STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285293	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Country Estates-Cottages	6082 Grand Lodge Avenue Papillion, NE 68133

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC 12-006.10B1 Licensure Reference Number 175 NAC 12-006.10B1a Licensure Reference Number 175 NAC 12-006.10D1 Based on observations, record review, and interview: the facility failed to administer medications while keeping a medication error rate not 5% or greater which affected 4 (Resident 9, 7, 8, and 2) of 6 sampled residents. The medication error rate was 9.8%. The facility census was 117. Findings are: A. A record review of Resident 9's Medical Diagnosis form printed 4/23/2024 revealed the resident admitted to the facility on [DATE] with a readmitted on 12/22/2020 with diagnoses of congestive heart failure (CHF-the heart doesn't pump blood as well as it should), hypertension (force of the blood against the artery walls is too high), edema (excess fluid in the tissues), and macular degeneration (loss in the center of the field of vision). A record review of Resident 9's Brief Interview for Mental Status (BIMS-tool used to identify the cognitive condition of the resident) dated 2/1/2024 revealed a score of 15 indicating the resident is cognitively intact. An observation on 4/23/2024 at 7:55 AM in Resident 9's room revealed Medication Aide (MA)-C gave Resident 9's scheduled morning medications with no blood pressure or heart rate taken prior to administration. A record review of Resident 9's April Medication Administration Record (MAR-a record used to document medications taken by the resident) revealed an order for Carvedilol (medication used to treat high blood pressure) 3.125 milligrams (mg) 1 tablet orally two times a day for hypertension with parameters to hold medication for systolic blood pressure greater than 90 or heart rate less than 60 with an effective date of 8/29/2023. Further record review of the MAR revealed the last day a blood pressure or heart rate was taken for this medication was documented on 4/20/2024. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/23/2024 at 8:45 PM with the Director of Nursing (DON) revealed there was no order from the physician to discontinue the blood pressure or heart rate parameter on the Carvedilol order and confirmed that a blood pressure and heart rate should have been taken prior to giving the medication. B. A record review of Resident 7's Medical Diagnosis form printed 4/23/2024 revealed the resident admitted to the facility on [DATE] with the diagnoses of dementia (progressive or persistent loss of intellectual functioning), heart failure (the heart doesn't pump blood as well as it should), major depressive disorder (persistently depressed mood or loss of interest in activities), anxiety (feelings of worry and fear that interfere with ones daily activities), and hypertension (force of the blood against the artery walls is too high). A record review of Resident 7's BIMS assessment dated [DATE] revealed a score of 9 which indicated moderate cognitive impairment. An observation on 4/23/2024 at 8:15 AM in Resident 7's room revealed MA-C gave Resident 7's scheduled medications and left a medication cup with a chewable tablet on the resident's bedside table, despite the resident stating [gender] didn't want it. The resident stated it was for her stomach and [gender] didn't need it and never takes them. A record review of Resident 7's Order Summary Report printed 4/23/2024 revealed an order for Cal-Gest Chewable (used to treat upset stomach, heartburn, or indigestion) 500 mg to be given orally in the morning. A record review of Resident 7's April MAR revealed that MA-C had documented that the chewable tablet was ingested by the resident. A record review of Resident 7's electronic health record revealed no self-administration assessment. An observation on 4/23/2024 at 8:40 AM in Resident 7's room revealed the chewable tablet was still in the medication cup on the bedside table. The resident was asked if [gender] was going to take it and the resident said no. An interview on 4/23/2024 at 8:45 AM with MA-C regarding whether [gender] normally documents a medication as taken without seeing the resident take the medication, [gender] replied no, but I knew [gender] would take it later. When notified that the resident had not taken the medication at 8:40 AM and was still in the medication cup in her room, she confirmed this was an error and should not have documented that the medication was taken. C. (continued on next page)

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 8's Medical Diagnosis form printed 4/23/2024 revealed an admitted to the facility on [DATE] with the diagnoses of heart failure (the heart doesn't pump blood as well as it should), morbid obesity, rheumatoid arthritis (chronic inflammatory disorder that affects small joints in the hands and feet), and major depressive disorder (persistently depressed mood or loss of interest in activities). A record review of Resident 8's BIMS assessment dated [DATE] revealed a score of 15 which indicated the resident is cognitively intact. An observation on 4/23/2024 at 8:20 AM in Resident 8's room revealed MA-C gave Resident 8's scheduled medications which included Metoprolol (medication used to treat high blood pressure) without taking a blood pressure or pulse prior to administration of the medication. A record review of Resident 8's Order Summary Report printed 4/23/224 revealed an order for Metoprolol Succinate ER tablet Extended Release 25 mg by mouth one time a day for hypertension with parameters to hold for systolic blood pressure less than 90 or pulse less than 60 with an order date of 10/21/2023. Further review of the Order Summary Report revealed an order for Diclofenac Gel 1% to be applied to left neck, knee, and shoulder three times a day for pain. A record review of the April Treatment Administration Record (TAR) revealed that MA-C had documented that Diclofenac gel (used to relieve symptoms of arthritis) was applied per physician's order at 8:20 AM. This was not witnessed during observation at 8:20 AM. An observation and interview on 4/23/2024 at 8: 45 AM with MA-C revealed the medication aide coming out of Resident 8's room with a blood pressure cuff in hand. MA-C confirmed that [gender] should have checked the resident's blood pressure and pulse before giving the Metoprolol and forgot. MA-C also stated she went back to the resident's room and applied the Diclofenac gel. An interview on 4/23/2024 at 8:35 AM with Resident 8 revealed that MA-C did not come back to room to apply the Diclofenac gel. D. A record review of Resident 2's Medial Diagnosis form printed 4/23/2024 revealed the resident was admitted to the facility on [DATE] with diagnoses of multiple sclerosis (MS-damage to the central nervous system with potential symptoms of vision loss, pain, fatigue, and impaired coordination), asthma (airways become inflamed, narrow and swell, extra mucous production making it difficult to breathe), hypertension (force of the blood against the artery walls is too high), and muscle weakness. A record review of Resident 2's BIMS assessment dated [DATE] revealed a score of 15 which indicated the resident is cognitively intact. An observation on 4/23/2024 at 7:45 PM in Resident 2's room revealed Licensed Practical Nurse (LPN)-D gave Resident 2 [gender] scheduled medications, an eye drop, and an as needed medication for a cough. A record review of the April MAR at 8:30 AM revealed that LPN-D documented that [gender] applied Betadine to the resident's right great toe. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 2's Order Summary Report printed 4/23/2024 revealed an order for betadine to the right great toe twice a daily for a wound. An interview on 4/23/2024 at 8:20 PM with Resident 2 revealed that LPN-D did not apply betadine to the right great toe. An interview on 4/23/2024 at 8:30 PM with LPN-D regarding the betadine to the right great toe revealed that [gender] did document that this was completed when it had not. LPN-D stated [gender] was going to do the treatment later. When asked if [gender] normally documents something as given or done before actually doing, [gender] replied 'no.' LPN-D confirmed that [gender] should not have documented that this was completed until after the betadine was applied to the right great toe. An interview on 4/23/2024 at 10:30 AM with the Director of Nursing (DON) confirmed that blood pressures and pulses need to be checked if ordered, medications or treatments should not be documented until completed. A record review of an undated facility policy Medication Administration and Provision revealed: 3. medications will be stored in a locked cart or cupboard, according to manufacturer's directions if applicable. 9. All medications will be administered to each guest/patient according to the following five rights: -right med -right guest/patient -right dose -right time -right route 11. Medications are documented as administered after the med aid/nurse has assured the guest/patient consumed the medication A record review of an undated Medication Pass Competency checklist revealed: 6. Vital signs taken prior to medication administration as ordered or required. 8. Nurse/med tech watched consumption; no meds left at bedside. 10. All medications given documented on the MAR as passed and given timely as ordered; controlled logs updated. 11. The Six Rights were practiced and followed throughout the med pass: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. right med b. right dose c. right route d. right time e. right resident f. right documentation 12. Refused or held doses recorded and reasons documented. (notified nurse) 14. Pain and behavioral assessments completed and documented during med pass.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC 12-006.10D Based on observations, record review, and interview; the facility failed to follow the five rights of medication administration causing significant medication errors which affected 2 (Resident 2 and 9) of 3 sampled residents. The facility census was 117. Findings are: A. A record review of Resident 2's Medial Diagnosis form printed 4/23/2024 revealed the resident was admitted to the facility on [DATE] with diagnoses of multiple sclerosis (MS-damage to the central nervous system with potential symptoms of vision loss, pain, fatigue, and impaired coordination), asthma (airways become inflamed, narrow and swell, extra mucous production making it difficult to breathe), hypertension (force of the blood against the artery walls is too high), and muscle weakness. A record review of Resident 2's BIMS assessment dated [DATE] revealed a score of 15 which indicated the resident is cognitively intact. A record review of Resident 2's Quarterly MDS (Minimum Date Set-a comprehensive assessment tool that measures health status of residents) dated 1/30/2024 revealed: -Section GG: Resident has impairment to legs and uses a wheelchair, is dependent on staff for dressing, toileting hygiene, bed mobility, and transfers with a mechanical lift , requires maximum assistance for personal hygiene and bathing, -Section J: Resident receives scheduled pain medication which makes it difficult to sleep and in the 5 days prior to the assessment, the resident experienced severe pain. An interview on 4/22/2024 at 1:30 PM with Resident 2 revealed there have been several times that [gender] was not getting their medications on time which included pain medication. Resident 2 further revealed there were at least 5 times in March that [gender] either didn't get the medications or they were very late causing her to have severe pain and made [gender] cry. The resident provided specific dates in which she knew things were not given timely. The resident revealed Easter weekend was awful. The resident stated that [gender] did not receive [gender] blood pressure medication for 3 days along with glaucoma medication as [gender] was told it was unavailable. The resident stated this occurred in April 2024. A record review of Resident 2's March 2024 Medication Administration Record (MAR-a document that details what medications were received by the resident) revealed the following: On 3/20/2024 the resident was to receive the below medications at 5:00 PM and all were documented to be given at 9:13 PM: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dulera 200-5 microgram (mcg) (an inhaler used to improve lung function) 2 puffs twice daily for shortness of breath/asthma every 12 hours, -Magnesium Oxide 400 milligram (mg) (a supplement that helps to regulate muscle and nerve function along with regulating blood pressure) twice a day, -Cetirizine (treats hay fever and allergy symptoms) 10 mg in the evening, -Naproxen Sodium (anti-inflammatory that treats pain) 220 mg twice a day, -Letrozole (a cancer medication)2.5 mg in the evening. On 3/22/2024 the resident was to receive the below medications at 5:00 PM and all were documented to have been given between 8:47 PM and 8:48 PM: -Dulera 200-5 mcg 2 puffs twice daily, -Magnesium Oxide 400 mg twice a day, -Cetirizine 10 mg in the evening, -Naproxen Sodium 220 mg twice a day, -Baclofen (used to treat muscle spasms) 20 mg 2 tablets twice daily, -Letrozole 2.5 mg in the evening. On 3/26/2024 the resident was to receive Norco (a scheduled II narcotic used to treat pain) 5-325 mg at bedtime. There is no documentation that this medication was given. On 3/29/24 the resident was to receive the below medications at 7:00 PM and there was no documentation that these medications were given: -Latanoprost (used to treat glaucoma) 0.005% -Instill 1 drop in both eyes at bedtime, -Norco 5-325 mg 1 tab at bedtime. On 3/30/2024 the resident was to receive the below medications at 5:00 PM and all were documented to have been given at 8:47 PM. The resident was to receive Nystatin powder to the armpits and breasts twice daily and there was no documentation that this was completed. -Cetirizine 10 mg in the evening, -Naproxen 220 mg twice daily, -Magnesium Oxide 400 mg twice a day, -Baclofen 20 mg 2 tabs twice a day, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Letrozole 2.5 mg in the evening, On 3/31/2024 the resident was to receive the below medications at 5:00 PM and all were documented to have been between 2:25 AM and 2:26 AM: -Dulera 200-5 mcg 2 puffs twice daily, -Cetirizine 10 mg in the evening, -Naproxen 220 mg twice daily, -Magnesium Oxide 400 mg twice a day, -Letrozole 2.5 mg in the evening, -Baclofen 20 mg 2 tabs twice a day. On 3/31/2024 the resident was to receive the below medications at 7:00 PM and all were documented to have been given between 2:25 AM and 2:35 AM. Latanoprost 0.005% 1 drop both eyes at bedtime, Gabapentin (used to treat neuropathy pain) 100 mg three times a day for nerve pain, Norco 5-325 mg at bedtime. A record review of Resident 2's electronic health record reviewed no progress notes related to late administration or medication not given or updates to the medical doctor. B. A record review of Resident 9's Medical Diagnosis form printed 4/23/2024 revealed the resident admitted to the facility on [DATE] with a readmitted on 12/22/2020 with diagnoses of congestive heart failure (CHF-the heart doesn't pump blood as well as it should), hypertension (force of the blood against the artery walls is too high), edema (excess fluid in the tissues), and macular degeneration (loss in the center of the field of vision). A record review of Resident 9's Brief Interview for Mental Status (BIMS-tool used to identify the cognitive condition of the resident) dated 2/1/2024 revealed a score of 15 indicating the resident is cognitively intact. An interview on 4/22/2024 at 2:00 PM with Resident 9 in regards to receiving medications timely, the resident replied honestly, no. The resident stated they have skipped [gender] a few times and then [gender] lays awake all night waiting for medication and when [gender] realized they are not coming, [gender] can't sleep. She said this is distressing as [gender] to go to bed between 6:30 PM and 7:00 PM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 9's March 2024 Medication Administration Record (MAR-a document that details what medications were received by the resident) revealed the following: On 3/17/2024 the resident was to receive the below medications at 5:00 PM and all were documented to have been given between 7:59 PM and 8:04 PM: -Acetaminophen (used to treat pain) 500 mg 2 tabs twice daily, -Carvedilol (used to treat high blood pressure and heart failure) 3.125 mg 1 tab twice daily, -Miralax (a laxative used to treat constipation) 17 gm (gram) twice daily, -Brimonidine/Timolol (an eye drop used to treat glaucoma) 0.2/.5%- Instill 1 gtt in both eyes twice daily, -Senexon-S (used to treat constipation) 8.6-60 mg 2 tabs twice daily. On 3/20/2024 the resident was to receive the below medications at 5:00 PM and was documented to have been given between 8:53 PM and 8:54 PM: -Miralax 1 gm twice a day, -Carvedilol 3.125 mg twice a day, -Senexon-S 8.6-50 mg 2 tabs twice daily, -Brimonidine/Timolol 1 gtt both eyes twice daily, -Acetaminophen 500 mg 2 tabs twice daily. On 3/22/2024 the resident was to receive the below medications at 5:00 PM and was documented to have been given between 8:38 PM and 8:39 PM. -Brimonidine/Timolol- Instill 1 gtt in both eyes twice daily, -Senexon-S 8.6-50 mg 2 tabs twice daily, -Carvedilol 3.125 mg twice daily, -Miralax 17 gm twice daily, -Acetaminophen 500 mg 2 tabs twice daily. On 3/30/2024 the resident was to receive the below medications at 5:00 PM and was documented to have been given between 9:12 PM and 9:14 PM: -Acetaminophen 500 mg 2 tabs twice daily, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Carvedilol 3.125 mg twice daily, -Miralax 17 gm twice daily, -Senexon-S 8.6-50 mg 2 tabs twice daily, -Brimonidine/Timolol 1 gtt both eyes twice daily, and -Latanoprost .005%- Instill 1 gtt both eyes- this medication not documented to have been given. On 3/31/2024 the resident was to receive the below medications at 7:00 AM and was documented to have been given between 12:04 PM and 12:14 PM: -Lasix (a diuretic used to treat fluid retention that causes an individual to urinate more) 20 mg 2 tabs in the morning, -Fluticasone (a nasal spray used to treat allergy symptoms) 50 mcg 1 spray each nare , -Acetaminophen 500 mg 2 tabs twice daily, -Potassium (used to treat low amounts of potassium in the body or used when an individual is on a diuretic) 10 meq Extended Release in the morning, -Vitamin D (a supplement for bone health) 1000 units in the morning. -Miralax 17 gms twice daily -Duloxetine (used for nerve pain and/or depression) 60 mg daily -Senexon-S 8.6-50 mg 2 tabs twice daily, -Cetirizine 10 mg daily, -Aspirin (anti-inflammatory used for pain) 81 mg in the morning, -Brimonidine/Timolol (eye drop for glaucoma) 1 gtt in both eyes twice daily, -Clopidogrel (used to thin the blood) 75 mg in the morning, -Carvedilol (used to treat high blood pressure and heart failure) 3.125 mg twice daily. On 3/31/2024 the resident was to receive the below medications at 11:00 PM and was documented to have been given between at 12:14 PM: -Lasix 20 mg at 12:00 PM, thus receiving a total of 60 mg Lasix at 12:14 PM as the morning dose was given at this time as well. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/31/2024 the resident was to receive the below medications at 5:00 PM and was documented to have been given between 1:57 AM and 2:00 AM: -Acetaminophen 500 mg 2 tabs twice daily, -Brimonidine/Timolol 1 gtt both eyes twice daily, -Senexon-S 2 tabs twice daily, -Carvedilol 3.125 mg twice daily, -Miralax 17 gm twice daily, -Melatonin 3 mg at bedtime, -Pravastatin 40 mg at bedtime, -Duloxetine 30 mg at bedtime, -Latanoprost .005% instill 1 gtt in both eyes at bedtime, -Gabapentin (used to treat nerve pain) 600 mg Q 8 hours. A record review of Resident 9's electronic health record reviewed no progress notes related to late administration of medications or updates to the medical doctor. An interview on 4/23/2024 at 8:45 PM with the Assistant Administrator (AADM), DON, Clincal Coordinator, Registered Nurse-A, and DCS-B regarding medication pass times and review of six days of the March MAR revealed no one in management reviews the MAR's or TARS for completeness and timeliness of medications passed. The DCS-B said the doctors are in the facility on Thursday's and review them. After explanation of the numerous times medications were given late, causing either pain or distress to two residents, the DON confirmed the medications were given outside of parameters and would be considered medication errors, along with medications not given entirely, and the medical doctor should have been notified. The team stated they were unaware that medications were passed at or after 2:00 AM on Easter weekend, but the DON confirmed this was far too late to be passing medications. A record review of Medication Administration Times for Hillcrest Facilities revealed: -Morning medications to be passed from 7:00 AM to 8:59 AM -Noon medications to be passed from 11:00 AM to 12:59 PM -Afternoon medications to be passed from 1;00 PM to 3:59 PM -Evening medications to be passed from 4:00 PM to 6:00 PM -Bedtime medications to be passed from 7:00 PM and 10:00 PM (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Night time medications to be passed from 10:00 pm to 5:59 AM A record review of an undated facility policy Medication Administration and Provision revealed: -3. medications will be stored in a locked cart or cupboard, according to manufacturer's directions if applicable. -9. All medications will be administered to each guest/patient according to the following five rights: *right med *right guest/patient *right dose *right time *right route -11. Medications are documented as administered after the med aid/nurse has assured the guest/patient consumed the medication A record review of an undated facility policy Medication Administration Policy revealed: Policy: It is the policy of the service line to ensure that each guest receives medications as prescribed by their providers according to the administration times as developed. 1. Medications eligible for scheduled dosing times: medications eligible for dosing times are those prescribed on a repeated cycle of frequency, such as once a day, BID (twice daily), TID (threes time a day), QID (four times a day), hourly intervals (every 1,2,3, or more hours), etc. The goal of this scheduling is to achieve and maintain therapeutic blood levels of the prescribed medication over a period of time. a. Time critical scheduled medications: those for which an early or late administration of greater than 30 minutes may have a negative impact on the intended therapeutic or pharmacological effects. Accordingly, scheduled medication identified under the service lines policies and procedures as time-critical must be administered within thirty minutes before or after their scheduled dosing time, for a total window of 1 hour. b. Non-time critical medications: medications for which a longer or shorter interval of time since the prior dose does not significantly change the medications therapeutic effect or otherwise can harm. 2. Medications NOT eligible for scheduled dosing times: medication orders or individual doses that require more exact or precise timing of administration, based on diagnosis type, treatment requirements, or therapeutic goals. (continued on next page)

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	285293	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Country Estates-Cottages	6082 Grand Lodge Avenue Papillion, NE 68133

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: 1. Time critical scheduled medications include: a. Scheduled pain medications 2. Non-time critical scheduled medications: a. medications scheduled for daily, weekly or monthly administration may be within 2 hours before or after the scheduled dosing time, for a total window that does not exceed four hours b. medications prescribed more frequently than daily but no more frequently that every 4 hours may be administered within 1 hour before or after the scheduled dosing time, for a total window that does not exceed 2 hours. 4. Missed or last administration of medications include: a. Missed medications: Missed medication administration should be reviewed with the provider and/or pharmacy to determine the next time of administration. The nurse must document in the electronic medication administration (EMAR) the reason for the missed administration. b. Late administration of medications: if a medication is administered outside the appropriate window, the nurse administering the medication must enter a reason for the late administration in the EMAR. A record review of an undated facility policy Medication Errors revealed: A medication not given as prescribed or according to the five rights of medication administration a medication error report is generated. 1. When a med error is noted by a team member, the medication error event process will be initiated by the team member recognizing the error. 2. The team member will complete the event report indicating the time and date of the error, the type of error, and the person finding the error. 3. The Director of Clinical Services or Clinical Coordinator will be notified. Significant medication errors will be reported to the Director of Clinical Services or designee immediately. 4. The DCS or designee will notify and discuss medication error with team member for review and learning. 5. The nurse providing the education and the team member making the error will provide documentation on the medication error report of what actions will be taken to prevent further errors of the same nature. 6. Medication error reports will be reviewed by the Director of Clinical Services for tracking and trending purposes. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the facility Incident log, which included reports of medication errors, listed no reports for Resident 2 or Resident 9.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC 12-006.12E1, Licensure Reference Number 175 NAC 12-006.12E1a, Licensure Reference Number 175 NAC 12-006.12E3 Based on observation, record review and interview; the facility failed to provide safe storage of drugs and biologicals as medications were left in unlocked medication cabinets in rooms [ROOM NUMBERS] in Cottage 70, both of which were occupied with a resident; failed to have a scheduled II medication under double lock and in original container with label in Resident 2's room; and failed to have a schedule eye drop in original container with label in Resident 8's room. The facility census was 117. Findings are: A. An observation on 4/23/2024 at 8:20 AM during a morning medication pass in room [ROOM NUMBER] revealed an unlocked medication cabinet with resident's drugs. An interview on 4/23/2024 at 8:20 AM with Medication Aide (MA)-C in the resident's room confirmed that the medication cabinet should be locked at all times. Further investigation of additional rooms in Cottage 70 revealed an unlocked medication cabinet in room [ROOM NUMBER] which was occupied by a resident who had medications in the cabinet. An interview on 4/23/2024 at 8:45 AM with MA-C confirmed that room [ROOM NUMBER]'s medication cabinet was unlocked and shouldn't be. MA-C tried to lock the cabinet but the cabinet would not lock. MA-C said [gender] would complete a maintenance order to fix the cabinet. An interview on 4/23/2024 at 7:30 PM with Licensed Practical Nurse (LPN)-D confirmed that all medication cabinets should be locked at all times. B. An observation on 4/23/2024 at 7:45 PM during an evening medication pass revealed LPN-D gave Resident 2 their scheduled medications. The resident said [gender] would take her pain medication now instead of waiting until 8:30 PM. LPN-D pulled a unlabeled medication cup out of the resident's medication cabinet with a white pill in it and gave the pill to Resident 2 to take. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/23/2024 at 7:50 PM with LPN-D in regard to what was in the medication cup revealed LPN-D stated it was the resident's Norco (a scheduled II narcotic). When asked about why it was in a medication cup or how is anyone to know what is in the cup, LPN-D replied that [gender] brought it over earlier from Cottage 60 where it is kept locked up. LPN-D stated a day nurse told [gender] to do this as the resident would need the medication later. LPN-D could not recall what time [gender] brought the medication over and put in the resident's cabinet. An observation on 4/23/2024 at 8:30 PM with LPN-D in Cottage 60 revealed a locked box containing narcotics sitting on a desk in a locked office. A record review on 4/23/2024 at 8:30 PM of a narcotic count sheet for Resident 2 revealed LPN-D pulled 1 Norco tablet from the locked box at 6:00PM. A record review of Resident 2's Order Summary Report printed 4/22/2024 revealed an order for Norco 5-325 mg at bedtime for pain. C. An observation on 4/23/2024 at 8:20 AM with MA-C during a morning medication pass in room [ROOM NUMBER] revealed a small open see through plastic package with 2 vials of an eye drop with a small label on each vial that said Lubricating eye drop 0.4-0.3%. The package has no date. MA-C removed 1 vial from the package and instilled 1 drop into each eye of the resident. An interview on 4/23/2024 at 8:20 AM with MA-C confirmed that the eye drops should be in the original box with a label that has the resident's name and directions for the eye drops. An interview on 4/23/2024 at 10:30 AM with the Director of Nursing (DON) confirmed that all medication cabinets should be locked, and medications should be kept in their original package with label. An interview on 4/23/2024 at 8:45 PM with the DON, Corporate Registered Nurse (RN-A), Clinical Coordinator (CC), and Assistant Administrator (AADM) regarding a single scheduled II pain medication sitting in a medication cup in a resident's medication cabinet under a single lock during the evening medication pass revealed no response from the group regarding this process. A record review of an undated facility policy Medication Administration and Provision revealed: -3. Medication will be stored in a locked cart or cupboard, according to a manufacturer's directions if applicable. -9. All medications will be administered to each guest/patient according to the following five rights: -right medication -right guest/patient -right dose (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-right time -right route A record review of an undated facility policy Medication Storage revealed: Medications and biologicals are stored safely, securely, and properly, following manufacturers' recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedure: 1.The pharmacy provider dispenses medications in containers that meet legal requirements. Medications are kept in these containers. Transferring medications from one container to another is to be done by the pharmacy only. 6. Except for those requiring refrigeration and/or scheduled II substances, medications intended for internal use are stored in guests' locked cabinet. 8. Schedule II medications are stored in a separate area under double lock.

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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. 49383 Licensure Reference Number 175 NAC 12-006.17B Licensure Reference Number 175 NAC 12-006.17D Based on observation, record review, and interviews; the facility failed to perform hand hygiene to prevent the potential of cross contamination between residents during morning and evening medication pass. This had the potential to affect 3 (Resident 9, 7, and 8) out of the 6 sampled residents. The facility census was 117. Findings are: A. An observation on 4/23/2024 at 7:55 AM in Resident 9's room with Medication Aide (MA)-C revealed MA-C stated [gender] already washed hands in the resident's bathroom sink. MA-C gave the resident [gender] scheduled medication, applied gloves, and instilled eye drops. MA-C then removed gloves and exited the resident's room with no hand hygiene after glove removal or upon leaving the room. B. An observation on 4/23/2024 at 8:15 AM in Resident 7's room with MA-C revealed MA-C washed their hands at the sink with soap and water for 10 seconds. MA-C proceeded to give the resident [gender] scheduled medication, applied gloves and applied Aquaphor cream to resident's lower legs. MA-C removed the gloves and exited the room with no hand hygiene after glove removal or upon leaving the room. C. An observation on 4/23/2024 at 8:20 AM in Resident 8's room with MA-C revealed MA-C washed [gender] hands at the sink with soap and water for 10 seconds. MA-C applied gloves and gave the resident [gender] scheduled medications and instilled eye drops. MA-C removed the gloves and took them out of the room with [gender] and disposed of them in a trash can in the kitchen. No hand hygiene was performed after removal of gloves or upon exiting the room. An interview on 4/23/2024 at 8:40 AM with MA-C regarding the policy on hand hygiene and glove usage, MA-C revealed [gender] was not sure but [gender] sings the ABC's. When informed that [gender] washed hands for 10 seconds with soap and water for 10 seconds and the facility policy is 20 seconds, [gender] confirmed that 10 seconds was not long enough. MA-C did not realize hands should be washed after removing gloves or before leaving the room. MA-C thought washing hands upon entering the room was all that was needed. An interview on 4/23/2024 at 10:30 AM with the DON (Director of Nursing) confirmed that hand hygiene is 20 seconds and hand hygiene should be performed after gloves are removed and before exiting the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. An observation on 4/23/2024 at 7:45 PM with LPN (Licensed Practical Nurse)-D during the evening medication pass revealed LPN-D stopped at the kitchen sink to wash hands with soap and water for 10 seconds. LPN-D had commented that [gender] needed to stop and wash hands as she had used hand sanitizer for so many times. An interview on 4/23/2024 at 8:30 PM with LPN-D regarding hand hygiene revealed LPN-D did not know the facility policy on amount of time that should be spent washing hands with soap and water. LPN-D said [gender] usually sings the happy birthday song. When informed that [gender] washed hands for 10 seconds and the facility policy is 20 seconds, LPN-D confirmed [gender] did not wash long enough. An undated facility policy Handwashing Competency Checklist revealed under: Skill/Procedure-Team member can state 6-8 times when he/she would wash hands: beginning and end of shift, before and after using restroom, coughing, sneezing, blowing nose; before and after breaks; before and after elder contact; after removal of gloves; anytime hands are soiled; before and after handling food; and before and after handling soiled articles. 1.Rub all surfaces of the hands, between fingers, under nails and at least 2 inches above the wrist continuously for at least 20 seconds.