| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325044 | A. Building<br>B. Wing | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Arch Center | 3200 Mission Arch Drive<br>Roswell, NM 88201 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>49827<br><br>Based on observation, interview, and record review, the facility failed to keep residents free from physical restraints for 1 (R #22) of 2 (R #22, and R #103) residents evaluated for bed rail use, when staff used the bed rails without orders, written consent or comprehensive assessment. This deficient practice could likely result in physical restraints being used for discipline or staff convenience; unnecessarily preventing residents from freedom, movement, or activity.<br><br>The findings are:<br><br>A. On 12/09/24 at 9:08 am, during an observation of R #22's room, the bed had small side rails times two at the head of his bed used for positioning.<br><br>B. Record review of R #22's physician orders revealed the use of bed rails were not ordered.<br><br>C. Record review of R #22's consent for bedrails dated 10/04/24 indicated does not want bedrails.<br><br>D. Record review of the 5-day MDS assessment, dated 11/29/24 indicated bedrails not in use.<br><br>E. On 12/12/24 at 1:05 pm, during an interview with the Director of Nursing (DON), she confirmed that R #22 did not have any orders, or consent for bedrails. The MDS did not indicate use of bedrails. The DON further stated that if there is not an order, consent and the MDS does not indicate bedrails are in use, then the bedrails should not be in used. |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 325044 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/12/2024 |
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| NAME OF PROVIDER OR SUPPLIER Mission Arch Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Mission Arch Drive Roswell, NM 88201 | |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827<br><br>Based on record review and interview, the facility failed to ensure the Minimum Data Set Assessment (MDS; a federally mandated assessment completed by facility staff) was accurate for 3 (R #4, R #22, and R #49) of 5 (R #4, R #22, R #49, R #81 and R #148) residents reviewed for accurate MDS assessments. If the MDS assessment is inaccurate, then residents are likely to not receive the services and support they need. The findings are:<br><br>R #4<br><br>A. Record review of R #4's face sheet revealed R #4 was admitted into the facility on [DATE] with multiple diagnoses including but not limited to:<br><br>1. Acute Respiratory Distress Syndrome<br><br>2. Traumatic Brain Injury<br><br>3. Contracture (is a permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult).<br><br>4. Unspecified Convulsions (a medical event in which nerve cell activity in the brain is disrupted, causing muscles to involuntarily contract and spasm).<br><br>B. Record review of R #4's Bed Safety assessment dated [DATE] revealed R #4 is safe to use bedrails with monitoring.<br><br>C. Record review of R #4's quarterly MDS assessment dated [DATE] indicated bedrails are not in use.<br><br>R #22<br><br>D. Record review of R 22's face sheet revealed R #22 was admitted into the facility on [DATE]. With multiple diagnoses including but not limited to:<br><br>1. Sepsis (a serious condition in which the body responds improperly to an infection)<br><br>2. Urinary Tract infection (UTI; an infection in any part of the urinary system, which includes the kidneys, ureters, bladder, and urethra)<br><br>3. Rhabdomyolysis (breakdown of skeletal muscle due to direct or indirect muscle injury. If not treated immediately, it can lead to kidney damage).<br><br>4. Chronic Obstructive Pulmonary Disease (COPD; lung disease)<br><br>5. Muscle Weakness<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | E. Record review of R #22's Bed Safety assessment dated [DATE] revealed the assessment was not current since the resident left the facility and did not return until 11/23/24. A new assessment was not completed.<br><br>F. Record review of R #22's quarterly MDS assessment dated [DATE], indicated bedrails are not in use.<br><br>G. On 12/12/24 at 1:05 pm, during an interview with the Director of Nursing (DON), she confirmed R #4's MDS assessment was not entered correctly. She also confirmed R #22's MDS assessment was not entered correctly and that the written consent indicated R #22 did not want to use bedrails.<br><br>R #49<br><br>H. Record review of R #49's face sheet revealed R #49 was admitted to the facility on [DATE] with multiple diagnoses including:<br><br>1. Nondisplaced Lateral Mass Fracture of First Cervical Vertebra (Spinal fracture).<br><br>2. Pneumonitis (Inflammation of lung tissue).<br><br>3. Congenital Malformations of Brain (Abnormalities in the brain)<br><br>4. Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment)<br><br>5. Hypertension (high blood pressure).<br><br>6. Chronic Obstructive Pulmonary Disease (COPD; lung disease)<br><br>7. Emphysema (a respiratory disorder that results in the reduction of air intake)<br><br>8. Congestive Heart Failure (CHF; impaired heart function) heart disease)<br><br>9. Muscle weakness<br><br>10. Hypernatremia (a medical term used to describe having too much sodium in the blood)<br><br>I. Record review of R #49's MDS dated [DATE], section O - Special Treatments, Procedures, and Programs, revealed R #49 was admitted to the facility on dialysis and continued dialysis while being a resident of the facility.<br><br>J. Record review of R #49's current medical orders revealed R #49 did not have any orders to receive dialysis.<br><br>K. On 12/12/24 at 12:30 pm, during an interview with the Director of Nursing (DON) she confirmed R #49's MDS assessment was not accurate, R #49 has never been on dialysis.<br><br>50207 |

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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** 51616

Based on interview and record review, the facility failed to ensure staff completed the comprehensive care plans for 3 (R #34, R #42, and R #90) of 3 (R #34, R #42, and R #90) residents reviewed for comprehensive care plans. This failure has the potential to adversely affect staff's ability to implement preventative measures for the residents' health and well-being. The findings are:

R #34

A. Record review of R #34's electronic files, revealed R #34 physician orders for:

1. Clopidogrel Bisulfate (anticoagulant; a medication used to treat blood clots) 75 mg, once daily for blood clot prevention dated 08/13/24.

2. Trazadone (psychotropic (any drug that affects brain activities associated with mental processes and behavior); a medication used to treat depression) 100 mg, once daily for depression dated 08/13/24.

B. Record review of R #34's MAR for December 2024, revealed R #34 was administered the following medications:

1. Clopidogrel Bisulfate 75 mg daily.

2. Trazadone 100 mg daily

C. Record review of R #34's comprehensive care plan dated 08/14/24 revealed the comprehensive care plan did not include the use of both anticoagulant and psychotropic medications.

D. On 12/12/24 at 12:42 pm during an interview, the DON confirmed R #34 took Clopidogrel Bisulfate and Trazadone. The DON confirmed the use of anticoagulant and psychotropic medications is required on comprehensive care plans.

R #42

E. Record review of R #42's face sheet revealed an admitted [DATE] and included the following diagnoses:

1. Type 2 diabetes mellitus with the following complications: diabetic retinopathy (eye disease caused by diabetes) with macular edema (swelling in the eye), diabetic nephropathy (kidney disease caused by diabetes), and hyperglycemia (high blood sugar);

2. Sepsis (unspecified organism) (occurs when chemicals release in the blood stream to fight an infection (when germs multiply and cause the body to react) triggers (a specific event that causes a particular outcome or starts a process) inflammation (an immune response that causes redness and swelling of an area of the body or possibly tissues within the body) through the body.

(continued on next page)

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Insomnia (is a sleep disorder where people have trouble sleeping or difficulty falling asleep).<br><br>4. Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).<br><br>F. Record review of R #42's care plan dated 10/23/24 revealed the focus, goals, and interventions sections were either incomplete or missing entirely from the comprehensive care plan.<br><br>R #90<br><br>G. Record review of R #90's face sheet revealed an admitted [DATE] and included the following diagnoses:<br><br>1. Urinary Tract Infection<br><br>2. Adult Failure to Thrive<br><br>3. Leiomyoma (common benign tumors in women of reproductive age)of uterus ( is an inverted pear-shaped muscular organ located between the bladder and the rectum in the female reproductive system, unspecified<br><br>4. Obstructive and Reflux uropathy, unspecified (when your urine can't flow through your ureter (a tube that carries the urine from the kidney to the bladder), bladder (a membranous sac in human and other animals in which urine is collected for excretion (process of eliminating or expelling waster matter), or urethra (an opening by which urine is conveyed out of the body from the bladder) due to some type of obstruction).<br><br>H. Record review of R #90's care comprehensive care plan dated 10/23/24 revealed the Foley Catheter care was not included on the care plan.<br><br>I. On 12/12/24 at 12:21 pm during an interview, the Director of Nursing (DON) verified the care plans were incomplete for R #34, R #42, and R #90. DON stated the care plans were incomplete.<br><br>51657<br><br>[NAME], Dawn |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51616<br><br>51657<br><br>Based on record review and interview, the facility failed to ensure staff revised the care plan for 4 (R #'s 34, 42, 67 and 90) of 4 (R #'s 34, 42, 67 and 90) residents reviewed when staff failed to:<br><br>1. Update the care plan to continue to monitor for pain medication effectiveness for R #34.<br><br>2. Update the care plan to continue with anti-depressant medications for behavior monitoring and side effects of the anti-depressant medication use for R #42.<br><br>3. Update the care plan to continue with care for R #67's left ankle fracture.<br><br>4. Update the care plan to continue with Foley Catheter for R #90.<br><br>These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are:<br><br>R #34<br><br>A. Record review of R #34's electronic files revealed a physician order dated 10/23/24 for Hydrocodone-Acetaminophen (a combination medication used to treat moderate to severe pain), 5-325 mg, 1 tablet every 6 hours, PRN (as needed) for pain.<br><br>B. Record review of R #34's MAR for the month of November 2024, revealed R #34 was administered Hydrocodone-Acetaminophen.<br><br>C. Record review of R #34's MAR for the month of December 2024, revealed R #34 was not administer Hydrocodone-Acetaminophen but is an active order that is available to be administered.<br><br>D. Record review of R #34's comprehensive care plan revised on 10/23/2024 revealed the comprehensive care plan did not include interventions for the following:<br><br>1. Monitoring for Pain.<br><br>2. Non-pharmacological interventions (strategies used to relieve symptoms without use of medication).<br><br>3. Effectiveness of pain medication use.<br><br>E. On 12/12/2024 at 12:42 pm during an interview, the DON confirmed R #34 had an active order Hydrocodone-Acetaminophen. The DON confirmed interventions for pain medications are required for comprehensive care plans. The revision of the comprehensive care plan for R #34 dated 10/23/2024 did not include interventions for pain medication monitoring.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R #42:<br><br>F. Record review of R #42's face sheet revealed R #42 was admitted into the facility on [DATE].<br><br>G. Record review of R #42's care plan dated 10/23/24 indicated an incomplete anti-depressant care plan, (this care plan was not individualized on the focus, had no goals, and lacked interventions).<br><br>R #67<br><br>H. On 12/08/2024 at 2:06 pm during an interview with R #67's wife stated R #67 recently broke his ankle on 09/18/24.<br><br>I. Record review of R #67 physician progress note dated 9/19/2024, revealed the resident had a left ankle fracture.<br><br>J. Record review of resident R #67's comprehensive care plan initiated on 04/07/2023, revealed the comprehensive care plan was not revised to indicate residents left ankle fracture.<br><br>K. On 12/12/2024 at 12:42 pm during an interview, the DON confirmed R #67's comprehensive care plan was not revised to include care for R #67's left ankle fracture and should have been.<br><br>R #90:<br><br>L. Record review of R #90's face sheet revealed R #90 was admitted into the facility on [DATE].<br><br>M. Record review of R #90's current care plan dated 08/07/24 did not indicate a revision was completed on 09/19/24 when left ankle fracture was confirmed.<br><br>N. On 12/12/24 at 12:31 pm during an interview with the DON, she stated the care plans were not up to date and have not been completed for change in conditions or quarterly as required. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>50207<br><br>Based on observation, record review, and interview, the facility failed to keep residents free from accidents for 1 (R #64) of 1 (R #64) residents reviewed for smoking when staff failed to hold smoking supplies. This deficient practice led to R #64 smoking in his room at the facility. The findings are:<br><br>A. Record review of R #64's face sheet revealed R #64 was admitted to the facility initially on 09/25/22 with multiple diagnoses including:<br><br>1. Multiple sclerosis (MS; a chronic progressive disease involving damage to the nerve cells in the brain and spinal cord, which may cause numbness, impairment of speech and muscular coordination, blurred vision and severe fatigue)<br><br>2. Anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).<br><br>3. Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).<br><br>B. Record review of R #64's Smoking Evaluation dated 10/03/23 revealed R #64 required supervision while smoking.<br><br>C. Record review of R #64's comprehensive care plan, revised on 11/13/24, revealed the following:<br><br>1. [Name of R #1] may smoke with supervision per smoking assessment.<br><br>2. Maintain patients smoking materials at nurses' station.<br><br>D. On 12/09/24 at 8:33 am, during an interview and observation with R #64 in his room, he stated that he does hold his cigarettes and lighter in his bag. A red plastic cup containing a paper towel and some kind of liquid with two used cigarette butts were in the cup holder of his wheelchair. R #64 confirmed that he had smoked in his room but would not say when he smoked in his room.<br><br>E. On 12/09/24 at 8:41 am, during an interview with CNA #1, she confirmed R #64 had smoked in his room before. She stated that R #64 knows he is not supposed to smoke in the building but he still did so.<br><br>F. On 12/12/24 at 1:24 pm during an interview with the Administrator (ADM), he confirmed that at one point, the facility was allowing residents to hold their smoking supplies instead of keeping it locked at the nurses' station. |

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| | 325044 | A. Building<br>B. Wing | 12/12/2024 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51657<br><br>Based on observation, interview and record review, the facility failed to provide Foley catheter (a flexible tube inserted into the bladder and anchored by a balloon to allow the free flow of urine into an attached bag) care for 1 (R #90) of 1 (R #90) residents reviewed for catheter care. This deficient practice is likely to result in a resident's catheters becoming unclean and unsanitary leading to urinary tract infections (UTI; an infection in any part of the urinary system) and other diseases. The findings are:<br><br>A. Record review of R #90's face sheet, revealed an initial admitted [DATE] and included the following diagnoses:<br><br>1. Metabolic Encephalopathy (is a change in how your brain works due to an underlying condition).<br><br>2. Adult Failure to Thrive (a state where an individual has a substantial decline in overall health and their functional ability).<br><br>3. Leiomyoma of Uterus, Unspecified benign tumors in the smooth muscle cells of the myometrium (thick middle layer of the uterus (inverted pear-shaped muscular organ located between the bladder and the rectum in the female reproductive system.<br><br>4. Altered Mental Status, Unspecified (a change to your average mental function).<br><br>5. Muscle Weakness (lack of muscle strength).<br><br>6. Obstructive and Reflux Uropathy, Unspecified (Swelling and other damage to one or both kidneys).<br><br>B. Record review of R #90's admission orders, dated 08/07/24, revealed R #90 had a urinary catheter tubing size, but it did not indicate the size of the catheter and the balloon size.<br><br>C. Record review of R #90's Minimum Data Set (MDS; an assessment tool used to assess the health and needs of nursing home residents), dated 08/10/24, revealed R #90 had an indwelling catheter upon admission.<br><br>D. Record review of R #90's physician orders revealed the following:<br><br>- An order dated, 11/04/2024 to 12/04/2024, for indwelling catheter every night shift every 30 days for Foley placement.<br><br>- The order did not include the size of the tubing,<br><br>- The order did not include the size of the balloon.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | E. On 12/12/24 at 11:25 pm, during an interview with Registered Nurse (RN) #2, she stated R #90 was sent out to the emergency roiagnom on [DATE] for low blood pressure and low blood sugar level. RN #2 stated R #90 had chronic (recurring or long lasting) UTIs and was a chronic catheter patient. She stated R #90 returned to the facility with a diagnosis of Bacteremia (presence of bacteria in the bloodstream).<br><br>F. Review of Centers for Disease Control (CDC) .once the catheter is inserted, maintaining it according to evidence-based guidelines is crucial to prevent Catheter Acquired Urinary Trach Infection (CAUTI).<br><br>G. On 12/12/24 at 12:25 pm, during an interview with the DON (Director of Nursing), she said there should be an order for R #90's indwelling urinary catheter. The DON confirmed R #90 did not have a completed order for urinary catheter care. All the maintenance orders for urinary catheter catheter care are not input into the computer and this is not acceptable to her. The DON confirmed R #90's order for a Foley catheter should have been confirmed upon admission, along with the accompanying orders to perform catheter care, measure and record urine output, change Foley catheter every 30 days or when indicated, empty the catheter drainage bag once per shift, replace drainage system and check for leaks.<br><br>H. Record review of the Center for Disease Infection Control and Prevention presentation titled, Indwelling Urinary Catheter Insertion and Maintenance, undated, revealed once the catheter is inserted, maintaining it according to evidence-based guidelines is crucial to prevent CAUTI. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>51616<br><br>Based on observation and interview, the facility failed to post nurse staffing data on a daily basis at the beginning of the shift that included the following:<br><br>a. Facility name.<br><br>b. The current date.<br><br>c. The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br><br>i. Registered nurses.<br><br>ii. Licensed practical nurses.<br><br>iii. Certified nurse aides.<br><br>iv. Resident census.<br><br>This deficient practice could likely result residents and visitors not knowing the staff working. The findings are:<br><br>A. On 12/08/24 at 11:30 pm, during an observation of the main entrance door, the nurse staffing data for the day was not posted.<br><br>B. On 12/08/24 at 1:35 pm, during an interview with Medical Records staff member, she confirmed the nursing staff data was not posted. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>50207<br><br>Based on interviews, the facility failed to ensure the consultant pharmacist's recommendations were reviewed and responded to by the physician. This deficient practice has the potential to affect all 96 residents living in the facility as identified by the census provided by the Administrator on 12/08/24. The findings are:<br><br>A. On 12/11/24 at 1:36 pm, during an interview with the Director of Nursing (DON) she stated that she does not have any documentation to submit to surveyors for review on the completion of medication regimen reviews because they were not completed prior to November 2024. The DON stated that she can provide the pharmacist's printed recommendations, but she has no evidence that the physician reviewed them.<br><br>B. On 12/11/24 at 4:17 pm, during an interview with the Administrator, he confirmed the pharmacist's recommendations made through the medication regimen review process have not been completed prior to November 2024. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325044 | A. Building<br>B. Wing | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mission Arch Center | 3200 Mission Arch Drive<br>Roswell, NM 88201 |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>51616<br><br>Based on record review and interview the facility failed to ensure adequate monitoring of medications for 1 (R #34) of 4 (R #34, R #49, R #67, and R #77) residents reviewed for unnecessary medications. This deficient practice is likely to result in failure to address adverse effects resulting in unnecessary medications. The findings are:<br><br>A. Record review of R #34's current physician orders revealed R #34 had orders for:<br><br>1. Clopidogrel Bisulfate (anticoagulant; a medication used to treat blood clots) 75 milligrams (mg), once daily for blood clot prevention dated 08/13/24.<br><br>2. Trazadone (psychotropic; a medication used to treat depression) 100 mg, once daily for depression dated 08/13/24.<br><br>B. Record review of R #34's medication administration record (MAR) for December 2024, revealed R #34 was administered the following medications:<br><br>1. Clopidogrel Bisulfate 75 mg daily.<br><br>2. Trazadone 100 mg daily<br><br>C. Record Review of R #34's documentation survey report (a detailed report that included tasks, interventions, frequency, documentation details, and responses) for December 2024 revealed R #34 was not monitored for any side effects for Clopidogrel Bisulfate and Trazadone medications.<br><br>D. On 12/12/24 at 12:42 pm during an interview, the Director of Nursing (DON) confirmed R #34 was administered Clopidogrel Bisulfate and Trazadone. The DON confirmed that anticoagulants and psychotropic medications were not being monitored. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>49827<br><br>Based on observation, record review, and interview, the facility failed to ensure the medication error rate was 5% or less when three medication errors occurred out of 31 opportunities, which resulted in an error rate of 6. 45% for 1(R #4) of 8 (R #4, R #32, R #40, R #44, R #71, R #80, R #89, and R #92) residents observed during medication administration. This deficient practice could likely result in the residents receiving the incorrect medication, not receiving the desired therapeutic effect, and exposing the resident to a higher risk of side effects. The findings are:<br><br>Incorrect Administration via Feeding Tube<br><br>A. On 12/11/24 at 11:49 am during an observation of medication administration via feeding tube for R #4 , Registered Nurse (RN) #2 poured 30 milliliters (ml's) of Guaifenesin (medication to help eliminate (remove) sputum (combination of saliva and mucus) from the respiratory tract) liquid into a cup, she then crushed Lamotrigine (medication used to treat epilepsy (a seizure disorder)) 100 milligrams (mg) capsule and poured into the same cup as the Guaifenesin liquid. RN #2 then added some water and mixed the contents together. She flushed the feeding tube as per physician orders, poured the contents of the cup into the feeding tube and flushed with prescribed amount after medication was given.<br><br>B. Record review of medications order dated 01/20/24 stated give GuaiFENesin Syrup Give 600 mg via (by way of) G-Tube three times a day for Congestion Give 30 ml and an order for the medication Keppra Solution 100 MG/ML (LevETIRAcetam) Give 500 mg via G-Tube every morning and at bedtime for seizures = 5 ml.<br><br>C. On 12/11/24 at 12:00 pm, during an interview with RN #2, she indicated that it was okay to mix medications together prior to administration depending on the quantity of medications.<br><br>D. Record review of the facility's policy Medication Policy - Enteral Tubes dated 05/23 point number 10, Each medication is administered separately to avoid interaction and clumping.<br><br>E. On 12/12/24 at 1:05 pm during an interview with the Director of Nursing (DON), she indicated that her expectation is that medications are given separately through the feeding tube. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49827<br><br>Based on observation and interview the facility failed to:<br><br>1. Ensure all medications were not expired.<br><br>2. Ensure medical supplies in the medication storage room were not expired.<br><br>These deficient practices are likely to negatively impact the health of all residents, if staff administered or used potentially compromised or contaminated medications and medical supplies due to inappropriate storage. The findings are:<br><br>Medications<br><br>A. On [DATE] at 2:05 pm, during an observation of the North Medication Storage room revealed three boxes of laxative enemas (injection of fluid to cleanse or stimulate the emptying of your bowel) with the expiration date of ,d+[DATE] and one bottle of opened Ibuprofen that expired on ,d+[DATE].<br><br>Medical Supplies<br><br>B. On [DATE] at 2:15 pm, during an observation of North Medication Storage room revealed four needless connectors that expired on ,d+[DATE].<br><br>C. On [DATE] at 2:20 PM, during an interview with Registered Nurse (RN) #1, she confirmed that the expired medication and supplies should be discarded. |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>50207<br><br>Based on observation, record review, and interview, the facility failed to provide sufficient support staff to carry out the functions of food and nutrition services at the facility. This deficient practice is likely to result in the resident's dietary needs not being met and longer waiting times for meal service for all 96 residents living in the facility as identified by the census provided by the Administrator on 12/08/24. The findings are:<br><br>A. On 12/08/24 at 11:30 am, during an initial observation of the facility, the doors to the dining room were closed and locked.<br><br>B. On 12/08/24 at 11:35 am, during an interview with Medical Records (MR) #1 stated the dining room was closed because there is not enough staff to open it.<br><br>C. Record review of the facility's posted mealtimes revealed meals are to be served at 7:00 am, 11:00 am, and 5:00 pm.<br><br>D. On 12/10/24 at 11:51 am, during a dining observation in the main dining room, the first meal was served at 11:53 am (fifty-three minutes after lunch was scheduled to be served).<br><br>E. On 12/10/24 at 12:02 pm, during an interview, R #64 stated that the food usually tastes good, but he does get tired of having to sit here and wait for it.<br><br>F. On 12/10/24 at 5:11 pm, during a dining observation in the activity room, the following was observed:<br><br>1. R #17 sat in her wheelchair at the table. At approximately 5:27 pm, R #17 began vocalizing and banging on the table and this behavior continued until she was served her meal at 5:45 pm.<br><br>2. R #16 sat in his wheelchair at the table. At approximately 5:35 pm, R #16 started to fall asleep, and remained asleep until staff sat down to assist R #16 with dinner at 5:51 pm.<br><br>G. On 12/10/24 at 5:40 pm, during an interview with the Administrator (ADM), he confirmed that dinner was served late by stating he would go find out what's wrong because dinner in the activity room was usually served by now.<br><br>H. On 12/11/24 at 7:17 am, during a dining observation of the main dining room, the first meal was served at 7:46 am (forty-six minutes after breakfast was scheduled to be served).<br><br>I. On 12/11/24 at 7:33 am, during an interview with R #42, she stated that she does not go to the dining room on time because she is used to meals being served late. |

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| F 0865<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a plan that describes the process for conducting QAPI and QAA activities.<br><br>49827<br><br>Based on record review and interview, the facility failed to develop, implement and maintain a Quality Assurance and Performance Improvement (QAPI) Plan. This can affect all 96 residents (per census list provided by the Administrator on 12/08/24). This deficient practice could likely result in the facility not making good faith attempts to identify and correct quality deficiencies that would lead to improvement in the lives of the residents. The findings are:<br><br>A. On 12/12/24 at 12:26 PM, during an interview, the Administrator (ADMIN) he stated, he does not have a QAPI plan in place, he has no records of QAPI to review and he does not have a QAPI monitoring system in place since July of 2024.<br><br>B. Record review of the facility's policy for QAPI, dated 10/24/22 revealed: Centers are committed to incorporating the principles of Quality Assurance and Performance Improvement (QAPI) into all aspects of the center work processes, service lines, and departments. QAPI activities will be integrated across all care and service areas and include clinical care, quality of life, and patient/resident (hereinafter patient) choice. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207<br><br>Based on observation, record review, and interview, the facility failed to develop and implement an ongoing infection prevention and control program (a program that is used to prevent, recognize, and control the onset and spread of infections). This deficient practice has the potential to affect all 96 residents living in the facility as identified by the census provided by the Administrator on 12/08/24. This deficient practice could likely result in the spread of infectious diseases.<br><br>A. On 12/08/24 at 1:33 pm, during a random observation of the facility, signs indicated special contact and droplet precautions were on the doorways of room [ROOM NUMBER] and 135.<br><br>B. On 12/10/24 at 11:11 am, during a random observation of the facility, Unit Secretary (US) walked past the personal protective equipment (PPE) carts (where the facility stores clean equipment such as gowns, masks, gloves, etc. for staff's use prior to entering a resident's room) located outside the doorways of rooms [ROOM NUMBERS] and entering each room without the use of PPE.<br><br>C. On 12/10/24 at 1:07 pm during an observation of the South Short hall, signs indicated special contact and droplet precautions were on the doors of rooms [ROOM NUMBERS]. Containers to discard used PPE were on the outside of rooms [ROOM NUMBERS].<br><br>D. On 12/10/24 at 1:15 pm during an interview with the Director of Nursing (DON), she confirmed that containers to discard used PPE are supposed to be located inside the room so staff can discard the used PPE prior to exiting the room.<br><br>E. Record review of the facility's Infection Control Outcome and Process Surveillance and Reporting policy, revision date of 03/01/24, revealed the following:<br><br>1. The Infection Preventionist will conduct regular outcome surveillance which consists of collecting/documenting data on individual cases and comparing the collective data to standard, written definitions of infection .<br><br>2. The Infection Preventionist will conduct regular process surveillance to review practices directly related to patient care .<br><br>F. On 12/12/24 at 12:30 pm during an interview with the DON, she confirmed that she does not have any documentation to submit to surveyors for review on the infection prevention and control program. The DON confirmed that the facility failed to develop and implement an ongoing infection prevention and control program prior to November 2024 due to the previous DON not completing these duties. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Implement a program that monitors antibiotic use.<br><br>50207<br><br>Based on interview and record review, the facility failed to ensure staff implemented a comprehensive antibiotic stewardship program (a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use). This deficient practice has the potential to affect all 96 residents living in the facility as identified by the census provided by the Administrator on 12/08/24. This deficient practice could likely result in the inappropriate use of antibiotics. The findings are:<br><br>A. On 12/11/24 at 1:36 pm, during an interview with the Director of Nursing (DON) she stated that she does not have any documentation to submit to surveyors for review on the facility's antibiotic stewardship program because the program was not implemented prior to November 2024.<br><br>B. Record review of the facility's Antibiotic Stewardship policy, revision date of 08/07/23 revealed that Centers will implement an Antibiotic Stewardship Program (ASP) that includes antibiotic use protocols and systems for monitoring antibiotic use. The Infection Preventionist (IP) is responsible for the Infection Prevention and Control program including ASP. The Administrator is ultimately responsible for the overall compliance with the ASP. The Director of Nursing (DON) and Medical Director are responsible for executing the ASP standards.<br><br>C. On 12/11/24 at 4:17 pm, during an interview with the Administrator, he confirmed the antibiotic stewardship program was not implemented prior to November 2024. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>50207<br><br>Based on record review and interview, the facility failed to ensure residents had completed and signed consent/refusal forms to show they consented to or declined the pneumococcal (for pneumonia, an infection and inflammation of the lung) vaccine for 2 (R #38 and R #74) of 5 (R #27, R #36, R #38, R #74, and R #85) residents reviewed for immunizations. If residents are not vaccinated as appropriate against pneumonia, then they have a higher likelihood of contracting the illness and spreading it to other residents in the facility. The findings are:<br><br>R #38<br><br>A. Record review of R #38's Electronic Health Record (EHR) revealed the last pneumococcal vaccine was received on 04/25/19.<br><br>B. On 12/12/24 at 12:30 pm, during an interview with the Director of Nursing (DON) she confirmed R #38's EHR does not contain any evidence that the facility offered the pneumococcal vaccination to R #38 since 04/25/19. The DON stated that the pneumococcal vaccination should have been offered to R #38 in April of 2024.<br><br>R #74<br><br>C. Record review of R #74's EHR revealed that staff failed to offer the pneumococcal vaccination to R #74.<br><br>D. On 12/12/24 at 12:30 pm, during an interview with the DON she confirmed that R #74's EHR does not contain any evidence that the facility offered the pneumococcal vaccination to R #74.<br><br>E. Record review of the facility's Pneumococcal Vaccination policy, revised on 09/13/24 revealed that pneumococcal vaccinations are to be offered to residents after education is received. Frequency of how often vaccine is to be offered was not indicated. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207<br><br>Based on record review and interview, the facility failed to offer COVID-19 (an acute respiratory disease in humans characterized mainly by fever and cough and capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) vaccinations to 3 (R #36, R #38, and R #74) of 5 (R #27, R #36, R #38, R #74, and R #85) residents reviewed for COVID-19 vaccinations. This deficient practice could likely result in residents getting COVID-19. The findings are:<br><br>R #36<br><br>A. Record review of R #36's Electronic Health Record (EHR) revealed the last COVID-19 vaccination that R #36 received was in October 2022.<br><br>B. On 12/12/24 at 12:30 pm, during an interview with the DON, she confirmed R #36's EHR does not contain any evidence that the facility offered the COVID-19 vaccination to R #36 after October 2022.<br><br>R #38<br><br>C. Record review of R #38's EHR revealed the last COVID-19 vaccination that R #38 received was in November 2021.<br><br>D. On 12/12/24 at 12:30 pm, during an interview with the DON she confirmed that R #38's EHR does not contain any evidence that the facility offered the COVID-19 vaccination to R #38 after November 2021.<br><br>R #74<br><br>E. Record review of R #74's EHR revealed staff failed to offer the COVID-19 vaccination to R #74.<br><br>F. On 12/12/24 at 12:30 pm, during an interview with the Director of Nursing (DON) she confirmed that R #74's EHR does not contain any evidence that the facility offered the COVID-19 vaccination.<br><br>G. Record review of the facility's COVID-19 Vaccination policy, revision date of 02/07/24 revealed that Centers will provide the opportunity to receive COVID-19 vaccinations following Centers for Disease Control and Prevention (CDC) recommendations .<br><br>H. Record review of the Center for Disease Control and Prevention's website, https://www.cdc.gov/covid/vaccines/long-term-care-residents.html, stated the following:<br><br>1. CDC recommends everyone ages 5-[AGE] years, including people who live and work in long-term care (LTC) settings, get 1 dose of a 2024-2025 COVID-19 vaccine.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. CDC recommends everyone ages [AGE] years and older, including people who live and work in LTC settings, get 2 doses of a 2024-2025 COVID-19 vaccine 6 months apart. |