STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285238	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Ridge Post Acute Nursing and Rehab	7501 Keystone Drive Omaha, NE 68134

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure Reference Number 175 NAC 006.09(H) Based on record review and interview, the facility failed to evaluate 1 (Resident 4) of 3 sampled residents following identification of an injury from unknown sources. The facility had a total census of 67 residents. Findings are: A. A record review of Resident 4's Admission Record revealed Resident 4 was admitted to the facility on [DATE] with diagnoses of Pick's disease (a type of frontotemporal dementia), Opioid Dependence (physical and psychological reliance on opioids), and Chronic Pain Syndrome. A record review of Resident 4's Care Plan revealed a focus area of being at risk for falls dated 3/31/24 with an identified preference of Resident 4's to sit on the floor. The Care Plan identified that the Team will not count my preference of sitting on the floor as a fall unless Resident 4 has visible injury. The following interventions were identified in the Care Plan: -Offer resident extra pillow to help define perimeter of bed and decrease change of rolling off, initiated on 1/7/23. -Fall mat placed next to bed to prevent injury, initiated 5/22/24. -Avoid rearranging furniture, dated 3/31/22. -Be sure the call light is within reach and encourage to use it to call for assistance as needed, initiated 3/31/22. -Ensure resident is wearing appropriate footwear when ambulating or wheeling in wheelchair, initiated 3/31/22. -Maintain a clear pathway, free of obstacles, initiated 3/31/22. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Occupational, Physical, Speech-Language Therapy evaluation and treatment per physician orders, initiated 3/31/24. -Place sign in room for a reminder to use call light for assistance, initiated 3/9/23. -Resident self-transfers from floor to recliner per therapy. Resident is aware to call for assistance but refuses to at times because resident wants to get in dresser and get out clothes and look through items, initiated 10/17/22. -Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter or remove any potential causes if possible. Educate resident/family/caregivers/interdisciplinary team as to causes, initiated 3/31/22. -Staff will ensure resident's bed is in the lowest position while the resident is in bed, initiated 3/4/23. A record review of a Weekly Skin Evaluation dated 10/8/24 at 12:19 AM revealed Resident 4 had some swelling on their left eye but Resident 4 said it was an itching spot. A record review of Resident 4's Progress Notes revealed the following: -10/8/24 at 5:09 PM resident with increased agitation and confusion during the day, scooting self on floor while throwing objects in rooms, knocked trash can over and ripped brief into shreds while on floor. Resident's temperature, 02 (oxygen saturation) and pulse within normal limits, resident refuses blood pressure check. Call placed to (Doctor) office with request for UA (urine analysis). Awaiting return phone call. -10/8/24 at 11:55 PM Resident continues series of jacking [jerking] movements, uncontrollable series of motion. Sometimes hitting head, lower extremities. Attempts to get vital signs and make assessment and Resident continues to show signs of stress. New bruises observed coming from the uncontrollable movements. Call made to On-Call DON (Director of Nursing) for order. Call placed to [doctor name] with order received to send resident to hospital to eval [evaluate] and treat. ER (emergency room) at (hospital) informed and Transfer documents forwarded with arrival of Squad. At 11:45 PM, Squad arrived for transportation of resident to (hospital). -10/9/24 at 1:18 AM At 1:15 AM, re-visiting ER for information on admission. Resident would be admitted for dehydration and AKI [acute kidney injury], possibility of a kidney injury would be determined after the result of CT scan. Further record review of Resident 4's Progress Notes did not reveal any documentation of an evaluation of Resident 4's left eye. In an interview on 10/9/24 at 12:06 PM, Medication Aide (MA)-E revealed that the left side of Resident 4's face was swollen and Resident 4 had dried blood on their mouth. MA-E also revealed that they had noted purple and red bruising on Resident 4's legs. MA-E also revealed that injuries were reported to the nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/9/24 at 1:27 PM, MA-F reported Resident 4 had a black eye and their mouth had dried blood in it. MA-F stated that the Resident 4 had reported hitting their head on the floor. MA-F reported Resident 4 had bruises on their legs from rolling on the floor. MA-F reported the injuries to the Assistant Director of Nursing (ADON) In an interview on 10/9/24 at 1:43 PM, Registered Nurse (RN)-C reported that Resident 4 had a black eye when RN-C came on shift. RN-C stated they had reported their concerns to Assistant Director of Nursing (ADON). In an interview on 10/9/24 at 3:38 PM, Licensed Practical Nurse (LPN)-D confirmed that Resident 4 had a black eye which was not unusual for Resident 4. LPN-D confirmed that the black eye had started small and had gotten much bigger. In interviews on 10/9/24 at 3:26 PM and 10/10/24 at 1:21 PM, the Director of Nursing (DON) reveaeled Resident 4's black eye had not been reported to them. The DON confirmed that neuro (neurological) checks should have been started and an incident report should have been completed. The DON reported that an order should have been placed in the Treatment Administration Record for a change of condition and shiftly follow up completed for 72 hours, then weekly until resolution. A record review of facility policy titled Quality of Care, in the subject section Incidents and Accidents revised 11/2023 revealed the following procedure: 1. Assisting Incident/Accident Victim: Any staff witnessing an accident/incident, or find it necessary to aid an accident victim (resident, staff), should: A. Render immediate assistance. Do not move the victim until he/she has been examined for possible injuries; B. If possible, move the injured to the treatment room, or if it is a resident in his/her room, move the resident to his or her bed; and C. If assistance is needed, summon help. If you cannot leave the victim ask someone to report to the nurses' station that help is needed, or if possible, use the call system located in the resident's room to summon help. 2. Licensed nurse will assess the resident (or visitor or staff), including vital signs, neuro checks if needed, complaints of pain and location, and determine if treatment or additional care is needed, including accessing the EMS [Emergency Medical System] system. 3. Licensed nurse will notify medical provider for residents, and obtain orders for further treatment or diagnosis as deemed necessary by the provider.

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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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49164 Licensure Reference Number 175 NAC 12-006.09(H) Based on record review and interview, the facility failed to complete INR monitoring tests to ensure therapeutic dosing of Coumadin for 1 [Resident 1] of 1 sampled resident requiring INR monitoring. The facility Administrator and Director of Nursing was notified on 10/9/24 at 5:00 PM of an Immediate Jeopardy (IJ) which began on 7/10/24. The IJ was removed on 10/9/24, as confirmed by surveyor onsite verification. The Findings are: Record Review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 09-30-2024 revealed the facility staff assessed the following about the resident: -Brief Interview of Mental Status (BIMS) was scored as a 10. According to the MDS [NAME] a score of 8-12 indicates moderate cognitive impairment. -Had Diagnosis of Atrial Fibrillation (a heart condition that causes the heart to beat irregularly and sometimes very fast), Coronary Artery Disease (a condition that occurs when the coronary arteries narrow or become blocked, preventing the heart muscle from receiving enough blood and oxygen) Cerebrovascular accident (a medical condition that occurs when blood flow to the brain is suddenly interrupted), and seizure disorder. -had a heart valve replacement. -Resident was taking an anticoagulant (medications that prevent blood clots from forming in the bloodstream.). They are given to people who are at high risk of developing blood clots, which can lead to serious conditions like heart attacks and strokes). Record Review of Resident 1's Electronic Health Record (EHR, a digital version of a patient's paper chart) revealed the following for PT/INR (A PT/INR test is most often used to: See how well Coumadin, an anti-coagulant or blood-thinning medicine, is working to prevent blood clots.) testing: -Check PT/INR on 07-10-2024- Resident 1's Treatment Administration Record (TAR) revealed a PT/INR was completed at 6:46 PM and no Coumadin dosing was present on the Medication Administration Record (MAR) for 07-10-2024. -Progress notes dated 07-11-2024 revealed facility followed up with prescriber for Coumadin orders. -Progress notes dated 07-12-2024 revealed the prescriber ordered a PT/INR on 07-15-2024 (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Record review of Resident 1's progress notes, MAR, TAR, and Coumadin Flow Sheet (CFS) revealed no PT/INR completed and no Coumadin dosing obtained. Furthermore, no Coumadin dosing was present on the MAR from 07-15-2024 through 07-22-2024. -Record review of Resident 1's progress notes dated 07-18-2024 revealed a PT/INR was obtained per order. -Record review of Resident 1's order listing, MAR, and TAR revealed no order to check PT/INR on 07-18-2024. -Record review of Resident 1's progress notes dated 07-19-2024 revealed Resident 1's responsible partly was updated on a new Coumadin order. -Record review of Resident 1's MAR, TAR and order listing revealed no order for Coumadin on 07-19-2024. -Record review of Resident 1's TAR for August 2024 revealed an order to check a PT/INR and call results to Coumadin clinic. The TAR revealed the PT/INR was completed at 8:37 PM. -Record review of Resident 1's progress notes dated 08-05-2024 revealed the staff were to follow up with the prescriber for Coumadin orders. -Record review of Resident 1's MAR for August revealed an order for Coumadin starting 08-06-2024 and no orders or dosing noted in the MAR for 08-05-2024. -Record review of Resident 1's TAR for August 2024 revealed an order to check a PT/INR on 08-09-2024 and call results to Coumadin clinic by noon. The TAR revealed the PT/INR was checked at 4:33 PM. -Record review of Resident 1's orders revealed an order to check a PT/INR on 08-26-2024 and call and communicate the results for new instructions. -Record review of Resident 1's TAR revealed a PT/INR was completed on 08-26-2024 at 5:20 AM. Results of INR were not called to prescriber until 08-27-2024 and the facility did not receive orders for dosing until 08-28-2024. -Record review of Resident 1's TAR revealed an order to check a PT/INR on 10-07-2024 and call results to the Coumadin clinic by noon. The TAR also revealed the PT/INR was completed on 10-07-2024 at 3:35 PM. -Record review of Resident 1's progress notes dated 10-08-2024 revealed the facility received for Coumadin dosing and an order to recheck PT/INR. An interview on 10-09-2024 at 3:50 PM with the Director of Nursing (DON) confirmed the missed doses of Coumadin were a significant medication error. Record Review of the Facility Policy Medication Errors and Adverse Reactions dated 01-2022 identified a medication error as an administration of medications that was not in accordance with the prescriber's order. Furthermore, Nursing must immediately implement and follow the physician's orders. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the DON on 10-10-2024 at 1:23 PM confirmed the expectation is nursing staff should have called the prescriber with the PT/INR results on the day the PT/INR was taken to avoid a lapse in Coumadin therapy. 04577 The Immediate Jeopardy situation was determined to have begun on 07/10/24. The facility was informed to the Immediate Jeopardy status on 10/9/24. The facility abatement plan was implemented on 10/9/24. The specific requirements that were violated was F760 and 175 NAC 12-006.10 (D) for failure to ensure medications were administered to residents in accordance with physician orders. The facility implemented the following actions on 10/9/24 to remove the immediacy of the situation and to protect the residents: -The DNS [Director of Nursing Services] or designee will identify all other residents on routine narcotics to complete full audit of eMAR [electronic Medication Administration Records] documented administration and verification of medication availability. This audit and verification will be completed by 8:00 PM 10/9/24. -The DNS or designee will educate nurses and CMAs [Certified Medication Aides] currently working and all other licensed staff prior to working their next shift. Electronic education will be completed with all nurses and CMAs by end of day 10/9/24. Education will include expected use and instructions on use of facility emergency medication kit, correct ordering of medication and clear expectation on time and expectation to complete physician ordered PT/INR [prothrombin time/international normalized ration] blood draw, as well as expectation of time deadlines to notify PCP [Primary Care Physician] or coumadin clinic, manually entering telephone orders for next INR and coumadin dose. -The DNS or designated clinical manager will complete all INR draws and notification x 2 weeks, while completing follow up education and verification of understanding with nurses. -The ED [Executive Director] or designee will audit staff education completion of the above areas every shift x 2 days. The DNS or designee will audit e MAR for omissions of missed narcotic prior to end of shift x 7 days or until substantial compliance is determined. The DNS or designee will audit eMAR and progress notes for omissions of INR completion and PCP notification x 4 weeks or until substantial compliance is determined. The above audits will submitted to QAPI [Quality Assurance Performance Improvement] monthly x 3 until substantial compliance is determined. -Resident 1 coumadin is on the building and the INR will be completed by ADON on 10/10/24 in the AM. Results will be called to coumadin clinic on 10/10/24. -Resident 4 is in the hospital but fentanyl patches are available in the EKit and oxycodone is currently available. At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	At the time of exit, the severity of the deficiency was lowered to the D level.

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49164 Licensure Reference Number 175 NAC 12-006.10(D) Based on record review and interview, the facility failed to ensure medications were administered in accordance with physician orders for 2 [Residents 1 and 4] of 4 sampled residents which resulted in significant medication errors. The facility Administrator and Director of Nursing was notified on 10/9/24 at 5:00 PM of an Immediate Jeopardy (IJ) which began on 7/10/24. The IJ was removed on 10/9/24, as confirmed by surveyor onsite verification. The Findings are: A. Record Review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 09-30-2024 revealed the facility staff assessed the following about the resident: -Brief Interview of Mental Status (BIMS) was scored as a 10. According to the MDS [NAME] a score of 8-12 indicates moderate cognitive impairment. -Had Diagnosis of Atrial Fibrillation (a heart condition that causes the heart to beat irregularly and sometimes very fast), Coronary Artery Disease (a condition that occurs when the coronary arteries narrow or become blocked, preventing the heart muscle from receiving enough blood and oxygen) Cerebrovascular accident (a medical condition that occurs when blood flow to the brain is suddenly interrupted), and seizure disorder -had a heart valve replacement. -Resident was taking an anticoagulant (medications that prevent blood clots from forming in the bloodstream. They are given to people who are at high risk of developing blood clots, which can lead to serious conditions like heart attacks and strokes). Record Review of Resident 1's Record Review of Resident 1's Medication Administration Record (MAR, a report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional) and Treatment Administration Record (TAR) for July 2024 revealed the following: -07-10-2024 no orders or coumadin (Coumadin (warfarin) is a blood-thinning medication that requires regular blood tests to monitor how well it's working and prevent blood clots. These tests measure your prothrombin time (PT) and calculate your international normalized ratio (INR) administered.) -07-10-2024 Check PT/INR (a test to evaluate blood clotting) -documented as completed. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-07-12-2024 lovenox (an injectable blood thinner) 100 Milligrams (MG or mg) /Milliliter (ML or ml) inject 1 ml twice a day- documented administered. -07-13-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-14-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-15-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-15-2024 no coumadin orders. -07-16-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-16-2024 no coumadin orders. -07-17-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-17-2024 no coumadin orders. -07-18-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-18-2024 no coumadin orders. -07-19-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-19-2024 no coumadin orders. -07-20-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-20-2024 no coumadin orders. -07-21-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-21-2024 no coumadin orders. -07-22-2024 lovenox 100 MG/ML twice a day- documented as administered -07-23-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-24-2024 lovenox 100 MG/ML twice a day- documented as administered. -07-25-2024 lovenox 100 MG/ML twice a day- documented as administered. Record review of Resident 1's orders revealed no orders to hold or skip a day of coumadin on 07-10-2024, or 07-15-2024 through 07-22-2024. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident 1's progress note dated 07-11-2024 revealed new orders for coumadin 8 mg now and start lovenox 100 mg injection twice a day and follow up with the coumadin clinic tomorrow per on call prescriber instruction. Record review of Resident 1's progress note dated 07-12-2024 revealed staff followed up with coumadin clinic and received orders for coumadin 8 mg today, 6 mg 07-13-2024 and 07-14-2024. Continue lovenox injection 100 mg twice a day. Obtain a PT/INR on 07-15-2024 and call the coumadin clinic with the results. Record review of Resident 1's progress notes, order listing and MAR revealed no PT/INR testing was completed for 07-15-2024. Record review of Resident 1's progress notes revealed on 07-18-2024 a PT/INR was collected and sent to the lab. Record review of Resident 1's progress notes dated 07-19-2024 Resident 1's responsible party was notified of new coumadin order. Record review of Resident 1's progress notes dated 07-22-2024 revealed staff received an order for Coumadin 8 mg on 07-22-2024, 07-23-2024, and 07-24-2024. Recheck PT/INR on 07-25-2024 and continue lovenox injections daily with subsequent coumadin dosing. Record Review of Resident 1's Record Review of Resident 1's MAR and TAR for August 2024 revealed the following: 08-05-2024- Recheck PT/INR -documented as completed on 10-05-2024. 08-05-2024- no coumadin orders present on MAR for this date. 08-12-2024 no coumadin orders present on MAR for this date. 08-15-2024 coumadin 4 mg documented as not given. 08-22-2024 coumadin 4 mg no documentation that medication was given. 08-26-2024 Recheck PT/INR prior to 12 pm. -documented as completed. 08-27-2024 no coumadin orders present on MAR for this date. Record review of Resident 1's orders dated 08-05-2024 revealed no orders for coumadin or follow up PT/INR testing. Record review of Resident 1's orders dated 08-09-2024 revealed orders for coumadin 6 mg on 08-09-2024 and 08-12-2024. Recheck PT/INR on 08-13-2024. Record review of Resident 1's orders for 08-13-2024 revealed an order for coumadin 6 mg on 08-13-2024 and coumadin 4 mg on 08-14-2024 and 08-15-2024. Recheck PT/INR on 08-16-2024. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident 1's orders for 08-19-2024 revealed an order for coumadin 4 mg on 08-19-2024 and 08-20-2024 and 08-22-2024. Record review of Resident 1's orders on 08-23-2024 revealed an order to recheck PT/INR on 08-26-2024 prior to 12 pm. Record review of Resident 1's orders on 08-27-2024 revealed no orders for coumadin or follow up PT/INR testing. An interview on 10-09-2024 at 3:50 PM with the Director of Nursing (DON) confirmed the missed doses of coumadin were a significant medication error. A follow up interview with the DON on 10-09-2024 at 5:00 PM confirmed no records were found for the identified omissions in July, August, September and October except on 08-26-2024 which the facility identified that missing dose as a medication error. Record review of Resident 1's MAR and TAR for September 2024 revealed the following: -09-10-2024 coumadin 6 mg no documentation that medication was given. Record review of Resident 1's orders dated 09-09-2024 revealed an order for coumadin 6 mg give on 09-09-2024, 09-10-2024, 09-12-2024, 09-13-2024, and 09-15-2024 and to give 4 mg on 09-11-2024 and 09-14-2024. Record Review of Resident 1's MAR and TAR for October 2024 revealed the following: -10-07-2024 Check PT/INR and call results into the Coumadin Clinic before noon. -Documented as completed at 3:35 PM. -10-07-2024 No coumadin ordered or given. An interview was conducted on 10-09-2024 with Licensed Practical Nurse (LPN) A at 2:00 PM revealed LPN A had worked on 10-07-2024 but did not know who checked the PT/INR on that day. LPN A confirmed they received orders for coumadin on 10-08-2024. An interview with the DON on 10-10-2024 at 1:23 PM confirmed the expectation is nursing staff should have called the prescriber with the PT/INR results on the day the PT/INR was taken to avoid a lapse in coumadin therapy. Record Review of the Facility Policy Medication Errors and Adverse Reactions dated 01-2022 identified a medication error as an administration of medications that was not in accordance with the prescriber's order. Furthermore, Nursing must immediately implement and follow the physician's orders. 04577 B. (continued on next page)

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	285238	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 4's Admission Record revealed Resident 4 was admitted to the facility on [DATE] with diagnoses of Pick's disease [a type of frontotemporal dementia], Opioid Dependence [physical and psychological reliance on opioids], and Chronic Pain Syndrome. A review of Resident 4's quarterly Minimum Data Set [a comprehensive assessment used for care planning] dated 7/16/24 revealed the following: -Resident 4 had pain frequently over the last 5 days -Resident 4 occasionally had pain that effected sleep in the last 5 days -Resident 4 occasionally had pain that limited day-to-day activities -Resident 4 rated pain intensity at 5 on a scale of 1-10 over the last 5 days A review of Resident 4's Care Plan revealed a focus area dated 3/31/222 for having chronic pain related to Pick's disease and chronic knee pain with a goal of voicing a level of comfort and the following interventions: -Medications and treatments as ordered initiated 7/25/24. -Monitor and document for side effects of pain medications including constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness, and falls. Report occurrences to the physician initiated 3/31/22. -Monitor and report to nurse loss of appetite, or refusal to eat and weight loss initiated 3/31/22. -Monitor and report to nurse resident complaints of pain or requests for pain treatment initiated 3/31/22. -Occupational, Physical, speech-Language therapy evaluation and treatment per physician orders initiated 3/31/22. -Pain assessment every shift initiated 3/31/22. -Prefers to have pain controlled by medication initiated 3/31/22. A review of Resident 4's 10/2024 MAR [Medication Administration Record] revealed the following orders: -Fentanyl [synthetic opioid] 25 mcg [microgram]/hour apply to middle of chest topically one time a day every 3 days dated 3/14/2024 -Oxycodone HCl [opioid analgesics] 5 mg [milligrams] tablet, 1 tablet by mouth 3 times per day for pain management dated 8/27/24 A review of Resident 4's Progress Notes revealed the following: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Progress Note dated 10/6/24 7:41 AM stated Fentanyl Patch was not available for administration. Patch was reordered pending delivery. -Progress Note dated 10/3/24 11:59 AM stated Fentanyl Patch was not available for administration -Progress Note dated 9/28/24 at 1:29 PM stated Oxycodone 5 mg tablet was not available for administration waiting on pharmacy -Progress Note dated 9/28/24 at 9:49 AM stated Oxycodone 5 mg tablet waiting on pharmacy for delivery -Progress Note dated 9/27/24 at 5:07 PM stated Oxycodone 5 mg not given waiting for pharmacy -Progress Note dated 9/27/24 at 2:02 PM Oxycodone 5 mg not given waiting on pharmacy A review of Resident 4's 10/2024 MAR revealed Fentanyl Patch 25 mcg/hour apply to middle of chest topically 1 time per day every 3 days was scheduled to be administered on 10/3/24 and 10/6/24 and was not administered on either date. A review of Resident 4's 9/2024 MAR revealed Oxycodone 5 mg 1 tablet 3 times per day was not administered on 9/27/24 or 9/28/24. A review of Resident 4's 9/2024 MAR revealed the following pain levels on a scale of 1-10 with 10 being the most pain for 9/27/24-9/28/24: -9/27/24 6 AM-5; 12 PM 3; 6 PM 6 -9/28/24 6 AM 0; 12 PM 3; 6 PM 3; A review of Resident 4's 10/2024 MAR revealed the following pain levels on a scale of 1-10 with 10 being the most pain for 10/3/24-10/8/24: -10/3/24 6 AM 0; 12 PM 7; 6 PM 5; -10/4/24 6 AM 0; 12 PM 3; 6 PM 3; -10/5/24 6 AM 0; 12 PM 6; 6 PM 0; -10/6/24 6 AM 0; 12 PM 5; 6 PM 4; -10/7/24 6 AM 0; 12 PM 0; 6 PM 5; -10/8/24 6 AM 0; 12 PM 0; 6 PM 5; A review of Resident 4's Progress Notes revealed the following: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-10/8/24 at 5:09 PM resident with increased agitation and confusion during the day, scooting self on floor while throwing objects in rooms, knocked trash can over and ripped brief into shreds while on floor. Resident temp [temperature], 02 [oxygen saturation] and pulse within normal limits, resident refuses blood pressure check. Call placed to [Doctor] office with request for UA [urine analysis]. Awaiting return phone call -10/8/24 11:55 PM Res continues series of jacking [jerking] movements uncontrollable series of motion. Sometimes hitting head, lower extremities. Attempts to get VS [vital signs] and make assessment and Resident continue to show signs of stress. New bruises observed coming from the uncontrollable movements. Call made to ON-CALL DON [Director of Nursing] for order. Call placed for [doctor name] with order received to send resident to Hospital to eval [evaluate] and treat. ER [emergency room] at [hospital] informed and Transfer documents forwarded with arrival of Squad. 11:45 PM Squad arrived for transportation of res to [hospital] -10/9/24 1:18 AM 1:15 AM Revisiting ER for information on admission. Resident would be admitted for dehydration and AKI [acute kidney injury] possibility of a kidney injury would be determined after the result of CT scan. In an interview on 10/9/24 at 2:22 PM, MA [Medication Aide] B confirmed that Resident 4 did not have a Fentanyl patch for administration on Sunday [10/6/24]. MA B stated that MA B had notified the nurse. In an interview on 10/9/24 at 1:43 PM, RN [Registered Nurse] C reported Resident 4 was having fits on the floor. RN C reported calling Resident 4's provider but did not receive a return call by the end of the shift. RN C reported that Resident 4's agitation increased throughout the day and Resident 4 was ripping off brief. RN C indicated that RN C was not aware that Resident 4 was missing medications. In an interview on 10/9/24 at 3:38 PM, LPN D reported Resident 4 was not responding in an understandable manner and was shaking so bad that vital signs could not be taken. LPN D reported Resident 4 had leg bruising from hitting body on the trash can. LPN D reported being unaware that Resident 4 did not have a Fentanyl patch and would have gotten one from the emergency kit. LPN D reported calling Resident 4's doctor and sending Resident 4 to the hospital. A review of email from facility pharmacy dated 10/9/24 at 3:54 PM revealed that Resident 4's Fentanyl patch was reordered thru Point Click Care [medical record and medication administration system] on 10/6/24. The email stated that narcotics cannot be reordered through that interface resulting in the refill request not going through. The email stated that controlled substances reorder requests must be faxed. In an interview on 10/9/24 at 5:01 PM, the DON confirmed that narcotics reorders must be faxed and can not be reordered thru Point Click Care. The DON confirmed that Resident 4's Fentanyl patch and Oxycodone were not refilled for the same reason. The DON confirmed that missing Oxycodone and Fentanyl would both be considered a significant medication error. The DON reported that both Fentanyl patches and Oxycodone were available in the facilities emergency kit. A review of facility policy titled Medication Errors and Adverse Reactions revised 1/2022 revealed the following: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Medication Error' means the observed or identified preparation or administration of medications or biologicals which is not in accordance with: -The prescriber's order; -Manufacturer's specifications (not recommendations) regarding the preparation or administration of the medication or biological; or -Accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils. A review of facility policy and procedure titled Care and Treatment under section Medications, Provision of Routine, Emergency and OTC [over the counter] revised 2/2022 revealed the following procedure: -1. Medications prescribed on a routine, emergency, or PRN should be administered in a timely manner. -2. When an emergency or stat order is received, the charge nurse: -Determines that the order is a true emergency, i.e., cannot be delayed until the scheduled pharmacy delivery. -Ascertains whether the ordered medication is contained in the emergency kit by referring to the list of contents posted at the nursing station or on the box. -If the medication is not available, calls the pharmacy, using the after-hours emergency number(s), if necessary. -3. The provider pharmacy supplies emergency or stat medications according to the provider pharmacy agreement. -4. Medications are not borrowed from other residents. The required medication is obtained either from the emergency box or from the provider pharmacy. -5. The provider pharmacy is called if an emergency arises requiring immediate pharmacist consultation, using the after-hours emergency number(s), if necessary. In the event that the provider pharmacy is unable to supply essential information regarding the appropriateness of a new drug order, the consultant Pharmacist is contacted. -6. OTC medication could be ordered from a supplier that the facility choses to, an inventory must be kept for the medication ordered and replaced the used ones. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Immediate Jeopardy situation was determined to have begun on 07/10/24. The facility was informed to the Immediate Jeopardy status on 10/9/24. The facility abatement plan was implemented on 10/9/24. The specific requirements that were violated was F760 and 175 NAC 12-006.10 (D) for failure to ensure medications were administered to residents in accordance with physician orders. The facility implemented the following actions on 10/9/24 to remove the immediacy of the situation and to protect the residents: -The DNS [Director of Nursing Services] or designee will identify all other residents n routine narcotics to complete full audit of eMAR [electronic Medication Administration Records] documented administration and verification of medication availability. This audit and verification will be completed by 8:00 PM 10/9/24. -The DNS or designee will educate nurses and CMAs [Certified Medication Aides] currently working and all other licensed staff prior to working their next shift. Electronic education will be completed with all nurses and CMAs by end of day 10/9/24. Education will include expected use and instructions on use of facility emergency medication kit, correct ordering of medication and clear expectation on time and expectation to complete physician ordered PT/INR [prothrombin time/international normalized ration] blood draw, as well as expectation of time deadlines to notify PCP [Primary Care Physician] or coumadin clinic, manually entering telephone orders for next INR and coumadin dose. -The DNS or designated clinical manager will complete all INR draws and notification x 2 weeks, while completing follow up education and verification of understanding with nurses. -The ED [Executive Director] or designee will audit staff education completion of the above areas every shift x 2 days. The DNS or designee will audit e MAR for omissions of missed narcotic prior to end of shift x 7 days or until substantial compliance is determined. The DNS or designee will audit eMAR and progress notes for omissions of INR completion and PCP notification x 4 weeks or until substantial compliance is determined. The above audits will submitted to QAPI [Quality Assurance Performance Improvement] monthly x 3 until substantial compliance is determined. -Resident 1 coumadin is on the building and the INR will be completed by ADON on 10/10/24 in the AM. Results will be called to coumadin clinic on 10/10/24. -Resident 4 is in the hospital but fentanyl patches are available in the EKit and oxycodone is currently available. At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level.