CNA) 6's employee file indicated her date of hire (DOH) was 08/10/23. Further review indicated that CNA6's background check was started 08/14/23, four days after her hire date and was not completed until 09/11/23. Review of CNA6's Punch Data, dated 08/10/23 through 09/11/23, indicated CNA6 worked the following dates: 08/10/23, 08/11/23, 08/12/23, 08/13/23, 08/17/23, 08/24/23, 08/25/23, 08/26/23, 08/27/23, 08/31/23, 09/03/23, 09/04/23, 09/07/23, 09/08/23, 09/09/23, and 09/10/23. 2. Review of CNA7's employee file indicated her DOH was 03/15/23. Further review indicated CNA7's background check was submitted on 03/15/23; however, it was not completed until 03/29/23, 14 days after her hire date. Review of CNA7's Punch Data, dated 03/15/23 through 03/29/23, indicated that CNA7 worked the following dates: 03/15/23, 03/17/23, 03/18/23, 03/19/23, 03/21/23, 03/22/23, 03/24/23, 03/28/23, and 03/29/23. 3. Review of CNA1's employee file indicated her DOH was 08/16/23. Further review indicated CNA1's background check was submitted on 08/18/23, two days after her hire date and not completed until 09/15/23. Review of CNA1's Punch Data, dated 08/16/23 through 09/15/23, indicated that CNA1 worked the following dates: 08/16/23, 08/18/23, 08/21/23, 08/22/23, 08/25/23, 08/26/23, 08/27/23, 08/28/23, 08/30/23, 08/31/23, 09/01/23, 09/04/23, 09/05/23, 09/06/23, 09/08/23, 09/09/23, 09/10/23, 09/11/23, 09/13/23, and 09/15/23. During an interview on 10/11/24 at 11:00 AM, the Administrator confirmed that background checks were late and stated they should have been conducted prior to hire date. (continued on next page)

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/11/24 at 11:22 AM, the Infection Preventionist (IP) confirmed background checks were not fully completed on the employees above prior to the start of their first shift.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on record review, interview, and policy review, the facility failed to ensure three of three residents (Resident (R) 21, R41, and R2) reviewed for hospitalization out of a total sample of 22 and their representatives were given a written notice of transfer to the hospital. In addition, the Ombudsman was not notified of the monthly hospitalization s. This failure created the potential for residents or their responsible party not to have the information needed to understand their transfer to the hospital. Findings include: Review of the facility's policy titled Transfer and Discharge from the Facility Policy, dated 2017, indicated, It is the policy of this facility that each resident has the right to remain in the facility and not transfer or discharge a resident unless a transfer or discharge from the facility is: A. Necessary for the resident's welfare and the resident's needs cannot be met in the facility .The resident and representative will receive timely notification, adequate preparation, orientation and information to make the transfer as orderly and safe as possible. The notice still contains information about the transfer and information about the resident's appeal rights. The facility will assist the residents to obtain, complete and submit an appeal form at the president's request. The resident will not be discharged during the appeal process. If the transfer is due to an emergency, the notice will be issued as soon as practicable. The facility forwards a copy of all discharge notices to the Office of the State Long-Term Ombudsman and required state agencies 1. Review of R21's undated "Face Sheet, located under the Profile tab in the electronic medical record (EMR) indicated that R21 was readmitted to the facility on [DATE]. a. Review of R21's Progress Note, dated 08/03/24, located under Notes tab in the EMR indicated [R21's Name] very anxious, tearful, and states that she is having difficulty remembering staff names and is confused .On call physician contacted and order given to transfer out R21." b. Review of R21's Progress Note, dated 09/28/24, located under Notes tab in the EMR indicated Spoke with [name of physician] who is on-call regarding R21 not feeling right, something is off .tremors gradually intensifying throughout the day .Nurse and R21 decided it would be best to get checked out at emergency department (ED)." Review of the Miscellaneous tab in the EMR indicated no evidence of a written transfer hospital notification. 2. Review of R41's undated Face Sheet, located under the Profile tab in the EMR indicated R41 was admitted to the facility on [DATE]. Review of R41's facility provided Transfer Form, dated 08/17/24 indicated [R41's Name] tested positive for Coronavirus disease (COVID) this morning. R41 complained feeling chilled, noted full body tremors. R41 was sent to the emergency room (ER). (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Miscellaneous tab in the EMR indicated no evidence of a written transfer hospital notification. During an interview on 10/09/24 at 1:20 PM, the Ombudsman stated there had not been a monthly hospitalization list sent from the facility since January 2024. During an interview on 10/10/24 at 9:01 AM, the Director of Nursing (DON) confirmed R21 nor R41 received a written transfer notice for hospitalization s. In addition, the DON confirmed the Ombudsman was not notified of hospitalization s. During an interview on 10/10/24 at 9:30 AM, the Administrator confirmed the Ombudsman had not been notified of hospital transfers, and there was no written transfer notice given to either the resident and/or resident representative. The Administrator stated he was aware of the regulations. 3. Review of R2's Admission Record, located under the Profile tab in the electronic medical record (EMR), revealed R2 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, type II diabetes mellitus, and unspecified dementia. Review of R2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/07/24 and located in the MDS tab of the EMR, revealed R2 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident was moderately cognitively impaired. Review of R2's Census located under the Clinical tab in the EMR, identified R2 was transferred to the hospital on 06/14/24 and readmitted to the facility on [DATE]. Review of R2's Nursing Note, dated 06/14/24 at 6:12 PM, located in the Progress Notes tab of the EMR, revealed Resident was eating supper when staff approached him after noticing he was acting sleepy/lethargic. Resident was unresponsive to verbal and tactile stimuli and proceeded to became very pale and slump in his wheelchair. Sternal rub performed to attempt to arouse the patient, and after 10 seconds resident woke up, coughing on food that he had pocketed into his mouth. Resident was awake and responsive at this point, but very confused. He proceeded to make animals noises at staff, growling and barking, and attempting to grope staff inappropriately. VS [vitals] were obtained at this time and were as follows: B/p [blood pressure]: 167/80, 95% on RA [oxygen on room air], HR-71 [heart rate], R-18 [respirations], T-97.6*F. [temperature] On call [physician] contacted and notified of resident's status and orders given to transfer to ED [emergency department] for further evaluation and treatment. Review of R2's Progress Notes and Misc tabs of the EMR revealed no documented evidence a written transfer notice was provided to the resident and/or the resident representative at the time of the transfer or soon after the transfer to the hospital on 06/14/24. During an interview with the DON and the Administrator on 10/10/24 at 1:50 PM, both confirmed the facility did not provide transfer/discharge notices to residents, resident representatives, or the Ombudsman. 25232

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on record review, interview, and policy review, the facility failed to ensure three of three residents (Resident (R) 21, R41, and R2) reviewed for hospitalization out of a total sample of 22 residents were given a written copy of a bed hold notice within 24-hours of emergency transfer to the hospital. This failure created the potential for residents and/or responsible parties not to have the information needed to safeguard their return to the facility. Findings include: Review of facility's policy titled, Bed Hold and Return to Facility Policy and Procedure, dated 2017, indicated, It is the policy of this facility that residents who are transferred to the hospital or go on a therapeutic leave are provided with written information about the State's bed hold duration and payment amount before the transfer . Residents and their representatives will be provided with bed hold and return information at admission and before a hospital transfer or therapeutic leave . Nursing and social work staff are educated about the resident's bed hold and return rights to ensure that required information is provided at the time the resident leaves the facility .Procedure: A. Bed Hold and Return Notice upon transfer: The facility will provide the resident and resident representative with a written notice which specifies the duration of the bed-hold policy at the time of transfer for hospitalization or therapeutic leave. This notice specifies the following information: a. The state bed-hold policy during which the resident is permitted to return and resume residence in the nursing facility. The facility's policies regarding bed-hold periods permitting resident to return: in the event of absence of the resident from [name of the facility] by reason of residents transfer to a hospital or other facility to receive medical care, resident may retain his/her room at [name of the facility] provided that resident/resident representative pays the daily charge for the room, [name of the facility] does not guarantee or assure that a room will be available to resident to resident at [name of the facility] any time thereafter. Medicare and [name of healthcare insurance] make no payment for holding beds, therefore, it is necessary for charge to be in pain privately. If you choose not to reserve the bed, [name of the facility] will admit the resident to the first available appropriate bed. The Social Service department will contact the resident/resident representative when this issue arises. 1. Review of undated R21's "Face Sheet, located under the Profile tab in the electronic medical record (EMR) indicated R21 was readmitted to the facility on [DATE]. a. Review of R21's Progress Note, dated 08/03/24, located under Notes tab in the EMR, indicated [R21's Name] very anxious, tearful, and states that she is having difficulty remembering staff names and is confused .On call physician contacted and order given to transfer out R21." b. Review of R21's Progress Note, dated 09/28/24, located under tab Notes in the EMR, indicated Spoke with [name of physician] who is on-call regarding [R21's Name] not feeling right, something is off .tremors gradually intensifying throughout the day .Nurse and [R21's Name] decided it would be best to get checked out at emergency department (ED)." (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Miscellaneous tab in the EMR indicated no evidence of a written bed hold notification. 2. Review of R41's undated Face Sheet, located under the Profile tab in the EMR, indicated that R41 was admitted to the facility on [DATE]. Review of R41's facility provided Transfer Form, dated 08/17/24 indicated [R41's Name] tested positive for Coronavirus disease (COVID) this morning. [R41's Name] complained feeling chilled, noted full body tremors. [R41's Name] was sent to the emergency room (ER). Review of the Miscellaneous tab in the EMR indicated no evidence of a written bed hold notification. During an interview on 10/10/24 at 9:01 AM, the Director of Nursing (DON) confirmed R21 nor R41 received a written bed hold notice. The DON stated every resident was allowed back to the facility. During an interview on 10/10/24 at 9:30 AM, the Administrator confirmed the residents and/or resident representatives were not given a written bed hold notice. 3. Review of R2's Admission Record, located under the Profile tab in the EMR revealed R2 was admitted to the facility on [DATE]. Review of R2's Census located under the Clinical tab in the EMR, identified R2 was transferred to the hospital on 06/14/24 and readmitted to the facility on [DATE]. Review of R2's Nursing Note, dated 06/14/24 at 6:12 PM, located in the Progress Notes tab of the EMR, revealed Resident was eating supper when staff approached him after noticing he was acting sleepy/lethargic. Resident was unresponsive to verbal and tactile stimuli and proceeded to became very pale and slump in his wheelchair. [A] Sternal rub was performed to attempt to arouse the patient, and after 10 seconds [the] resident woke up, coughing on food that he had pocketed into his mouth. Resident was awake and responsive at this point, but very confused. He proceeded to make animals noises at staff, growling and barking, and attempting to grope staff inappropriately. VS [vitals] were obtained at this time and were as follows: B/p [blood pressure]: 167/80, 95% on RA [oxygen on room air], HR-71 [heart rate], R-18 [respirations], T-97.6*F. [temperature] On call [physician] contacted and notified of resident's status and orders given to transfer to ED [emergency department] for further evaluation and treatment. Review of R2's Progress Notes and Misc tabs of the EMR revealed no documented evidence a written bed hold notice was provided to the resident and/or the resident representative at the time of the transfer or soon after the transfer to the hospital on 06/14/24. During an interview with the DON and the Administrator on 10/10/24 at 1:50 PM, both confirmed the facility did not provide written bed hold notices to residents or resident representatives. 25232

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on record review, interview, and facility policy review, the facility failed to ensure three residents (Resident (R) 1, R23, and R24) out of 22 sampled residents' Minimum Data Set (MDS) assessments were transmitted in a timely manner. This failure has the potential of non-payment for necessary resident care. Findings include: Review of facility's policy titled, MDS Transmission for Skilled Nursing Facilities (SNF), undated, indicated, . 3. Comprehensive assessments must be transmitted electronically within 14 days of the care plan completion date. All other MDS assessments must be submitted within 14 days of the MDS completion date. 1. Review of R1's Admission Record, located under the Profile tab in the electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE]. Review of R1's significant change in status MDS with an assessment reference date (ARD) of 03/05/23 and located under the MDS tab in the EMR revealed MDS completed on 03/17/23 and submitted on 04/12/23 which indicated it was transmitted outside the required 14 days. Review of R1's quarterly MDS with an ARD of 06/04/23 and located under the MDS tab in the EMR, revealed MDS completed on 06/16/23 and submitted on 07/07/23 which indicated it was transmitted outside the required 14 days. Review of R1's quarterly MDS with an ARD of 09/03/23 and located under the MDS tab in the EMR, revealed MDS completed on 09/15/23 and submitted on 10/06/23 which indicated it was transmitted outside the required 14 days. Review of R1's quarterly MDS with an ARD of 12/03/23 and located under the MDS tab in the EMR, revealed MDS completed on 12/15/23 and submitted on 01/11/24 which indicated it was transmitted outside the required 14 days. Review of R1's annual MDS with an ARD of 03/03/24 and located under the MDS tab in the EMR, revealed MDS completed on 03/15/24 and submitted on 04/10/24 which indicated it was transmitted outside the required 14 days. Review of R1's quarterly MDS assessment with an ARD of 06/02/24 and located under the MDS tab in the EMR, revealed MDS completed on 06/14/24 and submitted on 07/11/24 which indicated it was transmitted outside the required 14 days. 2. Review of R23's Admission Record, located under the Profile tab in the EMR revealed R23 was admitted to the facility on [DATE]. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R23's quarterly MDS with an ARD of 03/12/23 and located under the MDS tab in the EMR, revealed MDS completed on 03/14/23 and submitted on 04/12/23 which indicated it was transmitted outside the required 14 days. Review of R23's annual MDS with an ARD of 06/04/23 and located under the MDS tab in the EMR, revealed MDS completed on 06/16/23 and submitted on 07/07/23 which indicated it was submitted outside the required 14 days. Review of R23's quarterly MDS with an ARD of 09/03/23 and located under the MDS tab in the EMR, revealed MDS completed on 09/15/23 and submitted on 10/06/23 which indicated it was transmitted outside the required 14 days. Review of R23's quarterly MDS with an ARD of 12/03/23 and located under the MDS tab in the EMR, revealed MDS completed on 12/15/23 and submitted on 01/11/24 which indicated it was transmitted outside the required 14 days. Review of R23's quarterly MDS with an ARD of 03/03/24 revealed located under the MDS tab in the EMR, MDS completed on 03/15/24 and submitted on 04/10/24 which indicated it was transmitted outside the required 14 days. Review of R23's annual MDS with an ARD of 06/02/24 located under the MDS tab in the EMR, revealed MDS completed on 06/14/24 submitted on 07/11/24 which indicated it was transmitted outside the required 14 days. 3. Review of R24's Admission Record, located under the Profile tab in the EMR revealed R24 was readmitted to the facility on [DATE]. Review of R24's admission MDS with an ARD of 06/18/23 and located under the MDS tab in the EMR, revealed MDS completed on 06/21/23 and submitted on 07/07/23 which indicated it was transmitted outside the required 14 days. Review of R24's quarterly MDS with an ARD of 12/03/23 located under the MDS tab in the EMR, revealed MDS completed on 12/15/23 and submitted on 01/11/24 which indicated it was transmitted outside the required 14 days. Review of R24's quarterly MDS with an ARD of 03/03/24 and located under the MDS tab in the EMR, revealed MDS completed on 03/15/24 and submitted on 04/10/24 which indicated it was transmitted outside the required 14 days. Review of R24's annual MDS with an ARD of 06/02/24 and located under the MDS tab in the EMR, revealed MDS completed on 06/14/24 and submitted on 07/11/24 which indicated it was transmitted outside the required 14 days. During an interview on 10/10/24 at 8:35 AM, the Director of Nursing (DON) confirmed the assessments were transmitted late and stated they should have been transmitted within 14 days of being completed. Continued interview revealed the DON was unaware of the last time that she reviewed the missing assessment report.

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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** 11599 Based on observation, interview, and record review, the facility failed to provide the physician follow up information on a skin condition for one resident (Resident (R) 45) delaying treatment and failed to assess the need to crush medications for one resident (R5) out of a total sample of 22 residents. These failures increased the risk that residents would not receive timely and/or effective treatments. Findings include: 1. Review of R45's Admission Record, located under the Profile tab of the electronic medical record (EMR) identified R45 was admitted on [DATE]. Review of R45's quarterly Minimum Data Set (MDS), located under the RAI tab in the Electronic Medical Record (EMR), with an Assessment Reference Date (ARD) of 09/01/24, revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated R45 had short and long term memory problems, and the staff could not determine a BIMS score. R45 was identified as being dependent on staff for activities of daily living (ADL's). Review of R45's Nurses Note located under the Progress Notes tab in the EMR read 9/21/2024 16:03 [4:03 PM] Health Status Note: Resident has multiple blood blisters on palm of Rt [right] hand, some have opened & [and] are dried. Resident winces when hand is examined & she stated she doesn't know what happened. The note was completed by Licensed Practical Nurse (LPN) 5. Review of R45's communication form, dated 09/22/24, located under the MISC tab in the EMR, noted Blood blisters palm of right hand, some intact, some open and dried. Resident grimaces when hand examined. The form was signed by LPN5. There was no documented evidence in the EMR that the resident's physician had responded to the faxed communication form. During an interview on 10/10/24 at 2:23 PM, LPN4 confirmed that there was no evidence in the EMR that the resident's physician had responded to the 09/21/24 faxed communication form. Review of R45's Skin Condition Evaluation, located under the Assessments tab, noted the following information: On 09/21/24, R45 was identified to have Multiple blood blisters palm of Rt [right] hand, some have opened & dried. Resident winces when hand is examined. On 09/30/24, R45 was identified to have Palm of rt [right] hand has blisters bruising to bilat [bilateral] arms. On 10/05/24, R45 was identified to have Blisters noted to both palms of hands- RT [right] worse than LT [left]- some are popped and open- others are still blistered over- unknown etiology. (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 10/10/24 at 3:51 PM, R45's primary care physician (PCP) confirmed receipt of the faxed notification of blood blisters on palm of right hand. R45's physician stated, The resident had been transferred to the hospital shortly after the fax was sent for treatment of pneumonia. The physician stated that she had responded to the fax and asked for a report of the condition of the hand upon return to the facility. The physician was informed that her faxed return with the request for an update on the resident's hand upon return from the hospital was not located in the EMR. The physician stated I received a fax on 10/06/24 identifying bilateral palm blisters and on inner thighs. The facility asked for a culture. I received the fax at 9:07 AM on 10/07/24 and responded at 10:41 AM ordering the culture. The facility thought it might be staph [an infection caused by staphylococcus bacteria] possibly contact dermatitis. I instructed the staff to make an appointment with dermatology, if persists. I was told the resident representative declined to have the resident sent to dermatology. R45's physician said she did not believe the blisters started prior to 09/21/24 because she had seen R45 prior to that time without any skin concerns. R45's physician confirmed that she should have received the requested update in order to determine the next course of action. During an interview, on 10/10/24 at 10:42 AM, the Nursing Supervisor (NS), responsible for the facility wound care program, stated, We don't know what caused the blisters. The culture was negative, the physician ordered treatment today. The order read, Triamcinolone Acetonide External Cream 0.1 % (Triamcinolone Acetonide (Topical)) Apply to affected area to both han [hands] topically every day and evening shift for blistered areas on hands. The NS said R45's hands were wrapped in gauze, prior to the 10/10/24 treatment order, to help discourage scratching the blisters. 2. Review of R5's Admission Record, located under the Profile tab, indicated R5 was admitted on [DATE] with diagnoses that included spondylosis and cervicalgia. Review of R5's quarterly MDS, with an ARD of 09/22/24 revealed the facility assessed the resident to have a BIMS score of six out of 15 which indicated R45 was severely cognitively impaired. Observation on 10/08/24 at 3:12 PM revealed R5 seated in her wheelchair at a dining room table. Certified Medication Technician (CMT) 3 was observed to ask R5 her pain level on a scale of one-10. The resident stated six. CMT3 offered R5 Tylenol, which resident said would be good. CMT3 crushed the Tylenol, placed it in applesauce, brought a tissue to R5 and stated, I brought you water and a tissue, I know how much you hate this. R5 stated, I hate it, why they think I can't swallow a Tylenol. It gets under my dentures. R5 was observed to spit pieces of Tylenol into the tissue while stating I hate this. During an interview on 10/08/24 at 3:30 PM, CMT3 was asked had staff questioned if R5 could have the Tylenol administered in a different route. CMT3 stated she was not aware if that had been considered. Review of R5's Physician's Orders, located under the Orders tab in the EMR for the month of October 2024 revealed no order to crush the Tylenol or any of R5's medications. During an interview on 10/11/24 at 11:27 AM, CMT3 stated, We've always crushed all [of] R5's meds [medications] since she moved over from the other unit in April 2024. During an interview on 10/11/24 at 1:15 PM, the Director of Nursing (DON) stated, If you didn't see an order to crush, it's probably not there.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46319 Based on observation, interview, and facility policy review, the facility failed to ensure food stored in the kitchen was labeled and dated with an open date to ensure opened food items were discarded in a timely manner. This had the potential to increase the spread of foodborne illnesses for 72 out of 72 residents that receive meals from the kitchen. Findings include: Review of the facility's policy titled, Food Storage (Dry, Refrigerated, and Frozen), 2016 Edition, revealed Guideline: Food shall be stored on shelves in a clean, dry area free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. Procedure: 1. General storage guidelines to be followed: a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded. (1) See Date Marking Guidelines in this section for exceptions to dating individual dry storage food items . c. Discard food that has passed the expiration date, and discard food that has been prepared in the facility after seven days of storing under proper refrigeration . f. Leftover contents of cans and prepared food will be stored in covered, labeled and dated containers in refrigerators and/or freezers . During the follow up observation of the kitchen with the DM (Dietary Manager) on 10/09/24 at 9:40 AM, in the cooler there were a one gallon container of sweet and sour sauce, a one gallon container of salad dressing, and a five pound container of strawberry halves that had been opened and not labeled to indicate the open date of each item. Also, the dry food storage contained three boxes of cereal that were open and not dated with the open date. During an interview on 10/09/24 at 9:50 AM, the dietary aide (DA)1 stated they were supposed to date items when opened to ensure they get rid of food that had been in the refrigerator too long. During an interview on 10/09/24 at 10:00 AM, the DM stated the staff should have put an open date on the food items. The DM said he/she was working on getting everyone to put an open date and an out date on the things they open so residents don't get outdated food.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232 Based on observation, interview, and record review, the facility failed to ensure one of 22 sampled residents' (Resident (R) 4) call light was present and functioning. This failure had the potential to restrict residents from calling for assistance while using the restroom. Findings include: Review of an undated, and untitled document, provided by the facility, indicated, The nurse call policy for [name of the facility] is to ensure resident can effectively communicate with staff for assistance. Here are the key points: 1. Resident Call System Requirements:. Toilet and bathing facilities: The call system must also be accessible from toilet .Functionality: The system must be fully operational at all times .with alternative communication methods in place if necessary." Review of R4's Admission Record, located under the Profile tab in the electronic medical record (EMR) indicated R4 was admitted to the facility on [DATE]. During an interview and observation on 10/08/24 at 10:20 AM, R4 stated she fell while in the bathroom over the weekend and could not call for help due to the facility taking the call light out of the bathroom to replace the call light in her bedroom. R4 stated her family was aware and had spoken with the facility about this. During the interview there was no call light observed next to her toilet in the bathroom. Review of R4's quarterly "Minimum Data Set (MDS) with an assessment reference date (ARD) of 08/25/24 and located under the MDS tab in the EMR revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R4 was cognitively intact. Further review indicated R4 did not have any impairments in her extremities and that the resident was independent for personal hygiene, meaning that she can use the bathroom without assistance. Observations on 10/09/24 at 2:00 PM and 10/10/24 at 8:30 AM revealed no call light was observed next to the toilet. During an interview on 10/10/24 at 10:20 AM, Licensed Practical Nurse (LPN) 3, confirmed R4's bathroom did not contain a call light. During an interview on 10/10/24 at 10:27 AM, the Maintenance Director stated she was aware of the missing call light last week; however, she was unable to repair the call light. The Maintenance Director stated an outside company had been contacted; however, the company had not been to the facility yet. The Maintenance Director stated she did not replace the call light with another one or gave R4 a way to call for assistance.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 25232 Based on record review and interview, the facility failed to ensure that five of five employee files reviewed had the required Quality Assurance and Performance Improvement (QAPI) training. This failure had the potential to have a negative impact on staff for their unawareness about how to bring concerns to QAPI and in return this could impact the 72 residents currently residing at the facility. Findings include: Review of Certified Nursing Assistant (CNA)1's personnel file indicated CNA1's Date of Hire (DOH) was 08/16/23 and there was no evidence of CNA1 receiving the required QAPI training. Review of CNA6's personnel file indicated CNA6's DOH was 08/10/23 and there was no evidence of CNA6 receiving the required QAPI training. Review of CNA7's personnel file indicated CNA7's DOH was 03/15/23 and there was no evidence of CNA7 receiving the required QAPI training. Review of Environmental Services (ES) personnel file indicated ES's DOH was 03/12/87 and there was no evidence of ES receiving the required QAPI training. Review of Nursing Supervisor's (NS) personnel file indicated NS's DOH was 09/18/02 and there was no evidence of NS receiving the required QAPI training. During an interview on 10/11/24 at 9:30 AM, the Director of Nursing (DON) confirmed that there was no QAPI training for the facility staff.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 25232 Based on record review, interview, and policy review, the facility failed to ensure three of five Certified Nursing Assistants (CNA)1, CNA6, and CNA7) completed the minimum of 12 hours of in-service training per year. The lack of in-service training could have a negative impact on all 72 residents currently residing at the facility by the staff not knowing how to care for the residents. Findings include: Review of the facility policy titled, In-Service/Employee Education, revised 06/12, indicated, It is the policy of [name of the facility] that all nursing employees receive, at a minimum, 12-hours in-service education yearly . All [name of the facility] employees are required to attend at least one block mandatory in-service yearly, covering state and federal requirement. Procedure: 2. All department directors are responsible for ensuring the continuing competency of the employees within that department .4. The mandatory block in-service will be offered monthly. 5. The mandatory block in-service will cover, at a minimum: Resident rights, abuse and neglect, infection control, body substance precautions, handwashing, fire safety and evacuation procedures, resident safety, emergency preparedness, corporate compliance, and health insurance portability and accountability act (HIPPA). 6. Annual nursing staff in-service will include, at a minimum: bowel and bladder retraining, restorative nursing, proper positioning, transfers, ambulation, range of motion, activities of daily living (ADL) training, care of persons with cognitive impairment or dementia, current special resident needs, and any other needs identified .13. All nursing employees must attend, at a minimum, 12-hours of in-service yearly, including the mandatory block in-services .15. All in-service hours will be tracked from anniversary date to anniversary date." Review of CNA1's personnel file indicated CNA1's Date of Hire (DOH) was 08/16/23 and there was no evidence of CNA1 receiving the required 12-hours of in-service training during the past year (August 2023-August 2024). Review of CNA6's personnel file indicated CNA6's DOH was 08/10/23 and there was no evidence of CNA6 receiving the required 12-hours of in-service training during the past year (August 2023-August 2024). Review of CNA7's personnel file indicated CNA7's was hired on 03/15/23 and there was no evidence of CNA7 receiving the required 12-hours of in-service training during the past year (March 2023-March 2024). During an interview on 10/11/24 at 9:30 AM, the Director of Nursing (DON) confirmed that the three CNA's personal files did not include documentation of 12-hours of in-service training for the past year.