STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summerstone Health and Rehabilitation Center	485 Veterans Way Kernersville, NC 27284

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review and interviews with staff, Nurse Practitioner (NP), and the resident's representative, the facility failed to allow a resident with behaviors to remain in the facility and to provide written documentation which stated the reason the facility could not meet the resident's needs for 1 of 1 resident (Resident #205) reviewed for facility initiated discharge. Findings included: Resident #205 was admitted to the facility on [DATE] with the diagnosis of dementia and repeated falls. The admission Minimum Data Set (MDS) dated [DATE] for Resident #205 documented the resident had an intact cognition. The active diagnosis was dementia. Social Worker #1's note dated 9/24/24 at 3:59 pm documented she sent a referral for Resident #205's admission to a sister facility's memory care unit in another town for possible admission. The note indicated the Social Worker would continue to follow-up. Social Worker #1's note dated 9/24/24 at 5:09 pm documented an email was received from the sister facility for Resident #205's admission and they had no bed in the memory care unit at that time. The note indicated the Social Worker would continue to look for placement. Resident #205 had a significant change MDS dated [DATE] for cognitive decline and falls. Resident #205 had severe cognitive impairment. Resident #205 was coded with no behaviors, rejection of care, or wandering. The resident had 2 or more falls without injury since the previous MDS assessment. The NP documented in Resident #208's progress note dated 12/3/24 that he saw the resident for her monthly chronic conditions visit. The Resident's Representative had not conveyed any concerns. Nursing staff reported the resident had intermittent severe behavioral disturbance including exit seeking and was a fall risk. The resident was assessed and noted to have notable cognitive gaps (deficits). The plan for psychiatric conditions included major depressive disorder with psychotic episodes and the resident was restarted on Seroquel at bedtime. The NP will continue to collaborate with in-house psychiatry. The resident was clinically stable at the time of this encounter. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #205's discharge form documented she was transferred on 12/19/24 to a local nursing facility with a memory care unit. The form was signed by Nurse #4. The form was not signed by the resident's representative. There was no physician documentation in the medical record that indicated the specific resident needs the facility could not meet, the facility's efforts to meet those needs, or the services the receiving facility would provide to meet the needs of the resident which could be met at the current facility. On 1/9/25 at 8:46 am Nurse #4 was interviewed. Nurse #4 stated Resident #205's representative was not available (at the facility) at the time of discharge on 12/19/24 to sign the discahrge form. She was informed by Social Worker #1 that all paperwork had been completed. On 1/9/25 at 9:46 am a follow up interview was conducted with Nurse #4. Nurse #4 stated Resident #205 was discharged on [DATE] to a local nursing facility with a memory care unit. Social Worker #1 completed the paperwork. Nurse #4 stated she did not know why the Resident's Representative was not present at the time of discharge. The Resident's Representative normally signed the discharge paperwork. Nurse #4 stated Social Worker #1 informed her that the discharge paperwork was completed. Nurse #4 stated, I understood that the Resident's Representative knew about the discharge to a memory care unit. Nurse #4 indicated Social Worker #1 reported to her that the Resident's Representative had not wanted the resident discharged to the facility after the discharge had taken place. Nurse #4 stated the resident had declined quickly from dementia. She was combative, confused, and was frequently wandering and falling. The resident required increased supervision, including one on one, and was not safe without supervision. The NP was aware. On 1/9/25 at 12:05 pm an interview was conducted with Resident #205's Resident's Representative. The representative stated that she was notified by Social Worker #1 back in August 2024 that the resident would require a higher level of care with a memory care unit. The Resident's Representative was provided with 3 facilities that had a memory care unit. The Resident's Representative stated the 3 facilities had a 1-star rating (nursing home rating from 1 to 5 with 1 being the lowest), she observed the facilities, and declined the choices. The Resident's Representative stated that the facility discussed on multiple occasions that the resident needed a higher level of care, and that care could not be safely provided at this facility. Resident #205's Representative stated she provided one facility name in [NAME] to Social Worker #1 that she would agree to discharge the resident. The Resident's Representative stated in November 2024 she was approached about the discharge to a higher level of care/memory care unit again by Social Worker #1 and she (the Resident's Representative) asked for the resident to remain at the facility. In December 2024 she received a call from Social Worker #1 that the resident had been discharged to one of the three facilities the Resident's Representative was provided back in August 2024. The Resident's Representative stated she was not advised prior to the day of discharge that Resident #205 was being discharged to another facility with a memory care unit. She was notified on the day of discharge. When the Resident's Representative informed Social Worker #1 that she had refused this facility, the Social Worker denied being told that. Resident #205's Representative stated the resident remained at the new facility for a week and was discharged to and currently at hospice. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/25 at 12:36 pm the Nurse Practitioner (NP) was interviewed. The NP stated due to Resident #205's decline from dementia and frequent falls, the facility could not meet the needs of the resident. The resident required and was provided one on one supervision for wandering and behaviors. The Resident's Representative agreed that the resident required a higher level of care. The resident was discharged to a facility with a memory care unit for increased supervision. The Director of Nursing (DON) was interviewed on 1/9/25 at 10:10 am. The DON stated she remembered Resident #205's discharge was agreed upon with the Resident's Representative and Social Worker #1 and was not facility initiated for a higher level of care. She was discharged to another facility with a memory care unit. The DON stated all discharge paperwork would be in Resident #205's record. The DON had no other documentation, and Social Worker #1 was no longer employed at the facility and her phone number was disconnected. The DON believed there was a verbal consent by the Resident's Representative for discharge to a facility with a memory care unit. On 1/19/25 an interview was attempted with Social Worker #1 who was no longer with the facility. The phone number was disconnected. On 1/19/25 at 2:41 pm an interview was conducted with the Business Office Manager. The Business Office Manager stated Resident #205 was discharged to another facility in agreement with the Resident's Representative. Social Worker #1 would have completed the paperwork. She further stated that this discharge not a facility-initiated discharge. On 1/9/25 at 3:51 pm an interview was conducted with the Discharge Planner. The Discharge Planner stated she was aware that Resident #205's Resident's Representative spoke with Social Worker #1 about the planned discharge to another facility with a memory care unit to meet the resident's needs. The Discharge Planner stated the Resident's Representative agreed with the discharge to another facility with a memory care unit if it was in close proximity to her so she was able to visit the resident. The Discharge Planner stated she thought the Resident's Representative changed her mind on which facility after the discharge reported by the Social Worker. She was aware the Resident's Representative reported her disapproval.

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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** 46725 Based on record review, and staff and family interviews, the facility failed to ensure a safe and orderly discharge when a resident was discharged home without a referral for home health services for 1 of 2 residents reviewed for discharge (Resident #356). The findings included: Resident #356 was admitted to the facility on [DATE] with diagnoses including stroke. A review of the physical therapy discharge summary dated 10/10/24 indicated Resident #356 was ambulatory and able to walk 150 feet with supervision, able to climb 12 steps with supervision, and independent in mobility. The discharge recommendation was for home health services to continue physical therapy at home. A review of occupational therapy discharge summary dated 10/10/24 indicated Resident #356 was independent in toileting hygiene, toileting transfer, and required supervision with bathing and dressing. The discharge recommendation for home health services to continue occupational therapy at home. A review of physician order dated 10/11/24 revealed a discharge order for Resident #356 to discharge home with family with home physical therapy and occupational therapy services. Review of the discharge summary dated 10/11/24 indicated that Resident #356 was discharged from the facility on 10/11/24. The discharge summary was signed by Social Worker #2. The discharge summary indicated no home services were requested. An interview was conducted with Resident #356's family member on 1/17/25 3:26 pm. She indicated Resident #356 was discharged home on 10/11/24 with no home health orders from the facility and she felt the discharge was not a safe discharge. An interview was conducted with the Director of Rehabilitation services on 1/9/25 at 9:45 am. She indicated she met with Resident #356 to discuss his discharge planning needs prior to discharge. Resident #356 was cognitively intact and voiced that he wanted to be discharged . The Director of Rehabilitation further indicated she and Resident #356 agreed to move forward with the discharge plan to return home with family and to continue therapy at home. The Director of Rehabilitation revealed she made the Discharge Planner and additional interdisciplinary team members aware of the recommendation for home physical and occupational therapy. An interview was conducted with Social Worker #2 on 1/9/25 at 9:10 am. She indicated she was aware of the physician's discharge order on 10/11/24 which ordered home physical and occupational therapy. She further revealed that she did not follow through with the order as she thought the discharge order was standard for all residents and that the family had indicated they were planning to move and unsure of the new address. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Nurse Practitioner on 1/9/25 at 2:19 pm. He indicated he wrote the order to discharge Resident #356 home with home health physical and occupational therapy services and the Social Worker should have made the referral as ordered. An interview was conducted with the Administrator on 1/10/25 at 2:08 pm. She indicated the Social Worker should have followed the physician's discharge order to refer Resident #356 for home health services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review and interviews with staff, Nurse Practitioner, and the resident, the facility failed to provide care in a safe manner when a dependent resident rolled off her bed onto the floor during incontinence care. The resident was not injured. The deficient practice affected 1 of 7 residents reviewed for accidents (Resident #18). Findings included: Resident #18 was admitted to the facility on [DATE] with the diagnosis of osteoarthritis. Resident #18 had a significant change Minimum Data Set, dated dated dated [DATE] for mobility decline, pressure ulcer, and a fall. The resident required extensive assistance with bed mobility and was always incontinent of bowel and bladder. The care plan for Resident #18 dated 11/26/24 documented the resident had an increased risk for falls and required assistance with her activities of daily living for bed mobility, transfers, bathing, and personal hygiene. Resident #18's nurses' note dated 11/29/2024 at 7:36 am documented by Nurse #4 documented the resident fell from her bed to the floor. Nursing Assistant (NA) #3 informed Nurse #4 she was attempting to provide care to the resident, turned her, and the resident fell off the bed onto the floor. The resident was assessed and she complained of pain in her head and her right hip. The on-call physician was notified, an order was given to send the resident to the Emergency Department (ED) for assessment. Resident #18's change in status note dated 11/29/2024 at 6:05 am written by Nurse #4 documented the resident had fallen. At the time of evaluation, the resident's vital signs were: Blood Pressure (BP): 109/67, Pulse (P): 60, Respiratory Rate: 18, Temperature: T 98.1, oxygen saturation- 98.0 % on room air and Mental Status Evaluation: No changes observed A fall incident report for Resident #18 dated 11/29/24 was documented by Nurse #4. Resident #18 fell out of bed during care provided by NA #3. The staff was educated on resident bed mobility during care. The resident was sent to the ED. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/8/25 at 11:46 am Nurse #4 was interviewed. Nurse #4 stated she remembered Resident #18 and the fall incident on 11/29/24. Nurse #4 stated NA #3 was assigned and reported to her that when care was provided to Resident #18 the NA turned the resident and the resident rolled out of bed. Nurse #4 was not aware whether there were any side rails. The resident required maximal assistance in bed for turning and the NA should have 2 staff to prevent rolling out of bed when turning a dependent resident. Resident #18 was assessed and had no apparent injury and had no complaints. The resident was sent to the hospital for evaluation. Nurse #4 stated she asked NA #3 what happened, and the NA stated she provided care by herself and when she turned the resident for care she rolled out of bed onto the floor. Nurse #4 stated she provided the NA education to use 2 staff for a dependent resident. The Director of Nursing (DON) was informed. The physician was notified, and the resident was sent to the Emergency Department (ED) for an evaluation. The resident returned from the ED the same day and had no injury. Attempts were made to interview NA #3 by phone on 1/09/25 and 1/10/25. A voice mail was left but NA #3 did not return the calls. On 1/9/25 at 2:42 pm an interview was conducted with Resident #18. Resident #18 stated she remembered when she fell out of bed. Resident #18 stated when the NA was providing care she placed her on the side of the bed (the resident pointed to the right side of her bed) and I fell off. She further stated I was not hurt. The resident did not remember if the bed was raised for care. Resident #18's ED after visit summary dated 11/29/24 documented the resident was evaluated after a fall. A CAT (radiograph of the brain) scan of head showed no injury. The resident had pain in both knees and an x-ray was completed. The results were negative for injury. The resident had a history of osteoarthritis to both knees. The resident was sent back to the facility. A nurses' note dated 11/29/24 documented Resident #18 complained of right hip pain and had an x-ray completed at the facility after return from the ED. The x-ray result showed no fracture. There was moderate osteoarthritis of the hip joint. On 1/9/25 at 1:04 pm an interview was conducted with the DON. The DON was aware that Resident #18 had rolled out of bed during care by NA #3. The DON stated NA #3 was provided education. On 1/9/25 at 12:10 pm an interview was conducted with the Nurse Practitioner (NP). The NP stated he was not aware Resident #18 had rolled out of the bed. The NP stated the resident complained of left hip pain and an x-ray was done 11/30/24. The x-ray result was osteoarthritis, no injury. He further stated that the resident long standing pain from osteoarthritis in both hips and knees.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on observations, staff interviews, and facility record reviews, the facility failed to keep a urinary catheter bag and/or its tubing from touching the floor to reduce the risk of infection for 1 of 2 residents (Resident #9) reviewed for urinary catheters. The findings included: Resident #9 was admitted to the facility on [DATE] from a hospital. Her cumulative diagnoses included neuromuscular dysfunction of the bladder and a history of a urinary tract infection. An admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 had intact cognition. No behaviors nor rejection of care were reported. The assessment indicated Resident #9 required set-up or clean-up assistance for eating and personal hygiene, substantial to maximum assistance for bathing and bed mobility, and was totally dependent on staff for toileting and chair to bed to chair transfers. The MDS reported Resident #9 had an indwelling urinary catheter. Resident #9's care plan included an area of focus related to the resident having an indwelling urinary catheter due to her neuromuscular dysfunction of the bladder (Initiated on 12/9/24; Revision on 12/10/24). An initial observation and interview was conducted on 1/6/25 at 3:10 PM as Resident #9 was sitting in her wheelchair with a urinary catheter collection bag hanging from the back of her wheelchair. At the time of this observation, 2 to 3 inches of the bottom of Resident #9's urinary catheter bag and approximately 10 inches of the catheter tubing were lying on the floor. When asked about the use of the indwelling urinary catheter, the resident reported she had the catheter prior to admission to the facility. Resident #9 added that she was prone to developing urinary tract infections. On 1/7/25 at 9:25 AM, the resident was again observed to be sitting in her wheelchair. The urinary catheter bag was hanging from the back of the wheelchair and positioned so that the catheter bag was 1 inch from the floor. However, 3-4 inches of the urinary catheter tubing was again observed to be lying on the floor. An additional observation was conducted on 1/9/25 at 8:18 AM as approximately 5 inches of the bottom of Resident #9's urinary catheter bag was lying directly on the floor in front of the resident's wheelchair. The catheter bag was not attached to the wheelchair at the time of this observation. An interview was conducted with Nurse Aide (NA) #1 on 1/9/25 at 8:20 AM. NA #1 reported she was assigned to care for Resident #9. During the interview, the NA was asked about the positioning of resident's catheter bag lying on the floor without being attached to the wheelchair's frame. The NA stated she knew this was the case and had told the nurse about it. She reported the resident would be going out for an appointment later this morning and needed to have the catheter bag covered and the bag/tubing secured. When asked if the catheter bag and/or tubing should be on the floor, the NA stated Resident #9's wheelchair was low, so the catheter bag sometimes ended up on the floor when she was sitting in the wheelchair. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25 at 8:23 AM, the facility's Staff Development Coordinator (SDC) joined the conversation as she approached Resident #9's room. The SDC confirmed she was also the facility's Infection Preventionist. Upon inquiry, the SDC stated she was heading into Resident #9's room to take care of her urinary catheter and tubing. Upon informing the SDC of the previous observations made on 1/6/25 and 1/7/25, the SDC was asked if the resident's urinary catheter bag and/or tubing should be on the floor. The SDC stated, No. An interview was conducted with the facility's Director of Nursing (DON) on 1/9/25 at 11:40 AM. During the interview, the observations of Resident #9's catheter bag and/or tubing lying on the floor were discussed. In response, the DON stated she would have preferred for the NA to take care of this issue when it was first identified. Upon further inquiry as to whether a urinary catheter bag and/or its tubing should be on the floor, the DON stated, No, never.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32394 Based on observations, staff interviews, and record reviews, the facility failed to have a medication error rate of less than 5% as evidenced by 3 medication errors out of 29 opportunities, resulting in a medication error rate of 10.3% for 2 of 4 residents (Residents #32 and #86) observed during the medication administration observation. The findings included: 1-a. On 1/7/25 at 7:35 AM, Nurse #1 was observed as she prepared and administered 9 medications to Resident #32. The medications administered included one 81 milligram (mg) aspirin chewable tablet. A review of Resident #32's medication orders revealed the resident had a current order for one-81 mg aspirin EC [Enteric Coated] Tablet Delayed Release to be given as one tablet by mouth one time a day (ordered on 12/31/24). An interview was conducted on 1/7/25 at 3:55 PM with Nurse #1. During the interview, the discrepancy in the formulation of the 81 mg aspirin tablet administered to Resident #32 was discussed. Upon review of Resident #32's medication order, Nurse #1 confirmed she gave one-81 mg chewable aspirin tablet to Resident #32 instead of the enteric coated/delayed release formulation ordered for this resident. 1-b. On 1/7/25 at 7:47 AM, Nurse #1 was observed as she completed the administration of Resident #32's scheduled medications. At that time, Resident #32 reported he had pain and requested a pain medication. Nurse #1 returned to the medication cart and reviewed the resident's medication profile. Upon review, the nurse reported Resident #32 had an order for 650 milligrams (mg) acetaminophen to be given to the resident as needed (PRN) for pain. Nurse #1 was observed as she prepared and administered the PRN acetaminophen to Resident #32. A review of Resident #32's medication orders revealed the resident had a current order for 325 mg acetaminophen to be given as 2 tablets (total dose of 650 mg) every 8 hours as needed for pain. Further review of Resident #32's Medication Administration Record (MAR) revealed there was documentation which indicated 650 mg acetaminophen had previously been administered to Resident #32 on 1/7/25 at 6:04 AM. The resident also received the PRN dose of 650 mg acetaminophen observed and documented as given by Nurse #1 on 1/7/25 at 7:52 AM. The second dose of 650 mg acetaminophen was administered to the resident only 1 hour and 48 minutes after the first dose he received earlier that morning (instead of 8 hours later). An interview was conducted on 1/7/25 at 3:55 PM with Nurse #1. During the interview, Nurse #1 reviewed Resident #32's Medication Administration Record (MAR). The nurse stated that if she had known that a dose of acetaminophen was already given to the resident at 6:04 AM that morning, she would not have given him a second dose. The nurse reported she would have told the resident he had already received the medication and if his pain was not adequately managed, she may have consulted with his provider. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1-c. On 1/7/25 at 7:55 AM, Nurse #2 was observed as he prepared to administer 8 medications to Resident #86. The medications administered included one tablet of 81 milligram (mg) delayed release (DR) aspirin. A review of Resident #86's medication orders included a current order for one-81 mg aspirin EC [Enteric Coated] Tablet Delayed Release to be given as one tablet by mouth one time a day (ordered on 11/1/24). As Nurse #2 pulled Resident #86's medications from the medication (med) cart, he placed the tablet(s) and capsule(s) into a small medication (med) cup. In the process of pulling the medications scheduled for administration, Nurse #2 identified two stock medications that were not stored on the med cart. On two separate occasions, the nurse locked the med cart and went to obtain the medications needed from the medication storeroom and/or other med carts. Nurse #2 took the small med cup (containing the tablets and capsules pulled thus far) with him each time he left the med cart. Upon his last return to the medication cart, the med cup was observed to be missing the one-81 mg EC Delayed Release tablet of aspirin previously pulled for administration to Resident #86. Nurse #2 was not aware of the missing tablet. On 1/7/25 at 8:30 AM, Nurse #2 reported he was ready to administer the medications prepared for Resident #86. The nurse locked his medication cart and computer screen, picked up the med cup containing the tablets and capsules (but without the aspirin tablet), then left the med cart and headed to the resident's room. At that time, a request was made for the nurse to return to the med cart. Upon his return to the med cart, the nurse was asked if the aspirin tablet that he had pulled was in the med cup. The nurse reviewed the medications in the med cup and confirmed the aspirin tablet was no longer in the cup. Nurse #2 stated he did not know what happened to the aspirin tablet. He reported he would need to pull another 81 mg aspirin EC tablet from the cart for administration to the resident. Nurse #2 was observed as he obtained an 81 mg EC aspirin tablet from a stock bottle on the med cart, added it to the med cup, and administered the medications to Resident #86. An interview was conducted on 1/8/25 at 9:22 AM with the facility's Director of Nursing (DON). During the interview, the medication administration observations were discussed. The DON reported she would expect the nursing staff to be following the 5 rights of medication administration, including the right dosage and dosage form. She also confirmed that if there was an order for a medication to be given, she would expect it to be given. With regards to the PRN acetaminophen being given too soon for Resident #32, the DON stated, that shouldn't have happened. She reported if the computer software failed to automatically indicate when the last dose of a PRN medication was given, the nurse was expected to check the documentation to determine if enough time had elapsed to administer another dose.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on observations, interviews with the staff, Nurse Practitioner (NP), and dispensing pharmacist, and hospital and facility record reviews, the facility failed to correctly transcribe an order to administer the full course of an antibiotic treatment to a resident upon her return from a hospital stay for a urinary tract infection (UTI). This occurred for 1 of 3 residents (Resident #27) reviewed for antibiotic use. The findings included: Resident #27 was admitted to a hospital from 12/7/24 to 12/10/24. A review of the resident's hospital Discharge Summary dated 12/10/24 reported Resident #27 had been admitted to the hospital with symptomatic acute cystitis with hematuria (a bladder infection with visible blood present in the urine) and associated weakness. The Discharge Summary indicated, Due to her prior history of ESBL [Extended-spectrum beta-lactamases] she was placed on ertapenem [an intravenous antibiotic generally reserved for pathogens that are resistant to other antibiotics]. Urine culture did confirm ESBL E. coli [a strain of bacteria that produces enzymes which make an infection more difficult to treat]. The resident's hospital Discharge Summary noted she would be discharged from the hospital on fosfomycin [an oral antibiotic] to start on 12/11/24 and repeat dose 3 days later. Resident #27's hospital Discharge Medication List dated 12/10/24 included in part: fosfomycin (3 gram pack) with instructions to take 3 grams by mouth every 3 days for 2 doses. Start date: 12/11/24; End date: 12/15/24. Resident #27 was discharged from the hospital to the facility on [DATE]. A review of the resident's admission orders included an order transcribed into the resident's electronic medical record (EMR) on 12/10/24 by Nurse #3 for the following: fosfomycin oral packet 3 grams to be given as 3 grams by mouth one time a day for ESBL for one (1) administration (Start Date 12/14/24). The order did not include initiating a dose of fosfomycin on 12/11/24. An interview was conducted on 1/8/25 at 3:28 PM with Nurse #3. Nurse #3 was identified as the staff member who transcribed the order for fosfomycin into the facility's computer software on 12/10/24 upon Resident #27's admission to the facility. When asked, the nurse pulled up the resident's hospital discharge medication (med) list for review. He confirmed her Discharge Medication (med) List indicated two doses of fosfomycin were to be administered every 3 days upon discharge from the hospital with a start date of 12/11/24 and end date of 12/15/24. Nurse #3 also confirmed the order he transcribed into the computer system on 12/10/24 had a start date of 12/14/24 (not 12/11/24). The nurse was unable to explain why he incorrectly transcribed the order for fosfomycin to include only one dose instead of two. A review of the resident's December 2024 Medication Administration Record (MAR) revealed only one dose of fosfomycin was administered to Resident #27 after her admission to the facility. This one dose of fosfomycin was documented as administered on 12/14/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27's admission Minimum Data Set (MDS) dated [DATE] indicated the resident had moderately impaired cognition. The resident's care plan included an area of focus which read, I am at increased risk for UTI [urinary tract infection] due to history of recurrent urinary tract infections. Hx [History] of ESBL (Date Initiated 12/10/24). On 1/6/25, the resident's Nurse Practitioner (NP) ordered a urinalysis with a culture and sensitivity test. A culture and sensitivity test is a lab test that identifies the specific type of bacteria causing an infection and then identifies which antibiotics are most effective against the bacteria present. The urinalysis report dated 1/7/25 noted the urine sample was positive for several factors suggestive of a UTI (including urine white blood cells and urine bacteria). An interview was conducted on 1/8/25 at 10:57 AM with the NP assigned to care for Resident #27. At the time of the interview, the NP had access to Resident #27's EMR. During the interview, the NP was asked how many doses of fosfomycin were intended to be given to the resident upon her admission to the facility. He confirmed he had understood the hospital recommended two doses of fosfomycin should have been given to the resident (one dose on 12/11/24 and one on 12/14/24). Upon further inquiry, the NP stated he absolutely would have wanted 2 doses of fosfomycin to be administered to the resident after her admission to the facility. During the interview, the NP stated he saw Resident #27 on 1/3/25 and noted the family reported she had increased confusion. For this reason, he was concerned the resident may have a UTI and ordered a urinalysis and urine culture be sent out. The NP reported he was primarily waiting for the culture results to come back from the lab before he considered initiating an antibiotic. A telephone interview was conducted on 1/8/25 at 3:58 PM with a pharmacist at the facility's contracted dispensing pharmacy. When asked about Resident #27's fosfomycin, the pharmacist reported one (1) dose of 3 grams oral fosfomycin was dispensed and delivered from the pharmacy for Resident #27 on 12/10/24. When asked, the pharmacist reported a second dose of fosfomycin was not requested by the facility (or dispensed) for Resident #27. An interview was conducted with the facility's Director of Nursing (DON) on 1/9/25 at 11:40 AM. During the interview, the DON was informed of the concern related to the facility's failure to administer the full course of fosfomycin treatment ordered for Resident #27's UTI. During a follow-up interview conducted on 1/9/25 at 1:05 PM, the DON confirmed the resident was supposed to receive two doses of fosfomycin upon admission to the facility. She reported the provider was called and the NP decided he wanted to order another dose of fosfomycin for the resident at this time. A telephone follow-up interview was conducted on 1/9/25 at 2:34 PM with the NP. During the interview, the NP reported Resident #27's lab report from her urine culture came back inconclusive, so he decided to order the second dose of fosfomycin initially missed upon her admission to the facility. When asked, the NP reported he did not think missing this second dose of fosfomycin after her admission to the facility resulted in harm to the resident.

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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. 32394 Based on observations, interviews with staff, and record reviews, the facility failed to: 1) Store a medication in accordance with the manufacturer's storage instructions on 1 of 3 medication (med) carts observed (200 Hall Med Cart); and 2) Remove and dispose of expired medications observed to be stored in the drawer of 1 of 3 med carts observed (300 Hall Med Cart). The findings included: 1. According to the manufacturer, intact (unopened) bottles of latanoprost eye drops should be stored under refrigeration at 36 degrees Fahrenheit (o F) to 46 o F. An observation of the 200 Hall Med Cart was conducted on 1/9/25 at 2:10 PM in the presence of Nurse #4. The observation revealed an unopened 2.5 milliliter (ml) bottle of latanoprost eye drops was stored on the med cart. The pharmacy label on the latanoprost eye drops indicated the medication was dispensed from the pharmacy on 1/7/25 for Resident #76. A pharmacy auxiliary sticker placed on the container of the medication read, Refrigerate until opened. Upon inquiry, the nurse confirmed the eye drop bottle was unopened and should have been stored in the refrigerator. 2. An observation of the 300 Hall Med Cart was conducted on 1/9/25 at 2:25 PM in the presence of Nurse #5. The observation revealed one-300 milliliter (ml) bottle, and one-240 ml bottle of Magic Mouthwash (a compounded medication) were labeled by the pharmacy as having been dispensed for Resident #418 on 12/21/24. The expiration date on the pharmacy label of both bottles indicated the medication had an expiration date of 1/4/25. An auxiliary sticker placed on the 240 ml bottle of Magic Mouthwash read, Keep in refrigerator Do not Freeze. Upon inquiry, Nurse #5 confirmed both bottles of the Magic Mouthwash should have been stored in the refrigerator. He also acknowledged the pharmacy labeling on both bottles indicated the medication was expired. An interview was conducted on 1/9/25 at 3:10 PM with the facility's Director of Nursing (DON). During the interview, the medication storage observations were discussed. When asked, the DON reported she would expect the nursing staff to pay attention to any special instructions for the storage of medications when they were delivered from the pharmacy, including whether the medication should be refrigerated. Additionally, expired medications needed to be removed from the med cart.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50415 Based on observations and staff interviews, the facility failed to label, date, safely store food including an open box of unsealed corn on the cob, and discard expired food items that included a plastic container of partially used ice cream stored in the freezer of 1 of 1 walk-in freezers. The findings included: Accompanied by the facility's Dietary Manager, an observation was made of the walk-in freezer on [DATE] at 11:31 AM. The following items were stored in the freezer: - One undated box of corn on the cob that was open to air in its original unsealed plastic bag - One opened and undated box of turkey sausage - One opened and undated box of hot dogs - One opened and undated box of hamburger patties - One plastic container of vanilla ice cream partially used and dated [DATE] The Dietary Manager was interviewed on [DATE] at 11:35 AM. She stated she had been in the role of manager for a couple weeks, but she had educated staff on the expectation that all food should be labeled, dated, and stored correctly. She stated containers of food that had been partially used should be dated and discarded after 3 days. On [DATE] at 3:03 PM the Director of Nursing was interviewed. She stated that all foods in storage should be dated. If they have been opened, then they should have been wrapped and placed in another container and used in the timeframe specified for that product. The Administrator was unreachable by phone for interview after multiple attempts.

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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. 50415 Based on observations, record review, and staff interviews, the facility failed to implement their infection control policy and procedure for hand hygiene when a nurse failed to perform hand hygiene after removing gloves while providing wound care for Resident #408. This occurred for 1 of 2 nurses observed for infection control practices (Nurse #3). The findings included: The facility's policy entitled Hand Hygiene last revised on 10/2022 indicated that hand hygiene included after contact with body fluids or excretions, non-intact skin, wound dressings, and after removing gloves. If gloves are worn for a procedure, hand hygiene is to be completed before putting gloves on and after removal and deposit of gloves in appropriate container. The use of gloves does not replace hand hygiene. An observation was completed on 1/08/25 at 10:37 AM of Nurse #3 performing wound care on Resident #408. Nurse #3 positioned the treatment cart outside of Resident #408's room. After he donned a gown and gloves to perform wound care, due to Resident #408 being on enhanced barrier precautions, Nurse #3 entered the resident's room and positioned him on his left side. Nurse #3 then began removing the soiled dressing from the resident's lower right back. The nurse discarded the dressing in the trash, removed his gloves and exited the room. He did not cleanse his hands after removing his gloves. At the treatment cart, Nurse #3 used his unclean hands and removed a small stack of 4x4 gauze, a bottle of wound cleanser, and 4 skin prep swabs from the drawer on the wound care cart. He then donned a clean pair of gloves. When Nurse #3 returned to the bedside he laid the stack of 4x4 gauze and the 4 wound prep swabs on Resident #408's bed. Nurse #3 cleaned the resident's wound and used one skin prep swab to wipe along the edges of the resident's wound. After cleaning the wound Nurse #3 picked up the unused gauze from the bed and threw it in the trash. He then picked up the unused skin prep swabs in his gloved hands and placed them back in the drawer of the treatment cart. He then removed his gloves and placed them in the trash. Without washing his hands, he then donned another pair of clean gloves as Nurse #5 entered Resident #408's room to complete the wound care procedure. Nurse #5 cleaned the bedside table with a disinfecting wipe and laid down a barrier once it dried. He then gathered the supplies needed, green foam sponge with clear occlusive dressing packet and scissors, to reapply the negative pressure dressing for the resident. Nurse #5 cut the green sponge to fit the size of the wound opening and placed it in the wound bed. He then cut the occlusive drape and placed it over the foam. Nurse #5 then cut a small hole in the drape and placed the suction tubing over the opening. He connected it to the vacuum canister and turned it on. Nurse #3 assisted in handing supplies to Nurse #5 throughout the application of the new dressing change. Nurses #3 and #5 then gathered up all used supplies and threw them in the trash. They removed their soiled gloves and washed their hands. Then Nurse #5 cleaned his scissors and laid them on a paper towel on the wound care cart to dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/08/25 at 11:10 AM Nurse #3 was interviewed. He stated it was his usual practice to place a barrier down to lay supplies on before beginning wound care. He stated he was not sure why he did not place a barrier down when removing Resident #408's dressing during the procedure. He further stated that he thought he could return unused wound care supplies to the wound care cart if they were unopened. He was not aware he had not cleaned his hands after removing gloves and putting on a clean pair of gloves. The Director of Nursing (DON) and Administrator were interviewed on 1/08/25 at 11:18 AM. The DON stated staff were to follow the policy for providing wound care to residents. She further stated that she expected staff to wash their hands prior to wound care, in between glove changes, and after wound care is completed. She stated that she expected staff to throw away wound care supplies that came in contact with the resident's environment. The Administrator agreed that those were her expectations as well.