STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295045	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Torrey Pines Post Acute and Rehabilitation	1701 S. Torrey Pines Drive Las Vegas, NV 89146

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47860 Based on observation, interview, record review, and document review the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) level two referral was completed for 2 of 20 sampled residents (Residents 22 and 28). The deficient practice had the potential to deprive the residents of concern and other residents of necessary behavioral health services. Findings include: Resident 22 (R22) R22 was admitted on [DATE] with diagnosis including major depressive disorder, unspecified mood (affective) disorder, bipolar disorder, and psychotic disorder (other than schizophrenia. On 05/08/2024 at 7:49 AM, R22 was in the room sitting upright in wheelchair. R22 was calm in nature and did not display concerning, aggressive, or withdrawn behaviors when interviewed. A PASARR level one document dated 04/08/2014, revealed R22 did not have dementia, mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. A Leve of Care (LOC) document dated 04/09/2014, revealed an initial placement assessment and met criteria for nursing facility. The annual Minimum Data Set (MDS) dated [DATE] documented R22 had a negative PASARR one (no MI, MR, ID, or RC) and had a diagnosis of depression but did not have bipolar or psychotic disorder. The quarterly MDS dated [DATE] documented R22 had new diagnosis of bipolar disorder and psychotic disorder (other than schizophrenia). The medical record lacked documented evidence R22 was referred for a PASARR level two. On 05/10/2024 at 8:04 AM, a Social Worker confirmed R22 was diagnosed with bipolar disorder after admission and during stay at the facility. The Social Worker indicated these diagnosis met the requirement and should have been submitted for a PASARR level two review. The Social Worker confirmed R22 had not been referred for a PASARR level two review. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50289 Resident 28 (R28) R28 was readmitted on [DATE], with primary diagnoses including anxiety disorder, depression, bipolar disorder, schizophrenia, and a psychotic disorder (other than schizophrenia). On 05/07/2024 in the morning, R28 laid in bed with eyes on telephone with headphones on. R28 appeared lethargic and spoke stating R28 had been in the facility for a little while. The resident was able to make needs known asking about the ability to smoke marijuana in the facility and being able to use a power wheelchair in the facility. On 05/08/2024 in the afternoon, R28 laid in bed with eyes on telephone with headphones on and appeared lethargic. While talking to the resident about the facility's policy on no marijuana smoking, R28 was not able to talk in complete sentences and was not making sense. R28 was talking nonsensical. A PASARR level one document dated 03/14/2016, revealed R28 did not have dementia, mental illness (MI), intellectual disability, (ID) mental retardation (MR) or any related condition (RC) and was deemed appropriate for nursing facility placement. The admission minimum data set (MDS) dated [DATE], documented R28 had a negative PASARR one (no MI, MR, ID, or RC), cognitive deficits, and had diagnoses of anxiety disorder, depression, bipolar disorder, schizophrenia, and a psychotic disorder (other than schizophrenia) but did not have dementia. The physician note dated 01/25/2024, documented R28 had been sent to the hospital for a change of condition. A review of psychiatry notes revealed R28's schizophrenia had an onset date of 06/09/2023, bipolar disorder on 06/09/2023, and anxiety disorder on 07/07/2023. R28 readmitted on [DATE] with a new diagnoses of brief psychotic disorder, manic episode, and paranoid personality disorder and was prescribed Zolpidem Tartrate 10 milligrams (mg) (hypnotic) and Quetiapine Fumarate 200 mg (anti-psychotic.). The Division of Health Care Financing and Policy- Medicaid Services Manual- for Nursing Facilities Policy dated 05/01/2015, documented when an individual has been identified with possible indicators of mental illness, intellectual disabilities, or related condition, a PASARR Level II screening must be completed to evaluate the individual and determine if nursing facility services and/or specialized services are needed and can be provided in the nursing facility. Examples include: a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting a presence of a mental disorder (where dementia is not the primary diagnoses), or an intellectual disability or related condition was not previously identified and evaluated through PASARR. Social services would be responsible for keeping track of each resident's PASARR screening status and referring to appropriate authority. The medical record lacked documented evidence R28 was referred for a PASARR level two. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/2024 in the afternoon, the Assistant Administrator and the Social Worker confirmed R28 had a negative PASARR level one when first admitted on [DATE] but had new diagnoses of brief psychotic disorder, manic episode, and paranoid personality disorder, by the completion of the resident's re-admission MDS on 02/12/2024. The Assistant Administrator and the Social Worker confirmed the purpose of PASARR was to ensure residents were appropriately placed and the facility could meet the needs of the residents. The Assistant Administrator indicated admissions were not involved in the process of identifying and referring residents who met criteria for a new level of care (LOC) assessment or a PASARR level two referral. The admissions department deferred to the social services department for information on PASARR level two. On 05/09/2024 in the afternoon, the Admission Director indicated being responsible for ensuring all newly admitted residents had a PASARR level one or two in place. The Admissions Director indicated not being involved in the process of identifying and referring residents who met criteria for a PASARR two referral after new behaviors and psychiatric diagnoses were identified during their stay in the facility. On 05/09/2024 in the afternoon, the Social Worker (SW) explained the SW was responsible for completing the online PASARR requests. The SW indicated not being aware of social services' involvement with identifying and referring residents who met criteria for PASARR two referral. The Assistant Administrator confirmed social services' involvement with identifying and referring residents who met criteria for PASARR two referral was to be completed in their morning meeting.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observation, interviews, record reviews, and document review, the facility failed to ensure the medication administration record was not signed off before the medications were administered for 2 of 20 sampled residents (Residents 75 and 246). The deficient practice could have the potential risk to resident safety, medication errors, missed doses, or incorrect dosages, and adverse health outcomes. Findings include: Resident 246 (R246) R246 was admitted on [DATE], with diagnoses including osteomyelitis and anemia. On 05/09/2024 at 8:48 AM, a Licensed Practical Nurse (LPN) in the Northeast Unit prepared eight medications, placed in medication cups, and promptly signed the medication administration record (MAR) to confirm the medications were completely administered. R246 refused two medications. The LPN explained the MAR had been signed off before the actual medication administration due to being preoccupied later and might forget to sign. On 05/09/2024 at 11:41 AM, the Assistant Director of Nursing (ADON) indicated the MAR should not been signed off until the medications were completely administered. The ADON explained the residents might have refused the medications or might have been administered unsuccessfully, yet documented as administered. Resident 75 (R75) R75 was admitted on [DATE], with diagnoses including hypertension. On 05/09/2024 at 9:25 AM, a Licensed Practical Nurse (LPN) prepared four medications, placed in a medication cup, and promptly signed the medication administration record (MAR) as a confirmation the medications were completely administered. The LPN explained the practice was customary during the LPN's previous work out of state. 05/09/24 at 11:50 AM, the DON indicated the staff members were expected to sign off on the MAR after the completion of medication administration ensuring the accuracy of documentation per policy. A facility policy titled Administering Medications dated 04/2019, indicated medications were administered in a safe and timely manner and as prescribed. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observations, interviews, record reviews, and document reviews, the facility failed to ensure: 1) A resident's wound was cleansed, dressing was replaced or applied as ordered when the wound was soaked with urine and feces for 1 of 20 sampled residents (Resident 70), and 2) The wound treatment orders were obtained and transcribed before the treatment was provided for 1 of 20 sampled residents (Resident 55). The deficient practice could have the potential to cause delayed healing, worsened wounds, infection, and further complications. Findings Include: Resident 70 (R70) R70 was admitted on [DATE] and readmitted on [DATE], with diagnoses including pressure-induced deep tissue damage of the sacral region and the presence of a right artificial hip joint. A physician order dated 05/04/2024, documented wound care to the right buttock to cleanse with normal saline, pat dry, apply Medihoney, apply zinc paste, and cover with a clean dry dressing on day shift on Monday, Wednesday, and Friday for 30 days. The Pressure Ulcer Risk Protocol and Care Plan dated 02/26/2024, documented R70 was at risk for developing pressure ulcers related to impaired mobility. The Braden Scale-For Predicting Pressure Sore Risk dated 02/26/2024, documented a score of 11, which indicated a high risk of developing a pressure ulcer. The Wound Measurement dated 05/04/2024, documented the abrasion as 2.0 centimeters (cm) times (x) 0.4 cm by 0.1 cm. A care plan dated 05/04/2024, documented R70 had a right buttock abrasion. The approach included performing treatments as ordered. On 05/08/2024 at 12:01 PM, R70 was in bed in a supine position. R70's family was present at the bedside, who explained R70 was blind with confusion and dependent on staff for activities of daily living. The family reported the staff failed to turn and reposition R70 on schedule. The family indicated R70 had a facility-acquired wound in the buttocks but was uncertain when and how frequent the treatment and dressing changes were. On 05/08/2024 at 12:22 PM, R70 was in bed in a supine position. As verified, R70 had wounds in the buttocks with abrasive scar tissue on the wound edges. There was no wound dressing on R70's wounds, and feces were visible in the buttocks. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/2024 at 1:21 PM, a Certified Nursing Assistant (CNA) provided care to R70 assisted by the family member. R70's buttocks were wet and soiled with feces. The wound had no dressing and was soaked with feces. On 05/08/2024 at 1:35 PM, a Registered Nurse (RN) indicated R70 was blind, on bed rest, incontinent, and totally dependent on staff with bed mobility. The RN reported the wound care treatment nurse (WCTN) was treating R70 for wounds on the buttocks. The RN explained the process if the wound dressing was soiled, the attending licensed nurse, or WCTN, would be informed in a timely manner to cleanse the wound and replace the dressing. The RN indicated the wound should not be soaked in feces or urine to promote wound healing. The RN confirmed was not informed when R70's wound needed to be cleansed and the dressing replaced. On 05/08/2024 at 1:49 PM, a Certified Nursing Assistant (CNA) indicated incontinent care was provided early in the morning. The CNA indicated R70's wound dressing was dated 05/07/2024, it was soiled and removed. The CNA explained the process when the wound dressing had been soiled or removed, the WTCN or the attending nurse should have been informed to change the dressing to prevent contamination. The CNA confirmed the WTCN, or the attending nurse, was not notified. The CNA confirmed that R70's wound had been soaked in feces. The Treatment Administration Record documented R70's buttocks abrasion was treated on 05/06/2024 and 05/08/2024. On 05/08/2024 at 2:00 PM, the WCTN indicated the treatment was provided to R70, who was treated early in the in the morning, approximately at 7:30 AM. The WCTN described the wound as abrasive with scar tissue and skin redness. The WCTN confirmed was not notified R70's wound dressing was soiled and needed to be changed. The WCTN explained the wound should have been covered with a clean, dry dressing as ordered to promote healing and prevent infection. On 05/10/2024 at 10:38 AM, the wound nurse practitioner and the physician indicated the wound should have been covered and replaced when soiled to prevent contamination, infection, and healing. Both indicated the staff was aware of the need to cover the wound at all times to prevent contamination. Resident 55 (R55) R55 was admitted on [DATE] and readmitted on [DATE], with diagnoses including surgical amputation, absence of the right leg below the knee, and stage 3 pressure ulcers of the right and left buttocks. On 05/07/2024 at 11:00 AM, wound observation revealed the old dressings on the right leg stump and the left foot were undated. The wound nurse practitioner (WNP) confirmed the wound dressings were undated. The WCTN explained should have dated the dressings to reflect the date of the last treatment and the date of the dressing change. The WNP indicated R55's wounds had been treated the previous day following R55's admission. R55's medical records lacked documented evidence the physician's orders for wound treatments were obtained and transcribed until 05/07/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/10/2024 at 1:06 PM, the Director of Nursing (DON) indicated the wound treatment required an order, and the staff were expected to ensure orders were in place before providing the treatment per policy. On 05/10/2024 at 10:38 AM, the wound physician indicated the order should have been in place prior to treatment to provide prompt and continuous care. A facility policy titled Wound Care revised 12/2010, indicated the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. To verify there was a physician's order for the procedure and provide wound care treatment as ordered.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observations, interviews, record reviews, and document review, the facility failed to ensure: 1) The formula bag or container was labeled with the resident's name, TF rate, date/time, and nurse's initials as ordered, 2) A physician's order of the tube feeding (TF) rate was obtained and transcribed for 1 of 20 sampled residents (Resident 55) and, 3) The care orders for the gastrostomy (GT) site and dressing change were obtained, transcribed, and implemented for 1 of 20 sampled residents (Resident 55). These deficient practices could have led to complications such as ineffective nutrition, aspiration, or infection, jeopardizing the resident's health and well-being. Findings include: Resident 55 (R55) R55 was admitted on [DATE] and readmitted on [DATE], with diagnoses including dysphagia (difficulty swallowing) and gastrostomy malfunction. 1) On 05/07/2024 at 10:08 AM, R55 was lying in bed, awake with confusion. R55's TF Glucerna 1.2 was infusing at 70 milliliters (ml) with water flushes at 5 ml/hr. The TF bag or container and water bag had not been labeled with the resident's name, TF rate, date/time, and nurse's initials. A Physician order dated 05/06/2024, documented labeling the formula container with the resident's name, date, time, and nurse's initials every night shift. On 05/07/2024 at 11:35 AM, a Registered Nurse (RN) confirmed the observation, the TF bag was not labeled. The RN indicated the TF bag should have been labeled with the resident's name, date, TF rate, and nurse's initials. The RN explained there was a risk for misidentification if not labeled. The RN explained the Licensed Nurse from the previous shift was the one who hung the formula and administered it continuously until the dose was completely delivered. The RN's shift had started at 6:30 AM-3:00 PM. 2) A physician order dated 05/06/2024, documented Glucerna 1.2 via percutaneous endoscopic gastrostomy (PEG) (a feeding tube allowing nutrition through the stomach) at 70 milliliters (ml) per hour continuously. On 05/07/2024 at 10:08 AM, R55 was lying in bed with the TF Glucerna 1.2 infusing at 70 milliliters (ml). On 05/09/2024 at 9:00 AM, R55's TF Glucerna 1.2 was infusing at 66 ml/hr. The TF bag was labeled at 70 ml/hr. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record (MAR) dated 05/06/2024-05/09/2024, documented TF Glucerna 1.2 at 70 cc/hr. R55's medical records lacked documented evidence a physician order for TF Glucerna 1.2 at 66/ml per hour was obtained and transcribed. On 05/09/2024 at 2:14 PM, the RN confirmed R55's TF Glucerna 1.2 was infusing at 66 ml/hr. The RN explained it was endorsed previously R55's TF rate was decreased, but the RN assumed the order was transcribed and the MAR was updated. The RN confirmed the MAR documented the TF rate infused was 70 ml/hr., when the TF rate delivered was 66/ml per hour. On 05/09/2024 at 2:59 PM, the Registered Dietitian (RD) indicated there was a new recommendation for R55's TF order with Glucerna 1.2 at 66 ml per hour to run for 20 hours. The RD indicated the previous order from the hospital was Glucerna 1.2 at 70 ml/hour for 24 hours continuously. The RD explained the order was reduced to accommodate R55's needs. The RD confirmed the new order was not transcribed in the electronic record, and the MAR had not been updated. The RD confirmed the order should have been transcribed and updated the MAR to align with the actual TF rate the pump delivered. On 05/10/2024 at 11:06 AM, the Director of Nursing (DON) indicated the staff were expected to verify and transcribe the order, the MAR should have been updated, and the enteral pump adjusted as ordered. The DON indicated the staff skipped the process as to why there was confusion. The DON indicated the order should be in place, matched with paper MAR, and the enteral pump should match with the order. A facility policy titled Physician Orders dated 10/2014, indicated providing care and services to the resident in accordance with physician orders. All aspects of the resident's care, including but not limited to the following, shall only be provided if ordered by the physician. Document and transcribe physician orders received over the telephone onto the physician order sheet. 3. On 05/07/2024 at 10:08 AM, R55 was lying in bed and incoherent. The gastrostomy tube (GT) site dressing was labeled as 04/30. The RN confirmed the GT dressing was dated 04/30. The RN explained the GT site should have been cleansed and the dressing changed daily at night. The RN indicated R55's GT dressing had not been changed as scheduled. The RN indicated the wound nurses were responsible for the GT site cleaning and dressing. R55's medical record lacked documented evidence care orders for the GT site were obtained, transcribed, and implemented. On 05/10/2024 at 10:20 AM, the wound nurse practitioner (WNP) indicated the Licensed Nurses were responsible for the GT site monitoring and dressing change. The WNP recommended monitoring the GT site for signs or symptoms of infection, following any orders to cover the GT site, and changing the dressing accordingly. On 05/08/2024 at 1:00 PM, the facility WCTN explained Licensed Nurses were responsible for the resident's GT care and dressing change and not the wound care team. On 05/08/2024 in the afternoon, the Assistant Director of Nursing (ADON) indicated both the Licensed Nurse and the Wound Care Team were responsible for the resident's GT site care and management. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/10/2024 at 11:06 AM, the DON indicated the GT care required an order, and the Licensed Nurses were responsible for the monitoring and the dressing change to prevent infection. A facility policy titled Enteral Feeding Tube Care dated 10/2014, indicated to provide services to a resident receiving nutrition via an enteral feeding tube to prevent irritation and skin breakdown around the feeding tube, prevent odor and discomfort: Assess the condition around the site of tube insertion, cleanse the skin around the tube with normal saline, pat dry, and apply the dressing around the feeding tube at the site of insertion. A facility policy titled Enteral Nutrition dated 11/2018 documented, adequate nutritional support through enteral nutrition was provided to residents as ordered. The nurse confirms the orders for enteral nutrition were complete, including the volume and rate of administration.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40142 Based on observation, interview, record review and document review, the facility failed to ensure care and management orders were obtained, transcribed, and carried out for residents who were admitted with an intravenous (IV) access for 2 of 19 sampled residents (Residents 65 and 245). The deficient practice placed the residents at risk for an infection. Findings include: Resident 65 (R65) R65 was admitted on [DATE], with diagnoses including hydrocephalus, cardiomegaly, and status epilepticus. On 05/07/2024 at 9:42 AM, R65 laid in bed awake and alert. A double-lumen central venous catheter (CVC) was observed on R65's left upper chest with tape half off, exposing insertion site. R65 indicated the CVC was placed and used at the hospital but had not been used at the facility. R65 indicated staff flushed and replaced the catheter dressing at irregular intervals and no one had discussed with R65 whether the CVC was to be maintained or removed. A hospital radiology report dated 03/11/2024, revealed a dual lumen central venous catheter was placed in R65's left internal jugular vein with catheter tip in the right atrium of the heart. A Nursing Patient Evaluation dated 04/02/2024, failed to identify the presence of R65's left upper chest CVC. An Admit Nursing note dated 04/02/2024, failed to identify the presence of R65's left upper chest CVC. The Order Summary Report as of 05/07/2024, lacked documented evidence care orders were obtained for R65's left upper chest CVC. On 05/07/2024 at 9:46 AM, the Licensed Practical Nurse (LPN) confirmed R65's CVC had dressing which was half off with insertion site exposed. Using gloved hand, the LPN unfolded the dressing which revealed a date of 04/22/2024. The LPN indicated intravenous (IV) lines were flushed every shift and dressing changes were done weekly or more often as needed. The LPN indicated not being aware what the plans were for R65's CVC. On 05/07/2024 at 9:50 AM, the Assistant Director of Nursing (ADON) was rounding the unit with the IV cart. The ADON entered R65's room and confirmed the IV line was a CVC with dressing dated 04/22/2024. The ADON indicated not being certain what the plans were for R65's CVC. The medical record lacked documented evidence R65's CVC was identified during the admission assessment, a nurse obtained clarification from a physician regarding an indication for use, along with care, management, or removal orders for R65's left upper chest CVC. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/2024 at 9:59 AM, the ADON confirmed the admission nurse failed to identify R65's left upper chest CVC upon admission on 04/02/2024. The ADON acknowledged there were no care and management orders in place for R65's CVC which should have included flushing and site assessment every shift and weekly dressing changes and as needed when loose, soiled, or dirty. The ADON verbalized the oversight placed R65 at risk for a major infection since the tip of the central line was at the tip of the heart. On 05/09/2024 at 2:52 PM, the Director of Nursing (DON) indicated expecting admission nurses to do a full head to toe assessment which would have identified R65's left upper chest CVC. The nurse should have notified the physician regarding indication for use along with care, management, or removal orders. The DON indicated consequences for the CVC care being missed placed R65 at risk for an infection. The Dressing Change for Vascular Access Devices policy (undated) documented dressing changes for central venous catheters and midlines should be done every seven days and as needed when soiled, moist and inflamed. Resident 245 (R245) R245 was admitted on [DATE], with diagnoses including alkalosis and fluid overload. On 05/07/2024 at 9:15 AM, R245 laid in bed alert and was on Oxygen via nasal cannula. A left forearm peripheral intravenous (IV) access had a transparent dressing dated 04/21/2024 which R245 explained was placed in the hospital and was being used to administer IV Lasix (a diuretic - medications which increase excretion of fluid from the body). R245 indicated being readmitted on [DATE] and the IV had not been used, flushed, dressed nor had anyone in the facility discussed whether the IV was to be removed or maintained. On 05/07/2024 at 9:20 AM, the Infection Preventionist (IP) entered R245's room and described the resident's IV line as a Heplock (peripheral IV) 22-gauge single lumen with transparent dressing dated 04/22/2024 with ends coming loose. The IP corroborated the resident's account the IV line was placed at the hospital and was not currently being used in the facility. The IP indicated the admission nurse should have identified the IV line on admission and obtained a removal order from the physician since peripheral lines were not meant to stay for long periods. According to the IP, if another line was needed, the physician could order placement of a new line. A hospital nurse to nurse report dated 05/01/2024, revealed R245's left forearm Heplock was communicated to the admission nurse. A Nursing Patient Evaluation dated 05/01/2024, failed to document the presence of R245's left peripheral IV line. An Admit Nursing note dated 05/01/2024, failed to document the presence of R245's left peripheral IV line. (continued on next page)

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	295045	A. Building B. Wing	05/10/2024

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/07/2024 at 10:08 AM, the Assistant Director of Nursing (ADON) reviewed R245's medical record and confirmed the resident's peripheral IV was not identified by the admission nurse and care orders to include removal, flushing, dressing changes and site monitoring were clarified and obtained. The ADON indicated the oversight placed R245 at risk for infection. On 05/09/2024 at 2:52 PM, the Director of Nursing (DON) indicated the admission nurse should have identified R245's peripheral IV, notified the physician and clarified if the IV was to be removed or replaced. The DON verbalized R245 was placed at risk for an infection due to oversight. The Nursing Admission Assessment policy revised October 2019, documented licensed nurses were responsible for assessment of residents on admission to identify immediate needs to include IV therapy. The nurse would verify orders with the physician and communicate with other disciplines. The Maintaining patency of peripheral lines policy revised April 2007, documented vascular access devices were flushed after each infusion and a prescriber's order was needed for all IV flushes. All vascular accesses were flushed routinely when not in use to maintain patency. The Dressing change for vascular access devices (undated) documented dressing changes for short peripheral catheters were changed when integrity of the dressing was compromised, moist, or when blood or drainage were present, or infection was suspected.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observations, interviews, record reviews, and document review, the facility failed to ensure the resident's arteriovenous fistula (AVF) for dialysis access was assessed, a physician order was obtained, and the bruit/thrill was monitored for 1 of 20 sampled residents (Resident 70). This deficient practice posed a potential risk of infection and ineffectiveness in dialysis treatment. Findings include: Resident 70 (R70) R70 was admitted on [DATE] and readmitted on [DATE], with diagnoses including chronic kidney disease and dependence on renal dialysis. On 05/07/2024 at 1:41 PM, R70 was unavailable and out of the facility. A Registered Nurse (RN) indicated R70 was on dialysis. On 05/08/2024 at 1:00 PM, R70 was in bed, with eyes open and noted resident was blind. R70 had a permacath or tunneled catheter in the right upper chest covered with a dressing and arteriovenous fistula (AVF) in the left upper arm. The family indicated the AVF dialysis access site was placed approximately two months ago and explained the right chest catheter was prone to infection. The Consultation Report dated 04/05/2024, documented R70 was on hemodialysis and dialyzed via a right chest tunneled catheter which revealed decreased bruit and or thrill. An AVF was placed in R70's arm for dialysis access. The Dialysis Alert was placed on top of R70's physical chart. The alert documented R70's shunt site was listed in left AVF with dialysis days on Tuesday, Thursday, and Saturday. The Dialysis Communication Record from 04/30/2024 - 05/09/2024, documented R70's dialysis access in right upper chest and AVF in left upper arm. R70's medical records lacked documented evidence R70's left upper arm AVF was assessed, and care orders were obtained. The bruit/thrill was not observed or monitored. On 05/08/2024 at 1:38 PM, a Registered Nurse (RN) confirmed there was no care and monitoring orders in place for R70's AVF in left upper arm until 05/07/2024. The RN indicated the Dialysis center was responsible for the dressing during dialysis days but the facility nursing staff were responsible to monitor the bruit/thrill. The RN indicated if the AVF was not identified and the order was not obtained the AVF would not be monitored because there were no prompts. The RN indicated there should have been an order for R70's AVF for proper monitoring. On 05/09/2024 in the morning, the Assistant Director of Nursing (ADON) indicated R70 went to an appointment for AVF placement and there should have been an assessment and care orders in place for monitoring of the AVF. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/10/2024 10:00 AM, a Licensed Practical Nurse (LPN) in Southeast unit was uncertain what to monitor with the resident's AVF access. The LPN indicated the facility was responsible to reinforce the dressing but the dialysis center was changing the dressing during dialysis days. On 05/10/2024 at 10:09 AM, the LPN in Northwest indicated the bruit/thrill should have been monitored prior to dialysis. The whooshing sound was expected to be heard as an indication the fistula was patent and if not, it suggested obstruction. The LPN pointed out there should have been an order in place for monitoring because without familiarity with the resident, there was a tendency to overlook monitoring since R70 had two dialysis accesses in place. On 05/10/2024 in the morning, the Director of Nursing (DON) acknowledged R70's AVF in left upper arm was not identified. The DON indicated there should have been an assessment and order in place for the dialysis access. A facility policy titled Dialysis Care dated 10/2019, indicated to provide the standard of care to residents receiving dialysis care. The facility should ensure provision of standards of care including the AV shunt care, shunt dressing and hemodialysis vascular catheter. Shunt care should have been provided by a licensed nurse, upon orders of the physician. Shunt sites should be checked every shift. The Licensed Nurse should monitor and document on pre and post dialysis observations including the bruits, shunts area for color, warmth, redness, or edema.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40131 Based on observations, interviews, record reviews, and document reviews, the facility failed to ensure their medication error rate was below five (5) percent (%) when two errors were identified with 25 opportunities observed, calculating an error rate of 8 %. Failure to follow physician orders and timely administer medications posed a potential risk of injury or harm to the resident. Findings include: Resident 246 (R246) R246 was admitted on [DATE], with diagnoses including osteomyelitis and anemia. On 05/09/2024 at 8:48 AM, the LPN in the Northeast unit prepared eight medications, except Lactobacillus. A Physician order dated 04/29/2024, documented Lactobacillus oral capsules to give 1 capsule by mouth three times a day for gastrointestinal prophylaxis. The Medication Administration Record (MAR) dated 05/09/2024, documented the Lactobacillus was administered. On 05/09/2024 at 1:03 PM, a Licensed Practical Nurse (LPN) in the Northeast Unit confirmed the Lactobacillus was missed and was not administered timely. The LPN acknowledged R246 was taking an oral antibiotic, and Lactobacillus was to strengthen the digestive system. The LPN was uncertain what to do next if a medication was missed. On 05/09/2024 at 11:55 AM, the Director of Nursing (ADON) indicated the resident's medication, if missed, was a medication error and the physician should have been notified. The DON indicated the medication should have been administered within one hour of the prescribed time. A facility policy titled Administering Medications dated 04/2019, indicated medications were administered in a safe and timely manner and as prescribed. The medications were administered within one hour of the prescribed time. Resident 32 (R32) R32 was admitted on [DATE] and readmitted on [DATE], with diagnoses including cataract and dry eye syndrome. A Physician order dated 05/08/2024, documented artificial tears ophthalmic solution 0.2-1% (percent) to instill 1 (one) drop in both eyes twice a day. Space all eyedrops by five (5) minutes. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/09/2024 at 9:12 AM, a Registered Nurse (RN) in the Southeast Unit prepared and administered R32's medications. The RN administered the artificial tears to both eyes without any spacing, as ordered. The RN instilled the eye drop into one eye and then immediately administered one drop to the other eye in less than a minute. On 05/09/2024 at 3:08 PM, the RN confirmed during eye drop administration, the proper spacing was not followed. The RN indicated the order should have been verified and implemented. On 05/09/2024 in the afternoon, the Director of Nursing indicated the nurses were expected to follow the medication instructions or clarify the order. The DON indicated the eyedrops should be instilled with 5 minutes of spacing or interval to ensure absorption. A facility policy titled Medication Administration-Eye Drops dated 05/2016, indicated administering ophthalmic solution into the eye in a safe and accurate manner.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46265 Based on observation, interview and document review, the facility failed to ensure food items stored inside the stand-alone cooler and freezer were labeled, dated, and not expired; containers for juice machine were stored according to manufacturer instruction; items in the unit nourishment rooms were labeled, dated, and not expired. The deficient practice posed a potential risk to safety and health standards which could lead to contamination, inadequate storage, and place residents at risk of foodborne illness. Findings include: On [DATE] at 8:00 AM, the initial tour of the kitchen was completed with the following findings: - in the stand-alone refrigerator a container of sour cream had expired on [DATE]. - in the stand-alone freezer there were several food items in Ziploc plastic bags which were not labeled or dated. Items consisted of meat, fruits, vegetables, and dessert items. - the oven/stove ventilation system's last service date was [DATE] and should be cleaned every 90 days. - juice containers for drink machines were being stored in the dry storage area. There were 6 apple juice, 4 orange juice, and 1 cranberry cocktail containers. The manufacturer guidelines located on the product indicated to store in freezer and thaw in refrigerator 12 hours prior to use. The delivery date on the juice containers revealed the containers had been in dry storage since [DATE]. On [DATE] at 8:15 AM, the Dietary Manager acknowledged the manufacturer guidelines and indicated the product would be discarded. On [DATE] at 8:45 AM, in the unit nourishment rooms the following concerns were identified: - the nourishment room on the Northeast Unit in the resident refrigerator were two containers of yogurt which expired [DATE]. - the nourishment room on the Northwest Unit was being used as breakroom for staff with a folding table and chairs set up in room, mixture of staff belongings and unmarked food items were in cabinets and resident refrigerator including a personal lunchbox. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- a personal carton of milk was tested and was 53 degrees Fahrenheit, another carton was tested and was within acceptable range. - the nourishment room on the South Unit contained food items in resident refrigerator which were not labeled or dated. There were two items dated only with dates of [DATE] and [DATE]. On [DATE] at 9:00 AM, the Dietary Manager indicated there were two deliveries made per week and when items were placed in storage they would have the delivery date, use by date, and label to identify product. The Dietary Manager indicated the Certified Nursing Assistants would sometimes place unused items from meal tray in the resident refrigerator for future use. The Dietary Manager explained it was not appropriate for CNA staff to take unused items from resident meal tray and place in resident refrigerator unless it was labeled for a specific resident. The facility policy titled Food Receiving and Storage ([DATE]) documented dry foods stored in bins will be removed from original packaging, labeled, and dated. All foods stored in the refrigerator or freezer would be covered, labeled, and dated. All foods belonging to residents must be labeled with the resident name, the item, and the use by date. The facility policy titled Foods Brought by Family and Other Visitors ([DATE]) documented staff would discard resident food which showed obvious signs of potential foodborne danger such as mold, foul odor, or past due package expiration dates.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 40142 Based on interview and document review, the facility failed to ensure the facility assessment was reviewed and updated when staffing levels were reduced beginning October 2023, and the input of department heads were taken into consideration in accordance with the facility's policy. The deficient practice had the potential to ensure resident's care needs were met. Findings include: The Facility Assessment policy revised October 2018, documented a designated team would conduct a facility-wide assessment once a year and as needed to ensure resources were available to meet the specific needs of the residents. The facility assessment included a detailed review of the resident population which included resident acuity (severity of patient's illness or medical condition) as well as a detailed review of resources available to include staff type and staffing plan. The team would include the medical director, administrator, director of nursing services, infection preventionist, and all department heads (social services, dietary, activities, rehabilitation, environmental services). The facility assessment review dated 01/17/2023, documented the facility had 95 licensed beds and an average daily census of 90 to 95 residents. There was an average of 20 admissions and 12 discharges each month. Resident acuity involved 50 to 60 residents receiving rehabilitation services and 50 to 60 residents with behavior symptoms and cognition issues. The staffing plan needed to provide competent support and care for the resident population every day included: Five Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) including the charge nurse on days (6:00 AM to 2:30 PM) and evenings (2:30 PM to 10:30 PM) and four RNs or LPNs for nocturnal shift (10:30 PM to 6:30 AM). On 05/10/2024 at 9:48 AM, the Assistant Administrator confirmed staffing levels particularly licensed nurses were reduced in October 2023, starting with nocturnal shift (10:30 PM to 6:30 AM). The Assistant Administrator explained the reduction in staffing levels was a corporate decision stating budget or monetary reasons. On 05/10/2024 at 10:01 AM, the Administrator confirmed the facility assessment was not updated to reflect changes in staffing levels which began in October 2023. The Administrator confirmed the staffing plan was a substantial component of the facility assessment and which should have been reviewed and updated when the staffing plan changed in October 2023. The Administrator indicated the facility assessment should be reviewed and updated annually and as needed and a change in staffing levels merited a review or update. The facility assessment policy revised October 2018, documented during a review of resident needs and facility resources the facility systematically evaluated how well aligned these were. Each department provided input on current potential gaps in care or services due to possible misalignment or lack of appropriate resources. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/10/24 at 10:07 AM, the Assistant Administrator and the Administrator confirmed the department heads were not involved nor were they consulted on the changes in the staffing plan. The Administrator indicated the input of staff and department heads should have been taken into consideration in line with the facility assessment policy.