STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265757	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentwood Nursing & Rehab	1501 Charbonier Road Florissant, MO 63031

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** 40902 Based on observation, record review staff interview and policy review, the facility failed to ensure that a resident was assessed for self-administration of medications prior to medications being left at bedside and that the correct dose was given for one (Resident (R)169) out of four residents reviewed for medication administration. Findings include: Review of R69's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R69 was admitted to the facility on [DATE] with diagnoses including muscle weakness, neuropathy, and hypertension. Review of R69's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/29/24 revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated moderate cognitive impairment. Review of R69's care plan, located under the "Care Plan" tab of the EMR and dated 02/26/24, revealed "The resident was not care planned for self-administration of medications. Review of R69's Physician Orders, located under the Orders tab of the EMR dated 05/06/24, revealed an order for Methocarbamol 500 milligram (mg) one tablet three times a day, Gabapentin 300 mg one tablet three times a day, and Metoprolol 50 mg one tablet twice daily. Further review revealed no order for self-administration of medications. During an observation on 05/06/24 at 11:25 AM R69 was lying in bed with her back turned towards the door. Bedside table at bedside with a cup of water and a small plastic cup containing five pills. R69 said staff always left her medications with her in the room and do not watch her take them. She said they had been on her bedside table for a while, but she was unable to state what medications were in the cup. (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	During an interview on 05/06/24 at 11:48 AM Certified Medication Technician (CMT) 1 looked at the cup containing the pills and verified what each pill was. She said there was two-Gabapentin, two Methocarbamol, and one-Metoprolol. She said R69 was assessed to self-administer, and she left her medications at bedside and did not observe when R69 took them. She stated she usually came back to the R69's room within five minutes to make sure she took all her medications, but it was longer today because she hasn't had a chance to come back because she was busy with other residents. She said she was not aware there was not an order on file and did not know there needed to be an order for a resident to self-administer medications. She never gave more than the correct dose but verified she should not have given two doses of the Methocarbamol and Gabapentin medication at one time. She said she has not received any training on medication administration. During an interview on 05/09/24 at 5:03 PM the Director of Nursing (DON) stated she would have to review the facility policy on residents self-administering medications, but she was aware they had to be accessed and there needs to be a physician's order. She said she expected the order to be followed and it was not ok for staff to administer two doses at one time, and she expected the policy to be followed for residents to self-administer. Review of the facility's policy titled, Self-Administration of Medications revised August 2014, revealed, In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide and maintain complete accounting records, regarding the reconciliation of petty cash kept on hand, for the resident trust account. The census was 111. Review of the facility's Business Office Resident Trust Fund Policy and Procedure, undated, showed the following: -Policy Statement: Residents of a skilled nursing center are to have their funds managed and personal spending money available to them. Regardless of payment source, residents have the right to choose whether or not to open a Resident Trust Fund account with the Center. If the choice to open a trust fund account is made, the resident has the right to have their money safeguarded and accounted for by the Center. The residents have the right to have any funds deposited with the center, in an interest-bearing account, according to state guidelines. All resident account balances over $50.00 will accrue interest. The Administrator ultimately will be responsible for the oversight and management of resident funds; -Procedure: The Center shall maintain a Resident Trust Cash Box to provide for cash withdrawals of the resident. This will be kept in a separate cash box from all other Center petty cash. The Resident Trust Cash Box will have a set maximum balance to be established by the corporate office. If the Resident Trust Cash Box maximum fund should need to be increased, a request must be sent to the corporate office. When the Resident Trust Cash Box is replenished, funds should be used from the Resident Trust Bank account. Review of the bank statements for the resident trust on 5/14/24, showed the facility provided 12 reconciled bank statements which covered May 2023 through April 2024. The monthly reconciled bank statements did not include the reconciliation of the petty cash kept on hand. Observation and interview on 5/14/24 at 10:35 A.M., with Receptionist D and Business Office Manager (BOM), showed a count of $289.49 in the residents' petty cash box. The residents' petty cash box did not have a reconciliation sheet. Receptionist D said he/she did not know the starting balance of the petty cash box and did not have a reconciliation sheet. Receptionist D said he/she counts the money at night but does not know what should be in the residents' petty cash box. During an interview on 5/14/24 at 10:47 A.M., the BOM said she will replenish the money and compare it to the resident funds management system for petty cash. The BOM said she is responsible for the resident petty cash box. The petty cash should be reconciled at least on a daily basis but was not. The reconciliation will ensure the funds balance and there is no theft. During an interview on 5/14/24 at 10:53 A.M., the Administrator said she did not know the residents' petty cash was not being reconciled in a timely manner. She expected this to be completed to ensure accuracy of the petty cash.

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30687 Based on interview and record review, the facility failed to ensure third party liability (TPL) forms were completed within 30 days for the final accounting for residents who expired. This affected three residents who expired and had money in their accounts (Residents #201, #202 and #203). The census was 111. 1. Review of Resident #201's medical record, showed the following: -Expired on [DATE]; -Ending balance of $5781.19; -TPL completed on [DATE]. 2. Review of Resident #202's medical record, showed the following: -Expired on [DATE]; -Ending balance of $3029.82; -TPL completed on [DATE]. 3. Review of Resident #203's medical record, showed the following: -Expired on [DATE]; -Ending balance of $200.34; -TPL completed on [DATE] 4. During an interview on [DATE] at 12:16 P.M., the Business Office Manager (BOM) said she is responsible to ensure the ending balances are sent back within 30 days. There were some that were overlooked and should have been completed in a timely manner. 5. During an interview on [DATE] at 1:49 P.M., the Administrator said she was not aware the TPL was not completed in a timely manner. She expected this to be completed within the required timeframe.

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F 0600 Level of Harm - 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** 40902 Based on record review, interview, and policy review, the facility failed to protect the resident's right to be free from physical abuse by a resident for one of two residents (Resident (R)73 and R84) reviewed for abuse. The census was 106. Review of the facility's policy titled, Abuse Prevention revised 10/21/22, revealed the facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal guardians, surrogated, sponsors, friends, visitors, or any other individual. Review of R73's Admission Record, located in the Profile' tab of the EMR, showed R73 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, anxiety disorder, attention deficit hyperactivity disorder and major depressive disorder. Review of R73's Quarterly MDS with an ARD of 03/15/24 showed a BIMS score of 15 out of 15 which indicated no cognitive impairment. Review of R73's care plan, located under the Care Plan tab of the EMR and dated 01/23/24, showed "The resident has substance abuse/addition issues related to inadequate coping skills." Review of a Nurses Notes, dated 05/02/24 at 12:59 P.M., in the EMR, under the Resident Services tab written by Social Services Supervisor (SSS), showed R84 was in a verbal altercation in which R73. R73 stated that R84 physically hit her. R84 was educated that he can't physically put his hands on other residents. He stated that he did understand but he was upset because the other resident keeps lying on him and having visitors coming up here. R84 said it was making him mad because they know he has feelings. It was repeated to the resident that it still did not give him the right to physically hit anyone in the facility. Social Services will continue to monitor this situation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/07/24 at 2:00 P.M., R73 said on 05/02/24 R84 was drunk when he was coming back from the smoking area and passed her and her roommate on their way to the smoking area. R73 said R84 got into her face and was talking bad and told her On his momma he was going to kill her and took his fingers and made a gun symbol and put his fingers up against her forehead and pushed her head. She said it was in the hallway and the cameras saw it and so did the activities person. The next day R84 came up to her again and put his open hand on the side of her face and pushed it and took her wheelchair and pushed her into the door. She said she called the police after both incidents but Licensed Practical Nurse (LPN) 1 spoke with the police first and they never interviewed her or allowed her to file a police report. She said she and R84 used to be good friends, but he got jealous anytime she had a male visitor come to see her. She said anytime she or her roommate had a visitor R84 got upset and the visitor was kicked out and they were not allowed to come back. R84 hit her roommate's family member who came to visit in March, and he was no longer allowed back. She was afraid of R84 when he drank because he would get irate and violent. All the staff were aware of R84's aggression when he was drinking, and they also were aware he would leave to get alcohol all the time. She said the facility has not put any restrictions between her and R84 having contact with each other. She said in March R84 started punching the walls because he saw her with a male visitor when they walked to the smoking area. She said last week she was sent out to the emergency room because she was so upset that LPN1 was trying to convince her that R84 did not do anything to her and that she was lying. She said she had been in an abusive relationship in the past and she was not going to allow that to happen to her. During an interview on 05/09/24 at 10:48 A.M., R84 said it has been rocky for him lately and that he has been having nightmares, but he is not really interested in talking with anyone about it. He does attend AA classes and he has not been drinking that much lately. He did drink but he does not feel his drinking was an issue and felt he had it under control. R73 was a friend, and they were playing, talking, and touching each other. He said R73's roommate got involved and said some stuff, but there was nothing physical that occurred. He said he would not put his hands on anyone especially R73. He said everyone knew they played a lot, but he never put his hands on her or told her he was going to kill her. He said he never hit her on the side of the face with an open hand and never took her wheelchair and pushed her. R84 then stated he may have been pushing her and accidentally ran her into the wall. He remembered that R409 spit on him three times and came over and got in his face and he might have pushed her. During an interview on 05/07/24 at 5:02 P.M., Registered Nurse (RN)1 said R84 and R73 go together meaning they are in a relationship. RN1 said R73 was a manipulator and had male visitors come to visit her which made R84 very mad. R84 would sign out of the facility for leave of absence (LOA) and go to the store to get and consume alcohol. R84 drank alcohol during the day and by the evening shift he was intoxicated. She said one time R84 got hold of R73's wheelchair and pushed her into the wall and that R84 was hard to control. Staff started 15-minute checks. RN1 said that on Friday (05/03/24) she had to send R73 out to the emergency room (ER). She said R73 went to the smoking area and saw R84 out there and left and then said R84 came up to her and hit her on the face, but RN1 said that R84 said she did not do that. RN1 said she did not witness the incident, but she believed R84. She said that R73 ended up calling the cops and then became hysterical when police did not listen to her. R84 was not allowed to smoke in the same area as R73 but that R73 would come down to the 600 hall that R84 was on. But she said there was nothing else in place to supervise either resident. She said that R84 was hard to keep in his room to complete 15-minute checks and that staff can't keep him there, but they try to be aware of his whereabouts, but that staff do not put eyes on him every 15 minutes when he is in other parts of the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 05/08/24 at 9:52 A.M., LPN5 said on 05/02/24 she was made aware by staff there was an issue with R84 and R73, so she went to the front to see what was going on. She spoke with R73 who told her R84 took his fingers and pushed the middle of her forehead, but she said R73 said she pushed R84 first. She said she was not able to understand most of what R73 was saying due to her screaming. She spoke with R84 who denied touching R73. She separated them and they were not allowed to be around each other. Staff started 15-minute checks which are still ongoing with R84. During an interview on 05/08/24 at 10:31 A.M., SSS said R84 got along with staff and other residents, but did have an alcohol problem and became upset when he was unable to get alcohol. SSS has never personally seen R84 under the influence, but staff have reported that he has been. SSS stated, there was one time when R84 became belligerent, and staff believed he was under the influence, but the SSS was unsure when that occurred. Last week R73 had another male visitor come visit and R84 got mad and upset. The SSS said after R84 found out that another man visited R73, she witnessed R84 punching the walls, saying I can't believe you did this. She spoke with R73 who denied hitting R73. R84 has now started attending Alcoholics Anonymous (AA) meetings. All staff were aware they should be monitoring both residents and keeping them apart. She was unsure how that was communicated to staff, but she assumed they were aware. SSS was unsure what the plan was to monitor R84 if he became aware that R73 had a male visitor. She does meet with both residents separately three times a week. During an interview on 05/08/24 at 1:02 P.M., the ADON said she has never personally seen R84 become aggressive, but staff have reported he has. Staff have also reported that R84 becomes more aggressive when he is under the influence of alcohol. She said R73 and R84 have a relationship and they have had arguments and there have been some physical incidents between them that staff have reported. Staff have reported that R84 becomes upset when male visitors come to the facility to visit R73. Both residents have been reeducated by the social worker and the Administrator. They have done 15-minute checks for 72 hours after an altercation. But she was unsure what had been done to address R84's inability to handle his emotions and his aggression. He recently started attending AA, but she was unsure what else was done after R84 refused a Psychiatric evaluation or why there were no Psychiatric services in place to address the underlying issues that cause R84 to self-medicate with substance issues. And she was aware that R84 became irate and was punching walls after R73 had a male visitor. During an interview on 05/08/24 at 2:43 P.M., the Director of Nursing (DON) stated she was aware there was an incident between R84 and R73 last week. She said R84 got jealous after R73 had an outside boyfriend come to visit her in the facility last week.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 30687 Based on interview and record review, the facility failed to ensure newly hired employees were screened to rule out the presence of a Federal Indicator, with the Certified Nurse Aide (CNA) Registry, for five of 10 sampled employees hired since the last survey. The facility hired at least 200 new employees since the last survey. The census was 111. Review of the facility's Abuse Prevention Policy, dated 10/21/22, showed the following: -Policy: The facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual; -Screening: 1. The facility conducts employee background checks and will not knowingly employ any individual who has been convicted of abusing, neglecting, or mistreating individuals or misappropriation of property; 2. The facility will pre-screen all potential new employees and residents for a history of abusive behavior. 1. Review of Dietary Manager A's employee file, showed the following: -Hire date: 1/14/19; -No CNA registry check performed. 2. Review of Dietary Aide (DA) B's employee file, showed the following: -Hire date: 9/6/23; -No CNA registry check performed. 3. Review of DA C's employee file, showed the following: -Hire date: 10/17/23; -No CNA registry check performed. 4. Review of Receptionist D's employee file, showed the following: -Hire date: 12/2/23; -No CNA registry check performed. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of DA E's employee file, showed the following: -Hire date: 12/6/23; -No CNA registry check performed. 6. During an interview on 5/15/24 at 9:48 A.M., the Human Resource Manager (HRM) said he/she was not aware all newly hired staff needed to have a CNA registry checked performed. He/She thought it was just for CNAs. He/She has been with the facility since October 2022. 7. During an interview on 5/14/24 at 2:30 P.M., the Administrator said she was not aware all new hires needed to have the a CNA registry checked performed. The HRM would be in charge of this task.

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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** 32440 Based on interview and record review, the facility failed to send written notice of transfer/discharge to resident or resident representative for two of two resident (Residents (R) 63 and 108) reviewed for hospitalization s. Findings include: 1. Review of R108's undated Admission Record, located in the Profile tab of the Electronic Medical Record (EMR) revealed R108 was initially admitted to the facility on [DATE] with diagnoses of nondisplaced fracture of left tibial tuberosity, morbid obesity, and congestive heart failure. R108 was transferred to the hospital on 02/21/24. Review of a discharge Minimum Data Set (MDS) located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 02/21/24 was incomplete for R108. The MDS was marked as Discharge assessment- return not anticipated. Review of documents in R108's EMR located in the Misc tab, did not reveal a written notice of transfer/discharge for either hospital transfer. Review of R108's hard chart located at the nurse's station did not reveal a written notice of transfer for either hospital transfer. 2. Review of R63's undated Admission Record, located in the Profile tab of the EMR revealed R63 was initially admitted to the facility on [DATE] with diagnoses of epilepsy, unspecified, intractable, with status epilepticus, unspecified dementia, and chronic kidney disease. Review of a discharge MDS located in the EMR under the MDS tab, with an ARD of 02/22/24 indicated R63 was rated as having memory problem and Moderately impaired for cognitive skills for daily decision making. The MDS was marked as Discharge assessment- return anticipated. Review of a discharge MDS located in the EMR under the MDS tab, with an ARD of 03/18/24 indicated R63 was rated as having memory problem and Severely impaired for cognitive skills for daily decision making. The MDS was marked as Discharge assessment-return anticipated. Review of documents in the EMR located in the Misc tab, did not reveal a written notice of transfer/discharge for either hospital transfer. Review of R63's hard chart located at the nurse's station did not reveal a written notice of transfer for either hospital transfer. During an interview on 05/09/24 at 2:15 PM the Social Worker (SW) stated she does not send a written notice to the resident/guardian regarding notice of transfer/discharge but probably nursing does. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 2:55 PM Licensed Practice Nurse (LPN) 4 stated nursing does not send a written notice of transfer to the resident/guardian but nursing will call to notify. During an interview on 05/09/24 at 5:00 PM the Administrator stated she was unable to locate a written notice of transfer/discharge for R63 and R108 for either hospital transfer. During an interview on 05/09/24 at 6:00 PM the Administrator stated the facility does not have a policy specific to written notice of transfers/discharge. 35693

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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** 35693 Based on interview, record review and facility policy review, the facility failed to ensure a bed hold notice was provided to resident or resident representative for one of one resident (Residents (R) 63) reviewed for hospitalization s. Findings include: Review of R63's undated Admission Record, located in the Profile tab of the Electronic Medical Record (EMR) revealed R63 was initially admitted to the facility on [DATE] with diagnoses of epilepsy, unspecified, intractable, with status epilepticus, unspecified dementia, and chronic kidney disease. Review of a discharge Minimum Data Set (MDS) located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 02/22/24 indicated R63 was rated as having memory problem and Moderately impaired for cognitive skills for daily decision making. The MDS was marked as Discharge assessment- return anticipated. Review of a discharge MDS located in the EMR under the MDS tab, with an ARD of 03/18/24 indicated R63 was rated as having memory problem and Severely impaired for cognitive skills for daily decision making. The MDS was marked as Discharge assessment-return anticipated. Review of documents in the EMR located in the Misc tab, did not reveal a bed hold notice for either hospital transfer. Review of the hard chart at the nurse's station did not reveal a bed hold notice for either hospital transfer. During an interview on 05/09/24 at 2:15 PM the Social Worker (SW) stated the facility does not do bed holds. During an interview on 05/09/24 at 5:00 PM the Administrator stated R63 should have had a bed hold form filled out for those discharges. The Administrator stated she was unable to locate a bed hold notice for R63 for either hospital transfers. Review of a document titled, Resident Bed Hold, last reviewed 11/15/22, revealed The Facility will provide written information to the Resident and/or the Resident Representative regarding Bed Hold Policy prior to transferring a Resident to the hospital or Therapeutic Leave as required by State/Federal Guidelines.

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Bentwood Nursing & Rehab	1501 Charbonier Road Florissant, MO 63031

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40847 Based on interview, record review, and facility policy review, the facility failed to ensure an accurate Level 1 pre-screening of the resident for a mental disorder (MD) or intellectual disability (ID) prior to admission to the facility was completed or correct for one (Residents (R) 20) of four reviewed for Level 1 Pre-Admission Screening and Resident Review (PASARR). Findings include: Review of R20's undated, electronic Face Sheet located in the electronic medical record (EMR), in the Profile tab revealed an admitted [DATE]. Continued review of the electronic Face Sheet included the following diagnoses end stage renal disease, hypertension, major depression disorder and bipolar disorder. Review of R20's medical record did not indicate a PASARR Level I or Level II could be located at this time. Review of R20's electronic Physician's Orders for the month of May, located in the EMR, in the Orders tab included Mirtazapine Oral Tablet 30 Milligram (MG) for Depression, Sertraline HCl Oral Tablet 50 MG for major depressive disorder, antidepressant monitoring, sedative/hypnotic medication monitoring, antianxiety medication monitoring and may see Psychiatrist/Psychologist as needed. Review of R20's electronic Care Plan dated 04/23/24, located in the EMR, under the Care Plan tab indicated, .has been prescribed Psychotropic Medication. Review of R20's annual Minimum Data Set (MDS) located in the EMR, under the MDS tab, with an Assessment Reference Date (ARD) of 01/13/24, indicated a Brief Interview for Mental Status (BIMS) score, of 15 indicating resident is cognitively intact. The resident's mood assessment revealed a severity score of 14, indicating resident is at risk for depression and psychosocial. The resident takes antipsychotic and antidepressants and doesn't have any special treatments or programs triggered. Interview on 05/09/24 at 5:24 PM with the Social Services Supervisor stated she sent an email out to Central Office Medical Review Unit (COMRU) and a reply indicated they cannot provide copies of the application due to the level 2 being more than one year and the facility would need to submit a new application for replacement forms. The applications were complete 08/09/22 and sent to FSD (Family support division) on 08/18/22. Interview on 05/09/24 at 6:07 PM the Administrator stated the facility does not have a policy for PASARR. Interview on 05/09/24 at 6:20 PM with Director of Nursing (DON) stated the expectation of getting the PASSR level I and/or II for R 20 would be to reapply per the email sent to social service director.

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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** 40847 Based on observation, interview and record review, the facility failed to develop a activities care plan for two (Resident (R) 20 and R40) of two resident reviewed for activities. Failure to have activities care plan in place for R20 and R40 at risk for psychosocial decline. Refer F679 Findings include: 1. Review of the facilities policy titled, Comprehensive Centered Care Plan, dated 10/23/19 provided by the facility revealed, Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. Review of Medical Diagnosis, located in R20's electronic medical record (EMR) found in the Medical Diagnosis tab, revealed R20 was admitted to the facility on [DATE] with included the following diagnoses end stage renal disease, hypertension, major depression disorder and bipolar disorder. Review of R20's electronic Care Plan dated 04/23/24, located in the EMR, under the Care Plan tab did not include resident is care planned for activities. Observation of R20 on 05/08/24 at 11:58 AM of R20 sitting near the nurse's station having a conversation with staff and other residents. Observation of R20 on 05/08/24 at 3:08 PM sitting near nurse's station talking to other residents. 2. Review of Medical Diagnosis, located in R40's electronic medical record (EMR) found in the Medical Diagnosis tab, revealed R40 was admitted to the facility on [DATE] with included the following diagnoses end stage renal disease, hypertension, hyperkalemia and chronic diastolic heart failure. Review of R40's electronic Care Plan dated 03/11/24, located in the EMR, under the Care Plan tab did not include resident is care planned for activities. Observation of R40 on 05/06/24 at 12:18 PM sitting near the nurse's station talking to staff and other residents. Observation of R40 on 05/08/24 at 10:18 AM Observed resident sitting near the nurse's station, resident indicated he was getting ready to go outside and smoke. He stated he would still like to do other activities that the facility can provide like a trip to Walmart. Observation on 05/08/24 at 3:07 PM of R40 sitting up in wheelchair in room with eyes closed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/09/24 at 6:22 PM with Director of Nursing (DON) stated the expectation is to individualize activity care plans. Care plan nurse was out of the facility attending a funeral. 40902 Based on record review and staff interview, the facility failed to implement a care plan for a resident receiving antidepressant medication and a resident who had a catheter for two residents reviewed for care plan implementation (Resident (R)69 and R77). Refer to F554. As well as failed to develop a activities care plan for two (Resident (R) 20 and R40) of two resident reviewed for activities. Failure to have activities care plan in place for R20 and R40 at risk for psychosocial decline. Refer F679. Findings include: 1. Review of R69's Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R69 was admitted to the facility on [DATE] with diagnoses including muscle weakness, neuropathy, and hypertension and depression. Review of R69's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/29/24 revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15 which indicated moderate cognitive impairment. Review of R69's care plan, located under the "Care Plan" tab of the EMR and dated 02/26/24, revealed "The resident was not care planned for self-administration of medications. Review of R69's Physician Orders, located under the Orders tab of the EMR dated 05/06/24, revealed an order for Mirtazapine 30 milligram (mg) once at bedtime for depression. 2. Review of R77's "Admission Record," located in the "Profile" tab of the EMR, revealed R77 admitted to the facility on [DATE] with diagnoses including urinary tract infection, neuromuscular dysfunction of the bladder and paraplegia. Review of R77's Significant Change "MDS" with an ARD of 04/10/24 revealed a "BIMS" score of 10 out of 15 which indicated moderate cognitive impairment. The MDS coded the resident as using urinary catheter. Review of R77's care plan, located under the "Care Plan" tab of the EMR and dated 05/19/23, revealed "The resident was not care planned for catheter use. Review of R77's Physician Orders, located under the Orders tab of the EMR dated 05/09/24, revealed an order for indwelling catheter care every shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 5:03 PM the Director of Nursing (DON) stated MDS Coordinator was responsible for care plan implementation, but she was at a funeral and unavailable for an interview. A resident receiving Antidepressant medication or catheter care should be care planned. She said new orders were reviewed daily during morning meetings. She said it was important to have those care planned to ensure staff knew how to provide the appropriate care. 3. Review of the facilities policy titled, Comprehensive Centered Care Plan, dated 10/23/19 provided by the facility revealed, Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. Review of Medical Diagnosis, located in R20's EMR found in the Medical Diagnosis tab, revealed R20 was admitted to the facility on [DATE] with included the following diagnoses end stage renal disease, hypertension, major depression disorder and bipolar disorder. Review of R20's electronic Care Plan dated 04/23/24, located in the EMR, under the Care Plan tab did not include resident is care planned for activities. Observation of R20 on 05/08/24 at 11:58 AM of R20 sitting near the nurse's station having a conversation with staff and other residents. Observation of R20 on 05/08/24 at 3:08 PM sitting near nurse's station talking to other residents. 4. Review of Medical Diagnosis, located in R40's EMR found in the Medical Diagnosis tab, revealed R40 was admitted to the facility on [DATE] with included the following diagnoses end stage renal disease, hypertension, hyperkalemia and chronic diastolic heart failure. Review of R40's electronic Care Plan dated 03/11/24, located in the EMR, under the Care Plan tab did not include resident is care planned for activities. Observation of R40 on 05/06/24 at 12:18 PM sitting near the nurse's station talking to staff and other residents. Observation of R40 on 05/08/24 at 10:18 AM Observed resident sitting near the nurse's station, resident indicated he was getting ready to go outside and smoke. He stated he would still like to do other activities that the facility can provide like a trip to Walmart. Observation on 05/08/24 at 3:07 PM of R40 sitting up in wheelchair in room with eyes closed. Interview on 05/09/24 at 6:22 PM with Director of Nursing (DON) stated the expectation is to individualize activity care plans. Care plan nurse was out of the facility attending a funeral.

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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** 40847 Based on observation, policy review and staff interview the facility failed to ensure one-to-one activity for two residents (R20 and R40) of three observed in the facility for activities. This had the potential to result in a decline of the resident's psycho-social well-being. The facility census was 106 residents. Refer for F656 Findings include: Review of the facilities policy titled, Activities, dated 09/14/23 provided by the facility, indicated, It is the policy of the Facility to provide an ongoing program to support Residents in their choice of Activities based on their comprehensive evaluation, care plan, & preferences. Facility-Sponsored group, individual, & dependent Activities will be designed to meet the interest of and support the physical mental, and psychosocial well-being of each Resident, as well as encourage both independence and interaction within the Facility. Review of the Activities Calendar provided by the facility dated March 2024, April 2024 and May 2024 revealed the same activities monthly every week. No variety of activities. 1. Review of R20's undated, electronic Face Sheet located in the electronic medical record (EMR), in the Profile tab revealed an admitted [DATE]. Continued review of the electronic Face Sheet included the following diagnoses end stage renal disease, hypertension, major depression disorder and bipolar disorder. Review of R20's electronic Physician's Orders for the month of May, located in the EMR, in the Orders tab included the orders did not include activity restrictions. Review of R20's electronic Care Plan dated 04/23/24, located in the EMR, under the Care Plan tab did not include resident is care planned for activities. Review of R20's annual Minimum Data Set (MDS) located in the EMR, under the MDS tab, with an Assessment Reference Date (ARD) of 01/13/24, indicated a Brief Interview for Mental Status (BIMS) score, of 15 out of 15 indicating resident was cognitively intact. The resident's mood assessment revealed a severity score of 14, indicating resident is at risk for depression and psychosocial. A review of R20's customary routines revealed books, newspapers, magazines to read, music, go outside to get fresh air when the weather is good, participate in religious services or practices, doing favorite activities, and doing things with groups of people are somewhat important. Interview on 05/07/24 at 10:12 AM with R20 stated she is bored in the building because the facility doesn't do anything. Observation of R20 on 05/08/24 at 11:58 AM of R20 sitting near the nurse's station having a conversation with staff and other residents. Observation of R20 on 05/08/24 at 3:08 PM sitting near nurse's station talking to other residents. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/08/24 at 3:15 PM music being played in the dining room with one resident (R34) observed. An additional interview on 05/09/24 at 10:51 AM with R20 stated she doesn't want to be cooped up in the room all day and riding up and down the halls with nothing to do. 2. Review of R40's undated, electronic Face Sheet located in the EMR, in the Profile tab revealed an admitted [DATE]. Continued review of the electronic Face Sheet included the following diagnoses end stage renal disease, hypertension, hyperkalemia and chronic diastolic heart failure. Review of R40's electronic Physician's Orders for the month of May, located in the EMR, in the Orders tab included the orders did not include activity restrictions. Review of R40's electronic Care Plan dated 03/11/24, located in the EMR, under the Care Plan tab did not include resident is care planned for activities. Review of R40's Admission MDS located in the EMR, under the MDS tab, with an ARD of 12/06/23,indicated a BIMS score, of 15 out of indicating the resident was cognitively intact. The resident's mood assessment revealed a severity score of 13, indicating resident is at risk for depression and psychosocial. A review of R40's customary routines revealed music is somewhat important and go outside to get fresh air when the weather is good, participate in religious services or practices, doing favorite activities are very important. Observation of R40 on 05/06/24 at 12:18 PM sitting near the nurse's station talking to staff and other residents. Observation of R40 on 05/08/24 at 10:18 AM revealed the resident sitting near the nurse's station, resident indicated he was getting ready to go outside and smoke. He stated he would still like to do other activities that the facility can provide like a trip to Walmart. Observation on 05/08/24 at 3:07 PM of R40 sitting up in wheelchair in room with eyes closed. Observation on 05/08/24 at 3:15 PM music being played in the dining room with one resident (R34) observed. Interview on 05/08/24 at 12:02 PM with the Activities Supervisor stated the R20 doesn't want to do anything if former roommate doesn't. She stated the resident will sometimes attend bingo. She also stated most residents don't like to come out of their room so she will do one on one, some just want to do magazines cards, painting etc. Interview on 05/08/24 at 12:50 PM with the Administrator confirmed the activities calendar needs more variety of activities.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and policy review, the facility failed to appropriately address a resident's aggressive behaviors and put interventions to assist the resident with proper coping skills to prevent violent outbursts and acts of aggression towards others for one out of one resident (Resident (R)84) reviewed for behaviors. Refer to F600 Findings include: Review of R84's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R84 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit. Review of R84's Quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated no cognitive impairment. Review of R84's care plan, located under the "Care Plan" tab of the EMR and dated [DATE], revealed "The resident has the potential to demonstrate physical behaviors related to anger, and poor impulse control." Interventions in place as of [DATE] were social services one to one, assess and anticipate resident needs, provide physical and verbal cues to alleviate anxiety. Last intervention update was on [DATE] for a psych evaluation in ER [emergency room] that was refused. There were no updates since that time. Substance Abuse/Addiction: Inadequate coping skills with substitution of drugs or alcohol. Current diagnosis of substance abuse/addiction. Interventions in place as of [DATE] to assess mouth with medication administration, assist in identifying support system, and initiate counseling consult. The was no updates since that time. Review of a Nurses Notes, in the EMR, under the Resident Services tab written by Licensed Practical Nurse (LPN)1, dated [DATE] at 6:07 PM, indicated R84 was in a resident-to-resident altercation. It was stated that R409 accidentally coughed on R84 which caused R84 to get upset. R409 had gotten up from his chair, which caused R84 to stand up. R409 tugged on R84's shirt, causing R84 to push the R409 down. R84 was assessed for skin issues and bruises. Upon assessment R84 stated he did not get hit and did not have any bruises on him. Upon assessment, R409 had a raised bump on the left back side of his head the size of a quarter. The Administrator, Director of Nursing (DON), physician and power of attorney were notified of the incident. Neuro checks were started along with 15-minute checks put in place. Review of a Nurses Notes, in the EMR, under the Resident Services tab written by the DON, dated [DATE] at 2:33 PM, indicated R84 was in a physical altercation with a visitor. Staff members separated them and the visitor's mother who was a resident here. An ambulance was called, and he declined to go to the hospital. Police interviewed R84. He was placed on 15-minute check. At 4:45 PM, R84 signed himself out and left the facility. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nurses Notes, in the EMR, under the Resident Services tab written by Registered Nurse (RN)1, dated [DATE] at 8:13 PM, indicated R84 lost temper at a R73 when playing cards and started punching holes in the wall. Police responded and told him he would have to go to jail or the emergency room (ER). Both hands were bloodied , and swollen knuckles and ice pack applied. R84 was sent to the ER. Review of a Nurses Notes, in the EMR, under the Resident Services tab written by Social Services Supervisor (SSS), dated [DATE] at 12:59 PM, indicated R84 was in a verbal altercation in which R73 stated that he physically hit her. I educated R84 that he can't physically put his hands on other residents he stated that he understood but he was upset because he felt the other resident kept lying on him and having visitors coming up here and it was making R84 mad because they know he has feelings. I repeated to resident that still did not give him the right to physically hit anyone in the facility. Social Services will continue to monitor this situation. During an interview on [DATE] at 5:02 PM Registered Nurse (RN)1 said R85 drank and by the evening shift he was lit up [intoxicated]. R84 would sign out of the facility for leave of absence (LOA) and went to the store to get alcohol and would consume it. She said that R84 was hard to keep in his room to complete 15-minute checks and that staff can't keep him there, but they try to be aware of his whereabouts, but that staff do not put eyes on him every 15 minutes when he is in other parts of the facility. During an interview on [DATE] at 10:31 AM, the SSS said R84 got along with staff and other residents, but he did have an alcohol problem and became upset when he was unable to get alcohol. She stated she had never personally seen R84 under the influence, but staff have reported that he has been. There was one time when R84 became belligerent, and staff believed he was under the influence, but she was unsure when that occurred. All staff were aware they should be monitoring R73 and R84 and keeping them apart. But she was unsure how that was communicated to staff, and she assumed they were aware. But she was unsure what the plan was to monitor R84 if R73 had a male visitor come to the facility and R84 became aware because staff were not aware of a visitor until they were in the building. She does meet with R84 three times a week, but she was unsure what other interventions were in place to address his behaviors. During an interview on [DATE] at 1:02 PM the Assistant Director of Nursing (ADON) said she had never personally seen R84 become aggressive, but staff have reported that he has. She stated staff have also reported that R84 becomes more aggressive when he is under the influence of alcohol. She said R73 and R84 have a relationship that staff have reported there have had arguments physical incidents between them Staff have reported that R84 becomes upset when male visitators have come to the facility to visit R73. Both residents have been reeducated by the social worker and the Administrator. They have done 15-minute checks for 72 hours after an altercation. But she was unsure what had been done to address R84's inability to handle his emotions and his aggression. He recently started attending Alcoholic Anonymous (AA), but she was unsure what else was done after R84 refused a Psych eval or why there were no Psych services in place to address the underlying issues that cause R84 to self-medicate with substance issues. And she was aware that R84 became irate and was punching walls after R73 had a male visitor. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:43 PM the DO) stated she was aware that R84 had had some kerfuffle's, with a couple of residents in the facility and that he had an issue with alcohol abuse. She said R84 was currently going to AA, but he still drinks alcohol. She said Psych has not been to the facility to evaluate R84 but there were plans to have that done this week. She said there was nothing documented in the EMR since it was just conversations. She said anytime there was an incident with R84 the physician would be notified and there was a medication review, but she was unsure if there were any medications changes. And she was not aware of anything else that is currently being done with R84 to address his behaviors and that the facility had not put additional measures in place to address R84 behaviors when he became jealous and angry and acted out. During an interview on [DATE] at 10:48 AM R84 said had been rocky for him lately and that he had been having nightmares, but he is not really interested in talking with anyone about it. He does attend AA classes and he has not been drinking that much lately. He did drink but he does not feel his drinking was an issue and felt he had it under control.

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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 one of five residents (Resident (R) 16) reviewed for unnecessary psychotropic medications. Findings include: Review of R16's undated Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed R16 was admitted to the facility on [DATE]. R16's diagnoses included generalized anxiety disorder. Review of an admission Minimum Data Set (MDS), located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 02/17/24 indicated R16 had a Brief Inventory of Mental Status score (BIMS) of five indicating R16 was significantly cognitively impaired. The MDS also indicated R16 had taken an antipsychotic agent during the last seven days prior to the ARD. Review of R16's active Orders located in the EMR under the Orders tab revealed an order dated 03/15/24 for Risperdal (an antipsychotic medication) 1 milligram (mg) twice daily for anxiety. Review of R16's active orders did not indicate an order to monitor for Risperdal side effects. Review of the most recent Comprehensive Care Plan, located in the resident EMR under the Care Plan tab, initiated 06/29/23, indicated a focus area for depression related to dementia with the goal that the resident would remain free of signs and symptoms of distress, depression, anxiety or sad mood. The interventions included to administer medications as ordered - monitor/document side effects and effectiveness. Review of R16's Medication Administration Record (MAR) for April 2024 and May 2024, located in the EMR under the Orders tab in Reports revealed no evidence of monitoring for Risperdal side effects or efficacy. During an interview on 05/09/24 at 6:00 PM the Director of Nursing (DON) stated antipsychotics should be monitored and it should be in the orders and MAR. The DON reviewed R16's EMR orders and confirmed there was no order for the antipsychotic side effect monitoring and therefore not on the MAR. Review of a document titled, Psychotropic Management Guidelines last reviewed 07/26/23 revealed Procedure: IDT [Interdisciplinary Team] will individualize the Resident Care Plan and Address:. d. Outcomes. IDT team will review the following: . d. Monitoring and evaluating the potential reduction of Psychotropic Medications on an ongoing basis.

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	265757	A. Building B. Wing	05/15/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observation and staff interview, the facility failed to utilize Enhanced Barrier Precautions for three of 33 residents sampled (Resident (R)19, R60, and R77). The failure had the potential to increase the risk of adverse events of spreading infections to other residents in the facility. Findings include: During the initial tour of the facility on 05/06/24 beginning at 11:00 AM, R19, R60 and R77 did not have signage on their door to reflect the residents were in Enhanced Barrier Precautions. 1.Review of R19's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R19 was readmitted the facility on 02/04/21with the diagnosis of Alzheimer's disease and during R19's stay developed dysphagia which required a feeding tube for nourishment. Review of R19's annual Minimum Data Set (MDS) under the MDS Tab, with an Assessment Reference Date (ARD) of 04/09/24 documented that R19 acquired a feeding tube while a resident in the facility. 2.Review of R60's undated Face Sheet located under the Profile tab in the EMR revealed R60 was admitted the facility on 01/06/22 with the diagnosis of obstructive and reflux uropathy (urinary tract disorder that occurs when urine flow is blocked, causing urine to back up and damage the kidneys). Review R60's quarterly MDS with an ARD of 04/09/24 documented that R60 had an indwelling catheter. 3. Review of R77's undated Face Sheet located under the Profile tab in the EMR revealed R77 was admitted to the facility on [DATE] with the diagnosis of urinary tract infection. Review R77's significant change MDS with an ARD of 04/10/24 documented that R77 had an indwelling catheter with a diagnosis of neurogenic bladder. During an interview on 05/08/24 at 2:30 PM, when asked about Enhanced Barrier Precautions (EBP), Certified Medication Technician (CMT)2 denied knowing what EBP was and stated she had not received any training on this. During an interview on 05/08/24 at 2:35 PM, the Certified Nursing Assistant (CNA)3 stated, You would wear gloves, mask and maybe PPE (personal protection equipment). During an interview on 05/08/24 at 2:45 PM, when asked about EBP, Licensed Practical Nurse (LPN)4 stated, For C Diff, COVID, MRSA and sometimes HIV you would wear gowns and gloves. We haven't had any training on this at all. During an interview on 05'08/24 at 2:50 PM, when asked about EBP, LPN3 stated, Yes I have heard about it in the hospital where I worked before. During an interview on 05/08/24 at 4:23 PM, when asked about EBP, CNA1 stated, We have had a lot of training, and I just can't remember exactly what it is. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 05/09/24 at 9:58 AM, LPN2 stated, We have our standard universal precautions and if a resident has a medical device, you would use gloves if needed, if there is an infection. During an interview on 05/09/24 at 10:34 AM, the Director of Nursing (DON) confirmed R19, R60, and R77 were not in EBP. When asked if these residents should have been in EBP, the DON stated, I would have to read up on that to tell you specifically. During an interview on 05/09/24 at 12:57 PM, the Regional Nurse Consultant (RNC) was asked about EBP. The RNC stated, This is for anyone that has open ports, wounds, g-tubes or Foleys (indwelling catheters). The policy is currently being developed .we have a call next week concerning this [EBP] and will get this rolled out next week also. The RNC also confirmed staff had not been trained in EBP.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on interview, document review, review of Centers for Disease Control and Prevention (CDC) guidance, and review of facility policy, the facility failed to maintain an infection prevention and control program (IPCP) that included a functional Antibiotic Stewardship Program that followed the McGeer Criteria for antibiotics for one of 33 residents sampled (Resident (R)77). This had the potential to affect residents being prescribed antibiotics that were potentially unnecessary. Findings include: Review of R77's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R77 was readmitted to the facility on [DATE] with the diagnoses of urinary tract infection and paraplegia. Review of R77's progress notes, found under the Notes tab of the EMR, dated 05/06/24 at 11:12 AM, revealed, Resident c/o [complains of] burning sensation. Resident stated that his catheter is not flowing. This nurse flushed resident catheter with 10 ml [milliliters] flow down without issue .Call placed to physician n.o (sic) [new order] for Cipro 250 mg BID [twice a day] x [times] 7 days with a UA [urinalysis] . Review of R77's Medication Administration Record located under the Orders tab in the EMR revealed Cipro 250 milligrams (mg) BID by mouth was started on 05/08/24 and ended on 05/15/24. Review of R77's urinalysis , provided by the facility, obtained on 05/06/24 revealed positive for protein, bilirubin, leukocytes, and bacteria. The review of the urine culture and sensitivity report, dated 05/06/24 and reported to the facility on [DATE], revealed the culture had a growth of greater than 100,000 colony forming units. This report stated, .ID [identification] and sensitivity to follow. The facility did not provide any further report showing the sensitivity of the organism to a specific antibiotic. Review of the Antibiotic Stewardship Monthly Tracking logs, dated September 2023 through May 2024, consisted of name, type of infection, signs, and symptoms present, lab present, antibiotic used, and start and stop date of the antibiotic. There was no documentation on the logs which stated the criteria for antibiotic use was met or not met. Review of the May 2024 Antibiotic Stewardship Monthly Tracking log revealed R77 was listed on the document but did not indicate criteria for antibiotic use was met or not met. During an interview on 05/09/24 at 12:05 PM, Licensed Practical Nurse (LPN)2 stated, We utilize the McGeer's Criteria but wedon't have them [McGeer's Criteria Form] filled out for any of the other antibiotics on the logs. When asked what was the basis for which the antibiotic was warranted for this resident LPN2 stated, Based on the signs and symptoms of burning sensation and then the results of the lab work. During an interview on 05/09/24 at 12:57 PM, the Regional Nuse Consultant (RNC) stated, We should follow the McGeer's criteria. We don't have it in the policy per say but that is what we are using. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/09/24 at 1:13 PM, the Administrator stated, The IP [Infection Preventionist] is the sole person responsible for infection control. During the QAPI [Quality Assurance and Performance Improvement] meetings we discuss who are on antibiotics, reinfections, stop and start dates, and IV therapy. When asked if McGeer's criteria for antibiotic use had been discussed, the administrator stated, McGeer's name has come up. Review of the undated facility policy Antibiotic Stewardship Plan revealed, . 1. As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist or designee. 2. The IP, or designee, will review antibiotic utilization as part of the Antibiotic Stewardship Program and identity/ specific situations that are not consistent with the appropriate use of antibiotics. a. The organism is not susceptible to antibiotic chosen; b. The organism is susceptible to narrower spectrum antibiotic; c. Therapy was ordered for prolonged surgical prophylaxis; or d. Therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. 3. After the review, the provider will be notified of the review findings. 4. All resident antibiotic regimens will be documented on the facility approved antibiotic surveillance tracking form. The information gathered will include: a. Resident name b. Room number c. Date symptoms appeared; d. Name of antibiotic e. Start date of antibiotic f. Pathogen identified g. Site of the infection (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. Date of culture i. Stop date j. Total days of Therapy k. Outcome, and l. Adverse Events . Review of a CDC document undated titled, The Core Elements of Antibiotic Stewardship for Nursing Homes indicated .Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review, interviews, and policy review, the facility failed to offer and/or provide pneumococcal vaccines in two of five residents (Resident (R)77, and R98) reviewed for immunizations out of a total sample of 33 residents. This failure of not offering and/or providing immunization against pneumonia increases the risk of residents having this infection. Findings include: 1. Review of R77's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R77 was readmitted to the facility on [DATE] with the diagnoses of urinary tract infection and paraplegia. Review of R77's Vaccines located under the Immunizations tab in the EMR revealed no documentation of a pneumonia vaccine had not been offered and/or provided to R77. R77's date of birth was 04/05/49 and was [AGE] years old at the time of the survey. 2. Review of R98's undated Face Sheet located under the Profile tab in the EMR revealed R98 was admitted to the facility 04/02/24 with the diagnoses of diabetes, and chronic obstructive pulmonary disease. Review of R98's Vaccines located under the Immunizations tab in the EMR revealed no documentation of a pneumonia vaccine had either been offered and/or provided to R98. R98's date of birth was 10/21/51 and was [AGE] years old at the time of the survey. During an interview on 05/09/24 at 5:00 PM, the Director of Nursing (DON) stated, I don't have any other documentation for R77 and R98 for their pneumonia vaccine. During an interview on 05/09/24 at 5:10 PM, the Administrator stated, The documentation is to be in the EMR and the Infection Preventionist nurse is responsible this. The Infection Preventionist nurse was unavailable at this time to be interviewed on 05/ 09/24. Review of facility policy Pneumococcal Vaccine dated 04/28/22 revealed, Residents will be offered the Pneumococcal Vaccine upon Admission. Administration of additional doses will be completed in accordance with CDC guidelines . Residents; Document immunizations in EHR/PCC [electronic health record/Point Click Care] .