| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 325103 | A. Building<br>B. Wing | 11/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Farmington | 1101 West Murray Drive<br>Farmington, NM 87401 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>(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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to promote resident choices for 1 (R #2) of 1 (R #2) resident reviewed for choices, when an outside individual entered the resident's room and removed a religious item without obtaining authorization from the resident's Power of Attorney (POA; legal authorization for a designated person to make decisions about another person's property, finances, or medical care). If the facility does not honor residents' choices, then residents are likely to experience a loss of independence and self-worth leading to feelings of frustration and depression. The findings are: A. Record review of R #2's face sheet revealed he was admitted into the facility on [DATE] with the following diagnoses: Dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment),Parkinson's Disease (a disorder of the central nervous system that affects movement, often including tremors, difficulty with walking, movement and coordination), Nontraumatic Intracerebral Hemorrhage (is a type of stroke). B. Record review of R #2's Quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 09/28/25 revealed R #2's Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) is 03 (00 to 7 is severe impairment). C. On 11/17/25 at 11:39 a.m., during an interview with the facility's Ombudsman (a government official who investigates and tries to resolve complaints, usually through recommendations (binding or not) or mediation), she stated R #2's POA, reported a priest entered R #2's room and removed a statue containing a sacramental wafer (sacred element used in Christian rituals) on 06/18/25. The Ombudsman stated she informed the Director of Nursing (DON) during a face-to-face meeting on 06/27/25, and R #2's family believed the item should not have been removed. The Ombudsman also expressed concern that the camera in R #2's room had been turned off for approximately eight minutes around the time of the incident. D. On 11/17/25 at 12:07 p.m., during an interview with R #2's POA, she stated the religious item was a statue containing a consecrated wafer (a small piece of unleavened bread used in Christian (especially Catholic) communion that has been blessed by a priest). She stated volunteers from the Catholic Church photographed the statue and later a priest entered R #2's room and took the item without informing her. R #2's POA stated the priest claimed he asked R #2 for permission, but R #2 has dementia and could not reliably provide informed consent. R #2's POA stated she believed the removal of the item constituted theft and stated she expected to be notified before any personal belongings were removed. E. On 11/19/25 at 10:48 a.m., during an interview with the Director of Nursing (DON), she stated she was aware of the item being removed from R #2's room, but she was not aware of who turned off R #2's camera during the time of the priest being in the room. The DON stated it is her expectation that no one, regardless of their status, would enter R #2's room and turn off a camera or take anything from the resident's room without permission from the resident and/or the POA. F. On 11/20/25 at 10:45 a.m., during an interview with Medical Records (MR), she stated the priest spoke to R #2 before removing the wafer and then notified R #2's family. She stated she had notified the family on 06/18/25. G. On 11/20/25 at 2:26 p.m., during an interview with the Administrator (ADM), he stated the priest entered the facility, declared the item sacrilegious (an inappropriate or disrespectful use of a consecrated religious object), and removed it from R #2's room without notifying the POA. The ADM stated R #2 has dementia and is not consistently oriented, but the facility did not permit any outside individual regardless of clergy status to enter a resident's room and remove personal items without authorization from the legal decision maker and/or resident. The ADM confirmed the situation should have been addressed through a care conference with the R #2's POA, but it was not. |

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| F 0573<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Let each resident or the resident's legal representative access or purchase copies of all the resident's records.<br><br>(continued on next page) |

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| F 0573<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide access to medical records for 1 (R #3) of 1 (R #3) resident reviewed for access to medical records. If the facility fails to provide residents with access to their medical records upon request, then residents' rights to review, obtain, and understand their own health information is compromised.This deficient practice is likely to result in delays involving care, lack of informed decision-making, and unnecessary barriers to exercising their rights. The findings are: A. Record review of the facility's Health Information Management Manual dated 02/28/24 revealed the following: Each resident has the right to access his or her protected health information contained in the medical record. Residents are notified of their right to access Protected Health Information (PHI) in the Notice of Privacy Practices given upon admission to the facility. When a request is made by a current resident or another party to view or copy the medical record, those requests should be directed to the Health Information Management Director/Privacy Official. The resident or personal representative has the right to review his or her records under federal law. Requested copies should be provided within two working days (excluding weekends and/or holidays) if the resident currently resides at the facility unless state law mandates a shorter period. The facility must provide a timely, written denial to the individual, which includes the basis for the denial and, if applicable, a statement of the individual's review rights. B. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] with the following diagnoses: Anxiety disorder (a medical condition in which a person experiences ongoing, excessive fear or worry interfering with daily life).Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).Attention Deficit Hyperactivity Disorder (ADHD: a neurodevelopmental condition involving persistent patterns of inattention, hyperactivity, or impulsivity interfering with daily functioning or development). C. Record review of an email dated 07/01/25 at 4:45 PM, revealed the New Mexico (NM) State Ombudsman (a government official who investigates and tries to resolve complaints, usually through recommendations (binding or not) or mediation) requested medical records on behalf of R #3. D. Record review of an email dated 07/08/25 at 12:19 PM, from the Director of Nursing (DON) to the Pharmacist Consultant revealed the following: -Venlafaxine (antidepressant) was reordered by a facility Registered Nurse (RN) on 06/16/25. DON's request to the Pharmacy Consultant regarding documentation of R #3's medication delay. Documentation requested by NM State Ombudsman on behalf of R #3. E. Record review of an email dated 07/24/25 revealed a follow-up request from the NM State Ombudsman for R #3's medical records. F. Record review of an email dated 08/05/25 revealed the following: NM State Ombudsman's initial request on behalf of R #3's medical records occurred on 07/01/25. Request to be processed within 24 hours, per resident rights. G. Record review of an email dated 08/11/25 at 12:18 PM, revealed the Administrator (ADM) had requested the Medical Records Director (MRD) to hand-deliver R #3's medical records to R #3. H. On 11/18/25 at 8:34 AM, during an interview with the DON, she stated R #3 requested information regarding her medications the first week of July 2025. The DON stated R #3 wanted to know what had occurred with her (R #3) medications and how to prevent future delays. She stated pharmacy communication and records are not part of the resident's medical records and no medical records release form had been provided to R #3. I. On 11/18/25, at 10:25 AM, during an interview with R #3, she stated she had requested her medical records in the first week of July 2025. R #3 stated she requested the records from several facility nurses, the DON, MRD, and the ADM. R #3 also stated she has not received any records and was not given a reason for the lack of documentation and has not received anything in writing from the facility regarding her request for the delay. R #3 confirmed she has not been given any part of her medical records, which she states was also requested by the NM State Ombudsman on behalf of her request. J. On 11/18/25, at 11:32 AM during an interview with the MRD, she stated R #3's request for her medical records was initially received via email from the NM State Ombudsman on August 5, 2025. The MRD stated she spoke with R #3 on August 11, 2025, to clarify the request, and R #3 stated she wanted records regarding her medications. The MRD informed R #3 that her pharmacy information was not a part of the medical record request. The MRD confirmed emails were exchanged regarding R #3's medications between herself, the DON, and the Pharmacy Consultant, with the first discussion involving the medical records request occurring on 08/12/25. K. On 11/20/25, at 11:32 AM during an interview with the ADM, he stated he had not been aware of R #3's request for medical records in June 2025. He explained |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to notify the Medical Director (MD) of missed antidepressant doses for 1 (R #3) of 1(R #3) resident reviewed for medications when: The facility did not administer medications according to the prescribed schedule, including not following proper tapering protocols for an antidepressant medication. The facility failed to provide timely (immediate) communication with the Medical Director. These deficient practices are likely to result in untreated or worsening depression, delayed treatment, and adverse reactions for the residents. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] with the following diagnoses: Anxiety disorder (a medical condition in which a person experiences ongoing, excessive fear or worry interfering with daily life). Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Attention Deficit Hyperactivity Disorder (ADHD) (a neurodevelopmental condition involving persistent patterns of inattention, hyperactivity, or impulsivity that interfere with daily functioning or development. B. Record review of R #3's Physician Orders Summary Report dated 11/19/24 revealed the following: Venlafaxine oral tablet 75 mg (milligram), extend release -2 capsules by mouth for depression. May increase to 225 mg if patient tolerates well for one week. Methylphenidate (central nervous system stimulant medication used primarily to treat attention-deficit/hyperactivity disorder (ADHD) and narcolepsy) 20 mg 1 tablet by mouth 2 times daily. C. Record of review of R #3's Care Consultant Report dated 6/23/25 revealed the following: Gradual Dose Reduction (GDR; the stepwise tapering of 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 Methylphenidate.Dose reduction should occur in the modest increments over adequate period of time to minimize withdrawal symptoms and to monitor symptom recurrence.GDR is attempted in 2 separate quarters, with at least 1 month initiated such medications.DON accepted the recommendation, implement as written, working with psychiatric care (branch of medicine focused on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders) to slowly taper Methylphenidate. D. Record review of R #3 Medication Administration Record (MAR), dated 07/01/25 through 07/07/25 revealed the following: R #3 did not receive Venlafaxine for the dates of 07/01/25 through 07/07/25. E. Record review of R #3's provider visit notes dated 07/08/25 revealed the following: R #3 was out of her Venlafaxine for several days and had thoughts of suicide.R #3 is now back on her medication and no further suicidal ideations, still struggling with depression. Will change Venlafaxine to 150 mg every morning, if tolerating after one week increase to 225 mg. F. On 11/18/25 at 8:38 a.m., during an interview with the Director of Nursing (DON), she confirmed the Medical Director (MD) was not notified of R #3 missing multiple doses of Venlafaxine or not having the medication readily available, and the MD should have been notified. G. On 11/18/25, at 8:55 AM, during an interview with the Medical Director (MD), he stated he relied on the facility to notify him if medications were unavailable. The MD confirmed he was not contacted by the facility regarding R #3's missed Venlafaxine doses until the second week R #3 had not received that medication. The MD confirmed he should have been notified sooner and stated he would have written a hard copy prescription and arranged for it to be filled at a local pharmacy. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR; a federal requirement to help ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long-term care) was accurate for 1 (R #3) of 1 (R #3) resident reviewed for PASARR accuracy when the facility did not properly screen for mental disorders or intellectual disabilities prior to admission. This deficient practice is likely to result in the facility not providing the specialized services and support needed by residents. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] with the following diagnoses: Anxiety disorder (a medical condition in which a person experiences ongoing, excessive fear or worry interfering with daily life). Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Attention Deficit Hyperactivity Disorder (ADHD: a neurodevelopmental condition involving persistent patterns of inattention, hyperactivity, or impulsivity that interfere with daily functioning or development. B. Record review of R #3's Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 11/13/25, revealed the resident received antidepressant medication (medication to relieve the symptoms of depression). C. Record review of R #3's base line Care Plan, dated 11/19/2024, revealed R #3 used an antidepressant for depression. D. Record review of R #3's most recent PASARR, dated 01/17/25, revealed the following: Section A (Type of Review) was left blank. Section A identifies the type of PASRR review conducted (e.g., preadmission, annual review, significant change, or readmission) and establishes the purpose of the screening. Section C, which identifies mental illness evaluation criteria including diagnoses such as Schizophrenia (serious mental health condition that affects how people think, feel, and behave including hallucinations, delusions, and disorganized thinking and behavior, leading to a distorted sense of reality), disorders of mood, panic, anxiety, personality, psychotic, and substance-related disorders (this list is not all-inclusive), was answered No. E. On 11/18/25 at 9:52 AM, during an interview with the Admissions Director (AD), she stated R #3's PASARR dated 01/17/25 was incorrect. She stated Section A should not have been left blank, which meant that section had not been completed. The AD also stated Section C was inaccurate because R #3's mental illness section did not include her diagnoses and was marked No, despite her having major depressive disorder, anxiety disorder, and cognitive issues. The AD confirmed R #3's PASARR must reflect all relevant diagnoses and align with the information on the medical orders, but it did not. F. On 11/18/25 at 10:05 a.m., during an interview with the Social Services Assistant (SSA), she stated current PASARR responsibilities involve completing Level I screenings (a federal requirement designed to ensure that individuals with serious mental illness or intellectual disabilities are appropriately assessed before admission) and coordinating Level II evaluations (aims to determine the most appropriate placement and whether specialized services are needed) when indicated. The SSA stated she is familiar with the PASARR form but has not received formal PASARR training and receives instruction from the Social Services Director (SSD), who also addresses PASARR questions from Admissions. The SSA stated she did not complete R #3's PASARR dated 01/17/25 and was not involved in the completion or review of that PASARR. G. On 11/20/25 at 11:45 AM, during an interview with Administrator (ADM), he stated PASARR responsibilities are divided between Admissions and Social Services. Admissions handle PASARRs at intake, while Social Services manages post-admission updates for residents. The AD stated it is his expectation for all PASARRs to be screened properly for accuracy. H. On 11/20/25, at 1:27 PM, during an interview, the SSD stated the admission Department, and the Social Services Department complete the PASARR process together. She stated R #3's PASARR was incorrect because Section A was left blank and R #3's diagnosis was not listed in Section C. The SSD stated it is her expectation for all PASARRs to be screened properly to ensure residents who triggered the PASARR received the necessary services and support. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure 1 (R #3) of 1 (R #3) residents reviewed received the appropriate pharmacy services when: R #3 did not receive prescribed medications as ordered. A follow-up and coordination with the pharmacy and prescribing providers was completed when R #3's ordered medications were unavailable. The facility did not obtain nor administer the complete provider-ordered taper of Venlafaxine (antidepressant) during a cross-taper process (a process used when switching antidepressants. It involves gradually reducing the dose of one antidepressant while simultaneously increasing the dose of another) resulting in an unintended interruption of therapy. This deficient practice is likely to place residents at risk for withdrawal symptoms, worsening mental health symptoms, and delayed treatment. The findings are: A. Record review of R #3's face sheet revealed R #3 was admitted into the facility on [DATE] with the following diagnoses: Anxiety disorder (a medical condition in which a person experiences ongoing, excessive fear or worry interfering with daily life). Major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Attention Deficit Hyperactivity Disorder (ADHD) (a neurodevelopmental condition involving persistent patterns of inattention, hyperactivity, or impulsivity that interfere with daily functioning or development. B. Record review of R #3's Physician Orders Summary Report dated 11/19/24 revealed the following: Venlafaxine oral tablet 75 mg (milligram), extend release -2 capsules by mouth for depression. May increase to 225 mg if patient tolerates well for one week. Methylphenidate (central nervous system stimulant medication used primarily to treat attention-deficit/hyperactivity disorder (ADHD) and narcolepsy) 20 mg 1 tablet by mouth 2 times daily. C. Record of review of R #3's Care Consultant Report dated 6/23/25 revealed the following: Gradual Dose Reduction (GDR; the stepwise tapering of 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 Methylphenidate. Dose reduction should occur in the modest increments over adequate period of time to minimize withdrawal symptoms and to monitor symptom recurrence. GDR is attempted in 2 separate quarters, with at least 1 month initiated such medications. DON accepted the recommendation, implement as written, working with psychiatric care (branch of medicine focused on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders) to slowly taper Methylphenidate. D. Record review of R #3 Medication Administration Record (MAR), dated 07/01/25 through 07/07/25 revealed the following: R #3 did not receive Venlafaxine for the dates of 07/01/25 through 07/07/25. E. Record review of R #3's provider visit notes dated 07/08/25 revealed the following: R #3 was out of her Venlafaxine for several days and had thoughts of suicide. R #3 is now back on her medication and no further suicidal ideations, still struggling with depression. Will change Venlafaxine to 150 mg every morning, if tolerating after one week increase to 225mg. F. On 11/18/25 at 8:38 a.m., during an interview with the Director of Nursing (DON), she stated R #3 went approximately one week without receiving the prescribed Venlafaxine taper medication during a cross-taper process from a previous antidepressant to Wellbutrin (bupropion-antidepressant). The DON stated the pharmacy provided only the first week of the Venlafaxine taper capsules and failed to send the second week due to insurance-related issues, resulting in the medication not being available in the facility. The DON stated this resulted in the abrupt discontinuation of Venlafaxine, a medication known to cause withdrawal symptoms if stopped without an appropriate taper. The DON stated R #3 experienced increased anxiety and distress related to the interruption in her medication regimen, and the facility holds responsibility for ensuring residents receive all prescribed medications regardless of insurance or pharmacy barriers. G. On 11/18/25, at 8:55 AM, during an interview with R #3's Medical Doctor (MD), he stated he expected all residents to receive the full ordered taper, meaning the complete provider-prescribed tapering schedule, including all ordered doses and duration. The MD confirmed he relied on the facility to notify him if medications were unavailable. He stated he was contacted after the facility learned the second week of medication had not been supplied and confirmed he had not been previously informed the resident missed multiple doses. H. On 11/19/25 at 1:27 PM, during an interview with R #3's Psychiatric Provider (PP), he stated on July 14, 2025, R #3 reported she had not received her prescribed Venlafaxine. He stated R #3 described experiencing joint pain, urinary difficulties, emotional distress, including crying during the therapy session, and reported contacting the physician and working with the New Mexico State Ombudsman (a government official who investigates and tries to resolve |

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| F 0761<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 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>(continued on next page) |

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| | 325103 | A. Building<br>B. Wing | 11/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Life Care Center of Farmington | 1101 West Murray Drive<br>Farmington, NM 87401 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0761<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff administered and secured medications for all 112 residents listed on the facility census when: Medication carts were not secured and left unattended during medication pass. Medications were pre-poured (the practice of preparing and storing medications in advance of their scheduled administration) and left unattended without supervision. These deficient practices increased the risk of unauthorized access, medication diversion, contamination, and administration of medications to the wrong resident. Failure to ensure facility nursing staff do not pre-pour medications, do not leave medications unattended, and consistently secure medication carts is likely to create a substantial likelihood that residents, staff members, and/or visitors could access or remove medications that were not prescribed to them. The finding are: Medication Carts Unattended: A. Record review of the facility's Administration of Medications policy dated 09/09/25 stated only certified or licensed staff may administer medications and must adhere to the 10 Rights of Medication Administration, including verifying the right drug, right resident, right dose, right route, and right time immediately before administration. The policy requires staff to compare the medication label with the Medication Administration Record (MAR) three times: Before removing the medication from the drawer, as the drug is removed from the container, and at the bedside before administration to the resident. The policy further stated medications must be administered safely and appropriately and in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards. Staff must verify the resident's identity with two identifiers and confirm accuracy directly against the MAR before each administration. B. On 11/17/25 at 2:43 p.m., observation of the B-unit revealed the medication cart remained unlocked and unattended in the hallway, allowing unsupervised access to resident medications. C. On 11/17/25 at 2:43 p.m., during an interview with Register Nurse (RN) #1 stated the medication cart was her responsibility and she is required to keep it locked at all times. She stated an unsecured cart permits unauthorized individuals to access medications. RN #1 reported the cart contained all B- and C-Unit medications, including narcotic (opioid) medications. Rolling Table with Pre-Poured Medications: D. On 11/18/25 at 11:27 AM, during an observation in the 200 Hall on A-unit, revealed an unattended table containing multiple pre-poured medications in unlidded plastic medication cups. Several cups contained tablets and capsules labeled with resident names. Additional supplies on the table included open over the counter medication boxes labeled for specific residents, multiple plastic spoons and cups, and personal-use items. A licensed nurse was not present at or supervising the table. During the same observation, a Certified Medication Aide (CMA) walked out of a resident occupied room after leaving the cart for approximately one minute. E. On 11/18/25 at 4:00 p.m., during an interview, Certified Medication Aide (CMA) #1, she stated she prepared and pre-poured medications into cups prior to administration. She stated she pre-pours medications for residents who attend activities and prefer to receive medications in the activity room. She confirmed she left the pre-poured medications unattended on a table in the hallway while she entered room [ROOM NUMBER] to assist a resident who had spilled a drink, and the medications were left unattended for approximately five seconds. CMA #1 confirmed she is responsible for supervising medications at all times and acknowledged the facility's policy does not allow pre-pouring medications or leaving medications unattended. She stated the policy requires staff to ask a nurse or another CMA to monitor medications if they must step away during medication administration. She further stated the medications were not secured in the locked medication cart because she pre-poured them to transport to the activity room. CMA #1 stated leaving medications unattended creates a risk because a resident or visitor could take or ingest the medications. She confirmed this practice occurs once or twice a week and stated she typically pre-pours medications for multiple residents when transporting them to the activity area. F. On 11/18/25 at 4:45 p.m., during an interview, the Director of Nursing (DON) stated the facility does not permit pre-pouring medications and requires medications to remain secured and attended at all times during medication administration. She stated medications are not allowed to be left in open areas, such as hallway tables, and must remain locked unless actively being dispensed to a resident. She stated if a staff member must step away during a medication pass, medications must be secured in the locked medication cart. The DON stated Certified Nurse Aides (CNAs) are not permitted to hold, monitor, or supervise medications. She stated the licensed individual administering medications is responsible for ensuring medications are administered safely and in accordance |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 325103 | A. Building<br>B. Wing | 11/20/2025 |

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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>Based on interview and record review, the facility failed to implement and maintain an effective Infection Prevention and Control Program during a COVID-19 (a viral respiratory disease) outbreak affecting all 58 residents residing on Unit A, when: The facility failed to exclude symptomatic staff from resident contact. The facility did not effectively identify and control the spread of infection. The facility failed to prevent unit-wide clustered transmission consistent with uncontrolled spread. This deficient practice like resulted in residents acquiring COVID-19 infections with prolonged isolation precautions. The findings are: A. Record review of the facility's Infection Prevention and Control Program (IPCP) Policy, revised 06/02/25, revealed the facility is required to: Prevent, identify, report, investigate, and control infections. Maintain a system of surveillance to identify infections before they spread. Implement standard and transmission-based precautions; Exclude staff with communicable diseases from resident contact; Maintain a system for staff to report illness and remain off work while symptomatic. B. On 11/18/25 at 12:50 p.m., during an interview with the Infection Preventionist (IP), she stated the COVID-19 outbreak began when a Certified Nurse Aide (CNA) worked while sick, and a housekeeper had worked while symptomatic before testing positive. She stated the outbreak started on 08/20/25 through 09/04/25, and the facility conducted testing every three days until the entire facility tested negative for COVID-19. She stated many residents became symptomatic. The IP stated, one hall would get better, and another would start getting positives [with COVID-19], and the facility isolated all residents in their rooms due to ongoing spread. C. On 11/20/25 at 11:45 a.m., during an interview with the Administrator (ADM), he confirmed he was aware of the COVID-19 outbreak affecting Unit A from 08/20/25 through 09/04/25. He stated residents and staff were tested repeatedly as new positive cases occurred. The ADM confirmed it was his expectation staff would not work while experiencing COVID-19 symptoms. |