STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265481	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pin Oaks Living Center	1525 West Monroe Mexico, MO 65265

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51871 Based on observation, interview, record review, and facility policy review, the facility failed to ensure one resident (Resident (R)375) observed out of a total sample of 24 residents had an assessment and an order for self-administration of medications. These failures placed R375 at risk for medication errors, overdose, or misappropriation of medications. The facility census was 71. Findings include: Review of the facility policy titled, Medication Administration Guidelines, dated 02/07/13 revealed, Remain in the room while the resident takes the medication. Review of the facility policy titled, Medications, Self-Administration, Self-Storage, Leave At Bedside dated 02/07/13 revealed, The resident has a right to self-administer medication unless the interdisciplinary team has determined that this practice is unsafe for an individual resident . Self-administration and self-storage of over-the-counter medications: The resident's ability to self-administer over-the-counter medications and store them at the bedside (including external creams and ointments) shall be determined by the assessment and reassessment. A physician's order for these medications will also include 'may keep at bedside'. Review of R375's Face Sheet tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including insomnia, depression, anxiety, diabetes, low back pain, and constipation. Review of R375's Orders tab of the EMR revealed there was no order or assessment for R375 to have medications at her bedside for self-administration. During an observation on 11/11/24 at 12:34 PM in R375's room, revealed over-the-counter medications bottles on top of R375's dresser and on her bedside table. The room door was open and the resident was not in the room; the medications were visible from the hallway. The medications included, one bottle of melatonin pills (sleep aid), one large bottle of low dose aspirin, one bottle of opened Miralax (polyethylene glycol, a laxative), one bottle of Imodium (anti-diarrheal), one small bottle of lubricant eye drops, and one bottle of Osteo Bi-Flex (arthritis medication) capsules. During an interview on 11/12/24 at 10:26 AM, R375 said, I brought over-the counter medications in from my home. They [staff] know I have it. According to my outside doctor, I'm supposed to take it. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265481	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER Pin Oaks Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1525 West Monroe Mexico, MO 65265	

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/11/24 at 12:37 PM, Certified Medication Technician (CMT) 1 provided medications in a cup to R375. CMT1 set the cup of medications on the table next to R375's plate. CMT1 walked away without observing R375 take her medications. During an interview on 11/11/24 at 12:38 PM, R375 said, I took the meds. The tech placed them on my table. During an interview on 11/11/24 at 12:40 PM, CMT1 said, Normally I stay with the residents when I pass meds. I trusted that she [R375] would take it. During an observation and interview on 11/12/24 at 10:38 AM with Licensed Practical Nurse (LPN) 2 in R375's room, the LPN confirmed the resident had medications on her dresser and/or bedside table. LPN2 said, These medications should not be in here at her bedside. It's a safety issue. I don't know who allowed her to have these medications, because on admission they are supposed to take things like this away from the residents unless they have been assessed and have a doctor's order but even so, it's still not safe because her husband (R376) has dementia and comes here to visit her. During an interview on 11/13/24 at 11:15 AM, the Director of Nursing/Infection Preventionist (DON/IP) said, Residents may have medications at the bedside if the physician approves; they need an order. Residents require observation and nurses are to complete self-administration of medication observation form [assessment] which should be in residents' chart. If the residents have medications at the bedside, that tells me staff did not go through their belongings at time of admission, that's why they were there (at the bedside). The admitting nurse should have gone through R375's belongings on admission and would have found the medications and stored them. The DON/IP said, I expect nurses to pass medications according to the five rights of medication pass. The nurses/CMTs are to watch residents take the medications, sometimes residents will cheek the medications or just don't take it.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51871 Based on interview, record review, and facility policy review, the facility failed to ensure code status/advance directives would be honored when the facility failed to obtain a physician's signature or resident/responsible party signature for code status or advance directive paperwork for two residents (R375 and R48) of five residents reviewed for code status out of a total sample of 24 residents. The facility census was 71. Findings include: Review of the facility's undated Cardiopulmonary Resuscitation (CPR) Policy, revealed, Guidelines for CPR: NOTE: Do not initiate CPR if a valid DNR order is in place. Review of the facility's undated Advance Directive policy revealed it did not address code status and provision of or withholding CPR. 1. Review of R375's Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE]. Diagnoses included diabetes, anxiety disorder, and depression. The Face Sheet documented, Directive Copy on File: Notes-Do Not Resuscitate (DNR). Review of form titled Outside the Hospital Do-Not-Resuscitate (DNR) Order, located in the paper chart at the nurses' station, revealed the form was signed and dated by R375 on [DATE] but there was no physician signature or date on the form. During an interview on [DATE] at 4:38 PM, the Social Services Director (SSD) confirmed R375's DNR form was faxed to the physician, however, the physician had not signed the form because she was on vacation. The SSD stated that typically the nurse would get a verbal DNR order on the same day the form was completed; however, this was not done. The SSD stated there was a covering physician and nurse practitioner on call. The SSD stated in the event there were no orders for DNR, R375 would receive CPR and be considered Full Code status. During an interview on [DATE] at 4:46 PM, Registered Nurse (RN)1 stated she would perform full resuscitation on R375. (RN)1 said, I would normally check the chart to see if the DNR form is signed and if the DNR form is not signed, I would resuscitate. RN1 stated that R375 was fully cognitively intact and made her own decisions. RN1 stated that R375 told her she elected DNR. During an interview on [DATE] at 5:40 PM, R375 said, I do not want resuscitation. It's on my file. I have already signed the DNR form, and the staff are aware of my wishes. During an interview on [DATE] at 11:16 AM, the Director of Nursing/Infection Preventionist (DON/IP) said, in the case a resident should code, a full code means CPR would be started by the nurse. If a resident is a DNR according to the EMR and chart, I would not expect nurses to perform CPR. 51809 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R48's Face Sheet, located under the Resident tab of the EMR, revealed he was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Continued review revealed a Do Not Resuscitate (DNR) code status. Review of R48's Admission Minimum Data Set (MDS) with an assessment reference date (ARD) of [DATE] and located in the Resident Assessment Instrument (RAI) tab of the EMR, revealed a Brief Interview for Mental Status score (BIMS) of 13 out of 15 indicating he was cognitively intact. Review of R48's EMR under the Orders tab indicated an order dated [DATE] for Full Code status. Review of R48's Progress Note dated [DATE] revealed the Social Service Director (SSD) spoke with resident today and he has chosen to change code status to Full Code. He did not wish to be put on a vent or anything that breathes for him. Resident code status changed to Full Code. Review of R48's EMR revealed a new code status of DNR dated [DATE]. Review of R48's Care Plan, dated [DATE] and located in the Care Plan tab of the EMR, revealed, I have an Advanced Directive as evidenced by (AEB): Do Not Resuscitate, with interventions to include if observed without pulse and/or respirations, do not start cardiopulmonary resuscitation (CPR), do not call 911; keep my family informed of condition changes and review my code status quarterly and as needed. Review of R48's Hard Chart, located at the nurse's station, revealed a red laminated piece of paper located in the front of the chart that documented, Do Not Resuscitate (DNR). However, there was no documented evidence to support a physician-signed DNR order was placed in the medical record under the Advanced Directive tab or resident-signed code status election. During an interview on [DATE] at 3:30 PM with Registered Nurse (RN)1, she stated a purple signed Out of Hospital DNR form, which would contain the resident/representative signature as well as physician's signature, should be in the hard chart but R48 did not have one. She stated the DNR form should have been completed by the SSD when there was a change in code status and the SSD was responsible for ensuring the code status was updated in the medical record at the time the change was made. During an interview on [DATE] at 3:45 PM with R48, he stated staff had discussed code status with him when he arrived at the facility and he had informed them if his heart stopped beating and he stopped breathing, he did not want anything done to save him. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:20 AM with the SSD, she stated she was responsible for obtaining the code status on admission and making changes as needed. She further stated any nurse can obtain a physician's order and change code status upon the resident's request. The SSD stated changes in code status should be made immediately and a physician's order must be obtained and placed in the resident's chart and updated in the EMR. The SSD stated when a resident was found unresponsive, staff should look at the Hard Chart and the EMR to determine code status. She stated the first line of review would be to look at the Hard Chart to see if the color-coded laminated sheet was in front of the chart. She stated a red laminated sheet located in the front of the chart is for DNR and a purple form is an Out of Hospital DNR form and should be located under the Advanced Directives tab in the hard chart and the form should be signed and dated by the resident or the resident's representative and signed by the physician. She stated a green laminated sheet was located in the front of the chart for Full Code. The SSD stated RN1 brought it to her attention on [DATE] that R48 had conflicting code status orders, and a purple signed Out of Hospital DNR form was missing from R48's Hard Chart. The SSD stated she then went to R48 immediately on [DATE] and asked him what his preference was for code status and the resident told her he wanted to have CPR but if there was no hope, he did not wish to be intubated or be placed on a ventilator. The SSD stated she immediately notified the physician and made the change to the resident's chart. Review of R48's Progress Note dated [DATE] revealed the SSD documented, State surveyor alerted social services that resident had requested DNR status. Provider Partners Health Plan (PPHP), Registered Nurse (RN) and SSD spoke with the resident. It was explained to him what CPR was and what would/could happen. He stated again that he wanted CPR. The resident signed to be a Full Code and the physician signed the order. During an interview on [DATE] at 11:20 AM with the Administrator, she stated it was her expectation for all residents to have the appropriate code status on file and resident code status should be honored. During an interview on [DATE] at 1:30 PM with the Director of Nurses/ Infection Preventionist (DON/IP), she stated she expected nursing staff to obtain a signed resident or resident representative Out of Hospital DNR and signed physicians order and ensure the order was placed under the Advanced Directive tab in the resident's hard chart. She stated she expected the EMR and the Care Plan to reflect the residents' wishes regarding code status. She further stated changes in code status should be updated immediately to ensure the residents' advance directive wishes were honored.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693 Based on interview and record review, the facility failed to properly notify residents of potential non-coverage and beneficiary financial liability for two of three residents (Resident (R)225 and R227) reviewed for beneficiary notification out of a total sample of 24 residents. This had the potential to place undue financial liability on residents without their knowledge. The facility census was 71. Findings include: The facility did not provide a policy related to Advanced Beneficiary Notice (ABN). 1. Review of R225's undated Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), revealed R225 was admitted to the facility on [DATE] and discharged on [DATE]. Review of a document titled Notice of Medicare Non-Coverage (NOMNC) for R225 revealed a NOMNC dated 09/03/24 indicating a coverage end date of 09/14/24. There was no ABN with a benefits end date of 09/14/24 when R225's coverage for skilled nursing was due to end and R225 remained in the facility. Review of R225's Progress Notes revealed R225 remained in the facility and continued to receive skilled nursing care after 09/14/24. 2. Review of R227's undated Face Sheet, located in the Face Sheet tab of the EMR, revealed R227 was admitted to the facility on [DATE] and discharged on [DATE]. Review of a NOMNC dated 08/23/24 for R227 indicated a coverage end dated 08/25/24. There was no ABN with a benefits end date of 08/25/24 when R227's coverage for skilled nursing was due to end and R227 remained in the facility. Review of R227's Progress Notes revealed R227 remained in the facility and continued to receive skill nursing care after 08/25/24. During an interview on 11/14/24 at 6:26 PM the Administrator stated they used the wrong form for beneficiary notices for R225 and R227.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of facility policy, record review, and interview, the facility failed to ensure one resident (Resident (R) R25) out of three residents reviewed for abuse was free from resident to resident verbal abuse. R25 was verbally abused by R49. This failure created the potential for further resident to resident abuse and for R25 to experience psychosocial harm related to the abuse. A total of 24 residents were reviewed in the sample. The facility census was 71. Findings include: Review of the facility's undated Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy read, in pertinent part, It is the policy of this facility that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment, or involuntary seclusion; and examples include scolding, ignoring, ridiculing, or cursing a resident. 1. Review of R25's undated Face Sheet found in the Electronic Medical Record (EMR) under the Summary tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included dementia without behavioral disturbance and generalized anxiety disorder. Review of R25's annual Minimum Data Set (MDS) with an Assessment Reference (ARD) date of 08/04/24 found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated the resident was severely cognitively impaired. The assessment indicated R25 did not exhibit any behaviors during the assessment reference period. Review of R25's comprehensive Progress Notes, dated 09/01/24 through 11/15/24 found in the EMR under the Notes tab, revealed nothing related to the resident being abused. 2. Review of R49's undated Face Sheet, found in the EMR under the Summary tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Parkinson's Disease and history of hallucinations. Review of R49's annual MDS with an ARD of 08/03/24 and found in the EMR under the MDS tab, indicated a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. The assessment indicated R49 did not exhibit any behaviors during the assessment reference period. Review of R49's Progress Note, dated 09/16/24 and found in the EMR under the Notes tab, indicated, Resident (R49) at desk, yelling at another resident (R25) to shut the (expletive) up you stupid (expletive)! Resident began to yell at this writer and CMT (Certified Medication Tech) calling staff stupid (expletive) can't even make her shut up. Resident was asked to return to room. Review of the facility's reportable incident documentation for 09/01/24 through 11/15/24 revealed nothing to indicate the 09/16/24 incident perpetrated by R49 toward R25 was ever investigated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN1/UM on 11/13/24 at 3:19 PM, she confirmed she wrote the 09/16/24 progress note in R49's record related to the incident of resident-to-resident verbal abuse perpetrated against R25. She stated she witnessed the interaction between R49 and R25 and, although R25 did not recall the incident after it occurred and did not appear to be harmed in any way by the interaction, the incident was potential verbal abuse. During an interview with the Director of Nursing (DON) on 11/13/24 at 3:15 PM, she indicated the Unit Manager (Licensed Practical Nurse1/Unit Manager (LPN1/UM) may have reported the incident to her, but she could not recall for certain. The DON stated all residents were expected to remain free of abuse. During an interview with the Administrator on 11/13/24 at 3:27 PM, she indicated the incident had been discussed in the facility's daily nursing meeting and she was aware of the incident. She stated she was unsure of whether the incident was verbal abuse, but stated her expectation was all residents in the facility were to remain free from abuse of any kind.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of facility policy, record review and interview, the facility failed to ensure timely reporting of allegations of abuse related to three (Residents (R) R22, R25 and R49) out of a total of three residents reviewed for abuse. R22 reported an allegation of staff to resident abuse and R25 was verbally abused by another resident (R49) and neither incident was timely reported to the State Agency (SA), Ombudsman or local law enforcement. This failure created the potential for these and other residents to experience potential further abuse. A total of 24 residents were reviewed in the sample. The facility census was 71. Findings include: The facility's undated Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy read, in pertinent part, It is the policy of this facility that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, misappropriation of resident property and exploitation, corporal punishment, or involuntary seclusion; and examples include scolding, ignoring, ridiculing, or cursing a resident; and The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements. 1. Review of R22's undated Face Sheet found in the Electronic Medical Record (EMR) under the Summary tab, revealed the resident was admitted to the facility on [DATE]. Review of R22's quarterly Minimum Data Set (MDS) with an Assessment Reference (ARD) of 10/04/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. The assessment indicated the resident did not exhibit any behaviors during the assessment reference period. During an interview with R22 on 11/12/24 at 9:47 AM, she reported an allegation of potential staff to resident abuse perpetrated against her by a Certified Medication Tech (CMT). The resident did not give the CMT's name. R22 stated whenever she had a bowel movement (BM) in her bed, the staff member would get mean. R22 stated she felt humiliated by the way the staff member spoke to her and stated, She (the staff member) talks to me like I am a piece of (expletive). She is very stern and very nasty. R22 stated when the staff member assisted her with changing her clothing after she had a BM in her bed a couple of days earlier the staff member had grabbed her leg and hurt her and then had yelled at her when she removed the staff member's hand from her leg. R22 stated she had not reported the incident to anyone at the facility. R22's allegation of potential abuse was reported by the surveyor to the Administrator on 11/12/24 at 10:50 AM. The Administrator acknowledged the report and stated she would follow up and initiate an investigation into the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview with the Administrator on 11/13/24 at 2:32 PM, the survey requested an update on the progress of the investigation. The Administrator stated an investigation into the allegation was ongoing, however no report had been made related to the incident to the SA, the Ombudsman or local law enforcement. She stated she did not know she was required to report to these entities when a recertification survey was being conducted since she thought the surveyors would take care of all of the reporting related to the incident. 2. Review of R25's undated Face Sheet, found in the EMR under the Summary tab, revealed the resident was admitted to the facility on [DATE]. Review of R25's annual MDS with an ARD of 08/04/24 and found in the EMR under the MDS tab, indicated a BIMS score of two out of 15 which indicated the resident was severely cognitively impaired. The assessment indicated R25 did not exhibit any behaviors during the assessment reference period. 3. Review of R49's undated Face Sheet, found in the EMR under the Summary tab, revealed the resident was admitted to the facility on [DATE]. Review of R49's annual MDS with an ARD of 08/03/24 and found in the EMR under the MDS tab, indicated a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. The assessment indicated R49 did not exhibit any behaviors during the assessment reference period. Review of R49's Progress Note, dated 09/16/24 and found in the EMR under the Notes tab, indicated, Resident (R49) at desk, yelling at another resident (R25) to shut the (expletive) up you stupid (expletive)! Review of the facility's reportable incident documentation from 09/01/24 through 11/15/24 revealed nothing to indicate the 09/16/24 incident perpetrated by R49 toward R25 was ever reported to the SA, local law enforcement or the local Ombudsman. During an interview with LPN1/UM on 11/13/24 at 3:19 PM, she confirmed she wrote the 09/16/24 progress note in R49's record related to the incident of resident-to-resident verbal abuse perpetrated against R25 and stated the incident had been reported immediately to the DON. During an interview with the Director of Nursing (DON) on 11/13/24 at 3:15 PM, she indicated the Unit Manager (Licensed Practical Nurse1/Unit Manager (LPN1/UM) may have reported the incident to her, but she could not recall for certain. The DON further stated she did not think the incident had ever been reported to any outside agency, including the SA, the local Ombudsman or local law enforcement. The DON stated the reporting should have been done within two hours after the incident occurred. During an interview with the Administrator on 11/13/24 at 3:27 PM, she indicated she was aware of the incident and confirmed the incident had never been reported to the SA, the Ombudsman, or local Law Enforcement. The Administrator stated she was unsure of the reporting requirements related to an incident of Resident-to-Resident abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of facility policy, record review, and interview, the facility failed to ensure a thorough investigation was completed related to an incident of resident-to-resident verbal abuse involving two (Residents (R)25 and R49) out of a total of three residents reviewed for abuse. This failure created the potential for R25 and other residents to experience further abuse. A total of 24 residents were reviewed in the sample. The facility census was 71. Findings include: Review of the facility's undated Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy read, in pertinent part, Investigation: It is the policy of his facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. 1. Review of R25's Face Sheet, found in the Electronic Medical Record (EMR) under the Summary tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included dementia without behavioral disturbance and generalized anxiety disorder. Review of R25's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/04/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated the resident was severely cognitively impaired. 2. Review of R49's Face Sheet, found in the EMR under the Summary tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Parkinson's Disease and history of hallucinations. Review of R49's annual MDS with an ARD of 08/03/24 and found in the EMR under the MDS tab, indicated a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Review of R49's Progress Note, dated 09/16/24 and found in the EMR under the Notes tab, indicated, Resident (R49) at desk, yelling at another resident (R25) to shut the (expletive) up you stupid (expletive)! resident asked to please return to room and not to speak to other residents that way. Review of the facility's reportable incident documentation from 09/01/24 through 11/15/24 revealed nothing to indicate the 09/16/24 incident perpetrated by R49 toward R25 was ever investigated by the facility. During an interview with Licensed Practical Nurse/Unit Manager (LPN1/UM) on 11/13/24 at 3:19 PM, she confirmed she wrote the 09/16/24 progress note in R49's record related to the incident of resident-to-resident verbal abuse perpetrated against R25 and stated she did not know if the incident had ever been investigated as abuse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nursing (DON) on 11/13/24 at 3:15 PM, she indicated she thought the incident of abuse might have been reported to her, but she did not know if the incident had ever been investigated by the facility. The DON confirmed it was the responsibility of the Administrator, the DON, and/or the Social Services Director (SSD) to conduct investigations into any allegation of potential abuse or neglect. The DON stated she thought the abuse should probably have been investigated. During an interview with the Administrator on 11/13/24 at 3:27 PM, she indicated she was aware of the incident and confirmed the incident had never been investigated. The Administrator stated the management team had discussed psychiatric services for R49, however the incident had not necessarily been interpreted as abuse. The Administrator stated she was unsure of the investigation procedures related to an incident of Resident-to-Resident abuse.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review and staff interview, the facility failed to ensure three residents (R9, R48, and R53) of a total of 24 residents reviewed had comprehensive care plans in place to address all of their needs. R9 did not have a care plan with interventions to prevent the resident from experiencing another coffee burn. R48 did not have a care plan in place to address his behaviors or the administration of his psychotropic medications and R53 did not have a care plan in place to address the administration of her oxygen. This failure created the potential for comprehensive care to not be provided for the residents. The facility census was 71. Findings include: 1. Review of R53's Face Sheet, found in the Electronic Medical Record (EMR) under the Summary tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnosis included chronic obstructive pulmonary disease (COPD). Review of R53's quarterly Minimum Data Set (MDS)with an Assessment Reference Date (ARD) of 10/25/24 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident was receiving oxygen therapy. Review of R53's physician's Orders, found in the EMR under the Orders tab, revealed an order, dated 09/05/24, that indicated the resident was to receive oxygen 1 to 2 liters per minute (lpm) via nasal cannula as needed for shortness of breath. Review of R53's comprehensive Care Plan, most recently dated 10/25/24 and found in the EMR under the Care Plan tab, revealed no care plan for the resident's use of oxygen. During an observation on 11/11/24 at 10:29 AM, R53 was observed in her room receiving oxygen, as well as on 11/12/24 at 10:22 AM, 3:08 AM, on 11/13/24 at 7:54 AM and 9:26 AM. During an interview with Licensed Practical Nurse/Unit Manager (LPN1/UM) on 11/13/24 at 10:46 AM, she confirmed there was no care plan in the resident's record for the use of oxygen and stated there should be a care plan in place. During an interview with the Director of Nursing (DON) on 11/13/24 at 12:14 PM, she confirmed her expectation was care plans should be in place for residents to address all of their needs. During an interview with the MDS Coordinator (MDSC) on 11/14/24 at 11:48 AM, she stated she was behind with care planning for residents and confirmed a care plan should be in place for the administration of R53's oxygen. 51809 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R48's Face Sheet, located under the Resident tab of the electronic medical record (EMR), revealed he was initially admitted to the facility on [DATE] with a diagnosis of COPD. Review of R48's EMR under the Orders tab indicated orders dated 07/24/24 for hydroxyzine HCl (antihistamine) 50 milligrams (mg), one tablet orally three times a day as needed for depressive disorder and lorazepam (antianxiety) 0.5 mg 1 tablet orally three times a day as needed for COPD. Review of R48's Comprehensive Care Plan located in the EMR under the RAI tab dated 04/01/24 revealed: I have COPD with interventions to include, administer my medications as ordered . Continued review revealed R48 had not been care planned for Depressive Disorder or Anxiety related to COPD. 3. Review of R9's undated Face Sheet, found in the Electronic Medical Record (EMR) under the Summary tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnosis included dementia. Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/24 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated the resident was moderately cognitively impaired. Review of R9's Progress Notes, dated 11/08/24 and found in the EMR under the Notes tab, revealed, R9 returned from dining room by Certified Nursing Assistant (CNA) resident had spilled hot coffee on her left arm and abdomen. Noted resident to have redness with small blisters noted to left wrist and forearm, redness and small blisters also noted to left abdomen. Clothing removed and cool moist compresses held to areas. (Physician) notified of incident and NNO (no new orders) received at this time. (Family Member) notified of incident. Review of R9's comprehensive Care Plan most recently dated 10/21/24 and found in the EMR under the Care Plan tab, revealed nothing to indicate the resident's Care Plan had been updated with interventions to prevent the resident from experiencing another coffee burn. During an interview on 11/14/24 at 10:00 AM with Registered Nurse (RN)1 confirmed R48 was not care planned for his diagnoses of depressive disorder and anxiety so staff would know what to do to treat the resident appropriately. During an interview on 11/14/24 1:30 PM with the Director of Nursing/ Infection Preventionist (DON/IP) she confirmed R48 should have been care planned for his diagnoses of depressive disorder and anxiety to ensure staff provided the care needed to improve R48's overall well-being and quality of life. During an interview with the Administrator and DON together on 11/11/24 at 2:35 PM, the DON stated a lid had been added to R9's coffee cup to prevent further burns, however she was not sure if the intervention had been added to the resident's care plan.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51871 Based on interview, record review, and facility policy review, the facility failed to ensure a final discharge summary was completed upon discharge for one resident (Resident (R) 17) of three residents reviewed for discharge out of a total sample of 24 residents. This deficient practice had the potential to contribute to a lack of continuity of care and lack of necessary treatment and services. The facility census was 71. The findings include: Review of the facility's policy titled, Resident Discharge/Transfer Policy dated March 2015, revealed, Complete discharge summary and post discharge plan of care form. Have resident and/or representative or person responsible for care sign discharge summary and post discharge care form. Place the original form in the record. Review of R17's Face Sheet tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses that included: sepsis, palliative care, morbid (severe) obesity, schizophrenia, peripheral vascular disease, pain, diarrhea, constipation, multiple myeloma, type 2 diabetes mellitus. R17 was discharged from the facility on 10/12/24. Review of R17's Recapitulation of Stay and Discharge Summary form, dated 10/12/24 and located in the Observations tab of the EMR, revealed the form was not completed, all questions were left blank. During an interview on 11/14/24 at 1:47 PM, the Social Services Director (SSD) stated R17 was discharged to another facility upon his request on 10/12/24. The SSD stated R17 was admitted from the hospital with a diagnosis of multiple myeloma and was placed on hospice and since R17 had family in another city, he decided to transfer to a facility closer to his family. The SSD verified R17's Recapitulation of Stay and Discharge Summary electronic discharge summary was not completed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on facility policy review, observation, record review, and interviews, the facility failed to implement their scheduled activities programs for residents. The facility also failed to ensure one (Resident (R)9) of two residents reviewed for activities was provided with a consistent activity program to meet their needs. The resident was not offered activities based on assessment of her activity preferences. This failure created the potential for the resident to experience isolation related to lack of participation in facility activities. A total of 24 residents were reviewed in the sample. The facility census was 71. Findings include: Review of the facility's Activity, Volunteer and Recreational Services Policy dated 03/2012 read, in pertinent part, The facility provides for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. 1. Review of the facility's activity calendars for 11/01/24 through 11/30/24 were reviewed and showed activities such as Coffee and Donuts, BINGO, Word Find, Puzzles, Exercise, Whack a Mole, Coloring and Nail Care scheduled at specific times between 10:00 AM and 2:00 PM Monday through Friday. There were religious services offered by the local church on Sundays at 2:00 PM. Scheduled activities during the survey conducted between 11/11/24 and 11/14/24 were as follows: 11/11/24 (Monday): 10:00 AM Veteran's Day Recognition, 12:00 Puzzle, 2:00 Veteran's Day Craft. 11/12/24 (Tuesday): 10:00 AM Whack a Mole, 12:00 Coloring, 2:00 Nail Care. 11/13/24 (Wednesday): 10:00 1:1 Visits, 12:00 Word Find, 2:00 BINGO. 11/14/24 (Thursday) 10:00 Exercise, 12:00 Puzzle, 2:00 Glascow and Friends. Observations of scheduled activities on 11/11/24 through 11/14/24, showed of the 12 activities that were scheduled during that period of time, only the Veteran's Day Recognition (Monday), Whack a Mole (Tuesday), BINGO (Wednesday), and Glascow and Friends (Thursday) occurred. During a phone interview with the Activities Director on 11/14/24 at 1:25 PM, she stated she had been out of the facility for a couple of weeks, and thought other staff members were conducting scheduled activities when she was not in the facility, including evenings and on weekends. The AD stated she had not had time to document activity participation in resident activity logs for the previous few weeks. The AD stated she thought a lot of the residents participated in the church service on Sundays, but did not know if attendance was being documented or not. She stated the facility's Bookkeeper helped with BINGO on BINGO days and she thought Restorative Staff did exercises with residents sometimes. 2. Review of R9's undated Face Sheet, found in the Electronic Medical Record (EMR) under the Summary tab, indicated the resident was admitted to the facility on [DATE]. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/24 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated the resident was moderately cognitively impaired. Review of R9's Activities Care Plan, dated 04/26/22 and found in the EMR under the Care Plan tab, revealed the resident attended activities that she enjoyed with encouragement from staff and that she required staff supervision with activities. The care plan indicated the resident enjoyed going outside and BINGO. Interventions included encourage me to socialize during group activities, give me an activities calendar, and provide one to one visits for sensory stimulation, socialization, and emotional support. Review of R9's Interview for Resident Preferences and Activities Assessment, dated 01/17/24 and found in the EMR under the Observations tab, revealed it was somewhat important or very important for the resident to have books, the newspaper, and/or magazines to read, do things with groups of people, do favorite activities, and participate in religious activities. Review of R9's most recent Activities Assessment, dated 07/29/24 and found in the EMR under the Observations tab, revealed the resident participated in 1:1 activities, group activities, physical activities, projects, and resident council. The assessment indicated the resident enjoyed playing cards, crafts, exercise, music, and watching TV. The assessment indicated the resident's preferred activity participation time was in the afternoon and indicated the resident participated in activities 1/3 to 2/3 of the time. Review of R9's Activities Participation Documentation, dated 09/01/24 through 11/14/24 and provided directly to the surveyor in a binder kept in the Activities Director's Office, revealed no documentation of activity participation between 09/27/24 and 11/14/24. During observations of R9 she was observed either sleeping in her bed or seated in her Broda chair by the nurse's station on 11/12/24 at 9:16 AM, 2:37 PM, 3:05 PM, on 11/13/24 at 9:12 AM, 2:08 PM, on 11/14/24 at 9:35 AM, 1:05 PM and 2:21 PM. The resident was not observed participating in activities during any of the observations. BINGO was offered in the facility's dining room on 11/13/23 from 2:00 PM through 2:45 PM and a music program (Glascow and Friends) was offered on 11/14/24 from 2:00 PM through 3:00 PM, and although the resident was observed to be awake and seated in her Broda chair at the nurse's station at the time of these activities, she was not observed to participate in either of the activities even though the resident's activities assessments indicated interest in these activities. No alternative or 1:1 activities were observed to be offered to R9 during the survey period. During an interview with Licensed Practical Nurse/Unit Manager (LPN1/UM) on 11/12/24 at 2:37 PM, she stated no group activities were being offered on that date because the Activity Director (AD) was out of the building for personal reasons. LPN1/UM confirmed activities were on the activity schedule for 11/12/24, but had not been offered on that day since there was no staff in the building to do them. During an interview conducted by phone with the AD on 11/14/24 at 1:25 PM, she confirmed group activities had not been offered routinely during the most recent two weeks as she had been out of the facility on some days related to personal issues. The AD confirmed R9's activities participation had not been documented on her participation log. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 11/14/24 at 1:47 PM, she stated activities were expected to be provided to residents based on their individual activities assessment and preferences and participation in activities was expected to be documented.

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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** 18947 Based on facility policy review, review of Broda chair instructions, observation, record review, and interview, the facility failed to ensure one resident (R9) of two residents reviewed for pressure sores was provided with adequate care and treatment to prevent skin breakdown. This failure created the potential for the resident to experience further skin breakdown. A total of 24 residents were reviewed in the sample. The facility census was 71. Findings include: Review of the facility's undated Wound Care and Treatment Policy read, in pertinent part, It is the purpose of this facility to prevent and treat all wounds; and There must be a specific order for the treatment; and The care plan should reflect the current status of the wound and appropriate goals and approaches. Review of the facility's undated Instructions for Use When Using a Broda Chair document, provided directly to the survey team, read, Are Additional Cushions Recommended or Required? Not necessarily. Our proprietary Comfort Tension Seating system is typically sufficient for most users when paired with the standard Broda padding that comes with your wheelchair. Whether to use an alternative cushion depends on various factors, including the wheelchair user's skin integrity, wound history, medical conditions, etcetera. Review of R9's undated Face Sheet, found in the Electronic Medical Record (EMR) under the Summary tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included dementia and type 2 diabetes. Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/24 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident was at risk for developing pressure ulcers but did not have any current pressure ulcers at the time of the assessment. The assessment indicated a pressure reducing mattress was being used on the resident's bed but indicated a pressure reducing cushion was not in use on the resident's wheelchair. Review of R9's Progress Notes, dated 11/04/24 and found in the EMR under the Notes tab, revealed, Resident has a 2cm (centimeter) slit type open area in coccyx area, order received to start xeroform and cover with mepore (dressing) daily til (sic) healed. Review of R9's pressure ulcer Care Plan, most recently dated 11/13/24 and found in the EMR under the Care Plan tab, revealed the resident had developed a stage 2 pressure ulcer to her coccyx. The care plan indicated the area was to be kept clean and dry, wound treatment was to be done per physician's orders, and a pressure reducing cushion was to be applied to the resident's Broda chair. (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 R9's comprehensive physicians Orders, dated 11/14/24 and found in the EMR under the Orders tab, indicated orders, 11/08/24, that indicated the resident was to receive the following treatment: Xeroform (a wound dressing treatment) once per day (5 (inches) X 9 (inches) topical (to the resident's skin). The order did not include specifics related to what the dressing was being used for, where the dressing was to be applied, or instructions for cleansing and prepping the area of concern when the dressing was applied. Observations of R9 on 11/13/24 at 7:59 AM, 7:59 AM, 9:29 AM, 10:10 AM, 10:56 AM, 12:12 PM and on 11/14/24 at 9:35 AM revealed the resident was sitting in her Broda chair. There was not a pressure relieving cushion on the resident's Broda chair during any of the observations. During an observation of R9 on 11/13/24 at 10:20 AM along with Licensed Practical Nurse/Unit Manager (LPN1/UM) revealed R9 was laying in her bed and her Broda chair was next to the bed. LPN1/UN confirmed there was not a pressure reducing cushion on the resident's Broda chair. LPN1/UM confirmed the resident had developed a stage 2 pressure sore on 11/06/24. She stated administration told her pressure reducing cushions could not be applied to Broda chairs and that was why there wasn't one on R9's chair. LPN1/UM acknowledged there were no specific instructions entered into the wound care orders and stated she would update the orders to indicate the location of the wound and cleansing and dressing instructions related to the wound. During an interview with the Director of Nursing (DON) on 11/13/24 at 12:28 PM, she stated previous administration told her a pressure relieving cushion could not be used in a Broda chair and stated no pressure reducing cushion was being applied since the resident needed a Broda chair. The DON stated she thought the manufacturer's guidelines indicated a pressure reducing cushion could not be used in the Broda chair and stated she would see if she could find the manufacturer's instructions for use for the Broda chair. The DON stated her expectation was orders for wound care were to be complete and specific and the resident's care plan was to be accurate and followed related to the resident's wound care. During a follow-up interview with the DON on 11/13/24 at 3:33 PM, she provided the manufacturer's instructions for use for the Broda chair and confirmed there was nothing on the document to indicate a pressure reducing cushion could not be used in the chair. She stated, a cushion can be used and should have been applied (to the resident's Broda chair).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure residents were free from potential accident and hazards during smoking for one of one (Resident (R) 67) reviewed for safe environment out of a sample of 24 residents. This had the potential to place residents at risk of injury from a potential fire. The facility census was 71. Findings include: Review of the Oxygen Therapy Safety Guidelines from the National Institute of Health revealed the following: -Keep oxygen cylinders away from heat sources; -Keep oxygen delivery systems at least 5 feet from any heat source; -Oxygen supports combustion. No smoking is permitted around any oxygen delivery devices in the hospital or home environment. Review of the facility policy (undated) titled, Smoking-Resident revealed Anyone who provides smoking supervision to residents shall be advised of any restrictions/concerns and the plan of care related to smoking. Review of a document titled Dependent Resident Smoking Times undated and posted on the 100 hall nurses stations indicated maintenance, activities, housekeeping, laundry, and nursing staff were assigned to provide supervision for smokers. The document did not provide any instructions related to smokers and oxygen use. Review of R67's undated Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), revealed R67 was admitted to the facility on [DATE]. Diagnoses included chronic obstructive pulmonary disease. Review of R67's Orders located in the EMR under the Orders tab revealed an order dated 09/04/24 for oxygen 1-2 liters per minute (lpm) per nasal cannula continuous may titrate to keep oxygen saturation above 94%. Review of a 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/05/24 revealed R67 was staff assessed as having short-term and long-term memory problems and received continuous oxygen therapy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 11/14/24 at 9:30 AM, the Floor Tech (FT) was observed receiving a lighter from a nursing staff member, and then proceeded to walk down the hall to assist R67 to the door of the smoking patio. At this time, R67 was observed sitting in a wheelchair using oxygen via nasal cannula with the oxygen tank secured to the back of the wheelchair with the oxygen turned on. The FT then parked R67 in his wheelchair in the smoking patio next to another resident who was smoking. The surveyor who witnessed this immediately notified the Administrator who was standing at the doorway to the library across the hallway from the smoking patio door. The Administrator exited the hallway to the smoking patio and had the Maintenance Director (MD) remove the oxygen tank from the back of R67's wheelchair and the smoking patio. During an interview on 11/14/24 at 9:50 AM the FT stated he had not received any formal orientation or training to supervise smokers only that someone from nursing had told him to make sure the oxygen was turned off when residents use oxygen and smoke. He stated he had not been instructed to remove the oxygen tank from the smoking area. He stated he routinely supervised smokers during smoke breaks and there was a schedule regarding which department was to supervise smokers posted at the nurse's station. The FT stated he had assisted R67 to the smoking patio, ensured the oxygen was turned off and had not lit the cigarette before the Administrator arrived to intervene. He confirmed that there was already another resident smoking sitting next to R67 when he assisted R67 to the smoking patio. During an interview on 11/14/24 at 10:00 AM the Director of Nursing (DON) stated she was unaware of what training was provided to the staff who are assigned to supervise residents who smoke but they should not have the oxygen tanks in the smoking area. The DON confirmed that maintenance, activities, housekeeping, laundry, and nursing staff provide supervision to smokers. During interviews on 11/14/24 from 10:40 AM to 11:00 AM the Maintenance Director (MD), Housekeeper (HK) 1, and the Housekeeping Supervisor (HKS) stated they supervised residents during smoke breaks but had not received formal training related to smokers and oxygen use and were told only to turn off the oxygen when supervising residents who smoke. During an interview on 11/14/23 at 11:00 AM the Administrator confirmed staff had not received training related to smokers and oxygen use. The Administrator stated oxygen tanks should be kept away from the smoking area.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on review of facility policy, record review, and interview, the facility failed to ensure comprehensive dialysis services were provided for one resident (R22) out of a total of one resident reviewed for dialysis. There were no orders in place related to the care and maintenance of the resident's intravenous (IV) dialysis catheter. This failure created the potential for R22 to receive incomplete and inconsistent care of her dialysis catheter. A total of 24 residents were reviewed in the sample. The facility census was 71. Findings include: Review of the facility's undated Dialysis, Care of a Resident Receiving Policy read, in pertinent part, Care of a Subclavian or Femoral Vein Catheter: Treatment for cleaning as ordered by the physician .Nurses to maintain dressing to access site at all times. Site to be checked every shift and dressing reapplied or reinforced as needed. Review of R22's undated Face Sheet, found in the Electronic Medical Record (EMR) under the Summary tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnosis included End Stage Renal Disease (ESRD) and indicated the resident was receiving hemodialysis. Review of R22's quarterly Minimum Data Set (MDS)' with an Assessment Reference Date (ARD) of 10/04/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact. The assessment indicated the resident was receiving routine hemodialysis services. Review of R22's comprehensive physician's Orders, dated 11/01/24 through 11/14/24 and found in the EMR under the Orders tab, revealed no orders for the care or maintenance of the resident's hemodialysis catheter. Review of R22's Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 11/01/24 through 11/14/24 and found in the EMR under the Orders tab, revealed nothing to indicate routine care and/or maintenance of the resident's dialysis catheter was being done. Review of R22's Dialysis Care Plan, dated 10/01/24 and found in the EMR under the Care Plan tab, revealed the resident was receiving dialysis three times per week at a dialysis center in the community and a dialysis catheter was in place. The Care Plan indicated the resident frequently attempted to dislodge her dialysis catheter and/or remove the catheter dressing. Interventions included reminding the resident to not bother the catheter. The Care Plan indicated most of the catheter care would be provided by the dialysis center. During an interview with the Licensed Practical Nurse/Unit Manager (LPN1/UM) on 11/14/24 at 9:25 AM, she confirmed there were no orders for the care and maintenance of R22's dialysis catheter. She stated the orders should be in place in the resident's record. During an interview with the Director of Nursing (DON) on 11/14/24 at 10:01 AM, she stated her expectation was orders would be in place related to the care and maintenance of R22's dialysis catheter.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, staff interviews, and facility policy review, the facility failed to ensure two residents (R9 and R53) of a total of nine residents reviewed for accidents was appropriately assessed for the use of side rails on their beds. The facility further failed to ensure both residents had an informed consent for the use of rails on their beds. This failure created the potential for the residents to be injured related to use of potentially unnecessary side rails installed and in use on their beds. A total of 24 residents were reviewed in the sample. The facility census was 71. Findings include: Review of the facility's undated Bed Rails Policy read, in pertinent part, Prior to use of bed rails the facility should complete the Matrix Bed Rail Observation including the following: 1. Observation Detail 2. Clinical Assessment 3. Alternatives attempted prior to bed rail implementation 4. Bed Rail Details 5. Assessment of potential entrapment zones 6. Review of the risks and benefits with the resident and resident representative 7. Obtain informed consent with the resident and/or resident representative signature 8. Obtain physician order for medical symptom assessed requiring bed rail use; and Care Plan: Develop a care plan that outlines the medical factors necessitating bed rails and an explanation of how the use of a bed rail is intended to treat the specific resident's condition. 1. Review of R9's undated Face Sheet, found in the Electronic Medical Record (EMR) under the Summary tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included dementia and repeated falls. Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/24 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident required partial to moderate assistance of staff to roll from side to side in her bed and substantial to maximum assistance from staff to transfer in and out of her bed. The assessment indicated side rails were not in use for R9. During an observation on 11/12/24 at 2:37 PM, at 3:06 PM, and on 11/13/24 at 9:12 AM revealed R9 was observed laying in her bed with one 1/3 bed rail and one 1/8 bed rail in the raised position at the head of her bed. Review of R9's comprehensive physicians Orders dated 11/14/24 and found in the EMR under the Orders tab, indicated no orders for the resident's use of bed rails. Review of R9's comprehensive Care Plan most recently dated 09/20/24 and found in the EMR under the Care Plan Tab, indicated nothing to reflect the resident's use of side rails. Review of R9's EMR revealed nothing to show the resident had recently been assessed for use of bed rails or that informed consent had been provided for the use of rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/13/24 at 10:20 PM with Licensed Practical Nurse/Unit Manager (LPN1/UM) LPN1/UM confirmed the rails on R9's bed were in the raised position. R9's EMR was reviewed with LPN1/UM and she verified there was no assessment, physician's order, care plan or signed informed consent for the bed rails. 2. Review of R53's undated Face Sheet, found in the EMR under the Summary tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnosis included type 2 diabetes. Review of R53's quarterly MDS with an ARD of 10/25/24 and found in the EMR under the MDS tab, revealed a BIMS score of 12 out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident was independent with rolling from side to side in her bed and required supervision or touching assistance from staff to transfer in and out of her bed. The assessment indicated side rails were not in use for R53. During an observation on 11/13/24 at 7:54 AM and on 11/14/24 at 9:33 AM revealed R53 was observed laying in her bed with bilateral 1/3 bed rails in the raised position at the head of her bed. During an observation on 11/13/24 at 9:59 AM with Certified Nursing Assistant (CNA)3 confirmed R53's bed rails were in the raised position and stated the resident's rails were up all the time. Review of R53's comprehensive physicians Orders dated 11/14/24 and found in the EMR under the Orders tab, indicated an order for bilateral assist rails to aid in transfers and movement in bed. The original order date was 01/01/23. Review of R53's comprehensive Care Plan dated 09/22/22 and found in the EMR under the Care Plan tab, indicated nothing to reflect the resident's use of side rails. Review of R53's EMR revealed nothing to show the resident had been recently assessed for use of bed rails or that an informed consent had been provided for the use of rails. During an interview with R53 on 11/12/24 at 10:14 AM, she indicated she was able to use the rails on her bed for mobility. During an observation on 11/13/24 at 10:13 AM along with LPN1/UM on confirmed R53's bed rails were in the raised position. R53's EMR was reviewed with LPN1/UM and she confirmed the most recent assessment for the resident's use of bed rails had been completed on 01/01/23 (almost two years prior) and confirmed there was no care plan or signed consent for the use of the rails. During an interview with the Director of Nursing (DON) on 11/13/24 at 12:34 PM, she stated her expectation was use of bed rails required a current bed rail assessment (within the past year), physician's orders for the use of the rails, a care plan related to the rails and informed consent for the use of the rails.

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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. 51871 Based on observation, interview, and review of the Director of Nursing's (DONs) job description, the facility failed to ensure the DON served full time as DON and did not serve as charge nurse when the facility had an average daily occupancy of over 60 residents. This failure had the potential to affect the completion of nursing administration duties, including (but not limited to) staff training, quality improvement activities, and incident management for all 71 facility residents. The facility census is 71. Findings include: Review of the facility's DON Job description, dated May 2006 provided by the facility, revealed The DON must be in facility, or involved in other work-related activities a minimum of eight hours per day, Monday through Friday. In addition, routine second shift, third shift, and weekend on-site inspections are to be maintained. During observations during the survey from Monday, 11/11/24 through Thursday 11/14/24, the DON/Infection Preventionist (DON/IP) was observed working on Unit 1 as a floor nurse/charge nurse. During an interview on 11/14/24 at 1:30 PM with the DON/IP, she stated that antibiotics reviews should be done every day, but she was not always able to do this because of having to work as the interim DON/IP and working on the floor. She stated she worked on the floor when needed and typically worked on the floor three days a week as a nurse. The DON/IP commented that she was hired two years ago in another position and was supposed to be the full time IP, but has worked as an interim DON several times over the last year and a half. During an interview on 11/14/24 at approximately 5:20 PM, with the Administrator and DON/IP, the DON/IP said, I work two weeks straight and then off for one day. The Administrator confirmed the DON/IP worked 120 hours every two weeks. The DON/IP stated, When I work on the floor as a nurse, I am the charge nurse. I pass meds [medications], provide wound measurements for the residents. When I'm the nurse in charge I do admissions and discharges. I work two to three days a week as a charge nurse on the unit. The IP/DON said, In between charting, providing treatments for residents, and passing meds, I can make rounds to check on them [the staff] on other units and could delegate nursing responsibilities to other floor nurses when able to focus on DON duties, if possible. The IP/DON stated that she was also the IP. When asked how many hours she serves as the IP, the DON said, 30 hours. The DON stated she had been working dual roles for three and a half months, when two day-shift nurses and two night-shift nurses left. The Administrator stated she worked Monday through Friday and though she could be contacted by staff on the weekend via phone if there was an issue, she typically did not come into the facility on the weekend. The Administrator stated she had contacted the corporate office months ago regarding the use of agency nurses to supplement staff but added, We are still waiting for feedback on agency staffing.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693 Based on interview, record review, and facility policy review, the facility failed to ensure residents were monitored who were administered psychotropic medications for five of six residents (R23, R48, R49, R56 and R57) reviewed for unnecessary medications out of a total sample of 24 residents. This failure had the potential to lead to unwarranted medication side effects or improperly treated symptoms. The facility census was 71. Findings include: Review of the facility policy (undated) titled; Antipsychotic Medication revealed Antipsychotic medication therapy shall be used only when it is necessary to treat a specific condition. The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications. Review of an undated facility policy titled Antipsychotic Medication Use indicated that the attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, symptoms, and risks; the attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications; the staff will observe, document, and report to the attending physician regarding the effectiveness of any interventions, including antipsychotic medications; nursing staff shall monitor and report any of the following side effects to the attending physician: sedation, orthostatic hypotension, lightheadedness, dry mouth blurred vision, constipation, urinary retention, increased psychotic symptoms, extrapyramidal effects, akathisia, dystonia, tremor, rigidity and Akinesia or tardive dyskinesia. The facility did not have a policy specific to monitoring for antidepressant agents or psychotropic agents. 1. Review of R23's undated Face Sheet, located in the Face Sheet tab of the electronic medical record (EMR), revealed R23 was admitted to the facility on [DATE]. R23's diagnosis included depression unspecified. Review of R23's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/11/24 revealed R23 was assessed by staff to have had memory problems. The MDS indicated R23 had depression and had received antipsychotic medication and antidepressant medication during the seven days prior to the ARD. Review of R23's Orders located in the EMR under the Orders tab revealed an order for Cymbalta (antidepressant) 60 milligrams (mg) twice daily for depressive disorder and quetiapine 25 mg (antipsychotic agent) at bedtime for depressive disorder. The Orders did not include an order for behavior monitoring or side effect monitoring. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R23's Care Plan, located in the resident EMR under the Care Plan tab, indicated a focus area for antidepressant medications with interventions which included attempt GDR (gradual dose reduction) per pharmacy recommendations and as needed, assess behavioral symptoms, monitor for adverse reactions to medications. Review of R23's Observations,, Medication Administration Record (MAR), Treatment Administration Record (TAR), Point of Care response, Vitals, and Progress Notes in the EMR revealed no routine documentation related to behavior monitoring or antidepressant/antipsychotic side effect monitoring. During an interview on 11/13/24 at 12:20 PM Licensed Practical Nurse/Unit Manager (LPN/UM) 1 stated if a resident was on a psychotropic medication there should also be an order for behavior and side effect monitoring. Then the monitoring could be viewed on the MAR. She stated the facility used to have behavior and side effect monitoring on everyone but now no one on psychotropic medications had orders for monitoring. LPN1/UM confirmed there were no orders, or documentation, of monitoring for behaviors and side effects for R23. She also confirmed there was no other location in the EMR to routinely document behavior and side effect monitoring. During an interview on 11/13/24 at 5:05 PM the Director of Nursing (DON) stated residents do not have routine behavior and side effect monitoring because the staff document by exception. 18947 2. Review of R49's undated Face Sheet, found in the EMR under the Summary tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included depression, history of hallucinations, and anxiety. Review of R49's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/03/24 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. The assessment indicated R49 did not exhibit any behaviors or signs and symptoms of depression during the assessment reference period. Review of R49's physicians Orders dated 11/14/24 and found in the EMR under the Orders tab, revealed an order dated 05/32/22, for Clonazepam (an antianxiety medication) 1 milligrams (mg)by mouth every evening for anxiety and an order dated 06/08/23 for Sertraline (an antidepressant medication) 100 mg by mouth every night for depression. Review of R49's Psychotropic Drug Use Care Plan, dated 06/01/22 and found in the EMR under the Care Plan tab, revealed the resident was receiving psychotropic medications for anxiety and depression. Interventions included please monitor me for an increase in behaviors and adverse reaction/response to my medication and administer my medications as ordered. The plan of care did not indicate any specific behaviors to be monitored related to the administration of R49's psychotropic medication. Review of R49's Medication Administration Recor (MAR) and Treatment Administration Record (TAR), dated 11/01/24 through 11/14/24 and found in the EMR under the Orders tab, revealed nothing to indicate specific behaviors related to the administration of R49's psychotropic medications or side effects of the medication were being monitored. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R49's comprehensive EMR revealed nothing to show specific behaviors related to the administration of the resident's psychotropic medications had been identified and were being tracked, side effects of the resident's psychotropic medications were being tracked, or informed consent had been obtained for the administration of R49's psychotropic medications. 3. Review of R56's undated Face Sheet, found in the EMR under the Summary tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included vascular dementia with behaviors, depression, and anxiety. Review of R56's significant change MDS with an ARD of 08/15/24 and found in the EMR under the MDS tab, indicated a BIMS score of 12 out of 15 which indicated the resident was moderately cognitively impaired. The assessment indicated R56 exhibited behaviors (verbal and other behavioral symptoms) on one to three days of the reference period and signs or symptoms of depression on two to six days of the reference period. Review of R56's physicians Orders dated 11/14/24 and found in the EMR under the Orders tab, revealed an order, with an original order date of 06/12/24, for Lexapro (an antidepressant medication) 10 mg by mouth daily for depression, an order, dated 07/24/24, for Lorazepam (an antianxiety medication) 0.5 mg every 8 hours as needed for generalized anxiety disorder, an order dated 98/01/24, for Lorazepam 1.0 mg twice daily routinely for generalized anxiety disorder, an order dated 11/05/24, for Remeron (an antidepressant medication) 30 mg by mouth every morning for depression, and an order dated 11/05/24, for Olanzapine (an antipsychotic medication) 5 mg by mouth twice daily for depression. Review of R56's comprehensive Care Plan dated 11/14/24 and found in the EMR under the Care Plan tab, revealed nothing to indicate a care plan was in place for the resident's behaviors or administration of resident's psychotropic medication. Review of R56's Medication Administration Recor (MAR) and Treatment Administration Record (TAR), dated 11/01/24 through 11/14/24 and found in the EMR under the Orders tab, revealed nothing to indicate specific behaviors related to the administration of R56's psychotropic medications or side effects of the medication were being monitored. Review of R56's comprehensive EMR revealed nothing to show specific behaviors related to the administration of the resident's psychotropic medications had been identified and were being tracked, side effects of the resident's psychotropic medications were being tracked, or informed consent had been obtained for the administration of R56's psychotropic medications. During an interview with the DON on 11/13/24 at 12:14 PM, she confirmed her expectation was a care plan was expected to be in place for resident behaviors and administration of psychotropic medications, side effects of the medications were expected to be tracked. The DON stated she was not aware informed consent should be received for the administration of psychotropic medication or that specific behaviors should be identified and tracked related to the administration of each individual psychotropic medication. 20243 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of R57's undated Admission Record located in the EMR under the Admission tab, indicated the resident was admitted to the facility on [DATE] with diagnoses of dementia with anxiety, major depressive disorder, anxiety disorders, and Alzheimer's disease. Review of R57's Physician Orders dated 10/13/24 - 11/13/24, located in the EMR under the Orders tab, revealed an order for Seroquel (an antipsychotic medication) 25 mg (milligrams) one tablet every day in the morning and Seroquel 100 mg one tablet every day in the evening. Review of R57's November 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed there was no evidence of any monitoring of behaviors, efficacy or side effects related to the antipsychotic medication administered. 51809 5. Review of R48's Face sheet, located under the Resident tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). Review of R48's Quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 09/27/24 revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15, indicating moderate cognitive impairment. Continued review revealed R48 score zero for little interest or pleasure in doing things and feeling down, depressed, or hopeless and did not exhibit behaviors during the seven-day lookback period. Review of R48's comprehensive Care Plan located in the EMR under the Care Plan tab revealed, I have COPD with interventions to include: Administer my medications as ordered . The Care Plan did not address the resident's use of psychotropic medications, symptoms of anxiety, or behavioral interventions. Review of R48's EMR under the Orders tab indicated orders dated 07/24/24 for hydroxyzine (antihistamine) 50 milligrams (mg), one tablet orally three times a day as needed (PRN) for depressive disorder and lorazepam (Antianxiety) 0.5 mg 1 tablet orally three times a day PRN, for COPD. Review of R48's Medication Administration Record (MAR), dated 10/15/24 through 11/13/24 and located in the Reports tab of the EMR, revealed hydroxyzine and lorazepam had been administered concurrently on 10/16/24 at 10:13 PM, 10/18/24 at 10:56 PM, 10/26/24 at 5:22 PM, 10/29/24 at 4:20 PM, 10/30/24 at 5:57 PM, 10/31/24 at 1:39 AM, 11/02/24 at 4:13 PM, 11/03/24 at 4:01 PM, 11/07/24 at 3:53 PM, 11/08/24 at 9:37 PM, and 11/11/24 at 8:42 PM for behaviors/anxiety. Additional review revealed both medications had been effective for treating the behaviors/anxiety. However, the MAR did not indicate the specific behavior treated for each medication. Review R48's Progress Notes tab of the EMR revealed there was no documentation of behaviors expressed by the resident to warrant administration of either PRN medication. During an interview on 11/14/24 at 10:00 AM with Registered Nurse (RN)1, she confirmed R48 did not have monitoring in place related to the psychotropic medications he was being administered. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/24 at 1:30 PM with the DON/IP, she stated she expected nursing staff who were administering medications to monitor the effectiveness of the medication as well as the behaviors/symptoms the resident was exhibiting and report unresolved issues to the charge nurse and or the physician as needed to ensure the resident's quality of life and overall wellbeing.

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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. 20243 Based on observation, interview, and facility policy review, the facility failed to ensure one medication cart observed out of five medications carts was locked when left unattended. The facility further failed to ensure 18 cards of controlled medications were stored in a double lock manner. Lastly, the facility failed to ensure one medication room observed out of three medications rooms was locked when left unattended. This had the potential for residents, staff, and visitors to access the medications for possible misappropriation. The facility census was 71. Findings include: Review of the undated Medications, Storage of policy indicated that 1. All medications for residents must be stored at or near the nurse's station in a locked cabinet, a locked medication room, or one or more locked mobile medication carts. 2. All mobile medication carts must be under visual control of the staff at all times when not stored safely and securely. Carts must be either in a locked room or otherwise made immobile, and 15. An unattended medication cart must remain locked at all times. In the event the nurse is distracted from the task of passing medications by some unforeseen occurrence, the cart must be locked before leaving it or secured in a locked medication room. 1. During an observation on 11/13/24 at 7:53 AM, the medication cart on Hall 500 on South II Wing was left unlocked and unattended. There were no observed residents in the hallway. Observation further revealed Licensed Practical Nursing (LPN)2 returned to the cart after one minute and noticed that it was unlocked. LPN2 locked the cart and stated she thought she had locked it when she left the cart and had not noticed that it was unlocked. 2. During an observation on 11/14/24 at 3:34 PM, in Hall 100 on North Wing revealed the medication room door was wide open and no staff were in the area or in the medication room to monitor the room. Certified Medication Technician (CMT)3 returned from a room on Hall 100 approximately two to three minutes after the initial observation of the open medication room door and confirmed the door to med room was open. Approximately one minute later LPN1/Unit Manager (UM) came out of the Director of Nursing's (DON) office across the hall from the medication room. LPN1/UM confirmed the door was open and the cabinet with controlled medication in it was also unlocked. Both LPN1/UM and CMT3 confirmed the door to the medication room was to be locked when unattended at all times. LPN1/UM stated the cupboard door containing controlled medications was also to be locked at all times when nursing staff were not accessing the controlled medications. CMT3 was in possession of keys to both the medication room and the cupboard containing cards of overflow-controlled medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation and interview with LPN1/UM on 11/14/24 at 4:35 PM revealed 18 cards of controlled medications were observed in the medication room on top of the counter, one card each of clonazepam (a medication used to treat seizure disorders and panic disorders 0.5 mg (milligrams), pregabalin (a medication used to treat seizures, fibromyalgia, and nerve pain) 75 mg, lorazepam (a medication used to treat anxiety disorders) 0.5mg and lacosamide (a medication used to treat seizures) 200 mg; two cards each of Oxycodone (a narcotic medication used to treat pain) 5 mg and Hydrocodone (a narcotic medication used to treat pain) 5/325; three cards of Tramadol (a narcotic medication used to treat pain) 50 mg; and seven cards of lorazepam (a medication used to treat anxiety disorders) 1 mg. The LPN1/UM confirmed the 18 cards of narcotic medications were left on the counter and not locked in the cabinet. During an interview on 11/14/24 at 9:41 AM the Administrator confirmed medication carts should be locked at all times. During an interview on 11/14/24 at 4:50 PM the Administrator stated that the expectation going forward is for medication rooms to be locked at all times when unattended and that controlled medications will be maintained in a double lock manner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20243 Based on observation, interview, record review, and facility policy review, the failed to ensure infection control was maintained during medication administration, failed to ensure oxygen tubing was dated to ensure potential respiratory infection was prevented, and failed to ensure hand hygiene was completed during wound care. This affected four of 24 (Residents (R) 39, R53, R48, and R64) residents. This had the potential for a potential transmission of infection. The facility census was 71. Findings include: 1. During an observation on 11/13/24 at 8:03 AM, Licensed Practical Nurse (LPN)2 poured one ferrous sulfate tablet 324 milligrams (mg) from the pill bottle directly into her bare hand. LPN2 then administered the medication to R39. During an interview on 11/13/24 at 8:23 AM, LPN2 stated that she normally poured a pill directly from the medicine bottle into the medicine cup prior to administration. LPN2 stated that this pill tends to fly away, so she poured it into her hand. LPN2 stated that she did not recall receiving training regarding touching pills with bare hands during medication administration. During an interview on 11/14/24 at 9:41 AM the Administrator stated there was not a specific policy that covered touching pills with bare hands during medication administration. When asked what her expectations were regarding infection control and sanitary practices during medication pass, she stated she expected that medications would be dispensed directly from the pharmacy card or bottle directly into the medicine cup and not touched by hands. 51809 2. Review of R48's Face Sheet, located under the Resident tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of R48's EMR under the Orders tab indicated orders to administer budesonide (used to treat inflammation in the lungs) suspension for nebulization; 0.5 milligrams (mg)/2 milliliters (mL); 1 ampule (amp); inhalation twice a day and ipratropium-albuterol solution (used to treat COPD) for nebulization; 0.5 mg-3 mg base)/3 mL; 1 ampule; inhalation four times a day. Review of R48's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 09/27/24 revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15 indicating moderate cognitive impairment. During an interview and observation on 11/11/24 at 10:15 AM, R48 stated the nurse hands him the nebulizer and when his treatment is finished, he hangs the mask on the bedrail, and it stays there until his next treatment. R48 continued to state he has never seen the nurse clean the nebulizer cylinder after each use and the mask has never been placed in a bag at the bedside. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations of R48's room on 11/11/24 at 10:15 AM, on 11/11/24 at 11:43 AM, on 11/12/24 at 10:45 AM, on 11/13/24 at 8:25 AM, and on 11/14/24 at 9:25 AM, a nebulizer mask was hanging on the bedrail next to the window, not bagged or dated. During an interview and observation on 11/14/24 at 9:44 AM with Certified Medication Technician (CMT)1 confirmed R48's nebulizer mask was hanging on the bedrail next to the window, not bagged or dated. She stated the nebulizer mask should be bagged after each use and the medication cylinder should be washed with warm water after each use to prevent mold and the collection of germs. She stated the oxygen tubing and nebulizer equipment are changed weekly on Sundays by the night nurse and placed in a new bag and the bag is dated so staff know it's been changed, and then the person changing the equipment out is to initial it off on the Treatment Administration Record (TAR). During an interview on 11/14/24 at 1:30 PM with the DON/IP stated it was her expectation for all staff to follow the facility's Infection Control Policy and the nurses should be cleaning the nebulizer equipment and bagging it after each use to prevent the residents from getting a potential respiratory infection. 3. Review of the Wound Care and Treatment policy, note dated, revealed hand washing must be done as outlined in the guidelines . 3. Put gloves on. 4. Remove the soiled dressing and place it in the trash bag. Place the soiled scissors on one corner of the setup, not touching any of the other supplies. 5. Remove the gloves and discard them in the bag. 6. Clean scissors with 60 seconds of contact with alcohol and place on a clean [NAME] of setup. 7. Wash your hands and put on clean gloves. Review of R64's Face Sheet, located under the Resident tab of the EMR, revealed he was admitted to the facility on [DATE] with a diagnosis of skin ulcers. Review of R64's EMR under the Orders tab indicated an order dated 10/18/24 to clean left lateral ankle with normal saline (NS), pat dry, apply Xeroform to wound bed. Keep off edges if able, cover with four-by-four and optifoam daily. Review of R64's quarterly MDS with an ARD of 11/01/24 revealed a BIMS of 15 out of 15 indicating the resident was cognitively intact. Continued review revealed R64 had three venous wounds. During observation of R64's wound care on 11/13/24 at 10:45 AM, the Director of Nurses/ Infection Preventionist (DON/IP) applied a gown and gloves outside R64s room prior to entering the room. The DON/IP removed R64's left sock, removed her gloves, applied new gloves without sanitizing her hands first, grabbed a 4x4 gauze in one hand and a bottle of wound cleanser, sprayed the gauze with wound cleanser, and cleaned the left ankle wound. The IP/DON removed her gloves, did not wash, or sanitize her hands, applied new gloves, picked up the xeroform gauze and placed it over the wound, grabbed the optifoam dressing and secured it over the xeroform. The DON/IP then reached in her pocket, removed her ink pen, and dated the new dressing with her gloved hands. Continued observation revealed the DON/IP removed her gloves and without washing or sanitizing her hands she applied new gloves. The DON/IP then picked up a 4x4 gauze in one hand, and a bottle of wound cleanser in the other hand, sprayed the gauze with wound cleanser, cleaned the right-hand skin tear, and applied kerlix and tape with her gloved hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/24 at 1:30 PM with the DON/IP she stated she was very nervous during the wound care observation and realized after completing R64's treatment she had not washed or sanitized her hands between glove changes during R64's treatments to her wounds and should have. The DON/IP, also stated it was her expectation for all staff to follow the facility's Infection Control Policy. During an interview with the Administrator, she stated for the safety and wellbeing of the residents, she expected all facility staff to follow the facility's Infection Control Policy to prevent the development of diseases and infections. 18947 4. Review of the facility's undated Oxygen Administration Policy read, in pertinent part, Change humidifier and tubing per cleaning guidelines. Review of R53's Face Sheet, found in the Electronic Medical Record (EMR) under the Summary tab, indicated the resident was admitted to the facility on [DATE]. Diagnosis included chronic COPD. Review of R53's quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 10/25/24 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident was receiving oxygen therapy. Review of R53's physician's Orders found in the EMR under the Orders tab, revealed an order dated 09/05/24, that indicated the resident was to receive oxygen 1 to 2 liters per minute (lpm) via nasal cannula as needed for shortness of breath. Review of R53's comprehensive Care Plan dated 10/25/24 and found in the EMR under the Care Plan tab, revealed no Care Plan for the resident's use of oxygen. During an observation on 11/11/24 at 10:29 AM, on 11/12/24 at 10:22 AM, 3:08 PM, on 11/13/24 at 7:54 AM, and 9:26 AM revealed R53 was observed in her room and the resident's oxygen tubing had a label with a date of 10/21/24 (approximately three to three and one-half weeks prior to the observation dates). During an observation on 11/13/24 with Certified Nursing Assistant (CNA)3 confirmed the resident's oxygen tubing in use was dated 10/21/24 and stated she thought the tubing was supposed to be changed at least once per week. During an observation on 11/13/24 at 10:20 AM along with Licensed Practical Nurse/Unit Manager (LPN1/UM) confirmed the resident's oxygen tubing was dated 10/21/24 and stated the tubing was expected to be changed at least once per week on Sunday nights for prevention of potential infection. She stated the tubing change had been missed. During an interview on 11/13/24 at 12:34 PM with the Director of Nursing (DON) she stated her expectation was oxygen tubing was to be changed at least weekly on Sunday nights for infection prevention.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947 Based on record review, staff interview, and facility policy review, the facility failed to ensure the physical safety of bed rails for two (Residents (R)9 and R53) of a total of nine residents reviewed for accidents. Bed rails on both residents' beds were observed to be loose. This failure created the potential for the residents to be injured by improperly applied and unmaintained bed rails. A total of 24 residents were reviewed in the sample. The facility census was 71. Findings include: Review of the facility's undated Bed Rails Policy read, in pertinent part, Staff will conduct regular inspections of all bedframes, mattresses, and bed rails, to identify areas of possible entrapment. 1. Review of R9's undated Resident Face Sheet, found in the Electronic Medical Record (EMR) under the Summary tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included dementia and repeated falls. Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/24 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident required partial to moderate assistance of staff to roll from side to side in her bed and substantial to maximum assistance from staff to transfer in and out of her bed. The assessment indicated side rails were not in use for R9. During observations on 11/12/24 at 2:37 PM, 3:06 PM, on 11/13/24 and 9:12 PM revealed R9 was observed laying in her bed with one 1/3 bed rail and one 1/8 bed rail in the raised position at the head of her bed. The bed rail closest to the window was observed to be very loose. During an observation on 11/13/24 at 10:20 AM along with Licensed Practical Nurse/Unit Manager (LPN1/UM) on 11/13/24 at 10:20 AM. LPN1/UM confirmed the rails on R9's bed were in the raised position and the rail closest to the window was very loose. LPN1/UM stated, This rail is too loose. It should not be that loose. I will let maintenance know (about the loose rail). LPN1/UM stated an entry could be made in the unit's maintenance log to indicate the loose rail so that it cold be repaired and confirmed an entry had not been made related to the resident's loose bed rail prior to that date. 2. Review of R53's undated Face Sheet, found in the EMR under the Summary tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included type 2 diabetes. Review of R53's quarterly MDS with an ARD of 10/25/24 and found in the EMR under the MDS tab, revealed a BIMS score of 12 out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident was independent with rolling from side to side in her bed and required supervision or touching assistance from staff to transfer in and out of her bed. The assessment indicated side rails were not in use for R53. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 11/13/24 at 7:54 AM and on 11/14/24 at 9:33 AM R53 was observed laying in her bed with bilateral 1/3 bed rails in the raised position at the head of her bed. The rail closest to the door was observed to be very loose. During an observation on 11/13/24 at 9:59 AM along with Certified Nursing Assistant (CNA)3 on 11/13/24 at 9:59 AM. CNA3 confirmed the resident's rails were too loose. During an interview with R53 on 11/12/24 at 10:14 AM, she indicated she was able to use the rails on her bed for mobility but stated, Look at that rail (pointing at the raised rail closest to the door). It's very loose. During an observation on 11/13/24 at 10:20 AM with LPN1/UM of R9 and R53's beds the LPN1/UM confirmed the rails on R9 and R53's beds were very loose. LPN1/UM stated, The rails are too loose. They should not be that loose. I will let maintenance know (about the loose rails). LPN1/UM stated an entry could be made in the unit's maintenance log to indicate the loose rails so that they could be repaired and confirmed an entry had not been made related to either resident's loose bed rails prior to that date. During an observation on 11/13/24 at 11:10 AM with the Maintenance Director (MD) confirmed the bed rails were too loose on R9 and R53's bed. He further stated R53's bed was a hospice bed and maintenance had been told not to touch it. The MD stated if he happened to be in a resident's room he would look at the overall bed, but the facility did not have a formal process to ensure beds were routinely monitored to ensure the physical safety of bed rails. During an interview with the Director of Nursing (DON) on 11/13/24 at 12:34 PM, she stated her expectation was bed rails were to maintained and physically safe to use.