STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265471	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buffalo Prairie Center for Rehab and Healthcare	631 West Main Street Buffalo, MO 65622

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences when they failed to have hydration accessible for one resident (Resident #20) out of 20 sampled residents. The facility census was 50. Review of the facility's policy titled Resident Hydration and Prevention of Dehydration, revised October 2011, showed the following information: -The facility will endeavor to provide adequate hydration and to prevent and treat dehydration; -Nurses' Aides will provide and encourage intake of bedside, snack, and meal fluids, on a daily and routine basis as a part of daily care. -If potential inadequate intake or signs and symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan. Activities of Daily Living (ADL) status, diagnosis, individual preferences, habits, and cognitive and medical status will be considered in all interventions. Physician will be informed; -Orders may be written for extra fluids to be encouraged between meals and/or with medication passes. A specific minimum amount should be included in the order; -Minimum fluid needs will be calculated and documented on initial, annual, and significant change assessments, using current standards of practice; -The dietician will assess all residents for hydration adequacy at least quarterly. 1. Review of the resident's current face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses included chronic kidney disease, dysuria (difficulty urinating), chronic obstructive pulmonary disease (COPD - a lung disease that damages the airways and air sacs in the lungs making it difficult to breathe), and heart failure. (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool filled out by facility staff), dated 07/26/24, showed the following information: -Resident rarely or never being understood; -Required supervision from staff during eating; -Required partial to moderate assistance from staff for dressing; -Resident dependent on staff for transfers; -No complications with swallowing; -Received a mechanically altered and therapeutic diet. Review of the resident's care plan, revised on 07/27/24, showed nectar/mildly thick consistency liquid provided in a two handled cup with a lid and spout for drinks. Review of the resident's Dietary Profile, dated 09/18/24, showed the resident was not on a fluid restriction and should be offered eight cups of nectar thick fluid per day via sippy cup. Observation on 09/30/24, at 9:40 A.M., showed the resident lay in bed on his/her back, water located on the resident's bed side table, in front of the bedroom window and out of the resident's reach. Observation on 09/30/24, at 11:01 A.M., showed the resident lay in bed on his/her back, water located on the resident's bed side table, in front of the bedroom window and out of the resident's reach. Observation on 10/01/24, at 9:01 A.M., showed the resident lay in bed on his/her right side facing the wall with no water located in the room. Observation on 10/02/24, at 10:29 A.M., showed the resident waved to surveyor to come in his/her room. The resident lay in bed on his/her right side facing the wall and no water was located in the room. Upon nearing the resident, the resident opened his/her mouth, observed to be visibly dry. The resident said thirsty. During an interview on 10/07/24, at 10:00 A.M., Certified Nursing Assistant (CNA) A said the following: -The CNA's go around to every resident and pass ice and water each shift; -All residents should have water accessible; -At one point the CNA's were told that the resident couldn't have water in his/her room because he/she has thickened liquids and there was a potential for choking, but after the facility met with the resident's family member, the aides should now ensure the resident has water accessible; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If he/she was to walk into the resident's room and see that the resident did not have water, the aide would go to the kitchen where the thickener is, and make the resident some water before delivering it to the resident's room. During an interview on 10/07/24, at 10:15 A.M., Registered Nurse (RN) C said the following: -All residents should have access to water in their rooms; -The CNA's are responsible to ensure that all residents have water accessible. They should complete this task during rounds, which happens every two hours; -The resident should be provided water in his/her room. The staff needed to thicken it and place it in a sippy cup, prior to giving it to the resident. During an interview on 10/07/24, at 1:47 P.M., at the Director of Nursing (DON) said the following: -The CNA's are responsible to ensure that all residents have water accessible. They should complete this task at rounds and per request; -There is thickener in the dinning room. All the aides have to do is thicken the resident's water and provide it to him/her; -All staff should make sure the resident's hydration is within reach and/or also offer the resident a drink during rounds, which is every two hours; -The resident can have water in his/her room, he/she is cognitively aware, and can drink independently. During an interview on 10/07/24, at 1:47 P.M., the Administrator said staff should make sure that all residents have access to water.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on interview and record review, the facility failed to administer the required Preadmission Screening and Resident Review (PASARR) Screening (Level 1) to identify residents with a mental disability (MD), intellectual disability (ID) or a related condition for one resident (Resident #30) prior to admission to the facility. The facility census was 50. Review of a facility policy titled Admission Criteria, dated December 2016, showed the following: -Nursing and medical needs of individuals with mental disorders will be determined by coordination with Medicaid PASARR program to the extent practicable; -Potential residents with mental disorders will only be admitted if the state mental health agency has determined (through the preadmission screening program) that the resident has a physical or mental condition that requires the level of service provided by the facility. 1. Review of Resident #30's face sheet (a document that gives a resident's information at a quick glance) showed the following information: -admitted [DATE]; -Diagnoses included major depressive disorder, bipolar disorder (a mental health condition that causes extreme mood swings), and psychosis (a mental disorder characterized by a disconnection from reality). Review of the resident's quarterly Minimum Data Sheet (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 08/21/24, showed the following information: -Resident cognitively intact; -Resident unable to complete a mental status interview; -Resident had delusions (misconceptions or beliefs that are firmly held, contrary to reality); -Resident taking antidepressant, antianxiety, and antipsychotic medication. Review of the resident's current care plan showed the following: -Resident had confusion, inattention, disorganized thinking, altered level of consciousness, and non-congruent mood and affect; -Resident had exhibited on more than one account socially inappropriate behavior such as undressing, placing objects in body, pounding on the wall, and yelling; -Staff should remind resident not to play with bed control buttons or wrap call light cord around neck; (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident used psychotropic and antidepressant medication. Review of an email from Central Office Medical Review Unit (COMRU), dated 10/01/24, showed a PASARR had not been completed for the resident. During interviews on 10/02/24, at 9:47 A.M., and on 10/03/24, at 10:08 A.M., the Social Services Designee (SSD) said the following: -He/she was responsible for completing the Level 1 PASARR; -He/she completed a PASARR if the hospital does not complete one prior to admission to facility. During an interview on 10/07/24, at 1:47 P.M., the Administrator said the SSD was responsible for completing the PASARR and he/she expected it to be 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to consistently assess and document complete, thorough, and accurate weekly skin and weekly wound tracking of all wounds for two residents (Resident #152 and Resident #6) and when staff failed to enter a wound treatment orders and document completion of the wound treatments for one resident (Resident #152). Both resident had pressure ulcers (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). A sample of three residents was reviewed. The facility census was 50. Review of the facility's policy titled Wound Prevention and Treatment Documentation', revised September 2024, showed the following: -Staff to chart weekly a wound assessment including measurements and description of the wound during rounds. This can be on the weekly wound observation tool inside the computer system or on a paper assessment form. This description should match physicians or wound consultant team notes. Consultant notes alone do not support facility wound monitoring requirements; -Staff to make weekly wound progress note for each resident with wounds. Unless the following items have been documented on the assessment form include wound status, wound treatments that are ordered, if resident is having pain and what treatment for pain is, what nutritional and equipment interventions are in place, and that you notified the resident representative and physician and changed the treatment if the wound has declined; -Create, or review and revise, the wound plan of care weekly; -Log each wound onto the wound report weekly, or utilize the assessment reports in the computer system, adding if admitted or acquired and what type of wound it has been classified as per wound consultant; -Distribute log weekly to other interdisciplinary team members including registered dietician, pharmacy, care plan coordinator, therapy, Administrator, Director of Nursing (DON) and regional nurse; -There must be a system for nurses and direct care staff to report and document new possible skin issues. Assign nurses to complete a weekly skin check and document it. If there is a wound care nurse, it is in his/her job description to assist with monitoring them and the bathing sheets for any new areas of skin breakdown. Staff may utilize bath sheet, computer charting, stop and watch, or report sheets. Staff to make sure that whichever system is used there is documented notification and follow through of any changes including pain or other signs and symptoms of infection or non-healing issues; -If a new skin issue is noted, the charge nurse informs physicians, gets treatment order written and added to administration record, and if a new wound is developing a report in risk management should be filled out for investigation into the cause to prevent reoccurrence for individual and like residents; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pressure, venous (wound on the leg or ankle), arterial (deep wound on the skin of the lower leg or foot that does not heal normally due to poor blood flow), diabetic (group of diseases that result in too much sugar in the blood), surgical, [NAME] (a dark sore that develops rapidly on the skin of a patient who is near the end of life) and COVID (coronavirus disease 2019-an infectious disease) wounds are monitored weekly and as needed by the DON or designee in collaboration with hospice teams, wound consultant teams, or both; -All residents upon admission, quarterly, or significant change, should have an assessment completed to identify risks for skin breakdown, preventative interventions and equipment should be care planned and put into place to prevent that breakdown from occurring. 1. Review of Resident #152's face sheet (admission data) showed the following: -admitted [DATE]; -Pressure ulcer of the right buttock; -Pressure ulcer of the left buttock; -Cutaneous (affecting the skin) abscess (a confined pocket of pus that collects in tissues, organs or spaces inside the body) of buttock; -Alzheimer's disease. Review of there resident's Braden Scale for Predicting Pressure Ulcer Risk, completed by facility staff, dated 09/06/24, at 3:52 P.M., showed a staff assessed the resident as high risk for pressure ulcer development. Review of the facility's weekly wound tracking document, dated 09/06/24, showed the following: -The resident's left buttock wound measured 1.8 centimeter (cm) long by 0.6 cm wide by 0.1 cm in depth. The resident's wound status was improved. The treatment of calcium alginate (a non-adhesive non-woven wound dressing made from alginate, a natural polymer derived from brown seaweed) and border dressing was in place. Intervention of repositioning in place; -The resident's right buttock wound measured 0.8 cm long by 0.5 cm wide by 0.1 cm in depth. The resident's wound status was improved. Treatment of calcium alginate and border dressing was in place. Intervention of repositioning was in place. Review of the resident's nursing admission screening/history dated 09/06/24, at 2:30 P.M., showed a nurse documented the following: -Resident noted to have a cyst lanced on his/her right buttock; -Right buttock measured 1.4 cm long by 1.2 cm wide by 0.1 in depth, stage 2 pressure ulcer (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer); -Left buttock measured 2.2 cm long by 1.4 cm wide by 0.1 cm in depth, stage 2 pressure ulcer; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Will cover with foam border. Review of the resident's skilled evaluation dated 09/06/24, at 8:22 P.M., showed a nurse documented the resident's skin warm and dry with skin color within normal limits (WNL). The resident's turgor (the skin's elasticity) was normal. Review of the resident's skilled evaluation dated 09/07/24, at 9:47 P.M., showed a nurse documented the resident's skin warm and dry with skin color WNL. The resident's turgor was normal. Review of the resident's baseline care plan, dated 09/08/24, showed the following: -Resident had current skin integrity issues; -Resident had Stage 2 pressure ulcer to his/her bilateral buttock. Review of the resident's skilled evaluation dated 09/08/24, at 3:39 P.M. showed the DON documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue on left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound); -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/08/24, at 11:06 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue on left buttock measured 2 cm long by 2 cm wide and zero cm in depth; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's weekly observation tool dated 09/09/24, at 10:40 A.M., showed a nurse documented the following: -The resident admitted with stage 2 pressure ulcer to his/her right buttocks acquired on 09/06/24; -Epithelial (the thin tissue forming the outer layer of a body's surface) tissue present; -Small amount of serosanguinous (containing blood); -No odor present; -Measurements included 10 millimeters (mm) long by 7 mm wide by 1 mm in depth. The area was dry and intact; -Cleanse with wound cleanser, apply calcium alginate, and cover with border dressing three times weekly or as needed (PRN) for soiled dressing. Review of the resident's weekly observation tool dated 09/09/24, at 10:41 A.M., showed a nurse documented the following: -The resident admitted with a stage 2 pressure ulcer to his/her left buttocks; -Epithelial tissue present; -Small amount of serosanguinous; -No odor present; -Measurements include 20 mm long by 10 mm wide by 1 mm in depth. The area is dry and intact; -Cleanse with wound cleanser, apply calcium alginate, cover with border dressing three times weekly or PRN for soiled dressing. Review of the facility's weekly wound tracking document, dated 09/09/24, showed the following: -The resident's left buttock wound date of origination on 09/06/24 and measured 2.0 cm long by 1.0 cm wide by 0.1 cm in depth. A new treatment of calcium alginate border dressing ordered in place. Intervention of repositioning in place; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's right buttock date of origination on 09/06/24 and measured 1.0 cm long by 0.7 cm wide by 0.1 cm in depth. New treatment of calcium alginate border dressing ordered in place. Intervention of repositioning in place. Review of the resident's September 2024 Physician's Order Sheet (POS) and September 2024 Treatment Administration Record (TAR) showed staff did not document the orders referred to on the weekly tracking document. Review of the resident's skilled evaluation dated 09/09/24, at 3:18 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: No change. Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/09/24, at 11:08 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/10/24, at 9:50 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/10/24, at 11:11 P.M., showed Registered Nurse (RN) C documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: No change. Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skin observation tool dated 09/11/24, at 5:27 A.M., showed a nurse documented the following: -The resident had right and left buttock pressure ulcer; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident has pressure ulcers to bilateral buttocks. All treated three times weekly. Staff will continue to monitor. Review of the resident's skilled evaluation dated 09/11/24, at 5:00 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/11/24, at 9:38 P.M., showed the DON documented the following: -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/12/24, at 9:28 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin issue on left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/13/24, at 3:51 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Changed. Left buttock measured 1 cm long by 1 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/13/24, at 9:16 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery, and clear drainage; -No odor present; (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/14/24, at 2:06 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: No change. Left buttock measured 1 cm long by 1 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/14/24, at 10:14 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: No change. Left buttock measured 1 cm long by 1 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) (continued on next page)

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	265471	A. Building B. Wing	10/07/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's skilled evaluation dated 09/15/24, at 11:27 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/16/24, at 2:52 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/16/24, at 10:38 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the facility's wound tracking document, dated 09/16/24, showed staff documented the following: -The resident's left buttock wound measured 1.8 cm long by 0.6 cm wide by 0.1 in depth. The stage two pressure ulcer showed improved status. Treatment of calcium alginate with border dressing and intervention of re-positioning in place. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's September 2024 POS and September 2024 TAR showed staff did not document the treatment orders referred to on the weekly tracking document. Review of the resident's skilled evaluation dated 09/17/24, at 2:36 P.M., showed a RN C documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's skilled evaluation dated 09/17/24, at 11:02 P.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/18/24, at 11:10 A.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skin observation tool dated 09/18/24, at 4:01 P.M., showed a nurse documented the following: -The resident had right and left buttock pressure ulcer; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident has pressure ulcers to bilateral buttocks. All treated three times weekly. Staff will continue to monitor. Review of the resident's September 2024 POS and September 2024 TAR showed staff did not document the orders referred to on the skin observation tool. Review of the resident's skilled evaluation dated 09/19/24, at 12:13 A.M., showed a nurse documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) Review of the resident's skilled evaluation dated 09/19/24, at 9:18 A.M., showed RN C documented the following: -Skin warm and dry; -Skin color WNL; -Skin turgor normal; -Skin issue: Left buttock measured 2 cm long by 2 cm wide and zero cm in depth; -Thin, watery and clear drainage; -No odor present; -No tunneling; -Stage 2 pressure ulcer. (Staff did not document regarding pressure ulcer on the right buttock.) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's discharge summary dated 09/19/24, at 2:38 P.M., showed a nurse documented the resident discharged to the hospital. Review of the resident's admission MDS, dated [DATE]. showed the following: -Severely impaired cognitive skills; -Resident had a stage one or greater pressure ulcer; -At risk for development of pressure ulcers; -One or more unhealed pressure ulcers at stage one or higher; -Two stage 2 pressure ulcers. Two stage 2 pressure ulcers were present upon admission. Review of the resident's September 2024 POS and September 2024 TAR showed staff did not document treatment orders for the wound noted on the resident's admission MDS. Observation on 10/02/24, at 10:30 A.M., showed the resident in his/her bed. Staff provided incontinent care of loose liquid stool on the resident. The resident had one red circular dime size area located on his/her inner right buttock and one dime size area located on his/her inner left buttock. The areas did not appear to drain with no signs of infection. The areas were red and did not appear to be abscess. The resident's buttocks appeared excoriated (abrasion of the skin's surface). Review of the resident's care plan, dated 10/02/24, showed the following: -The resident was at risk for impaired skin integrity related to incontinence and requiring assistance with mobility; -The resident had an open area to his/her right buttocks that he/she had upon readmission; -Staff to apply barrier cream as ordered; -Staff to assist with repositioning to prevent skin breakdown; -Complete weekly skin assessment per schedule. Review of the resident's October 2024 TAR showed an order, dated 10/02/24, for staff to cleanse the left buttock with wound cleanser, apply calcium alginate to wound bed, and cover with island dressing. Staff to change daily and PRN for soilage. (This was the first document wound care order (27 days after admission).) During an interview on 10/02/24, at 1:50 P.M., the DON said the following: -The resident had a little slit on his/her buttock when he was admitted to the facility on [DATE]; -On 09/09/24 the wound nurse completed a weekly wound assessment; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The former wound nurse should have entered wound treatment orders in the computer which would have showed up on the TAR; -She did not see any treatment orders for the resident's pressure ulcers in the computer; -Nurses should have entered a temporary order to cover the resident's area with abdominal gauze pads (ABD) used to absorb discharge or wet to dry (a type of wound dressing); -The 09/09/24, wound assessment showed for staff to use wound cleanser calcium alginate and staff should had entered the treatment in the computer and on the TAR in order for the nurses to treat and document; -The former wound nurse completed the wound care and did not enter the orders in the computer system. During an interview on 10/03/24, at 9:54 A.M., Certified Medication Technician (CMT) I said the following: -The resident's bottom looked better since readmission from the hospital; -The resident had a small opening on his bottom when admitted to the facility on [DATE] which had a dressing on it and it was closed. During an interview on 10/03/24, at 10:05 A.M., Certified Nurse Aide (CNA) J said the following: -He/she did not know for sure if the resident had any areas upon admission. He/she saw his/her skin a few days before the 09/19/24 discharge to the hospital and he/she did not have any areas on his/her bottom; -The resident had an ulcer spot on the inside of his/her left buttock by his/her rectum which drained; -The resident's bottom was red, but not open. When he/she came back from the hospital (09/27/24), the resident had an ulcer spot on inside of his/her left buttock up by his/her rectum, but the area cleared up. During an interview on 10/03/24, at 10:27 A.M., RN C said the following: -The resident's order for calcium alginate and ABD pad should be entered in the computer and on the TAR. -The resident's 09/09/24 weekly wound assessment showed for staff to cleanse the resident's wound with wound cleanser, apply calcium alginate, and cover with a border dressing three times weekly; -He/she did not see the order on the resident's TAR until 10/02/24; -He/she did not know anything about the resident's wound treatment. Today was the first time he/she saw the treatment order; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she was not aware of the resident's sore; -He/she did not do any treatments on the resident while a charge nurse. During interviews on 10/02/24, at 1:50 P.M., on 10/03/24, at 2:31 P.M. and 3:10 P.M., and on 10/04/26, at 9:26 A.M., the DON said the following: -The former wound nurse received a verbal order from the physician for the resident's wound treatment; -The former wound nurse should have entered the wound treatment; -She knew the resident had bandages on him/her which she saw when she assisted staff with his/her care one time; -The resident's pressure ulcer was almost healed before his/her 09/19/24 discharge to the hospital; -The resident's area on the inside of his/her left buttock was worse when readmitted to the facility on [DATE]. She did not see the area until yesterday (10/02/24); -Staff treated it like it was a pressure area; -The resident did not have treatment orders entered in the computer when he/she was readmitted from the hospital on 09/27/24; -The 09/27/24 admission assessment says right buttock but it is wrong, the wound is on the left buttock; -Staff did not complete the wound measurements on the 09/11/24 and 09/18/24 wound assessment; -The resident was admitted on a Friday evening on 09/06/24 which the charge nurse assessed; -The wound nurse did not assess the resident's skin until 09/09/24; -The wound nurse completed the resident's treatment every Monday, Wednesday and Friday and did not document the treatment or enter the orders in the computer. -Upon admission, the charge nurse should conduct a skin assessment on the first day or the first 24 hours; -The nurse should contact the physician to obtain treatment orders for any skin issues if not on hospital orders. 50185 2. Review of Resident #6's face sheet showed the following information: -admitted [DATE]; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses included type two diabetes, low blood pressure, peripheral vascular disease (PVD- a circulatory condition in which narrowed blood vessels reduce blood flow to limbs), and heart failure. Review of the resident's annual MDS, dated [DATE], showed the following information: -At risk for developing pressure ulcers; -Has stage one or greater pressure ulcer; -Two stage 2 pressure ulcers present at admission. Review of the resident's care plan, last revised on 08/15/24, showed the following information: -Complete Braden scale upon admission; -Complete weekly skin assessment per schedule; -Notify physician of any new skin impairment and implement treatment orders; -Order from physician to cleanse wound to left gluteal (buttock) fold, apply collagen powder (used to promote wound healing) to wound bed, cover with sacral (tailbone) border dressing as needed and daily on Monday, Wednesday, and Friday; -Order from physician to cleanse wound to left posterior (back of) thigh, apply calcium alginate to wound bed, cover with optifoam (a brand of foam dressings used to treat wounds), secure with border dressing three times a week, on Monday Wednesday and Friday, and as needed; -Provide wound care as ordered and monitor for signs and symptoms of infection and worsening of wounds. Review of the resident's skilled evaluation, dated 09/03/24, showed the following information: -Skin warm and dry, skin color is within normal limits, and turgor normal; -Skin issue #001 was pressure ulcer/injury of left posterior thigh. Wound length 5 cm, width 2.6 cm, and depth 0.1 cm. Epithelial tissue with serous (clear to yellow) drainage. Peri-wound (skin surrounding a wound) was fragile. Dressing saturation minimal at 25 percent, no odor, tunneling or undermining (edges of wound separate from healthy tissue, creating a pocket or dead space under the wound). Treatment was three times a week. Pressure ulcer staging was stage 2- partial thickness loss and painful; -Skin issue #002 was pressure ulcer/injury of left buttock. Wound length 7 cm, width: 2.5 cm, and depth: 0.1 cm. Granulation tissue with serous drainage. Peri-wound: fragile with dressing saturation minimal at 25 percent, no odor, tunneling or undermining. Treatment three times a week. Pressure ulcer staging of stage 2, painful, skin tissue mushy; (Staff did not document regarding left gluteal fold wound.) (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Wound-Weekly Observation Tool, dated 09/03/24, showed the following information: -Left gluteal fold wound acquired on 07/02/24; -Wound is pressure in type and Stage 2; -Epithelial and granulation (pink-red moist tissue that fills an open wound, when it starts to heal) tissue present with serosanguinous drainage, no odor, 2 cm x 1.6 cm x 0.1 cm; -Cleanse area with wound cleanser, apply collagen powder to wound bed, cover with border dressing and as needed for soiled dressing; -Wound is improving. (Staff did not document regarding the resident's wounds on left thigh or left buttock.) Review of the resident's September 2024 POS showed the following orders: -An order for wound care of left gluteal fold. Staff to cleanse area with wound cleanser, apply collagen powder to wound bed, and cover with sacral dressing every Monday, Wednesday, and Friday, and as needed. The order was discontinued on 09/09/24; -An order, dated 09/09/24, for wound care clinic to evaluate and treat. Review of the resident's Skin Observation Tool, dated 09/13/24, no new areas of concern. Resident reports no pain related to skin issues. Resident continued to have wound care to left gluteal fold and right upper thigh three times a week. No new issues noted, Will continue to monitor. Review of the wound care clinic's assessment, dated 09/19/24, showed the following information: -Moderate risk for pressure ulcers; -Wound to left gluteal fold, stage three pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed), 35 percent granulation tissue, 10 percent slough (non-viable yellow, tan, grey, green, or brown tissue, usually moist), 15 percent epithelial, 15 percent scab, and 25 percent skin with moderate serosanguinous exudate. Measurements included length 6.7 cm x width 7. 7 cm; -Recommended treatment to cleanse wound with hypochlorous acid (used to prevent/treat infection), apply collagen pad, cover with bordered gauze, change every other day, and as needed for soiling. Review of the resident's Skin Observation Tool, dated 09/20/24, showed no new areas of concern. Resident reported no pain related to skin issues. Resident continued to have wound care to left gluteal fold and right upper thigh three times a week. No new issues noted. Staff will continue to monitor. Review of wound care clinic's assessment, dated 09/26/24, showed the following information: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Wound had deteriorated and was larger this week with more open areas; -Wound of left gluteal fold, stage three pressure ulcer, 35 percent granulation tissue, 15 percent epithelial, 15 percent scab, and 35 percent skin with moderate serosanguinous exudate. Measurements included 10 cm x 10.6 cm; -Recommended treatment to cleanse wound with hypochlorous acid, apply calcium alginate to wound base, cover with super absorbent dressing, change dressing daily and as needed for soiling. Review of the resident's September 2024 POS showed the following orders: -An order, dated 09/26/24, for wound care of left posterior thigh to be cleanse area with wound cleanser, apply calcium AG to wound bed, cover with border foam three times a week on Monday, Wednesday, and Friday, and as needed; -An order for wound care of right gluteal fold to included cleanse area with wound cleanser, apply calcium AG to wound bed, and cover with optifoam three times a week and as needed (Staff did not document order for wound care of left buttock wound, weekly wound observations, or skin assessments.) Review of the residents Skin Observation Tool, dated 09/27/24, showed no new areas of concern Resident reported no pain related to skin issues. Resident continued to have wound care to left gluteal fold and right upper thigh three times a week. No new issues noted. Staff will continue to monitor. Review of the resident's October 2024 POS showed the following orders: -An order, dated 09/09/24, for wound care clinic to evaluate and treat. -An order, dated 09/26/24, for wound care of right gluteal fold to cleanse area with wound cleanser, apply calcium AG to wound bed, cover with optifoam, and secure with border dressing three times a week and as needed; -An order, dated 09/26/24, for wound care of left posterior thigh to b

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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** 49585 Based on observation, interview, and record review, the facility failed to provide respiratory care per standards of practice when staff failed to ensure staff changed oxygen equipment per professional standards for two residents (Resident #46 and #36) and failed to accurately document oxygen orders and care plan the use of oxygen for one resident (Resident # 36) out of a sample of 20 residents selected for review. The facility had a census of 50. Review showed the facility did not provide a policy regarding oxygen administration. 1. Review of Resident #46's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), heart disease (condition where the heart does not pump blood as well as it should), and chronic kidney disease (disease that causes progressive damage and loss of function to the kidneys). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/22/24, showed the following: -Cognitively intact; -Set up and clean up assistance with eating, toileting, and oral hygiene; -Partial to moderate assistance with dressing, showering, bed mobility, and transfers; -Uses wheelchair for mobility. Review of the resident's care plan, revised on 08/18/24, showed the following: -Required staff supervision for transfers, toileting, dressing, and hygiene; -Required oxygen at 3 liters via nasal cannula continuously to maintain oxygen saturation above 90%. Review of the resident's September 2024 Physician Order Sheet (POS) showed the following: -An order, dated 06/12/24, to change oxygen humidifier weekly every Monday for oxygen dependence; -An order, dated 06/12/24, to change and date oxygen tubing and storage bag weekly on Monday nights for oxygen dependence; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 06/12/24, for oxygen at 3 liters via nasal cannula to maintain oxygen saturation above 90%. Review of the resident's September 2024 Medication Administration Record (MAR) showed staff documented oxygen tubing and humidifier changed as ordered on 09/02/24, 09/09/24, 09/16/24, 09/23/24, and 09/30/24. Observation on 09/30/24, at 3:20 P.M., of resident's room showed an oxygen concentrator with an undated nasal cannula attached. The oxygen humidifier and tubing attached to the concentrator were each dated 09/16/24. A portable oxygen tank with nasal cannula attached had an illegible date written on a sticker attached to the tubing. Observation on 10/02/24, at 9:25 A.M. of the resident's room showed an oxygen concentrator with an undated nasal cannula attached. The oxygen humidifier and tubing attached to the concentrator were each dated 09/16/24. 2. Review of the resident #36's face sheet showed the following: -admitted [DATE]; -Diagnoses included COPD and interstitial pulmonary disease (lung disease which causes progressive scarring of the lung tissue). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -On oxygen therapy; -Set up and clean up assistance with eating, oral hygiene, and showering; -Independent with dressing, mobility, and transfers; Review of the resident's care plan, revised on 08/18/24, showed staff did not care plan the resident's oxygen use. Review of the resident's September 2024 POS showed the following: -An order, dated 07/07/24, to change oxygen humidifier weekly on Mondays; -An order, dated 07/07/24, to change and date oxygen tubing and storage bag weekly on Monday nights; -An order, dated 07/07/24, for oxygen at 3 Liters via nasal cannula to maintain oxygen saturation above 90%. Review of the resident's September 2024 MAR showed the following: (continued on next page)

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Buffalo Prairie Center for Rehab and Healthcare	631 West Main Street Buffalo, MO 65622

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff documented oxygen tubing and storage bag changed as ordered on 09/02/24, 09/09/24, 09/16/24, 09/23/24, and 09/30/24; -No order to change the humidifier or oxygen 3 Liters via nasal cannula indicated. Observation on 09/30/24, at 2:38 P.M., of the resident's room showed an oxygen concentrator with an undated nasal cannula attached. The oxygen humidifier and tubing attached to the concentrator were each dated 09/16/24. A portable oxygen tank with nasal cannula attached had a date of 09/16/24 written on a sticker attached to the tubing. Observation on 10/02/24, at 9:28 A.M. of the resident's room showed no date on the nasal cannula tubing attached to concentrator. The oxygen humidifier bottle and tubing attached to concentrator each labeled with a sticker dated 09/16/24. Observation on 10/03/24, at 10:26 A.M., of the resident's room showed no date on nasal cannula tubing attached to concentrator. The oxygen humidifier bottle and tubing attached to concentrator each labeled with a sticker dated 09/16/24. The nasal cannula attached to portable oxygen tank in room labeled with a sticker dated 09/16/24. 3. During an interview on 10/03/24, at 9:30 A.M., Certified Medication Technician (CMT) E said the following: -Certified nurse aides (CNA) change oxygen tubing at night; -Tubing should have a piece of tape with a date attached and be changed once a week at night. 4. During an interview on 10/03/24, at 11:08 A.M., Registered Nurse (RN) C said oxygen tubing change was scheduled on night shift. He/she was unaware of when and how scheduled as he/she does not work that shift. 5. During an interview on 10/04/24, at 10:15 A.M., CNA F said the following: -Nurses were responsible for oxygen tubing; -CNA's obtain new oxygen tanks when needed and turn them on; -CNA's adjust the oxygen flow level on resident's tank and concentrators, but confirm with the nurse before changing liter flow. 6. During an interview on 10/04/24, at 10:26 A.M., Licensed Practical Nurse (LPN) D said the following: -Nurses are responsible for everything related to oxygen; -Oxygen tubing should be changed once a week. 7. During an interview on 10/04/24, at 10:58 A.M., CNA G said the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNAs will change oxygen tubing on night shift occasionally; -He/she will ask the nurse what the oxygen flow rate should be and adjust it accordingly. 8. During an interview on 10/04/24, at 12:02 P.M., the Director of Nursing (DON) said the following: -Oxygen tubing is changed weekly on Monday overnight shift; -Nurse and aides are responsible for tubing change; -List at nurse station for all residents currently on oxygen; -Oxygen should be listed on the care plan; -CNA's should put tubing on resident only and not adjust liters on equipment. 9. During an interview on 10/07/24, at 1:47 P.M., the Administrator said he/she expected nurses to change the oxygen tubing as ordered.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to provide effective pain management for all residents when staff failed to administer pain medications as ordered for two residents (Resident #252 and #36) and when staff failed to document an order for pain medication for one resident (Resident #36). A sample of 20 residents was reviewed in the facility with a census of 50. Review of the facility's policy titled Pain Assessment and Management, revised in March 2015, showed the following information: -Pain management was defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals; -Pain management is a multidisciplinary care process that includes, assessing the potential for pain, effectively recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying cause of pain, developing and implementing approaches to pain management, identifying and using specific strategies for different levels of pain, monitoring for effectiveness of interventions, and modifying approaches as necessary; -Assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain; -Observe the resident during rest and movement for physiologic and non-verbal signs of pain; -Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognition level; -The physician and staff will establish a treatment regimen based on consideration of the resident's medical condition, current medication regimen, the nature, severity, and cause of pain, the course of illness, and treatment goals; -Implement the medication regimen as ordered, carefully documenting the results of the interventions; -Reassess the resident's pain and consequences of pain at least each shift; -If pain has not been adequately controlled the multidisciplinary team shall reconsider approaches and make adjustments as indicated. -Document the resident's reported level of pain with adequate detail as necessary and in accordance with the pain management program; -Report any significant changes, adverse effects, or prolonged unrelieved pain despite care plan interventions, to the physician. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident #252's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses included displaced fracture of posterior wall of right acetabulum (a break in the back portion of the hip socket), posterior dislocation (out of place in the back portion) of right hip, multiple rib fractures, and high blood pressure. Review of the resident's care plan, dated 10/01/24, showed the following information: -Administer analgesic (pain killing) medications as ordered by physician; -Attempt non-pharmacological interventions prior to giving as needed medications; -Document and report adverse reactions to analgesic therapy; -Pain assessment to be completed upon admission, quarterly, and as needed with changes. Review of the resident's September 2024 Physician's Order Sheet (POS) showed the following orders: -An order, dated 09/21/24, for pain assessment check and record every shift; -An order, dated 09/21/24, for morphine sulfate (used to treat moderate to severe pain) 15 milligrams (mg) tablet, give one tablet by mouth every six hours as needed (PRN) for pain. The order was discontinued on 09/24/24; -An order, dated 09/24/24, for morphine sulfate 15 mg tablet, give one tablet by mouth four times a day for pain management; -An order, dated 09/24/24, for Percocet (used to treat moderate to severe pain) 5-325 mg tablet, give two tablets by mouth four times a day for pain. Use Percocet in place of morphine 15 mg and discontinue when morphine arrives from pharmacy. Order end date of 09/28/24. Review of the resident's September 2024 Medication Administration Record (MAR) showed scheduled morphine sulfate 15 mg tablet was not administered on 09/24/24, at 1:00 P.M., with the reason awaiting from pharmacy noted. Review of the resident's pain assessments, located in the Medication Administration Record (MAR), dated 09/25/24, showed a pain level of a three out of ten documented on the 6:00 P.M. to 6:00 A.M. shift. Review of the resident's September 2024 MAR showed the scheduled morphine sulfate 15 mg tablet was not administered on 09/25/24, at 5:00 P.M. and 8:00 P.M., with the reason awaiting from pharmacy noted. Staff did not administer the Percocet 5-325 mg due to reason of awaiting from pharmacy noted. Review of the resident's pain assessments, located in the MAR, dated 09/26/24, showed the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pain level of a four out of ten documented on the 6:00 A.M. to 6:00 P.M. shift; -Pain level of a five out of ten documented on the 6:00 P.M. to 6:00 A.M. shift. Review of the resident's September 2024 MAR showed the Percocet 5-325 mg was administered on 09/26/24, at 8:00 A.M., 1:00 P.M., and 5:00 P.M. Review of the resident's September 2024 MAR showed the scheduled morphine sulfate 15 mg tablet was not administered on 09/26/24 through 09/27/24, at 8:00 A.M., 1:00 P.M., 5:00 P.M., and 8:00 P.M. with the reason awaiting from pharmacy noted. Staff did not administer the Percocet 5-325 mg on 09/27/24, due to reason of awaiting from pharmacy noted. Review of the resident's pain assessments, located in the MAR, dated 09/27/24, showed pain level of a five out of ten documented on the 6:00 A.M. to 6:00 P.M. shift. Review of the resident's pain assessments, located in the MAR, dated 09/28/24, showed a pain level of five out of ten on the 6:00 P.M. to 6:00 A.M. shift. Review of the resident's September 2024 MAR showed the scheduled morphine sulfate 15 mg tablet was not administered on 09/28/24, at 8:00 A.M., with the reason awaiting from pharmacy noted. Staff did not administer the Percocet 5-325 mg due to reason of awaiting from pharmacy noted. Review of the resident's pain assessments, located in the MAR, dated 09/29/24, showed a pain level of five out of ten on the 6:00 A.M. to 6:00 P.M. shift. During interviews on 10/01/24, at 9:24 A.M. and 12:10 P.M., the resident said he/she was often in pain due to his/her right hip being broken and having multiple rib fractures. He/she did not receive ordered pain medication for several days after admitting to the facility, despite asking for it. The staff told him/her the reason they were unable to administer the pain medication was because the pharmacy was located far away from the facility, and it takes days for medications to arrive. He/she asked the staff if there was anything else they could do, to which he/she said the staff said no. The staff did not offer him/her any other pain medication other than Tylenol, which does not touch the pain. Review of the resident's October 2024 POS showed an order, dated 10/01/24, for morphine sulfate 15 mg tablet, give one tablet by mouth four times a day for pain management. Review of the resident's pain assessments, located in the MAR, dated 10/01/24, showed a pain level four out of ten on the 6:00 A.M. to 6:00 P.M., shift. Review of the resident's October 2024 MAR showed the morphine sulfate 15 mg not administered on 10/01/24, at 5:00 P.M. Review of the resident's pain assessments, located in the MAR, dated 10/02/24, showed a pain level of four out of ten on the 6:00 A.M. to 6:00 P.M. shift. Review of the resident's pain assessments, located in the MAR, dated 10/03/24, showed a pain level of four out of ten on the 6:00 P.M. to 6:00 A.M. shift. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's October 2024 MAR showed morphine sulfate 15 mg not administered on 10/03/24, at 8:00 P.M. During an interview on 10/07/24, at 10:15 A.M., Registered Nurse (RN) C said he/she could not recall any instances where the resident complained of pain and he/she wasn't able to administer his/her medication. During an interview on 10/07/24, at 1:47 P.M., the Director of Nursing (DON) said she believes this resident's case is an error of documentation. 2. Review of Resident #36's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), prostate cancer, and interstitial pulmonary disease (lung disease which causes progressive scarring of the lung tissue). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/19/24, showed the following: -Cognitively intact; -Resident had routine and as needed pain medication; -Had frequent pain that interfered with day-to-day activities. Review of the resident's care plan, revised on 07/16/24, showed the following: -Resident at risk for pain; -Administer analgesic medications as ordered by doctor; -Attempt non-pharmacological interventions prior to giving as needed medications; -Document and report adverse reactions to analgesic therapy. Review of resident's September 2024 POS showed the following: -An order, dated 07/06/24, for Tylenol 650 mg tablet, give 1300 mg two times daily for prostate cancer; -An order, dated 07/13/24, for ibuprofen (pain medication) 200 mg tablet, give 400 mg every six hours as needed for pain; -An order for oxycodone (opioid pain medication) 10 mg, give one tablet every six hours as needed for pain that was discontinued 09/17/24; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 09/17/24, for oxycodone 15 mg tablet, give one tablet every six hours as needed for pain. Review of resident's September 2024 MAR showed the ordered Tylenol was not administered at the following dates and times due to medication not available: -On 09/02/24 at 4:00 P.M.; -On 09/03/24 at 7:30 A.M. and 4:00 P.M.; -On 09/04/24 at 4:00 P.M.; -On 09/12/24 at 7:30 A.M. and 4:00 P.M.; -On 09/13/24 at 7:30 A.M. and 4:00 P.M.; -On 09/17/24 at 7:30 A.M.; -On 09/18/24 at 7:30 A.M. and 4:00 P.M.; -On 09/25/24 at 4:00 P.M.; -On 09/26/24 at 7:30 A.M. and 4:00 P.M. Review of resident's progress notes, dated 09/26/24, showed staff administered a half tablet of oxycodone (7. 5 mg instead of the ordered 15 mg) as the medication was not in stock and unavailable in the emergency kit. Nurse will follow up with pharmacy. Review of resident's September 2024 MAR showed the ordered Tylenol was not administered at the following dates and times due to medication not on 09/27/24 at 7:30 A.M. Review of resident's progress notes showed the following: -On 09/27/24 to 09/29/24 at 3:11 P.M., resident on leave of absence from facility. -On 09/29/24, at 3:11 P.M., resident returned from leave of absence with family. Resident requested pain medication as he/she walked in the door. -On 09/29/24, at 3:29 P.M., resident requested oxycodone, however facility did not have the medication in stock or in the emergency kit. Staff contacted physician who ordered hydrocodone (opioid pain medication) 10/325 mg as a substitute for the oxycodone. Staff notified pharmacy of all outages at this time. Review of the resident's September 2024 physician orders showed no order entered for hydrocodone 10/325 mg. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's September 2024 MAR showed no order for the hydrocodone 10/325 mg entered, no pain medication administered on 09/29/24 or 09/30/24, and resident pain scale not assessed on 09/29/24. Resident pain scale on 09/30/24, indicated pain level of 6 on a scale of 0 to 10 in the morning and a pain level of 3 in in the evening. During interviews on 09/30/24, at 2:44 P.M., and on 10/02/24, at 10:12 A.M., the resident said the following: -He/she had been in pain since yesterday; -He/she went on a leave to visit family on Friday and the nurse told him no pain medications were available to send with resident over the weekend visit; -He/she requested a pain pill upon return to facility on Monday and the nurse said oxycodone had not been delivered, but obtained a substitute order from the physician at that time; -He/she received only one pain pill since his return to the facility at 3:00 P.M. yesterday; -The substitution order from the physician did not relieve his/her pain; -His/her pain level was 9.5 to 10 on a scale of 0 to 10 at the time of the interview; -He/she requested a pain pill before lunch today and the nurse advised there are no pain pills to administer. During an interview on 09/30/24, at 3:00 P.M., RN C said the facility had difficulty obtaining medications through the pharmacy due to physician is not signing the prescription. The nurse on duty last night called to get a substitute pain medication as the oxycodone is not available. Review of the resident's October 2024 MAR showed no order listed for hydrocodone 10/325 mg. Review of resident October Physician Order Sheet (POS) showed the following: -An order, dated 07/06/24, for Tylenol 650 mg tablet, give 1300 mg two times daily for prostate cancer; -An order, dated 07/13/24, for ibuprofen 200 mg tablet, give 400 mg every six hours as needed for pain; -An order, dated 09/17/24, for oxycodone 15 mg tablet, give one tablet every six hours as needed for pain; -No order for hydrocodone 10/325 mg. Review of a progress note dated 10/01/24, at 8:55 A.M., showed oxycodone documented as administered, but per the physician, hydrocodone 10/325 mg substituted from the emergency kit until medication is received from the pharmacy. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/03/24, at 3:28 P.M., Certified Medication Tech (CMT) B said the following: -Staff document yes or no in the MAR of medication administration; -He/she clicks no and hold/progress note and documents in the progress note if a medication is not available; -He/she checks if the medication is ordered and hits the reorder button if need to order a medication; -Nurses administer the pain pills to residents; -The nurses can only administer the narcotics to the residents and pulls it from the emergency kit as long as available and it was empty; -The facility was out of the resident's pain pills for a week and half for the resident; -The resident complained his/her ribs hurt; -The facility was out of the resident pain medication and the scheduled Tylenol strength was out for a couple of months. During an interview on 10/03/24, at 11:08 A.M., RN C said the following: -He/she did not give resident medications prior to leave from the facility, but is sure he received them; -Resident's oxycodone order was received last night; -No oxycodone was available on Monday morning when he/she worked; -The nurse that obtained the oxycodone substitution order did not enter it into the physician orders or include it on the MAR; -He/she received information on the substituted medication in report and the nurse who obtained order documented a progress note; -He/she would enter a medication order into the physician orders, write a progress note, and include it in the MAR; -He/she has administered the hydrocodone by documenting oxycodone was given on the MAR and including a note about the substituted medication. During an interview on 10/04/24, at 10:15 A.M., Certified Nurse Aide (CNA) F said the resident had severe discomfort at times and asked for pain medication. The resident stays in bed and becomes antisocial when in pain. He/she would advise the nurse when resident requests a pain pill. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/04/24, at 10:26 A.M., Licensed Practical Nurse (LPN) D said the following: -The resident will advise the nurse if he/she is in pain; -Resident had not been out of pain medications that he/she knew of, but he/she only works one day per week; -He/she would enter the order in physician orders and notify family of any new order; -When the nurse enters the medication into the computer system as a new order it automatically populates in the MAR; -If a medication is not on the MAR, then there is not a physician order in place; -If a substitution medication was only noted in the progress notes, he/she would contact the physician to verify before administering medication. During an interview on 10/07/24 at 11:33 A.M., CMT E said all medication orders should be listed in the MAR or the nurse should not administer medication. 3. During an interview on 10/03/24, at 2:00 P.M., the Medical Director said the facility often had trouble with getting medications from the pharmacy timely. 4. During an interview on 10/03/24, at 3:28 P.M., CMT B said the following: -When preparing to administer medication, if staff were to find the medication is not available, they should click medication not available within the MAR and then click hold/see progress note. Staff should write the reason in the progress note that the medication was not able to be administered; -The nurses administer pain medication; -He/she heard the physian was resigning and was no longer signing any scripts for the pharmacy. 5. During an interview on 10/07/24, at 10:00 A.M., CNA A said the following: -If a resident complained of pain the aides reported it to the charge nurse. The charge nurse will go and assess the resident and provide pain medication, if ordered; -The aides should go and reassess the resident's pain level and ensure effectiveness of the nurses intervention. 6. During an interview on 10/07/24, at 10:15 A.M., RN C said the following: -If a resident complained of pain, he/she went and assessed the resident and obtained the resident's level of pain; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the resident had pain medication ordered, and the medications were available, they would be administered. If pain medication was not ordered or available, the RN would call the physician for advisement; -The facility has standing orders for Tylenol; -It does take some time for medications to arrive from the pharmacy. Sometimes they are just in need of a script. In that case the nurse would report that to the DON to handle; -If there is a delay with the pharmacy, the physician will sometimes write a new order for a medication that may be in the E-Kit (locked safe located at the facility, that contains all kinds of medications). -Nurses are who administer PRN (as needed) pain medications. 7. During an interview on 10/07/24, at 1:47 P.M., the DON said the following: -Staff should be assessing residents for pain every shift, which is twice a day; -All residents should have some type of medication for pain; -Nurses are the responsible staff members to administer PRN pain medications; -After administering pain medication, the nurse should re-evaluate the resident for effectiveness of the medication; -Narcotics are re-ordered through the pharmacy every Sunday. The medications typically arrive by the next night; -If for some reason the medication doesn't come in by the following night, the DON contacts the physician for the physician to get into contact with the pharmacy. -If there continues to be a delay in medication delivery, the DON contacts the physician again for an additional order for medication that is in the facility's E-kit. -Percocet is usually the alternative for Morphine; -All orders should be listed in the POS and the MAR. 8. During an interview on 10/07/24, at 1:47 P.M., the Administrator said staff should be assessing resident's for pain every shift. Pain medication should be administered, re-assessed, and documented. 49585 34871

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 34871 Based on interview and record review, the facility failed to ensure consistent and sufficient Registered Nurse (RN) and Director of Nursing (DON) hours to allow the DON to complete the duties of DON when the DON frequently had to work the charge nurse or a certified nurse aide (CNA). The facility census was 50. Review of the facility's job description titled, Director of Nursing Services, undated, showed the following: -The primary purpose of the position was to plan, organize, develop, and direct the overall operation of the nursing service department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility and as may be directed by the Administrator or the Medical Director to ensure that the highest degree of quality care is maintained at all times; -The Director of Nursing Services is delegated the administrative authority, responsibility, and accountability necessary for carrying out assigned duties. In the absence of the Medical Director, the Director of Nursing Services is charged with carrying out the resident care policies established by the facility; -Duties and responsibilities include administrative functions, personnel functions, committee functions, nursing care functions, staff development, safety and sanitation, equipment and supply functions, care plan and assessment functions, care plan and assessment functions, budget and planning functions, and resident rights. 1. During interviews on 10/03/24, at 2:31 P.M., and on 10/04/24, at 9:26 A.M. and the DON said the following: -She was behind on her DON duties due to covering the floor; -DON duties include reviewing the computer 'dashboard' for physician orders, tracking labs, hiring and terminating staff, monitoring wounds, the infection prevention program, and the antibiotic stewardship program; -She has had to work the floor as a certified nurse aide and a charge nurse. During an interview on 10/07/24, at 9:48 A.M., the DON said she worked the floor on the following shifts: -On 09/17/24 on the 6 A.M. to 6 P.M. shift; -On 09/18/24 on the 6 A.M. to 6 P.M. shift; -On 09/23/24 on the 6:00 P.M. to 6 A.M. shift; (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On 09/27/24 on the 6:00 P.M. to 6 A.M. shift; -On 09/29/24 on the 6 A.M. to 6 P.M. shift; -She worked every Saturday and Sunday in September 2024 on the 6 A.M. to 6 P.M. shift. Interview and record review, showed the facility failed to implement an effective and complete antibiotic stewardship program when staff failed to track residents on antibiotics for various infections in the facility by not completing a current and ongoing antibiotic log of residents with active infections. During interviews 10/01/24, at 12:43 P.M., and on 10/04/24, at 11:44 A.M., the DON said no measures were in place to track outcome surveillance related to antibiotic use. Observation, interview, and record review, showed the facility failed to ensure all residents were free of significant medication errors when staff failed to administer warfarin sodium (blood thinner that be used to treat and prevent blood clots) per the physician's order. Interview and record review showed the facility failed to provide pharmaceutical services to meet the needs of each resident when facility staff documented ordered medication could not be administered on multiple dates due to not being available on-site for one resident. During interviews on 10/02/24, at 1:50 P.M., and on 10/03/24, at 2:31 P.M., the DON said the following: -She reviews the computer dashboard everyday for missed medications or unavailable medications; -The dashboard on the computer shows medications not administrated. She then asks the nurse if they called the pharmacy for the medication; -The CMT notifies the charge nurse if a medication is not in yet; -She should review the dashboard everyday for medications not administered. During an interview on 10/07/24, at 1:47 P.M., the Administrator said the following: -She expected staff to administer medications as ordered to residents. -She expected staff to follow guidelines for prescribed antibiotics. -She was aware of the DON working shifts as charge nurse and a nurse aide.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on interview and record review, the facility failed to provide pharmaceutical services to meet the needs of each resident when facility staff documented ordered medication could not be administered on multiple dates due to not being available on-site for one resident (Resident #15). The facility census was 50. Review of the facility's policy Documentation of Medication Administration, revised April 2007, showed the following: -The facility shall maintain a medication administration record to document all medications administered; -A nurse or certified medication aide (where applicable) shall document all medications administered to each resident on the resident's Medication Administration Record (MAR); -Administration of medication must be documented immediately after (never before) it is given. Review of the facility's policy titled 'Medication Orders' revised November 2014, showed the following: -The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders; -A current list of orders must be maintained in the clinical record of each resident; -Medications to be reordered from pharmacy in a timely manner to ensure no lapse of administration of medications. Medications not received from pharmacy after reorder, nursing staff to follow up with pharmacy on availability and time frame to be delivered. Staff may pull medications from STAT safe if available and notify physician for any need in order change and notify resident/representative if any new orders obtained. 1. Review of Resident #15's face sheet (admission data) showed the following: -admitted [DATE]; -Readmitted [DATE]; -Diagnoses included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), major depressive disorder, and hallucinations. Review of the resident's care plan, revised 12/23/23, showed the following: -Required psychoactive medications for diagnosis of schizophrenia and major depressive disorder; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff to administer psychotropic medications as ordered and report any side effects noted, such as nausea, vomiting, over sedation, and increased agitation. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 09/04/24, showed the following information: -Moderately impaired cognitive skills; -No behaviors. Review of the resident's current Physician Order Sheet (POS) showed an order, dated 11/26/22 with an end date of 09/13/24, for escitalopram oxalate (an antidepressant) tablet 10 milligrams (mg) for staff to give one tablet by mouth (PO) one time a day for depression. Review of the resident's August 2024 Medication Administration Record (MAR) showed the following: -An order, dated 11/26/22 with an end date of 09/13/24, for escitalopram oxalate tablet 10 mg, one tablet PO one time a day for depression; -On 08/14/24, Certified Medication Tech (CMT) I documented administration of the escitalopram oxalate; -On 08/15/24, CMT I documented the escitalopram oxalate was not administered. Review of the resident's progress note dated 08/15/24, at 8:12 A.M., CMT I documented the medication ordered on 08/14/24 and was unavailable to administer. Review of the resident's August 2024 MAR showed on 08/16/24, CMT I did not administer the resident's escitalopram oxalate. Review of the resident's progress note dated 08/16/24, at 8:57 A.M., CMT I documented the resident's escitalopram oxalate was ordered on 08/14/24 and has not been received from the pharmacy. Review of the resident's August 2024 MAR showed the following: -On 08/17/24, CMT I documented administration of the escitalopram oxalate; -On 08/18/24, a staff documented administration of the escitalopram oxalate; -On 08/19/24, staff did not administer the resident's escitalopram oxalate. Review of the resident's progress note dated 08/19/24, at 9:44 A.M., showed a nurse documented staff were waiting on the escitalopram oxalate from the pharmacy. Review of the resident's August 2024 MAR showed the following: -On 08/20/24, CMT I documented administration of the resident's escitalopram oxalate; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/21/24, CMT I did not administer the resident's escitalopram oxalate. Review of the resident's progress note dated 08/21/24, at 8:14 A.M., showed CMT I documented the resident's escitalopram oxalate ordered on 08/18/24. Review of the resident's August 2024 MAR showed on 08/22/24, CMT I did not administer the resident's escitalopram oxalate. Review of the resident's progress note dated 08/22/24, at 8:49 A.M., showed CMT I documented the resident's escitalopram oxalate was ordered on 08/18/24. Review of the resident's August 2024 MAR showed on 08/23/24, 08/24/24, and 08/25/24, CMT I documented administration of the resident's escitalopram oxalate. Review of the resident's progress note dated 08/24/24, at 8:25 A.M., showed CMT I documented the resident's oxalate pulled from the emergency kit and the medication ordered on 08/18/24. Review of the resident's August 2024 MAR showed the following: -On 08/26/24, a staff documented administration of the resident's escitalopram oxalate; -On 08/27/24, staff did not administer the escitalopram oxalate. Review of the resident's progress note dated 08/27/24, at 9:07 A.M., showed a nurse documented the resident's escitalopram oxalate on order from the pharmacy and not given. Review of the resident's August 2024 MAR showed the following: -On 08/28/24, CMT I documented administration of the resident's escitalopram oxalate; -On 08/29/24, showed CMT I did not administer the resident's escitalopram oxalate; Review of the resident's progress note dated 08/29/24, at 9:09 A.M., showed CMT I documented the resident's escitalopram oxalate was reordered on 08/29/24. Review of the resident's August 2024 MAR showed on 08/30/24, CMT I did not administer the resident's escitalopram oxalate. Review of the resident's progress note dated 08/30/24, at 9:00 A.M., showed CMT I documented the resident's escitalopram oxalate was unavailable from the pharmacy. Review of the resident's August 2024 MAR on 08/31/24, CMT I documented administration of the resident's escitalopram oxalate. Review of the resident's September 2024 MAR showed the following: -On 09/01/24, 09/02/24, and 09/03/24, staff documented administration of the resident's escitalopram oxalate; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 09/04/24, CMT I did not administer the resident's escitalopram oxalate. Review of the resident's progress note dated 09/04/24, at 8:08 A.M., showed CMT I documented the resident's escitalopram oxalate was ordered on 08/29/24 and had not been received it from the pharmacy. Review of the resident's September 2024 MAR showed on 09/05/24, CMT I did not administer the resident's escitalopram oxalate. Review of the resident's progress note dated 09/05/24, at 7:29 A.M., showed CMT I documented the resident's escitalopram oxalate was unavailable from the pharmacy and not in the emergency kit. Review of the resident's September 2024 MAR showed on 09/06/24, CMT I did not administer the resident's escitalopram oxalate. Review of the resident's progress note dated 09/06/24, at 9:17 A.M., showed CMT I documented the resident's escitalopram oxalate had not been received. He/she notified the nurse that the facility did not receive the medication. During an interview on 10/03/24, at 11:05 A.M., CMT I said the following: -He/she documented in the progress notes if a medication was not available and informed the charge nurse or Director of Nursing (DON); -The charge nurse or DON called the pharmacy if a medication was not available; -He/she documented the number 9 in the progress notes which meant see progress note; -He/she did not administer the resident's medications for the listed August 2024 and September 2024 dates due to the medication was not available; -He/she did not know why the medication was not available on dates listed and available on the other dates; -He/she did not remember if he/she reported the medication not available to the charge nurse or DON. During an interview on 10/03/24, at 10:52 A.M. CMT E said the following: -Staff should check the emergency kit and notify the nurse if a medication is not available; -Nurses contact the physician if a medication is not available. During interviews on 10/03/24, at 10:27 A.M. and 12:17 P.M., Registered Nurse (RN) C said the following: -Staff did not administer the resident's medication on the dates noted on the August 2024 and September 2024 MAR; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she did not know the resident's escitalopram oxalate was not available for several days; -Nurses enter orders in the computer if a resident is admitted from the hospital; -The DON enters orders into the computer and if she is not here, the charge nurse enters the orders; -The facility computer system automatically goes to the pharmacy; -Nurses fax any new orders to the pharmacy and the medications should arrive to the facility within 24 hours unless a controlled substance; -Staff should check the emergency kit if a medication is unavailable; -Staff should notify the DON if a medication is unavailable and the DON calls the pharmacy; -The DON runs a report daily of medications not given or not available; -Staff should inform the nurse if a medication dose is not administered. During interviews on 10/02/24, at 1:50 P.M., and on 10/03/24, at 2:31 P.M., the DON said the following: -The missed doses of escitalopram oxalate were around the time she had to redo the physician orders for the pharmacy; -Staff informed her they administered the escitalopram oxalate from the emergency kit; -She reordered from the pharmacy and did not hear from the pharmacy; -She must have called the pharmacy to get enough medications to get through the weekend for the 09/04/24, 09/05/24 and 09/06/24; -She must not had reviewed the dashboard those days since she worked as a CNA and a nurse; -She considered the medication unavailable for the escitalopram oxalate to be a missed doses; -Nurses enter the physician order in the computer which connects to the pharmacy; -Nurses fax new admission orders to the pharmacy; -The pharmacy delivers through a courier service and usually delivers the following day; -Nurses call the pharmacy if a medication is not delivered the following day; -The nurse or she calls the pharmacy if a medication is not available; -She reviews the computer dashboard everyday for missed medications or unavailable medications; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The dashboard on the computer shows medications not administrated. She asks the nurse if they called the pharmacy for the medication; -The CMT notifies the charge nurse if a medication is not in yet; -She should review the 'dashboard' everyday for medications not administered. During an interview on 10/07/24, at 1:47 P.M., the Administrator said she expected the staff to administer resident's medications as ordered and report if unavailable.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of 5% or less when facility staff made five medication errors out of 39 opportunities (12.82% error rate) affecting three residents (Resident #9, #34, and #49). The facility census was 50. Review of the facility's policy titled Medication Administration, undated, showed the five rights to be followed were the right patient, right drug, right dose, right time and right route; 49585 1. Review of Resident #9's face sheet (a document that gives a resident's information at a quick glance) showed the following information: -admitted [DATE]; -Diagnoses included diabetes mellitus (chronic, metabolic disease characterized by elevated levels blood glucose) and congestive heart failure (CHF - chronic condition in which the heart doesn't pump blood as well as it should). Review of the resident's quarterly Minimum Data Sheet (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 08/07/24, showed resident cognitively intact. Review of resident's October 2024 Medication Administer Record (MAR) showed the following: -An order, dated 10/01/24, for guaifenesin DM (medication to relieve chest congestion) liquid 200 milligrams (mg) per 10 milliliters (ml), give 10 ml by mouth three times a day for cough and then as needed. Observations on 10/03/24, at 11:52 A.M., showed Certified Medication Technician (CMT) E administered one guaifenesin 200 mg tablet to the resident. (The physician had ordered a liquid administered.) 2. Record review of Resident #34's face sheet showed the following information: -admitted [DATE]; -Diagnoses included throat cancer, lupus (condition that occurs when the immune system attacks healthy tissues and organs), and diabetes mellitus. Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact, taking an antipsychotic, and had no behavioral symptoms. Review of resident's current Physician Order Sheet (POS) showed the following orders: -An order, dated 09/18/24, for olanzapine (antipsychotic medication) 5 mg tablet, give one tablet three times daily; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 09/18/24, for ondansetron hydrochloride (HCL) (medication for nausea and vomiting) 4 mg tablet, give one tablet by mouth four times daily. Observations on 10/03/24, at 11:52 A.M., showed CMT E administered olanzapine 10 mg tablet and ondansetron orally dissolving tablet (ODT) 4 mg. (The physician had ordered a different dosage of olanzapine and a different form of ondansetron.) 50185 3. Review of the National Library of Medicine document Preventing Errors When Drugs Are Given Via Enteral Feeding Tubes, dated 2013, showed the following: -The most common improper administration techniques included mixing multiple drugs together to give at the same time and failing to flush the tube before giving the first drug and between giving subsequent drugs; -Appropriate administration techniques must be used to prevent incompatibility (between medications and the feeding formula) and tube occlusions; -The tube should be flushed with at least 15 mL of purified water before and after each medication is given Review of the Resident #49's face sheet showed the following information: -admitted [DATE]; -Diagnoses included nontraumatic intracerebral hemorrhage intraventricular (bleeding into the fluid-filled areas, or ventricles, surrounded by the brain), convulsions (a medical condition that causes the body's muscles to contract and relax rapidly and repeatedly, resulting in uncontrolled shaking), respiratory failure, and altered mental status. Review of the resident's admission MDS, dated [DATE], showed the following information: -Resident rarely or never understood; -Feeding tube use. Review of the resident's care plan, revised on 10/03/24, showed the following information: -Administer medications and flushes via g-tube per physician order; -Elevate head of bed 30 degrees at all times. Review of the resident's October 2024 Physician Order Sheet showed the following: -An order, dated 09/06/24, for hydralazine HCl (medication used to treat high blood pressure) oral 100 mg tablet, give one tablet via g-tube (feeding tube) three times a day for high blood pressure; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An order, dated 09/20/24, for tramadol HCl (medication used to treat pain) oral 50 mg tablet, give one tablet by mouth three times a day for pain. (Staff did not note an order to combine medications.) Review of the resident's October 2024 MAR, showed the following: -An order, dated 09/06/24, for hydralazine HCl oral 100 mg tablet, give one tablet via g-tube three times a day for high blood pressure; -An order, dated 09/20/24, for tramadol HCl oral 50 mg tablet, give one tablet by mouth three times a day for pain. (Staff did not note an order to combine medications.) Observation on 10/02/24, at 2:43 P.M., showed the following: -The Director of Nursing (DON) prepared to administer medication to the resident, by obtaining and crushing one 50 milligram tablet and one hydralazine 25 mg tablet; -After crushing the medication, the DON poured the medications into one medicine cup, together and added warm water to the medicine cup; -The DON donned a gown, gloves, and mask before entering the residents room; -The DON unclamped the resident's g-tube and flushed the g-tube with 30 ml of water using a 30 ml syringe; -The DON obtained the medications into the 30 ml syringe and administered the medications through the g-tube. After administering the medications, the DON flushed the g-tube again with 30ml of water; -The DON doffed gown, gloves, mask, and sanitized her hands. 4. During an interview on 10/07/24, at 11:33 A.M., CMT E said a physician order is required to change the route, dosage, or any medication changes. 5. During an interview on 10/04/24, at 10:26 A.M., Licensed Practical Nurse (LPN) D said the medication name, dosage, and type should be matched with the order indicated on the MAR during medication administration. 6. During an interview on 10/07/24, at 10:15 A.M., RN C said the following: -Staff should follow the 5 routes of medication administration, including right patient, dose, right time, right route, and right drug; -Staff should have the medications separated while administering. The process for administration should be to flush the g-tube with water, administer one medication, flush with water, administer the second medication, flush, and continue with that process until all medication is administered. (continued on next page)

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Buffalo Prairie Center for Rehab and Healthcare	631 West Main Street Buffalo, MO 65622

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During an interview on 10/07/24, at 1:47 P.M., the DON said staff should follow physician orders and include the right medication, dose, route, and route of administration. Staff should alert the nurse of any medication problem. There should be an order to combine medications. 8. During an interview on 10/07/24, at 1:47 P.M., the Administrator said the following: -All orders should ensure the 5 routes of medication administration recommendation are followed; -There should be orders to combine medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on observation, interview, and record review, the facility failed to ensure all residents were free of significant medication errors when staff failed to administer warfarin sodium (blood thinner that be used to treat and prevent blood clots) per the physician's order and failed to notify nurse management or the physician of the missed doses for one resident (Resident #152). The facility census was 50. Review of the facility's policy Documentation of Medication Administration, revised April 2007, showed the following: -The facility shall maintain a Medication Administration Record (MAR) to document all medications administered; -A nurse or certified medication aide, where applicable, shall document all medications administered to each resident on the resident's MAR; -Administration of medication must be documented immediately after, never before, it is given; -Documentation must include, as a minimum: name and strength of the drug, dosage, method of administration, date and time of administration; reason(s) why a medication was withheld, not administered or refused (as applicable); signature and title of the person administering the medication; and resident response to the medication, if applicable for as needed (PRN) medication and pain medications, etc. Review of the facility's policy titled Medication Administration, undated, showed the following: -Five rights to be followed: right patient, right drug, right dose, right time, and right route; -Document the administration after it is confirmed that the resident has taken the medication in the resident's medical record and sign; -Any discrepancies in medication administration must be immediately brought to the Director of Nursing (DON). The physician and the family must be notified. An incident report needs to complete. 1. Review of Resident #152's face sheet (admission data) showed the following: -admitted [DATE] with readmitted [DATE]; -Diagnoses included other thrombophilia (an abnormality of blood coagulation (the process through which blood changes from a liquid and becomes thicker, like a gel) that increases the risk of thrombosis (the formation of a blood clot in a blood vessel or the heart, which can restrict blood flow)); -Abnormal coagulation profile. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's September 2024 Physician Orders, dated 09/01/24 through 10/03/24, showed an order, dated 09/06/24, for warfarin sodium oral tablet, 5 milligrams (mg), give one tablet by mouth (PO) in the evening for blood thinner. The order showed a hold began on 09/06/24, at 3:11 P.M. Review of the resident's September 2024 MAR showed an order, dated 09/06/24, for warfarin sodium oral tablet, 5 mg, give on tablet PO in the evening for blood thinner. The order showed a hold began on 09/06/24 at 3:11 P.M. Review of the resident's baseline care plan, dated 09/08/24, showed medications included use of anticoagulants (a substance that prevents or treats blood clots in the heart and blood vessels). Review of the resident's September 2024 Physician Orders dated 09/01/24 through 10/03/24 showed an order, dated 09/06/24, for warfarin sodium oral tablet, 5 mg, give one tablet PO in the evening for blood thinner. The order showed the hold ended on 09/11/24, at 3:10 P.M. Review of the resident's September 2024 MAR showed the following: -An order, dated 09/06/24, for warfarin sodium oral tablet, 5 mg, give one tablet PO in the evening for blood thinner. The order showed the hold ended on 09/11/24, at 3:10 P.M. -On 09/11/24, Certified Medication Technician (CMT) B documented he/she did not administer the resident's medication. Review of the resident's progress note dated 09/11/24, at 7:14 P.M., showed CMT B documented warfarin sodium was not available. Staff did not document physician or DON notification of the missed dose. Review of the resident's September 2024 MAR, dated 09/12/24, showed CMT B documented he/she did not administer the resident's warfarin sodium. Review of the resident's progress note dated 09/12/24, at 5:44 P.M., showed CMT B documented warfarin sodium was not available. Staff did not document physician or DON notification of the missed dose. Review of the resident's September 2024 MAR, dated 09/13/24, showed CMT B documented he/she did not administer the resident's warfarin sodium. Review of the resident's progress note dated 09/13/24, at 5:58 P.M., showed CMT B documented warfarin sodium was not available. Staff did not document physician or DON notification of the missed dose. During an interview on 10/03/24, at 3:28 P.M., CMT B said the following: -On 09/11/24, 09/12/24, and 09/13/24, he/she thought the warfarin was not available and staff did not inform him/her the medication was in a pill bottle until the resident's responsible party informed him/her; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident missed three doses of the wafarin; -He/she did not remember if he/she reported the resident's missed dose to the charge nurse or the Director of Nursing (DON). During an interview on 10/03/24, at 9:54 A.M., CMT I said staff should report to the DON if a medication is unavailable. During an interview on 10/03/24 at 10:52 A.M. CMT E said the following: -The MAR shows up as yellow of when to administer and is red if past time; -The MAR turns green when staff administered a medication; -Staff should check the emergency kit and notify the nurse if a medication is not available; -Nurses contact the physician if a medication is not available. During interviews on 10/03/24, at 10:27 A.M. and 12:17 P.M., Registered Nurse (RN) C said the following: -On 09/11/24, 09/12/24, and 09/13/24, the resident's MAR showed staff documented the resident's warfarin was unavailable; -He/she did not know the resident did not receive the warfarin on those days; -Nurses enter orders in the computer if a resident is admitted from the hospital; -The DON enters orders into the computer and if she is not here, the charge nurse enters the orders; -The facility computer system automatically goes to the pharmacy; -Nurses fax any new orders to the pharmacy and the medications should arrive to the facility within 24 hours unless a controlled substance; -Staff should check the emergency kit if a medication is unavailable; -Staff should notify the DON if a medication is unavailable and the DON calls the pharmacy; -The DON runs a report daily of medications not given or not available; -Staff should inform the nurse if a medication dose is not administered. During an interview on 10/03/24, at 2:00 P.M., the Medical Director said the following: -He recalled the resident and his/her recent hospital stay and testing of the PT/INR levels (labs used to determine how thin or thick, clotting time of blood) based on a phone call from the DON; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It was not good the resident went without the warfarin for the three days. During interviews on 10/02/24, at 1:50 P.M., and on 10/03/24, at 2:31 P.M., the DON said the following: -She requested laboratory test results for the resident's PT/INR levels due to she did not know what the resident's results were while in the hospital and put the resident's warfarin on hold until results; -On 09/13/24, the nurse contacted the physician to restart the warfarin; -On 09/11/24, 09/12/24, and 09/13/24 the resident's MAR showed staff documented the resident's medication not available. She did not know why the staff would document that; -She expected CMT B to notify the charge nurse if the medication was unavailable or check the emergency kit; -The resident should not go without the wafarin for more than a couple days due to the risk of blood clots; -Staff should have notified the physician of the resident's missed doses; -The resident's Warfarin was on hold from 09/06/24 through 09/11/24; -Staff did not report the medication not available on 09/11/24, 09/12/24, and 09/13/24; -The medication was suppose to be started and staff should have notified her if the medication was not at the facility; -The medication was probably in the emergency kit; -Staff did not document notification of the physician of the missed dose of the resident's medication. -She reviews the computer dashboard everyday for missed medications or unavailable medications; -The dashboard on the computer shows medications not administrated. She then asks the nurse if they called the pharmacy for the medication; -The CMT notifies the charge nurse if a medication is not in yet; -She should review the dashboard everyday for medications not administered. During an interview on 10/07/24, at 1:47 P.M., the Administrator said she expected staff to administer medications as ordered to residents. 49585

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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** 33187 Based on observation, interview, and record review, the facility failed to ensure all medications were stored and labeled in accordance with standards of practice when staff failed to store controlled substances under two locks for two residents (Resident #1 and Resident #39) and when medication carts were left unlocked when unattended. The facility census was 50. Review of the facility's Storage of Medication Policy, undated, showed the following: -The facility shall store all drugs and biological's in a safe, secure, and orderly manner; -The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner; -Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biological's shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others; -Medication requiring refrigeration must be stored in a refrigerator per the manufactures recommendation and located in the drug room at the nurses' station or other secured locations; -Only person authorized to prepare and administer medications shall have access to the medication room, including any keys. Review of the Controlled Substance Guidelines for Missouri Practitioners, issued by the Bureau of Narcotics and Dangerous Drugs (BNDD), dated 11/08/24, showed the following: -Individual practitioners must store controlled substances in a securely locked, substantially constructed cabinet or safe. Access to the storage area should be restricted to persons specifically authorized to handle the controlled substances. -The safe or cabinet should remain locked at all times. It is not allowed to have it remain unlocked throughout the day while you are open for business. -If controlled substances are stored in a refrigerator then the refrigerator must have a lock. 1. Review of Resident #1 face sheet, dated 10/07/24, showed and admitted [DATE] and diagnoses including human immunodeficiency virus, acute kidney failure, epilepsy (seizures), and symptoms with concerns for food and fluid intake. Record review of the resident's October 2024 Physician Order Sheet, dated 10/07/24, showed an order, dated 10/02/24, for dronabinol capsule 2.5 milligram (mg) (a controlled medication that controls nausea, vomiting, and appetite) twice daily for symptoms and signs concerning food and fluid intake. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/03/24, at 10:06 A.M., of the main medication store room refrigerator showed the following: -The medication room was locked and accessed with a key by Certified Medication Tech (CMT) E; -The medication refrigerator was not locked; -The medication refrigerator contained a pharmacy card of the resident's dronabinol 2.5 mg, 60 capsules. 2. Review of Resident 39's face sheet, dated 10/07/24, showed an admitted [DATE] and diagnoses that included benign intracranial hypertension (increased pressure in the brain), malignant neoplasm of unspecified kidney (cancer), atrial fibrillation (irregular heartbeat), and actinomycotic encephalitis (a rare bacterial infection that affects the brain and surrounding tissues). Record review of the resident's October 2024 Physician Order Sheet showed an order, dated 07/21/24, for dronabinol capsule 5 mg, twice daily for nausea related to cancer treatment. Observation on 10/03/24, at 10:06 A.M., of the main medication store room refrigerator showed the following: -The medication room was locked and accessed with a key by CMT E; -The medication refrigerator was unsecured; -The refrigerator contained a pharmacy card of the resident's dronabinol 5 mg, 12 capsules. 3. Observation on 10/02/24, at 11:20 A.M., showed the following: -A nurse medication cart located outside of the Director of Nursing (DON)'s office, facing the hallway, unlocked; -The cart contained several insulin pens, narcotics inside of narcotic box, and assorted medication cards; -Resident #6 sat by the cart awaiting medication, while other residents walked past the cart to get into the dinning room; -The DON arrived at the cart by 11:31 A.M., obtained supplies and left the cart unlocked; -The DON locked the cart at 11:40 A.M. 4. Observation on 10/02/24, at 12:11 P.M., showed the following: -The DON left the cart unlocked near the nurses' station and certified nurse aides' (CNA) room door, and entered the medication room, shutting the door behind her; -Several residents were nearby and/or passing; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The DON arrived back to the cart at 12:13 P.M. 5. During an interview on 10/03/24, at 9:58 A.M. and 10:35 A.M., CMT E said the following: -The nurses have access with keys to the locks on the medication carts, medication storage room, and medication lock box for in the refrigerator; -The CMT's are able to access scheduled narcotics in the medication cart; -No narcotics are kept in the medication room or medication refrigerator that he/she is aware of; -CMT's don't pass any medications that are stored in the refrigerator; -If an unsecured medication is discovered, staff are expected to secure the medication, and notify the Director of Nursing (DON) immediately. 6. During an interview on 10/03/24, at 11:02 A.M., CMT I said if an unsecured narcotic/medication is found, staff are expected to report to the charge nurse and DON. 7. During interviews on 10/07/24, at 10:15 A.M. and 12:31 P.M., Registered Nurse (RN) C said the following: -Medication carts should be locked unless it is actively in use; -Narcotic medications are kept in one of the three medication carts when they are delivered from the pharmacy; -Refrigerated medications are stored in the main medication room that remains locked; -The nursing staff and the CMT's have keys and access to the medication room; -All staff constantly check to make sure the medication are secure when they access the cart or medication room; -The medication cart is expected to be locked when unattended; -If the medication cart or medication storage room is found to be unlocked, the RN would lock the cart and notify the person who is responsible for the cart. 8. During an observation and interview on 10/03/24 at 10:43 A.M., the DON said she expects staff to lock medication in a secure manner. 9. During an interview on 10/07/24, at 1:47 P.M., the DON and Administrator said the following: -Medication carts should be locked at all times; -Medication should be stored in a safe and secure manner; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The controlled medications were unsecured in the refrigerator and the main storage room door was locked; -Narcotic medication should be stored under a double lock; -For any concerns with medication storage, the staff should contact the pharmacy and investigate safety of the medication. 50185

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on interview and record review, the facility staff failed to employ a qualified dietary manager for food and nutrition services with accredited education in food service management. The facility census was 50. Review of the facility's policy titled, Director of Food and Nutrition Services, undated, showed the following: -The Director of Food and Nutrition Services (DFNS) will be responsible for all aspects of the food and nutrition services department including but not limited to food safety, staff safety, cost management, and meeting nutritional needs of patients/residents served; -The DFNS will be hired by corporate staff, the Administrator, or by the immediate supervisor of the position as deemed appropriate by the facility; -The DFNS will be qualified according to the position's job description and guidelines put forth by the agency that regulates the facility. A facility that does not have a full time dietitian (registered dietitian nutritionist or RDN) or clinically qualified nutrition professional must designate a person to serve as DFNS. According to the Centers for Medicare and Medicaid (CMS) services State Operations Manual for nursing homes F tag 801, the DFNS hired prior to 11/28/16 must meet the following requirement no later than five years after 11/28/16, or no later than one year after 11/12/16, for those hired or designated to that position after 11/28/16: -The DFNS must be a certified dietary manager (CDM); certified food service manager; have a similar national certification for food service management and safety from a national certifying body; or have an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management from an accredited institution of higher learning; and in states that have established standards for food service managers or dietary managers, must meet state requirements for food service managers or dietary managers. 1. During an interview on 10/02/24, at 3:13 P.M., the Dietary Manager (DM) said the following: -A Registered Dietitian came to the facility monthly and reviewed residents' weight loss; -She started the DM position in March 2024; -She worked at a head start as a nutritional assistant for [AGE] years; -She had a card that showed she completed a certificate of proper temperatures safety through the health department; -He/she was not a CDM and not enrolled in a training/certification course; (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He/she was not a Certified Food Services Manager and did not have an associate's degree or higher in food service management or hospitality. Review showed the facility did not provide documentation of certification, training, or experience that met the requirements for a DFNS in a long-term care setting. During an interview on 10/02/24, at 3:36 P.M., the Administrator said she did not know of the needed qualifications for the DM and would send him/her to the required classes.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on observation, interview, and record review, the facility failed to maintain complete medical records for all residents when staff failed to document full details and notifications related to two residents (Resident #41 and #46) who transferred to the hospital and later returned to the facility. The facility census was 50. Review of the facility's policy titled Charting and Documentation, revised April 2008, showed the following: -All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record; -All incidents, accidents, or changes in the resident's condition must be recorded; -Documentation of procedures and treatments shall include care-specific details and shall include at a minimum the date and time the procedure/treatment was provided; the name and title of the individual(s) who provided the care; the assessment data and/or any unusual findings obtained during the procedure/treatment; how the resident tolerated the procedure/treatment; whether the resident refused the procedure/treatment; notification of family, physician or other staff, if indicated; and the signature and title of the individual documenting. Review of a facility policy titled, Transfer or Discharge Documentation, dated December 2016, showed the following: -When a resident is transferred or discharged , details of the transfer will be documented in the medical record; -The following information will be documented in the medical record when a resident is transferred or discharged : the basis for transfer; that appropriate notice was given to resident or representative; the date and time of the transfer or discharge; the new location of the resident; mode of transportation; a summary of resident's overall medical, physical, and mental condition; and disposition of personal effects and medications. 1. Review of Resident #41's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included cerebral infarction (condition that occurs when the blood supply to part of the brain is blocked or reduced), atrial fibrillation (irregular, often rapid heart rate that can cause poor blood flow), and fracture of right femur (thigh bone). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/02/24, showed the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognitively intact; -Required set up and clean up assistance with eating and oral hygiene; -Required partial to moderate assistance with dressing, toileting, showering, bed mobility, and transfers; -Used wheelchair for mobility. Review of the resident's care plan, revised on 08/18/24, showed the following: -Required maximum assistance for transfers, toileting, dressing, and hygiene; -At risk for falls related to weakness, balance deficit, and history of falls. Review of the resident's nursing progress note dated 09/01/24, at 11:24 P.M., showed the nurse received an update from the hospital regarding resident. The resident admitted to Intensive Care Unit (ICU) with a diagnosis of atrial fibrillation, urinary tract infection, and sepsis (condition when the body responds improperly to an infection). There was no estimated discharge given. Review of resident's September 2024 Physician Order Sheet (POS) showed no order to transfer resident to the hospital on 09/01/24. Review of the resident's nursing progress notes, dated 09/01/24, showed staff did not document regarding the reason for the transfer, time of transfer, or notification to physician of the transfer. Review of resident's nursing progress notes, dated 09/05/24, showed staff did not document the time or date resident returned from hospital or physician notification of the resident's return. 2. Review of Resident #46's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), heart disease (condition where the heart does not pump blood as well as it should), and chronic kidney disease (disease that causes progressive damage and loss of function to the kidneys). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Resident on isolation or quarantine for an active infectious disease; -Required set up and clean up assistance with eating, toileting, and oral hygiene; -Required partial to moderate assistance with dressing, showering, bed mobility, and transfers; (continued on next page)

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	265471	A. Building B. Wing	10/07/2024

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Used wheelchair for mobility. Review of the resident's care plan, revised on 08/18/24, showed the following: -Required staff supervision for transfers, toileting, dressing, and hygiene; -At risk for falls related to debility. Review of the resident's nursing progress note dated 07/10/24, at 12:30 P.M., showed staff documented the resident complained of continuing diarrhea and vomiting. The nurse assessed the resident and determined the resident was weak. This nurse decided after assessment that resident is at risk of dehydration and acute kidney injury related to vomiting and diarrhea for last 4 to 5 days. The nurse sent the resident out to emergency room via Emergency Medical Services (EMS) at 12:20 P.M. (Staff did not document notification of the physician of the transfer to the hospital.) Review of the resident's July 2024 Physician Order Sheet showed no order for transfer of resident to hospital on 07/10/24. Review of the residents hospital after visit summary, dated 07/16/24, showed the resident admitted to the hospital on 07/10/24 related to an intestinal infection due to Clostridiodes difficile (bacteria which can cause inflammation of the colon). The resident was discharged back to the skilled nursing facility on 07/16/24. Review of the resident's nursing notes, dated 07/16/24, showed staff did not document regarding the resident's return to the facility or physician notification of the return. 3. During an interview on 10/03/24, at 11:08 A.M., Registered Nurse (RN) C said the following: -The nurse should obtain an order from the physician for a resident transfer; -He/she would note the transfer order in the physician orders; -For a resident transfer to hospital, he/she would assess the resident, notify the Director of Nursing (DON) and physician, contact family and EMS, complete a transfer form, and document this in the resident chart. 4. During an interview on 10/04/24, at 10:26 A.M., Licensed Practical Nurse (LPN) D said the following: -Nurses should assess the resident and obtain vital signs for a resident with a change of condition requiring transfer; -The nurse should obtain and document an order for transfer; -Nursing notes should be made to and include the details and time of transfer, assessment, and notifications. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During interviews on 10/03/24, at 2:31 P.M., and on 10/04/24, at 12:02 P.M., the DON said the following: -He/she expected nurses to notify the physician and the DON of the resident condition and need to transfer out of the facility; -Nurse documentation should include where the resident is sent and the reason; -A physician order is needed for transfer; -The nurse on duty did notify the physician of Resident #46's transfer to the hospital, but did not document it; -Staff should document any notifications made. 5. During an interview on 10/07/24, at 1:47 P.M., the Administrator said he/she expected nurses to document resident transfers. 33187 34871

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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. 36974 Based on observation, interview and record review, the facility failed maintain a complete and effective infection control program when the facility failed to have a thorough program for the prevention of the growth of the Legionella bacteria (a bacteria which causes a respiratory disease when breathing in small droplets of water in the air that contain Legionella. A Legionella infection is also called Legionnaires' Disease. It can become a health concern when it grows and spreads in human-made water systems.) in the facility water supply or where moist conditions existed. The facility also failed to perform hand hygiene per standards of practice during medication passes involving multiple residents. The facility census was 50. 1. The Centers for Disease Control (CDC) Toolkit for Legionella (which is officially titled Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings) showed that healthcare facilities need to actively identify and manage hazardous conditions that support growth and spread of Legionella by: -Identifying building water systems for which Legionella control measures are needed; -Assess how much risk the hazardous conditions in those water systems pose; -Apply control measures to reduce the hazardous conditions, whenever possible, to prevent Legionella growth and spread; -Make sure the program is running as designed and is effective; -Legionella grows best at 77 to 108 degrees Fahrenheit (F); -Disinfectants (one way to prevent Legionella) are only effective in certain pH levels (usually 6.5 - 8.5); -How often to check depends on several factors (which should be determined by the facility from its Water Management Program); -The water temperatures and pH levels should be checked at regular intervals. Record review of the facility's policy titled Legionella Prevention and Management, undated, showed the following: -It is the policy of the facility to establish protocols for the prevention and control of transmission of Legionnaires' Disease; -Steps to prevent Legionella include staff taking samples of potable (drinkable) water per the facility water management plan; -The Environmental Department will keep a log of testing the water distribution system. This log will be reviewed annually by the Administrator through the Quality Assurance program; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Education will be provided annually for Legionella awareness to facility staff. Review showed the facility did not provide documentation of a Legionella risk assessment, including not having a diagram or scheme for the facility's water, completed for the facility. During an interview on 10/01/24, at 4:20 P.M., the Maintenance Director said the following: -He flushed the toilets and sinks of all resident rooms that were empty, but the rooms were rarely empty of residents for long periods; -He didn't know of levels of water temperature or pH appropriate to prevent the growth or spread of Legionella; -The facility used to have a map/diagram of the facility's water system, but doesn't know where it is currently; -He attends a regular meeting for quality assurance and it is noted at that time which resident rooms are empty; -He didn't know of any other steps being taken by the facility to prevent Legionella. During an interview on 10/01/24, at 4:30 P.M., the Administrator said during department head meetings, empty resident rooms are noted (for maintenance to follow-up by flushing sinks and toilets). Only sinks and toilets in resident rooms were flushed and no other areas of the building were addressed (areas where any water could potentially stagnate, or conditions promoting Legionella growth could be present). She didn't know of any other steps taken by any staff to enact or follow the CDC Toolkit for Legionella or follow the facility policy Legionella Prevention and Management. 49585 2. Review of facility records showed the facility did not provide a policy or procedure regarding hand hygiene and/or the use of alcohol-based hand rubs. Review of the CDC Clinical Safety: Hand Hygiene for Healthcare Workers, updated 02/27/24, showed the following: -Hand hygiene means cleaning hands with handwashing with water and soap (e.g., plain soap or with an antiseptic), or antiseptic hand rub (alcohol-based foam or gel hand sanitizer); -Cleaning hands reduces the potential spread of deadly germs to patients; the spread of germs, including those resistant to antibiotics; and the risk of healthcare personnel colonization or infection caused by germs received from the resident; -Staff should perform hand hygiene immediately before touching a resident; before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; before moving from work on a soiled body site to a clean body site on the same resident; after touching a resident or resident's surroundings; after contact with blood, body fluids, or contaminated surfaces; and immediately after glove removal. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Unless hands are visibly soiled alcohol-based hand sanitizer (ABHS) is preferred over soap and water in most clinical situations because it is more effective at killing germs on hands than soap; is easier to use when providing care, especially when moving from soiled to clean activities on the same resident or when moving between care of residents in shared rooms; and improves hand hygiene adherence. -Staff should wash with soap and water when hands are visibly soiled; before eating; after using the restroom; and during the care of patients with suspected or confirmed infection during outbreaks of C. difficile and norovirus. Observation on 10/02/24, at 11:31 A.M., showed the Director of Nursing (DON) wheeled Resident #6 into her office to perform a blood sugar check. The DON did not perform hand hygiene, donned gloves, obtained an alcohol swab, lancet, and the glucometer. The DON obtained the residents blood sugar. The DON disposed of sharps, doffed gloves, and disinfected the glucometer. The DON did not perform hand hygiene. The DON obtained an insulin pen, primed the pen, and dialed the dose to 11 units. The DON obtained gloves from her pockets, donned one glove to her right hand, and obtained an alcohol swab. The DON cleansed the insertion site on the resident and administered the insulin dose with the gloved hand. The DON discarded the used insulin needle and doffed the glove. The DON did not perform hand hygiene. The DON locked the medication cart and wheeled the resident into the dinning room. Observation on 10/02/24, at 11:41 A.M., showed the did not perform hand hygiene and prepared and administered one morphine ER (pain medication) 15 milligram (mg) tablet to Resident 46. Without performing hand hygiene, the DON prepared and administered one hydrocodone (pain medication) 5-325 mg tablet to Resident #14. Without performing hand hygiene, the DON touched the tea dispenser in the dinning room and provided the resident with a cup of tea. Observation on 10/02/24, at 12:45 P.M., of the medication pass by Certified Medication Technician (CMT) I showed the CMT did not perform hand hygiene between medication passes to four residents. CMT I was observed to cough into her right hand while preparing medication for a resident and did not perform hand hygiene. Observation on 10/02/24, at 12:03 P.M., showed the DON donned gloves without performing hand hygiene and obtained an alcohol swab, lancet, and the glucometer. The DON obtained Resident #1's blood sugar. The DON disposed of sharps, doffed gloves, and disinfected the glucometer. Without performing hand hygiene, the DON obtained an insulin pen, primed the pen, and dialed the dose to 18 units. The DON donned gloves and obtained an alcohol swab and cleansed the insertion site on the resident. The DON administered the insulin dose to the resident. The DON doffed gloves and placed them onto the medication. The DON picked up the dirty gloves and disposed of them in the trash, put her hands in her pockets to obtain the medication cart keys and unlocked the cart. The DON did not perform hand hygiene after doffing the gloves and touching the dirty gloves. Observation on 10/02/24, at 12:14 P.M., showed the DON entered the doorway of Resident #9's room. Without performing hand hygiene, the DON donned gloves, accessed the resident's IV in the resident's right arm, unclamped the IV tubing, cleansed the port with an alcohol swab, and flushed the IV with normal saline. The DON obtained the resident's antibiotic medication and connected the medication to the IV port. The DON doffed gloves. The DON did not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 10/03/24, at 11:52 A.M., of the medication pass by CMT E showed the CMT prepared and passed medication to three separate residents without performing hand hygiene. During an interview on 10/04/24, at 10:15 A.M., Certified Nurse Aide (CNA) F said hand hygiene should be completed before and after resident care and with any change of gloves. During an interview on 10/04/24, at 10:26 A.M., Licensed Practical Nurse (LPN) D said hand hygiene should be done before and after any resident contact. During an interview on 10/07/24, at 10:58 A.M., Certified Nurse Assistant (CNA) A said staff should wash hands all the time and especially when changing gloves, resident contact, and serving food. During an interview on 10/07/24, at 12:32 P.M. Registered Nurse (RN) C said hand hygiene should be completed when changing gloves, entering or exiting resident rooms, and between residents during a medication pass. Hand hygiene should be done after sneezing or coughing. During interviews on 10/04/24, at 11:44 A.M., and on 10/07/24, at 1:47 P.M., the Director of Nursing (DON) said staff should perform hand hygiene in between medication passes. During an interview on 10/07/24, at 1:47 P.M., the Administrator said he/she expected staff to perform hand hygiene. 50185 51208

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 49585 Based on interview and record review, the facility failed to implement an effective and complete antibiotic stewardship program when staff failed to track residents on antibiotics for various infections in the facility by not completing a current and ongoing antibiotic log of residents with active infections. This failure could potentially place all residents at risk of infection. The facility census was 50. Review of a facility policy titled, Antibiotic Stewardship - Order for Antibiotics, dated December 2016, showed the following: -Antibiotics will be prescribed and administered to residents under the general guidance of the Antibiotic Stewardship Program; -Prescribers will provide the drug name, dose, frequency, duration, route, and indication for antibiotic orders; -The prescriber will assess the resident within 24 hours of a telephone antibiotic order; -Appropriate indications for the use of antibiotics will include resident meeting criteria for a clinical definition of an active infection and pathogen susceptibility, based upon a culture and sensitivity test. 1, Review showed the facility provided a computer printout of all residents prescribed antibiotics for the month of September. Staff provided no further documentation of antibiotic tracking information provided upon request. During interviews 10/01/24, at 12:43 P.M., and on 10/04/24, at 11:44 A.M., the Director of Nursing (DON) said the following: -He/she obtains a report of antibiotic usage monthly and reviews it with the physician. -No residents in facility were currently on antibiotics. -There are no other antibiotic tracking measures or notes from the monthly physician meeting documented. -He/she said no measures were in place to track outcome surveillance related to antibiotic use. -He/she obtains a new urinalysis upon completion of antibiotics but does not maintain a log with results. During an interview on 10/07/24, at 1:47 P.M., the Administrator said he/she expected staff to follow guidelines for prescribed antibiotics.