STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265506	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine View Manor Inc	307 N Pineview Street Stanberry, MO 64489

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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. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to ensure 1 (Resident #5) of 1 sampled resident reviewed for self-administration of medications was assessed to determine if they were clinically appropriate to do so after the resident expressed a desire to self-administer one of their medications. Findings included: A facility policy titled, Self-Administration of Medications, revised in 12/2016, indicated Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and d. Ability to recognize risks and major adverse consequences of his or her medications. An Admission Record revealed the facility readmitted Resident #5 on 07/11/2022. According to the Admission Record, Resident #5 had a medical history that included a diagnosis of chronic obstructive pulmonary disease (COPD). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 04/10/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had an active diagnosis of non-Alzheimer's dementia. Resident #5's care plan included a focus area, revised 01/24/2024, that indicated the resident had an activities of daily living self-care performance limitation related to limited mobility from a left shoulder fracture and spinal stenosis. Resident #5's care plan did not address self-administration of any medications. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #5's physician's orders contained an order, dated 05/23/2024, for Flonase allergy relief nasal suspension, two puffs to each nostril every 12 hours as needed for allergies. The order indicated Resident #5 was able to keep the medication at their bedside. Nursing Progress Notes dated 05/23/2024 at 12:46 PM indicated the MDS Coordinator documented that a provider was at the facility for rounds and ordered Flonase to be kept at Resident #5's bedside. There was no documented evidence the facility determined whether self-administration of medications was clinically appropriate for Resident #5. Resident #5's electronic medical record Standard Assessments beginning 10/11/2023 revealed no documented evidence the facility assessed the resident for self-administration of medication. During an interview on 05/31/2024 at 11:24 AM. Resident #5 stated they had asked the physician to write an order that allowed them to keep their Flonase in their room to use when needed. Resident #5 stated they had used Flonase for years and administered two sprays into each nostril once a day; however, Resident #5 stated staff had not completed an assessment for self-administration and no staff had watched the resident self-administer their Flonase. A telephone interview on 05/31/2024 at 1:10 PM with the MDS Coordinator, the nurse who documented Flonase was ordered to be kept at the resident's bedside, revealed she believed the only thing required for a resident to keep a medication at the bedside was a physician's order. The MDS nurse confirmed an assessment for self-administration of medication was not completed for Resident #5. Registered Nurse (RN) #5 was interviewed on 05/31/2024 at 10:51 AM. RN #5 stated that prior to a resident self-administering medication, the physician had to write an order for the medication to be kept at bedside. RN #5 stated she was unaware residents needed to be assessed for self-administration of medications. The Director of Nursing Services (DNS) was interviewed on 05/31/2024 at 1:00 PM. The DNS stated that prior to a resident self-administering a medication, the staff had to make sure the resident was capable of self-administering the medication. The DNS stated if a resident was going to self-administer their medication, staff educated the resident and then observed a return demonstration of self-administration. The DNS stated documentation of the education and assessment findings should be found in the electronic medical record progress notes. An interview with the Administrator on 05/31/2024 at 1:22 PM revealed that before a resident could self-administer medication, she expected the resident to be assessed and the assessment documented in their progress notes.

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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. 39714 Based on observation, interview, record review, and facility policy review, the facility failed to develop a care plan addressing the use of as needed, supplemental oxygen for 1 (Resident #3) of 3 sampled residents reviewed for respiratory care. Findings included: A facility policy titled, Oxygen Administration, revised in 10/2010, indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration. The policy further indicated, 2. Review the resident's care plan to assess for any special needs of the resident. An Admission Record revealed the facility admitted Resident #3 on 06/19/2023. According to the Admission Record, the resident had a medical history that included diagnoses of pneumonia and heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/2024, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #3's Order Summary Report, listing active orders as of 05/31/2024, contained an order, started on 06/19/2023, for two liters of supplemental oxygen via nasal cannula as needed for shortness of air. The Order Summary Report also contained an order, started on 06/19/2023, for two liters of supplemental oxygen via NC at bedtime for hypoxia (low blood oxygen levels). Resident #3's care plan did not address the resident's supplemental oxygen usage prior to 05/31/2024 (during the survey). During an interview on 05/31/2024 at 9:20 AM, Registered Nurse (RN) #5 stated care plans should address a resident's use of oxygen. RN #5 said the care plan should reflect the ordered flow rate, whether the oxygen was used continuously or as needed, and any parameters set by the physician. During an interview on 05/31/2024 at 2:05 PM, the Administrator stated she expected care plans to address the use of oxygen.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 22445 Based on observation, record review, interview, and facility policy review, the facility failed to ensure only licensed personnel adjusted the flow rate on an oxygen concentrator for 1 (Resident #45) of 3 residents reviewed for supplemental oxygen use. Findings included: A facility policy titled, Administering Medications, reviewed 05/12/2017, revealed, Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so. An Admission Record revealed the facility admitted Resident #45 on 03/19/2024. According to the admission record, Resident #45 had a medical history that included a diagnosis of chronic obstructive pulmonary disease (COPD). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/26/2024, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #45 had an active diagnosis of asthma, COPD, or chronic lung disease. The MDS indicated Resident #45 received oxygen therapy while a resident. Resident #45's care plan revealed a focus area initiated 04/02/2024, that indicated Resident #45 had diagnoses of emphysema and COPD. Interventions directed staff to give oxygen therapy as ordered by the physician (initiated 04/02/2024). Resident #45's Order Summary Report, with active physician's orders as of 05/29/2024, revealed an order for supplemental oxygen to be delivered at 2 to 3 liters by nasal cannula (NC) to maintain blood oxygen saturation levels above 91 percent (%) each shift, with a start date of 03/19/2024. An observation on 05/29/2024 at 1:52 PM revealed Resident #45's oxygen concentrator was set to deliver 2. 5 liters per minute by NC. During an interview at the time of the observation, Resident #45 stated they had just finished walking with therapy staff and was short of breath. Resident #45 activated their call light at 2:55 PM. At 3:05 PM Certified Nurse Aide (CNA) #1 entered the room and adjusted the resident's oxygen concentrator to deliver 3 liters of supplemental oxygen per minute. CNA #1 was interviewed on 05/30/2024 at 12:53 PM. CNA #1 stated she had not completed a Certified Medication Technician (CMT) course and was not allowed to administer medication. CNA #1 stated she had been taught that supplemental oxygen was a medication, and she was not allowed to change the setting on an oxygen concentrator. CNA #1 acknowledged she had adjusted Resident #45's supplemental oxygen on 05/29/2024 and stated she did not know why and added that she was not thinking and just wanted to give Resident #45 supplemental oxygen. CNA #1 sated she realized afterwards that she should not have altered the resident's oxygen concentrator and should have reported Resident #45's shortness of breath to the Director of Nursing Services (DNS). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CMT #4 was interviewed on 05/31/2024 at 9:23 AM. CMT #4 stated either a nurse or a CMT could change the setting on an oxygen concentrator. CMT #4 stated supplemental oxygen was considered a medication and a CNA was not able to change an oxygen concentrator's setting. Registered Nurse (RN) #5 was interviewed on 05/31/2024 at 10:43 AM. RN #5 stated nurses were responsible for adjusting oxygen concentrators and added that she did not think the CMTs were allowed to adjust the oxygen concentrators and stated that CNAs were not allowed to adjust oxygen concentrators. RN #5 stated that she considered supplemental oxygen a medication and if a CNA adjusted an oxygen concentrator, it may cause under oxygenation or over oxygenation of a resident. The DNS was interviewed on 05/31/2024 at 12:55 PM. The DNS stated she did not consider supplemental oxygen a medication. The DNS stated the CNAs had completed an oxygen safety course that included instruction on setting up portable oxygen tanks and making sure the tanks had no oxygen leaks. The DNS stated the CNAs were shown how to know if a resident was receiving the correct dosage of supplemental oxygen. The DNS stated prior to adjusting the supplemental oxygen flow rate, she expected the CNAs to check with the nurse. The DNS stated she was the nurse on duty when CNA #1 adjusted the supplemental oxygen flow rate for Resident #45 and added that the CNA had not reported that Resident #45 was short of breath or that she had adjusted the resident's supplemental oxygen flow rate on the concentrator. The DNS stated it was not unusual for Resident #45 to become short of breath with activity, but the shortness of breath resolved when the resident rested. The Administrator was interviewed on 05/31/2024 at 1:22 PM. The Administrator stated a physician's order was needed for supplemental oxygen but added that she was not sure if supplemental oxygen was considered a medication but stated that it probably was. The Administrator stated the CNAs were not expected to adjust a resident's oxygen concentrator.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 42192 Based on observation, interview, record review, and facility policy review, the facility failed to specify dose parameters for 1 (Resident #7) of 3 residents reviewed for supplemental oxygen use. Specifically, the facility failed to ensure Resident #7's supplemental oxygen orders specified liters per minute (L/min) parameters. Findings included: A facility policy titled, Oxygen Administration, revised October 2010, indicated under the section titled Preparation to Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. The policy also indicated, Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. Resident #7's Admission Record revealed the facility admitted the resident on 09/15/2022. According to the Admission Record, the resident had a medical history that included diagnoses of hypoxemia (low blood oxygen levels) dystonia (involuntary muscle movements causing twisting and contorting), torticollis (involuntary muscle movements causing twisting and contorting of the neck), and pneumonia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2024, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident received oxygen therapy during the assessment period. Resident #7's Care Plan, included a focus area revised on 03/25/2024, that indicated the resident had oxygen therapy related to ineffective gas exchange from dystonia. Interventions directed staff to monitor for signs and symptoms of respiratory distress and report to the medical doctor as needed, humidified supplemental oxygen setting via nasal prongs at 2 liters continuously at night and as needed during the day, and to promote lung expansion and improve air exchange by positioning with proper body alignment and if tolerated, position the head of bed above 45 degrees. Resident #7's Order Summary Report revealed an order dated 12/24/2023 for supplemental oxygen by way of nasal cannula (NC) to maintain above 91 percent (%) blood oxygen saturation level every shift and to keep on at night. Resident #7's Treatment Administration Record [TAR], dated March 2024, April 2024, and for the timeframe from 05/01/2024 through 05/28/2024, revealed the staff had documented the resident had blood oxygen saturation levels over 90% every day on all three shifts. During an observation and interview on 05/28/2024 at 11:20 AM, Resident #7 was in their room. The resident's NC was askew on their nostrils and the supplemental oxygen concentrator was set at 2 L/min. Resident #7 stated they had no concerns about staff treatment or care provisions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/30/2024 at 8:45 AM, Certified Nurse Aide (CNA) #1 stated she assisted residents with their supplemental oxygen. She stated she would enter the resident's room and make sure the supplemental oxygen was on. She stated supplemental oxygen use was in the resident's care plan. She stated she would make sure the cannula was correctly placed on the resident and would check the L/min, but she did not adjust the settings. She stated any concerns noticed were reported to the nurse and she would follow any directive given to assist the resident. She stated she would monitor the resident's blood oxygen saturation using the pulse oximeter. She stated the supplemental oxygen orders were relayed to her by the nurse. She stated Resident #7 was to have their supplemental oxygen on while in bed but could wear it while up at their discretion. She stated if the resident's blood oxygen saturation level was below 95%, she would reapply the NC for the resident. She stated the resident was compliant with their oxygen therapy when their blood oxygen saturation levels were outside the parameters. During an interview on 05/30/2024 at 12:41 PM, Registered Nurse (RN) #5 stated that as the RN she would check oxygen saturation readings for residents who required monitoring and make sure their blood oxygen saturation levels were good. She stated that when residents were in their rooms, they were connected to an oxygen concentrator and when they were out of bed they were connected to a portable tank, which was checked before application and refilled as needed. She stated supplemental oxygen orders should include as needed or continuous use, L/min, and any titration guidelines. She stated that when she received orders from physicians, she would review them and enter them into the resident's record, before placing them in the orders basket for the night nurses to verify. She stated if she found a discrepancy with the orders, she would call the Director of Nursing Services (DNS) and physician to verify. She stated if there was a supplemental oxygen order without parameters for L/min she would start off with 2 L/min and monitor per the resident's condition. RN #5 stated she worked with Resident #7 and double checked their NC placement frequently as it tended to become askew. She stated the resident's blood oxygen saturation levels were regularly between 90% and 92%. She stated she monitored the L/min setting and would reposition the resident if the resident's blood oxygen saturation levels were low. She stated Resident #7 was on 3 L/min supplemental oxygen flow. She stated if the resident's blood oxygen saturation levels read below 91%, she would call the physician. Review of Resident #7's medical record on 05/30/2024 at 12:56 PM with RN #7 revealed the resident's supplemental oxygen order indicated oxygen by way of NC to maintain above 91% sat [saturation] every shift keep on at night. After reviewing the order, RN #7 stated the only parameter was to maintain blood oxygen saturation levels above 91% and she did not see any L/min indication on the order to start from. She stated supplemental oxygen orders should be accompanied by L/min. During an interview on 05/30/2024 at 3:57 PM, Licensed Practical Nurse (LPN) #15 stated supplemental oxygen orders typically started at 2 L/min and titration was attempted from there to achieve blood oxygen saturation levels. She stated the resident's blood oxygen saturation levels were checked at least once a shift, so three times a day. She stated supplemental oxygen orders should be accompanied by L/min parameters, so the nurses had a starting point and was unsure why there was no L/min associated with the order. During an interview on 05/31/2024 at 1:06 PM the DNS stated any order for supplemental oxygen should be accompanied by L/min parameters. She stated she was made aware of the concern regarding Resident #7 on 05/30/2024 and the facility was awaiting a call back from the physician with L/min parameters to update the order. She stated the original order should have been accompanied by L/min parameters. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/31/2024 at 1:58 PM, the Administrator stated supplemental oxygen orders should be accompanied by L/min parameters, so the nurses knew where to start oxygen flow. During an interview on 05/31/2024 at 4:04 PM, Medical Doctor (MD) #17 stated supplemental oxygen orders should be accompanied by L/min parameters and there was no situation where that would not be the case. She stated the L/min was the dosage information.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 22445 Based on interview, record review, and facility policy review, the facility failed to ensure 1 (Resident #50) of 5 residents reviewed for unnecessary medications was free of significant medication errors. Specifically, staff administered metoprolol tartrate (a medication used for high blood pressure) to Resident #50 despite the resident's blood pressure being below the ordered parameters for administration and without monitoring the resident's pulse. Findings included: A facility policy titled, Administering Medications revised 12/2012, indicated, 3. Medications must be administered in accordance with orders, including any required time frame. The policy revealed, 8. The following information must be checked/verified for each resident prior to administering medications: a. Allergies to medications; and b. Vital signs, if necessary. An Admission Record revealed the facility admitted Resident #50 on 04/24/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of essential (primary) hypertension. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/01/2024, revealed Resident #50 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS also indicated the resident had an active diagnosis of hypertension. Resident #50's 05/2024 Medication Administration Record [MAR] revealed a transcription of a physician's order dated 04/24/2024 for metoprolol tartrate 25 milligrams (mg) twice daily for hypertension, with instructions to hold the medication if the resident's systolic blood pressure (the top number of the blood pressure reading) was below 120 millimeters of mercury (mmHg), the diastolic blood pressure (the bottom number of the blood pressure reading) was less than 60 mmHg or if the resident's heart rate was less than 60 beats per minute. The 05/2024 MAR revealed no documented evidence staff checked the resident's heart rate prior to administering metoprolol tartrate. The MAR revealed staff documented that they administered metoprolol tartrate 25 mg to Resident #50 on the following dates and times despite the resident's blood pressure reading that required the medication be held: - 05/01/2024 at 5:00 PM with a blood pressure of 110/60 mmHg, - 05/02/2024 at 8:00 AM with a blood pressure of 110/60 mmHg, - 05/02/2024 at 5:00 PM with a blood pressure of 108/60 mmHg, - 05/03/2024 at 8:00 AM with a blood pressure of 108/60 mmHg, - 05/03/2024 at 5:00 PM with a blood pressure of 112/62 mmHg, - 05/06/2024 at 5:00 PM with a blood pressure of 159/51 mmHg, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 05/08/2024 at 5:00 PM with a blood pressure of 104/66 mmHg, - 05/12/2024 at 5:00 PM with a blood pressure of 112/67 mmHg, - 05/14/2024 at 8:00 AM with a blood pressure of 110/62 mmHg, - 05/14/2024 at 5:00 PM with a blood pressure of 96/64 mmHg, - 05/15/2024 at 8:00 AM with a blood pressure of 101/60 mmHg, - 05/15/2024 at 5:00 PM with a blood pressure of 106/59 mmHg, - 05/16/2024 at 8:00 AM with a blood pressure of 112/63 mmHg, - 05/16/2024 at 5:00 PM with a blood pressure of 124/58 mmHg, - 05/18/2024 at 8:00 AM with a blood pressure of 113/65 mmHg, - 05/19/2024 at 5:00 PM with a blood pressure of 110/70 mmHg, - 05/20/2024 at 8:00 AM with a blood pressure of 119/60 mmHg, - 05/21/2024 at 5:00 PM with a blood pressure of 110/60 mmHg, - 05/22/2024 at 5:00 PM with a blood pressure of 112/58 mmHg, - 05/23/2024 at 8:00 AM with a blood pressure of 110/64 mmHg, - 05/23/2024 at 5:00 PM with a blood pressure of 110/70 mmHg, - 05/26/2023 at 8:00 AM with a blood pressure of 116/64 mmHg, - 05/26/2023 at 5:00 PM with a blood pressure of 114/68 mmHg. Certified Medication Technician (CMT) #4 was interviewed on 05/31/2024 at 9:25 AM. CMT #4 stated if vital signs, such as a blood pressure or pulse, were required to meet certain parameters, then the vital signs were required to be recorded on the MAR. CMT #4 reviewed the 05/2024 MAR for Resident #50 and stated the resident's pulse was not documented on the MAR. She also reviewed Resident #50's recorded blood pressures and stated there were several that did not meet the physician's parameters and the medication should not have been given. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CMT #10 was interviewed on 05/31/2024 at 9:50 AM. CMT #10 stated if a medication was not given due to not meeting vital sign parameters, she chose either a code 4 (indicating vitals outside of parameters) or code 9 (indicating other/see nurse notes) and entered the code on the MAR. CMT #10 reviewed the MAR for Resident #50 and identified her initials indicated she gave metoprolol to Resident #50 when the blood pressure parameters were not met for the blood pressure medication. CMT #10 reviewed the MAR and stated Resident #50's heart rate was not recorded daily as directed. CMT #10 stated she did not follow the physician's orders for administering Resident #50's blood pressure medication and gave the medication when it should have been held. During an interview on 05/31/2024 at 3:59 PM, CMT #11 stated she gave Resident #50 metoprolol when the resident's blood pressure did not meet the parameters and acknowledged she should have held the medication. CMT #11 stated she had not taken the resident's pulse and overlooked the blood pressure parameters. Registered Nurse (RN) #5 was interviewed on 05/31/2024 at 10:48 AM. RN #5 stated she had worked each Thursday in 05/2024 and no one had reported Resident #50's blood pressure had not met the parameters for giving metoprolol. RN #5 reviewed Resident #50's MAR and stated the days the systolic blood pressure was less than 120 mmHg the medication should not have been given and stated she would have liked for the CMT to have reported the low blood pressure to her. RN #5 reviewed the MAR and stated Resident #50's heart rate had not been documented and stated the CMTs that had given the medication to Resident #50 had not followed the physician's order. RN #5 stated the danger of giving the medication would be Resident #50's blood pressure drooping even lower, and the resident could faint. A telephone interview was held with the Consultant Pharmacist (CP) on 05/31/2024 at 11:29 AM. The CP stated giving metoprolol to Resident #50 when the resident's blood pressure had not met the physician's parameters would make the blood pressure drop even more. The CP stated the medication should have been held. The Director of Nursing Services (DNS) was interviewed on 05/31/2024 at 12:48 PM. The DNS stated if Resident #50 had parameters for blood pressure and heart rate they should have been documented on the MAR. The DNS stated if the resident's blood pressure had not met the parameters, then the metoprolol should have been held and if the medication was held frequently the staff should have notified the physician. The DNS stated she was unaware the mediation was administered even though the resident's blood pressure parameters were not met. The DNS stated she was also unaware that Resident #50's heart rate had not been added to the MAR. The DNS stated staff did not follow the physician's orders. The Administrator was interviewed on 05/31/2024 at 1:22 PM and stated she expected physician's orders to be followed, and if the order was not to give blood pressure medications if the parameters were not met, the medication should not have been administered and she expected the physician to be notified.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to ensure medication was safely stored for 1 (Resident #5) of 1 sampled resident reviewed for self-administration of medication. Specifically, Resident #5 had an order to keep their Flonase nasal spray at the bedside; however, the facility failed to ensure the medication was stored in a safe and secure place, not accessible to other residents, as directed by the facility's policy. Findings included: A facility policy titled, Self-Administration of Medications, revised in 12/2016, indicated 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. An Admission Record revealed the facility admitted Resident #5 on 07/11/2022. According to the Admission Record, Resident #5 had a medical history that included a diagnosis of chronic obstructive pulmonary disease (COPD). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 04/10/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed the resident had an active diagnosis of non-Alzheimer's dementia. The MDS revealed the resident was independent with chair/bed to chair transfers and sitting to standing. Resident #5's physician's orders contained an order, dated 05/23/2024, for Flonase allergy relief nasal suspension, two puffs to each nostril every 12 hours as needed for allergies. The order indicated Resident #5 was able to keep the medication at their bedside. An observation and interview on 05/28/2024 at 9:49 AM, revealed a bottle of Flonase was on Resident #5's dresser. Resident #5 stated the physician told staff to leave the medication in the resident's room for the resident to use when needed. An observation on 05/29/2024 at 1:39 PM, revealed Resident #5 and the resident's roommate were in the room. The Flonase bottle remained on the resident's dresser and was visible from the open doorway. Resident #5 was interviewed on 05/31/2024 at 11:24 AM. Resident #5 stated they had asked the physician to write an order that allowed them to keep their Flonase in their room. Resident #5 stated that on 05/28/2024 and 05/29/2024 the resident kept the Flonase on top of the dresser. Afterward, the resident's family member put the medication in a dresser drawer so no other resident could get the medication. Resident #5 stated facility staff had not provided any instructions on how to store their Flonase. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nurse Aide (CNA) #1 was interviewed on 05/30/2024 at 12:48 PM. CNA #1 stated Resident #5 had nasal spray in their room that was kept on top of their dresser. CNA #1 stated the medication had been in the resident's room for the last couple of months and the CNA had been told the resident was able to have the medication at bedside. Certified Medication Technician (CMT) #3 was interviewed on 05/30/2024 at 2:01 PM. CMT #3 stated Resident #5 had an order to keep their Flonase at bedside. CMT #3 stated she thought Resident #5 left the Flonase on the table. Registered Nurse (RN) #5 was interviewed on 05/31/2024 at 10:51 AM. RN #5 stated medications kept at bedside were kept on top of the resident's bedside table or in the bedside table drawer. The Director of Nursing Services (DNS) was interviewed on 05/31/2024 at 1:00 PM. The DNS stated medications that were kept in a resident's room were expected to be stored in a bathroom cabinet. The Administrator was interviewed on 5/31/2024 at 1:22 PM. The Administrator stated she expected medications to be stored out of sight.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42192 Based on observation, interview, and facility policy review, the facility failed to maintain professional standards in the kitchen. Specifically, the facility failed to ensure dented canned foods were not in circulation in 1 of 1 dry storage area observed. This had the potential to affect all 55 residents who resided in the facility and received meals from the kitchen. Findings included: A facility policy titled, Food Receiving and Storage, revised 05/29/2024, indicated, Foods shall be received and stored in a manner that complies with safe food handling practices. The policy also indicated, When food is delivered to the facility it will be inspected for safe transport and quality before being accepted. During an interview on 05/29/2024 at 2:56 PM, the Administrator stated the facility had no specific policy regarding dented canned food. Observations of the facility's dry storage area on 05/28/2024 at 10:08 AM revealed compromised canned foods in the facility storage rack, specifically: - One unlabeled 6-pound can of food had dents along the rim, - One dented 46 ounce (oz.) can of V8, - One unlabeled 3-pound can was in with other 3 pound cans of cream of mushroom soup, and - One dented rim of a 55 oz can of olives. Further observation revealed no designated dented can area was seen in the dry storage area. During an interview on 05/29/2024 at 10:29 AM, the Certified Dietary Manager (CDM) stated canned foods could be put away by anyone, but she preferred to put away the deliveries. She stated some of the dietary staff would take initiative and put things away on their own. She stated she would come in to find things everywhere at times. During an interview on 05/29/2024 at 11:38 AM, [NAME] #8 stated that when putting deliveries away she would make sure items received were not open or dented. She stated damaged items were put aside so the facility could get credit from the distributor. She stated that when she found damaged items she took a picture and sent it to the CDM. She stated she would then remove the damaged item and write on it that it was damaged and to not be used. Follow-up observations of the facility's dry storage area on 05/29/2024 at 11:44 AM revealed compromised canned goods in the facility storage rack, specifically: - Two dented 6-pound cans of sweet potatoes, both had dented rims, and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- One dented 6.5-pound can of pinto beans. During an interview on 05/29/2024 at 11:55 AM, the CDM stated dented cans could allow oxygen into the canned food, causing microbe and bacteria growth and making the food unsafe and could cause illness. During an interview on 05/29/2024 at 12:22 PM, Dietary Aide (DA) #7 stated all dietary staff were to help unload the deliveries. He stated he would put deliveries away, and canned goods that were damaged or unlabeled should be thrown away. He stated if the distributor was alerted of the damaged product in the allotted timeframe the facility would get a credit. During an interview on 05/29/2024 at 12:30 PM, [NAME] #9 stated she had worked in the facility kitchen for a year and a half. She stated she was told by the CDM that they were going to be putting away the deliveries. She stated she had not help put away dry goods recently. She stated canned goods should be inspected for dents around the lid to make sure the food was not open and possibly contaminated. She stated if a can was dented it should be removed to the CMD's office. Observations in the CDM's office on 05/29/2024 at 12:40 PM after the CDM had gone through the dry storage can rack revealed that 36 compromised cans of food had been removed in total from the dry storage can rack, this included the compromised cans observed on 05/28/2024 at 10:08 AM and 05/29/2024 at 11:44 AM. Two cans were unlabeled and the other 34 were dented. The removed cans were all either 6-pounds or 46 oz of various foods. During an interview on 05/29/2024 at 1:00 PM, the Administrator stated if canned goods were delivered dented, they should be sent back and not used. She stated if dented cans of food were found after delivery they should be labeled and removed from storage. During an interview on 05/31/2024 at 1:06 PM, the Director of Nursing Services (DNS) stated dented cans of food should not be on the rack in dry storage. She stated she was unaware of the risks regarding compromised canned foods.

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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. 22445 Based on observation, interview, record review, and facility policy review, the facility failed to ensure 1 (Certified Medication Technicians [CMT] #4) of 4 staff observed during medication administration wore gloves while performing fingerstick blood sugar checks and washed hands between residents for 2 (Resident #47 and Resident #41) of 6 residents observed during medication pass observations. In addition, the facility failed to ensure oxygen supplies were labeled and stored in a manner to prevent the development or spread of infection for 1 (Resident #3) of 3 residents reviewed for respiratory care. Findings included: 1. A facility policy titled, Obtaining a Fingerstick Glucose Level, revised 06/26/2017, indicated, The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level. The policy The policy revealed the Steps in the Procedure included, 6. Wear clean gloves and 19. Wash hands or hand sanitize. A facility policy titled, Personal Protective Equipment - Gloves, reviewed on 05/30/2024, revealed Gloves must be worn when handling blood, body fluids, secretions, mucous membranes, and/or non-intact skin. The policy further revealed, 8. Wash your hands after removing gloves. An Admission Record revealed the facility admitted Resident #47 on 11/21/2023. According to the Admission Record, Resident #47 had a medical history that included a diagnosis of type one diabetes mellitus without complications. Resident #47's Order Summary Report, listing active orders as of 05/31/2024, contained an order, dated 01/24/2024, to complete fingerstick blood sugar checks four times a day. An Admission Record revealed the facility admitted Resident #41 on 06/29/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of type two diabetes mellitus with unspecified complications. Resident #41's Order Summary Report, listing active orders as of 05/31/2024, contained an order, dated 12/21/2023, to complete fingerstick blood sugar checks three times a day before meals. During medication pass observations on 05/30/2024 at 11:36 AM, CMT #4 entered Resident #47's room and completed a fingerstick blood sugar check without donning gloves. After completing Resident #47's fingerstick blood sugar check, CMT #4 did not wash her hands, and proceeded to complete a fingerstick blood sugar check for Resident #41 at 11:45 AM, again without donning gloves. CMT #4 was interviewed on 05/30/2024 at 11:59 AM. CMT #4 stated she had no explanation for not washing her hands between the residents. CMT #4 further stated it was the facility's policy to wear gloves when there was a potential for contact with blood, such as fingerstick blood sugar checks. Per CMT #4, she forgot to wear gloves when completing the residents' blood sugar checks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of Nursing Services (DNS) was interviewed on 05/31/2024 at 1:32 PM. The DNS stated staff were expected to wash or sanitize their hands after patient care, any time the hands were soiled, and after completing a fingerstick blood sugar check. The DNS stated staff were also expected to wear gloves when performing blood sugar checks. The Administrator was interviewed on 05/31/2024 at 1:22 PM. The Administrator stated she expected staff to wash or sanitize their hands between resident care, including fingerstick blood sugar checks. She further stated she expected staff to use gloves when performing blood sugar checks due to potential contact with blood. 39714 2. A facility policy titled, Oxygen Administration, revised in 10/2010, indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration; however, the policy did not address infection control measures for labeling or storage of oxygen equipment/supplies. During an interview on 05/31/2024 at 12:20 PM, the Director of Nursing Services (DNS) stated that night shift staff should change oxygen tubing once per week. The DNS stated the tubing should be labeled and stored in a blue bag. An Admission Record revealed the facility admitted Resident #3 on 06/19/2023. According to the Admission Record, the resident had a medical history that included diagnoses of pneumonia and heart failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/06/2024, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #3's Order Summary Report, listing active orders as of 05/31/2024, contained an order, started on 06/19/2023, for two liters of supplemental oxygen via nasal cannula as needed for shortness of air. The Order Summary Report also contained an order, started on 06/19/2023, for two liters of supplemental oxygen via NC at bedtime for hypoxia (low blood oxygen levels). On 05/28/2024 at 8:34 AM, an observation of Resident #3 revealed the resident's oxygen tubing and nasal cannula were lying on the resident's bed. The nasal cannula was not stored in a bag and the tubing was not dated. During an interview on 05/28/2024 at 8:35 AM, Resident #3 stated that they had been utilizing supplemental oxygen since returning from the hospital. Resident #3 stated they only used supplemental oxygen at night. An observation on 05/29/2024 at 2:12 PM, revealed Resident #3's nasal cannula and oxygen tubing were hanging on the resident's bed rail. The tubing was dated 05/29/2024 but was not stored in a bag. During an interview on 05/29/2024 at 2:12 PM, Resident #3 stated staff put a date on the tubing during the morning on 05/29/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 05/30/2204 at 9:45 AM, revealed Resident #3's nasal cannula and oxygen tubing were hanging on the resident's bed rail, and the tubing was not dated and was not stored in a bag. During an interview on 05/30/2024 at 2:02 PM, Certified Nurse Aide (CNA) #1 revealed Resident #3 only used oxygen at night when in bed and staff shut off the oxygen machine during the day. CNA #1 stated that the oxygen tubing normally just hung on the bed rail, and no one really put it in a bag. During an interview on 05/31/2024 at 8:54 AM, Certified Medication Technician (CMT) #14 stated night shift staff was responsible for changing oxygen tubing every week, and the day shift staff were responsible for monitoring to ensure the tubing stayed clean. The CMT stated Resident #3 only utilized oxygen at night, and when not in use, the tubing should be stored in a bag and dated. During an interview on 05/31/2024 at 9:20 AM, Registered Nurse (RN) #5 stated night shift staff were responsible for changing and dating oxygen tubing. During an interview on 05/31/2024 at 11:32 AM, the MDS Coordinator stated Resident #3 only used oxygen at night. She stated typically, the night shift charge nurse dated and stored the tubing when the tubing was changed. An interview with the Administrator on 05/31/2024 at 2:05 PM revealed their expectation was for oxygen tubing to be dated and stored in a bag.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 39714 Based on interview, record review, and review of the Facility Assessment Tool, the facility failed to ensure nurse aides received 12 hours of required in-service training per year for 2 (Certified Medication Technician [CMT] #3 and CMT #10) of 5 nurse aide employee files reviewed. Findings included: The Facility Assessment Tool, reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee on 08/23/2023, revealed, Required in-service training for nurse aides. In-service training must: - Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. - Include dementia management training and resident abuse prevention training. CMT #3's Orientation Checklist revealed she was hired as a CMT on 06/28/2018. CMT #3's Employee Inservice Attendance Record revealed that for the timeframe from 06/18/2022 to 06/18/2023 (most recent full year based on her hire date of 06/28/2018), CMT #3 attended only four in-services, none of which pertained to dementia management. The Employee Inservice Attendance Record did not reflect the number of in-service hours awarded for each in-service CMT #10 attended. CMT #10's Orientation Checklist revealed she was hired as a CMT on 12/03/2019. CMT #10's Employee Inservice Attendance Record revealed that for the timeframe from 12/03/2022 to 12/03/2023 (most recent full year based on her hire date of 12/03/2019), CMT #10 attended only four in-services, none of which pertained to dementia management. The Employee Inservice Attendance Record did not reflect the number of in-service hours awarded for each in-service CMT #10 attended. The Administrator (ADM) was interviewed on 05/30/2024 at 12:05 PM. The ADM acknowledged that there may have been missing in-service training records and stated that the facility recently hired a full-time Staff Development Director (DSD); however, per the ADM, the DSD had not yet started working at the facility.