STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325123	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fiesta Park Wellness & Rehabilitation	8820 Horizon Boulevard NE Albuquerque, NM 87113

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46064 Based on interview and record review, the facility failed to investigate an allegation of missing money for 1 (R #121) of 1 (R #121) resident reviewed for missing money. This deficient practice is likely to result in resident financial hardship. The findings are: A. On 01/14/25 at 2:07 PM during an interview with R #121, she stated she had $150.00 in a green baggie under her mattress and it was missing. She further stated that she did not remember the exact date that the money went missing but it was sometime in December 2024. She did not file a formal grievance but she verbally reported the missing money to the Administrator. B. Record review of the facility's incidents and grievances for the months of August 2024 through January 2025 revealed there was not any documentation of R #121's missing money. C. On 01/15/25 at 2:04 PM during an interview with the Administrator, she stated she was aware of the alleged missing money. She was told about the missing money by R #121. She further stated she had asked R #121 if she wanted to file a police report or file a formal grievance in regard to the money and R #121 refused. D. On 01/16/25 at 1:25 PM during an interview with the Administrator, she stated R #121 did not say that she thought someone took the money. R #121 told her the money was under her mattress before she had left to [name of local Behavioral Health Hospital] and when she came back to the facility the money was missing. Administrator stated they did look for R #121's money, it was not found and no further investigation was done.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview, the facility failed to provide sufficient preparation for 1 (R #81) of 1 (R #81) resident reviewed by not ensuring that referral for services had been received, accepted and was scheduled to provide care for the resident upon her discharge home. This deficient practice could likely result in resident not receiving needed services and having to navigate referral process for services unassisted. The findings are: A. Record review of R #81's Face Sheet dated revealed R #81 was admitted to the facility on [DATE] with multiple diagnoses including: -Spina Bifida (a birth defect that causes the spinal column to not develop properly usually leaving an open hole to the spinal cord) with hydrocephalus (fluid collecting at the base of the brain). -Pressure Ulcer (a wound that develops over a boney area of the body) of Sacral (lower back just above the buttocks) Region. Face sheet also revealed R #81 was discharged from facility on 01/07/25 B. Record review of R #81's skin assessments (a nursing assessment that reports of noted wounds found on a resident's body) dated 01/07/25, revealed a pressure ulcer to Coccyx (area of body just above the buttocks), pressure ulcer to right gluteal fold (buttock) and deep tissue injury (a pressure ulcer that is not open but affects the deeper skin) of the left heel. D. Record review of R #81's insurance denial of service with rights to appeal dated 01/01/25, revealed R #81's insurance notified her of her insurance provider's refusal to continue payment of services. The letter included a phone number to appeal the decision for denial of care. E. Record review of R #81's daily care notes revealed the following: -01/03/25 a general note stated R #81 was given a letter of denial that her insurance provider would refuse to pay for any further care. The note indicated that the Social Services Assistant discussed R #81's options regarding her pending discharge. -01/03/25 a social services note stated R #81 was provided a denial letter (a letter from insurance notifying R #81 of their refusal to continue payment of care). The note indicated that R #81 would be discharged on [DATE]. -01/06/25 a general note stated R #81 met with multiple staff including Social Services Director (SSD) and Social Services Assistant (SSA) who explained that her insurance will no longer pay for her care at the facility and she had been set up for care with a home health agency upon discharge. R #81 stated she refused to leave on her expected discharge date of [DATE]. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-01/06/25 a general note stated R #81 informed the Assistant Director of Nursing (ADON2) #2 that her boyfriend would be picking her up the next day (01/07/25). -01/07/25 a social services note stated R #81 would be discharged to her home with medications on 01/07/25 at 11:00 am and [name of home health agency (HH#1)] was to provide in home therapy and health aide services. F. Record review of R #81's Discharge Planning Review dated 01/07/25, revealed R #81 was to be discharged on [DATE] due to non-payment. R #81 was to return to her home. R #81 was to receive Home Health nurse/aide and home health therapy. R #81 was referred to [name of HH#1] with a phone number provided. G. On 01/06/25 at 4:11 pm during interview with R #81 in her facility room, she stated she was aware that she had been notified of her pending discharge from the facility. She stated she needed home health services upon discharge. She stated she had a large pressure ulcer located on her back end and she was unable to tend to the necessary dressings and changes without help. R #81 stated she had not been told by any staff of her planned discharge services, whether home health had been arranged for her. She stated she did not know if the home health services had been confirmed or how to contact the home health agency upon discharge. R #81 stated she had not been contacted by any home health agency to discuss her needs and care plan. She stated she did not have a phone number to contact any assigned home health agency. H. On 01/14/25 at 11:15 am during phone call interview with HH #1 admission clerk, she stated she had received an email referral from the facility regarding R #81. The clerk stated they did not accept R #81 for home health care because R #81's insurance would not cover her costs. The clerk stated she passed R #81's referral to another [name of HH #2]. I. On 01/14/25 at 11:22 am during phone call interview with HH #2 admission clerk, she stated a referral from HH #1 had not been received nor had a referral from the facility been received for R #81. HH #2 clerk confirmed that R #81 was not reviewed or placed on home health services. J. On 01/14/25 at 11:24 am during interview with the SSD, he stated that a resident who is being discharged due to non-payment would still receive a safe discharge. He stated this would include a referral to a home health agency if needed. He stated the home health referral would be followed up to assure that the resident had been accepted by the receiving home health agency before discharge. SSD further stated R #81's referral to HH #1 was sent on 01/07/25 about 9:00 am. SSD confirmed that two hours later (11:00 am) R #81 was discharged from the facility. SSD could not confirm if R #81 had been accepted by [name of HH #1]. SSD confirmed that R #81's discharge had been planned on 01/04/25, and that R #81 refused to be discharged on that day. SSD stated that HH #1 has a representative who is in the facility daily and he assumed that the representative would have notified him if R #81 had been denied services. SSD stated he did not try to contact HH #1 representative before R #81 was discharged . (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	K. On 01/23/25 at 11:30 am during phone interview with R #81, she stated she was discharged from the facility, and she had been home for two weeks. R #81 stated she read in her documentation provided to her upon discharge that she had been referred to [Name of HH #1] for home health needs. R #81 stated she had not started any home health care services since her discharge. She stated she was now trying to arrange for services on her own. She stated she was very frustrated by the lack of help and communication from the facility either before or after her discharge from the facility.

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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** 41988 Based on record review and interview, the facility failed to ensure staff revised the care plan for 2 (R #'s 11 and 112) of 2 (R #'s 11 and 112) residents reviewed when staff failed to: 1. Conduct a quarterly care plan meeting as required for R #11 in accordance with his admitted and Minimum Data Set (MDS)assessment. 2. Update R #11's plan of care to include Libre2 ([NAME] based glucose monitor embedded in the skin) use for diabetic management. 3. Update R #112's plan of care to include oxygen (O2) use. These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: Care Plan Meeting: R #11: A. Record review of R #11's face sheet revealed R #11 was admitted into the facility on [DATE]. B. Record review of R #11's social service progress notes dated 10/06/24 revealed R #11's Emergency Contact (EC) was notified of the scheduled care plan meeting, but it did not contain a date of the schedule care plan meeting. C. Record review of R #11's MDS page located in R #11's Electronic Health Record (EHR) revealed R #11's quarterly MDS assessment occurred on 12/11/24. D. Record review of R #11's assessments page located in R #11's EHR, revealed R #11 did not have a care plan meeting assessment completed in his record. E. On 01/07/25 at 1:43 pm during an interview with R #11, he stated that neither him nor his EC had ever been a part of a care plan meeting and that is something that he would like to have. R #11 also stated that he had researched the rules regarding care plan meetings in the past and wanted one to occur. F. On 01/15/25 at 10:57 am during an interview with the Social Services Assistant (SSA) #1, she stated she was not sure why R #11's care plan meeting did not occur, but a care plan meeting for R #11 should have been in December 2024. The SSA confirmed R #11 did not have a quarterly care plan meeting as required, should have had a care plan meeting completed by now, and documented in R #11's EHR under the assessment section. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Updating Care Plans: R #11: G. Record review of R #11's provider note dated 01/08/25, revealed R #11 informed the Physician's Assistant (PA) #1 that he had his Libre2 blood glucose monitor and he wanted nursing staff to use that when checking his blood sugar, rather than using the finger stick method. H. Record review of R #11's physician orders dated 01/08/25, revealed staff were to place R #11's Libre2 monitor on his arm and utilize the Libre2 to monitor R #11's blood sugars. I. Record review of R #11's care plan reviewed on 01/15/25 revealed there was no care plan present for Libre2 use. J. On 01/09/25 at 1:43 pm during an interview with R #11, he stated that his Libre2 blood glucose device had been approved for use, but the facility nursing staff was not using it and still checking his blood sugar via finger sticks. R #11 also stated that the reason he got the Libre2 was to avoid getting his blood sugar taken via finger sticks so often. K. 01/16/25 at 2:03 pm during an interview with the Assistant Director of Nursing (ADON), she stated R #11's Libre2 order was not care planned and should have been. R #112: L. Record review of R #112's face sheet revealed R #112 was admitted into the facility on [DATE]. M. Record review of R #112's physician orders dated 01/04/25, revealed R #112 use of O2 as needed to keep her O2 saturations greater than or equal to 90% (percent). N. Record review of R #112's care plan dated 01/05/25 revealed the care plan did not contain any documentation of R #112's use of O2. O. On 01/16/25 at 2:03 pm during an interview with the ADON, she stated R #112's O2 order should have be care planned and it was not.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to provide a quality care that meets professional standards for 1 (R # 11) of 1 (R #11) resident when the facility failed to: 1. Communicate with a provider (Physician Assistant- PA, Nurse Practitioner- NP) the discontinuation of a medication (sodium zirconium- medication that binds potassium and treats Hyperkalemia- elevated potassium). 2. Review and implement R #11's Nephrologist (a doctor who specializes in diagnosing and treating kidney conditions) medication recommendations. 3. Follow physician orders to utilize R #11's Libre2 ([NAME] based glucose monitor embedded in the skin) when performing diabetic management. These deficient practices are likely to result in residents not receiving the appropriate medications and treatments if facility staff is not communicating with providers, ordering the appropriate medications for residents, and following physician orders. The findings are: Provider Communication and Medication Implementation: A. Record review of R #11's face sheet revealed R #11 was admitted into the facility on [DATE]. B. Record review of R #11's physician orders dated 09/11/24, revealed R #11 ordered 10 GM (grams) of Sodium Zirconium daily. C. Record review of R #11's physician orders dated 09/26/24, revealed R #11 order for Sodium Zirconium was discontinued. D. Record review of R #11's provider progress notes assessment and plan section revealed the following: - 11/22/24: Hyperkalemia-Continue Sodium Zirconium. - 12/15/24: Hyperkalemia-Continue Sodium Zirconium. - 01/14/25: Hyperkalemia-Continue Sodium Zirconium. - This indicated that the provider (Physician's Assistant- PA #1) did not know that R #11's Sodium Zirconium had been discontinued for Hyperkalemia use as it was still included in his current plan of care/treatment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Record review of R #11's Nephrologist consultation report dated 01/03/25, revealed a recommendation to start a potassium binder medication after latest CMP (Comprehensive Metabolic Panel- blood test that measures proteins, enzymes, electrolytes, minerals and other substances in your body), indicating R #11's need for a potassium binder with the amount to be determined by his latest lab values. F. Record review of R #11's physician orders dated 01/15/25, revealed R #11 was to have CMP completed. Lab values were not available as of 01/16/25. G. On 01/07/25 at 1:38 pm during an interview with R #11, he stated that there has been a delay getting certain medications, with the potassium binder being one of them. R #11 further stated that his Nephrologist informed him that he need to be on a potassium binder medication, but that has not happened yet and he would like that to happen. H. On 01/16/25 10:24 am during an interview with Licensed Practical Nurse (LPN) #8, he stated he entered R #11's Sodium Zirconium ordered on 09/11/24, but he did not remember why the Sodium Zirconium would have been discontinued. LPN #8 confirmed when an order was discontinued, the provider should have been made aware but he did not remember informing the provider of the discontinuation as he was unaware himself why the medication was discontinued. I. On 01/16/25 at 11:15 am during an interview with PA #1, she stated she thought R #11 was still taking the potassium binding medication Sodium Zirconium, and does not know why the Sodium Zirconium was discontinued. PA #1 also stated that she was not made aware of the discontinuation of Sodium Zirconium and she should have been made aware of that. PA #1 confirmed R #11's potassium binder request from the Nephrologist should have been reviewed and ordered if necessary sooner. Diabetic Management: J. Record review of R #11's provider note dated 01/08/25, revealed R #11 informed the PA #1 that he had his Libre2 blood glucose monitor and he wanted nursing staff to use that when checking his blood sugar, rather than using the finger stick method. K. Record review of R #11's physician order dated 01/08/25, revealed staff were to place R #11's Libre2 monitor on his arm and utilize the Libre2 to monitor R #11's blood sugars. L. On 01/09/25 at 1:43 pm during an interview with R #11, he stated his Libre2 blood glucose device had been approved for use, but the facility nursing staff had not been using the Libre2 and is still checking his blood sugar via finger sticks. R #11 further stated that the reason he got the Libre2 was to avoid getting his blood sugar taken via finger sticks so often. M. On 01/15/25 at 4:47 pm during an interview with LPN #4, she stated she was aware of R #11's Libre2, but she did not know there was an order to begin using the Libre2. LPN #4 confirmed she checked R #11's blood glucose earlier that day and used the finger stick method. N. On 01/16/25 at 10:24 am during an interview with LPN #9, she stated she did not know R #11 very well and did not know about R #11's Libre2 device. LPN #9 confirmed she checked R #11's blood sugar level in the morning and used the finger stick. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O. On 01/16/25 at 2:01 pm during an interview with the Assistant Director of Nursing (ADON), she stated R #11's Libre2 order did not notify the nursing staff when they access R #11's records and it should have, meaning the order was not entered correctly to notify the nursing staff of the new order. The ADON confirmed nursing staff should have checked R #11's orders to see any new orders and the nurses should have been using R #11's Libre2 to check his blood sugar per physician orders. P. On 01/16/25 at 11:19 am during an interview with PA #1, she stated she was aware of R #11's Libre2 and she educated nursing staff on using the Libre2 when she put in the order on 01/08/25. PA #1 also stated that both her and R #11 prefer staff to use the Libre2 to check his blood sugar.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on interview and record review, the facility failed to ensure ongoing communication and collaboration with the dialysis (clinical purification of blood as substitute for normal kidney functioning) facility regarding dialysis care and services for 1 (R #51) of 1 (R #51) resident reviewed for dialysis. If the facility is unaware of the status, condition or complications that arise during dialysis treatment, then residents are likely to not receive the appropriate monitoring and care they need. The findings are: A. Record review of the facility's dialysis care policy dated 06/2020, revealed facility nursing staff will utilize dialysis communication records or similar forms to convey information regarding dialysis care to the dialysis provider, and keep those documents in the residents Electronic Health Record (EHR). B. Record review of R #51's face sheet revealed R #51 was admitted into the facility on [DATE]. C. Record review of the physician order dated 12/11/24, revealed R #51 received dialysis on Mondays, Wednesdays, and Fridays at 10:30 am. D. Record review of R #51's care plan dated 12/11/24, revealed R #51 received dialysis on Mondays, Wednesdays, and Fridays at 10:30 am. The care plan further stated facility staff was to assess for any signs and symptoms of bleeding as needed, along with other post dialysis symptoms. E. Record review of R #51's EHR revealed dialysis communication forms revealed the communication forms were missing for the following dates 12/13/24, 12/16/24, 12/18/24, 12/20/24, 12/29/24, 01/08/25, and 01/10/25. F. On 01/07/25 at 5:51 pm during an interview with R #51, he stated that he goes to dialysis on Mondays Wednesdays, and Fridays. R #51 also stated that he does not miss his dialysis appointments. G. On 01/14/25 at 3:04 pm during an interview with Licensed Practical Nurse (LPN) #1, she stated the facility nursing staff are to complete the dialysis communication forms before and after each dialysis appointment. The LPN #1 also stated that sometimes the dialysis center will not send the dialysis communication form back, but nurses should contact the dialysis center to get all pertinent information for that resident. The LPN #1 confirmed dialysis communication forms help the nursing staff tremendously because they are aware of any changes made by the dialysis facility during treatment, or any symptoms or changes experienced by R #51 after the dialysis treatment. H. On 01/15/25 at 4:23 pm during an interview with LPN #3, he stated R #51 goes to dialysis on Mondays, Wednesdays, and Fridays. The LPN #3 confirmed a dialysis communication form should be completed before and after each of R #51's dialysis appointments and then documented in R #51's EHR. I. On 01/16/25 at 1:55 pm during an interview with the Assistant Director of Nursing (ADON), she stated her expectation is for nursing staff to complete a dialysis communication form before and after each of R #51's dialysis appointments, and then document in R #51's EHR. The ADON confirmed R #51 had missing dialysis communication forms in his EHR and should not have had any forms missing.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 39509 Based on observation, record review and interview, the facility failed to ensure that medications were administered with an error rate less than 5%. Medications were observed being administered to 2 (R #61 and R #97) of 4 (R #61, R #97, R #192, and R #365) During observation there were 26 medications administered with 13 medication errors observed. This resulted in a medication error rate of 50%. If medications are not administered at the scheduled ordered times, the treatment may be less effective and residents will receive less than optimal care. The findings are: A. On 01/09/24 at 8:40 am during an observation of R #61's medication administration, Certified Medication Aide (CMA) #1 administered the following medications: -Aspirin (an over the counter medication administered to manage blood coagulation and pain) 81 mg (milligrams). -Furosemide (a prescribed medication to reduce fluid and water from the body) 80 mg. -Gabapentin (a prescribed medication to reduce pain) 100 mg. -Sertraline (a prescribed medication to mange symptoms of depression) 25 mg. B. Record review of R #61's medication administration record (MAR) dated January 2025, revealed the aspirin, furosemide, gabapentin and sertraline were scheduled to be administered at 7:00 am. C. On 01/09/24 at 8:55 am during an observation of R #97's medication administration and interview, CMA #2 administered the following medications: -Gabapentin 300 mg. -Losartan (a prescribed medication to reduce high blood pressure) 100 mg. -Flomax (a prescribed medication to reduce treat Benign Prostatic Hyperplasia (BPH) (medical condition that causes the prostate to swell) 0.4 mg. -Senna (an over the counter medication administered to manage constipation) 8.6 mg gave two tablets. -Duloxetine (a prescribed medication to treat symptoms of depression) 60 mg. -Fluticasone Spray (an over the counter medication administered to reduce symptoms of allergies) 2 sprays in both nostrils of the nose. -Magnesium (an over the counter medication administered to supplement bodily needs) 400 mg. -Miralax (an over the counter medication administered to manage constipation) 17 grams mixed with water. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fiesta Park Wellness & Rehabilitation	8820 Horizon Boulevard NE Albuquerque, NM 87113

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lidocaine Patch (an over the counter medication administered to reduce pain is a specific location of the body) 4% patch. During the administration of medication, CMA #2 stated she was late administering each medication and that each of the medication was due at 7:00 am. D. Record review of R #97's MAR dated January 2025 revealed that each of R # 97's medications were scheduled to be administered at 7:00 am. E. On 01/16/25 at 2:06 pm during interview with Assistant Director of Nursing (ADON) #2, she stated the medications scheduled to be administered at 7:00 am should be administered within one hour before to one hour after the scheduled times. She stated that R #61 and R #97's medications should have been administered by 8:00 am or they would be considered late.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 41988 Based on observation, record review, and interview, the facility failed to ensure the nutritional needs and preferences were met for 1 (R #11)of 1 (R #11) resident reviewed, when staff failed to serve the food items listed on the meal ticket. If the facility is not providing a meal as listed on the meal tickets, then residents are likely to experience weight loss, frustration, and depression. The findings are: A. Record review of R #11's meal ticket dated 01/07/25, revealed R #11 was on a Consistent Carbohydrate (CCHO) diet (Spreading carbohydrate consumption throughout the day to prevent blood sugar spikes) and was to be served salad with his dinner. B. On 01/07/25 at 1:32 pm during an interview with R #11, he stated that the kitchen staff does not always follow instructions and he is supposed to be getting a side salad with his dinner, but that does not happen. R #11 confirmed he had mentioned this to the nursing staff, who informed the dietary staff, but he still does not receive a side salad. C. On 01/07/25 at 5:08 pm during a dinner observation, R #11 was served a meatball sub on a bun, potato chips, and a vegetable blend and without a side salad present. D. On 01/07/25 at 5:10 pm during an interview with Licensed Practical Nurse (LPN) #7, she confirmed R #11 was not served the side salad and should have been served that. E. On 01/07/25 at 5:13 pm during an interview with the Dietary Manager (DM), he confirmed R #11 was not served a side salad with his dinner and he was not aware that R #11 wanted a side salad. The DM confirmed R #11 should have received the side salad since it was on his meal ticket.

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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. 41988 Based on observation and interview, the facility failed to store and serve food under sanitary conditions when staff failed to ensure: 1. Food items were labeled and dated in the kitchen refrigerator and freezer. 2. Food items were stored off the kitchen floor and appropriately in the dry storage. 3. Dietary staff were wearing appropriate hairnets while in the kitchen. 4. Frozen meats were thawed in a safe manner (under running water and not in stagnate water). These deficient practices are likely to affect all 107 residents listed on the resident census list provided by the Administrator on 01/06/25 and are likely lead to foodborne illnesses in residents if food is not being stored properly and safe food handling practices are not adhered to. The findings are: A. On 01/06/25 at 9:59 am, observation of the kitchen revealed the following: - Six plastic bags of diced potatoes were not dated and stored in the kitchen refrigerator. - Six plastic bags of salad mix (iceberg lettuce, carrots, and purple cabbage) were not dated and stored in the kitchen refrigerator. - Two plastic packages of diced ham were not labeled or dated and stored in the kitchen freezer. - Two plastic packages of ground pork were not labeled or dated and stored in the kitchen freezer. - Seven plastic packages of chicken breast were not labeled or dated and stored in the kitchen freezer. - One flour scoop was stored on top the on a bag a flour and out in the open in the dry storage. B. On 01/06/25 at 10:11 am during an interview with the Dietary Manager (DM), he stated the frozen food items labels do not stay on the product because of them being in the freezer, but they should still be labeled. The DM confirmed all labeling, dating, and storage findings, and stated all food items should be labeled and dated, and all flour scoops should be stored in a sanitary place. C. On 01/16/25 at 11:13 am, observation of the kitchen revealed the following: - Six plastic packs of meat were stored on the kitchen floor. - Dietary Aide (DA) #1 was not wearing a hairnet. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Packages of bologna and turkey were thawing in a kitchen sink in stagnate water instead of running water. D. On 01/16/25 at 11:18 am during an interview with the DM, he confirmed the meat storage, hairnet, and meat thawing findings, and stated food should not be stored on the floor, staff should be wearing hairnets while in the kitchen, and frozen meats should be thawed in a safe manner. 34439

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 39509 Based on record review and interview, the facility failed to maintain accurate and complete records in accordance with accepted professional standards and practices for 7 (R #'s 34, 54, 69, 193, 194,195, and 196) of 7 (R #'s 34, 54, 69, 193, 194,195, and 196) residents. The facility failed to properly document that pharmacist recommendations were reviewed by the facility providers. this could adversely impact resident medication needs by not have accurate information. A. Record review of the monthly pharmacist reviews dated December 2023 to December 2024 of R #'s 34, 54, 69, 193, 194,195, and 196 medications revealed the following recommendations: -Note to Attending Physician/Prescriber dated 12/21/23 for R #34 recommended Paroxetine (medication for symptoms of depression) 40 mg (milligrams) and Trazodone (medication for symptoms of depression and sleep disturbance) 50 mg be reviewed for benefit versus risk and consider for periodic dose reduction trials. The response to the recommendation stated that patient has a good response to treatment and requires dose for conditions stability. Where physician/provider response was indicated, it was document that R #34 is being followed by psychiatric services and dose maintains patients depression with no adverse side effects. The recommendation was signed by the Assistant Director of Nursing (ADON2) #2. The document was not signed by the provider and the documentation did not have any indication that the provider reviewed and responded to the pharmacist's recommendation. -Note to Attending Physician/Prescriber dated 12/21/23 for R #54 revealed R #54 had been taking Lamotrigine (a prescribed medication that treats symptoms of seizures and mood) 100 mg for manic depression and recommended a gradual dose reduction be attempted. The response to the recommendation stated the resident has had a good response, maintain current dose-see progress notes. The recommendation was signed by the ADON2. The document was not signed by the provider and the documentation did not have any indication that the provider reviewed and responded to the pharmacist's recommendation. -Note to Attending Physician/Prescriber dated 08/27/24 for R #69 revealed the resident had been taking lorazepam (a prescription medication that treats symptoms of anxiety) 0.5 mg for anxiety to be taken as needed. The recommendation was the medication must have an ending date not to exceed 14 days unless the prescriber provides a rational to continue the medication. The response to the recommendation stated resident was on hospice and medication was changed to be given on as scheduled. The recommendation was signed by the ADON2. The document was not signed by the provider and the documentation did not have any indication that the provider reviewed and responded to the pharmacist's recommendation -Note to Attending Physician/Prescriber dated 10/29/24 regarding R #193 which recommended resident had been taking lorazepam 0.5 mg to be taken as needed. The recommendation was the medication must have an ending date not to exceed 14 days unless the prescriber provides a rational to continue the medication. The response to the recommendation stated add 14 day stop date. The recommendation was signed by the ADON2. The document was not signed by the provider and the documentation did not have any indication that the provider reviewed and responded to the pharmacist's recommendation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Note to Attending Physician/Prescriber dated 04/19/24 regarding R #194 which recommended resident had been taking Benzonatate (a prescribed medication that treats persistent cough) 100 mg three times daily. The recommendation was to provide the medication as needed. The response to the recommendation stated hospice service opted to discontinue the medication. The recommendation was signed by the ADON2. There was no signature by the provider and no indication the provider reviewed and responded to the pharmacist's recommendation. -Note to Attending Physician/Prescriber dated 08/27/24 regarding R #195 which recommended resident had been taking lorazepam 0.5 mg to be taken as needed. The recommendation was the medication must have an ending date not to exceed 14 days unless the prescriber provides a rational to continue the medication. The response to the recommendation stated patient was on hospice. Lorazepam is now scheduled. The recommendation was signed by the ADON2. The document was not signed by the provider and the documentation did not have any indication that the provider reviewed and responded to the pharmacist's recommendation -Note to Attending Physician/Prescriber dated 03/22/24 regarding R #196 which recommended resident had been taking Levemir (a long acting insulin that treats symptoms of diabetes) 12 units daily. The recommendation was the medication is not reliably available from the pharmacy and is no longer being covered by insurance. The recommendation offered an alternate long term insulin. The response to the recommendation stated discontinue Levemir and begin Lantus (a long acting insulin that treats symptoms of diabetes) 10 units twice daily-permission granted. The recommendation was signed by the ADON2. The document was not signed by the provider and the documentation did not have any indication that the provider reviewed and responded to the pharmacist's recommendation' -All above pharmacist recommendations failed to include any indication the provider had been contacted, that an order had been provided or that the order had been read back to the prescriber. B. On 01/15/24 at 11:03 am during interview with ADON2, she stated that she received and reviewed the monthly pharmacist recommendations. She stated she then contacts the appropriate provider, reviews the recommendation with the provider then selects the recommended changes as given by the provider. She stated she considers this to be a telephone review and order which she is allowed to do as a Registered Nurse. She acknowledged that the pharmacy recommendations did not indicate the recommendations were done by telephone and any changes were done as a result of a telephone order. C. Record review of the facility's policy dated 06/2020, labeled Telephone Orders for Medications. The policy stated verbal communication of prescription or medication orders, and test results is limited to urgent situations in which immediate written or electronic communication is not feasible. The procedure for receiving telephone orders requires the nurse receiving the telephone order to document the order including date/time received, patient name, drug name, strength or concentration, dose, frequency, route, quantity/duration, name of prescriber and signature of recipient. Before terminating a conversation, the order will be repeated back to clarify and ensure correct information is provided and received. The authorized prescriber must countersign the order within a reasonable timeframe after communicating the order.