STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265717	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Manor Health Care Center	3645 Cook Ave Saint Louis, MO 63113

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 30687 Based on interview and record review, the facility failed to have a system in place to ensure residents' individual trust fund accounts were not allowed to go into a negative balance. The facility managed funds for 61 residents. A sample of eight residents were chosen and the deficient practice affected six residents (Residents #8, #30, #37, #64, #66 and #78). The census was 104. Review of the facility's Resident Trust Policy, dated 2/2/24, showed the following: -Purpose: Complete Procedures on Resident Trust Responsibilities; -Negative Balances in Resident Accounts; -On the last day of every month the Resident Trust Clerk must confirm that all transactions for the month have been posted and then should run a Current Account Balance report from the banking system on the last day of the month to verify resident balances. If any resident has a negative balance on the last day of the month a positive adjustment must be posted in the banking system to make their balance zero. The banking system batch should be labeled Negatives to Fund in the batch description. The state agency will cite the facility for any overdrawn resident accounts so this step is very important. Review of the facility's Resident Trust Transaction History, dated 5/1/24 through 9/13/24, showed the following: -Resident #8: 9/10/24, negative balance ($456.23); -Resident #30: 9/3/24, starting negative balance ($50.00) through 9/4/24, negative balance ($1038.00); -Resident #37: 9/4/24, negative balance ($126.47); -Resident #64: 9/3/24, starting negative balance ($29.97) through 9/4/24, negative balance ($5444.00); -Resident #66: 9/4/24, negative balance ($898.00); -Resident #78: 9/4/24, negative balance ($212.00). (continued on next page)

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

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/13/24 at 12:04 P.M., the Business Office Manager (BOM) said the resident trust accounts should never go into the negative and she was aware of the negative balances. The BOM said the reason for the negative balances was the facility was waiting to become representative payee for some residents. This would fix the negative balances. At that time the Administrator said she was aware and agreed with the BOM.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 30687 Based on interview and record review, the facility failed to complete and maintain monthly account reconciliations of the facility's bank statements for two months. The census was 104. Review of the facility's Resident Trust Policy, dated 2/2/24, showed the following: -Purpose: Complete Procedures on Resident Trust Responsibilities; -Resident Trust Bank Reconciliation: A reconciliation of the bank statement module must be completed monthly. This will be completed by the facility's staff accountant responsible for the facility's financials. The reconciliation must be done by someone other than the Resident Trust Clerk. Review of the facility's resident trust accounts, showed no documentation of bank statement reconciliation's from January 2024 and April 2024. During an interview on 9/13/24 at 12:05 P.M., the Business Office Manager (BOM) and the Administrator said the previous owners of the facility no longer allowed access to the bank statements. The BOM said she thought she had copies of the bank statements. The new owners took over in May 2024.

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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. 21382 Based on record review, interview, and policy review, the facility to provide one of one residents (Residents (R) 81) a Centers for Medicare and Medicaid Services (CMS) for Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) when he completed his Medicare A therapy services. This failure to provide the CMS for SNF ABN prevented the resident from knowing he had days remaining under Medicare A. Findings include: Review of the facility's policy titled, Advanced Beneficiary Notice implemented 01/01/24 stated, .The current CMS-approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative). [sic] Contents of the form shall comply with related instructions and regulations regarding the use of the form. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary (SNF ABN), Form CMS-10055. Record review of R81's Face Sheet, located in the Profile tab of the electronic medical record (EMR) was admitted to the facility for long-term care and was being skilled in therapy after a hospital stay. Further review revealed the Social Services Director (SSD) issued a Notice of Medicare Non-Coverage 08/21/24 and the resident signed it for himself. His last covered day was 08/23/24. R81 remained in the facility and reverted back to Medicaid. Several attempts to interview R81 were made to interview with R81 however he did not wish to speak me. During an interview with the SSD on 09/10/24 at 3:58 PM, he stated he did not know he was supposed to use both forms for a resident that had Medicare A days available, and the facility team had determined the resident had returned to his prior level of function.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on interview, record review and policy review, the facility failed to notify the Ombudsman of a transfer for one of three residents (Resident (R) 84) out of a total sample of 26 residents. Findings include: Review of the facility's policy titled, Resident Transfer/ Discharge, Immediate Discharge, and Therapeutic Leave Policy last revised 05/14/24, indicated, . Who Must Receive Notice. In the case of an emergency or immediate discharge, copies shall be sent to the Ombudsman. In Section III. r their legal representative, a copy of the Bed Hold Policy. Review of R84's Face Sheet located in the Profile tab of the electronic medical record (EMR) revealed he was initially admitted on [DATE] for long-term care. Among his diagnoses on his Face Sheet were Type 2 diabetes mellitus and dementia. Review of R84s's most recent Quarterly Minimum Data Set (MDS) with an Assessment Review Date (ARD) on 06/23/24 revealed his Brief Interview of Mental Status (BIMS) was an 11, indicating he was moderately cognitively impaired. Review of the Documents tab of the EMR revealed there were no documents uploaded reflecting a transfer information was provided to the Ombudsman when R84 was sent out on 06/06/24 because he had missed two sessions of dialysis. An interview was attempted with R84 however the resident did not respond to questioning. During an interview on 09/12/24 at 1:05 the Social Services Director (SSD) verified that no transfer notice was provided to the Ombudsman when R84 transferred to the hospital. During an interview with the Administrator and Director of Nursing on 09/13/24 at 2:00 PM confirmed they were unaware the transfer information was not being sent to the Ombudsman.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 Based on interview, record review, and policy review, the facility failed to issue one of three residents (Resident (R) 84) or their responsible party out of a total sample of 26 residents a bed hold notice when R84 was sent to the emergency room . This failure could leave a resident to believe they would not be allowed to return when hospital ready from Findings include: Review of the facility policy titled, Bed Hold Policy, last revised 11/06/23 stated, .When a resident is discharged to the hospital . the Facility will provide to the resident or their legal representative, a copy of the Bed Hold Policy. Review of R84's Face Sheet located in the Profile tab of the electronic medical record (EMR) revealed he was initially admitted on [DATE] for long-term care. Among his diagnoses on his Face Sheet were Type 2 diabetes mellitus and dementia. Review of R84s's most recent Quarterly Minimum Data Set (MDS) with an Assessment Review Date (ARD) on 06/23/24 revealed his Brief Interview of Mental Status (BIMS) was an 11, indicating he was moderately cognitively impaired. Review of the Documents tab of the EMR revealed there were no documents uploaded reflecting a bed hold form was provided to R84 when he was sent out on 06/06/24 because he had missed two sessions of dialysis. An interview was attempted with R84 however the resident did not respond to questioning. During an interview on 09/12/24 at 1:05 PM the Social Services Director (SSD) verified that no bed hold notice was provided to R84 upon transfer to the hospital.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693 Based on interview, record review, and facility policy review, the facility failed to ensure each resident's drug regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being for two of six residents (Resident (R) 30 and R1) reviewed for unnecessary psychotropic medications. Findings include: Review of the facility's policy titled, Use of Psychotropic Medication Policy last revised 06/26/24 revealed Purpose: Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication .13. The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. 1. Review of R30's undated Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed R30 was admitted to the facility on [DATE]. R30's diagnoses included schizophrenia, unspecified. The Admission Record did not include a diagnosis related to depression. Review of an admission Minimum Data Set (MDS), located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 06/19/24 indicated R30 had a Brief Inventory of Mental Status score (BIMS) of 15 out of 15 indicating R30 was cognitively intact. The MDS also indicated R30 had one psychiatric diagnosis, schizophrenia, and was taking an antipsychotic agent and an antidepressant agent during the last seven days prior to the ARD. Review of the most recent Comprehensive Care Plan, located in the resident EMR under the Care Plan tab, initiated 08/22/24, indicated a focus area of the resident is at risk for adverse reaction r/t [related to] polypharmacy, with the goal that the resident will be free of adverse drug reactions through the review date. The interventions included If resident has more than one prescribing MD [Medical Director] < ensure that each physician has the full list of meds available, including OTC [over the counter] and PRN [as needed] meds, while ordering. Request physician to review and evaluate medications. Review pharmacy consult recommendations and follow up as indicated. The Comprehensive Care Plan also included a focus area of the resident uses antidepressant medication. The interventions included Monitor/document side effects and effectiveness Q-Shift. Monitor/document/report PRN adverse reactions to antidepressant therapy. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R30's active Orders located in the EMR under the Orders tab revealed an order dated 07/25/24 for mirtazapine (an antidepressant medication) 7.5 milligram (mg), amitriptyline (an antidepressant medication) 25 mg dated 07/23/24, sertraline (an antidepressant medication) 50 mg dated 06/06/24, and duloxetine (an antidepressant medication) 30 mg (an antidepressant medication) dated 06/07/24. The orders for mirtazapine, sertraline and duloxetine had an indication of schizophrenia. The order for amitriptyline had an indication for diabetes mellitus. R30's active orders did not indicate an order to monitor for antidepressant adverse effects. R30's active orders included two orders dated 06/06/24 for two antipsychotic medications with the same mechanism of action; risperidone (an antipsychotic medication) 1 mg and lurasidone (an antipsychotic medication) 40 mg, with an indication for schizophrenia. Review of R30's Medication Administration Record (MAR) for August 2024 and September 2024, located in the EMR under the Orders tab in Reports revealed no evidence of monitoring for antidepressant adverse effects. Review of a document titled -Psychiatric Progress Note dated 09/14/23 and provided by the Director of Nursing (DON) revealed a diagnostic impression which included major depressive disorder and paranoid schizophrenia. A review of two psychiatric progress notes, dated 10/12/23 and 11/10/23, revealed a diagnostic impression which included schizophrenia and depression. The treatment recommendations on all three notes indicated R30 should continue with duloxetine and lurasidone treatment. Review of a document titled Consultant Pharmacist's Medication Regimen Review dated 08/15/24 and provided by the DON, revealed the clinical pharmacist had indicated the order for amitriptyline had an inappropriate diagnosis attached to the order in the EMR and that the indication should be changed to major depressive disorder. The document had a follow-through response, dated 08/19/24, to change the indication for amitriptyline to pain. Review of the facility's pharmacy drug regimen reviews for the last 12 months did not reveal any additional pharmacy recommendations related to R30's antipsychotic or antidepressant agents. During an interview on 09/11/24 at 10:30 AM the DON stated for R30 the amitriptyline order should not be read for diabetes and the other antidepressants (mirtazapine, sertraline and duloxetine) should not have an indication of schizophrenia. She stated she was not sure why R30 was ordered the antidepressants and why they were listed with an indication of schizophrenia. The DON could not determine why R30 was also on risperidone and lurasidone combined. The DON stated if the care plan included side effect monitoring, then there should be an order and documentation in the MAR for side effects. During an interview on 09/12/24 at 1:47 PM the Clinical Pharmacist stated for R30 he would consider risperidone and lurasidone as polypharmacy because they are from the same drug class, and staff should be monitoring for antidepressant side effects. He stated the indications for the antidepressants need clarification and should be for a diagnosis the resident has. He stated he had submitted a recommendation with the August reviews for the amitriptyline indication. 2. Review of R1's undated Admission Record, located in the Profile tab of the EMR revealed R1 was admitted to the facility on [DATE]. R1's diagnoses included abnormal weight loss, but did not include a diagnosis related to depression or mood. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly MDS located in the EMR under the MDS tab with an ARD of 06/24/24 indicated R1 had a BIMS of 3 indicating R1 was cognitively severely impaired. The MDS indicated an active diagnosis of malnutrition but did not indicate any psychiatric diagnoses. The MDS indicated R1 was taking an antidepressant during the last seven days prior to the ARD. Review of the most recent Comprehensive Care Plan, located in the resident EMR under the Care Plan tab, initiated 08/16/24, indicated a focus area for malnutrition with interventions which included Administer medications as ordered. Monitor/document for side effects and effectiveness. The Comprehensive Care Plan did not include any further focus areas that addressed antidepressant medications. Review of R1's active Orders' located in the EMR under the Orders tab revealed an order for mirtazapine (an antidepressant medication) with an indication for mood disorder and escitalopram (an antidepressant medication) with an indication for mood disorder. Review of all active orders revealed no order to monitor for antidepressant adverse effects. Review of R1's MAR for August 2024 and September 2024, located in the EMR under the Orders tab in Reports revealed no evidence of monitoring for antidepressant adverse effects. Review of R1's Progress Notes located in the EMR under the Progress Notes tab revealed a nutrition note dated 07/31/24 that referred to the addition of supplement and a Remeron (mirtazapine) order to increase appetite. During an interview on 09/11/24 at 10:30 AM the DON acknowledged that R1's mirtazapine order should have been ordered with an indication for appetite stimulation not mood disorder and there should be side effect monitoring for the antidepressant medications.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30067 35693 Based on medical record reviews, staff interviews and facility policy review, the facility failed to maintain complete and accessible medical records for three of 31 sampled residents ((R)6, R9 and R47) whose electronic medical records (EMRs) were reviewed for the recertification and complaint survey. Specifically, the EMRs for R6, R9 and R47 contained no current care plans following the facilities migration from one electronic medical record system to another. This meant the Certified Nurse Aids could not access a current Plan of Care to provide appropriate care and services. As well as failed to ensure the one out of eight residents (R95) medication prescription was accurately documented in the medical record. The findings include: Review of the facility policy titled, Medical Records, dated 02/2024 revealed, .The facility shall maintain medical records on each resident that are complete, accurately documented, accessible and organized. In an interview with the Administrator and Regional Director of Operations (RDO) on 09/09/24 at 3:50 PM revealed the facility had recently changed ownership and have adopted a new EMR system. They stated most of the resident's data had been migrated to the new EMR but they are still scanning hard copy chart data. They confirmed each resident should have a current care plan in the EMR. 1.a. Record review of R6's Face Sheet found in the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] from a closing sister facility. R6's diagnoses included paranoid schizophrenia, anxiety disorder, history of ETOH abuse, and sepsis. Review of R6's quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 of 15 points indicating that R6 was cognitively intact. R6 was ambulatory without a wheelchair for short distances, however he had one in his room for longer distances/appointments. R6 was independent with most Activities of Daily Living (ADLs) and he required only standby assistance and reminders from staff. R6 had behaviors of impulsivity and poor safety awareness. The EMR review failed to include a current and active care plan for R6 since his move from the closed sister facility in December 2023. b. Record review of R9's Face Sheet found in the Profile tab of the EMR that revealed he was admitted to the facility on [DATE] with diagnoses including moderate intellectual disabilities and hemiplegia to unspecified site following unspecified cerebrovascular disease, and mood disorder. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's annual MDS Assessment with an ARD of 07/12/24 revealed a Brief Interview for Mental Status BIMS score of eight out of a 15indicating moderate to severe cognitive impairments. R9 was ambulatory per himself in a wheelchair, and he required moderate staff assistance with Activities of Daily Living (ADLs). R9 also exhibited behaviors intermittently, primarily refusals to bathe/shower, and a tendency to become loud and aggressive with staff that tried to clean him up anyway. Review of the current EMR failed to include a current and implemented care plan for R9. c. Review of R47's undated Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed R47 was admitted to the facility on [DATE]. R47's diagnoses included chronic kidney disease, polyneuropathy, essential hypertension, age-related cognitive decline, anemia, and muscle weakness. Review of R47's Medical Diagnosis, located in the Diagnosis tab of the EMR, revealed R47 also had a diagnosis of major depressive disorder, pain in the right leg, and alcohol abuse with intoxication, unspecified. Review of a quarterly Minimum Data Set (MDS), located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 07/15/24 indicated R47 had a Brief Inventory of Mental Status score (BIMS) of 15 indicating R47 was cognitively intact. The MDS also indicated R47 was independent for almost all activities of daily living. Review of the most recent Comprehensive Care Plan, located in the resident EMR under the Care Plan tab, initiated 05/24/24, indicated only two focus areas: one for advanced directives for code status and a second for no known allergies. Review of a document titled Care Plan provided by the Administrator from MatrixCare, last reviewed/revised 05/01/24, revealed focus areas for behavioral symptoms related to intoxication, activities, nutritional status, behavioral symptoms related to resisting care, mood state, psychosocial well-being, pain, psychotropic drug use, falls risk, activities of daily living, and cognitive loss/dementia. In an interview with the Administrator and Director of Nurses (DON) on 09/12/24at 12:15 PM they confirmed the three residents above did not have current, accurate and accessible care plans in the current EMR for staff to access and implement. They confirmed the migration to the new electronic system had not been an easy transition, but they stated they were still working thru the changes .we fix things as we find them in chart audits . 2. Review of the facility's policy titled, Pharmacy Services Policy, revised 05/18/24, revealed Pharmaceutical Services refers to: The process (including documentation, as applicable: of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packing, labeling, distributing, administering, monitoring responses to, using and/or disposing of all medications, biological, chemicals .Policy: The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements, and reflect current standards of practice. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R95's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed R95 was admitted to the facility on [DATE] with diagnoses which included Crohn's disease, unspecified, without complications. Review of R95's quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 07/10/24, revealed R95 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R95 was cognitively intact. The MDS indicated R95 was coded for pain, with a frequency of Almost constantly. Review of an Order, located in the Order tab of the EMR and dated 08/28/24 revealed an order for oxycodone-acetaminophen oral tablet 7.5/325 milligram (mg). Review of R95's Medication Administration Record (MAR), dated 08/24 and located under the Reports tab in the EMR, revealed R95 received four days of oxycodone-acetaminophen oral tablet 7.5-325 mg, from 08/28/24 to 08/31/24. Review of R95's MAR dated 09/24 and located under the Reports tab in the EMR, revealed R95 received 11 days of oxycodone-acetaminophen oral tablet 7.5-325 mg, from 09/01/24 to 09/11/24. During observations on 09/11/24 at 6:00 AM Licensed Practical Nurse (LPN) 4 was observed during medication administration punching a half tablet of oxycodone 15 mg from a blister packet that contained 51 of 90 half tablets of oxycodone 15 mg to fulfill the oxycodone/acetaminophen 7.5-325 mg order for R95. During an interview on 09/11/24 at 6:00 AM LPN4 stated the oxycodone 15 mg half tablet was what she had been administering to R95 for pain since before her recent hospitalization and that was what the pharmacy had sent. LPN 4 stated orders entered in the EMR were automatically transmitted electronically to the pharmacy for dispensing. LPN4 was unable to determine how the pharmacy sent a card for oxycodone 15 mg half tablets rather than the oxycodone-acetaminophen 7.5-325 mg tablets order found in the EMR. During an interview on 09/11/24 at 10:30 AM the DON stated the original physician's order for R95 was for oxycodone 7.5 mg without acetaminophen. The DON stated she did not know why the order was entered as oxycodone 7.5 mg with acetaminophen 325 mg. The DON acknowledged that she had entered the order in error. She stated the pharmacy filled the order from the original order sent to the pharmacy by the physician, not the order sent electronically by the facility via the EMR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265717	A. Building B. Wing	09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Manor Health Care Center	3645 Cook Ave Saint Louis, MO 63113

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on observation, interview, record review and policy review, the facility failed to ensure nursing staff properly stored a residents BiPAP mask when not in use for one of one sampled resident (Resident (R) 32). Findings include: A review of the facility's policy titled CPAP/BiPAP Cleaning Policy revised 05/14/24 revealed, BiPAP mask should be cleaned daily after use, dry well and cover with plastic bag or completely enclosed in machine storage when not in use Review of R32's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed readmission to the facility on [DATE] and with diagnosis of respiratory failure, sleep apnea and chronic obstructive pulmonary disease (COPD). Review of R32's Admission Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 07/14/24, revealed the Brief Interview for Mental Status (BIMS), revealed a score of 15 out of 15 which indicated no cognitive impairment. The resident was coded as receiving noninvasive mechanical ventilator (BiPAP). During observations on 09/10/24 at 12:35 PM, and on 09/12/24 at 9:45 AM the resident's BiPAP mask was lying on top of the table at the bedside uncovered. R32 said she used her BiPAP machine daily and that staff covered it in a plastic bag one time but have not covered it since then. During an observation and interview on 09/12/24 at 9:45 AM with Licensed Practical Nurse (LPN)1 and LPN3 observed R32 in bed with BiPAP mask lying on top of the bedside table uncovered. R32 said she used her BiPAP machine last night and they use to store it in a bag, but they have not for a while. LPN1 said the BiPAP mask should be stored in a bag and LPN3 also said it was supposed to be in a bag and asked if there was a bag placed by the mask to be stored in but there was not. During an interview on 09/12/24 at 12:19 PM the Regional Director of Operations (RDO) stated BiPAP masks should be cleaned after use and bagged when not in use.