STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285093	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Cozad	318 West 18th Street Cozad, NE 69130

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49382 Licensure Reference Number 175NAC 12-006.05(12) Based on observation, interview, and record review the facility failed to treat 2 residents (Resident #10 and Resident #34) of 5 sampled residents with dignity. The facility stated census was 43. Findings are: Review of a facility supplied document labeled Residents Rights not dated revealed the resident has the right to privacy and to be treated with respect and dignity. Review of a facility supplied document labeled Skills Check Perineal Care which is the cleansing of the genital and rectal areas of a person's body, and not dated, revealed to gather equipment, and explain the procedure and screen the resident for privacy. A. Review of an Admission Record revealed the facility admitted Resident #10 on 02/22/2024 with diagnoses of: Dementia (the impaired ability to remember, think, or make decisions that interfere with doing everyday activities), pain to the left and right leg, and Osteoporosis (a condition where bones become weak and brittle). The comprehensive Minimum Data Set (MDS), which is mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning, dated 05/31/2024 revealed Resident #10 was unable to complete the Brief Interview for Mental status (BIMS) which indicated the resident was severely cognitively impaired. The resident required substantial or maximal assistance from staff with eating, toilet use, and transfers, and partially to moderately dependent on staff assistance with bed mobility. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation completed on 06/12/2024 at 12:01 PM Resident #10 was observed to be standing in the main dinning area beside the tall cart that contained other residents' trays with food on them. Resident #10 used their hands to reach into the open cart and moved items on one of the food trays stating ohhhh can I have that. NA-A was standing approximately 75 feet away from the resident and called out loudly to Resident #10 No, don't mess with that you can't have that. NA-A then approached Resident #10 from behind and stated, I said don't touch that now go to your table. Resident #10 then walked away from the cart containing the meal trays to a table where other residents were sitting eating their meal. Resident #10 approached one of the residents and stood over them and attempted to touch items on the resident's food tray. NA-A in a loud voice stated, No that is not yours go sit at your table. Resident #10 remained at this table standing over the resident who was eating for 1-2 minutes then walked to an open chair at this table and sat down. NA-A loudly called to Resident #10 that is not your seat, but I guess you will sit where you want to. In an interview on 06/12/2024 at 12:10 PM with NA-A, NA-A confirmed that should not have called out loudly to the resident across the dinning area. NA-A confirmed that should have assisted Resident #10 to their seat to assist in preventing Resident #10 from wandering and touching items during the meal service. In an interview on 06/12/2024 at 12:30 PM with the Director of Nursing (DON) revealed NA-A should not have been calling out to Resident #10 and telling the resident No in the dinning are. B. Review of an Admission Record revealed the facility admitted Resident #34 on 08/04/2023 with diagnoses of: ementia, which is the impaired ability to remember, think, or make decisions that interfere with doing everyday activities, Hypertension, which is when the blood pressure in your blood vessels is too high, and Palliative care, which is specialized care focusing on comfort and pain relief. The comprehensive Minimum Data Set (MDS), which is mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning, dated 05/31/2024 revealed Resident #34 had a Brief Interview for Mental status (BIMS) score of Zero indicating the resident was severely cognitively impaired. The resident required substantial or maximal assistance from staff with eating and was dependent on staff assistance with bed mobility, toilet use, and transfers. Resident #34 was frequently incontinent of bladder and always incontinent of bowel. In an observation completed on 06/11/2024 at 2:53 PM resident #34 was sitting in their recliner in the resident's room. Nurse Aide C, (NA-C) used a mechanical lift to assist Resident #34 into a standing position from the resident wheelchair. The resident's wheelchair was positioned in front of an uncovered window. Once Resident #34 was in a standing position NA-A with gloved hands pulled down Resident #34 pants and incontinence product exposing Resident #34 bare buttock in front of the uncovered window. In an interview with NA-C completed on 06/11/2024 at 3:15 PM, NA-C stated that they should have provided privacy for Resident #34 by pulling the curtain over the window prior to providing care to the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the DON on 06/11/2024 at 3:20 PM the DON confirmed that the staff did not provide Resident #34 with privacy during cares by leaving the window uncovered. DON stated that the staff should have provided privacy for the resident by closing the curtains prior to providing care.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49382 Licensure Reference Number 175 NAC 12-006.18 Based on observation and interview, the facility failed to ensure exhaust fans in 4 (Rooms 101, 103, 105, and 107) of 18 sampled resident bathrooms were operational and ensure the cleanliness of the laundry area of the facility which had the potential to affect all of the residents residing in the facility that have laundry done by the facility. The facility stated census was 43. Findings are: A. Review of a facility supplied document labeled Regular Maintenance and Safety Inspection dated 06/13/2024 revealed instructions for monthly verification of the operation of all exhaust fans. In an observation completed on 06/13/2024 at 8:58 AM it was observed that the exhaust fans in the bathrooms of rooms 101, 103, 105, and 107 did not pull up a single ply piece of tissue. In an interview conducted on 06/13/2024 at 8:58 AM with the Maintenance Supervisor (MS), and the Housekeeping Supervisor (HS), it was confirmed that the exhaust fans in rooms 101, 103, 105, and 107 could not pull up a single ply piece of tissue indicating they were not operational. B. Review of a facility supplied document labeled Clean Dryer Filters every two hours not dated revealed initials present in the 7am to 9am slot. In an observation completed on 06/13/2024 at 9:25 AM it was observed in the facility laundry area that the tiles in front of the washing machines were cracked chipped and uneven with buildup of black, brown dry crumbly material build up present to the cracked and chipped off areas. The drain area behind the washing machines had gray black thick moist build up on the white PVC drainpipes and the floor had brown, orange crumbly moist build up over the floor from the back of the washing machine to the wall and drain area. The laundry area had two industrial sized dryers and in the lower compartment of the dryers there was fuzzy white gray material built up to the top of the lint filter holders and the corners of both compartments. In an interview on 06/13/2024 at 9:30 AM with the MS, the MS confirmed the cracked and chipped tiles with build up present, confirmed the buildup on the drainpipes and to the floor behind the washing machines. In an interview on 06/13/2024 at 9:31 am with the HS, the HS confirmed the presence of the fuzzy white gray material build up in the lint compartments of the dryers. HS confirmed that the form was initaled indicating the the lint dryer filters had been cleaned though there was still lint present.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50105 Licensure Reference Number: 175 NAC 12-006.09D Based on record reviews and interviews, the facility failed to ensure follow up was completed for 1 sampled Resident (Resident 21) with abnormal blood glucose readings in accordance with physician orders. Sample size was 1. Facility census was 44. Findings are: A. Record review of Resident 21's Minimum Data Set (MDS-a federally mandated comprehensive assessment used to develop the resident care plan) dated 04/12/2024 revealed the following: -resident admitted was 10/09/2020. -diagnoses of type 1 diabetes mellitus with unspecified complications (an autoimmune condition in which your immune system mistakenly attacks insulin-producing cells, which turns off insulin production). -cognitive score of 15/15, revealed no cognitive impairment. -resident receives orders for insulin 7 out of 7 days. Record review of Resident 21's Care Plan (CP-a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) revealed the following: -resident is appropriate for long term care related to the need for 24/7 supervision/care secondary to type 1 diabetes mellitus with unspecified complications. -resident is at risk for hypo/hyperglycemic episodes and other complications related to history of diabetes. Interventions on the CP revealed: -alert the physician of ongoing low/high blood sugar readings Record review of Resident 21's physician orders revealed the following orders for Type 1 diabetes mellitus: 1. Insulin Aspart Injection 100/milliliters (ml) Inject subcutaneous (Sq) per sliding scale before meals & at bedtime with parameters set at: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Less than 201=0 units (u); 201-250=2u; 251-300=4u; 301-350=6u; 351-400=8u; 401-500=10u; 501-550=12u; 551-600=14u; *Call Medical Doctor (MD) If blood glucose less than 60 or greater than 600* 2. Novolog Injection Solution 100 u/ml (Insulin Aspart) Inject as per sliding scale: If 1 - 200 = 0 If Below 69, Call primary care physician (PCP) or on-call; 201 - 250 = 5u; 251 - 300 = 7u; 301 - 350 = 9u; 351 - 400 = 11u; 401 - 500 = 13u; 501 - 550 = 15u; 551 - 600 = 17u Call PCP or on call if greater than 600, subcutaneously in the morning related to type 1 diabetes mellitus with unspecified complications (E10.8) and inject as per sliding scale: If Below 69, Call PCP or on-call; If 1 - 200 = 0; 201 - 250 = 8u; 251 - 300 = 10u; 301 - 350 = 12u; 351 - 400 = 14u; 401 - 500 = 16u; 501 - 550 = 18u; 551 - 600 = 20u *Call PCP or on-call if greater than 600* subcutaneously two times a day related to type 1 diabetes mellitus with unspecified complications. 3. Basaglar kwikpen-100unit/ml Inject 7 units subcutaneously at bedtime 4. Glucagon kit 1mg inject 1 ml as needed for hypoglycemia (blood glucose less than 60 and unable to take oral medication or unresponsive) recheck and repeat in 15 minutes as needed (additional directions: recheck and repeat in 15 minutes as needed) 5. Glucose 15 gel 40% take 15gram (gm) by mouth as needed for hypoglycemia Source: Health.com/normal-blood-sugar-7559012 reports that a normal blood sugar reading is about 70-100 milligrams per deciliter of blood (mg/dL). Dangerous blood sugar levels according to health.com and Michigan Medicine is a reading of 300 mg/dL or higher, and for those who have more than one 300 mg/dL reading in a row should seek immediate medical attention. Record review of Resident 21's Blood Sugar Summary for February, March, April, May, and June of 2024 revealed the following significantly low and/or elevated blood sugar recordings: -05/24/2024 - 600.0 milligrams per deciliter of blood (mg/dL) -05/22/2024 - 600.0 mg/dL -05/17/2024 - 600.0 mg/dL -05/12/2024 - 600.0 mg/dL -05/10/2024 - 600.0 mg/dL -05/05/2024 - 600.0 mg/dL -04/29/2024 - 600.0 mg/dL -04/29/2024 - 55.0 mg/dL -04/29/2024 - 44.0 mg/dL (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-04/29/2024 - 33.0 mg/dL -04/26/2024 - 600.0 mg/dL -03/18/2024 - 43.0 mg/dL -03/17/2024 - 46.0 mg/dL -03/16/2024 - 600.0 mg/dL -03/13/2024 - 41.0 mg/dL -02/23/2024 - 600.0 mg/dL Interview with the MDS Coordinator (MDSC) and Licensed Practical Nurse (LPN-J) on 06/12/2024 at 11:08 AM revealed the physician is to be notified when the resident's blood sugar is out of range. Upon further discussion, the MDSC stated the physician is to be notified either by fax or a phone call and documented in the progress notes on the significant low and high blood sugars. LPN-J stated when a blood sugar reading is out of range above 600 mg/dL, the reading is considered high and the reading is listed as 600 on the blood sugar summary log. Record review of Resident 21's electronic progress notes and electronic medical record after April of 2024 and documentation in the resident medical record chart revealed missing documentation that the physician was notified on the abnormally low and high blood sugar readings. There were no documentation describing nursing interventions, a response to interventions or follow up blood sugar tests to determine if the resident's blood sugars improved. Interview with the Director of Nursing (DON) on 06/12/2024 at 2:52 PM confirmed Resident 21's blood sugar readings were significantly high on 04/26/2024, 04/29/2024, 05/05/2024, 05/10/2024 and 05/24/2024. The DON also revealed the facility nursing staff failed to notify the physician on the significant low and high blood sugars. There were no interventions documented or responses to interventions or follow up blood sugar testing to determine if the resident's blood sugars improved, or the condition of the resident at the time of the readings Record review of policy titled; Notification of Changes dated 01/2024 reveals the following: Policy -It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). All pertinent information will be made available to the provider by the facility staff. Overview of Components of the Policy A. Requirements for notification of resident, the resident representative, their physician: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. An accident involving the resident, which results in injury and has the potential for requiring physician intervention. ii. A significant change in the resident's physical, mental, or psychosocial status. 1. A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications. iii. A need to alter treatment significantly. 1. A need to alter treatment significantly (that is, a need to discontinue an exiting form of treatment due to adverse consequences, or to commence a new form of treatment); Notification is provided to the physician to facilitate continuity of care and obtain input from the physician about changes, additions to or discontinuation of treatments.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.09D7b(3) Based on observation, interview, and record review the facility failed to ensure that interventions to prevent resident falls were in place for 2 residents (Resident 14 and 36). This had the potential to allow residents to experience falls with injury. The facility census was 43. Findings are: A. Record review of the facility policy titled Falls Management dated 1/2024 revealed that the facility will assess and review resident risk factors for falls and injuries after a fall. The facility will communicate interventions to the care giving teams. Post fall, the facility will adjust/add interventions on the plan of care (care plan-a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident). The facility will update and communicate interventions. Record review of the Admission Record for Resident 14 dated 6/11/24 revealed that Resident 14 admitted into the facility on [DATE]. Diagnoses included dizziness, severe obesity, and Parkinson's Disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination). Record review of the Care Plan dated 6/11/24 for Resident 14 revealed that Resident 14 was at risk for falls. Interventions to prevent falls included dycem (a non-slip material that keeps objects from sliding or rolling) in wheelchair, and resident teaching to call for help if items are out of reach. Observation on 6/11/24 at 10:08 AM in the room of Resident 14 revealed that Resident 14 sat in their motorized wheelchair. The wheelchair had a black pressure reduction cushion on the seat. There was no dycem in place on the wheelchair seat. Observation on 6/13/24 at 8:22 AM in the room of Resident 14 revealed that Resident 14 sat in the motorized wheelchair. Medication Aide-G (MA-G) brushed the resident's hair. No dycem was observed in place on the seat of the wheelchair. Interview on 6/13/24 at 8:22 AM with MA-G revealed that MA-G was unsure if dycem was to be in place in the resident's wheelchair. MA-G confirmed that there was no dycem in the resident's wheelchair. Observation on 6/13/24 at 12:21 PM in the facility dining room revealed that Resident 14 sat in a non-motorized wheelchair. There was no dycem in place in the wheelchair. Resident 14 revealed that they were in the non-motorized wheelchair instead of their motorized wheelchair since they had an appointment that afternoon. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/13/24 at 12:21 PM in the room of Resident 14 revealed that the motorized wheelchair was parked in the room. The black saddle contoured pressure cushion was in place. No dycem was in the wheelchair. Interview on 6/13/24 at 12:42 PM with Nurse Aide-H (NA-H) confirmed that Resident 14 was at risk for falls. NA-H revealed that they were unaware of the intervention for Resident 14 to have dycem in their wheelchair. Record review of the facility incident log dated 6/10/24 revealed that Resident 14 revealed that Resident 14 had falls on 2/27/24 and 3/14/24. Record review of the progress note for Resident 14 dated 2/27/24 at 3:48 PM revealed that the nurse was called to the room of Resident 14 after the resident was heard hollering. Resident 14 was observed leaning up against the bed with their knees on the floor. The resident's right leg was tangled in the foot pedal of the wheelchair. Resident 14 revealed that they were reaching for the pad on the bed and slipped out of the wheelchair. Resident 14 complained of pain to their right ankle. Record review of the progress note dated 2/28/24 at 10:53 AM for Resident 14 revealed that a note was sent to the resident's physician regarding the resident's complaints of pain to the right ankle/shin due to the fall from the wheelchair. Record review of the progress note dated 2/28/24 at 10:54 PM for Resident 14 revealed that Resident 14 continued to complain of right ankle pain. Interview on 6/11/24 at 10:08 AM with Resident 14 revealed that the resident slipped out of the wheelchair in February 2024 and their right foot got caught in the foot pedal and twisted. Resident 14 revealed that this caused a fracture of the right foot. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 14 dated 3/22/24 revealed that Resident 14 had a fall with major injury (bone fracture). Interview on 6/13/24 at 2:01 PM with the facility Director of Nursing (DON) confirmed that the facility expectation is to adjust or add interventions for a resident after each fall. The DON confirmed that interventions to prevent falls are to be communicated to the care giving teams. The DON confirmed that the interventions are expected to be in place to prevent resident falls. B. Record review of the Admission Record for Resident 36 dated 6/11/24 revealed that Resident 36 admitted into the facility on [DATE]. Diagnoses included dementia, anxiety, and lack of coordination. Record review of the care plan for Resident 36 dated 6/11/24 revealed that Resident 36 was at risk for falls related to problems with balance, history of falls, and muscle weakness. Interventions to prevent falls included having the wheelchair by the bed with wheels locked in case the resident attempts to transfer self from the bed to the wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/11/24 at 3:20 PM in the room of Resident 36 revealed that Resident 36 was in bed with their eyes closed. Snoring sounds were heard. The resident's wheelchair was parked in the middle of the room approximately 4 feet away from the bed per visual measurement. Observation on 6/13/24 at 1:52 PM in the room of Resident 36 revealed that Resident 36 was in bed. The resident's wheelchair was positioned just inside the room doorway. The resident's bed was across the room against the wall furthest from the doorway. The wheelchair was approximately 9 feet away from the resident bed per visual measurement. Interview on 6/13/24 at 10:31 AM with Nurse Aide-I (NA-I) confirmed that Resident 36 had fallen several times and was at risk for falls. NA-I revealed that most of the falls were due to the resident standing up by themselves without assistance. NA-I revealed that interventions to prevent falls for Resident 36 included a chair alarm, bed alarm, and anti-roll back on the wheelchair. This surveyor asked NA-I where the wheelchair of Resident 36 was to be placed when the resident was in bed. NA-I revealed that the resident's wheelchair is to be placed across the room on the other side of the wall so Resident 36 can't reach it. Interview on 6/13/24 at 1:47 PM with Medication Aide-F (MA-F) revealed that MA-F was told of Resident 36 being a fall risk. MA-F revealed fall prevention interventions included alarm on, gripper socks, and call light in reach. MA-F revealed that Resident 36's wheelchair should not be left close to the resident while the resident is in bed, so the resident doesn't get up on their own. Record review of the facility incident log dated 6/10/24 revealed that Resident 36 had falls on 1/19/24, 3/8/24, 3/31/24, 4/2/24, 4/10/24, 4/14/24, 4/15/24 at 2:20 PM, 4/15/24 at 7:15 PM, 4/17/24, 4/28/24, 5/13/24, 5/16/24, 5/22/24, 5/31/24, and 6/2/24. Record review of the progress note dated 4/17/24 at 3:17 PM for Resident 36 revealed that Resident 36 was found lying on the floor with a puddle of blood under their head. Resident 36 complained of right shoulder pain. Record review of the progress note dated 4/17/24 at 3:55 PM for Resident 36 revealed that 911 was called. Resident 36 was transported to the hospital by ambulance. Record review of the progress note dated 4/24/24 at 4:13 PM for Resident 36 revealed that Resident 36 returned to the facility after their hospital stay. Record review of the MDS assessment dated [DATE] for Resident 36 revealed that the MDS was conducted due to discharge with resident return to the facility anticipated. The MDS revealed that Resident 36 had 1 fall with major injury.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 49382 Licensure Reference Number 175 NAC 12-006.09D Based on observation, interview, and record review the facility failed to implement nonpharmacological interventions prior to the use of as needed psychotropic medications and re assess the use of psychotropic medications for 3, (Resident #10, #34, and #21) of 4 sampled residents. The facility states census was 43. Findings are: Review of a facility supplied document titled Mood and Behavior Policy and Procedure dated 01/2024 revealed, #5 Mood and Behavior Tracking documentation will be completed to identify interventions attempted and outcomes of approaches. A. Review of an Admission Record revealed the facility admitted resident #10 on 02/22/2024 with diagnoses that included Dementia, which is the impaired ability to remember, think, or make decisions that interfere with doing everyday activities, pain to the left and right leg, and Osteoporosis which is a condition where bones become weak and brittle. The comprehensive Minimum Data Set (MDS), which is mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning, dated 05/31/2024 revealed Resident #10 was unable to complete the Brief Interview for Mental status (BIMS) which indicated the resident was severely cognitively impaired. The resident required substantial or maximal assistance from staff with eating, toilet use, and transfers, and partially to moderately dependent on staff assistance with bed mobility. The MDS revealed the resident exhibited the mood of trouble concentrating on things nearly every day during the look back period and had behaviors of physician behavior towards others one to three days during the look back period, verbal behaviors towards others four to six days during the look back period, other behavioral symptoms not directed towards others one to three days during the look back period, rejection of care one to three days during the look back period, and wandering four to six days during the look back period. These behaviors were documented as not having an impact on the resident or others and were unchanged from prior assessment. The MDS indicated that the resident received anti-anxiety and antidepressant medication during the look back period. Review of Resident #10's Care Plan dated 06/11/2024 revealed: (continued on next page)

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Emerald Nursing & Rehab Cozad	318 West 18th Street Cozad, NE 69130

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident had a history of behavior problems with target behaviors including agitation, wandering and rejection of care. The resident would sit then self on the floor when they did not want to do something dated 03/12/2024. Interventions were listed a to minimize the potential for the residents' disruptive behaviors by offering tasks which divert attention such as asking the resident what they would like to do and ensuring activities of interest were available for the resident dated 06/03/2024. The resident used antianxiety medications as needed dated 02/23/2024 with intervention listed to observe, document, and report adverse reactions and or side effects of the medication dated 02/23/2024. The resident had a mood problem due to irritability and anger with target moods including agitation, yelling, physical aggression towards staff, and rejection of care dated 05/31/2024. Interventions listed to assist the resident as needed with meaningful program activities that interest the resident and to encourage and provide opportunities for exercise and physical activity dated 03/13/2024. The resident was receiving antidepressant medication dated 02/23/2024 with interventions listed as to observe document and report adverse reactions to antidepressant medication dated 02/23/2024. Review of Resident #10's Electronic Medication Administration Record (EMAR) from 05/10/2024 through 06/11/2024 revealed the as needed Lorazepam, an anti-anxiety psychotropic medication, was administered 8 times with no documentation of nonpharmacological interventions being used prior to administration of the as needed medication. In an interview conducted on 06/11/2024 at 3:55 PM with the Director of Nursing (DON), the DON confirmed that there was no documentation present of nonpharmacological interventions being attempted prior to administration of the as needed medication for Resident #10. B. Review of an Admission Record revealed the facility admitted Resident #34 on 08/04/2023 with diagnoses that include Dementia, which is the impaired ability to remember, think, or make decisions that interfere with doing everyday activities, Hypertension, which is when the blood pressure in your blood vessels is too high, and Palliative care, which is specialized care focusing on comfort and pain relief. The comprehensive Minimum Data Set (MDS), which is mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning, dated 05/31/2024 revealed Resident #34 had a Brief Interview for Mental status (BIMS) score of Zero indicating the resident was severely cognitively impaired. The resident required substantial or maximal assistance from staff with eating and was dependent on staff assistance with bed mobility, toilet use, and transfers. The resident was documented to have no alterations in mood and displayed behaviors of physician and verbal behavioral symptoms directed towards others that occurred four to six days of the look back period and rejection of care that occurred one to three days in the look back period. None of these behaviors were documented as having a significant impact on the resident or others. These behaviors were also documented as being the same as on the prior assessment. The MDS indicated the resident had received anti-anxiety and antidepressant during the look back period. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #34's Care Plan dated 06/11/2024 revealed: The resident had a behavior problem with target behaviors including repetitive movement, yelling and screaming, grabbing, wandering, rejection of care and lack of safety awareness dated 03/14/2024. Interventions were listed as: provide non-pharmacological interventions to prevent and or reduce behaviors. The most effective interventions for the resident include assurance that needs are met and activities of interest. The resident was to be allowed to sleep to reduce aggression with staff in the morning when woken up dated 05/23/2024. A stop sign was placed on the resident's doorway to deter other residents from entering room dated 04/25/2024. The resident used antianxiety medications as needed dated 06/04/2024 with intervention listed to observe, document, and report adverse reactions and or side effects of the medication dated 06/04/2024. The resident had a mood problem due to depression and received anti-depressant medication with target moods listed as self-isolation and changes in sleep pattern dated 08/14/2023. Interventions were listed to observe for signs and symptoms of adverse reaction to the medication and to assist the resident as needed with a program of activities that is meaningful and of interest staff to encourage and provide opportunities for exercise and physical activity. Review of Resident #34's Electronic Medication Administration Record (EMAR) from 05/10/2024 through 06/11/2024 revealed the as needed Lorazepam, an anti-anxiety psychotropic medication, was administered 11 times with no documentation of nonpharmacological interventions being used prior to administration of the as needed medication. In an interview conducted on 06/11/2024 at 10:48 AM with Nurse Aide D (NA-D), NA-D stated resident #34 had a behavior of being resistive to cares and would strike out at staff when attempting cares. NA-D stated if the resident was exhibiting this behavior [gender] would get a second person to help provide the care and let the Medication Aide or Nurse know the resident was having the behavior. NA-D revealed [gender] was unaware of what nonpharmalogical interventions were to be completed for Resident #34. In an interview conducted on 06/11/2024 at 3:55 PM with the DON, the DON confirmed that there was no documentation present of nonpharmacological interventions being attempted prior to administration of the as needed medication for Resident #34. 50105 C. Record review of Resident 21's Minimum Data Set (MDS-a federally mandated comprehensive assessment used to develop the resident care plan) dated 04/12/2024 revealed the following: -resident admitted was 10/09/2020. -diagnoses of diabetes mellitus, depression, adjustment disorder with mixed anxiety and depressed mood, insomnia, and pain. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-cognitive score of 15/15, revealed no cognitive impairment. -no behaviors were noted, -the resident receives the following high risk drug class medications: antipsychotic, antianxiety, antidepressant, diuretic, antiplatelet, and hypoglycemic medications. Record review of Resident 21's Care Plan with a revision date of 04/26/2024 revealed the following: -the resident uses an antianxiety medication. -the resident uses an antidepressant medication. -the resident uses an antipsychotic medication. -consult with pharmacy, MD to consider dosage reductions when clinically appropriate. -the resident has a mood problem related to an adjustment disorder with mixed anxiety and depressed mood, major depressive disorder, recurrent, severe with psychotic symptoms; demoralization and apathy. -target moods include refusal of care, not wanting to get out of bed, lack of motivation, mixed anxiety and depressed, mood, decreased appetite, tearfulness. -discuss with the MD and family regarding the ongoing need for use of medication, and -educate the resident/family/caregivers about risks, benefits, and the side effects of the medications. Record review of the Resident 21's order summary report of physician orders revealed the following ordered psychotropic medications: -Buspirone (antianxiety) 5 milligram (mg) three times daily for the treatment of an adjustment disorder with mixed anxiety and depressed mood, -Aripiprazole (antipsychotic) 2mg daily for the treatment of an adjustment disorder with mixed anxiety and depressed mood and major depressive disorder, recurrent, severe with psychotic symptoms, -Venlafaxine (antidepressant) 150mg daily for the treatment of an adjustment disorder with depressed mood, and -Methylphenid (antipsychotic) 5mg two times daily for the treatment of an adjustment disorder with mixed anxiety and depressed mood. Record review of the Medication Administration Report (MAR) revealed Resident 21 receive the following psychotropic medications: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Buspirone 5 milligram (mg) three times daily ordered on 07/11/2022. -Aripiprazole 2mg daily ordered on 04/28/2022. -Venlafaxine 150mg daily ordered on 06/23/2021. -Methylphenid 5mg two times daily ordered on 09/22/2023. Further Review of the MAR for target behaviors revealed the following; -no signs or symptoms of behaviors or target behaviors noted. Record review of Resident 21's medical record for Gradual Dose Reduction (GDR) revealed the following: -Buspirone ordered on 07/11/2022 had no evidence a GDR or a documented contraindication had been completed. -Aripiprazole ordered on 04/28/2022, a GDR had been completed on 08/31/2023. -Venlafaxine ordered on 06/23/2021 had no evidence a GDR or a documented contraindication had been completed. Methylphenid on 09/22/2023, a GDR had been completed on 02/07/2024. Record review of the facility policy for Use of Psychotropic Drugs dated 11/2017 revealed the following information: -Policy: -It is the facility's policy that each resident's drug regimen is free from unnecessary drugs, including unnecessary antipsychotic drugs. -Policy Explanation and Compliance Guidelines: -#3. Residents who use psychotropic drugs receive GDR and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. An interview on 06/12/2024 at 2:50 PM with the Director of Nursing (DON) revealed that a GDR or documented contraindication had not been attempted or documented for medications Venlafaxine and/or Buspirone.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 49382 Licensure Reference Number 175 NAC 12-006.10D Based on observation, record review, and interview the facility failed to ensure a medication error rate of less than 5% (2 errors out of 40 opportunities resulting in an error rate of 5.0%) affecting 1 Resident (Resident #2), of 6 sampled residents. The facility stated census was 43. Findings are: Review of a facility policy titled Medication Administration dated 05/2017 revealed Purpose to administer the following right medication, dose, dosage form, documentation, route, resident, and time. #7 read the Electronic Medication Administration Record (EMAR) for the ordered medication, dose, dosage form, route, and time. #9 verify the pharmacy prescription label matches the EMAR. #14 document the administration of the medication on the EMAR as soon as the medications are given to the resident. In an observation on 06/12/2024 at 9:29 AM during medication administration by Licensed Practical Nurse E (LPN-E) to resident #2 the following was observed: LPN-E prepared each of the residents' medications by comparing the pharmacy label on the medication packaging to the EMAR then placing each medication into a medication cup. After placing each medication into the medication cup LPN-E signed off each medication in the EMAR. Resident #2's order for Cholestyram Powder a binding medication used to help lower cholesterol, 4 grams had the directions to mix the powder in liquid or drink and to administer the medication separate from other medications. LPN-E mixed the powder in water and gave the mixture to the resident at the same time as the resident's other medications. The resident used the mixture to drink when ingesting their other medications. Resident #2's order for Simethicone which is a gas reliving medication, Chewable tablet 80 milligram had the direction to take one tablet by mouth before meals and at bedtime. LPN-E placed the Simethicone Chewable tablet in the medication cup with the other medications and took the medications to the resident at the dinning table. Resident #2's plate and bowel were observed to be empty of food items. Only crumbs were present on the plate and a small amount of white liquid in the bottom of the bowel. LPN-E sat the cup of medications and mixture of liquid in front of the resident. The resident separated the medications out into groups of three medications. The resident grouped the Simethicone tablet with 2 other capsules then placed all three into their mouth. The resident picked up the cup with the Cholestyram powder mixed in the liquid and used it to swallow all the medications. The resident did not chew the Simethicone tablet. LPN-E stated to the resident that they had eaten all their meal. The resident confirmed that had eaten all their meal. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an in interview on 06/12/2024 at 9:45 AM LPN-E confirmed that the directions for administration of the Cholestyram Powder was the medication was not to be given with any other medications and the directions for administration of the Simethicone was to be given before meals. LPN-E confirmed that they did not follow the providers direction for administration of these medications. LPN-E confirmed they should not have signed off the medications as administered until after the resident had taken them. In an interview on 06/13/2024 at 8:30 AM with the Director of Nursing (DON), the DON confirmed the directions for administration of the Cholestyram Powder and Simethicone were not followed, and these were medication errors. The DON confirmed that medications should not be signed out as administered until they are administered to the resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49382 Licensure Reference Number 175 NAC 12-006.17D Based on observation, interview, and record review the facility failed to esure hand wasing for 20 seconds and complete hand sanitization while performing personal cares for 1 (Resident #34) of 5 sampled residents. Facility stated census of 43. Findings are: Review of a facility policy titled Infection Control Standard Precautions Handwashing, dated 01/2024 revealed #7 use an alcohol-based hand rub or soap and water for the following situations: before and after direct contact with residents, before performing and non-surgical invasive procedures, before moving from a contaminated body site to a clean body site during resident care, after contact with blood or bodily fluids, after handling contaminated equipment or supplies, and as the final step after removing and disposing of personal protective equipment (gloves). Washing hands, #2 rub hands together vigorously for at least 20 seconds. Review of an Admission Record revealed the facility admitted Resident #34 on 08/04/2023 with diagnoses that include Dementia, which is the impaired ability to remember, think, or make decisions that interfere with doing everyday activities, Hypertension, which is when the blood pressure in your blood vessels is too high, and Palliative care, which is specialized care focusing on comfort and pain relief. The comprehensive Minimum Data Set (MDS), which is mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning, dated 05/31/2024 revealed Resident #34 had a Brief Interview for Mental status (BIMS) score of Zero indicating the resident was severely cognitively impaired. The resident required substantial or maximal assistance from staff with eating and was dependent on staff assistance with bed mobility, toilet use, and transfers. Resident #34 was frequently incontinent of bladder and always incontinent of bowel. In an observation on 06/11/2024 at 2:53 PM the following was observed: Nurse Aide C (NA-C) was preparing to assist NA-A to provide cares to Resident #34. NA-C entered Resident #34's bathroom and performed hand washing or sanitization only rubbing hands for 8 seconds prior to rinsing the soap off. NA-C did not rub hands together for the minimum of 20 seconds. NA-A applied gloves to both hands. NA-A did not complete hand sanitization prior to applying gloves in preparation to provide direct care to Resident #34. With gloved hands NA-A used a disposable wipe to cleanse Resident #34 right and left buttock then gluteal cleft. A brown thick pasty substance was visible on the disposable wipe and NA-A glove. NA-A obtained a clean incontinence product from off Resident #34 bed then applied and fastened the clean incontinence product in place on Resident #34. NA-A did not change gloves and or complete hand sanitization when working from soiled to clean area when providing resident care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with NA-C completed on 06/11/2024 at 3:15 PM, NA-C confirmed that should have rubbed hands for 20 seconds prior to rinsing soap off of hands when washing hands. In and interview with NA-A completed on 06/11/2024 at 3:15 PM, NA-A confirmed they did not change gloves and complete hand sanitization when changing from working with a soiled area to a clean area. In an interview with the Director of Nursing (DON) on 06/11/2024 at 3:15 PM the DON confirmed that NA-C should have rubbed hands for 20 seconds not 8 seconds and NA-A should have changed gloves and performed hand sanitization when going from working with soiled area to a clean area.