STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325030	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Fe Care Center	635 Harkle Road Santa Fe, NM 87505

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 20402 Based on record review, interviews, and facility policy review, the facility failed to have written documentation of the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) CMS [Centers for Medicare and Medicaid Services]-10055 for one of three residents (Resident (R) 27) reviewed for beneficiary notices of 20 sample residents. The facility failed to have written documentation to indicate R27 or their legal representative were notified in writing of the SNFABN, the reason why Medicare might not pay for services, and the estimated daily cost the resident would be responsible for should they choose to receive skilled services. By not having written documentation, the resident was unable to make an informed decision and was unaware of additional costs and services when skilled services are ending. Findings include: Review of the facility's policy titled, Medicare and Medicaid Benefits, revised April 2017, indicated, Residents are provided with information verbally and in writing about how to apply for and use Medicare and Medicaid benefits .Upon admission, and when a resident become eligible for Medicare/Medicaid benefits, a representative of the business office will inform the resident verbally and in writing of: a. the services and items covered under the facility's Medicare/Medicaid payment rate; and b. the charges for non-covered items or services that are available to the resident .When changes are made to items and services covered by Medicare or Medicaid State plans, residents will be informed of these changes as soon as possible .Inquiries concerning Medicare and Medicaid eligibility requirements should be referred to the business office, and/or to the Social Services Department. Review of an undated list of Beneficiary Notice- Residents discharged Within the Last Six Months, document provided by the Administrator, listed residents who were discharged from Medicare covered Part A services with benefit days remaining who either were discharged home, transferred to another facility, or chose to remain in the facility. On the list R27 was the only resident marked as Remaining in the facility. (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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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated document titled, SNF Beneficiary Notification Review for R27, indicated .Medicare Part A Skilled Services Episode State date was: 11/28/23. The last covered day of Part A Services was on 02/29/24 The form indicated, Benefit days weren't exhausted, resident wanted to stay . Further review of the document indicated, Was an SNF/ABN, Form (CMS-10055) provided to the resident? It was marked, No. The reason indicated was, MRA [Medical Reimbursement Arrangement] payor used NOMNC [Notice of Medicare Non-Coverage]. There was no written documentation or evidence that R27 was issued the SNF/ABN, no written documentation of the reason Medicare may not pay for services, and the estimated cost the resident would be responsible for while remaining in the facility was not included. Review of the complete medical record for R27 revealed no documentation that communication took place between R27 and/or representative to discuss potential additional costs that the resident might have to pay if they chose to continue to receive services. During an interview on 07/09/24 at 3:15 PM, the Social Services Director (SSD) stated, If there are a few extra days remaining I let them know that I talked with Physical Therapy and with the cost, if they are needing extra days to stay, I let them know the co-pays. I review the cost per day with them. When specifically asked if the SNFABN document was reviewed with R27 or the representative of R27 to include the estimated costs per day, or why Medicare may not pay for services, the SSD stated that she had not. During an interview on 07/09/24 at 4:44 PM, when asked about the process for issuing the SNFABNs, the Business Office Manager (BOM) stated, I have never issued or seen the SNFABN form. I'm not familiar with this form. When reviewing the SNF Beneficiary Notification Review document for R27 with the SSD and the BOM, the SSD stated a SNFABN was not issued to R27. The SSD stated that R27 chose to remain in the facility and receive services. During a second interview on 07/10/24 at 8:49 AM with the SSD and the BOM regarding R27, the BOM stated that the last covered day for skilled services was 02/29/24 and R27 Did have some remaining days to use for services. We did not use the SNFABN form for her and she is still here in the facility.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 20402 Based on observation, record review, interviews, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure a Significant Change MDS Minimum Data Set was completed within 14 days of a significant change for one of one resident (Resident (R) 10) receiving hospice services of 20 sample residents. Specifically, R10 was admitted to hospice services on 03/18/24 and no significant change MDS was completed within 14 days of the significant change. By not ensuring completion of a significant change MDS, this failure could potentially place the resident at risk for unmet care needs being addressed. Findings include: Review of the MDS-3.0 RAI Manual-v1.17.1, October 2019, under section A0310A Coding Instructions for Significant Change in Status Assessment indicated, If a nursing home resident elects the hospice benefit, the nursing home is required to complete the MDS Significant Change in Status Assessment (SCSA). It further indicated, It is a CMS [Centers for Medicare and Medicaid Services] requirement to have an SCSA completed EVERY time the hospice benefit has been elected, even if a recent MDS was done and the only change is the election of the hospice benefit. Review of the facility's policy titled, Electronic Transmission of the MDS, revised October 2023, indicated All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) .are completed and electronically encoded into our facility's MDS information system . It further indicated, All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the Resident Assessment Instrument (RAI) .The MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data . During an observation made on 07/08/24 at 2:00 PM, R10 was observed sitting in his room in a wheelchair. When attempting to communicate with the resident, he was not able to communicate his needs and could only mumble words. Review of R10's undated Profile page, under the Profile tab in the electronic medical record (EMR) indicated R10 was receiving hospice services. Review of R10's Physician orders, dated 03/18/24, located in the EMR under the Orders tab, indicated Hospice Eval and treat per family request. Additional physician orders, dated 03/19/24, indicated [name of hospice] as of 03/18/24 Dx: [diagnosis] sequelae of cerebrovascular disease. Review of a [name of hospice] New Admission Packet, dated 03/18/24 and located in the EMR under the Misc [Miscellaneous] tab, indicated Resident request for Hospice care in a Nursing facility. The document was signed by R10's representative on 03/18/24. Review of a Hospice Physician Order located in R10's EMR under the Misc tab, dated 03/18/24, and electronically signed by the Hospice physician on 03/25/24, indicated Hospice Benefit Period of 03/18/24-06/25/24. Terminal Diagnosis: Unspecified sequelae of unspecified cerebrovascular disease. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Hospice Written Certification document and electronically signed by the Hospice physician on 03/19/24, indicated I certify that [name of R10] is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. The document further indicated a certification period from 03/18/24-06/15/24 and indicated, [name of R10] .primary hospice diagnosis of sequelae of cerebrovascular accident .Patient is referred from his LTC [long term care] facility with overall decline in condition with deterioration in his cognitive condition .Pt. qualified for hospice with a <6mo [less than 6 month] prognosis due to the deteriorating cognitive condition with multiple comorbidities . Review of the Comprehensive Care Plan located in the EMR under the Care Plan tab, dated 03/19/24, indicated [name of R10] on Hospice. My hospice provider is [name of Hospice company]/ Hospice care that focuses on the palliation of a chronically ill, terminally ill, or seriously ill. Interventions are: End of life care as needed . Review of the EMR for R10 revealed there was no significant change MDS completed within 14 days of when R10 went onto hospice services on 03/18/24. During an interview on 07/10/24 at 10:19 AM, regarding a significant change MDS not being completed within 14 days, MDS1 stated that R10 was admitted to hospice services on 03/18/24 and she did not complete a significant change MDS. During this interview, MDS2 stated, There should have been a significant change MDS completed, and I do not see one. There should have been a significant change MDS completed. Yes, but when looking in the EMR, we are not seeing that it was done. It should have been completed within the fourteen-day timeframe. We go by the RAI manual as our guide. During an interview on 07/11/24 at 9:28 AM with, the Director of Nursing (DON) and the Administrator, the DON stated, My expectation would be that the MDS are done and coded accurately, and they are completed in a timely manner. I would be expecting my staff to be reviewing the hospice diagnosis, reason for hospice services, reviewing any progress notes and any doctor orders. Staff would have access to that. Everything is uploaded into our electronic medical records. The Administrator stated, Whenever there is a significant change, that would trigger a significant change in the MDS and there should be a significant change completed. It should be completed whenever there is a change in condition for any of our residents. The DON then stated, I would expect my staff to be following the RAI manual and do a significant change within the 14-day look back period.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on interview, record review, and facility policy review, the facility failed to complete a quarterly assessment for one of one resident (Resident (R) 43) reviewed for completion of Minimum Data Set (MDS) assessments out of 20 sample residents. The facility was overdue by 25 days in completing the quarterly assessment. Findings include: Review of the facility's policy titled, Resident Assessments, revised October 2023, revealed, .OBRA [Omnibus Budget Reconciliation Act]- Required Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. OBRA assessments include .Quarterly Assessment .Non-Comprehensive MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status . Non-comprehensive assessments include Quarterly assessments . Review of R43's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R43 was admitted to the facility on [DATE] with diagnoses that included type two diabetes mellitus, hypothyroidism, peripheral vascular disease, acute hematogenous osteomyelitis, end stage renal disease, and complete traumatic amputation of the right midfoot. Review of R43's MDS tab of the EMR revealed an admission MDS assessment was completed on 08/30/23 and quarterly assessments were completed on 11/30/23 and 03/01/24 for R43. There was no documented evidence that a third quarterly MDS assessment, due by 06/15/24, had been completed for R43. During an interview on 07/10/24 at 3:23 PM, MDS1 confirmed there was a quarterly MDS assessment due in June 2024 for R43. MDS1 confirmed the last MDS assessment completed was on 03/01/24. She stated, I just missed him. MDS1 stated she had a calendar she used to record when MDS assessments were due and that MDS2 checked to make sure she did not miss updating care plans, but R43's quarterly MDS assessment had been missed. She stated, I don't know how I skipped him.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20402 Based on observations, record reviews, interviews, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to accurately code the Minimum Data Set (MDS) for two of three residents (Residents (R) 7 and R10) receiving hospice services and one of three residents (R29) receiving Insulin of 20 sampled residents. By not ensuring the accuracy of the MDS these failures could potentially place the residents at risk for care needs not being addressed. Findings include: Review of the MDS-3.0 RAI Manual-v1.17.1, October 2019, under Section J1400 Prognosis: indicated Definition: Condition or chronic disease that may result in a life expectancy of less than 6 months; In the physician's judgement, the resident has a diagnosis or combination of clinical conditions that have advanced or will continue to advance to a point that the average resident with that level of illness would not be expected to survive more than 6 months. This judgement should be sustained by a physician note .Steps for Assessment: 1. Review the medical record for documentation by the physician that the resident's condition of chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness. 2. If the physician states that the resident's life expectancy may be less than 6 months, request that he or she document this in the medical record. 3. Review the medical record to determine whether the resident is receiving hospice services. Coding Instructions: Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services. Code 1, yes: if the medical record includes physician documentation: 1) that the patient is terminally ill; or 2) the resident is receiving hospice services . Section O0100K, Hospice Care, Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. Review of the facility's policy titled, Electronic Transmission of the MDS, revised October 2023, indicated All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) .are completed and electronically encoded into our facility's MDS information system . It further indicated, All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the Resident Assessment Instrument (RAI) .The MDS coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data . Review of the facility's policy titled, Resident Assessments, revised October 2023, revealed, .Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews . 1. During an observation on 07/08/24 at 2:15 PM, R7 was observed to be sitting in a wheelchair with oxygen on. At this time, R7 was not able to communicate her needs. Review of R7's undated Profile page, under the Profile tab in R7's electronic medical record (EMR) indicated R7 was receiving hospice services. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physician orders, dated 06/07/23, located in R7's EMR under the Orders tab, indicated Admit to [name of hospice] effective today 06/07/23. Review of a Hospice Physician Order located in R7's EMR under the Misc tab, dated 06/07/23 and electronically signed by the Hospice physician on 06/07/23, indicated, Hospice Benefit Period of 06/07/23-08/04/23. Terminal Diagnosis: Malignant Neoplasm of brain, unspecified. Review of the Comprehensive Care Plan located in R7's EMR under the Care Plan tab, dated 06/08/23, indicated [name of R7] on Hospice. My hospice provider is [name of Hospice company]. Hospice care that focuses on the palliation of a chronically ill, terminally ill, or seriously ill. Interventions are: End of life care as needed . Review of R7's quarterly MDS located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 10/18/23, revealed Section J and Section O of the MDS were completed by MDS1 on 11/02/23. Section J1400 of the MDS Prognosis was coded as No for R7 not having a terminal condition or chronic disease that may result in a life expectancy of less than 6 months. Hospice of the MDS was coded as While a resident at the facility was receiving hospice services. This MDS was identified as being coded incorrectly as R7 had been receiving hospice services since 06/07/23. Review of an additional Hospice Physician Order located in R7's EMR under the Misc tab, dated 05/01/24, and electronically signed by the hospice physician on 05/01/24, with Benefit period of 04/02/24-05/31/24 indicated, Terminal Diagnosis: Malignant neoplasm of brain, unspecified. Review of R7's annual MDS located in the EMR under the MDS tab, with an ARD date of 04/19/24, revealed Section J and Section O of the MDS were completed by MDS1 on 04/26/24. Section J1400 of the MDS was coded as No for R7 not having a terminal condition or chronic disease that may result in a life expectancy of less than 6 months. Section O0110.K1 Hospice of the MDS was coded as While a resident at the facility R7 was not receiving hospice services. This MDS was identified as being coded incorrectly as R7 had been receiving hospice services since 06/07/23. During an interview on 07/10/24 at 9:41 AM, Assistant Director of Nursing (ADON) 1 stated, She [referring to R7] never came off hospice services. To my knowledge, she has always had a terminal diagnosis and has been on hospice since 2023. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/24 at 9:43 AM, regarding the coding of the MDS for R7, MDS1 stated that R7 was admitted to hospice services 06/07/23. MDS1 confirmed that she completed Hospice on both the quarterly MDS for R7 on 10/18/23 and the annual MDS on 04/19/24. During the interview, MDS1 stated, I look at physician orders to see when hospice started and that is all the documentation I review. When asked if any additional documentation was reviewed when completing Section J and Section O of the MDS, MDS1 stated, No. When reviewing the inaccurate coding with MDS1 from the 10/18/23 quarterly MDS, and the 04/19/24 annual MDS, MDS1 stated, It was just my error that they are coded incorrectly. I see on the quarterly Section J it is marked with no terminal prognosis. It is marked No. I'm seeing Section O was marked yes as receiving hospice services. MDS1 then stated, I completed the annual on 04/19/24 and I'm seeing I marked it as 'No' for a terminal prognosis and Section O is marked 'No' for receiving hospice. MDS1 stated, I think what happens is when the system is updated, it will automatically populate in the system and if I'm in a hurry, I may not always catch it. Every now and then, I will miss one, I'm only looking for red areas that are highlighted in the system and yes, I may have missed it. MDS1 stated, She [referring to R7] has not come off of hospice services. MDS1 further stated that she used the RAI manual to go by when coding the MDS. 2. During an observation made on 07/08/24 at 2:00 PM, R10 was observed sitting in his room in a wheelchair. When attempting to communicate with the resident, he was not able to communicate his needs and could only mumble words. Review of R10's undated Profile page, under the Profile tab in R10's EMR indicated R10 was receiving hospice services. Review of Physician orders, dated 03/18/24, located in R10's EMR under the Orders tab, indicated Hospice Eval and treat per family request. Additional physician orders, dated 03/19/24, indicated [name of hospice] as of 03/18/24 Dx: [diagnosis] sequelae of cerebrovascular disease. Review of a Hospice Physician Order located in R10's EMR under the Misc tab, dated 03/18/24, and electronically signed by the Hospice physician on 03/25/24, indicated Hospice Benefit Period of 03/18/24-06/25/24. Terminal Diagnosis: Unspecified sequelae of unspecified cerebrovascular disease. Review of the Comprehensive Care Plan located in R10's EMR under the Care Plan tab, dated 03/19/24, indicated [name of R10] on Hospice. My hospice provider is [name of Hospice company]. Hospice care that focuses on the palliation of a chronically ill, terminally ill, or seriously ill. Interventions are: End of life care as needed . Review of R10's quarterly MDS located in the EMR under the MDS tab, with an ARD of 04/16/24, revealed Section J and Section O of the MDS were completed by MDS1 on 04/25/24. Section J1400 of the MDS Prognosis was coded as No for R10 not having a terminal condition or chronic disease that may result in a life expectancy of less than 6 months. Section O0110.K1 Hospice of the MDS was coded as While a resident at the facility was not receiving hospice services. This MDS was identified as being coded incorrectly as R10 had been receiving hospice services since 03/18/24. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/24 at 10:19 AM, regarding the coding of the MDS for R10, MDS1 stated that R10 was admitted to hospice services on 03/18/24. MDS1 confirmed that she completed Section J1400 and Section O0110.K1 Hospice on the quarterly MDS for R10 on 04/16/24. During the interview, MDS1 stated that she coded Section J as No as R10 not having a terminal condition or life expectancy of less than 6 months, and coded Section O as not receiving hospice services. When asked why, MDS1 stated, Same as before. I only would have reviewed the physician orders. I just missed it. It's the same reason as before. I didn't catch it for hospice. During an interview with the Director of Nursing (DON) and the Administrator on 07/11/24 at 9:28 AM, regarding the inaccurate coding of the MDS for R7 and R10, the DON stated, It would be my expectation that the MDS are done and coded accurately and also completed in a timely manner. When the DON was asked what documentation she would expect her staff to review specifically for residents receiving hospice services, the DON stated, I would expect my staff to be reviewing the hospice diagnosis, the reason for hospice services, any progress notes, and any doctor orders. The staff would have access to that since everything is uploaded into our electronic medical records. The DON and Administrator then stated that they were not aware of the MDS being coded inaccurately for R7 and R10. 25225 3. Review of R29's Admission Record, located under the profile tab of the EMR, revealed R29 was readmitted to the facility on [DATE] with diagnoses that included type two diabetes mellitus. Review of R29's quarterly MDS with an ARD of 05/02/24 and located under the MDS tab of the EMR, revealed coding that R29 had received insulin injections on seven of the preceding seven days. Review of R29's Physician Orders, located under the Orders tab of the EMR, revealed no orders for R29 to receive insulin. It was ordered R29 was to receive semaglutide (Ozempic) injections, an antidiabetic medication, once weekly. During an interview on 07/10/24 at 3:27 PM, MDS1 confirmed R29 was not receiving insulin. MDS1 stated R29 had been started on Ozempic, and she did not know how to capture the injection for MDS assessment and payment purposes, so she left it as an insulin injection. MDS1 confirmed the 05/02/24 MDS assessment was inaccurately coded. MDS1 confirmed she knew that medications were supposed to be coded by their pharmaceutical classification and that Ozempic was not an insulin. During an interview on 07/10/24 at 3:54 PM, the Administrator and Director of Nursing (DON) stated it was their expectation for MDS assessments to be coded accurately.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750 Based on observation, interview, record review and facility policy review, the facility failed to ensure a comprehensive care plan was developed for three of 20 sample residents (Resident (R) 43, R47, and R67) reviewed for care plans to include dialysis with a central venous catheter (CVC) for R43, oxygen for R47, and Post Traumatic Stress Disorder (PTSD) for R67. This deficient practice had the potential for residents to not receive the care and treatment they needed. Findings include: Review of the facility's policy titled, Care Plans, Comprehensive Person Centered, revised March 2022, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation .3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .7. The comprehensive, person-centered care plan: a. includes measurable objectives and time frames: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical. mental. and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment .(3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions . 1. Review of R43's Admission Record located in the electronic medical record (EMR) under the Profile tab, indicated R43 was admitted on [DATE] with end stage renal disease, and complete traumatic amputation of right midfoot. Review of the Orders located in the EMR under the Orders tab, revealed on 11/17/23 R43 was to receive dialysis on Mondays, Wednesdays, and Fridays. Review of Instructions for After Care for a Central Line located in the EMR under the Miscellaneous tab, revealed R43 had received a CVC on 04/04/24. Review of the quarterly Minimum Data Set (MDS) assessment located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 03/01/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident had intact cognition. The MDS triggered dialysis. During an interview on 07/08/24 at 1:21 PM, R43 stated he had a catheter for dialysis treatments on the right side of his chest. Review of the Care Plan located in the EMR under the Care Plan tab, revealed R43 did not have a care plan for dialysis or for the CVC. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/11/24 at 9:19 AM, MDS1 and MDS2 were asked to review the care plan and if they found a care plan for dialysis and the CVC. MDS1 stated she did not see one. She stated that there should have been one. MDS2 stated R43 had just gotten the CVC. When asked if R43 should have been care planed for the catheter, MDS2 stated, Yes. 2. Review of R47's Admission Record located in the EMR under the Profile tab, indicated R47 was admitted on [DATE] with diagnoses of acute respiratory failure with hypoxia (an absence of enough oxygen to sustain the function of the body tissue). Review of the Orders located in the EMR under the Orders tab, revealed on 04/08/24 R47, requires supplemental oxygen at 2 liters per minute via NC. Keep O2 sats (saturation) above 90%. Titrate off for RA [room air] sat greater than 90%. Review of the MDS located in the EMR under the MDS tab with an ARD of 04/16/24 revealed a BIMS score of 15 out of 15 which indicated the resident had intact cognition. The MDS revealed oxygen was triggered. During an observation on 07/08/24 at 2:28 PM, R47 was in bed with oxygen on through nasal canula (NC) attached to an oxygen (O2) concentrator at two liters per minute (lpm). Review of the Care Plan located in the EMR under the Care Plan tab, revealed R47 did not have a care plan for oxygen. During an interview on 07/11/24 at 9:28 AM, MDS1 and MDS2 were both asked if they could find a care plan addressing oxygen. Both verified no and stated yes there should have been one. 3. Review of R67's Admission Record located in the EMR under the Profile tab, indicated R67 was admitted on [DATE] with diagnoses of post-traumatic stress disorder, unspecified. Review of the MDS located in the EMR under the MDS tab with an ARD of 02/07/24 revealed a BIMS score of 15 out of 15 which indicated the resident had intact cognition. The MDS triggered PTSD. During an interview on 07/08/24 at 3:52 PM, R67 indicated he had a diagnosis of PTSD. Review of the Care Plan located in the EMR under the Care Plan tab, revealed R67 did not have a care plan for PTSD. During an interview on 07/11/24 at 1:35 PM, MDS2 looked to see if R67 was care planned for PTSD. MDS2 stated she did not see a care plan. MDS2 stated yes there should have been a care plan that indicated what triggered his PTSD. MDS2 added, That is why he does not have a roommate because he does not get a long. During an interview on 07/11/24 at 1:32 PM, the Director of Nursing (DON) stated, There should be a person-centered care plan for residents and all their health and psychosocial issues.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a medication order was written to include proper dosage for the prescribed medication per current standards of practice for one of three residents (Resident (R) 50) observed for medication administration out of a total of 87 residents. This had the potential to cause residents to receive the wrong dosage of ordered medications. Findings include: Review of the facility's policy titled, Medication Orders, revised November 2014, revealed .When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered . Review of R50's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R50 was admitted to the facility on [DATE] with diagnoses that included pain in right shoulder. Review of R50's Physician Orders, dated 07/01/24 and located under the Orders tab of the EMR, revealed an order for R50 to receive, Lidoderm External Patch (used to treat pain) 5% .Apply to affected area topically one time a day for pain. Applied to both shoulders in the morning and off at bedtime . During an observation on 07/09/24 at 8:29 AM, Licensed Practical Nurse (LPN) 3 was observed administering R50's medications. LPN3 applied a 4% Lidoderm patch to R50's right shoulder. During an interview on 07/10/24 at 9:12 AM, LPN3 confirmed she had applied a 4% Lidoderm patch to R50's right shoulder. LPN3 was asked why a 5% patch was not applied. She stated that the facility only had 4% patches because that was what insurance would pay for. LPN3 was asked to review R50's orders for the dosage. She reviewed the EMR and stated there was no dosage recorded on the medication administration record (MAR) for the Lidoderm patches. Review of the MAR, dated July 2024 and located under the Orders tab of the EMR, revealed there was no dosage recorded for R50's Lidoderm patch on the MAR. During an interview on 07/10/24 at 9:46 AM, the Nurse Practitioner (NP) stated she wanted R50 to receive Lidoderm 4% patches because the insurance would not pay for 5%. The NP stated she did not know where the 5% listed on the order came from because she did not write it. She stated she did not ever write a dosage when ordering Lidoderm patches because the 4% patches were an over-the-counter medication, and the EMR did not require her to enter a dosage. The NP was asked what current standards of practice were related to including dosages on medication orders. She stated it depended on the medication. During an interview on 07/10/24 at 3:18 PM, the Director of Nursing (DON) stated her expectation, and the current standard of practice was for all medication orders to be written with a dosage included.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, and review of facility policy, the facility failed to assess the cause of a continual, gradual, and unintentional weight loss and failed to identify and implement interventions to prevent further weight loss for one of four residents (Resident (R) 12) reviewed for nutrition out of 20 sample residents. This had the potential to contribute to a significant to severe weight loss for R12. Findings include: Review of the facility's policy titled, Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, revised September 2017, revealed .The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparison over time .The staff and physician will .identify individuals with .weight loss .The staff and physician will identify pertinent interventions based on identified causes and overall resident condition, prognosis, and wishes . Review of R12's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R12 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis, asthma, hypertension, and vitamin D deficiency. Review of R12's Physician Orders, dated 07/19/22, revealed R12 was to receive a regular diet with pureed texture and thin liquids. There were no orders for a physician prescribed weight loss program. There were no orders for any supplements or fortified foods. Review of R12's Weights, located under the Wts (Weights)/Vitals tab of the EMR, revealed the following weights for R12: -01/01/24 - 137.6 lbs. -02/01/24 - 139.6 lbs. -03/01/24 - 135.6 lbs. -04/01/24 - 131.8 lbs. -05/01/24 - 130.8 lbs. (4.9% weight loss in 4-months) Review of R12's Quarterly Dietary Interview, dated 05/10/24, written by the Dietary Manager (DM) and located under the Assessments tab of the EMR, revealed .[R12] meal intake 75-100% Dependent while dining .Current weight 130.8#, gradual weight loss x 3 months, BMI 24.7 .will refer to RD [Registered Dietician] on next scheduled visit r/t [related to] gradual weight loss, will continue to monitor daily intake and weight as ordered . Review of R12's Assessments tab, Progress Notes tabs, and Misc (miscellaneous) tabs of the EMR revealed no documented evidence of an assessment or evaluation by the RD after the 05/10/24 Quarterly Dietary Interview through 07/10/24. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R12's Care Plan, dated 05/10/24 and located under the Care Plan tab of the EMR, revealed a focus of R12 receiving a regular diet with puree texture. It was recorded R12 was at risk for weight loss and dehydration related to the use of constipation medications and a history of gradual non-significant weight loss. Interventions included honoring R12's food preferences, providing a diet as ordered, monitoring weights and documenting changes, and Dietary Recommends: There were no dietary recommendations recorded. Review of the care plan revealed no documented evidence of a weight loss plan. Review of R12's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/22/24 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated R12 was moderately cognitively impaired. It was recorded R12 was dependent on staff for eating, weighed 131 lbs., did not have a weight loss of 5% or more in the last month or 10% in the last six months, and received a therapeutic diet. Review of R12's Weights, located under the Wts (Weights)/Vitals tab of the EMR revealed the following weights for R12: -06/01/24 128.8 lbs. -07/03/24 127.2 lbs. (7.5% weight loss in 6-months) During an observation on 07/08/24 at 12:30 PM, R12 was observed in the main dining room, being fed by staff. During an interview on 07/09/24 at 5:53 PM, the RD stated she was at the facility once weekly. She stated she attended the IDT (interdisciplinary team) meetings and weight variances were discussed. The RD stated the facility provided her with weights, and she documented that in the EMR. The RD was asked if she had responded to the referral written by the DM regarding R12's gradual weight loss. She stated she had looked at the weights provided by the facility, and there were no significant weight losses. The RD stated, I only intervene if there is a significant weight loss. She stated since R12 had not had a significant weight loss, she would not have charted on it. The RD stated unless a resident had something else going on, like a pressure ulcer, to go along with a gradual weight loss, she would not chart on it. The RD was asked if she would not intervene with an unexplained gradual weight loss. She stated, There are times I would if there was an insidious loss. The RD stated that when she came to the facility for her visits, the DM would talk with her about any concerns. The RD stated she did not recall if the DM had brought R12's weight loss to her attention. The RD stated she did not believe there had been any nutritional interventions implemented for R12 during 2024. The RD stated R12's weight was above her ideal weight, so weight loss would make things easier for the resident. The RD was asked if R12 or her responsible party had verbalized they wanted R12 to lose weight. She stated, I'm not sure. I would have to check. During an interview on 07/09/24 at 6:17 PM, the DM stated she had provided R12's 05/10/24 dietary interview information to the RD but did not document it. She stated it was her role to look at gradual weight losses. The DM stated R12 had been experiencing a continuing gradual weight loss since January 2024 despite consuming the majority of her meals. During an observation on 07/10/24 at 12:20 PM, R12 was observed in the main dining room, being fed by staff. It was noted R12 had consumed more than 75% of her meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/24 at 4:19 PM, the Administrator and Director of Nursing (DON) stated the RD should have attempted to identify and implement interventions for R12's gradual weight loss.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750 Based on observation, interview, record review and facility policy review, the facility failed to ensure the oxygen (O2) concentrators had a filter or dust free filters on the inlet where the air came into the machine for five of five residents (Resident (R) 7, R19, R16, R47, and R132) of 20 sample residents. This deficient practice had the potential to allow an increased chance of infection and unnecessary respiratory treatment. Findings include: Review of the facility's policy titled, Departmental (Respiratory Therapy)- Prevention of Infection, revised November 2011, revealed Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff . Steps in the procedure: Infection control Considerations Related to Oxygen Administration .9. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry . Review of the facility's policy titled, Oxygen Administration, dated October 2010 and provided by the facility, indicated Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. The policy further indicated, Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. 1. Review of R7's undated Face Sheet located in R7's electronic medical record (EMR) under the Med Diag (Medical Diagnosis) tab, indicated diagnoses to include hypoxemia (a low level of oxygen in the blood), and COPD (chronic obstructive pulmonary disease). Review of Physician Orders, dated 03/22/22 and located in R7's EMR under the Orders tab, indicated Change 02 [oxygen] tubing, water weekly and clean filter every day shift every Mon [Monday] to ensure infection control . Review of Physician Orders, dated 11/06/23 and located in R7's EMR under the Orders tab, indicated Oxygen @ 2L PM [at 2 liters per minute] via NC [nasal cannula] to keep saturations >90%. Review of the Care Plan, revised on 03/23/22 and located in R7's EMR under the Care Plan tab, indicated [R7] has COPD and hx [history] of smoking. She requires supplemental oxygen. Interventions on the care plan included, Change 02 tubing/water weekly and clean filter. During an observation on 07/08/24 at 1:03 PM, R7's oxygen concentrator was located in R7's room and was observed to have a black oxygen filter on the back of the concentrator. It was observed to be full of a buildup of white lint and heavy debris and was observed to be very dirty. A large amount of white lint was observed in the filter at this time. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/08/24 at 2:00 PM, R7's oxygen concentrator filter was again observed to have a very thick buildup of white lint and debris on the filter. When checked, a large amount of white lint was also observed to fall out off the back of the oxygen concentrator where the filter was located. During observations on 07/09/24 at 8:25 AM and at 8:44 AM, R7's oxygen concentrator filter was observed to have the same amount of dust buildup, full of debris and large amount of white lint buildup from the day before. When checked, the inside of the oxygen filter was observed to also have a large amount of white lint buildup coming out of the port holes on the back of the oxygen concentrator. During an interview on 07/09/24 at 3:33 PM, Licensed Practical Nurse (LPN) 3 was asked who was responsible for ensuring the oxygen filters were cleaned. LPN3 stated, Either Central Supply, the CNAs (Certified Nurse Aides) or me (with nursing). We should be changing them out at least once a week. I believe on Mondays on day shifts or if not, on evening shift. LPN3 stated, With the oxygen filters, we don't have extra of those, so the CNAs should be rinsing them off, or [name of Central Supply person] or the nurses get them and rinse them and put them back. During an observation and interview on 07/09/24 at 3:39 PM, R7's oxygen concentrator filter, in the presence of LPN3, was observed to have the same thick buildup of dust, lint, and heavy debris. When LPN3 observed this, she stated, It's a dusty filter for sure. When asked if she was aware of the heavy buildup of lint, dust, and debris on the oxygen filter, LPN3 stated, No, I don't think the staff even opened this to check it. LPN3 then stated, It's dirty. I will let someone know. We need to do an in-service on this. LPN3 then stated, I think [name of Central Supply person] is supposed to check these, but I'm not sure if anybody is specifically checking the filters. It is all of our responsibility. To me, it should be all of our responsibility to be checking the oxygen filters and making sure they are changed out and cleaned. During an interview on 07/09/24 at 3:43 PM, the Hospitality Aide (HA) stated, If the water in the oxygen humidifier is empty, I change it out and the oxygen tubing, I change that out and put a new cannula with the date, but the oxygen filters, No. I don't do anything with the filters. I don't know who is supposed to change those out. During an interview on 07/09/24 at 3:46 PM, the Central Supply (CS) staff was asked if he changed out the oxygen concentrator filters, he stated, Yes, if I see it's very dirty, I will change them myself. I do routine rounds every Monday and I keep a log. When specifically asked how often the oxygen concentrator filters were changed and cleaned, he stated, Every six months I would say. When the CS person was asked if he was checking the oxygen filters when his rounds were being done on Mondays, he stated, Yes, everything gets checked. When he was asked if he was aware of the heavy buildup of dust, lint, and heavy debris located on R7's oxygen concentrator, the CS person stated, I wasn't aware. I would expect the staff to let me know if there is a heavy buildup of dust on those, since I'm in charge of it all. I wasn't informed of anything. It would only take less than two minutes to fix. We would just rinse them with hot water. Review of an audit sheet located in the Central Supply mailbox, dated 07/08/24 and provided by the Director of Nursing (DON), indicated R7's name was on the list and date of her audit was 07/08/24, however there was no documentation to confirm R7's oxygen filter had been observed, cleaned, changed out, by any staff. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 07/09/24 at 3:52 PM, the DON stated, Nursing on the night shift should be changing out the oxygen humidifiers. They can change out the equipment and with filters, our staff can clean those as well. During an observation of R7's oxygen concentrator filter in the presence of the DON, there was still a large amount of thick heavy white debris, dust, and white lint observed on R7's oxygen filter. At this time, the DON stated, I see it needs to be changed. I was not made aware of this, and I can see it needs to be cleaned out. We meet daily with nursing in our clinical meetings, and they should also be documenting this in the chart. I would say, by looking at this [referring to R7's oxygen concentrator filter] it is very dirty and needs to be cleaned right away. During an interview on 07/10/24 at 8:20 AM, the CS staff stated, With my audits, they are done every Monday. I change out the cannulas and I do the audits one resident at a time. I go to each room. When asked if he observed the heavy buildup of lint, dust, and debris on R7's oxygen filter, or changed it out during his audit on 07/08/24, he stated, As far as the filter, I may have missed it. I may have been called away to do something else. I'm not sure. I don't remember looking at her concentrator to be honest with you. That is something I normally do on my audits, and I may have missed it. During an interview on 07/11/24 at 9:28 AM with the DON and Administrator regarding the responsibility of ensuring resident oxygen filters were being cleaned, the Administrator stated, Central Supply is supposed to be completing audits and checking the filters to make sure they are being cleaned. The DON stated, They should also be cleaned every seven days on Mondays. When both the Administrator and DON were asked if they were aware, or made aware by any staff of R7's oxygen concentrator filter not being cleaned, or having a large amount of dust, and debris, both stated, No. The DON stated, I was not made aware until we both observed it and you showed it to me. 2. Review of R19's Admission Record, located under the Resident tab of the EMR, revealed R19 was admitted on [DATE] with diagnoses lobar pneumonia, unspecified organism, muscle weakness (generalized), and other malaise. Review of R19's quarterly Minimum Data Set (MDS) located in the EMR under the RAI [Resident Assessment Instrument] tab with an Assessment Reference Date (ARD) of 06/12/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated R19 was cognitively intact. Review of R19 's Physician Order Sheet, located in the EMR under the Resident tab, revealed the following order, dated 07/10/24: Oxygen (O2) 1-5l/min to keep O2 sats 90% or better; every shift for sob (shortness of breath). During observations on 07/08/24 at 10:32 AM and, 07/09/24 at 10:26 AM, R19's oxygen concentrator had a dust filled filter. 3. Review of R16's Admission Record, located under the Resident tab of the EMR, revealed R16 was admitted on [DATE] with diagnoses of persistent vegetative state, and anoxic brain damage, not elsewhere classified. Review of R16's quarterly MDS located in the EMR under the RAI tab with an ARD of 06/10/24 revealed the resident had a BIMS score of zero out of 15, indicating R16 had severely impaired cognition. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R16 's Physician Order Sheet, located in the EMR under the Resident tab, revealed the following order, dated 06/14/24: Oxygen (O2) 1-5l/min to keep O2 sats 90% or better; two times a day. During observations on 07/08/24 10:30 AM and 07/10/24 9:42 AM, R16's oxygen concentrator had a dust filled filter. During an interview on 07/10/24 at 10:04 AM, Assistant Director of Nursing (ADON) 2 observed the oxygen concentrator in R16's room and stated the filter was dirty and she would get it cleaned. During an interview on 07/10/24 1:31 PM, ADON1 stated oxygen concentrator filters were cleaned weekly on Sunday evenings during the night shift. During an interview on 07/10/24 1:45 PM, the Director of Nursing (DON) stated oxygen concentrator filters should be cleaned every seven days. 4. Review of R47's Admission Record located in the EMR under the Profile tab, indicated R47 was admitted on [DATE] with diagnoses of acute respiratory failure with hypoxia (an absence of enough oxygen to sustain the function of the body tissue). Review of the Orders located in the EMR under the Orders tab, revealed on 04/08/24 R47 requires supplemental oxygen at 2 liters per minute via NC. Keep O2 sats (saturation) above 90%. Titrate off for RA [room air] sat greater than 90%. During an observation on 07/08/24 at 2:28 PM, R47 was in bed with oxygen on through nasal canula (NC) attached to an oxygen concentrator at two liters per minute. The concentrator did not have a filter on the inlet where the air entered the machine. During an observation on 07/09/24 at 9:30 AM, the concentrator did not have a filter on the inlet. R47 was sitting in bed with NC on. During an interview on 07/10/24 at 2:20 PM, Registered Nurse (RN) 3 was asked to look at the concentrator and look for the filter. RN3 looked at the machine and stated there was no filter. RN3 stated, There should be a filter. RN3 was asked who should see that there was a filter on the concentrator. RN3 stated the nurses should on Mondays when they change the tubing. 5. Review of R132's Admission Record located in the EMR under the Profile tab, indicated R132 was admitted on [DATE] with diagnoses of COPD and obstructive sleep apnea. Review of the Orders located in the EMR under the Orders tab, revealed on 06/19/24 R132, oxygen at 3-5 liters via nasal canula continuous to maintain saturation of 90% or greater. During an observation on 07/08/24 at 10:30 AM, R132 was observed in her room wearing a NC. There was a concentrator in her room with no filter on the inlet. During an interview on 07/10/24 at 2:25 PM, RN3 was asked to look at the concentrator and look for the filter. RN3 looked at the machine and stated there was no filter. RN3 stated, There should be a filter. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 0710/24 at 2:29 PM, the DON was asked her expectations for residents receiving oxygen therapy. The DON stated, I expect the equipment to be complete to include the inlet filters. The filters are there to keep dust and whatever is in the air out. 20402 27375

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F 0757 Level of Harm - Minimal harm or potential for actual harm 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** 25225 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the resident did not receive an unnecessary medication when they failed to perform physician ordered blood pressure monitoring prior to the administration of lisinopril (a medication used to treat hypertension) and failed to withhold the blood pressure medication with low blood pressure readings according to the physician ordered parameters for one of five sampled residents (Resident (R) 48) reviewed for unnecessary medications out of 20 sample residents. This had the potential to cause R48 to suffer adverse consequences including hypotension. Findings include: Review of the facility's policy titled, Medication Utilization and Prescribing - Clinical Protocol, revised April 2018, revealed .The physician and staff will identify any situation in which a resident is taking medications associated with potentially significant medication related problems .The physician and staff will evaluate the effectiveness and effects of the medications in a resident's regimen . Review of R48's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R48 was readmitted to the facility on [DATE] with diagnoses that included essential hypertension. Review of R48's Physician Orders, dated 12/01/23 and located under the Orders tab of the EMR, revealed R48 was to receive lisinopril 40 milligrams (mg) one tab daily and to hold the medication if R48's systolic blood pressure was less than 100. Review of R48's Blood Pressures, dated 04/01/24 through 07/09/24 and located under the Wts (weights)/Vitals) tab of the EMR, and Medication Administration Record (MAR), dated 04/01/24 through 07/09/24 and located under the Orders tab of the EMR, revealed the following: -April 2024 - R48's blood pressure was only recorded on seven of 30 days; however, it was recorded R48 received lisinopril on 30 of 30 days. There was no documented evidence R48's blood pressure was monitored on 23 days before the administration of lisinopril. -May 2024- R48's blood pressure was only recorded on 14 of 31 days; however, it was recorded R48 received lisinopril on 31 of 31 days. There was no documented evidence R48's blood pressure was monitored on 17 days before the administration of lisinopril. On 05/14/24, R48's blood pressure was recorded to be 90/57 and on 05/14/24, R48's blood pressure was recorded to be 91/52. It was recorded R48 received lisinopril on both days even though the systolic blood pressure was less than 100. -June 2024 - R48's blood pressure was only recorded on 11 of 30 days; however, it was recorded R48 received lisinopril on 30 of 30 days. There was no documented evidence R48's blood pressure was monitored on 19 days before the administration of lisinopril. On 06/07/24, R48's blood pressure was recorded to be 86/49 and on 06/30/24, R48's blood pressure was recorded to be 97/50. It was recorded R48 received lisinopril on both days even though the systolic blood pressure was less than 100. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-07/01/24 through 07/09/24 - R48's blood pressure was only recorded on one day; however, it was recorded R48 received lisinopril on nine of nine days. There was no documented evidence R48's blood pressure was monitored on eight days before the administration of lisinopril. During an observation and interview on 07/10/24 at 8:26 AM, Licensed Practical Nurse (LPN) 5 was observed preparing medications for R48. LPN5 confirmed it was ordered to monitor R48's blood pressure prior to the administration of lisinopril. LPN5 directed a nurse aide to obtain R48's blood pressure reading. During an interview on 07/10/24 at 3:31 PM with the Administrator and Director of Nursing (DON), the DON stated her expectation was for a resident's blood pressure to be taken and recorded in the electronic medical record if there were physician ordered parameters to be followed with blood pressure medications. The DON confirmed that R48's lisinopril should not be administered if the systolic blood pressure was less than 100. The DON stated the machines used to obtain blood pressures were set up to automatically enter the blood pressure reading into the EMR. She stated the only time a staff member would have to record it is if the blood pressure reading was taken manually. The Administrator reviewed the blood pressure readings for R48 and confirmed they were taken inconsistently.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a medication error rate of less than 5% with five errors out of 25 opportunities which resulted in a 20% error rate for three of three residents (Resident (R) 50, R48, and R56) observed for medication administration out of a total of 87 residents. The facility failed to ensure Lidoderm patches (used for neuralgic pain) were applied or removed as ordered by the physician for R50, levothyroxine (used to treat hypothyroidism) and lisinopril (used to treat hypertension) were administered as ordered by the physician for R48, and Vitamin B-12 was administered in the correct dosage for R56. This failure had the potential to affect resident medication safety. Findings include: Review of the facility's policy titled, Administering Medications, revised April 2019, revealed, .Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders, including any required time frame . 1. Review of R50's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R50 was admitted to the facility on [DATE] with diagnoses that included pain in right shoulder. Review of R50's Physician Orders, dated 07/01/24 and located under the Orders tab of the EMR, revealed an order for R50 to receive, Lidoderm External Patch .Apply to affected area topically one time a day for pain. Applied to both shoulders in the morning and off at bedtime . During an observation on 07/09/24 at 8:29 AM, Licensed Practical Nurse (LPN) 3 was observed administering R50's medications. LPN3 entered R50's room and lifted his shirt. An undated Lidoderm patch was noted to R50's right shoulder. There was no patch on the left shoulder. LPN3 removed the patch on the right shoulder and asked R50 where he would like the new Lidoderm patch to be positioned on his right shoulder. LPN3 applied the Lidoderm patch and began to reposition R50's clothing. LPN3 noted there was a Lidoderm patch stuck inside R50's shirt. LPN3 removed the Lidoderm patch and exited R50's room. Review of R50's Medication Administration Record (MAR), dated 07/09/24 and located under the Orders tab of the EMR, and Progress Notes, dated 07/09/24 and located under the Progress Notes tab of the EMR, revealed no documented evidence that R50 had refused a Lidoderm patch to his left shoulder. There was no documented evidence of removal of the Lidoderm patches at bedtime on 07/08/24. During an interview on 07/10/24 at 9:12 AM, LPN3 was asked to read R50's physician's order for the Lidoderm patch. LPN3 stated, He doesn't want them for both shoulders. LPN3 stated R50 refused at times, and she had already asked him if he wanted a Lidoderm patch on both shoulders. LPN3 was asked if the order read for the Lidoderm patch to be removed at night. She stated, Yes. LPN3 was asked where removal of the patch would be documented. She stated, I don't work nights. LPN3 confirmed there had been a Lidoderm patch on R50's right shoulder on 07/09/24 at 8:29 AM and she had to remove it when she went to apply the new patch. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/10/24 at 9:46 AM, the Nurse Practitioner (NP) stated, If I wrote bilateral shoulders, that is what they [staff] are supposed to do. The NP stated the Lidoderm patch was supposed to be removed at night, but the electronic charting system did not allow for the removal to be listed on MAR. The NP stated she would have to re-educate the staff. 2. Review of R48's Admission Record, located under the Profile tab of the EMR, revealed R48 was admitted to the facility on [DATE] with diagnoses that included hypothyroidism and essential hypertension. Review of R48's Physician Orders, located under the Orders tab of the EMR, revealed an order, dated 06/01/24, for levothyroxine 175 micrograms (mcg) one tab daily and an order, dated 12/01/23, for lisinopril 40 milligrams (mg) one tab daily, hold if systolic blood pressure less than 100. During an observation on 07/10/24 at 8:26 AM, LPN5 was observed preparing medications for R48. LPN5 obtained R48's levothyroxine medication card, stated R48 refused the medication most of the time and then placed the medication card to the side. LPN5 did not place any levothyroxine in R48's medication cup. LPN5 stated R48's systolic blood pressure was above 100, so she would receive the ordered lisinopril. LPN5 placed the lisinopril medication card to the side without placing any into R48's medication cup. At 8:33 AM, LPN5 was asked to count the number of pills that were in R48's medication cup. She stated, Six. LPN5 entered R48's room and administered the medications from the medication cup. At 8:36 AM, LPN5 was asked what medications had been provided to R48. LPN5 reviewed the EMR and named seven medications. She was asked how many medications she had counted in the cup prior to administration. LPN5 stated, Six, what did I miss? LPN5 was informed she did not administer the lisinopril. During an interview on 07/10/24 at 8:51 AM, LPN5 was asked why she did not attempt to administer R48's levothyroxine. LPN5 stated, I usually ask, but I didn't this time. LPN5 stated R48 usually refused her levothyroxine because her dentist told her that it was causing her teeth to loosen. LPN5 stated, I should have asked her if she wanted to take it. 3. Review of R56's Admission Record, located under the Profile tab of the EMR, revealed R56 was admitted to the facility on [DATE] with diagnoses that included essential hypertension. Review of R56's Physician Orders, dated 07/04/24 and located under the Orders tab of the EMR, revealed R56 was to receive Vitamin B-12 500 mcg once a day. During an observation on 07/10/24 at 8:41 AM, LPN5 was observed preparing medications for R56. LPN5 placed a 1000 mcg Vitamin B-12 tablet in R56's medication cup and administered the medication. During an interview on 07/10/24 at 9:34 AM, LPN5 was asked to show the surveyor all the Vitamin B-12 containers in the medication cart. She stated, All we have is 1000 mcg. LPN5 confirmed R56 was supposed to receive 500 mg. She stated, We aren't supposed to cut anything in half. I've been giving 1000 mcg. LPN5 stated, Maybe we should just order 500 from the pharmacy. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/10/24 at 2:59 PM, the Administrator and Director of Nursing (DON) stated their expectation was for staff to attempt to give medications if they were ordered by the physician and to inform residents of medication risks and benefits. The Administrator stated the physician should be informed of any medication refusals. The Administrator and DON stated their expectation was for residents to receive medications in the dosages ordered by the physician and for medications to be administered per physician orders.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25225 Based on interview, record review, and facility policy review, the facility failed to conduct physical and occupational therapy evaluations as ordered by the physician for one of one resident (Resident (R) 231) reviewed for rehabilitation services out of 20 sample residents. This had the potential to cause a physical decline for R231. Findings include: Review of the facility's policy titled, Scheduling Therapy Services, revised July 2013, revealed .Therapy services shall be scheduled in accordance with the resident's treatment plan . Review of R231's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R231 was admitted to the facility on [DATE] with diagnoses that included type two diabetes mellitus, major depressive disorder, muscle weakness, other reduced mobility, and the need for assistance with personal care and continuous supervision. Review of R231's Physician Orders, dated 06/27/24 and located under the Orders tab of the EMR, revealed orders for physical and occupational therapy evaluations and treatment. Review of R231's Care Plan, located under the Care Plan tab of the EMR, revealed a focus related to R231 being a risk for falls related to confusion, deconditioning, and unawareness of safety needs. It was also recorded R231 had suffered frequent falls. Interventions included physical therapy evaluation and treatment as ordered or as needed. Review of R231's Misc (Miscellaneous) tab, Progress Notes tab, and Assessments tab of the EMR revealed no documented evidence that R231 had been evaluated for physical or occupational therapy. During an interview on 07/08/24 at 3:12 PM, R231 stated she was supposed to be on rehabilitation services and that was why she had come to this facility, but she had not received any therapy. During an interview on 07/10/24 at 1:30 PM, the Director of Therapy (DT) confirmed R231 had not been evaluated for either physical or occupational therapy. The DT stated it had been communicated that R231 was at the facility as a long-term care resident and private pay, and because of that, the evaluations had not been done. The DT stated she had completed a quick screening of R231, but the best practice was to do the evaluations. During an interview on 07/10/24 at 4:25 PM, the Administrator stated that it was his expectation that therapy evaluations be completed as ordered by the physician.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750 20402 25225 Based on observation, interview, record review, and review of facility policy, the facility failed to sanitize glucometers between use during fingerstick blood sugar tests (FSBS) in a manner that prevented cross-contamination for three (Resident (R) 58, R48, and R232) of three residents observed receiving FSBS tests; ensure enhanced barrier precautions (EBP) were in place as required for 10 of 10 sampled residents (Resident (R) 231, R56, R29, R42, R8, R10, R21, R131, R42, and R47) who had indwelling urinary catheters, suprapubic catheters, and/or feeding tubes and were reviewed for EBP out of a total sample of 20; update infection control policies and procedures on an annual basis; and have control measures in place to monitor their water safety management program. This had the potential to affect 87 of 87 residents who resided at the facility. This failure had the potential to lead to the spread of infection throughout the facility. Findings include: Review of the facility's policy titled, Blood Sampling - Capillary (Finger Sticks), revised September 2014, revealed .Equipment .Disinfect blood glucose meter .Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses .Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use .Replace blood glucose monitoring device in storage area after cleaning . Review of the undated blood glucose meter owner's manual revealed .Indirect transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) during the delivery of healthcare services has been increasingly reported. Persons using blood glucose monitoring systems have been identified as one risk group due to sharing .blood glucose meters .The meter MUST be cleaned and disinfected after use on each patient .The following disinfecting wipe can be used to clean and disinfect the meter. CAVIWIPES DISINFECTING TOWELETTES .Cleaning and Disinfecting frequency: after each use . Thoroughly wipe the entire surface of the meter with disinfecting wipes listed to clean any possible dirt, dust, blood and other body fluids. 2. Take another disinfecting wipe and wipe the meter thoroughly .Allow the surface to remain wet for 2 minutes .Allow to air dry . Review of the Quality, Safety and Oversite Memo dated 03/20/24, revealed In July 2022, the CDC [Centers for Disease Control and Prevention] released updated Enhanced Barrier Precautions [EBP] recommendations for Implementation of PPE [Personal Protective Equipment] Use in nursing homes to prevent spread of MDROs [multidrug-resistant organisms], and therefore, CMS [Centers for Medicare and Medicaid] is updating its infection prevention and control guidance accordingly. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's policy titled, Legionella Surveillance and Detection, revised September 2022, revealed Policy Statement: Our facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella. Legionella disease is included as part of our infection surveillance activities . Review of the facility's policy titled, Legionella Water Management Program, revised September 2022, revealed Policy Statement: Our facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation .f. The control limits or parameters that are acceptable and that are monitored . 1. Review of R58's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R58 was admitted to the facility on [DATE] with diagnoses that included type two diabetes mellitus. Review of R58's Physician Orders, dated 07/01/24 and located under the Orders tab of the EMR, revealed R58 was to receive FSBS checks before each meal. Review of R48's Admission Record, located under the Profile tab of the EMR, revealed R48 was readmitted to the facility on [DATE] with diagnoses that included type two diabetes mellitus with hyperglycemia (high blood sugars). Review of R48's Physician Orders, dated 06/28/24 and located under the Orders tab of the EMR, revealed R48 was to receive FSBS checks before each meal. Review of R232's Admission Record, located under the Profile tab of the EMR, revealed R232 was readmitted to the facility on [DATE] with diagnoses that included type two diabetes mellitus with hyperglycemia. Review of R232's Physician Orders, dated 07/09/24 and located under the Orders tab of the EMR, revealed R232 was to receive FSBS checks before each meal and at bedtime. During an observation on 07/09/24 at 10:42 AM, Registered Nurse (RN) 1 was observed completing a FSBS check for R58, using a [NAME] Quintet AC blood glucose meter. RN1 removed a basket containing lancets and a glucometer from the top drawer of the medication cart. RN1 gathered supplies including the glucometer, glucometer strips, a lancet, and alcohol wipes and proceeded to R58's room. Without sanitizing the glucometer, RN1 performed the FSBS check for R58 and then wiped the glucometer with an alcohol wipe. RN1 returned to the medication cart, placed the meter into the basket, removed her gloves, and performed hand hygiene. Continuing with the observation on 07/09/24 at 10:47 AM, RN1 removed the same glucometer used for R58 from the basket, gathered supplies of a lancet, glucometer strips, and alcohol wipes and proceeded to R48's room. Without sanitizing the glucometer, RN1 performed a FSBS check for R48 and then wiped the glucometer with an alcohol wipe. RN1 returned to the medication care, placed the glucometer into the basket, and placed the basket into the top drawer of the medication cart. During an observation and interview on 07/09/24 at 10:48 AM, RN1 was asked what she wiped the glucometer with after each use. She stated, Alcohol wipe. RN1 confirmed there was a container of Super Sani-Cloth disinfecting wipes in the fourth drawer on the left side of the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 07/9/24 at 11:06 AM, Licensed Practical Nurse (LPN) 2 was observed completing a FSBS check for R232, using a blood glucose meter. LPN2 placed the glucometer into his right-side pants' pocket, obtained a container of glucometer strips, alcohol wipes, a lancet and proceeded to the dining room where R232 was seated. LPN2 placed the supplies on the dining room table and went to the therapy department to get gloves. LPN2 donned (put on) gloves and performed R232's FSBS check. At 11:10 AM, LPN2 returned to the medication cart, doffed (took off) his gloves, placed the glucometer on top of the medication cart, and began looking at the electronic charting system. He did not sanitize the glucometer. At 11:14 AM, LPN2 placed the glucometer back into his right-side pants' pocket, left the medication cart, and placed a phone call to the physician. From 11:15 AM through 11:26 AM, LPN2 moved throughout the facility attempting to locate the physician to inform him of R232's FSBS check result. The glucometer remained in his pocket. During an interview on 07/09/24 at 11:26 AM, LPN2 confirmed that he kept the glucometer in his pants' pocket. During an interview on 07/09/24 at 12:26 PM, RN1 confirmed the facility's policy was to use antiviral wipes to clean the glucometers before and after use. RN1 confirmed she did not use a sanitizing wipe to clean the glucometer. She stated, Honestly, I usually use an alcohol wipe. During an interview on 07/09/24 at 12:33 PM, LPN2 stated the facility's policy was to clean the glucometer after each use and to use alcohol wipes to clean it. LPN2 confirmed he carried the glucometer in his pants' pocket and that he did not sanitize the glucometer before placing it into his pocket or before or after performing R232's FSBS check. LPN2 stated he placed the glucometer in his pocket while he was working with an individual resident. He stated there were two glucometers on each cart, and that was the way he kept them separated while doing the FSBS checks. LPN2 confirmed there was a container of Clorox disinfecting wipes on his medication cart. During an interview on 07/09/24 at 12:36 PM, the Director of Nursing (DON) stated her expectation and the facility's policy was for glucometers to be sanitized between residents and allowed to dry. She stated that each medication cart had two glucometers so that one could dry while the other was used. The DON was asked what should be used to clean the glucometers. She stated she would have to look that up since she had only been at the facility for four weeks, and she was unsure what solution was used. The DON was asked if carrying the glucometer in a clothing pocket was appropriate. She stated, No, that is an infection control issue. Absolutely not. During an interview on 07/09/24 at 12:42 PM, RN1 confirmed she had used the same glucometer for R58 and R48. She stated there were two glucometers on her medication cart, but she had used the same one. During an interview on 07/09/24 at 2:00 PM, the Infection Preventionist (IP) stated it was the facility's policy to clean the glucometer before and after each use. The IP stated neither the facility's policy nor the glucose meter manual addressed what to use to clean the glucometer. 2. a. Review of R231's Admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R231 was admitted to the facility on [DATE] with diagnoses that included neuromuscular dysfunction of the bladder. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R231's Physician Orders, dated 06/27/24 and located under the Orders tab of the EMR, revealed R232 had an indwelling urinary catheter due to neuromuscular dysfunctions of the bladder. During an observation and interview on 07/08/24 at 11:13 AM, R231 was observed lying in her bed. The resident was noted to have an indwelling catheter. There was no signage noted detailing EBP were in place for the resident. There was no personal protective equipment (PPE) noted outside or inside R231's room. R231, who answered questions of orientation appropriately, stated staff wore gloves but did not wear a gown when assisting with transfers, cleaning her urinary catheter, providing care, or changing linens. Observations on 07/08/24 through 07/10/24 revealed no EBP were in place related to the urinary catheter. b. Review of R56's Admission Record, located under the Profile tab of the EMR, revealed R56 was admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia (BPH) with lower urinary tract symptoms and urinary retention. Review of R56's Physician Orders, dated 02/03/24 and located under the Orders tab of the EMR, revealed R56 had a suprapubic urinary catheter related to complications of BPH. During an observation on 07/08/24 at 11:05 AM, two staff members were observed transferring R56 from his bed to his wheelchair. The staff members did not have gowns on. There was no signage noted detailing EBP were in place for the resident. There was no PPE noted outside or inside R56's room. Observations on 07/08/24 through 07/10/24 revealed no EBP were in place related to the urinary catheter. c. Review of R29's Admission Record, located under the Profile tab of the EMR, revealed R29 was admitted to the facility on [DATE] with diagnoses that included BPH and urinary retention. Review of R29's Physician Orders, dated 06/06/24 and located under the Orders tab of the EMR, revealed R29 had a suprapubic urinary catheter. Review of R29's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/02/24 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R29 was cognitively intact. During an observation and interview on 07/08/24 at 11:02 AM, R29 was observed to have a suprapubic urinary catheter. There was no signage noted detailing EBP were in place for the resident. There was no PPE noted outside or inside R29's room. R29 stated staff wore gloves but did not wear a gown when transferring him, changing his linens, emptying his urinary drainage bag, or cleaning his suprapubic catheter. R29 stated he did not know what EBP were. Observations on 07/08/24 through 07/10/24 revealed no enhanced barrier precautions were in place related to the urinary catheter. d. Review of R42's Admission Record, located under the Profile tab of the EMR, revealed R42 was readmitted to the facility on [DATE] with diagnoses that included urinary retention. Review of R42's Progress Note, dated 06/11/24 at 4:46 PM and located under the Progress Notes tab of the EMR, revealed R42 had been sent to the emergency room due to urinary retention and returned to the facility with an indwelling urinary catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of R42's 5-day PPS (Pay Per Service) MDS, with an ARD of 07/01/24 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15 which indicated R42 was cognitively intact. During an observation and interview on 07/08/24 at 11:59 AM, R42 was observed to have a urinary catheter in place. There was no signage noted detailing EBP were in place for the resident. There was no PPE noted outside or inside R42's room. R42 stated staff wore gloves but did not wear a gown when assisting him with transfers, changing his linens, emptying his urinary drainage bag, or cleaning his catheter. Observations on 07/08/24 through 07/10/24 revealed no EBP were in place related to the urinary catheter. During an interview on 07/09/24 at 1:30 PM, LPN2 was asked if he knew what EBP were. He stated no. During an interview on 07/10/24 at 8:55 AM, LPN5 was asked if she knew what EBP were. She asked, You mean like gloves and the whole works? EBP was explained to her. LPN5 stated, I don't remember that. During an interview on 07/10/24 at 1:52 PM, Certified Nurse Aide (CNA) 1 stated she did not know what EBP were and that she had not been educated on the subject. During an interview on 07/10/24 at 3:37 PM, the Administrator was asked if he had received the memo from the Centers of Medicare and Medicaid Services (CMS) that detailed the need and required implementation of EBP for residents with urinary catheters, feeding tubes, wounds, or indwelling medical devices. He stated he did not recall. The Administrator stated it was his responsibility to obtain CMS memos and disperse the information to his staff. The Administrator stated he did not recall if he had done so with the CMS memo related to EBP. e. Review of R8's undated Medical Diagnosis located in the EMR under the Med Diag tab, indicated diagnoses to include encounter for fitting and adjustment of gastrointestinal appliance and device, gastrostomy, diaphragmatic hernia, and Barrett's esophagus without dysplasia. Review of R8's Physician Orders, dated 09/28/23 and located in the EMR under the Orders tab, indicated Cleanse G-tube site daily and prn [as needed] every day shift. During an interview on 07/08/24 at 10:00 AM, when LPN3 was asked if there were any residents in isolation on the 100 unit, LPN3 stated, No. When asked if there were any residents on the 100 unit on any type of enhanced barrier precautions, LPN3 stated, No. During an observation on 07/08/24 at 11:00 AM, R8 was observed in his room. At this time, R8 was observed unable to communicate his needs. There was no evidence of any type of signage posted for enhanced barrier precautions. There was also no evidence of any type of isolation cart inside or outside of R8's room to include any type or PPE. During a second interview on 07/08/24 at 1:30 PM, LPN3 stated that R8 has a feeding tube. A g-tube. He eats in restorative dining and gets his medications and flushes through the G-tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 07/09/24 at 8:50 AM, R8 was observed to be laying in a low bed with a floor mat at the bedside. At this time, the door to R8's room was opened and there was no evidence of any signage for EBP in place, or any type of isolation cart inside or outside of the room containing PPE. f. Review of R10's undated Medical Diagnosis located in the EMR under the Med Diag tab, indicated diagnoses to include acute pyelonephritis, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, obstructive and reflux uropathy, and neuromuscular dysfunction of bladder. Review of R10's Physician Orders, dated 05/13/24 and located in the EMR under the Orders tab, indicated Suprapubic cath [catheter] 22 Fr [French] 10cc [cubic centimeters] change indwelling cath. Review of a Comprehensive Care Plan, dated 05/22/24 and located in the EMR under the Care Plan tab, indicated, Has an indwelling suprapubic catheter 22 Fr with 10cc balloon due to dx [diagnosis] of neurogenic bladder, urine retention and obstructive uropathy. During an interview on 07/08/24 at 1:30 PM, LPN3 stated that R10 had a suprapubic catheter in place. During an observation on 07/08/24 at 2:00 PM, R10 was observed sitting in his room in a wheelchair. At this time, R10 was not able to communicate his needs. Further observation revealed catheter tubing was in place and observed in a blue privacy bag. At this time, there was no signage posted on R10's door for EBP. There was also no isolation cart located inside or outside of R10's room to include any PPE. g. Review of R21's Admission Record located in the EMR under the Profile tab, indicated R21 was admitted on [DATE] with diagnoses of dependence on renal dialysis. Further review no indication of orders for EBP. During an interview on 07/08/24 at 10:00 AM, R21 stated he received dialysis and had a catheter on the right side of his chest. There was no indication the resident was on EBP such as signs or PPE. h. Review of R131's Admission Record located in the EMR under the Profile tab, indicated R131 was admitted on [DATE] with diagnoses pressure ulcer of buttock, contusion of left lower leg, and cellulitis of the right lower limb. Further review no indication of orders for EBP. During an interview on 07/08/24 at 11:02 AM, R131 was lying in bed and stated that she had a pressure ulcer on her buttocks and both feet had surgical dressings on them. There was no indication the resident was on EBP such as signs or PPE. i. Review of R43's Admission Record located in the EMR under the Profile tab, indicated R43 was admitted on [DATE] with of end stage renal disease, and complete traumatic amputation of right midfoot. Further review no indication of orders for EBP. During an interview on 07/08/24 at 1:21 PM, R43 stated he had a catheter for dialysis treatments on the right side of his chest and a wound at the site of his right foot amputation. There was no indication the resident was on EBP such as signs or PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	j. Review of R47's Admission Record located in the EMR under the Profile tab, indicated R47 was admitted on [DATE] with diagnoses of pressure ulcer of sacral region and retention of urine. Further review no indication of orders for EBP. During an interview on 07/08/24 at 2:04 PM, R47 stated she had pressure ulcers on her coccyx and had a Foley catheter placed. There was no indication the resident was on EBP such as signs. or PPE. During an interview on 07/09/24 at 1:00 PM, MDS1 stated she had conducted some education for staff but was not aware of EBP. During an interview on 07/09/24 at 1:17 PM, the Administrator stated that his staff were professionals and he expected them to have knowledge. The Administrator stated he usually kept up with the update to rules and regulations but could not recall anything about EBP. During an interview on 07/09/24 at 1:33 PM, Assistant Director of Nursing (ADON) 1 stated that EBP would be used if a resident had an infection and there was going to be splashing of bodily fluids. The ADON stated staff needed to wear gown, gloves, and face shield. ADON1 was asked if there was anyone in the facility who should be on EBP and he stated, Not at this time. During an interview on 07/09/24 at 2:06 PM, ADON2 was asked about her knowledge of EBP. ADON2 stated EBP was when there was splashing of bodily fluids and staff should be wearing PPE. During an interview on 07/10/24 at 2:20 PM, RN3 was asked if she knew what EBP was and when to use it. RN3 stated we use standard precautions by wearing gloves and mask when need to. I don't know what EBP is. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Review of the facility's policies and procedures titled, Policy and Procedure [NAME] for Long-Term Care, Infection Control revealed various sections such as the following: Blood or body Fluids Exposure revised July 2016. Cleaning and Disinfection of Environmental Surfaces, revised August 2019. Cleaning and Disinfection of Resident-Care items and Equipment, revised September 2019. Cleaning Spills or Splashes of Blood or Body Fluids, revised February 2023. Exposure Classification of Tasks/Procedures, revised January 2012. Exposure Determinations, revised September 2020. Herpes Zoster Vaccine, revised August 2016. Infection Preventionist, revised September 2022. Influenza, Prevention and Control of Seasonal, revised March 2022. Influenza Vaccine, revised March 2022. Laundry Bedding Soiled, revised September 2022. Legionella Surveillance and Detection, revised September 2022. Legionella Water Management Program, revised September 2022. Mpox Virus, revised February 2023. Needlesticks and Cuts, revised August 2013. Outbreak Communicable Diseases, revised September 2022. Sharp Disposal, revised January 2012. Standard Precautions, revised September 2022. Surveillance of Infections, revised September 2017. Vaccination f Residents, revised October 2019. Visitation, Infection Control During, revised August 2019. Cleaning Broken Glass When Contaminated with Blood or Body Fluids, revised October 2011. Cleaning Spills or Splashes of Blood or Body Fluids, revised January 2012. Departmental (Environmental Services)- Laundry and Linen, revised January 2014. Departmental (Occupational Therapy)- Prevention of Infection, revised September 2010. Departmental (Physical Therapy)- Prevention of Infection, revised September 2010. Departmental (Recreational Therapy)- Prevention of Infection, revised September 2010. Departmental (Respiratory Therapy)- Prevention of Infection, revised November 2011. Diapers/ Underpads [sic], revised September 2010. Diarrhea and Fecal Incontinence, revised September 2010. Medical Waste, Handling of, revised September 2010. Needle Handling and/or Disposal, revised January 2012. Personal Protective Equipment- Using Face Mask, revised September 2010. Personal Protective Equipment- Using gloves, revised September 2010. Personal Protective Equipment- Using Gowns, revised September 2010. Personal Protective Equipment- Using Protective Eyewear, revised September 2010. During an interview on 07/11/24 at 2:20 PM, the Administrator stated, We use Med Pass and when there is an update we are sent that on a flash drive. We rely on med pass to send us the updated policies, but we have not gotten any new updated policies. Some policies don't change. We try and review annually. 4. During an interview on 07/10/24 at 12:39 PM, the Maintenance Director (MD) was asked what parameters or range you set for the determination of whether there was Legionella or not. The MD stated, We have to test it. The MD was asked for the test results. The MD stated, We just ordered a test kit. I don't have anything unless the city can provide it. We put a call out but have received nothing. They had a diagram of the building, and it indicated the areas of concern. The MD stated that he checked areas monthly and ran sinks that were not used weekly. No documentation was provided to confirm that was completed. During an interview on 7/11/24 at 2:20 PM, The Administrator was asked about the Legionella Program. He stated, We haven't had any outbreaks. We know where our at-risk areas are. The water heaters are checked out monthly. We have zero cases; we have never had a case. We know where our risk areas are. The ice machine, water heaters and any unused faucets, sinks, hoses are all flushed monthly. That is our preventative maintenance program. To my knowledge we are not doing testing. I was under the impression testing is conducted by the city. We don't have any hot tubs, fountains where it would breed.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 18750 Based on interview, record review, and facility policy review, the facility failed to have an Infection Preventionist (IP) that had completed specialized training in infection prevention and control. This deficient practice had the potential to allow staff to go without the proper knowledge and training of infection control practices for 87 census residents. Findings include: Review of the facility's policy titled, Infection Preventionist, revised September 2022, revealed Policy Statement: The infection preventionist is responsible for coordinating the implementation and updating of the infection prevention and control program .Specialized Training: 2. Evidence of training is provided through a certificate(s) of completion or equivalent documentation. During entrance conference interview on 07/08/24 at 9:00 AM, the Administrator indicated Minimum Data Set (MDS) 1 was the IP and had been the IP since February of 2024. Review of the certificates provided by the facility for the IP revealed there was no certificate presented for the IP named at entrance. During an interview on 07/09/24 at 1:00 PM, Minimum Data Set (MDS) 1 was asked if she was the IP. MDS1 stated, As of yesterday, (indicating 07/08/24). MDS1 was asked if she had any training for the IP position. MDS1 stated, I took a state training on COVID-19. I am starting the other training. During an interview on 07/09/24 at 1:17 PM, the Administrator was asked about the IP. The Administrator stated, Our former DON [Director of Nursing] was the IP, but she left in March of 2024. As of today, there is no IP. It would fall to the DON. The plan is to get the DON the training. She has only been here three weeks. MDS1 is working on the certification as we speak.