STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325087	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northgate Unit of Lakeview Christian Home	1905 West Pierce Street Carlsbad, NM 88220

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 49313 Based on observation and interview, the facility failed to provide reasonable accommodation of resident needs for 2 (R #37 and R #41) of 2 (R #37 and R #41) residents reviewed for care when the facility failed to ensure that resident's bedside table with frequently used items were within the resident's reach. This deficient practice could result in the residents' needs not being met, leaving them at risk for accidents and falls. The findings are: R #37 A. On 03/26/24 at 10:10 AM, during an interview and observation of R #37, the following was revealed: 1. R #37 sat in chair next to his bed. 2. R #37's call bell sat on R #37's bed behind him. The call bell was out of R #37's eye sight and out of his reach. 3. R #37's bedside table with drinks was at the foot of R #31's bed and was approximately four feet away from resident 4. R #37 stated that he was unable to get up on his own and unable to get his drinks. B. On 03/26/24 at 10:31 AM, during an interview with CNA #22, she confirmed the following: 1. R #37 was not able to get up on his own. 2. R #37's drinks were out of his reach. 3. The bedside table with drinks should be within R #37's reach. R #41 C. On 03/26/24 at 9:40 AM, during an observation and interview with R #41, the following was revealed: (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R #41 lay in her bed. 2. R #41 said she was not able to get out of bed on her own. 3. R #41's bedside table with R #41's drinks and a box of tissue was about three feet away from R #41's bed. 4. R #41 said she was unable to get a drink since the bedside table was out of her reach. D. On 03/26/24 at 9:43 AM, during an interview with CNA #23, she confirmed the following: 1. R #41 was not able to get up on her own. 2. R #41's drinks were out of her reach. 3. The bedside table with drinks and other items, she frequently needs should be within R #41's reach. E. On 03/29/24 at 8:48 AM, during an interview with LPN #23, she confirmed R #41's bedside table with drinks and frequently needed items should be within R #41's reach. F. On 03/29/24 at 12:34 PM, during an interview with the DON, she confirmed resident's bedside table with drinks and other frequently used items should be within residents reach.

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	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. 50497 Based on observation and interview the facility failed to provide a homelike environment for all 76 residents. Residents were identified by the resident matrix provided by the Administrator on 03/25/24, when they failed to repair the broken roof tiles in the activity room. If residents do not have a homelike environment, they could likely become depressed and anxious and feel not valued. The findings are: A. On 03/25/24 at 1:23 PM, during an observation of the activity room revealed the following: 1. One ceiling tile had the corner piece broken off. 2. A second tile had a corner piece broken off and missing the corner of the tile. 3. A third tile had a crack on the corner. B. On 04/02/24 at 11:32 AM, during an interview the Maintenance Director confirmed roofing tiles were replaced but did not specify where and when. C. On 04/02/24 at 11:34 AM, during an interview with Administrator, she confirmed one tile in activity room was cracked. The Administrator stated that she did not see any other tiles that were broken, maintenance confirmed roofing tiles were replaced but did not specify where and when.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 41755 Based on record review and interview the facility failed to ensure that residents, their representatives, and the Ombudsman (a resident advocate that is a government employee who investigates and tries to resolve complaints, usually through recommendations or mediation) received a written notice of transfer as soon as practicable for 6 (R #16, R #24, R #34, R #37, R #59, and R #65) of 6 (R #16, R #24, R #34, R #37, R #59, and R #65) residents reviewed for hospitalization . This deficient practice could likely result in the resident and/or their representative not knowing the reason or location the resident was discharged . The findings are: R #16 A. Record review of R #16's medical record revealed the following: 1. R #16 was transferred to the hospital on 02/18/24 after a fall. 2. Staff did not provide a written transfer notice to R #16 or her representative. 3. Staff did not provide a copy of a written transfer notice to the Office of the State Ombudsman. R #24 B. Record review of R #24's medical record revealed the following: 1. R #24 was transferred to the hospital on 12/08/23 due to having blood in her stool. 2. Staff did not document that a written transfer notice was provided to R #24 and her representative. R #34 C. Record review of R #34's medical record revealed the following: 1. R #34 was transferred to the hospital on 03/13/24 for pain. 2. R #34 was transferred to the hospital on 03/17/24 due to a positive Methicillin-resistant Staphylococcus aureus (MRSA, group of gram-positive bacteria that are genetically distinct from other strains of Staphylococcus aureus. MRSA is responsible for several difficult-to-treat infections in humans) culture. 3. Staff did not provide a written transfer notice to R #34 or his representative for the hospital transfers on 03/13/24 and on 03/17/24. 4. Staff did not provide copies of the written transfer notices on 03/13/24 and on 03/17/24 to the Office of the State Ombudsman. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #37 D. Record review of R #37's medical record revealed the following: 1. R #37 was transferred to the hospital on 02/28/24 for pain. 2. Staff did not document that a written transfer notice was provided to R #37 or his representative for the hospital transfer on 02/28/24. 3. Staff did not document that the copy of the written transfer notice on 02/28/24 was sent to the Office of the State Ombudsman. R #59 E. Record review of R #59's medical record revealed the following: 1. R #59 was transferred to the hospital on 10/15/23 due to being lethargic (unusual decrease in consciousness). 2. Staff did not document that a written transfer notice was provided to R #59 and her representative. R #65 F. Record review of R #65's medical record revealed the following: 1. R #65 was transferred to the hospital on 11/24/23 for shortness of breath. 2. Staff did not provide a written transfer notice to R #65 or her representative. 3. Staff did not provide a copy of a written transfer notice to the Office of the State Ombudsman G. On 03/28/24 at 11:17 AM, during an interview with the Administrator, she confirmed the facility does not have a written transfer notice form. H. On 04/02/24 at 2:55 PM, during an interview with the Ombudsman, she confirmed that she received a faxed list of resident names (not a copy of the written notices) who were transferred to the hospital from the facility monthly. 47510 49313

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 41755 Based on record review and interview, the facility failed to ensure that residents and their representatives received a written notice of the bed hold policy which indicated the duration the bed would be held for 6 (R #16, R #24, R #34, R #37, R #59, and R #65) of 6 (R #16, R #24, R #34, R #37, R #59, and R #65) residents reviewed for hospitalization . This deficient practice could likely result in the resident and/or their representative being unaware of the bed hold policy upon return from the hospital. The findings are: R #16 A. Record review of R #16's medical record revealed the following: 1. R #16 was transferred to the hospital on 02/18/24 after a fall. 2. R #16's medical record did not contain a written notice of bed hold policy for the transfer on 02/18/24. R #24 B. Record review of R #24's medical record revealed the following: 1. R #24 was transferred to the hospital on 12/08/23 due to having blood in her stool. 2. R #24's medical record did not contain a written notice of bed hold policy for the transfer on 12/08/23. R #34 C. Record review of R #34's medical record revealed the following: 1. R #34 was transferred to the hospital on 03/13/24 for pain. 2. R #34 was transferred to the hospital on 03/17/24 due to a positive Methicillin-resistant Staphylococcus aureus (MRSA, group of gram-positive bacteria that are genetically distinct from other strains of Staphylococcus aureus. MRSA is responsible for several difficult-to-treat infections in humans) culture. 3. R #34's record did not contain a written notice of the bed hold policy for R #34's hospital transfers on 03/13/24 and on 03/17/24. R#37 D. Record review of R #37 medical record revealed the following: (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R #37 was transferred to the hospital on 02/28/24 for pain. 2. The record did not contain a written notice of the bed hold policy for R #37's hospital transfer on 02/28/24. R #59 E. Record review of R #59's medical record revealed the following: 1. R #59 was transferred to the hospital on 10/15/23 due to being lethargic (unusual decrease in consciousness). 2. R #59's medical record did not contain a written notice of bed hold policy for the transfer on 10/15/23. R #65 F. Record review of R #65's medical record revealed the following: 1. R #65 was transferred to the hospital on 11/24/23 for shortness of breath. 2. R #65's medical record did not contain a written notice of bed hold policy for the transfer on 11/24/23. G. On 03/28/24 at 11:17 AM, during an interview with the Administrator, she confirmed the following: 1. The receptionist sends a bed hold notice in the mail to the resident representative that is responsible for the residents bill the next business day. 2. The residents were not given the bed hold notice. 3. The facility does not keep a copy of the bed hold notice. 4. The facility does not have documentation that the bed hold notices were sent. H. On 03/28/24 at 11:23 AM, during an interview with Receptionist #21, she confirmed the following: 1. She completes bed hold notices every morning Monday through Friday based off the census. 2. If the census shows the resident is discharged to the hospital, she completes a bed hold notice. 3. She sends the notice to the family member has the highest priority in the resident's medical record. 4. If a resident returns to the facility prior to the census being printed, she does not complete a bed hold notice. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. She does not give a copy of the bed hold notice to the resident. 6. She does not keep a copy of the bed hold notice. 7. She does not document in the medical record that a bed hold notice was completed and who it was sent to. 47510 49313

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS; assessment instrument completed by facility staff) was accurate for 1 (R #58) of 6 (R #4, R #7, R #24, R #52, R #57, and R #58) residents reviewed for MDS accuracy. This deficient practice could likely result in the facility not having an accurate assessment of resident's care needs. The findings are: A. Record review of R #58's nursing progress note dated 12/16/23 at 11:59 AM, revealed that staff documented that R #58 complained of burning pain upon urination. B. Record review of R #58's McGreer's Criteria form (surveillance tool that is used to help identify and track infections among residents) dated 12/16/23 at 2:05 PM revealed: 1. Acute dysuria (painful urination) or acute pain was marked yes. 2. At least 100,000 colony count (number of bacteria in a urine sample indication urinary infection) of no more than 2 species of microorganisms (microscopic organism, especially a bacteria, virus, or fungus) in a voided urine sample was marked yes. C. Record review of the R #58's physician orders revealed: an order start date of 01/06/24, gentamicin (antibiotic used to treat severe or serious bacterial infections) solution administer 60 milligrams every 8 hours for urinary tract infection. D. Record review of R #58's Nurse Practitioner progress note dated 01/06/24 revealed: assessment, UTI (urinary tract infection). E. Record review of the quarterly MDS assessment for R #58, dated 01/09/24, revealed staff did not document a diagnosis of UTI in the last 30 days. F. On 03/29/24 at 4:23 PM, during an interview with the MDS Coordinator, she confirmed that she did not code the diagnosis of UTI for R #58. The MDS Coordinator confirmed the MDS assessment dated [DATE] was not accurate for R #58.

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F 0657 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41755 Based on record review and interview, the facility failed to ensure care plan revision and care plan meeting requirements occurred for 10 (R #4, R #12, R #16, R #24, R #31, R #37, R #39, R #59, R #65, and R #179) of 13 (R #4, R #12, R #16, R #24, R #31, R #37, R #39, R #52, R #57, R #58, R #59, R #65, and R #179) residents reviewed for care plans when they failed to: 1. Have the required Interdisciplinary Team (IDT, team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities, and includes other appropriate staff or professionals in disciplines as determined by the resident's needs) members (Hospice and R #39) as well as resident representatives participate in the care plan meeting for R #31 and R #39. 2. Have the care plan meeting within seven days after the completion of the MDS assessment for R #31. 3. Revise the care plan with the most current resident information for R #4, R #16, R #24, R #37, R #39, R #59, R #65, and R #179. These deficient practices could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: Resident Representatives/Hospice Members R #31 A. Record Review of R #31's social services progress notes revealed the following: 1. On 12/14/23, R #31 had a care plan meeting, R #31's representative did not attend the meeting. 2. On 09/14/23, R #31 had a care plan meeting, R #31's representative did not attend the meeting B. On 03/26/24 at 10:44 AM, during an interview, R #31's Family Member (FM #1) stated he lives out of state and is R #31's representative. FM #1 stated he does not receive phone calls for care plan meetings so he could attend. FM #1 also confirmed he receives letters informing him of the care plan meetings but they arrive after the meeting has already taken place, so he was not able to attend. C. Record Review of R #39's social services progress notes revealed the following: 1. On 01/25/24, R #39 had a care plan meeting, R #39's representative did not attend the meeting. 2. On 09/14/23, R #39 had a care plan meeting, R #39's representative did not attend the meeting (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 03/26/24 at 4:45 PM, during an interview, R #39's FM #2 stated her and her brother have not attended a care plan meeting in almost a year. FM #2 stated her sister who is the conservator (guardian) gets notified about care plan meetings and have attended some. FM #2 stated all three of R #39's children would like to attend care plan meetings and be notified if one of them is not available since they are all co-guardians. E. Record review of the facility's care plan notification spreadsheet (not dated) revealed Social Services Assistant (SSA) did not contain any documentation of specific dates, times or who she called to notify of upcoming care plan meetings. F. On 03/27/24 at 2:56 PM, during an interview the SSA confirmed MDSC sets up care plan meetings. The SSA confirmed that the SSD, Dietician Director, Activities Director and herself attend the care plan meetings. SSA stated R #39's family member gets notified through a letter and a phone call to notify them two weeks prior to a care plan meeting. She stated R #39 does not attend meetings, and is not invited because of his cognition. R #39 BIM score was 00 (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses, R #39 BIM score is 00 impaired cognition). The family can attend via teleconference if needed since family lives out of town. First person contact receives letters. SSA stated the facility had contacted one of R #39's family on 01/12/24 via letter (SSA was not specific about which family member) and FM #2 was contacted by phone call. SSA confirmed she completes a spreadsheet for care plan notification. The SSA stated she called R #39's family three times with no return phone call (SSA did not specify which family member). G. On 03/27/24 at 3:52 PM, during an interview, Social Services Director (SSD) confirmed hospice staff are invited to meetings but sometimes they will not attend due to emergencies or because they are out in the field caring for other residents. SSD confirmed staff do not document that hospice did not attend residents meeting. The SSD confirmed facility does not keep a copy of the notification letter for care plan meetings in R #39's medical record. H. On 03/27/24 at 4:11 PM, during an interview with MDSC, she confirmed Hospice staff did not attended care plan meetings in person December 2023 and January 2024. Care Plan Timing R #31 I. Record review of R #31's quarterly MDS assessment revealed it was completed on 03/01/24. J. Record review of R #31's care plan revealed it was completed on 12/14/23. K. On 03/28/24 at 11:14 AM, during an interview the MDS Coordinator (MDSC) verified the quarterly MDS assessment for R #31 was completed on 03/01/24. (MDSC was mistaken the care plan should have been completed seven days after completion of the MDS). The MDSC confirmed R #31's care plan meeting has not taken place. L. On 03/28/24 at 11:24 AM, during an interview the SSA and SSD confirmed R #31's care plan conference has not been scheduled. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care plan review/revision R #4 M. Record review of R #4's Quarterly Minimum Data Set assessment, dated 03/19/24, Section GG: Functional Abilities and Goals revealed: 1. Question GG0130.B - Oral hygiene; The resident required set-up or clean-up assistance. One staff sets up or cleans up; resident completes activity. Staff assist only prior to or following the activity. 2. Question GG0130.C- Toileting hygiene; The resident required substantial/maximum assistance. One staff helps and provides more than half the effort. 3. Question GG0130.E- Shower/bathe self; The resident required partial/moderate assistance. One staff helps and provides less than half the effort. 4. Question GG0130.F- Upper body dressing; The resident required partial/moderate assistance. One staff helps and provides less than half the effort. 5. Question GG0130.G- Lower body dressing; The resident required partial/moderate assistance. One staff helps and provides less than half the effort. 6. Question GG0130.I- Personal hygiene (combing hair, shaving, applying makeup, washing/drying face and hands); Independent. The resident is independent. Resident completes the activity by themselves with no assistance from staff. 7. Question GG0170.A- Roll left and right (ability to move from left to right side in bed); The resident required partial/moderate assistance. One staff helps and provides less than half the effort. 8. Question GG0170.B- Sit to lying (ability to move from sitting on side of bed to lying flat on the bed); The resident required partial/moderate assistance. One staff helps and provides less than half the effort. 9. Question GG0170.C- Lying to sitting on side of bed (ability to move from lying on the back to sitting on the side of the bed with no back support); The resident required partial/moderate assistance. One staff helps and provides less than half the effort. 10. Question GG0170.E- Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). The resident required partial/moderate assistance. One staff helps and provides less than half the effort. 11. Question GG0170.FF- Tub/shower transfer: The ability to get in and out of a tub/shower. The resident required partial/moderate assistance. One staff helps and provides less than half the effort. N. Record review of R #4's care plan, review/revise dated 03/26/24, revealed: Approach (portion of care plan that addresses how staff will assist resident) start date 07/11/23 for the following activities of daily living: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Encourage/provide oral care. 2. Requires extensive assistance (resident involved in activity, staff provide weight-bearing support) x (times 1; assistance of 1 staff) with toilet use. 3. Requires extensive assistance x 1 with showers. 4. Requires extensive assistance x 1 with dressing. 5. Requires extensive assistance x 1 with personal hygiene. 6. Requires extensive assistance x 1 with bed mobility. 7. Requires extensive assistance x 1 with transfers O. On 04/02/24 at 11:38 AM, during an interview, the MDS Coordinator confirmed that R #4's care plan was not updated to match what was on the most recent MDS assessment dated [DATE] because R #4's abilities fluctuate depending on her mood and her physical abilities. R #16 P. Record review of R #16's lab results, dated 03/05/24, revealed R #16 had a urine culture (a lab test to check for bacteria or other germs in a urine sample) result that was positive for Proteus Mirabilis (a gram-negative bacteria). Q. On 03/26/24 at 4:51 PM, during an interview with R #16's Power of Attorney (POA, the authority to act for another person in specified or all legal or financial matters), she revealed the following: 1. R #16 currently has a urinary tract infection (UTI). 2. The hospice facility decided not to treat R #16's UTI due to not having any symptoms and R #16 having an allergy to Penicillin (antibiotic used to treat a wide range of infections). R. Record review of R #16's hospice nursing progress note, dated 03/06/24, revealed that R #16's POA decided not to treat R #16's UTI due to R #16 not having any symptoms and having a resistance to multiple antibiotics. S. Record review of R #16's care plan, revised on 03/21/24, revealed R #16's UTI was not included in the Care Plan. T. On 03/27/24 at 3:49 PM, during an interview with RN #21, he confirmed the following: 1. R #16's lab results showed a positive urine culture on 03/05/24. 2. R #16 did not receive treatment for the UTI. (continued on next page)

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	325087	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R #16's care plan did not include that R #16 had a UTI or for staff to monitor for symptoms of a UTI. U. On 03/29/24 at 11:09 AM, during an interview with the MDS Coordinator, she confirmed the following: 1. R #16 had a positive urine culture on 03/05/24. 2. R #16 did not receive treatment for the UTI. 3. R #16's care plan did not include R #16's UTI. 4. R #16 did not have any symptoms of infection. 5. The MDS Coordinator does not include a UTI in the care plan unless it meets McGreer criteria (a tool used for retrospectively counting true infections. To meet the criteria for definitive infection, more diagnostic information (e.g., positive laboratory tests) is often necessary. Used by the facility for all potential UTI's.) for diagnosing a UTI. R #24 V. Record review of R #24's medical record revealed the following: 1. R #24 was transferred to the emergency roiagnom on [DATE] due to having blood in her stool. 2. R #24 was hospitalized on [DATE] and discharged on [DATE] with a diagnosis of gastrointestinal bleed (GIB; serious condition involving bleeding in the gastrointestinal tract, can be anywhere from the mouth to the rectum). 3. R #24 required 2 units of packed red blood cells (PRBC; type of blood replacement product used for blood transfusions, typically given in situations where the patient has lost a large amount of blood) during her hospitalization . 4. R #24 took clopidogrel (platelet inhibitor medication; reduces the chance of blood clot formation but can also increase the chance of serious bleeding) daily at bedtime. W. Record review of R #24's care plan last reviewed/revised on 03/25/24 revealed: 1. The care plan was not revised to include the hospitalization for GI bleed and what specific monitoring R #24 required given recent hospitalization due to GI bleed. 2. The care plan did not include R #24 medication of clopidogrel and that she had a risk of bleeding due to this medication. X. On 04/02/24 at 11:53 AM, during an interview, the MDS Coordinator confirmed that R #24's care plan was not revised to include risk for bleeding related to recent hospitalization for GI bleed and the medication clopidogrel was not included in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #37 Y. Record review of R #37's physician's orders revealed an order dated 10/12/23, for compression stockings (specially made socks that fit tighter than normal so they gently squeeze your legs to promote circulation) to be applied before getting up and removed at night. Z. Record review of R #37's care plan dated 07/24/23 revealed that staff did not document R #37's compression stockings on the care plan. AA. On 03/28/24 at 4:55 PM, during an interview, the DON confirmed that R #37's compression stockings were not care planned for. The DON said that R #37's stockings and the interventions should be care planned. R #39 BB. On 03/26/24 at 4:33 PM, during an interview R #39's Family member (FM) #2 stated R #39 used to wear eyeglasses. CC. Record Review of R #39's care plan dated 01/25/24 revealed the following: 1. R #39 was care planned for eyeglasses. DD. On 03/27/24 at 11:46 AM, during an observation of R #39 revealed R #39 was not wearing glasses. EE. On 03/27/24 at 4:11 PM, during an interview with MDSC, she confirmed R #39 does not wear glasses anymore. The MDSC confirmed R #39's care plan was not updated and eyeglasses have not been removed. R #59 FF. Record review of R #59's medical record revealed: 1. A urine culture (lab test to detect and identify bacteria in urine that can cause infection) and sensitivity (report that identifies which antibiotics are most effective against the bacteria identified), final report date 09/27/23 revealed R #59's urine culture was positive for Escherichia Coli (E. Coli; bacteria normally found in the gastrointestinal tract that can often cause urinary infection by entering the urinary tract via stool). Resident was treated with ciprofloxacin (antibiotic medication used to treat a variety of bacterial infections) from 10/02/23 through 10/09/23 for urinary tract infection (UTI). 2. Resident was hospitalized [DATE] through 10/18/23 with a diagnosis of UTI which was treated with ceftriaxone intravenous (IV; through the vein) antibiotics. 3. Resident continued treatment of her UTI with IV ceftriaxone (antibiotic medication used to treat many kinds of bacterial infection) until 10/20/23. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A urine culture and sensitivity final report date 01/26/24 revealed R #59's urine culture was positive for klebsiella pneumoniae (bacteria that normally live in your intestines and feces that can cause urinary infection by entering the urinary tract via the stool). Resident was treated with ciprofloxacin from 01/28/24 through 02/03/24 for urinary tract infection (UTI). GG. Record review of R #59's care plan, last reviewed/revised on 12/28/23, revealed R #59's frequent UTI's and risk for frequent UTI's was not included in the Care Plan. HH. On 04/02/24 at 11:26 AM, during an interview, the MDS Coordinator confirmed that she could not find that R #59's care plan included UTI's. R #65 II. On 03/26/24 at 12:38 PM, during an observation and interview with R #65, the following was revealed: 1. R #65's right lower leg was swollen. 2. R #65 stated he had compression stockings. JJ. Record review of R #65's Physician's orders revealed an order, dated 01/11/24, to apply knee high compression stockings before getting up in the morning and remove at night. KK. Record review of R #65's diagnoses revealed R #65 had a diagnosis of localized edema (swelling caused by too much fluid trapped in the body's tissues. Edema can affect any part of the body. But it's more likely to show up in the legs and feet). LL. Record review of R #65's care plan, review date 03/22/24, revealed the following: 1. R #65's diagnosis of localized edema was not included in the care plan. 2. R #65's order for knee high compression stockings was not included in the care plan. MM. On 03/29/24 at 8:58 AM, during an interview with the MDS Coordinator, she confirmed the following: 1. R #65 had an order for compression stockings. 2. R #65 had a diagnosis of localized edema. 3. R #65's diagnosis of localized edema and knee high compression stockings were not included on R #65's care plan. 4. R #65's diagnosis of localized edema and order for knee high compression stockings should have been included in R #65's care plan. R #179 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NN. Record review of R #179's physician's orders revealed the following 1. An order dated 02/28/24 for 2-4 liters of oxygen as needed for shortness of breath. 2. An order dated 02/28/24 to document if the resident is continuously using oxygen. OO. Record review of R #179's care plan dated 03/11/24, revealed that R #179's oxygen and interventions was not care planned for. PP. On 03/28/24 at 4:55 PM, during an interview, the DON confirmed that R #179's oxygen is not care planned for. The DON said that R #179's oxygen and the interventions should be care planned. 47510 49313 50497

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41755 Based on observation, record review, and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 2 (R #59 and R #65) of 2 (R #59 and R #65) residents when they failed to: 1. Start antibiotics for R #59 until five days after the positive urine culture (test result that shows the presence of bacteria in the urine) received. 2. Place compression stockings on R #65's legs as ordered by physician. These deficient practices could likely lead to residents needs not being met and/or a worsening of their condition. The findings are: R #59 A. Record review of R #59's medical record revealed: 1. A urine culture (lab test to detect and identify bacteria in urine that can cause infection) and sensitivity (report that identifies which antibiotics are most effective against the bacteria identified), final report date 09/27/23 revealed R #59's urine culture was positive for Escherichia Coli (E. Coli; bacteria normally found in the gastrointestinal tract that can often cause urinary infection by entering the urinary tract via stool). 2. The results of the final urine culture and sensitivity for 09/27/23 were sent to facility provider via email on 09/27/23. 3. Facility did not attempt to contact the facility provider regarding the positive urine culture received on 09/27/23 until 10/01/23, via email. 4. The facility provider ordered antibiotics for R #59 on 10/02/23, five days after the culture results were received. B. On 04/02/24 at 11:26 AM, during a joint interview with the MDS coordinator and the DON, they confirmed that the antibiotics to treat R #59 were not started in a timely manner. R #65 C. On 03/26/24 at 12:38 PM, during an observation and interview with R #65, the following was revealed: 1. R #65 right lower leg was swollen. 2. R #65 stated that he had compression stockings 3. R #65 was not wearing compression stockings. (continued on next page)

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	325087	A. Building B. Wing	03/29/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Record review of R 65's Physician's orders revealed and order, dated 01/11/24 to apply knee high compression stockings before getting up in the morning and remove at night. E. Record review of R #65's diagnoses revealed resident has a diagnosis of localized edema (swelling caused by too much fluid trapped in the body's tissues. Edema can affect any part of the body. But it's more likely to show up in the legs and feet.). F. Record review of R #65's care plan, reviewed on 03/22/24, revealed the following: 1. R #65's diagnosis of localized edema was not included in the care plan. 2. R #65's order for knee high compression stockings was not included in the care plan. G. On 03/29/24 at 08:30 AM, during an observation of the common area near of the nurses station, R #65 was not wearing compression stockings. H. On 03/29/24 at 8:33 AM, during an interview with CNA #21, she stated that R #65 does not wear compression stockings, he wears regular socks. I. On 03/29/24 at 8:35 AM, during an interview with LPN #21, she confirmed the following: 1. R #65 does not wear compression stockings. 2. LPN #21 was not aware of R #65's order for compression stockings. 3. R #65 was not wearing compression stockings at the time of the interview. 4. R #65 should be wearing compression stockings. J. On 03/29/24 at 12:32 PM, during an interview with the DON, she confirmed that if a resident had an order for compression stockings, the CNA's are expected to put on the compression stocking in the morning and remove them at night. 49313

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47510 Based on observation, interview, and record review, the facility failed to keep residents free from accidents for all 53 residents in the East Unit and H Unit. Residents were identified by the resident Census provided by the Administrator on 03/25/24, when they failed to: 1. Keep treatment carts (a movable piece of equipment used in healthcare facilities to store, transport, and dispense treatment supplies and tools.) locked when not supervised by staff. 2. Ensure the fall mat (a safety feature that is placed along the side of the bed to prevent injury) was placed next to R #41's bed. These deficient practices could likely result in injury to residents due to falling without a fall mat or residents obtaining medical equipment which can cause injury/death. The findings are: Treatment Carts A. On 03/25/24 at 1:29 PM, during an observation of the East Unit, the treatment cart was unlocked and staff were not present. B. On 03/25/24 at 1:31 PM, during an interview RN #31 confirmed treatment cart was unlocked. RN #31 confirmed that the treatment carts are supposed to be locked. C. On 03/26/24 at 12:15 PM, during an observation of the H Unit, the treatment cart was unlocked and staff were not present. D. On 03/26/24 at 12:20 PM, during an interview with RN #32 confirmed treatment cart was unlocked. RN #32 confirmed that the treatment carts are supposed to be locked. E. On 03/26/24 at 9:22 AM, during an observation of the East wing, the treatment cart was unlocked and staff were not present. F. On 03/26/24 at 9:23 AM, during an interview, CMA #11 confirmed that the cart was not locked. CMA #11 confirmed that it should be locked when staff is not around. G. On 03/28/24 at 8:31 AM, during an observation of the East Unit nurses station, the treatment cart was unlocked and staff was not present. H. On 03/28/24 at 8:32 AM, during an interview with LPN #21, she confirmed the following: 1. The treatment cart in the East Unit was unlocked. 2. The treatment cart should be locked when staff are not present. (continued on next page)

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	325087	A. Building B. Wing	03/29/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I. On 03/29/24 at 8:26 AM, during an observation of the East Unit nurses station, the treatment cart was unlocked and staff were not present. J. On 03/29/24 at 8:27 AM, during an interview with LPN #21, she confirmed the following: 1. The treatment cart in the East Unit was unlocked. 2. The treatment cart should be locked when staff are not present. K. On 04/02/24 at 12:01 PM, during an interview with the DON, she confirmed that treatment carts should be locked when staff are not present. Fall Mat L. Record review of care plan, created 10/26/23, revealed that a fall mat was supposed to be next to R #41's bed when she was in bed. M. On 03/26/24 at 9:40 AM, during an observation and interview with R #41, the following was revealed: 1. R #41 lay in bed. 2. R #41 stated she fell recently, she was unsure of the date. 2. R #41 said she is not able to get out of bed on her own. 3. There was no fall mat next to R #41's bed. 4. A fall mat was folded up behind the recliner in R #41's room. N. On 03/26/24 at 9:43 AM, during an interview with CNA #23, she confirmed the following: 1. R #41 was a high fall risk. 2. R #41 should have a fall mat next to her bed to prevent injury if she falls. O. On 03/29/24 at 8:48 AM, during an interview with LPN #23, she confirmed a fall mat should be next to R #41's bed to prevent injury if she falls. P. On 03/29/24 at 12:34 PM, during an interview with the DON, she confirmed that if a fall mat was included in the resident's care plan, staff should ensure a fall mat is next to the residents bed when they are in the bed. 49313 50497

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 47510 Based on record review and interview, the facility failed to ensure the the physician provided rationale for not following the pharmacist's recommendation for 2 (R #36 and R #41) of 2 (R #36 and R #41) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications that are no longer necessary and may cause unnecessary drug interactions or adverse side effects. The findings are: R #36 A. Record review of the pharmacy consultation report for R #36, dated 02/27/24, revealed: 1. R #36 received Metformin (insulin), 500 mg bid (twice daily), for diabetes. 2. The pharmacist recommended increasing the dosage to 500 mg TID (three times daily). 3. The provider denied the recommendation but did not provide a rationale. B. Record review of R #36's physician's orders revealed that R #36 had an order dated 03/04/23 for Metformin 500 mg, 1 tablet twice a day. C. On 03/29/24 at 11:14 AM, during an interview, the DON confirmed that the provider did not provide a rationale for denying the recommendation. R #41 D. Record review of the pharmacy consultation report for R #41, dated 12/21/23, revealed the following: 1. R #41 had orders for divalproex (an anticonvulsant medication that can treat seizures, bipolar disorder, and prevent migraine headaches) 125 mg twice a day. 2. R #41 had orders for seroquel (an antipsychotic medication used to treat several kinds of mental health conditions including schizophrenia and bipolar disorder) 25 mg at bedtime. 3. The pharmacist recommended R #41's provider to consider a reduction of divalproex or a reduction of Seroquel. 4. The provider selected the check box for gradual dose reduction (GDR; gradually lowering the dosage of medication over a period of time) contraindicated and signed the form on 01/18/24 (no further documentation from the provider was on the form). 5. The provider did not document a rationale for why a GDR of divalproex or seroquel were contraindicated. (continued on next page)

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	325087	A. Building B. Wing	03/29/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Record review of R #41's physician's orders revealed the following: 1. R #41 had an active order, dated 07/08/23, for divalproex 125 mg twice a day. 2. R #41 had an active order, dated 06/07/23, for Seroquel 25 mg at bed time. F. Record review of R #41's Electronic Medical Record (EMR), no date, revealed the physician did not document a rationale for why the pharmacist recommendation to decrease divalproex or Seroquel was not acted upon. G. On 01/10/24 at 12:56 PM, during an interview, the DON confirmed the following: 1. The provider did not document a rationale for why the pharmacist's recommendations were not acted upon. 2. A dose reduction for divalproex or seroquel had not been ordered by the provider. 49313

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 41755 Based on record review and interview, the facility failed to: 1. Initiate a gradual dose reduction (GDR; decreasing a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued altogether) of medication as recommended by the pharmacist and ordered by the facility provider. 2. Ensure the medical record has documented rationale as to why the facility provider does not want to complete a GDR. for 2 (R #24 and R #41) of 5 (R #15, R #16, R #24, R #36, and R #41) residents reviewed for unnecessary medication. If consultant pharmacist recommendations and physician's orders are not implemented in a timely manner, residents are likely to be administered medications they do not need and could likely suffer from adverse side effects. The findings are: R #24 A. Record review of consultant pharmacist progress note for R #24, dated 12/31/23, revealed: 1. [Name of R #24] received Depakote (medication used to treat seizures, bipolar disorder, and prevent migraines) mg daily (decreased 02/12/23) gabapentin (medication used to prevent and control seizures also used to relieve nerve pain) 300 mg three times daily (increased 10/14/23) 2. R #24 had three falls in November and three falls in December 2023. 3. Several notations regarding daytime drowsiness. 4. Due to overall decline, frequent falls, daytime drowsiness and mostly cigarette related irritability, recommend GDR of Depakote and gabapentin. 5. The facility provider marked GDR for Depakote contraindicated for the following reason: very low dose, doesn't have effect on falls. 6. The facility provider marked GDR for gabapentin as follows: 100 mg three times daily. B. Record review of R #24's physician's orders revealed: 1. Order start date 10/14/23, gabapentin 300 mg three times daily. 2. The record did not contain information to show a new order for 100 mg three times daily. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. On 04/02/24 at 11:53 AM, during a joint interview with the DON and MDS coordinator, they confirmed that the resident was still on the same dose of gabapentin and the GDR had not been completed as the facility provider had agreed to. R #41 D. Record review of the pharmacy consultation report for R #41, dated 12/21/23, revealed the following: 1. R #41 had orders for divalproex (an anticonvulsant medication that can treat seizures, bipolar disorder, and prevent migraine headaches) 125 mg twice a day. 2. R #41 had orders for seroquel (an antipsychotic medication used to treat several kinds of mental health conditions including schizophrenia and bipolar disorder) 25 mg at bedtime. 3. R #41's divalproex was previously decreased from 250 mg three times a day to 125 mg twice a day on 03/23/23. 4. The pharmacist recommended R #41's provider to consider a further reduction of divalproex or a reduction of seroquel due to resident not exhibiting behaviors. 5. The provider selected gradual dose reduction (GDR; gradually lowering the dosage of medication over a period of time) contraindicated (suggest or indicate that (a particular technique or drug) should not be used in the case in question) and signed the form on 01/18/24. 6. The provider did not document a rationale for why a GDR was contraindicated. E. Record review of R #41's physician's orders revealed the following: 1. R #41 had an active order, dated 07/08/23, for divalproex 125 mg twice a day. 2. R #41 had an active order, dated 06/07/23, for seroquel 25 mg at bedtime. 3. The record did not contain information that the physician ordered a GDR for divalproex or seroquel after the pharmacists recommendation on 12/21/23. F. Record review of R #41's Electronic Medical Record (EMR), not dated, revealed the physician did not document a rationale for why the pharmacist's recommendation to decrease divalproex or seroquel was not acted upon. G. On 04/10/24 at 12:56 PM, during an interview, the DON confirmed the following: 1. The provider did not document a rationale for why the pharmacist's recommendations were not acted upon for R#41. 2. The provider had not ordered a dose reduction for divalproex or seroquel for R #24. 49313

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325087	A. Building B. Wing	03/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 41755 Based on observation and interview, the facility failed to store medications properly and ensure medication carts were locked for all 53 residents in the East Unit and in the H Unit/ Residents were identified by the resident census list provided by the Administrator on 03/25/24, when they failed to: 1. Secure a medication cart on the H Unit. 2. Ensure the medication carts did not contain loose medications. 3. Ensure that insulin is stored per manufacturer's instructions. These deficient practices could likely result in residents obtaining or being administered medication not prescribed to them, residents receiving medications that are less effective and may result in adverse side effects. The findings are: Unlocked Medication Carts A. On 03/26/24 at 12:15 PM, during an observation of the H Unit, the medication cart was unlocked and staff was not present. B. On 03/26/24 at 12:20 PM, during an interview with RN #32, he confirmed the medication cart was unlocked. RN #32 stated the medication cart should be locked. C. On 04/02/24 at 12:02 PM, during an interview with the DON, she confirmed the medication carts should be locked when staff is not present. Loose Medications D. On 03/29/24 at 11:20 AM, during an observation of the H Unit medication cart, half of a white round tablet was loose under the medication cards (cardboard and foil packaging prefilled with prescription medication) in the drawer of the medication cart. E. On 03/29/24 at 12:22 PM, during an observation of the East unit medication cart, one white round tablet with the imprint HH 223 was loose under the medication cards. Insulin storage F. On 03/29/24 at 12:26 PM, during an observation of the East unit medication refrigerator, One Admelog SoloStar (insulin lispro prefilled insulin pen; fast acting insulin used to lower blood sugar quickly) for R #34 was labeled with open date 03/01/24 and stored in the refrigerator. G. Record review of Admelog SoloStar manufacturer's instructions revealed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Keep your pen at room temperature below 86 F (30 C). 2. Keep your pen away from heat or light. 3. Store your pen with the pen cap on. 4. Do not put your pen back in the refrigerator. 5. Only use your pen for up to 28 days after its first use. Throw away the ADMELOG SoloStar pen you are using after 28 days, even if it still has insulin left in it. H. On 03/29/24 at 4:40 PM, during an interview, the DON confirmed medication should not be loose in medication carts and she was not aware that Admelog should not be stored in the refrigerator after opening. 50497

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49313 Based on observation and interview, the facility failed to serve food under sanitary conditions by professional standards of food service safety. This failure could potentially affect all 76 residents in the facility who eat food prepared in the kitchen. Residents were identified by the Resident Matrix provided by the Administrator on 03/25/24. When they failed to: 1. Have staff perform hand hygiene when distributing food trays to residents in the H Unit. 2. Have staff perform hand hygiene when assisting residents in the main dining room. If the facility fails to adhere to safe food handling practices and hygiene practices, residents could likely be exposed to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). The findings are: A. On 03/26/24 at 11:27 AM, during an observation of the dining room of the H Unit revealed the following: 1. CNA #33 did not wash or sanitize her hands with hand sanitizer in between meal pass. B. On 03/26/24 at 11:31 AM, during an observation of the dining room the following was revealed: 1. CNA #24 and Nurse Aide (NA) #21 sat at one table with four residents (R #7, R #19, R #20, and R #57). 2. CNA #24 assisted R #19 and R #20 with eating and drinking. 3. CNA #24 did not perform hand hygiene when she moved between R #19 and R #20. CNA #24 took turns feeding the resident in succession (one after the other). 4. NA #21 assisted R #7 and R #57 with eating and drinking. 5. NA #21 did not perform hand hygiene when she moved between R #7 and R #5. NA #21 took turns feeding the residents in succession. C. On 03/28/24 at 9:18 AM, during an interview with NA #21, she confirmed the following: 1. NA #21 did not perform hand hygiene when she moved between R #7 and R #57, while she took turns feeding the residents in succession during the lunch meal on 03/26/24. 2. CNA #24 did not perform hand hygiene when she moved between R #19 and R #20, while she took turns feeding residents in succession during the lunch meal on 03/26/24. 3. Staff do not typically perform hand hygiene between feeding residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. Staff should perform hand hygiene when feeding separate residents. D. On 04/02/04 at 11:25 AM, during an interview with the DON, she said that staff do not need to perform hand hygiene when alternating between feeding two different residents unless a resident touches the item the staff member is using to feed the residents. 50497

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47510 Based on observation, interview, and record review, the facility failed to follow proper infection control practices for 3 (R #14, R #65 and R #179) of 3 (R #14, R #65 and R #179) residents identified during random observation when the facility failed to ensure resident's nasal cannulas (a device that delivers extra oxygen through a tube and into your nose) were labeled with the date that they were changed. This deficient practice could likely result in the spread of contagious and resistant illnesses to other residents. The findings are: R #14 A. On 03/28/24 at 4:02 PM, during an observation of the dinning area, R #14 sat in her wheelchair, wore a nasal cannula attached to the portable oxygen tank on her wheelchair. Staff did not label the nasal cannula with a date that indicated a date the nasal cannula was changed. B. On 03/28/24 at 4:03 PM, during an interview, RN #11 confirmed that staff did not date the tubing. RN #11 also confirmed that there should be a date on it. [Facility practice is to change the nasal cannulas weekly and date the cannulas for tracking purposes.] R #65 C. On 03/28/24 at 4:09 PM, during an observation of R # 65's room, the following were found: 1. R #65 had an oxygen concentrator (uses the air in the atmosphere, filters it, and produces air that is 90%-95% oxygen) in his room. 2. R #65 had a portable oxygen tank (light, small and quiet devices that provide supplemental oxygen while out of the home) on the back of his wheelchair. 3. The nasal cannula was attached to the oxygen concentrator in R #65's room had illegible writing on it. 4. R #65 sat in his wheelchair wearing a nasal cannula attached to the portable oxygen tank on his wheelchair. 5. Staff did not label the nasal cannula with a date that indicated a date the nasal cannula was changed. D. On 03/26/24 at 12:44 PM, during an interview with CNA #22, she confirmed the following: 1. Nasal cannulas should be changed out every Sunday. 2. Staff should label the nasal cannula with a date that indicated a date the nasal cannula was changed. 3. She was unable to determine the when the last time staff changed R #65's nasal cannulas. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. On 03/26/24 at 5:08 PM, during an interview with RN #21, he confirmed that staff are expected to change out nasal cannulas weekly and label the nasal cannulas with the date they were changed. R #179 F. Record review of R #179's physicians order dated 02/28/24 revealed R #179's nasal cannula to be changed on the first Sunday of the month. On 03/28/24 at 4:05 PM, during an observation of R #179's room, the following were found: 1. R #179 had a portable oxygen tank. 2. R #179 was sitting in his wheelchair wearing a nasal cannula attached to the portable oxygen take on his wheelchair. 3. Staff did not label the nasal cannula with a date that indicated a date the nasal cannula was changed. G. On 03/28/24 at 4:09 PM, during an interview, RN #11 confirmed that the tubing was not dated. RN #11 also confirmed that there should be a date on it. I. On 03/28/24 at 4:55 PM, during an interview, the DON confirmed that oxygen tubing should be labeled with the date it was changed. 49313

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 47510 Based on record review and interview, 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 76 residents in the facility. Residents identified on the matrix provided by the Administrator on 03/25/24. This deficient practice could likely result in the inappropriate use of antibiotics that can lead to resistance of multi-drug resistant organisms. The findings are: A. Record review of the Antibiotic Sterwardship Program Policy dated 02/29/24, revealed that nursing staff will conduct an antibiotic timeout within 48-72 hours of antibiotic therapy to monitor response to the antibiotic and review laboratory results and will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings. B. On 03/26/24 at 10:49 AM, during an interview with family member (FM) #1, he said R #31 was recovering from a UTI. C. Record review of R #31 physician's orders revealed the following: 1. On 03/19/24 ceftriaxone (antibiotic) for UTI (an infection in any part of the urinary system) discontinued on 03/21/24. 2. On 03/26/24 ceftriaxone for UTI discontinued on 03/28/24. D. Record review of R #31's MAR for March 2024 revealed the following: 1. Staff document ceftriaxone was administered to R #31 as ordered through 03/21/24 for UTI. 2. Staff document ceftriaxone was administered to R #31 as ordered starting on 03/26/24 for UTI. E. On 03/29/24 at 12:02 PM, during an interview, the IP stated that the normal protocol is to have staff talk about residents and the antibiotics they are on every day. The IP said that they discuss how the residents are doing on the antibiotics and if the residents are having any adverse reactions to them. The IP confirmed that the physician is not involved in the daily meetings. F. On 03/29/24 at 12:17 PM, during an interview with DON she said that they do not do 48 hour time outs for antibiotics. 50497

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 47510 Based on observation and interview, the facility failed to ensure call lights worked and that the pull cords for the call lights in the resident's bathrooms were in reach to allow residents to call for help using the call light system, for 10 (R #5, R #11, R #21, R #28, R #30, R #36, R #37, R #41, R #54 and R #68) of 10 (R #5, R #11, R #21, R #28, R #30, R #36, R #37, R #41, R #54 and R #68) residents randomly sampled for call light function, when the facility failed the following: 1. To have the pull cords for the call light system in the resident's bathrooms in reach from the floor for R #5, R #11, R #21, R #28, R #30, R #36, R #37, R #41, R #54 and R #68. 2. The alarm sound for the call lights in R #36 and R #68's rooms worked. 3. Ensure the call light were within reach for R #37 and R #41. This deficient practice could likely result in residents being unable to call for assistance and staff not hearing the alarm for the call light. The findings are: R #36 A. On 03/25/24 at 3:45 PM, during an interview, R #36 said that her call light on her bed lights up but that the alarm does not sound when pushed. B. On 03/25/24 at 3:46 PM, during an observation, R #36's call light was pushed. The light outside R #36's room did light up. The alarm was not making a sound to alert staff to the call light. The pull cord for the call light in R #36's bathroom by the toilet was coiled up, with no slack and tucked behind the hand rail. The pull cord in R #36's shower was rolled up with no slack at head level. C. On 3/27/24 at 10:48 AM, during an observation and interview, LPN #11 confirmed the following: 1. The pull cords for the toilet and shower in R #5's bathroom was not in reach from the floor. 2. The pull cords for the toilet and shower in R #11's bathroom was not in reach from the floor. 3. The pull cords for the toilet and shower in R #21's bathroom was not in reach from the floor. 4. The pull cords for the toilet and shower in R #28's bathroom was not in reach from the floor. 5. The pull cords for the toilet and shower in R #30's bathroom was not in reach from the floor. 6. The pull cords for the toilet and shower in R #36's bathroom was not in reach from the floor. 7. The audible alarm to alert staff that R #36's call light had been initiated was not working. 8. The pull cords for the toilet and shower in R #54's bathroom was not in reach from the floor. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. The pull cords for the toilet and shower in R #68's bathroom was not in reach from the floor. 10. The audible alarm to alert staff that R #68'S call light had been initiated was not working. D. On 03/27/24 at 3:07 PM, during an interview, the DON confirmed that the call lights in the resident's bathroom should be in reach of the resident if they were to fall and were on the floor. E. On 03/27/24 at 3:14 PM, during an interview, the Administrator confirmed that the call lights in the resident's bathrooms should be in reach from the floor. The Administrator confirmed that the alarms should be audible. R #37 F. On 03/26/24 at 10:10 AM, during an interview and observation of R #37, the following was revealed: 1. R #37 sat in chair next to his bed. 2. R #37's call light sat on the bed behind R #37, where he could not see or reach the call light. 3. R #37 said he uses the call light to call the nurse if he needs anything. 4. R #37 said he was not sure where the call light was during the interview. 5. R #37 said he was unable to get up on his own to look for the call light. G. Record review of R #37's care plan, dated 07/24/23, revealed R #37's call light was to be kept within R #37's reach. H. On 03/26/24 at 10:31 AM, during an interview with CNA #22, she confirmed the following: 1. R #37 was not able to get up on his own. 2. R #37 could not reach his call light. 3. R #37 call light should be within reach, so he can call for assistance when he needs it. R #41 I. On 03/26/24 at 9:40 AM, during an observation and interview with R #41, the following were found: 1. R #41 lay in bed. 2. R #41 said she is not able to get out of bed on her own. 3. R #41 stated that she cannot use the call light because it is hung where she cannot reach it. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. The call light was observed to be hung on R #41's bed rail and out of R #41's reach. J. On 03/26/24 at 9:43 AM, during an interview with CNA #23, she confirmed the following: 1. R #41 was not able to get up on her own. 2. R #41 could not reach her call light. 3. R #41 call light should be within reach, so she can call for assistance when she needs it K. Record review of R #41's care plan, dated 02/01/23, revealed that R #41's call light was to be kept within reach. L. On 03/29/24 at 8:48 AM, during an interview with LPN #23, she confirmed R #41's call light should be on her. M. On 03/29/24 at 12:34 PM, during an interview with the DON, she confirmed the expectation is for staff to ensure residents have their call light within reach. 49313

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 49313 Based on record review and interview, the facility failed to provide abuse, neglect, and exploitation (ANE) training and Dementia Management training to 4 (CNA #26, LPN #21, LPN #22, and RN #21) of 6 (CNA #25, CNA #26, CNA #27, LPN #21, LPN #22, and RN #21) staff sampled for training. This deficient practice could likely result in staff not knowing who, what, and when to report abuse, neglect, and exploitation. The findings are: A. Record review of CNA #26's training transcript for date range 03/01/23 through 02/29/2, revealed CNA #26 did not complete the Dementia Management training. B. Record review of LPN #21's training transcript for date range 03/01/23 through 02/29/24, revealed LPN #21 did not complete the Dementia Management training. C. Record review of LPN #22's training transcript for date range 03/01/23 through 02/29/24, revealed LPN #22 did not complete the ANE training. D. Record review of RN #21's training transcript for date range 03/01/23 through 02/29/24, revealed RN #21 did not complete the Dementia Management training. E. On 03/29/24 at 4:28 PM, during an interview with the Administrator and the DON, they said that the facility does not use an electronic training system to train staff. The trainings are face-to-face with the instructor. F. On 04/02/24 at 10:17 AM, during an interview with the Administrator, she confirmed the following: 1. The facility provides monthly training that goes over different subjects every month. 2. Throughout the year, the monthly facility trainings cover all the regulatory mandatory trainings. 3. A staff member could miss a mandatory training if they missed a monthly training.