STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345144	A. Building B. Wing	04/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Health and Rehabilitation Center	706 Pineywood Road Thomasville, NC 27360

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276 Based on record review, resident, staff interviews and student interviews, the facility failed to treat a resident in a dignified manner for 1 of 23 residents reviewed for dignity (Resident #17). Nurse #2 told Resident #17, in a loud and demeaning tone, to get back in her room and stop stalking her. Resident #17 stated Nurse #2's statement made her feel embarrassed and humiliated to be spoken to as if she were a child. Findings included: Resident #17 was admitted to the facility on [DATE] with the most recent readmission on 11/18/22. Her diagnoses included, in part, stroke, hemiplegia, diabetes mellitus and arthritis. An annual Minimum Data Set assessment dated [DATE] revealed Resident #17 cognitively intact and she required substantial to maximal assistance with her activities of daily living. She was independent in her wheelchair for ambulation. On 04/11/24 at 10:20 AM, while preparing to enter room acroos from Resident #17, this surveyor and Nurse #3 overheard Nurse #2 speak to Resident #17 in a demeaning manner. Nurse #2 told Resident #17 to get back in her room and to stop stalking her. Nurse #2 further told Resident #17 she would not attend to her any faster because she was sitting and watching her. Nurse #2 told Resident #17 her priority was the diabetics. The nurse was positioned a few rooms away on the same side of the hall as Resident #17. There was approximately 40 feet of distance between Nurse #2 and the Resident. Resident #17 blushed and backed her wheelchair back into her room. An interview was conducted with Resident #17 on 04/11/24 at 10:50 AM and she stated when Nurse #2 yelled down the hall and told her to go to her room she felt embarrassed and humiliated. She said Nurse #2 spoke to her like a child and she was not a child. She said it was demeaning to be spoken to in that manner. She stated she was not stalking Nurse #17; she was just sitting in the hall waiting for her medications because she did not want to miss getting her as needed pain medication. She stated she had not asked the nurse for anything prior to the nurse telling her to get back in her room. Resident #17 stated she was just watching for Nurse #2 because she had chronic pain and had to stay ahead of her pain, or it was too hard to control. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/11/24 at 11:12 AM an interview was conducted with Nurse #3, and she stated she heard Nurse #2 tell Resident #17 loudly, from between room [ROOM NUMBER] and 208, to go back in her room, stop stalking me, I'm not coming to you yet. Nurse #3 stated Nurse #2 talked to Resident#17 in an unprofessional and harsh manner. Nurse #3 stated Nurse #2's tone was too loud and was demeaning. Nurse #3 stated Nurse #2 had been sent home immediately. Nurse #3 added it was not common practice for the facility staff to speak to the residents in that manner. She stated the facility did not tolerate bad customer service. An interview was conducted with Nurse #2 on 04/11/24 at 1:00 PM and she stated she and Resident #17 always spoke to each other in that manner. Nurse #2 stated Resident #17 liked her and knew that was how she talked. She stated Resident #17 was a smoker and wanted her medications before she went to smoke. Nurse #2 stated she told Resident #17 that she had to administer medications to the diabetics and administer blood pressure medications first. She further stated she had to provide for residents going to dialysis and appointments and administer important medications before she could attend to Resident #17. Nurse #2 said Resident #17 was rushing her and she did not want to make a medication error. Nurse #2 stated Resident #17 sat and watched her from her bedroom door. Nurse #2 stated it was not about pain for Resident #17, it was about getting her medications prior to her smoke break. She stated she could not prioritize a cigarette break over diabetics and dialysis residents and other important matters. She further stated That's just how I sound, I don't speak like a Southerner, and I think everyone thinks I am talking harshly and nasty. Nobody is culturally competent in the south about my accent. People don't understand Northerners and now I look like the bad guy. On 04/11/24 at 1:35 PM an interview was conducted with the Director of Nursing (DON) and she stated Nurse #2 received a final written warning due to her unprofessional language with Resident #17. The DON stated Nurse #2 had not had any disciplinary action prior, but the unprofessional behavior necessitated a final level of disciplinary action. She stated the facility did not tolerate staff speaking to residents in such a manner. An interview was conducted with the Administrator on 04/11/24 at 1:49 PM and she stated she wrote the incident between Nurse #2 and Resident #17 up as a grievance and followed up with the Resident. She stated she expected staff to provide good customer service and to treat residents with dignity and respect.

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on record reviews, residents, family and staff interviews the facility failed to offer 2 residents (Resident #47 and Resident #49) and 1 family member (Resident #80) the opportunity to participate in care plan meetings. This was discovered for 3 of 5 sampled residents reviewed for care planning Findings included: 1. Resident #47 was admitted to the facility on [DATE] with diagnoses which included: hemiplegia affecting her left nondominant side. The quarterly minimum data set (MDS) dated [DATE] indicated Resident #47 was cognitively intact. There was no documentation in the medical record or provided by the social worker indicating Resident #47 attended or refused to attend her care plan meetings. During an interview on 4/9/24 at 1:13 p.m., Resident #47 revealed she was not invited to, or participated in any of her care plan meetings in over a year. On 4/11/24 at 10:05 a.m., during a telephone interview, Resident #47's family member (the resident is her own responsible party) expressed concern that the resident had not had a care plan meeting with the facility in over a year. During an interview on 4/13/24 at 10:16 a.m., the Social Worker (SW) stated she began working at the facility on August 1, 2023, and her responsibilities included scheduling the care plan meetings for all the facility residents. The SW revealed she scheduled the care plan meetings with the residents and/or their Responsible Party (RP) 2-3 days in advance, in person and/or via telephone. When a resident and/or the resident's RP preferred not to attend the upcoming care plan meeting, she would document the refusal in the resident's medical record. The SW also revealed she was responsible for maintaining each resident's care plan meeting participation sign in sheets but was unable to locate any participation sheets for Resident #47. After reviewing her files and the resident's medical records, the SW stated the most recent documentation of Resident #47's participation in her care plan meeting was on 9/14/22. The SW acknowledged Resident #47's most recent MDS was in January 2024, and the resident should have been invited to the care plan meeting. 2. Resident #49 was admitted to the facility on [DATE] with diagnoses which included secondary Parkinsonism. The quarterly minimum data set (MDS) dated [DATE] indicated Resident #49 was cognitively intact. There was no documentation in the medical record or provided by the social worker indicating Resident #49 attended or refused to attend her care plan meetings. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/24 at 12:02 p.m., during an interview Resident #49 revealed she had not been invited to or attended her care plan meetings. During an interview on 4/13/24 at 10:16 a.m., the Social Worker (SW) stated she began working at the facility on August 1, 2023, and her responsibilities included scheduling the care plan meetings for all the facility residents. The SW revealed she scheduled the care plan meetings with the residents and/or their responsible party (RP) 2-3 days in advance, in person and/or via telephone. When a resident and/or the resident's RP preferred not to attend the upcoming care plan meeting, she would document the refusal in the resident's medical record. The SW also revealed she was responsible for maintaining each resident's care plan meeting participation sign in sheets. The SW confirmed there was a care plan meeting for Resident #49 in March 2024 but she there was no available documentation indicating the resident was invited to or participated in any care plan meetings since her admission to the facility in June 2023. 38904 3. Resident #80 was admitted to the facility on [DATE]. Her cumulative diagnoses included respiratory disease and dementia. A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #80 was severely cognitively impaired. During an interview with the Family Member on 4/9/2024 at 1:13 pm she stated she had not been invited to a care plan meeting. During an interview with the Social Worker on 4/11/2024 at 1:19 pm she stated she had worked at the facility for the past 8 months. She stated Resident #80 did not have a care plan meeting since 2/2023. She stated she met with Resident #80's Family Members informally but had not scheduled a formal care plan meeting where other members of the interdisciplinary team met with them. She stated she normally sets a care plan meeting and therapy, dietary, nursing, and activities departments were invited to the care plan for each resident. The Social Worker stated she sends out a mailed invitation to the Family Member and the resident is notified of a scheduled care plan meeting. The Social Worker stated since she meets with Resident #80's Family Member frequently she failed to schedule a formal care plan meeting with other disciplines available. The Administrator was interviewed on 4/11/2024 at 6:37 pm and she stated Resident #80 should have a scheduled care plan meeting every 3 months and the resident and the resident representatives should be invited to the care plan meeting. The Administrator stated the Social Worker was responsible for scheduling the care plan meeting.

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F 0584 Level of Harm - Potential for minimal 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276 Based on observations and staff interviews, the facility failed to maintain walls (Rooms 111 B, 114 B, and 115 A) and a door (room [ROOM NUMBER]B) in good repair for 3 of 15 rooms (rooms [ROOM NUMBER]) on the 100-hall reviewed for environment. Findings included: 1a. Observations of room [ROOM NUMBER] B on 04/09/24 at 12:32 PM and on 04/10/24 at 12:34 PM revealed areas of gouged drywall to the left of the bathroom door. A 3-to-4-inch triangular section of the bottom corner of the bathroom door was broken completely off from the hinge side of the door. 1b. Observations of room [ROOM NUMBER] B's bathroom on 04/09/24 at 11:30 AM, and on 04/10/24 at 12:30 PM revealed the vinyl baseboard molding had separated from the wall on the right side from the commode in the bathroom. The 12-inch section of baseboard molding was attached to the bottom of the wall but hung loose from the wall at the top. 1c. Observations of room [ROOM NUMBER] A on 04/09/24 at 4:35 PM and on 04/12/24 at 5:20 PM revealed a section of gouged drywall behind the head of the bed. The section of gouged drywall was 3 feet wide and 3 feet long with multiple vertical gouges from top to bottom. During an interview and room observations with the Maintenance Director on 4/12/24 at 3:32 PM he stated he had been the Maintenance Director for a short time. He further stated facility staff notified him of repairs that were needed in residents' rooms. The Maintenance Director shared he was aware that there were many areas in the facility that needed repairs, and they were prioritizing the areas as they identified concerns. He explained he prioritized repairs by working on those which impacted resident safety first. He stated he used a web-based software to manage building tasks and work orders. On 04/13/24 at 3:25 PM an interview was conducted with the Administrator, and she stated she expected the Maintenance Director to complete repairs that impacted patient safety first and then attend to cosmetic repairs.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32394 Based on record review and staff interviews, the facility failed to develop a comprehensive care plan which included an area of focus related to nutrition for 2 of 5 residents (Resident #90 and Resident #75) reviewed for nutrition. The findings included: 1. Resident #90 was admitted to the facility on [DATE] with cumulative diagnoses which included cancer, dementia, and Type 2 diabetes. His admission orders included a diet order for a Cardiac, Consistent Carbohydrate Diet with regular textures. The resident's weight history was reported to include a weight of 151.5 pounds (#) on 2/2/24 and 149.0# on 2/14/24. A progress note authored by the facility's consultant Registered Dietitian (RD) was dated 2/14/24. The RD note reported the resident's meal intake was 50-100 percent (%) meals. She indicated the cardiac dietary restriction was not appropriate at that time and recommended Resident #90's diet be liberalized to a Consistent Carbohydrate Diet with regular textures. A physician's diet order was received in accordance with this recommendation to provide Consistent Carbohydrate Diet with regular textures (initiated 2/14/24) for Resident #90. Further review of the resident's weight history included the following: --On 2/28/24, the resident weighed 146.5#; --His weight was reported to be 141.0# on 3/12/24, which was indicative of a significant weight loss of 5.37% in one month (from 2/14/24 to 3/12/24). An RD progress note dated 3/13/24 reported Resident #90 experienced a significant weight loss of 5% over the previous 30 days. He was noted to have increased nutritional needs related to this significant weight loss. A recommendation was made to initiate 120 milliliters (ml) of Med Pass 2.0 (a high calorie, high protein liquid nutritional supplement) to be given to Resident #90 twice daily. A physician's order was received on 3/13/24 for initiation of 120 ml of Med Pass 2.0 given twice daily in accordance with the RD's recommendation. Review of Resident #90's electronic medical record (EMR) revealed his most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. The MDS indicated the resident had moderately impaired cognition. He was assessed as being independent with eating. Resident #90 was reported to be 72 inches tall and weighed 141 pounds (#). He received a therapeutic diet. The MDS assessment indicated the resident had a significant weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months but was not on a physician-prescribed weight-loss regimen. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #90's current Care Plan (last revised on 2/12/24) was reviewed. The care plan did not include a Nutrition area of focus with dietary orders, goals, and/or interventions to provide for Resident #90's nutritional care. The facility's Dietary Manager was not available for an interview. A telephone interview was conducted on 4/11/24 at 11:55 AM with the facility's consultant RD. During the interview, the RD reported it was the Dietary Manager's responsibility to initiate and revise the nutrition care plans. When asked if she would expect a nutrition care plan to be completed for Resident #90, she stated, Any nutrition intervention should be care planned. An interview was conducted on 4/11/24 at 3:19 PM with the facility's MDS Nurse. Upon inquiry as to who was responsible to complete a Nutrition care plan for a resident with a significant weight loss, she stated, someone from dietary. During a follow-up interview conducted on 4/11/24 at 3:40 PM with the MDS Nurse, the nurse reported the Nutrition care plan had apparently been missed for Resident #90 prior to 4/11/24. An interview was conducted on 4/11/24 at 3:49 PM with the facility's Regional Dietary Consultant. During the interview, the Consultant was informed there wasn't a Nutrition area of focus for Resident #90, who had experienced a significant weight loss. She stated the Dietary Manager was responsible for completing the Nutrition area of focus in the residents' care plans. When asked if she would expect a Nutrition area of focus to be included in a care plan for a resident with a significant weight loss, she nodded her head to indicate she would expect it. An interview was conducted on 4/13/24 at 9:26 AM with the facility's Director of Nursing (DON). During the interview, the DON stated the Dietary Manager may not have been aware that it was her responsibility to complete the Nutrition care plan. 38904 2. Resident #75 was admitted to the facility on [DATE] with diagnoses of a progressive neurological disease, seizure disorder, and dementia. A Significant Change Minimum Data Set assessment was completed 3/21/2024 and indicated Resident #75 was severely cognitively impaired, required extensive assistance with eating, and had a significant weight loss. During a review of Resident #75's Care Plan dated 3/26/2024 no care plan for nutrition was found. Resident #75 had a Dietician's Progress Note dated 3/26/2024 that indicated he had a significant weight loss, received a medication to stimulate his appetite, and had increased nutritional needs related to the weight loss. Nurse #5 was interviewed on 4/9/2024 at 5:39 pm and she stated Resident #75 will only eat a few bites of a meal but will eat snacks. She stated she was not aware he did not have a care plan for nutrition and dietary would be responsible for developing a nutrition care plan. The facility's Dietary Manager was not available for an interview. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/11/2024 at 11:48 am the Consultant Registered Dietician was interviewed by phone, and she stated she saw Resident #75 on 3/25/2024 and he presented with significant weight loss. She stated the Dietary Manager is responsible for the nutritional care plans. The Administrator was interviewed by phone on 4/11/2024 at 6:38 pm and she stated Resident #75 should have a care plan for significant weight loss and she thought it must have been overlooked by the Dietary Manager.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32394 Based on staff and consultant pharmacist interviews and record reviews, the facility failed to limit the duration of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) ordered on an as needed (PRN) basis to 14 days and/or indicate the duration and rationale for the PRN order to be extended beyond 14 days, when appropriate. This occurred for 2 of 7 residents whose medications were reviewed (Resident #71 and Resident #73). The findings included: 1. Resident #71 was admitted to the facility on [DATE] with re-entry from a hospital on 7/2023. His cumulative diagnoses included a history of a stroke and anxiety disorder. A review of the resident's electronic medical record (EMR) revealed a physician's order dated 2/27/23 was received for 0.5 milligram (mg) lorazepam (an antianxiety medication) to be given as one tablet by mouth three times daily for anxiousness. Lorazepam is a psychotropic medication and a controlled substance medication. Further review of Resident #71's EMR revealed a physician's order was received on 9/8/23 for 2 mg / milliliter (ml) lorazepam to be given as 1 mg intramuscularly (IM) every 12 hours as needed (PRN) for agitation until oral lorazepam arrived, then discontinue. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated [DATE]. Resident #71 was reported to have severely impaired cognition with no behaviors nor rejection of care. He was dependent on staff for all of his Activities of Daily Living (ADLs), except for requiring only supervision or touching assistance for eating. The Medication section of the MDS revealed Resident #71 received an antianxiety medication during the 7-day look back period. Resident #71's EMR indicated the physician's orders for both the scheduled lorazepam (initially ordered on 2/27/23) and the PRN injectable lorazepam (initially ordered on 9/8/23) continued as active orders up through the date of the review on 4/10/24. A review of Resident #71's Medication Administration Records (MARs) revealed no doses of PRN lorazepam were documented as having been administered to the resident from 9/8/23 through 4/10/24. A telephone interview was conducted on 4/12/24 at 1:47 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported she was addressing the use of PRN psychotropic medications with the facility. Most recently, the pharmacist reported a statement included in the Executive Summary Comments from her April 2024 Consultant Report indicated there were still some psychotropic medications ordered PRN with no stop date. The consultant pharmacist stated she requested the facility please make sure that this was observed for all residents, including Hospice. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 4/13/24 at 9:26 AM with the facility's Director of Nursing (DON). Upon inquiry, the DON reported nursing staff was aware that PRN psychotropic medications must have a stop date. The DON stated she thought Resident #71's order for the PRN lorazepam had inadvertently been left on the resident's current orders. 2. Resident #73 was admitted to the facility on [DATE]. Her cumulative diagnoses included Alzheimer's disease. She was admitted to Hospice on 3/12/24. A review of the resident's electronic medical record (EMR) revealed a physician's order dated 3/21/24 was received for 1 milligram (mg) lorazepam (an antianxiety medication) to be given as one tablet under the tongue (sublingually) every 4 hours as needed (PRN) for end of life care / anxiety / agitation. The end date for the PRN lorazepam order in Resident #73's EMR was Indefinite. Lorazepam is a psychotropic medication and a controlled substance medication. Resident #73's most recent Minimum Data Set (MDS) was a Significant Change assessment dated [DATE]. The resident was reported to have severely impaired cognition with no behaviors nor rejection of care. She was dependent on staff for all of her Activities of Daily Living (ADLs). The Medication section of the MDS revealed Resident #73 did not receive an antianxiety medication during the 7-day look back period. A review of the controlled substance declining inventory sheets for Resident #73 was conducted on 4/12/24 at 3:00 PM. This review revealed 12 tablets of 1 mg lorazepam were dispensed from the pharmacy on 3/21/24 and stored on the medication cart for this resident. None of the lorazepam tablets were documented as having been removed from the inventory. Documentation on Resident #73's March 2024 and April 2024 Medication Administration Records (MARs) revealed no doses of PRN lorazepam were administered to the resident through the date of the review. A telephone interview was conducted on 4/12/24 at 1:47 PM with the facility's consultant pharmacist. During the interview, the pharmacist reported she was addressing the use of PRN psychotropic medications with the facility. Most recently, the pharmacist reported a statement included in the Executive Summary Comments from her April 2024 Consultant Report indicated there were still some psychotropic medications ordered PRN with no stop date. The consultant pharmacist stated she requested the facility please make sure that this was observed for all residents, including Hospice. An interview was conducted on 4/13/24 at 9:26 AM with the facility's Director of Nursing (DON). Upon inquiry, the DON reported nursing staff was aware that PRN psychotropic medications must have a stop date. She stated these medications were typically limited to 14 days or extended up to 90 days with a stop date designated in the order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and staff interviews, the facility failed to: 1) Discard expired medications stored on 1 of 2 medication (med) carts (200 Hall Med Cart) and in 1 of 1 Med Storeroom (100/200/300 Hall Medication Storeroom); 2) Date injectable medications as to when they were opened to allow for the determination of its shortened expiration date for medications stored on 1 of 2 med carts (200 Hall Med Cart) and in 1 of 1 Med Storeroom (100/200/300 Hall Medication Storeroom); and 3) Store medications in accordance with the manufacturer's storage instructions on 1 of 2 med carts (200 Hall Med Cart). The findings included: 1. An observation was conducted on 4/9/24 at 3:15 PM of the 200 Hall Medication (Med) Cart in the presence of Nurse #1. The observation revealed the following medications were stored on the med cart: a. According to the manufacturer, in-use vials of Lantus insulin should be stored under refrigeration or at room temperature and used within 28 days. An opened vial of Lantus insulin (100 units/ml) dispensed from the pharmacy on 2/10/24 for Resident #19 was dated as opened on 3/1/24 (39 days prior to the date of the observation). A pharmacy auxiliary sticker placed on the medication vial containing the insulin read in part, Expires 28 days after opening. b. According to the manufacturer, in-use vials of Lantus insulin should be stored under refrigeration or at room temperature and used within 28 days. An opened vial of Lantus insulin (100 units/ml) dispensed from the pharmacy on 3/1/24 for Resident #30 was dated as opened on 3/1/24 (39 days prior to the date of the observation). A pharmacy auxiliary sticker placed on the medication vial containing the insulin read in part, Expires 28 days after opening. c. According to the manufacturer, in-use vials of Novolog insulin should be stored under refrigeration or at room temperature and used within 28 days. An opened vial of Novolog insulin (100 units/ml) dispensed from the pharmacy on 3/1/24 for Resident #30 was dated as opened on 3/2/24 (38 days prior to the date of the observation). d. According to the manufacturer, in-use vials of Lantus insulin should be stored under refrigeration or at room temperature and used within 28 days. An opened vial of Lantus insulin (100 units/ml) dispensed from the pharmacy on 2/13/24 for Resident #18 was dated as opened on 3/4/24 (36 days prior to the date of the observation). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. According to the manufacturer, in-use vials of Humalog insulin should be stored under refrigeration or at room temperature and used within 28 days. An opened vial of Humalog insulin (100 units/ml) dispensed from the pharmacy on 3/1/24 for Resident #18 was dated as opened on 3/6/24 (34 days prior to the date of the observation). f. According to the manufacturer, in-use vials of Lantus insulin should be stored under refrigeration or at room temperature and used within 28 days. An opened vial of Lantus insulin (100 units/ml) dispensed from the pharmacy on 3/9/24 for Resident #5 was not dated as to when it had been opened to allow for the determination of its shortened expiration date. The insulin vial was dispensed 31 days prior to the date of the observation. g. The Center for Disease Control and Prevention (CDC) Injection Safety Guidelines include information on when multi-dose vials (MDVs) should be discarded. The Guidelines state, Medication vials should always be discarded whenever sterility is compromised or cannot be confirmed. In addition, the United States Pharmacopeia (USP) General Chapter 797 recommends the following for multi-dose vials of sterile pharmaceuticals: If a multi-dose [vial] has been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. An opened 20 milliliter (ml) multi-dose vial of 1% lidocaine solution was stored on the med cart. The vial of 1% lidocaine was not dated as to when it had been opened to allow for the determination of its shortened expiration date. h. The Center for Disease Control and Prevention (CDC) Injection Safety Guidelines include information on when single-dose vials (SDVs) should be discarded. The Guidelines state, Vials that are labeled as single-dose or single-use should be used for only a single patient as part of a single case, procedure, injection . Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient nor stored for future use on the same patient. An opened 10 ml single-dose vial of sterile water for injection dispensed for Resident #26 was stored on the med cart. The vial of sterile water for injection was labeled for single use only. i. 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 unopened bottle of latanoprost eye drops dispensed from the pharmacy on 4/7/24 for Resident #19 was stored on the med cart. A blue pharmacy auxiliary sticker placed on the bottle read, Refrigerate until opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Nurse #1 on 4/9/24 at 3:45 PM. During the interview, the nurse reviewed each vial of expired insulin and confirmed the dating of (or failure to date) each of the vials. Upon inquiry, the nurse reported she would need to contact the pharmacy to request replacement vials of insulin for those that were identified as expired. Additionally, the hall nurse reported the multi-dose vial of 1% lidocaine needed to be discarded since she could not determine when it had been opened and the single-dose vial of sterile water for injection should have been discarded after the first use. When asked, Nurse #1 acknowledged the latanoprost eye drops should have been stored in the refrigerator until opened. An interview was conducted with the facility's Director of Nursing (DON) on 4/9/24 at 4:00 PM. At that time, the DON confirmed Nurse #1 had shown her the expired insulin vials and the vials of lidocaine and sterile water for injection. The DON reported she was surprised by the findings of the 200 Hall Med Cart observation because the med carts had been inspected the previous week to ensure proper storage of the medications. A follow-up interview was conducted with the DON on 4/13/24 at 9:43 AM. During the interview, the DON reported she would have expected nursing staff to date the vials of insulin as to when they had been opened, remove any expired medications from the medication carts, and notify the pharmacy of the need to replace these medications so they were available when needed for the resident. Additionally, the DON stated a single-use vial of sterile water for injection should have been discarded immediately after it was used for the first time. She also noted the unopened bottle of latanoprost eye drops should have been refrigerated until needed. 2. Accompanied by Nurse #1, an observation was conducted on 4/9/24 at 3:46 PM of the 100/200/300 Hall Medication Storeroom. The observation revealed the following medications were stored in the Medication Storeroom: a. A manufacturer's box of 650 milligrams (mg) acetaminophen suppositories with 9 suppositories remaining in the box were observed to be stored in the Med Storage Room. The manufacturer's expiration date for the suppositories was June of 2023. b. According to the manufacturer labeling, a vial of PPD solution in use for more than 30 days should be discarded. One (1) opened multi-dose vial of Tuberculin PPD injectable solution (used for skin testing in the diagnosis of tuberculosis) was stored in the med room refrigerator. The PPD solution was labeled as having been opened on 3/7/24 (33 days prior to the date of the observation). c. Three (3) unopened bottles of 80 milligrams (mg) simethicone chew tablets (each containing 100 tablets) were expired with a manufacturer's expiration date of March 2024. Simethicone is an over-the-counter medication used to prevent or reduce excessive intestinal gas. d. One (1) - 8 ounce, unopened bottle of Kaopectate medication was expired with a manufacturer expiration date of March 2024. Kaopectate is an over-the-counter medication used to treat occasional upset stomach, heartburn, and nausea. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the DON on 4/13/24 at 9:43 AM. During the interview, the DON reported she would expect the nursing staff to date everything as to when it was opened and to discard expired medications in accordance with the manufacturer's instructions. She stated the hall nurses were responsible to check the facility's stock medications in the Med Storeroom to ensure they were not expired.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20670 Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint surveys completed on 6/17/21 and a complaint investigation completed on 2/24/22. This was for 4 deficiencies that were cited in the areas of: Resident Rights/Exercise of Rights (550) which was cited on 6/17/21, 2/24/22 and recited on the current recertification and complaint survey of 4/13/24; Right to Participate in Planning Care (553) which was cited on 6/17/21 and recited on the current recertification and complaint survey of 4/13/24; Develop/Implement Comprehensive Care Plan (656) which was cited on 6/17/21 and recited on the current recertification and complaint survey of 4/13/24; and Safe/Clean/Comfortable/Homelike Environment (584) which was cited on 2/24/22 and recited on the current recertification and complaint survey of 4/13/24. The continued failure of the facility during three federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program (QAA). The findings included: This citation is cross-referenced to: F550: Based on record review, resident, staff interviews and student interviews, the facility failed to treat a resident in a dignified manner for 1 of 23 residents reviewed for dignity (Resident #17). Nurse #2 told Resident #17, in a loud and demeaning tone, to get back in her room and stop stalking her. Resident #17 stated Nurse #2's statement made her feel embarrassed and humiliated to be spoken to as if she were a child. During the recertification and complaint survey on 6/17/21, the facility failed to treat a resident in a respectful and dignified manner for 1 of 1 resident reviewed for dignity when the Speech Therapist and a Nursing Assistant referred to a resident as a feeder. During the complaint investigation survey on 2/24/22, the facility failed to treat residents in a dignified manner when residents did not receive incontinent care for several hours during a period when there was just one Licensed Practical Nurse and two Nursing Assistants in the facility to provide care for 98 residents. 2 of 5 interviewed residents stated the lack of incontinent care for an extended period of time made them feel like they were defeated, not treated with dignity, neglected, dirty, mad, sad, helpless, and abandoned. Emergency personnel reported that residents were observed crying. This deficient practice negatively impacted residents in the facility. F553: Based on record reviews, residents, family and staff interviews the facility failed to offer 3 of 5 residents (Residents #47, #49 and #80) reviewed for care planning, the opportunity to participate in care plan meetings. During the recertification and complaint survey on 6/17/21, the facility failed to invite 2 of 2 residents reviewed for care plan meeting invitations. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F584: Based on observations and staff interviews, the facility failed to maintain walls (Rooms 111 B, 114 B, and 115 A) and a door (room [ROOM NUMBER]B) in good repair for 3 of 15 rooms (rooms [ROOM NUMBER]) on the 100-hall reviewed for environment. During a complaint investigation survey on 2/24/22, the facility failed to provide a clean environment for 2 of 2 days investigated for environment. Interviews with first responders who arrived at the facility described and provided photographic evidence bags of garbage in the hallways and an observation on 1/17/22 revealed a room with overflowing garbage, garbage on the floor, garbage under the bed, and spilled fluids. F656: Based on record review and staff interviews, the facility failed to develop a comprehensive care plan which included an area of focus related to nutrition for 2 of 5 residents (Resident #90 and Resident #75) reviewed for nutrition. During a recertification and complaint survey on 6/17/21, the facility failed to develop a care plan for discharge plans for 2 of 4 residents reviewed for discharge planning. During an interview on 4/13/24 at 3:37 p.m., the Administrator stated the QA (Quality Assurance) committee met monthly and consisted of the Administrator, Director of Nursing, Medical Director and the Directors of the facility's departments. When an area of concern was identified during an IDT (Interdisciplinary Team) meeting, a PIP (performance improvement project), including audits with results was submitted to the QA committee every month until the concern was resolved. She further revealed that as oversight, the corporate consultants also have access to this information via SharePoint to audit, submit recommendations, and follow-up to the QA Committee.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review and staff interviews the facility failed to provide consents with the benefits and risks of receiving the influenza vaccine for 2 of 5 residents (Resident #64 and Resident #80). Resident #64 did not receive the influenza vaccine at the Responsible Party's request and Resident #80 was not offered the influenza vaccine. Findings included: a. Resident #64 was admitted to the facility on [DATE] with diagnoses of dementia with anxiety and stroke. A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #64 was severely cognitively impaired. During a review of Resident #64's medical record a consent with benefits and risks was not found for an influenza vaccine for the last year. The Director of Nursing was interviewed on 4/11/2024 at 4:49 pm and she stated she could not find consents with the benefits and risks of taking the influenza vaccine for 2023 that should have been reviewed with Resident #64's Responsible Party. The Director of Nursing stated before residents were given a vaccine the nursing staff should obtain a signed copy of the consent which included the risks and benefits of the vaccine and if they could not get a signed consent two nurses should witness a verbal consent with the Responsible Party by phone if the resident was cognitively impaired and cannot give consent. The Director of Nursing stated Resident #64 was not given the influenza vaccine at the Responsible Party's request. b. Resident #80 was admitted to the facility on [DATE] with diagnoses of respiratory disease and dementia with agitation. A quarterly Minimum Data Set assessment dated [DATE] indicated Resident #80 was severely cognitively impaired. During a review of Resident #80's medical record a consent with benefits and risks was not found for an influenza vaccine for the last year. On 4/11/2024 at 4:53 pm an interview was conducted with the Director of Nursing, and she stated she could not find a consent with the benefits and risks of taking the influenza vaccine for 2023 for Resident #80. The Director of Nursing stated they had issues with getting consent signed by the family members of residents that are cognitively impaired and unable to sign for themselves. The Director of Nursing stated Resident #80 did not receive the influenza vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed by phone on 4/11/2024 at 6:37 pm and stated Resident #64 and Resident #80 should have been provided the benefits and risks of receiving the influenza vaccine and if a resident is not cognitively intact the Family Member should be contacted for consent for the influenza vaccine.