STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325125	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Canyon Rehabilitation Center	5123 Juan Tabo Boulevard NE Albuquerque, NM 87111

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 40671 Based on record review and interview, the facility failed to ensure residents or their guardians were aware of what medications they received and understood the reasons, risks, and benefits of the medications for 1 (R #70) of 3 (R #31, R #58 and R #70) residents reviewed for unnecessary medications. If the residents or their guardians are not informed of the risks and benefits of the medication, they are not able to make informed decisions. The findings are: A. Record review of R #70's physician's orders revealed the following: - An order for buspirone HCl oral tablet (antianxiety medication), 5 milligrams (mg.) Give one tablet by mouth two times a day for anxiety/depression. Start date: 07/13/24. - An order for citalopram hydrobromide oral tablet (antidepressant medication) 10 mg. Give two tablets by mouth one time a day for depression, crying, wandering into other resident rooms, inability to redirect, hitting staff, and screaming. Start date: 01/11/24. B. Record review of R #70's medical record revealed the record did not contain a consent form from the resident/responsible party for the buspirone 5 mg tablets and for the citalopram 10 mg tablets. C. On 02/06/25 at 12:52 pm during an interview, the Director of Nursing (DON) verified R #70's medical record did not contain consent forms for the buspirone 5 mg and the citalopram 10 mg. She stated there should be a signed consent form for R #70's antianxiety and antidepressant medications.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on record review and interview, the facility failed to ensure the resident's current advance directive (a document which provides an individual's wishes for emergency and lifesaving care) was properly documented for 1 (R #16) of 1 (R #16) resident reviewed for advance directives. This deficient practice is likely to cause confusion and delay potentially lifesaving procedures. The findings are: A. Record review of R #16's face sheet revealed R #16 was admitted into the facility on [DATE]. B. Record review of R #16's facesheet, dated [DATE], revealed R #16's advanced directive was Full Code (desired life saving procedures, such ascardiopulmonary resuscitation (CPR)). C. Record review of R #16's physician orders, dated [DATE], revealed R #16 chose Do Not Resuscitate [DNR; does not want to have CPR attempted on them if their heart or breathing stops] for her advanced directive code status. D. On [DATE] at 1:05 PM during an interview with the Director of Nursing (DON), she stated R #16's code status should be DNR and not Full Code.

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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** 40671 Based on record review and interview, the facility failed to ensure accuracy of the Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) for 1(R #42) of 3 (R #31, R #42 and R #58) residents reviewed for accuracy of assessments. If the MDS assessment is inaccurate, then residents are likely to not receive the services they need. The findings are: A. Record review of R #42's face sheet, dated 10/23/24, revealed an initial admission with the following diagnoses: - Cerebral palsy (group of conditions that affect movement, and posture caused by brain damage before birth), - Muscle weakness, - Lack of coordination, - Difficulty in walking, - Sequelae of cerebral infarction (long term effects and complications that can occur after a stroke), - Iron insufficiency anemia (when there is not enough iron in the blood), - Reduced mobility, - Peripheral vascular disease (PVD; disorder that causes abnormal narrowing of arteries). B. Record review of R #42's hospital discharge orders, dated 10/23/24, revealed an order for clopidogrel (blood thinning medication) 75 milligrams (mg) daily. Route: Oral (by mouth). Date first scheduled: 10/11/24. C. Record review of R #42's admission MDS, dated [DATE], revealed the following: - Active diagnoses: Cerebrovascular accident (CVA; stroke), transient ischemic attack (TIA; when blood flow to part of the brain stops for a brief period of time), or stroke. - Medications: Antiplatelet and/or anticoagulant were not selected. D. On 02/07/25 at 9:18 am during an interview, the DON stated she expected the information in R #42's admission MDS and hospital discharge documentation to match, but they did not.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 40671 Based on record review and interview, the facility failed to create an accurate Baseline Care Plan (minimum healthcare information necessary to properly care for a resident immediately upon their admission to the facility) for 1 (R #42) of 3 (R #31, R #42 and R #58) residents reviewed for Baseline Care Plans. This deficient practice could likely result in a decline in the residents' health due to staff not being aware of the residents' needs and residents not able to attain or maintain their highest practical level of well-being. The findings are: A. Record review of R #42's face sheet, dated 10/23/24, revealed an initial admission with the following diagnoses: - Cerebral palsy (group of conditions that affect movement, and posture caused by brain damage before birth), - Muscle weakness, - Lack of coordination, - Difficulty in walking, - Sequelae of cerebral infarction (long term effects and complications that can occur after a stroke), - Abnormalities of gait and mobility, - Reduced mobility - Iron deficiency anemia (low iron levels in the blood), - Peripheral vascular disease (PVD; disorder that causes abnormal narrowing of arteries). B. Record review of R #42's hospital discharge orders, dated 10/23/24, revealed an order for clopidogrel (blood thinning medication) 75 milligrams (mg) daily. Route: Oral (by mouth). Date first scheduled: 10/11/24. C. Record review of R #42's Baseline Care Plan, dated 10/24/24, revealed the baseline care plan did not include the use of antiplatelet medication (medication that is used to help prevent blood clots.) D. On 02/07/25 at 9:18 am during an interview, the Director of Nursing (DON) stated that when she verified R #42's admission orders, she missed the order for clopidogrel (antiplatelet medication) and that may be why there was no mention of the antiplatelet medication on his baseline care plan.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671 Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (R #42) of 3 (R #31, #42 and #58) residents when they failed to monitor R #42 for signs and symptoms of stroke and to treat R #42 with blood thinning medication as ordered. This deficient practice is likely to result in residents experiencing worsened conditions or death. The findings are: A. Record review of R #42's face sheet revealed an admitted [DATE] and included the following diagnoses: - Cerebral palsy (group of conditions that affect movement and posture caused by brain damage before birth), - Muscle weakness, - Lack of coordination, - Difficulty in walking, - Sequelae of cerebral infarction (long term effects and complications that can occur after a stroke), - Reduced mobility, - Peripheral vascular disease (PVD; disorder that causes abnormal narrowing of arteries). B. Record review of R #42's hospital discharge records, dated 10/23/24, revealed the following : - An order for clopidogrel (blood thinning medication) tablet, 75 milligrams (mg) daily. Route: Oral (by mouth). Date first scheduled: 10/11/24. - History of pontine cerebrovascular disease (a life-threatening blockage of blood flow to part of the brainstem). Patient was hospitalized in February 2024 for transient ischemic attack (TIA; when blood flow to part of the brain stops for a brief period of time) in the setting of medication noncompliance (failure to take prescribed medications as directed by a healthcare provider). Continue home medication Lipitor (medication that lowers the amount of fats in the blood), 890 mg daily and Plavix (brand name for clopidogrel) 75 mg daily. - Discharge summary notes: On 09/19/24 [information included on discharge summary from a previous hospitalization] patient was cleared to resume Plavix by gastrointestinal (GI; diseases affecting the stomach and intestines) specialist on 09/18/24 after his recent episode of GI bleed. - During his hospitalization , there were not any reported signs of overt (obvious) GI bleed, and hemoglobin (protein in red blood cells) remained stable around baseline. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	C. Record review of R #42's history and physical (H&P), dated 10/24/24, revealed the following: - The resident had a history of pontine cerebrovascular accident (CVA; stroke) and TIA. - The record did not mention treatment to prevent another CVA. D. Record review of R #42's admission Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff), dated 10/29/24, revealed the following: - Active diagnoses: CVA, TIA, or Stroke. - Medications: The resident did not receive an antiplatelets (medication that prevents blood clots) or anticoagulants (blood thinner). E. Record review of R #42's Medication Administration Records (MAR), dated October 2025 through February 6, 2025, revealed there was no order for or instructions for staff to administer clopidogrel, 75 mg to R #42. F. Record review of R #42's Treatment Administration Records (TAR), dated December 2024 through February 2025, revealed the following: - Diagnoses included unspecified sequelae of cerebral infarction and PVD. - The record did not instruct staff to monitor for signs and symptoms of stroke. G. Record review of R #42's quarterly MDS, dated [DATE], revealed the following: - Active Diagnoses: CVA, TIA or Stroke. - Medications: The resident did not receive an antiplatelet and/or anticoagulant. H. Record review of R #42's current physician orders, dated February 2025, revealed the record did not contain an order for clopidogrel, 75 mg or any other antiplatelet or blood thinner medication. I. On 02/04/25 at 9:28 am during an interview, R #42 stated he needed to be on a blood thinner. He stated he used to be on heparin (blood thinning medication), but when he came to the facility from the hospital, the facility staff did not give him the blood thinner. J. On 02/06/25 at 4:58 pm during an interview with the Medical Director (MD), he stated R #42's hospital discharge records contained an order for clopidogrel 75 mg, and R #42 should have received the medication while at the facility. He verified staff did not administer the clopidogrel to R #42 since his admission to the facility [10/23/24]. He reviewed R #42's medical record and stated someone at the facility dropped the ball. K. On 02/07/25 at 9:18 am during an interview with the Director of Nursing (DON), she confirmed that she was responsible for verifying the admission orders during the post admission resident review, but she missed the order for clopidogrel, therefore it was not ordered and was not being administered to R #42. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	L. On 02/07/25 at 10:47 am during an interview, the Nurse Practitioner (NP) stated the order for clopidogrel 75 mg was on R #42's admission orders from the hospital, but the orders were not clear about how long the resident should continue to take the medication. She stated staff should have administered the clopidogrel to R #42 based on the admission orders from the hospital. M. On 02/25/25 at 12:47 pm during an interview with the Administrator and the DON, they stated the R #42 had multiple diagnoses, and he had complex medical needs. They stated the resident's stroke occurred over a year ago, and it was not the primary reason for his admission to the facility. The Administrator and the DON stated the resident had an initial care plan meeting on 10/27/25, and he attended the meeting. They stated the resident had a Brief Interview of Mental Status (BIMS; a screening for cognitive impairment) score of 14, cognitively intact; but he did not mention that he should take a blood thinning medication. The Administrator and the DON confirmed R #42's medical record did not instruct staff to monitor the resident for signs and symptoms of stroke. They stated they monitor all residents for signs of a change of condition. The Administrator and the DON confirmed they did not treat the resident for his history of CVA. Based on record reviews and interviews, an Immediate Jeopardy (IJ) was identified. The facility Administrator was notified on 02/07/25 at 10:42 am. The facility took corrective action by providing an acceptable Plan of Removal (POR). The Plan of Removal was approved on 02/07/25 at 3:15 pm. Implementation of the POR was verified onsite on 02/10/25 by conducting record reviews and staff interviews. Scope and Severity was reduced to Level 2, E. Plan of Removal: All residents have the potential to be affected by this alleged deficient practice. The following corrections were completed by 02/07/25: - Audit all residents with a diagnosis of CVA to ensure antiplatelet therapy was in place as ordered. - Audit of recent admissions to ensure accurate medication reconciliation, review, and continuation of medications and treatments. - All licensed staff educated regarding medication transcription, medication reconciliation upon admission, and documentation in the resident's chart. - During morning clinical meetings, medication reconciliation audits occur for new admissions and medication order changes. - Nurse Practice Educator or Designee will begin education on 02/07/25 and continue until all licensed nursing staff have been educated prior to their next shift. Any licensed staff member on leave of absence (FMLA), vacation, or PRN (as needed) staff will be re-educated prior to returning to duty. New hires will be educated on this process upon hire. - The Director of Nursing (DON) or designee will audit five random residents three times a week to ensure all medications reconciliations have occurred. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	- The DON or designee will bring results of audits to Quality Assurance and Performance Improvement (QAPI) committee for further recommendations based on tracking and trending. It will be presented monthly for the next two months or until ongoing compliance is achieved. The QAPI committee is overseen by the Administrator.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 35632 Based on interview and record review, the facility failed to complete staff competencies for 2 (Certified Nursing Assistants (CNA) #6, and CNA #7) of 5 (CNA #4, CNA #5, CNA #6, CNA #7, and CNA #8) CNAs sampled for annual training. This deficient practice could likely result in staff being undertrained and providing inadequate care. The findings are: A. Record review of the facility's employee competencies revealed CNA #6 and CNA #7 did not have a competency assessment (an evaluation of skills, knowledge, and core abilities required for fulfilling job duties) completed during the last twelve months. B. On 02/06/25 at 10:56 am, during an interview with the Director of Nursing (DON), she stated she did not have any documentation to show competency assessments were completed for CNA #6 and CNA #7 during the last twelve months. C. On 02/06/25 at 11:32 am, during an interview with the Educator, she stated staff competency assessments should be completed yearly in order to identify what trainings staff need. She could not state if all of the staff had a competency assessment completed in the last year.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 51919 Based on record review and interview, the facility failed to ensure the resident's medication regimen was free from unnecessary medications for 1 (R #104) of 1 (R #104) residents, when the attending physician: - Did not provide clinical basis when he disagreed with the facility's pharmacist consultant's recommendation on R #104's Medication Regimen Review (MMR), - Did not document in R #104's medical record the action he took to address the recommended medication dose reduction. This deficient practice is likely to cause R #104's medication regimen to not be properly evaluated resulting in a possible over medication. The findings are: A. Record review of R #104's face sheet, dated 09/17/24, revealed R #104 was under psychiatric care (branch of medicine focused on the diagnosis, treatment, and prevention of mental, emotional, and behavioral disorders.) B. Record review of R #104's physician orders revealed the following: - On 09/13/24, R #104's psychiatrist entered an order for quetiapine (an antipsychotic medication) 12.5 milligrams (mg) twice daily for depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). - On 09/17/24, R #104's psychiatrist entered an order for trazodone (antidepressant and sedative) 50 mg once nightly for insomnia (a sleep disorder that makes it hard to fall asleep or stay asleep). C. Record review of R #104's MMR, dated 11/11/24, revealed the following: - The facility's consultant pharmacist recommended to evaluate the current dose and to consider a dose reduction for two the antipsychotic medications, quetiapine and trazodone. - The facility's attending physician responded to continue the same orders, and R #104's psychiatrist was following the resident's care. D. On 02/07/25 at 3:20 pm, during an interview with the facility's Medical Director, he stated the attending physician who responded to R #104's MMR, dated 11/11/24, did not work at the facility any longer. The Medical Director stated he expected the previous attending physician to consult with R #104's psychiatric provider, in order to evaluate the recommended medications dose reduction, to examine R #104's response to the antipsychotic medications, and to make a decision on the recommended medications dose reduction. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. On 02/12/25 at 3:45 pm, during an interview, the facility's consultant pharmacist stated she expected the previous attending physician to consult with R #104's psychiatrist to decide on R #104's medication dose reduction.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 51919 Based on record review and interview, the facility failed to ensure the resident medication regimen was free from unnecessary medications for 1 (R #104) of 1 (R #104) resident, when R #104's hospice physician ordered an as needed (PRN) antipsychotic (a class of drugs that treat psychotic symptoms and disorders) medication without a 14 day stop date. This deficient practice is likely to cause R #104's medication regimen to not be properly evaluated and result in a possible over medication. The findings are: A. Record review of R #104's face sheet, dated 09/26/24, revealed R #104 was under hospice care. B. Record review of R #104's Hospice Physician order, dated 01/14/25, revealed an order to give haloperidol (antipsychotic medication) 2 milligrams (mg) every six hours PRN for agitation (a feeling of irritability, mental distress or severe restlessness). The hospice physician entered the stop date as indefinite. C. Record Review of R #104's Medication Regimen Review (MMR), dated 01/16/25, revealed the following: - The facility's Pharmacist Consultant recommended an evaluation of R #104's antipsychotic medication order for haloperidol, since the order did not have a 14 day stop date. - The facility's Attending Physician responded that R #104's hospice physician entered the order. D. On 02/07/25 at 3:20 pm, during an interview with the facility's Medical Director, he stated the Hospice Physician entered R #104's haloperidol order. The Medical Director stated the Hospice Physician should evaluate R #104's response to the medication and decide to continue or discontinue the order. E. On 02/12/25 at 3:45 pm, during an interview with the facility's Pharmacist Consultant, she stated R #104 had an order for haloperidol 2 mg every six hours PRN for agitation. She stated an antipsychotic medication must have a 14 day stop date, but the Hospice Physician entered the stop date as indefinite. The Pharmacist Consultant stated the Attending Physician should evaluate R #104's response to the medication in order to decide to continue or discontinue the medication. The Pharmacist Consultant stated the Attending Physician should consult with R #104's Hospice Physician to come up with a decision on R #104's haloperidol order.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40671 Based on record review and interview, the facility failed to administer clopidogrel (blood thinning medication used to prevent heart attacks and strokes in persons with heart disease, recent stroke, or blood circulation disease) as ordered by the physician for 1 (R #42) of 3 (R #31, #42 and #58) residents reviewed for medications. This deficient practice is likely to result in a resident failing to obtain maximum wellness or suffer prolonged illness. The findings are: Cross Reference findings from F684. A. Record review of R #42's face sheet revealed an initial admitted [DATE] and included the following diagnoses: - Sequelae of cerebral infarction (long term effects and complications that can occur after a stroke), - Congestive systolic and diastolic heart failure, - Peripheral vascular disease (disorder that causes abnormal narrowing of arteries). B. Record review of R #42's hospital discharge records, dated 10/23/24, revealed the following : - An order for clopidogrel (blood thinning medication) tablet, 75 milligrams (mg) daily. Route: Oral (by mouth). Date first scheduled: 10/11/24. - Continue home medication Lipitor (medication that lowers the amount of fats in the blood), 890 mg daily and Plavix (brand name for clopidogrel) 75 mg daily. C. Record review of R #42's Medication Administration Records (MAR), dated October 2025 through February 6, 2025, revealed staff did not administer clopidogrel, 75 mg to R #42. D. On 02/06/25 at 4:58 pm during an interview with the Medical Director (MD), he stated R #42's hospital discharge records contained an order for clopidogrel 75 mg on admission to the facility. He verified staff missed the order and did not administer clopidogrel to R #42 since the resident's admission to the facility on [DATE]. E. On 02/07/25 at 9:18 am during an interview, the Director of Nursing (DON) stated she missed the resident's order for clopidogrel when she verified R #42's admission orders. F. On 02/07/25 at 10:47 am during an interview, the Nurse Practitioner (NP) stated R #42's hospital discharge orders included an order for clopidogrel. She stated R #42 should have received clopidogrel while at the facility. Based on record reviews and interviews, an Immediate Jeopardy (IJ) was identified. The facility Administrator was notified on 02/07/25 at 10:42 am. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325125	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Canyon Rehabilitation Center	5123 Juan Tabo Boulevard NE Albuquerque, NM 87111

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The facility took corrective action by providing an acceptable Plan of Removal (POR). The Plan of Removal was approved on 02/07/25 at 3:15 pm. Implementation of the POR was verified onsite on 02/10/25 by conducting record reviews and staff interviews. Scope and Severity was reduced to Level 2, E. Plan of Removal: All residents have the potential to be affected by this alleged deficient practice. The following corrections were completed by 02/07/25: - Audit all residents with a diagnosis of CVA to ensure antiplatelet therapy was in place as ordered. - Audit of recent admissions to ensure accurate medication reconciliation, review, and continuation of medications and treatments. - All licensed staff educated regarding medication transcription, medication reconciliation upon admission, and documentation in the resident's chart. - During morning clinical meetings, medication reconciliation audits occur for new admissions and medication order changes. - Nurse Practice Educator or Designee will begin education on 02/07/25 and continue until all licensed nursing staff have been educated prior to their next shift. Any licensed staff member on leave of absence (FMLA), vacation, or PRN (as needed) staff will be re-educated prior to returning to duty. New hires will be educated on this process upon hire. - The Director of Nursing (DON) or designee will audit five random residents three times a week to ensure all medications reconciliation have occurred. - The DON or designee will bring results of audits to Quality Assurance and Performance Improvement (QAPI) committee for further recommendations based on tracking and trending. It will be presented monthly for the next two months or until ongoing compliance is achieved. The QAPI committee is overseen by the Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0761 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50752 Based on observations, interviews, and record review, the facility failed to ensure nurses and Certified Medication Aids (CMAs) dated opened insulin glargine (a medication prescribed to help the body turn food into energy and manage blood sugar levels) pens and discarded glargine pens within 28 days of opening for 1 (R #19) of 1 (R #19) resident and to ensure medication carts were locked when unattended. These deficient practices are likely to result in R #19 receiving medications that are less effective or expired and is likely to negatively impact the health of residents on the 200 unit if they were to ingest (swallow) medications not intended for them. The findings for medication storage are: A. Record review of R #19's physician orders, dated [DATE], revealed R #19 received insulin glargine. B. Record review of the manufacturer's instructions for insulin glargine pens, dated ,d+[DATE], revealed staff must throw away all opened pens after 28 days of first use, even if there was insulin left in the pen. C. On [DATE] at 1:47 pm, during an observation of the 600-hall medication cart, three insulin glargine pens were opened and not dated. The pens belonged to R #19. D. On [DATE] at 1:50 pm, during an interview, Nurse #12 stated the insulin glargine pens belonged to R #19, and the resident actively received it. He stated he should have dated the insulin glargine pens and discarded them within 28 days of the opening date. Nurse #12 stated he just missed it. He also stated the assigned nurse on each hall should check the expiration date before administering the insulin to the resident. E. On [DATE] at 10:55 am, during an interview with the Director of Nursing, she stated staff must date the opened glargine insulin pens and discard them within 28 days from the opening date. F. On [DATE] at 9:00 am, during an interview, the facility's pharmacist consultant stated she expected nurses and CMAs to date the opened glargine insulin pens and discard them within 28 days from the opening date. Medication carts: G. On [DATE] at 7:47 am, during an observation of the 200-unit medication cart, the medication cart was unattended and unlocked. H. On [DATE] at 7:47 am, during an interview, Registered Nurse (RN) #1 confirmed the medication carts should be locked and secured at all times when left unattended. 51919

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325125	A. Building B. Wing	02/10/2025

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 35632 Based on record review and interview, the facility failed to ensure Certified Nurse Aides (CNAs) received the required in-service training of at least 12 hours per year for 4 (CNAs #4, #5, #6, and #7) of 5 (CNAs #3, #4, #5, #6, and #7) CNAs randomly reviewed for required in-service training. This deficient practice is likely to result in the nurses aides not receiving the necessary training to meet the care needs of the residents. The findings are: A. Record review of the facility's employee training transcripts, dated 01/01/24 through 12/31/24, revealed the following: - CNA #4 completed 6.33 hours of training. - CNA #5 completed 6.30 hours of training. - CNA #6 completed 1.22 hours of training. - CNA #7 completed 1.38 hours of training. B. On 02/06/25 at 10:56 am, during an interview with the Director of Nursing (DON), the DON stated CNA #4, CNA #5, CNA #6, and CNA #7 did not have any other trainings during the last 12 months. She stated she was aware the CNAs did not meet the annual 12 hour training requirement.