STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325040	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Sands Healthcare	5715 North Lovington Highway Hobbs, NM 88240

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207 Based on observation, record review, and interview, the facility failed to promote care with dignity and respect for 2 (R #52 and R #9) of 2 (R #52 and R #9) residents reviewed for rights when they: 1. Provided a medical assessment in the dining area during mealtime. 2. Interrupted a resident during mealtime to prepare her to take medications. This deficient practice could result in residents feeling as if they were unimportant and not having privacy. The findings are: R #52 E. Record review of R #52's face sheet revealed he was admitted to the facility on [DATE] with the following diagnoses: 1. Type 2 diabetes mellitus without complications, 2. Unspecified protein-calorie malnutrition, 3. Unspecified dementia, severe with anxiety and behavioral disturbance, 4. Cardiomegaly (enlarged heart). F. Record review of R #52's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) revealed a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 2, severely impaired. G. On 01/07/25 at 12:16 pm, during a mealtime observation in the main dining room, staff served R #52 his meal at 12:21 pm, and R #52 ate his food. At 12:46 pm, Medical Provider (MP) #1 approached R #52 with a computer cart. R #52 stopped eating, and MP #1 took R #52's vitals [body temperature, pulse rate, respiration rate (rate of breathing), oxygen saturation (amount of oxygen in the blood), and blood pressure]. Other residents and staff members were present in the dining room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. On 01/07/25 at 1:06 pm, during an interview with R # 52, the resident was unable to answer questions regarding the his care. R #9 E. I. On 01/10/25 at 8:25 am during an observation of a medication administration, R #9 sat in the dining room and ate breakfast. Registered Nurse (RN) #1 entered the dining room and walked over to R #9. The resident stopped eating, and RN #1 placed a wrist blood pressure cuff (device used to measure blood pressure) on the resident's left anterior Delete. This medical term is not needed to tell the story. wrist. RN #1 took the rest of R #9's vitals while she sat in the dining room. Other residents and staff members were present in the dining room. F. On 01/10/25 at 8:35 am during an interview with RN #1, he stated he normally administered medications to residents in the privacy of their own room, but he was in a hurry to get R# 9 her blood pressure medications. G. On 01/13/25 at 4:00 pm, during an interview with the Director of Nursing (DON), she stated staff should not conduct medical assessments during mealtimes or in the dining room if others are present.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 50207 Based on interview, record review, and observation the facility failed to ensure residents received information on how to contact the State Survey Agency to file a complaint. This deficient practice could likely affect all 110 residents residing in the facility as identified on the census provided by the Administrator (ADM) on 01/05/25. The findings are: A. On 01/05/25 at 12:15 pm during a random observation of the facility, signs or posters regarding filing a complaint with the state survey agency were not visible throughout the facility. B. On 01/07/25 at 10:58 am during an interview with the Resident Council (RC; R #9, R #28, R #29, R #36, R #46, R #73, R #77, R #86, and R #97), they stated they were unaware they could contact the State Survey Agency to file a complaint. C. On 01/08/25 at 12:39 pm during an interview and random observation of the facility with the Administrator, one sign regarding contacting the State Survey Agency to file a complaint hung on the front entrance door and faced outside the building. Further observation revealed there were not any signs or posters visible to residents from inside the facility. The bottom of the sign was approximately four feet from the ground and printed on a piece of paper measuring 8.5 inches wide by 11 inches long. The sign included information to call the New Mexico Department of Health intake hotline to file a complaint. Further observation revealed there were not any signs or posters visible to residents from inside the facility. The ADM confirmed there are not any other signs with information on how to contact the State Agency that were accessible to the residents inside the facility.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50207 Based on observation and interview, the facility failed to provide a clean and homelike environment when staff did not clean vomit off the floor in the dining area of the memory care unit. This deficient practice could likely affect all 21 residents residing in the memory care unit as identified by the census provided by the Administrator on 01/05/25. Failure to provide a clean and homelike environment is likely to result in unsafe conditions and prevent residents from enjoying everyday activities. The findings are: A. On 01/06/25 at 9:10 am, a random observation of the memory care unit revealed vomit on the floor in the dining area by the door leading outside. B. On 01/06/25 at 9:13 am, during an interview with Licensed Practical Nurse (LPN) #1, she stated the vomit was on the floor since breakfast. She stated she informed housekeeping staff, and they told her someone would clean it later. C. On 01/13/25 at 2:07 pm, during an interview with the Director of Nursing, she stated nursing staff should clean up bodily fluids such as vomit. She stated her expectation would be for nursing staff to clean it as soon as they are able to do so, and housekeeping would then disinfect the area. 51657

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207 51616 Based on record review and interview, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR; a screening to help ensure that individuals are not inappropriately placed in nursing homes for long term care) assessment was accurate for 5 (R #23, R #25, R #95, R #98, R #104) of 6 (R #17, R #23, R #25, R # 95, R #98, R #104) residents reviewed for PASRR accuracy. This deficient practice is likely to result in the residents not receiving the services they need. The findings are: R #23 A. Record review of R #23's face sheet revealed R #23 was admitted into the facility on [DATE] with the following diagnoses: 1. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), 2. Anxiety disorder (feelings of fear or apprehension), 3. Schizoaffective disorder (a mental condition that causes both psychosis and mood problems)-bipolar type (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). B. Record review of R #23's PASRR, dated 7/31/24, revealed staff documented R #23 did not have a diagnosis or suspected mental illness. R #25 C. Record review of R #25's face sheet revealed R #25 was admitted into the facility on [DATE] with the following diagnoses: 1. Bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), 2. Major depressive disorder, 3. Anxiety disorder. D. Record review of R #25's PASRR, dated 12/20/24, revealed staff documented R #25 did not have a diagnosis or suspected mental illness. R #95 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Record review of R #95's face sheet revealed R #95 was admitted into the facility on [DATE] with the following diagnoses: 1. Mood disorder (a mental health condition that affects a person's emotional state), 2. Major depressive disorder, 3. Anxiety disorder, 4. Post traumatic stress disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety). F. Record review of R #95's PASRR, dated 07/27/24, revealed staff documented R #95 did not have a diagnosis or suspected mental illness. R #98 G. Record review of R #98's face sheet revealed R #98 was admitted into the facility on [DATE] with the following diagnoses: 1. Post-traumatic stress disorder, 2. Major depressive disorder, 3. Anxiety disorder, 4. Alcohol abuse with alcohol-induced psychotic disorder with hallucinations (symptoms of mental disorder present during or shortly after heavy alcohol intake). H. Record review of R #98's PASRR, dated 05/14/24, revealed staff documented R #98 did not have a diagnosis or suspected mental illness. R.#104 I. Record review of R #104's face sheet revealed R #104 was admitted into the facility on [DATE] with the following diagnoses: 1. Post-traumatic stress disorder, 2. Major depressive disorder, 3. Anxiety disorder. J. Record review of R #104's PASRR, dated 08/21/24, revealed staff documented R #104 did not have a diagnosis or suspected mental illness. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	K. On 01/13/25 at 1:45 pm during an interview with the Social Services Director (SSD), she stated the facility should have made sure R #23's, R #25's, R #95's, R #98's, and R #104's PASRR level 1 was correct prior to admission, but they did not.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 49827 Based on observation, record review, and interview, the facility failed to develop and implement an accurate, person-centered comprehensive care plan for 2 (R#1 and #26) of 8 (R #1, R #23, R #25, R #26, R #55, R #65, R #95, and R #98) residents reviewed for care plans. This deficient practice could likely result in staff being unaware of the current and actual needs of the residents. The findings are: R #26 A. Record review of R #26's face sheet revealed she was originally admitted to the facility on [DATE] with the following diagnoses: 1. Idiopathic chronic gout (a type of arthritis that causes intense pain, swelling, redness and tenderness of an affected joint). 2. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), recurrent, mild, 3. Blindness, left eye, 4. Heart failure, unspecified, 5. Chronic kidney disease, severe (CKD; impaired kidney function.) B. Record review of R #26's care plan, revised on 08/07/24, revealed R #26 had a communication problem related to a hearing deficit and being hard of hearing. C. Record review of R #26's medical record revealed the resident did not have a diagnosis related to a hearing deficit. D. Record review of R #26's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 10/30/24, revealed the following: 1. R #26's hearing was adequate without the use of a hearing aid. 2. A Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 14, cognitively intact. E. On 01/06/25 at 04:14 pm, during an interview, R #26 denied any concerns with her hearing, and there were no communication issues during this interview. F. On 01/13/25 at 1:16 pm during an interview with the Administrator (ADM), he stated R #26 did not have a hearing deficit, and the resident's care plan was incorrect. He stated his expectation is for care plans to accurately reflect the resident's needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #1 A. Record review of R #1's face sheet revealed that he was admitted to the facility on [DATE] with multiple diagnoses including: 1. Quadriplegia (paralysis of all four limbs), unspecified, 2. Unspecified mental disorder due to known physiological condition (a mental health issue that can be traced back to a physical health problem), 3. Unspecified intracranial injury (injury to the brain caused by an external force) with loss of consciousness of unspecified duration, initial encounter, 4. Contracture (a fixed tightening of muscle, tendons, ligaments, or skin) of left elbow, contracture of left ankle, and contracture of right ankle. B. Record review of R #1's quarterly MDS, dated [DATE], revealed a BIMS score of 00, severe impairment. C. Record review of R #1's care plan, revised on 09/13/24, revealed the following interventions: 1. R #1 was to wear bilateral (having or relating to two sides; affecting both sides) resting hand splints and bilateral elbow extension splints as tolerated. Monitor (splint, brace, etc.) for signs and symptoms of skin breakdown with application and removal (splint, brace, etc.), and notify the nurse of any changes. 2. R #1 was to wear bilateral elbow extension splints and right resting hand splint daily, or as tolerated. 3. R #1 had contractures on all the extremities. Provide skin care when turning as needed to keep clean and prevent skin breakdown. Loosen and remove splints periodically and check for any skin breakdown. Clean palms of hands to help prevent odor build up. D. Record review of R #1's physician orders revealed the record did not contain an order for the resident to use splints. E. On 01/06/25 at 3:30 pm during an interview with R #1's mother, she stated R #1 was supposed to wear splints on his hands, elbows, and arms; but he never had them on when she visited him. She stated she talked to several people from the facility to report it. She stated nothing changed because the facility still did not put the splints on R #1. E. During observations on 01/06/25 at 3:53 pm, 01/07/25 at 2:16 pm, 01/08/25 at 9:36 am, and 01/09/25 at 3:43 pm, R #1 did not wear splints on his hands or elbows. 50207 52102

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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** 50207 Based on observation, record review, and interview, the facility failed to provide respiratory care in accordance with professional standards for 2 (R #17 and R #104) of 3 (R #17, R #70, and R #104) residents reviewed for respiratory care when staff failed to change the oxygen concentrator (a medical device that provides extra oxygen) tubing. If the facility fails to provide new, clean tubing for oxygen concentrators then residents are at risk of becoming ill. The findings are: R #17 A. Record review of R #17's face sheet revealed she was admitted to the facility on [DATE] with multiple diagnoses including: 1. Unspecified dementia, severe with psychotic disturbance, anxiety, and behavioral disturbance, 2. Seizures, 3. Chronic kidney disease (kidneys are damaged and can't filter blood the way they should), 4. Other bipolar disorder (mental health condition that causes extreme mood swings), 5. Dependence on supplemental oxygen (treatment that provides extra oxygen to people who have trouble breathing or lung diseases). B. Record review of R #17's current medical orders revealed the resident did not have an order for the use of oxygen or the care of the equipment. C. On 01/05/25 at 2:00 pm, during an observation of R #17's room, an oxygen concentrator sat on the floor next to R #17's bed, and the oxygen tubing was dated 12/22/24. D. On 01/05/25 at 2:17 pm, during an interview with LPN #2, she confirmed R #17 used oxygen, and the oxygen tubing was dated 12/22/24. LPN #2 stated the date on the oxygen tubing indicated the date it was last changed. LPN #2 stated staff was supposed to change the tubing on Sundays, and she was not sure why it was not done on 12/29/24. She stated her expectation was for staff to change all oxygen tubing weekly. R #104 E. Record review of R #104's face sheet revealed he was admitted to the facility on [DATE] with multiple diagnoses including: 1. Acute respiratory failure with hypoxia [when the lungs cannot adequately oxygenate (supply, treat, charge, or enrich with oxygen) the blood, leading to low oxygen levels in the bloodstream], 2. Unspecified dementia, severe with mood disturbance, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Chronic obstructive pulmonary disease (COPD; lung disease) with acute exacerbation (to make something that is already bad, even worse). F. On 01/05/25 at 2:20 pm, during an observation of R #104's room, an oxygen concentrator sat on the floor next to R #104's bed, and the oxygen tubing was not dated. G. Record review of R #104's medical orders revealed an order, dated 09/05/24, for staff to change the resident's oxygen tubing every four weeks. H. On 01/05/25 at 2:29 pm, during an interview with LPN #2, she confirmed R #104 used oxygen, and the oxygen tubing was not dated. LPN #2 stated staff was supposed to change the tubing on Sundays, and she was not sure why it was not done on 12/29/24. She stated her expectation was for staff to change all oxygen tubing weekly and to date the tubing with the date it was last changed. 51657

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827 Based on observation, record review, and interview, the facility failed to ensure residents were assessed for risk of entrapment (state of being stuck or caught on bed rail) in bed rails for 6 (R #23, R #25, R #55, R #65, R # 95, and R # 98) of 8 (R #21, R #23, R #25, R #55, R #65, R #77, R #95, and R #98) resident reviewed for accidents. This deficient practice has the potential to cause serious injury by becoming trapped between the mattress and bed rail. The findings are: R #23 A. Record review of R #23's admission record revealed R #23 was admitted to the facility on [DATE]. B. On 01/09/25 at 10:55 AM, during an observation, R #23's bed had two bilateral (on both sides) quarter side rails (horizontal metal or plastic bars that extend about a quarter of the length of a bed) in place. C. Record review of R #23's physician orders reviewed, dated 08/09/24 through 01/09/24, revealed the resident did not have a physician order for bed rails. D. Record review of R #23's care plan, dated 11/17/24 and revised date 08/18/23, revealed R #23 used bed rails for bed mobility and positioning. E. Record review of R #23 comprehensive Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 10/21/24, revealed the resident did not use bed rails. F. Record review of R #23's medical record revealed the record did not contain the following: - Assessment of the resident for risk of assessment, - Review of risk and benefits of the bed rails with the resident or resident representative, - Consent from the resident or resident representative, - Documentation the bed's dimensions were appropriate for the resident's size and weight. G. On 01/13/25 at 2:07 pm during an interview with the Director of Nursing (DON), she stated that bedrail assessments should be completed quarterly for any residents that utilized bedrails. The DON was not able to provide evidence that a bedrail assessment for R #23 was completed prior to 01/09/25. R # 25 H. Record review of R #25's admission record revealed R #25 was admitted to the facility on [DATE]. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. On 01/09/25 at 11:15 AM, during an observation, R #25's bed had two bilateral quarter side rails in place. J. Record review of R #25's physician orders, dated 12/20/24 through 01/09/24, revealed the resident did not have a physician order for bed rails. K. Record review of R #25's care plan, dated 12/26/24, revealed staff did not document the residents' use of bedrails. L. Record review of R #25's admission MDS, dated [DATE], revealed the resident did not use bed rails. M. Record review of R #25's medical record revealed the record did not contain the following: - Assessment of the resident for risk of assessment, - Review of risk and benefits of the bed rails with the resident or resident representative, - Consent from the resident or resident representative, - Documentation the bed's dimensions were appropriate for the resident's size and weight. N. On 01/13/25 at 2:07 pm during an interview with the DON, she stated bedrail assessments should be completed quarterly for any residents that utilized bedrails. The DON was not able to provide evidence that a bedrail assessment for R #25 was completed prior to 01/09/25. R #55 O. Record review of R #55's admission record revealed R #55 was admitted to the facility on [DATE]. P. On 01/09/25 at 11:00 AM, during an observation, R #55's bed had two bilateral quarter side rails in place. Q. Record review of R #55's physician orders, dated 10/18/24 through 01/09/24, revealed the resident did not have a physician order for bed rails. R. Record review of R #55's care plan, dated 11/30/24, revealed staff did not document the residents' use of bedrails. S. Record review of R 55's quarterly MDS, dated [DATE], revealed the resident did not use bed rails. T. Record review of R #55's medical record revealed the record did not contain the following: - Assessment of the resident for risk of assessment, - Review of risk and benefits of the bed rails with the resident or resident representative, (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Consent from the resident or resident representative, - Documentation the bed's dimensions were appropriate for the resident's size and weight. U. On 01/13/25 at 2:07 pm during an interview with the DON, she stated that bedrail assessments should be completed quarterly for any residents that utilized bedrails. The DON was not able to provide evidence that a bedrail assessment for R #55 was completed prior to 01/09/25. R #65 V. Record review of R #65's admission record revealed R #65 was admitted to the facility on [DATE]. W. On 01/06/25 at 11:57 AM, during an observation, R #65's bed had two bilateral quarter side rails in place. X. Record review of R #65's physician orders, dated 9/22/23 through 01/07/24, revealed the resident did not have a physician order for bed rails. Y. Record review of R #65's care plan, dated 10/23/24, revealed the use of bedrails was documented. Z. Record review of R #65's quarterly MDS, dated [DATE], revealed the resident did not use bed rails. AA. Record review of R #65's medical record revealed the record did not contain the following: - Assessment of the resident for risk of assessment, - Review of risk and benefits of the bed rails with the resident or resident representative, - Consent from the resident or resident representative, - Documentation the bed's dimensions were appropriate for the resident's size and weight. BB. On 01/13/25 at 2:07 pm during an interview with the DON, she stated the resident did not need the bedrails. R #95 CC. Record review of R #95's admission record revealed R #95 was admitted to the facility on [DATE]. DD. On 01/09/25 at 11:03 AM, during an observation, R #95's bed had two bilateral quarter side rails in place. EE. Record review of R #95's physician orders, dated 07/27/24 through 01/08/24, revealed the resident did not have a physician order for bed rails. (continued on next page)

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	325040	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White Sands Healthcare	5715 North Lovington Highway Hobbs, NM 88240

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	FF. Record review of R #95's care plan, dated 12/26/24, revealed staff did not document the resident's use of bedrails. GG. Record review of R #95's quarterly MDS, dated [DATE], revealed the resident did not use bed rails. HH. Record review of R #23's medical record revealed the record did not contain the following: - Assessment of the resident for risk of assessment, - Review of risk and benefits of the bed rails with the resident or resident representative, - Consent from the resident or resident representative, - Documentation the bed's dimensions were appropriate for the resident's size and weight. II. On 01/13/25 at 2:07 pm during an interview with the DON, she stated that bedrail assessments should be completed quarterly for any residents that utilized bedrails. The DON was not able to provide evidence that a bedrail assessment for R #95 was completed prior to 01/09/25. R #98 JJ. Record review of R #98's admission record revealed R #98 was admitted to the facility on [DATE]. KK. On 01/09/25 at 11:18 AM, during an observation, R #98's bed had two bilateral quarter side rails in place. LL. Record review of R #98's physician orders, dated 05/15/24 through 01/06/24, revealed the resident did not have a physician order for bed rails. MM. Record review of R #98's care plan, dated 11/15/24, revealed staff did not document the resident's use of bedrails. NN. Record review of R #98's quarterly MDS, dated [DATE], revealed the resident did not use bed rails. OO. Record review of R #98's medical record revealed the record did not contain the following: - Assessment of the resident for risk of assessment, - Review of risk and benefits of the bed rails with the resident or resident representative, - Consent from the resident or resident representative, - Documentation the bed's dimensions were appropriate for the resident's size and weight. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PP. On 01/13/25 at 2:07 pm during an interview with the DON, she stated that bedrail assessments should be completed quarterly for any residents that utilized bedrails. The DON was not able to provide evidence that a bedrail assessment for R #98 was completed prior to 01/09/25. 50207 52102

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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. 51657 Based on observation, record review, and interview, the facility failed to ensure that the medication error rate was 5% or less when staff administered medications without wearing gloves or using a medication cup for 1 (R# 30) of 1 (R# 30) residents reviewed during medication administration. This resulted in a medication error rate of 15.63%. If the staff members do not wear gloves or use a medication cup when administering medications, then residents are likely to become ill due to cross-contamination. The findings are: A. On 01/10/25 at 8:30 am during an observation of medication administration for R# 30, RN #1 entered the resident's room and asked if he was ready for his medications. R# 30 stated he was ready. RN #1 cleaned his hands with alcohol-based hand sanitizer (ABHS; hand cleanser that has alcohol in it to kill bad germs). He pulled out the over the counter (OTC) medications (medications that do not need a prescription from the physician and can be bought in most stores) from the medication cart in the hallway. RN #1 used his bare hands to open the first bottle of a multivitamin and poured the pill into his bare hand. RN #1 continued the same procedure for Senna-Plus (a bowel stimulant (to help the bowels move), zinc (boosts immune system (helps the body fight off infections), and Vitamin C (a vitamin that plays an important role in body functions). B. On 01/10/25 at 8:53 am during interview with RN #1, he stated he normally pours medications directly into the cap of the medication bottle and then into the pill cup. He stated he was not sure why he did not use gloves or a medication cup this time. C. On 01/13/25 at 2:10 pm during an interview with the Director of Nursing (DON), she stated staff should wear gloves and use medication cups when preparing and administering medications.

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F 0761 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51657 Based on observation and interview, the facility failed to: 1. Ensure medications and other medical supplies were not expired. 2. Ensure medications for 1 (R #88) of 1 (R #88) residents were destroyed after completion of therapy. This deficient practice has the potential to affect all 110 residents identified on the facility census list provided by the Administrator on [DATE]. The use of expired medication is likely to cause residents to receive medications which are less effective due to a breakdown in chemical makeup, leading to less-than-optimal benefit from medications. Continuing to leave discharged /completed medications in the medication storage room is likely to cause residents to receive a medication that is not theirs. The findings are: Expired Medication A. On [DATE] at 8:20 am, during observation and interview with Assistant Director of Nursing (ADON) in the medication room located on the Skilled Care Unit, an Ultrasound Gel, 8.5 ounce (oz), expired on [DATE] sat on top of the refrigerator by the bladder scanner. The ADON reviewed the ultrasound gel and confirmed it expired on [DATE]. The ADON stated that any expired medication, and supplies should be removed from the medication storage room and the medication carts on or before the date of expiration. R #88 B. Record review of R #88's medical orders revealed an order dated [DATE] to mix and administer one gram of ceftriaxone (an antibiotic used to treat an infection) with lidocaine HCL, 1 percent (%; a medication used to numb pain) for three days. C. On [DATE] at 8:30 am, during an observation of the medication room located on the Skilled Care Unit, two unused bottles of ceftriaxone and two bottles of lidocaine HCL, 1% for R #88 were located in the bottom closet. D. On [DATE] at 9:00 am, during interview with the ADON, she stated R #88's ceftriaxone and lidocaine should have been removed from the medication storage room as soon as the order was completed. The ADON stated R #88's medication orders were completed on [DATE], but staff did not remove the vials from the medication storage room.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50207 Based on observation, record review, and interview, the facility failed to store and serve food under sanitary conditions when they failed to remove an unlabeled and undated pitcher of white liquid from the television area of the memory care unit. This deficient practice could likely affect all 21 residents residing in the memory care unit as identified on the census provided by the Administrator (ADM) on 01/05/25. The findings are: A. On 01/06/25 at 10:10 am, a random observation of the memory care unit revealed a pitcher of white liquid that was not labeled or dated. Further observation revealed the pitcher sat on a tray in the television room of the memory care unit, and there were several residents present including R #72 and R #61. B. On 01/06/24 at 10:13 am, during an interview, Nurse Aide in Training (NAIT) #1 she stated the pitcher of white liquid was not labeled or dated and should not have been left on the tray where residents had access to it. She stated the pitcher was probably milk from breakfast. C. Record review of the facility's mealtimes revealed that breakfast was served in the memory care unit from 7:30 am to 9:00 am.