STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325127	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Suites Rio Vista	2410 19th Street, SE Rio Rancho, NM 87124

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, record review, and interview, the facility failed to provide reasonable accommodations of resident needs and preferences for 1 (R #47) of 1 (R #47) residents reviewed by not ensuring R #47 had access to her call light. These deficient practices are likely to result in residents being unable to request assistance, such as needing help with transferring, after falling or other acute distress. The findings are: A. Record review of R #47's face sheet revealed R #47 was admitted into the facility on [DATE]. B. Record review of R #47's care plan 12/05/23 revealed R #47 experienced left sided hemiplegia (paralysis or weakness on one side of the body) and impaired gait, which required a call light pad and her call light to be within reach. C. On 11/06/24 at 1:09 pm during an observation and interview with R #47, R #47 was observed sitting in a wheelchair next to her bed and her call light pad was placed on the opposite side of her bed and not in reach. R #47 stated that she could not reach her call light pad and staff should have put it closer to her. D. On 11/06/24 at 1:10 pm during an interview with Certified Nursing Assistant (CNA) #1, she confirmed R #47's call light pad was not within reach for R #47 and R #47's call light pad should have been placed closer to her. E. On 11/14/24 at 4:14 pm during an interview with the Director of Nursing (DON), she stated R #47's call light pad should be within reach of R #47 at all times when she is in her room.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 34439 46064 Based on observation and interview the facility failed to safeguard clinical record information by leaving Private Health Information (PHI) where unauthorized persons had access to it for residents of the 300 unit, 500 unit and R #78 during random observations. If resident's clinical information is not sufficiently safe guarded, resident's PHI is likely to be viewed by unauthorized residents, visitors, and staff. The findings are: A. On 11/06/24 at 11:19 am during random observation of the 500 wing nurses station a vital sign sheet sat face up on the counter containing all vital signs for all residents residing on the 500 wing able to be observed by all unauthorized persons coming to the nurses station. B. On 11/06/24 at 11:20 am during an interview with Certified Nurse Aide (CNA) #1 confirmed that vital sign sheet should not be left sitting on the counter for all to view, and if it is it should be face down. C. On 11/14/24 at 9:20 pm during a random observation of the 300 unit Registered Nurse (RN) #2 was observed walking away from his medication cart leaving his computer open to the 300 unit Medication Administration Record (MAR) (a drug chart or report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional). D. On 11/14/24 at 9:23 pm, RN #2 verified that he should always lock his computer before walking away from it. E. On 11/14/24 at 9:24 pm during random observation a 500 wing vital sheet was left face up on the medication cart unattended. RN#1 confirmed that the vital sheet contained personal resident information and should no be left on the cart to be viewed by any passerby's. F. On 11/14/24 at 9:33 pm, during a random observation of the 500, 600 and 700 unit nurses station a clipboard with R #78's neuro check form (a medical form used to assess and document a patient's neurological (relating to, or affecting the nervous system) status) was observed face up on the counter where unauthorized persons had access to it. G. On 11/14/24 at 9:35 pm, Certified Nursing Assistant (CNA) #2 verified the clipboard with PHI for R #78's neuro check information was face up on counter and should not have been.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41988 Based on observation, record review, and interview, the facility failed to maintain an environment that was clean, in good condition, and free from clutter for 3 (R #'s 31, 68, and 71) of 3 (R #'s 31, 68, and 71) residents sampled for a homelike environment by facility staff leaving used resident meal trays in residents rooms. Failure to maintain the building in a clean and comfortable manner is likely to result in unsafe conditions and prevent residents from enjoying everyday activities. The findings are: A. Record review of the facility meal service times revealed residents were served meals during the following times: - Breakfast: 7:30 am to 9:00 am. - Lunch: 12:00 pm to 1:30 pm. - Dinner: 5:00 pm to 6:30 pm. B. On 11/06/24 at 11:20 am during an observation of R #'s 68 and 71's room, R #'s 68 and 71's breakfast meal trays with trash and with old food still present on the tray were observed to still be in the residents rooms and on their dressers. R #71 became frustrated and stated the facility staff never collects used trays on time and it upsets him because it's gross. R #68 also became frustrated due to the tray still being in his room. C. On 11/06/24 at 11:22 am during an observation of R #31's room, R #31's breakfast meal trays with trash and with old food still present on the tray was observed to still be in the residents rooms and on her night stand. D. On 11/06/24 at 11:25 am during an interview with Registered Nurse (RN) #3, she confirmed R #'s 31, 68, and 71's breakfast meal trays were still present in those residents rooms and should not have been. RN #3 stated the CNAs should have collected those trays awhile ago. E. On 11/14/24 at 11:12 am during an interview with the Director of Nursing (DON), she stated she would expect the CNAs and nursing staff to collect the residents breakfast meal trays sooner than they did for R #'s 31, 68, and 71.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR; a screening to help ensure that individuals are not inappropriately placed in nursing homes for long term care) assessment was accurate for 1 (R #71) of 1 (R #71) residents reviewed for PASRR accuracy. This deficient practice is likely to result in the facility not providing the services needed by residents. The findings are: A. Record review of R #71's PASRR Level 1 Identification Screen Section C: Identification of Mental Illness Evaluation Criteria dated 11/30/23 revealed R #71 required referral to PASRR prior to admitting into the nursing facility. B. Record review of R #71's face sheet revealed R #71 was admitted into the facility on [DATE]. C. Record review of R #71's Electronic Health Record (EHR) revealed no documentation was present for R #71's PASRR Level 2 referral. D. On 11/14/24 at 2:43 pm during an interview with the Social Services Director (SSD), she stated R #71 did not have a PASRR Level 2 referral completed prior to admission into the facility and he should have. E. On 11/15/24 at 10:35 am during an interview with the Administrator (ADM), he stated R #71's PASRR level 1 was incorrect and R #71 did not require a PASRR Level 2 referral. The ADM confirmed the facility should have made sure R #71's PASRR level 1 was correct prior to admission and they did not.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on record review and interview facility failed to complete a resident centered, comprehensive care plan for 2 (R #45 and 195) of 2 R #45 and 195) residents. The facility failed to provide a plan for activities and the resident's perferred activities. This deficient practice is likely to result in residents mental and psychosocial needs not being met and residents being bored and uninterested. The findings are: R #45 A. Record review of R #45's face sheet dated 11/14/24 revealed she was admitted to the facility on [DATE] with multiple diagnoses including but not limited to: -Metabolic Encephalopathy (A disease of the brain that causes confusion, memory loss) -Depression (a state of sadness) -Chronic Kidney Disease (disease that causes disruption of the functions of the kidneys) -Generalized Anxiety Disorder (a condition of fear and concerns) B. Record review of R #45 activities assessment dated [DATE] revealed preferences for religious services, being outside to enjoy fresh air and listen to music. C. Record review of R #45 care plan dated 09/24/24 failed to find any care plan related to R #45's activity preferences. R #195 D. Record review of R #195 face sheet dated 11/14/25 revealed he was admitted to the facility on [DATE] with multiple diagnoses including but not limited to: -NonTraumatic Intracerebral hemorrhage (stroke) -Depression -Vascular Dementia with Agitation (a chronic and progressive disease of the brain the disrupts memory and brain functions) -Hemiplegia and Hemiparesis (partial and one sided paralysis) E. Record review of R #195 activities assessment dated [DATE] revealed a preference to interact with family and participate in group activities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. Record review of R #195 care plan dated 10/16/24 failed to find any care plan related to R #195's activity preferences. G. On 11/08/24 12:11 PM during interview with Activities Director (AD) he reported that he had completed an activities assessment of all residents and that he completed these assessments soon after each resident is admitted . He stated he had not updated care plans of residents.

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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 43, 58 and 88) of 2 (R #'s 43, 58 and 88) residents reviewed when staff failed to: 1. Update the care plan to include the amount of staff assistance required for activities of daily living (ADL; activities related to personal care such as bathing, showering, dressing, walking, toileting, and eating) care for R #43. 2. Update the care plan to include hospice services (a home providing care for the sick or terminally ill for R #'s 58 and 88. These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: R #43: A. Record review of R #43's face sheet revealed R #43 was admitted into the facility on [DATE] with the following diagnoses: 1. Aphasia (acquired communication disorder) 2. Dysphagia (difficulty swallowing) 3. Traumatic Brain Injury R #43 was discharged to the emergency room (ER) on [DATE]. B. Record review of Minimum Data Set (MDS) dated [DATE] revealed R #43 is dependent (Helper does ALL of the effort. Resident does non of the effort to complete the activity. or, the assistance of 2 or more helpers is required for the resident to complete the activity) on staff for assistance. C. Record review of R #43's care plan dated [DATE] revealed R #43 experienced a physical functioning deficit due to cervical spondylosis with myelopathy (impaired function of the spinal cord caused by degenereative changes in the discs and joints of the neck), which required R #43 to have bed mobility assistance and toileting assistance. R #43's care plan did not state how many staff were required for ADL assistance. D. On [DATE] at 4:27 pm during an interview with Certified Nursing Assistant (CNA #2), she stated that R #43 required a lot of assistance and usually needed at least two CNAs for transfers. E. On [DATE] at 4:29 pm during an interview with Registered Nurse (RN) #4, she confirmed R #43 required extensive CNA assistance for ADL care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On [DATE] at 4:09 pm during an interview with the Director of Nursing (DON), she confirmed ADL care staff assistance for R #43 was not care planned and should have been. R #58: G. Record review of R #58's face sheet revealed R #58 was admitted into the facility on [DATE]. H. Record review of R #58's physician orders dated [DATE] revealed R #58 was admitted to hospice services due to severe calorie malnutrition. I. Record review of R #58's care plan dated [DATE] revealed hospice services was not care planned for R #58. J. On [DATE] at 12:33 pm during an interview with the Hospice Registered Nurse (HRN), she confirmed R #58 has been on hospice services since [DATE] and she visits R #58 twice a week in the facility. K. On [DATE] at 4:17 pm during an interview with the DON, she confirmed hospice services for R #58 was not care planned and should have been. 51919 R # 88 L. Record review of R #88's face sheet dated [DATE] revealed R #88 was admitted into the facility on [DATE] with diagnoses: - Diastolic Congestive Heart Failure (weak heart) - Respiratory Failure (difficulty breathing) . M. Record review of R #88's physician orders dated [DATE] revealed R #88 was admitted to hospice services on [DATE]. N. Record review of R #88's care plan dated [DATE] revealed hospice services was not care planned for R #88. O. On [DATE] at 08:38 am during a phone interview with the Hospice Supervisor (HS), she confirmed R #88 had been on hospice services from [DATE] untill his death on [DATE]. P. On [DATE] at 1:16 pm during an interview with the Director of Nursing (DON) she stated hospice services would send their care plan. DON didn't know what is their policy for care planning. She was unable to confirm if R #88 had a hospice care plan.

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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 observation, record review, and interview, the facility failed to provide a quality care that meets professional standards for 2 (R #'s 71 and 195) of 2 (R #'s 71 and 195) residents when the facility failed to: 1. Complete an assessment and provide physician orders to allow R #71 to check his own blood sugar and inject his own insulin with staff supervision. 2. Administer antiviral (medication that is meant to treat viral infections) on time and as ordered by the resident provider for R #195. This deficient practice is likely to result in residents not receiving antibiotics in a timely manner prolonging their infection and the physical effects (temperature, pain, discomfort) caused by the infection; and residents becoming at risk for improper medication administration without the proper self-administering assessments and orders provided. The findings are: R #71: A. Record review of R #71's face sheet revealed R #71 was admitted into the facility on [DATE] with the following diagnoses: 1. Diabetes. B. Record review of R #71's care plan dated 12/11/23 revealed R #71 had diabetes and required his medications and blood sugar to be checked as ordered. C. Record review of R #71's care plan meeting nursing progress note dated 03/27/24 revealed, Patient [R #71] has been able to do his own shots [insulin and blood sugar checks] now. D. On 11/06/24 at 11:15 am during an interview with R #71, he confirmed he has diabetes and takes insulin. R #71 stated that he checks his own blood sugar and even injects himself with his own insulin with staff supervision. E. On 11/08/24 at 11:27 am during a medication administration observation, R #71 was observed checking his own blood sugar with a glucometer (a device for measuring the concentration of glucose in the blood) and being supervised by Certified Medication Aide (CMA) #1. F. On 11/08/24 at 2:42 pm during an interview with CMA #1, she stated that R #71 checks his own blood sugars with her presence. CMA #1 also stated that she was told by the facility nursing staff that R #71 was allowed to do so. G. On 11/08/24 at 2:48 pm during an interview with Licensed Practical Nurse (LPN) #2, she stated R #71 administers his own insulin with her supervision and he administers his own insulin every day with staff supervision. LPN #2 also stated that she was told by facility management that R #71 could do that. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	H. Record review of R #71's Electronic Health Record (EHR) revealed there was no completed self-administration assessment completed for R #71 to check his own blood sugar and administer his own insulin with staff assistance. I. Record review of R #71's physician orders revealed the following: 1.08/26/24: Insulin Lispro, 100 units/ml (milliliter)- no order provided for self administration. 2. 09/09/24: Lantus (insulin) 100 units/ml- no order provided for self administration. 3. No physician order was present that indicated R #71 could check his own blood sugar with staff supervision. J. On 11/14/24 at 1:13 pm during an interview with the Nurse Practitioner (NP) #1, she stated that there should be a physicians order for R #71 to check his own blood sugar and inject his own insulin with staff supervision. NP #1 confirmed there should also be a completed assessment that indicated R #71 was able to perform those tasks. K. On 11/14/24 at 4:11 pm during an interview with the Director of Nursing (DON), she stated that there should be an assessment and physicians order for R #71 to self-administer his own insulin and check his own blood sugar supervised by staff, and there was not. 39509 R #195: L. Record review of R #195 face sheet reveals that he was admitted to the facility on [DATE] with multiple diagnoses including: -Non-Traumatic Intracerebral Hemorrhage (stroke) -COVID-19 (a viral infection of the upper respiratory system) -Vascular Dementia (a chronic debilitating disease of the brain that causes decline in mental and physical functioning) -Hemiplegia and Hemiparesis (paralysis and loss of function of the muscles of one side of the body) following Cerebral Infarction (stroke) M. Record review of R #195 provider orders revealed an order dated 11/01/24 to administer Molnupiravir (a antiviral medication) Oral Capsule 200 MG (milligrams) give four capsules by mouth two times a day for COVID for 5 days. Review of all provider orders dated 11/01/24 to 11/05/24 failed to reveal an order to alter, amend or extend this medication order to a later date. N. Record review of Medication Adminstration Record (MAR) revealed that Molnupiravir Oral was to begin on 11/01/24 and the last dose was administered on 11/06/24 at the morning administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O. Record review of R #195 daily care notes revealed the following: -11/01/24 at 2:28 pm Change of Conditions (R #195) has low grade fever, cough, feels tired. (R #195) tested for COVID .positive for COVID. Provider notified and ordered retroviral (anti-viral medication) medications. -11/01/24 at 8:20 pm Molnupiravir Oral unavailable. -11/02/24 at 12:44 pm Molnupiravir Oral pharmacy yet to send -11/03/24 at 11:24 pm Molnupiravir Oral needs to be ordered -11/04/24 at 5:00 pm Antiviral medication and all other scheduled medications administered with good result. No adverse reaction to antiviral medications. -Record review of all daily care notes dated 11/01/24 to 11/05/24 failed to reveal any notation of notice to the provider that the Molnupiravir Oral was not availabe for administration on 11/01/24, 11/02/24 or 11/03/24. P. On 11/06/24 at 10:00 am during interview with R #195 and his wife, she reported that R #195 was recovering from COVID but she did not think he got all the medication that was ordered for him. She stated she was aware that they didn't have the medication from the pharmacy on the day it was to start or for several days after. Q. On 11/14/24 at 3:45 pm during interview with the DON, she reviewed R #195's medical record. She noted that he was tested positive for COVID 19 on 11/01/24 and that the provider ordered the administration of Molnupiravir Oral on that evening. She stated the record indicated the medication was not available for the first three days of the order. She stated the provider should have been notified of the unavailable medication. DON stated that there was no notation of the provider haveing been notified of the unavailable medication. She stated the medication order was not changed and stated that had the provider been notified then she would have expected the end date to have been extended to allow for the full five days administration of the medication. DON confirmed that R #195 did not receive the ordered medication.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interview, the facility failed to ensure residents received proper treatment to maintain vision 1 (R #71) of 1 (R #71) residents reviewed for vision. If the facility is not assisting residents in accessing treatment to maintain their vision, then residents are likely to lose their ability to see, which will compromise their quality of life. The findings are: A. Record review of R #71's face sheet revealed R #71 was admitted into the facility on [DATE]. B. Record review of R #71's physician orders dated 09/13/24 revealed R #71 required an optometry appointment for eye glasses. C. Record review of R #71's Electronic Health Record (EHR) revealed no optometry appointment had been scheduled and/or completed for R #71. D. On 11/06/24 at 11:14 am during an interview with R #71, he stated that he has been waiting a long time for glasses and he has not had a vision appointment for them yet, which has made him upset. R #71 also stated that he needs them to see and he really needs help with this [getting glasses]. E. On 11/13/24 at 1:43 pm during an interview with the Social Services Director (SSD), she stated that R #71's vision appointment was scheduled for 12/05/24, but the facility did not attempt to schedule R #71's vision appointment until 10/15/24. SSD confirmed R #71's appointment should have been scheduled sooner than 10/15/24 since R #71's physician order was dated 09/13/24. F. On 11/14/24 at 6:00 pm during an interview with the Director of Nursing (DON), she confirmed R #71's appointment should have been scheduled sooner than 10/15/24 since R #71's physician order was dated 09/13/24.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46064 Based on observation and interview, the facility failed to ensure that 1 (R #3) of 1 (R #3) residents reviewed was free from accidents and hazards by not securing an electric cord that is in a direct path to the residents bed. This deficient practice is likely to put residents at risk of unsafe situations. The findings are: A. On 11/13/24 at 10:22 AM during an interview with R #3 he stated that staff was repositioning him and the Certified Nursing Assistant (CNA) on his left side tripped on the electric cord connected to the bed. The CNA was able to catch herself and did not fall to the floor but bumped the side of his bed. B. On 11/13/24 at 10:24 AM a black electric cord was observed to be unsecured and in the direct walking path to R #3's bedside. C. On 11/13/24 at 10:37 AM Licensed Practical Nurse (LPN) #1 verified that the electrical cord to R #3's bed was unsecured and a tripping hazard.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39509 Based on observation, record review and interview the facility failed to assure that 1 (R #195) of 1 (R #195) resident was provided respiratory care including provider orders to monitor, clean, use a C-PAP (Continuous Positive Airway Pressure) or Bi-PAP (Bilevel positive Airway Pressure) (a non-invasive devices that provide assistive breathing usually during rest and sleep). If the facility fails to assist, manage and maintain equipment as ordered then resident are likely to not get the therapeutic results needed. The findings are: A. Record review of R #195 face sheet revealed he was admitted to the facility on [DATE] with multiple diagnoses including but not limited to: -Chronic Obstructive Pulmonary Disease (COPD) (a chronic, progressive disease of the lungs which causes a reduction of respiratory function especially during sleep and rest) -NonTraumatic Intracerebral hemorrhage (stroke) -Vascular Dementia with Agitation (a chronic and progressive disease of the brain the disrupts memory and brain functions) -Hemiplegia and Hemiparesis (partial and one sided paralysis) B. Record review of R #195's care plans revealed a care plan initiated 10/17/24 focus regarding potential for impaired gas exchange related to COPD and task to use CPAP as ordered. C. On 11/05/24 at 1:03 pm during observation of R #195's room it was readily noted that a C-PAP device was sitting on the table next to his bed. The device consisted of a mask connected to a flexable tube that was connected to the C-PAP equipment that was plugged in to a wall socket. D. On 11/05/24 at 1:03 pm during interview with R #195 and his wife, she stated that R #195 used a Bi-PAP every night and that use was required. She stated that he had a C-PAP prior to his admission to the facility and that she brought the C-PAP with her from the hospital. She stated she set the equipment up next to his bed. She stated family assisted him to set up and use the C-PAP equipment each night. She stated he was present in the facility for about two weeks when she was provided Bi-PAP equipment which she substituted for the C-PAP equipment. She stated she was not aware if the facility staff knew of his C-PAP/Bi-PAP machines or his requirements for nightly use but she stated the equipment was always on his bedside table and his nightly set up included the use of a mask that covered his mouth and nose, a hose that connected the mask to the C-PAP/Bi-PAP and the PAP equipment that plugged into a wall socket. E. Record review of provider orders dated 11/06/24 revealed multiple orders to assist, manage and maintain R #195's C-PAP equipment. No orders were noted regarding R #195's use of a Bi-PAP or conversion from C-PAP to Bi-PAP. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 11/14/24 at 4:18 pm during interview with the Director of Nursing, she reviewed R #195's provider orders and confirmed there was no order for staff to monitor, maintain or use either C-PAP or Bi-PAP prior to 11/06/24. She stated that these orders should have been entered and staff should have begun monitoring his C-PAP/Bi-PAP upon admission.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 39509 Based on record review and interview, the facility failed to assure that physicians responded to recommendations submitted during the pharmacist's written monthly review or obtain physician rational specific to the resident to agree or disagree with the pharmacist's monthly recommendations for 6 (R #7, R #20, R #26, R #27, R #42, R #43) of 6 (R #7, R #20, R #26, R #27, R #42, R #43) residents. This deficient practice is likely to cause resident medication regimen to not be properly evaluated resulting in possible over medication. A. Record review of documents submitted by the facility pharmacist consultant on 06/17/24 for review and action by each resident's provider: 1. R #26 Recommendation for additional lab testing of resident. The document indicates no Physician/Prescriber Response and is signed and dated on 09/03/24 by the former Director of Nursing (DON). The recommendation had a handwritten note-ordered. 2. R #67 Recommendation Gradual Dose Reduction of Mirtazapine (a psychotropic medication prescribed to manage depression). The document indicates no Physician/Prescriber Response and is signed and undated by the former Director of Nursing. The recommendation had a handwritten note-clinically contraindicated. 3. R #17 Recommendation for Gradual Dose Reduction of Sertraline (a psychotropic medication prescribed to manage anxiety). The document indicates no Physician/Prescriber Response and is signed and dated on 09/03/24 by the Licensed Practical Nurse (LPN). The recommendation had a handwritten note- MD refused request. No rationale is provided. 4. R #38 Recommendation for Gradual Dose Reduction of Duloxetine (a psychotropic medicaton prescribed to manage depression). The document indicates no Physician/Prescriber Response and is signed and dated on 09/03/24 by LPN. The recommendation had a handwritten note-MD Refused. No rationale is provided. 5. R #63 Recommendation to increase the dose of Donepezil (a medication prescribed to manage dementia [a chronic, progressive disease that caused decline of memory and brain function]). The document indicates no Physician/Prescriber Response and is signed and dated on 09/03/24 by LPN. The recommendation had a handwritten note-MD Refused Request. No rationale is provided. 6. R #44 Recommendation for Gradual Dose Reduction of Duloxetine (a psychotropic medication prescribed to manage anxiety) and Buspirone (a psychotropic medication prescribed to manage anxiety). The document indicates no Physician/Prescriber Response and is signed and dated on 09/03/24 by LPN. The recommendation had a handwritten note-MD refused request. No rationale is provided. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. R #08 Recommendation for Gradual Dose Reduction of Trazadone (a psychotropic medication prescribed to manage insomnia and depression) and Sertraline (a psychotropic medication prescribed to manage depression and anxiety). The document indicates no Physician/Prescriber Response and is signed and dated on 09/03/24 by LPN. The recommendation had a handwritten note-MD refused request. No rationale is provided. B. Record review of documents submitted by the facility pharmacist consultant on 08/15/24 for review and action by each resident's provider: 1. R #26 Recommendation to review duration of PRN (Pro Re Nata) (administration of a medication as needed rather than a scheduled time) administration of psychoactive Medications due to regulation that require PRN orders for psychoactive medications are limited to 14 days. The document indicates no Physician/Prescriber Response and is signed and dated on 08/29/24 by former Director of Nursing. The recommendation had a handwritten note that record was documented and updated. No rationale was provided 2. R #09 Recommendation for Gradual Dose Reduction of Lorazepam (a psychoactive medication prescribed for anxiety). The document indicates no Physician/Prescriber Response and is signed and dated on 08/20/24 by former Director of Nursing. The recommendation had a handwritten note to refer to Hospice (a nursing service that provides additional support during end of life). No rationale is provided. 3. R #20 Recommendation for Gradual Dose Reduction of Fluoxetine (a psychoactive medication prescribed for treatment of depression). The document indicates no Physician/Prescriber Response and is signed and dated on 08/20/24 by former Director of Nursing. The recommendation had a handwritten note as GDR evalueted and declined by IDT (InterDisciplinary Team). No rationale is provided. 4. R #29 Recommendation to review duration of PRN administration of antipsychotic Prochlorpearazine (a psychoactive medication prescribed to control nausea). The document indicates no Physician/Prescriber Response and is signed and dated on 08/20/24 by former Director of Nursing. The recommendation had a handwritten note- Hospice. 5. R #66 Recommendation to update diagnosis needed to support therapy. The medication order did not include the necessary supporting diagnosis to prescribe Trazadone. The document indicates no Physician/Prescriber Response and is signed and dated on 08/07/24 by former Director of Nursing (DON). The recommendation had a handwritten note to updated a diagnosis of insomnia for administration of Trazadone. 6. R #75 Recommendation to update diagnosis needed to support therapy. The medication order did not include the necessary supporting diagnosis to prescribe Trazadone. The document indicates no Physician/Prescriber Response and is signed and dated on 08/29/24 by former Director of Nursing (fDON). The recommendation was noted to be documented and updated. The recommendation had a handwritten note updating a diagnosis of insomnia for administration of Trazadone. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. R #37 Recommendation of possible duplication of therapy. Resident is receiving both Famotidine (a medication that treats acid stomach and heartburn) and Omeprazole (a medication that treats acid stomach and heartburn). Data does not support any benefit of giving these two medications at the same time. The document indicates no Physician/Prescriber Response. C. On 11/13/24 at 5:14 pm during interview with the Assistant Director of Nursing (ADON), he stated he was familiar with the pharmacy review process. He stated he understood the each month, the consulting pharmacist reviewed each resident's medication regimine and made recommendations as necessary. ADON stated that any pharmacist recommendations were suppose to be reviewed by the resident's assigned provider who would then select the preferred response to the recommendation, provide a rational for each response and sign each recommendation. ADON reviewed the pharmacist recommendations for the months of June and August 2024. He stated that recommendations appeared to have been reviewed and signed by the former Director of Nursing or by an Licensed Practical Nurse. ADON confirmed that none of the recommnedations had been reviewed with an order, a rational for the order and signed by the resident's provider.

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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 the medication error rate did not exceed 5% for 1 (R #74) of 5 (R #33, 71, 74, 75, 80) residents reviewed during medication administration. 34 medications were observed administered with 6 errors resulting in a medication error rate of 14.71%. If medications are administered in error, residents are likely to experience less than optimal results from their medication regimen (a prescribed systematic form of treatment for a course of drugs). The findings are: A. On 11/13/24 at 9:37 am during observation of Certified Medication Aide (CMA) #1 she drew, poured and administered all morning medication to R #74 including the following: -Amoldipine 10 mg (milligrams) (a medication prescribed to manage blood pressure) -Aspirin Tablet Delayed Release 81 mg (a medication prescribed to prevent blood clots) -Colecalciferol Oral Tablet 25 mcg (micrograms) (Vitamin C a medication to provide vitamin supplement) -Hydrochlorothiazide Oral Tablet 25 mg (a medication prescribed to manage blood pressure) -Lisinopril Oral Tablet 40 mg (a medication prescribed to manage blood pressure) B. Record review of R #74 medication administration record (MAR) revealed the following medications with their expected time of administration: -Amlodipine Oral Tablet 10 mg (milligrams) give 1 tablet by mouth for High Blood Pressure at 8:00 am. -Aspirin Tablet Delayed Release 81 mg give 1 tablet by mouth for prophylaxis (prevention of blood clots) at 8:00 am. -Colecalciferol Oral Tablet 25 mcg (micrograms) give 1 tablet by mouth one time daily for vitamin deficiency at 8:00 am. -Hydrochlorothiazide Oral Tablet 25 mg give 1 tablet by mouth one time a day for high blood pressure at 8:00 am. -Lisinopril Oral Tablet 40 mg give 1 tablet by mouth one time a day for high blood pressure at 8:00 am. C. On 11/13/24 at 9:37 am during interview with CMA #1, she stated that she had not provided R #74 her morning medications as she was waiting to obtain her blood pressure before giving her her morning medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. On 11/14/24 at 11:00 am during interview with Administrator (ADM) he stated that the facility had an administration policy to provide medications that are indicated on the MAR to be administered at a specific time to be given within a 2 hour period-1 hour before to 1 hour after the specific time stated on the MAR. ADM stated that medications indicated in the MAR as being administered during morning could be administered any time between 7:00 am and 11:00 am.

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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. 34439 Based on observation and interview the facility failed to ensure medication carts were locked when unattended. This deficient practice is likely to negatively impact the health of residents if they were to ingest medications not intended for them. The findings are: A. On 11/14/24 at 9:23 PM during an observation of the 300 wing medication cart, RN #2 was observed walking away from the medication cart without locking it. B. On 11/14/24 at 9:25 PM during interview with RN #2, he confirmed that medication carts should not be left unlocked and unattended. C. On 11/14/24 at 9:24 PM during an observation of the 500 wing medication cart, the cart was unlocked and staff left the cart unattended, also observed on top of the medication cart was a cup with four unidentified medication and five lancets (a small medical implement used for blood sampling). D. On 11/14/24 at 9:30 PM during interview with RN #1, she confirmed that medication carts should not be left unlocked and unattended. RN #1 picked up the medication cup and walked away again leaving the medication cart unlocked. F. On 11/15/24 at 9:55 PM during an interview, Assisted Director of Nursing (ADON) confirmed that medication carts were unlocked and should not be unlocked and unattended. 46064

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on record review and interviews, the facility failed to ensure residents obtained routine dental care for 1 (R #36) of 1 (R #36) residents reviewed for dental services. This failure is likely to result in the resident experiencing pain, embarrassment over condition of teeth, and potential weight loss. The findings are: A. Record review of R #36's face sheet revealed R #36 was admitted into the facility on [DATE]. B. Record review of R #36's physician orders dated 10/20/24 revealed R #36 required referral for in-house dentist for dental pain and recurrent gingivitis (inflammation of the gums). C. Record review of R #36's Electronic Health Record (EHR) revealed no indication that R #36 was seen by a dentist after the 10/20/24 physician order. D. On 11/06/24 at 11:45 am during an interview with R #36, she stated that she has not had a dental appointment in sometime and she has several teeth that need to be pulled, and she experiences pain in her gums often. R #36 confirmed she told the facility nursing staff of this. E. On 11/13/24 at 1:40 pm during an interview with the Social Services Director (SSD), she stated that shortly after R #36's dental order was put in the system, the in-house dentist canceled their contract with the facility. The SSD confirmed R #36 had not been seen by a dentist per physicians order and should have been. The SSD also confirmed the facility just scheduled R #36 to be seen by an out of facility dentist on 12/03/24. F. On 11/14/24 at 4:09 pm during an interview with the Director of Nursing (DON), she stated R #36 should have been seen by a dentist sooner than what was scheduled and was not.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, interview, and record review, the facility failed to maintain the kitchen in a sanitary manner when staff failed to: - Label and date open food items in the kitchen and in the unit nourishment refrigerators. - Store frozen food in the freezer in the kitchen. These failures have the potential to result in cross contamination, the growth of foodborne pathogens, and foodborne illness. This failure had the potential to affect all residents who ate food from the kitchen and unit nourishment refrigerators/freezers. The findings are: Kitchen Findings: A. On 11/05/24 at 11:29 am during an initial kitchen observations, the following was observed: - 1- 3.5 L (liter) container sliced tomatoes was not labeled or dated and stored in the kitchen refrigerator. - 1 plastic container of sliced onions was not labeled or dated and stored in the kitchen refrigerator. - 3 packages of Conestoga Pioneer 6 extra crisp English muffins was not dated and stored in the kitchen refrigerator. - 2 packages of Hilltop Hearth Homestyle Waffles- keep frozen, and were stored in the kitchen refrigerator, not freezer. - 1 package of Roseli pepperoni was not dated and stored in the kitchen freezer. - 5- 12 count (ct) hamburger buns were not labeled or dated and stored in the kitchen dry storage. - 1- 12 ct container of hard taco shells was not labeled or dated and stored in the kitchen dry storage. B. On 11/05/24 at 11:50 am during an interview with the Dietary Manager (DM), he confirmed all initial kitchen tour findings and stated that all food should be labeled, dated, and stored appropriately in the kitchen. Unit Nourishment Room Findings: C. On 11/14 24 at 5:09 pm during a skilled unit nourishment room tour, the following was observed: 1- Styrofoam cup of white liquid was not labeled or dated and stored in the unit refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1- plastic bag of [NAME] Farms everything chopped salad kit and Fresh Gourmet cheese and garlic croutons was not labeled or dated and stored in the unit refrigerator. D. On 11/14 24 at 5:16 pm during a long term care unit nourishment room tour, the following was observed: 1- 2 pack pepperoni pizza hot pocket was not labeled or dated and stored in the unit freezer. 1-1.5 quart Breyers vanilla, strawberry, and chocolate ice cream and was stored in the unit freezer. E. On 11/14/24 at 5:27 pm during an interview with the DM, he confirmed all nourishment room unit findings and stated each food/beverage item should be labeled and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41988 Based on observation, interview, and record review, the facility failed to maintain proper infection prevention measures for 2 (R #'s 71 and 75) of 6 (R #'s 33, 39, 44, 71, 75 and 80) residents observed when the facility: 1. Failed to store R #71's nebulizer mask (a drug delivery device used to administer medication in the form of mist) appropriately in a bag. 2. During medication administration when the Certified Medication Aide (CMA) used her bare fingers to pour mediations. This deficient practices are likely to result in the spread of infectious diseases. The findings are: R #71: A. Record review of R #71's face sheet revealed R #71 was admitted into the facility on [DATE]. B. Record review of R #71's physician orders revealed the following: 1. 01/23/24: Albuterol inhalation solution (medication used to open airways in the lungs). 2. 10/26/24: Ipratropium inhalation solution (medication used to open airways in the lungs). C. On 11/06/24 at 11:18 am during an observation and interview with R #71, R #71's nebulizer mask was observed to lying on his nightstand and not in a bag to keep clean. R #71 stated that he was never given a bag to store his nebulizer mask in and he would like one. D. On 11/06/24 at 11:25 am during an interview with Registered Nurse (RN) #3, she confirmed R #71's nebulizer mask was lying on his nightstand and not in a sealed bag. RN #3 stated that R #71's nebulizer mask should be stored in a bag and not on the table. E. On 11/14/24 at 4:09 pm during an interview with the Director of Nursing (DON), she stated, It [R #71's nebulizer mask] should be cleaned, taken a part to dry, and stored in a bag. 39509 R #75: (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. On 11/13/24 at 9:37 am during observation of medications administration, CMA #1 was observed as she poured medications for R #75. She drew a bottle of Aspirin (a medication used to reduce fever and thin blood) from the medication cart, she removed the cap and began to pour the medication from the bottle. CMA #1 then used her index finger to push a single pill from the bottle into the medication cup. CMA #1 then returned the cap to the bottle and replaced the bottle in the medication cart. CMA #1 then removed a bottle of Vitamin D (a medication used to supplement nutrients and vitamins) and proceeded to remove the cap and began to pour the medication from the bottle. CMA #1 then used her index finger to push a single pill from the bottle into the medication cup. CMA #1 then proceeded to give the medications to R #75. G. On 11/13/24 at 9:40 am during interview with CMA #1 she stated that she had used her bare index finger from the two bottles of medication to help pour the pills into R #75's medication cup. CMA #1 stated she was having difficulty removing the pills from the bottle. She stated she probably should not have used her bare finger to remove the pills from the bottle. H. On 11/14/24 at 11:00 am during interview with DON, she stated that staff should not be using their bare finger touch and transfer medication from a bottle to resident's medication cup.