STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365447	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookview Healthcare Center	214 Harding Street Defiance, OH 43512

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on resident interview, medical record review, hospital record review, staff interview, and policy review, the facility failed to ensure residents received timely treatment for constipation. This resulted in actual harm after Resident #14 had no bowel movement (BM) for seven days in the facility and was admitted to the hospital the following day with abdominal pain and was found to be impacted with stool. This affected one (#14) resident reviewed for bowel movements. The facility census was 72. Findings include: Review of the medical record for Resident #14 revealed an admitted [DATE] with diagnoses of constipation, anxiety, and generalized abdominal pain. Review of the comprehensive admission assessment completed 12/14/24 revealed Resident #14 had intact cognition and was occasionally incontinent of bowel. Constipation was not present at the time of the assessment. Resident #14's care plan, reviewed on 03/26/25, revealed a care area initiated 01/17/25 indicating Resident #14 was at risk for alteration in elimination constipation. The goal was for Resident #14 to have a bowel movement every 1-3 days. Interventions included assessing for abdominal distention and noting type, color, and amount of stool. Review of the current care plan, revised 03/27/25, revealed Resident #14 was at risk for constipation. The goal indicated Resident #14 would have a normal, soft formed, bowel movement through the review date. Interventions included following the facility bowel protocol for bowel management. Review of Resident #14's physician orders active on 01/29/25 revealed an order initiated 12/31/24 for sennosides-docusate sodium oral tablet 8.6-50 milligrams (mg) once daily for constipation. Additionally, Resident #14 had a physician order dated 01/14/25 for Dulcolax rectal suppository 10 mg (bisacodyl), insert one suppository rectally every 24 hours as needed for constipation. Additionally, Resident #14 had a physician order initiated 01/14/25 for Milk of Magnesia Oral Suspension, give 30 milliliters (ml) by mouth as needed for constipation. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Finally, Resident #14 had a physician order initiated 12/08/24 for polyethylene glycol powder, give 17 grams by mouth every 24 hours as needed for constipation. Review of Resident #14's physician order initiated 02/05/25 and discontinued on 02/06/25 revealed an order for Enema Rectal Enema (Sodium Phosphates), insert one unit rectally one time only for constipation. Review of Resident #14's BMs in January 2025 and February 2025 revealed no BMs were documented from 01/29/25 through 02/04/25 (seven days). A small BM was documented in the evening of 02/05/25. Review of the Medication Administration Record (MAR) for January 2025 revealed Resident #14 received sennosides-docusate sodium once daily as ordered. No as-needed medications for constipation were administered between 01/29/25 and 01/31/25. Review of the MAR for February 2025 revealed Resident #14 received sennosides-docusate sodium once daily as ordered. Further review revealed Resident #14 received a rectal enema on 02/05/25 at 4:31 P.M. Additionally, Resident #14 received an as-needed dose of Milk of Magnesia on 02/06/25 at 12:24 A.M. Review of a nursing progress note dated 02/06/25 at 8:43 A.M. revealed Resident #14 continued to cry out in pain and requested to go to the emergency room (ER) as Resident #14 stated she had not had a BM in 12 days. Further review revealed the night shift nurse stated Resident #14 was given an enema with no results. The physician was contacted and staff were awaiting a response. Review of the hospital emergency room document, dated 02/06/25 at 11:00 A.M., revealed Resident #14 presented with severe abdominal pain and was dry-heaving. A manual disimpaction was completed with a significant amount of stool removed. Review of the hospital document, General History and Physical, dated 02/07/25 at 11:53 A.M., revealed Resident #14 had abdominal pain and was found to be impacted with stool. Resident #14 was disimpacted and was having bowel movements. Interview on 03/24/25 at 10:07 A.M. with Resident #14, who was lying in her recliner, revealed she was hospitalized after having no BM for 12 days in the facility. Interview on 03/25/25 at 3:46 P.M. with the Director of Nursing (DON) confirmed Resident #14's medical record indicated she had no stool beginning on 01/29/25 through 02/04/25 (seven days). Interview on 03/25/25 at 4:59 P.M. with the DON confirmed no as-needed interventions for constipation were provided to Resident #14 until 02/05/25, after Resident #14 had gone seven days without a BM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the undated policy, Bowel Elimination Policy and Procedure, revealed if a resident has been without a BM for 48 hours the facility would provide 120 ml of prune juice or bran mixture. Further, if the resident has been without a noted BM for 72 hours (24 hours after prune juice or prune mixture has been given) the nurse will consider administering an osmotic laxative such as Milk of Magnesia per physician order. Additionally, if the resident has been without a BM 8 hours after Milk of Magnesia, the nurse will obtain an order, or follow established PRN (as needed) order for a stimulant laxative such as Dulcolax suppository and administer. (This should be effective within 15-60 minutes). Finally, if the resident has been without a bowel movement 8 hours after the suppository was given, the nurse will administer a phosphate enema as ordered by the physician (or as ordered by primary care provider if not previously ordered). Should no results occur at this time, resident assessment and interventions will be reported to the primary care provider for further measures to be taken until bowel elimination has occurred and the resident has no acute symptoms of constipation.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on observation, resident and staff interview, record review, and policy review, the facility failed to ensure residents received interventions to offset significant weight loss. This affected two (#31 and #60) of three residents reviewed for significant weight loss. The facility census was 72. Findings include: 1. Review of the medical record for Resident #31 revealed an admitted [DATE] with diagnoses of dehydration and moderate protein-calorie malnutrition. Review of the initial comprehensive Minimum Data Set (MDS) assessment, dated 03/03/25, revealed Resident #31 had intact cognition and required set-up or clean-up assistance for eating. Further review of the medical record revealed Resident #31 was hospitalized overnight for altered mental status from 03/10/25 through 03/11/25. Review of the weight history for Resident #31 revealed he weighed 157.7 pounds on 03/10/25, and weighed 138.2 pounds on 03/11/25, upon return from the hospital. Review of the hospital discharge records, dated 03/11/25, revealed no hospital weight and revealed no indication any procedures were performed (such as fluid removal) that could have caused notable weight loss. Review of a current physician order dated 03/11/25 revealed Resident #31 received a sugar-free healthshake with meals for supplement. Review of a nutrition progress note dated 03/19/25 revealed Resident #31 had a significant weight loss of 13.5% since 03/01/25. Further review revealed the current nutrition intervention was a sugar-free house shake with meals. The recommendation was to add liquid protein 30 milliliters once daily. Interview and observation on 03/25/25 at 11:50 A.M. revealed Resident #31 lying in bed with his meal tray on his overbed table. Resident #31 had consumed some of his meal but was more interested in receiving personal care than finishing his meal. Resident #31 stated he was aware he had lost weight. No nutrition supplement was observed on the meal tray or overbed table. Observation on 03/26/25 at 5:34 P.M. revealed the dinner trays were delivered to Resident #31's hall on a cart. Interview on 03/26/25 at 05:40 P.M. with Unit Manager (UM) #314 and concurrent observation of Resident #31's meal tray, still on the cart, revealed no nutrition supplement was on the tray. Additionally, concurrent review of Resident #31's electronic medical record (EMR) with UM #314 confirmed the sugar-free healthshake was to be provided with meals. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/27/25 at 8:46 A.M. revealed Certified Nursing Assistant (CNA) #312 talking with Resident #31 in his room. Resident #31's breakfast tray remained on his overbed table and Resident #31 had consumed all of his meal. CNA #312 confirmed there was no evidence Resident #31 received a sugar-free healthshake with his meal. Interview on 03/27/25 at approximately 8:50 A.M. with Dietary Manager #333 revealed she coordinated care for residents with the Registered Dietitian (RD). DM #333 stated the facility usually provided nutrition supplements between meals rather than on meal trays. Upon request from the Surveyor, DM #333 provided a sugar-free healthshake to the Surveyor. Interview on 03/27/25 at approximately 9:00 A.M. with Resident #31 revealed he recognized the sugar-free healthshake in the Surveyor's hand. Resident #31 stated the supplements were full of vitamins, he liked them, and he wanted to drink them. The Surveyor returned the sugar-free healthshake to staff to provide to Resident #31 as ordered. 2. Review of the medical record for Resident #60 revealed an admitted [DATE] with diagnoses of dementia and dysphagia (difficulty swallowing). Review of the quarterly MDS assessment dated [DATE] revealed Resident #60 had impaired cognition, was able to feed himself with set-up or clean-up assistance. Review of the weight history for Resident #60 revealed a weight of 162 pounds on 11/01/24, indicating a significant weight loss of 8.1% over 30 days from a weight of 176.2 pounds on 10/04/24. Resident #60's weights remained in the 160-pound range from 11/01/24 through 03/26/25. Review of a dietary progress note dated 11/04/24 revealed a reweigh was requested and pending. Review of a dietary progress note dated 12/02/24, written by RD #405, revealed Resident #60 had a significant weight loss of 9.2% over 90 days. Further review revealed the weight loss was stabilized and Resident #60's current body mass index (BMI) was 26.2 indicating Resident #60 was overweight. RD #405 did not recommend any new interventions for Resident #60 to offset the significant weight loss. Review of a dietary progress note dated 03/10/25, written by RD #405, revealed Resident #60's weight had stabilized in the 160-pound range, though he showed a significant weight loss of 12% over 180 days. RD #405 recommended double portions for added nutrition support. Review of the current physician order, dated 02/03/25 and revised 03/24/25, revealed Resident #60 received a gluten free, mechanical soft texture, nectar thickened liquids diet with food in separate bowls. All bowls to be suction cup bowls. Small red spoon on all meal trays. Resident intolerant of gluten and dairy products. Double portions. Interview on 03/25/25 at 11:24 A.M. with [NAME] #337 and DM #333 revealed they both were aware Resident #60 was recently changed to double portions. Observation on 03/25/25 at 11:26 A.M. during the noon meal service revealed Resident #60 independently consuming his meal. Resident #60 received cauliflower, sweet potatoes, and ground chicken, each in separate bowls. The cauliflower and sweet potatoes did not appear to be a double portion. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #60's meal ticket indicated he should receive large portions. Observation on 03/26/25 at 11:01 A.M. revealed [NAME] #337 plating Resident #60's lunch meal. [NAME] #337 served one 4-ounce scoop of vegetable blend, one 4-ounce scoop of mashed potatoes, and one 4-ounce scoop of ground beef brisket. [NAME] #337 covered each bowl with a plastic lid. Concurrent interview with [NAME] #337 confirmed she provided a single scoop of each food item for Resident #60. [NAME] #337 then read Resident #60's meal ticket and determined Resident #60 should receive double portions. [NAME] #337 proceeded to remove the lids from each bowl and add a second scoop. Telephone interview on 03/26/25 at 4:30 P.M. with RD #405 confirmed Resident #60's weight on 11/01/24 revealed a significant weight loss. RD #405 confirmed no re-weight was obtained. RD #405 confirmed she should have written a progress note and assessed Resident #60 after the significant weight change on 11/01/24. RD #405 further confirmed she did not recommend any nutrition intervention to offset the significant weight loss in the progress note dated 12/02/24. Additionally, RD #405 confirmed she recommended double portions for Resident #60 on 03/10/25 and the double portions were not added to Resident #60's orders until 03/24/25. Review of the policy, Weight Management Program and Weight Gain/Loss Policy, revised 08/2024, revealed if there is a weight loss/gain of five percent or more from the previous month, the resident will be reweighed. Additionally, the Director of Nursing (DON) or designee will review the dashboard for high-risk weight change progress notes daily and address accordingly.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on observation, medical record review, staff and resident interview, and policy review, the facility failed to ensure resident's dialysis access sites were monitored by the facility. Additionally, the facility failed to ensure pre and post dialysis evaluations were completed. This affected two residents (#21 and #24) of two reviewed for dialysis. This facility census was 72. Findings include: 1. Review of the medical record of Resident #21 revealed an admitted [DATE]. Diagnoses included end stage renal disease and dependence on renal dialysis. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was cognitively intact, and diagnoses were listed. The assessment further indicated Resident #21 was on hemodialysis while a resident. Review of the physician orders revealed an order dated 02/24/25 to monitor the AV fistula for bruit and thrill every shift. A second order was placed on 03/25/25, after surveyor inquired, to monitor the left arm for bruit/thrill every shift. Review of the medical record revealed Resident #21 the following pre/and or post dialysis evaluations absent: 02/24/25 no post; 02/27/25 no post; 03/03/25 pre and post; 03/05/25 pre and post; 03/07/25 pre; 03/10/25 post; 03/12/25 post; 03/14/25; post; 03/17/25 post; 03/19/25 post; 03/21/25 post; and 03/21/25 pre and post. The evaluation consisted of assessing the access site for bruit, thrill, decreased circulation distal to the site, and skin color and turgor. This form was to be sent to the dialysis center with Resident #21. Interview on 03/24/25 at 8:36 A.M. with Resident #21 revealed the facility staff do not monitor his arteriovenous graft. He stated he removes the Band-Aid the day after dialysis himself. Interview on 3/25/25 at 11:22 A.M. with the Director of Nursing (DON) revealed Assistant DON #301 had placed an order on 02/24/25 to monitor the fistula every shift, for bruit and thrill, but had failed to schedule the times, henceforth, it had not appeared on the MAR or TAR. Interview on 03/25/25 at 3:18 P.M. with Registered Nurse #376 revealed the nurse will complete a pre-dialysis assessment in the electronic record, print it off and send it with the resident. The dialysis center will send it back with the weights and any notes. As far as she knows, the facility does not keep these. Interview on 03/25/25 at 3:31 P.M. with Regional Clinical Support Nurse (RSCN) #396 revealed the facility should be sending communication with the resident. A follow-up interview with RCSN #396 revealed the facility practice is to fill out the pre-dialysis assessment, print it out, and send that with the resident to the dialysis center. Interview on 03/26/25 at 1:00 P.M. with RCSN #396 provided verification of the lack of pre and/or post dialysis assessments. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy titled Dialysis Care revised 08/24, revealed the bruit and thrill of the fistula was to be assessed every shift for patency and recorded on the Medication Administration Record. The facility shall use a form to communicate with the dialysis center with each visit. The nurse will complete an assessment of the resident prior to leaving the facility and upon return from the dialysis center. 37451 2. Review of Resident #24's medical record revealed an admitted [DATE]. Diagnoses included end stage renal disease, type II diabetes, dysphagia, muscle weakness and dependence on renal dialysis. Review of Resident #24's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score 15 indicating Resident #24 was cognitively intact. Resident #24 was independent with toilet use, bed mobility, and transfer. Resident #24 required moderate assistance with bathing. Resident #24 displayed no behaviors during the review period. Resident #24 was on dialysis at the time of the review. Review of Resident #24's care plan revised 03/24/25 revealed the resident received hemodialysis Monday, Wednesday, and Friday. Dialysis interventions included check for new orders upon return from dialysis, diet as ordered, maintain communication with dialysis staff and physician, monitor dialysis access site, left chest port for signs and symptoms of infection, and weights as ordered. Review of Resident #24's physician orders revealed an order dated 02/11/25 for a dialysis port left chest. There was no order found for the placement of Resident #24's fistula and no order for monitoring Resident #24's fistula for thrill and bruit for her new graph site which began on 03/20/25. Review of Resident #24's Medication Administration Record (MAR) and Treatment Administration Record (TAR) found neither record contained documentation or a location to document monitoring of Resident #24's new graph site, thrill or bruit. Interview on 03/24/25 at 2:39 P.M. with Resident #24 found she had just returned from dialysis. Resident #24 reported she had a port that was currently being used for her dialysis. Resident #24 reported she had previously had a fistula access on her right arm but it repeatedly was clogged so the port was added and the right arm fistula was removed. Resident #24 stated a port was not supposed to be for long term use so last week she had a fistula created on her left upper arm. Interview on 03/26/25 at 1:14 P.M. with Licensed Practical Nurse (LPN) #298 verified Resident #24 had a fistula graph created in her left upper extremity on 03/20/25. LPN #298 also verified the standard of practice was to check the thrill and bruit of a fistula and there was not a place in the system for Resident #24's monitoring to be documented. LPN #298 reported she checked Resident #24's fistula for thrill and bruit but verified there was no direction for others to do the same and no documentation the checks were completed. Review of the facility policy titled, Dialysis Care, revised August 2024 revealed bruit and thrill of the fistula was to be assessed every shift for patency and recorded on the Medication Administration Record. In addition, the facility would complete an assessment of the resident prior to leaving the facility and upon return to the facility for each dialysis visit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44815 Based on resident interview, medical record review, and staff interview, the facility failed to ensure residents received medications as ordered. This affected two (#21 and #123) of eight residents reviewed for medications. The facility census was 72. Findings include: 1. Review of the medical record for Resident #123 revealed an admitted [DATE] with diagnoses of metabolic encephalopathy, and type 2 diabetes mellitus. Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 03/17/25, revealed Resident #123 had intact cognition. Review of a discontinued physician order, active 03/11/25 through 03/19/25, revealed Resident #123 received Lactulose Oral Solution 10 grams (gm) per 15 milliliters (ml). Give 60 ml by mouth three times daily for hyperammonemia (elevated ammonia in the blood). Review of a discontinued physician order, active 03/19/25 through 03/26/25, revealed Resident #123's Lactulose Oral Solution dose increased to 75 ml three times daily. Review of the current physician order, dated 03/26/25, revealed Resident #123's Lactulose Oral Solution dose increased to 85 ml three times daily. Review of a laboratory test collected 03/18/25 and reported 03/18/25 revealed Resident #123's ammonia level was 159 micromols per liter (umol/L). Further review revealed the normal range was 18-72 umol/L. Review of a laboratory test collected 03/20/25 and reported 03/20/25 revealed Resident #123's ammonia level increased to 186 umol/L. Review of the physician office visit progress note dated 03/19/25 revealed Resident #123's hepatic encephalopathy was stable. The physician documented Resident #123's ammonia level was elevated to 189 on that day, and the plan was to increase the lactulose dose to 75 ml three times daily. Review of the March 2025 Medication Administration Record (MAR) for Resident #123 revealed a 5 in the afternoon and a 9 for the evening dose of lactulose on 03/11/25. Further review revealed a 9 for the afternoon and evening dose on 03/24/25 and a 9 for the morning dose of lactulose on 03/25/25. All other doses of lactulose had a checkmark. Review of the Chart Codes for the MAR revealed a 5 indicated hold/see nurse notes, and a 9 indicated other/see nurse notes. Review of a progress note dated 03/11/25 at 6:08 P.M. revealed Resident #123's lactulose was not given because it was on order. Review of a progress note dated 03/11/25 at 9:49 P.M. revealed Resident #123's lactulose was not given because the facility was awaiting delivery. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note dated 03/24/25 at 4:40 P.M. revealed Resident #123's lactulose was not given because it was in transit from the pharmacy. Review of a progress note dated 03/24/25 at 9:50 P.M. revealed Resident #123's lactulose was not given because the facility was awaiting delivery. Review of a progress note dated 03/25/25 at 2:38 A.M. revealed the facility contacted the pharmacy regarding Resident #123's lactulose and the pharmacy indicated the lactulose would be delivered 03/25/25. Review of a progress note dated 03/25/25 at 9:59 A.M. revealed Resident #123's lactulose was not given because the facility was waiting on delivery. Interview on 03/24/25 at 9:59 A.M. with Resident #123 revealed she had cirrhosis of the liver and the ammonia level in her blood built up. Resident #123 stated she received lactulose to keep the ammonia levels down. Resident #123 stated she did not receive her full dose of lactulose with her morning medications and was told the facility was out of lactulose. Interview on 03/25/25 at 9:07 A.M. with Resident #123 revealed she had not received her morning medications. Further interview with Resident #123 revealed she did not receive her afternoon or evening doses of lactulose on 03/24/25. Interview on 03/25/25 at 9:47 A.M. with Licensed Practical Nurse (LPN) #400 revealed she received report from the night shift nurse who stated the facility did not have any lactulose for Resident #123. LPN #400 stated the pharmacy was supposed to deliver it on 03/25/25. Interview on 03/25/25 at 2:33 P.M. with LPN #400 revealed no lactulose had been delivered. Observation and interview on 03/25/25 at 3:15 P.M. with LPN #400 revealed she received the lactulose for Resident #123 and was in the process of pouring the 75 ml dose. Interview on 03/27/25 at 3:12 P.M. with the Assistant Director of Nursing (ADON) #301 and concurrent review of the March 2025 MAR for Resident #123 confirmed Resident #123 did not receive the first two doses of lactulose upon admission on 03/11/25. ADON #301 stated sometimes medications were not available the first day of admission. 35031 2. Review of the medical record of Resident #21 revealed an admitted [DATE]. Diagnosis included dysfunctional dyspepsia. Review of the admission MDS assessment dated [DATE] revealed Resident #21 was cognitively intact. Review of the physician order dated 02/21/25 revealed an order for Tenapanor (for irritable bowel syndrome) 25 milligrams by mouth twice daily. Review of the Medication Administration Records for 02/25 and 03/25 revealed Resident #21 had not received the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress note dated 02/25/25, written by Director of Nursing (DON), revealed Doctor notified that Tenapanor is not available for pharmacy. No further communications with either the pharmacy nor the doctor was located until this surveyor mentioned it. A second progress note dated 03/26/25 at 1:16 P.M. revealed a discussion with the pharmacy regarding the delay in delivery of Tenapanor. The pharmacy stated the medication had fallen off their medication list and needed to be re-ordered. The lack of medication was also reported to the dialysis center, checking to see if this medication was administered at the dialysis center. The dialysis nurse stated that is not one they administer. The doctor was notified of the restart of this medication. Interview on 03/27/25 at 2:40 P.M. with DON provided verification the Tenapanor had not been administered and the lack of communication with the doctor.

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	365447	A. Building B. Wing	03/27/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35031 Based on a review of pharmacy recommendations, record review, and staff interview, the facility failed to ensure timely response to pharmacy recommendations for residents on psychotropic medications. This affected three (#11, #60, and #62) of five residents reviewed for pharmacy recommendations. The facility census was 72. Findings include: 1. Review of the medical record of Resident #11 revealed an admitted [DATE]. Diagnoses included anxiety disorder, schizoaffective disorder, major depressive disorder, paranoid schizophrenia, long-term use of opiate analgesic, and chronic pain syndrome. Review of the, Physician Recommendation Forms, the facility failed to ensure a physician addressed the recommendations of the pharmacist. On 03/09/24 the pharmacist indicated hydroxyzine 25 milligrams (mg) was ordered twice daily and was due for an evaluation for continued use. On 04/10/24 the pharmacist indicated a quarterly review was due for further use of Trazadone 150 mg at bedtime, per State and Federal regulations. On 06/21/24 per the guidelines for psychotic drug therapy, the antipsychotic Quetiapine 150 mg twice daily was due for evaluation for continued use. On 07/05/24 a quarterly review was due for further use according to State and Federal regulations for Trazadone 150 mg at bedtime. On 08/12/24 per the guidelines for psychotic drug therapy, Buspirone 10 mg three times daily was due for the semi-annual review for continued use. On 10/08/24 a quarterly review was due for the psychoactive medication Trazadone 150 mg at bedtime for continued use as per State and Federal regulations. On 01/13/25 the antipsychotic medication Quetiapine 100 mg at bedtime was due for the semi-annual review for continued use per State and Federal regulations, and a quarterly review of Trazadone 150 mg at bedtime. On 02/18/25 the antidepressant medication Duloxetine 30 mg daily was due for a semi-annual review for continued use. None of the forms had been signed by a physician. Interview on 03/27/25 at 2:40 P.M. with Director of Nursing provided verification none of the forms had been signed/addressed by the physician. 44815 2. Review of the medical record for Resident #60 revealed an admitted [DATE] with diagnoses of dementia and heart disease. Review of the quarterly MDS assessment, dated 01/19/25, revealed Resident #60 had impaired cognition, and received medications for anxiety and depression. Review of a pharmacy recommendation dated 08/12/24 revealed a recommendation for Resident #60 to have laboratory tests drawn every six months. Further review revealed the physician agreed, and the agreement to order laboratory tests was noted 09/20/24. Review of the laboratory test results completed for Resident #60 revealed they were drawn on 09/24/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record for Resident #62 revealed an admitted [DATE] with diagnoses of Alzheimer's disease, dementia, and psychotic disorder with delusions. Review of the quarterly MDS assessment dated [DATE] revealed Resident #62 had impaired cognition and received antipsychotic medications. Review of a pharmacy recommendation, dated 11/20/24, revealed Resident #62 received olanzapine 5 mg twice daily. Further review revealed a recommendation for a gradual dose reduction. Review of a nursing progress note dated 02/14/25 revealed the Nurse Practitioner ordered olanzapine be decreased from 5 mg twice daily to 5 mg in the morning and 2.5 mg in the evening. Review of the current physician order, dated 02/15/25, revealed Resident #62 received olanzapine (an antipsychotic medication), 5 milligrams (mg) every morning and 2.5 mg every night. Interview on 03/27/25 at 2:40 P.M. with the Director of Nursing confirmed the facility did not respond timely to the pharmacy recommendations for Resident #60 and Resident #62.

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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** 44815 Based on resident interview, record review, staff interview, and policy review, the facility failed to ensure residents received insulin as ordered by the physician. This affected one (#123) of eight residents reviewed for medications. The facility census was 72. Findings include: 1. Review of the medical record for Resident #123 revealed an admitted [DATE] with diagnoses of metabolic encephalopathy and type 2 diabetes mellitus. Review of the comprehensive admission Minimum Data Set (MDS) assessment, dated 03/17/25, revealed Resident #123 had intact cognition. Review of the baseline care plan dated 03/13/25 revealed Resident #123 had diabetes. Review of the current physician order dated 03/11/25 revealed Resident #123 received Humalog KwikPen Subcutaneous Solution Pen-Injector 100 units per milliliter (ml) (Insulin Lispro), inject 8 units subcutaneously (SQ) three times a day for diabetes mellitus (DM). The scheduled dosing times were 8:00 A.M., 11:00 A.M. and 5:00 P.M. Review of the current physician order dated 03/13/25 revealed Resident #123 received Humalog Injection Solution (Insulin Lispro) per sliding scale for type 2 DM, AC (before meals) and HS (bedtime). The scheduled dosing times were 7:30 A.M., 11:00 A.M., and 4:00 P.M. Interview on 03/25/25 at 9:07 A.M. with Resident #123 revealed she had not received her morning medications. Interview on 03/25/25 at 9:47 A.M. with Licensed Practical Nurse (LPN) #400 revealed she worked for an agency and worked infrequently at the facility. LPN #400 confirmed she had not provided Resident #123's medications yet. Continued interview and concurrent review of the electronic medical record (EMR) for Resident #123 with LPN #400 revealed the orders Resident #123's two Humalog insulin injections were overdue. Interview on 03/25/25 at approximately 5:15 P.M. with Regional Clinical Support Nurse (RCSN) #396, and concurrent review of the EMR for Resident #123, confirmed the morning Humalog doses for Resident #123 were given at 9:55 A.M. and both medications were overdue. 2. Review of the hospital discharge orders for Resident #123, dated 03/11/25, revealed Resident #123 should receive Tresiba FlexTouch (insulin) 200 unit per ml, give 9 units into the skin daily. Review of the physician office visit progress note dated 03/19/25 revealed Resident #123's blood glucose levels had been fluctuating, with several readings in the high 200's and 300's. Further review revealed the physician ordered an increase in Tresiba from 9 units SQ daily to 11 units SQ daily. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current physician orders on 03/25/25 at 3:15 P.M. for Resident #123 revealed no active orders for Tresiba. Interview on 03/25/25 at 3:19 P.M. with the Director of Nursing (DON) and concurrent review of Resident #123's EMR revealed Resident #123 received one dose of Tresiba, 9 units, on 03/11/25 and did not receive any other doses. The DON confirmed the order for Tresiba, 9 units, was initiated 03/11/25 and discontinued on 03/11/25. Further, the DON confirmed the order for Tresiba, 11 units, was initiated 03/21/25 and discontinued on 03/21/25 and Resident #123 received no dose of Tresiba at 11 units. Follow-up interview on 03/25/25 at 4:59 P.M. with the DON revealed the pharmacy who provided the facility's medication canceled the order for Tresiba with the intention of replacing it with a generic version. The DON stated the pending order for the generic version was never confirmed and therefore, Resident #123 did not receive Tresiba as ordered after 03/11/25. Review of the undated policy, Medication Dispensing System, revealed medications are administered in a timely fashion as specified by policy.

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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** 35031 Based on observation, staff interview, and policy review, the facility failed to ensure staff wore gloves when administering injections. This affected three residents (#21, #122, and #123) observed for insulin injections. Additionally, the facility staff did not disinfect a glucometer between resident use. This affected two residents (#21 and #122). Further, the facility failed to ensure staff wore proper personal protective equipment and practiced appropriate hand hygiene. This affected two residents (#122 and #123). The facility census was 72. Findings include: 1. Review of the medical record of Resident #21 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus. Review of the medical record of Resident #122 revealed an admitted [DATE]. Diagnoses included type II diabetes mellitus. Review of the medical record of Resident #123 revealed an admitted [DATE] Diagnoses included type II diabetes mellitus. Observation on 03/26/25 at 8:05 A.M. revealed Licensed Practical Nurse (LPN) #400 administered seven units of Humalog insulin subcutaneously (sq) to Resident #21 without wearing gloves. At 8:30 A.M. LPN #400 administered 12 units Humalog insulin sq to Resident #123 without wearing gloves. At 8:44 A.M. LPN #400 administered 14 units Lantus insulin sq to Resident #122 without wearing gloves. Interview on 03/26/25 at 9:00 A.M. with LPN #400 provided verification she had not worn gloves while administering insulin injections to Residents #21, #122, and #123. 2. Observation on 03/26/25 at 8:00 A.M. revealed Licensed Practical Nurse (LPN) #400 exit the room of Resident #21 with a glucometer. LPN #400 placed the device into the drawer of the medication cart, without disinfecting, a second device was in the drawer. At 8:40 A.M. LPN #400 obtained a glucometer from the drawer and used it to obtain a blood sugar reading on Resident #122. Interview on 03/26/25 at 9:00 A.M. with LPN #400 provided verification she had not disinfected the glucometer between use on Residents #21 and #122. Review of the policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 10/18, revealed equipment will be cleaned and disinfected before use by another resident. 44815 3. Review of the medical record for Resident #122 revealed an admitted [DATE] with congestive heart failure, bacteremia, and methicillin susceptible staphylococcus aureus (MSSA) infection. Review of the Nursing Admission Evaluation, dated 03/19/25, revealed Resident #122 was alert and oriented to self, time, and place. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician order dated 03/20/25 revealed Resident #122 received cefazolin sodium injection solution (an antibiotic) for MSSA bacteremia. Review of the physician order dated 03/24/25 revealed Resident #122 was in contact precautions due to an infection of his wound. Observation on 03/24/25 at approximately 2:40 P.M. revealed an orange sign posted on Resident #122's door reading Contact Precautions. Wear gown and gloves upon entering. Further observation revealed a plastic set of drawers in the hallway outside Resident #122's door containing disposable gowns, gloves, and masks. Interview and observation on 03/24/25 at approximately 2:45 P.M. with Resident #122 revealed he had a dark substance under his fingernails. Resident #122 stated he often scratched at his scabs and verified the substance under his nails could be blood. Resident #122 further stated he was able to independently wash and clean his own fingernails. Additional observation revealed Resident #122 holding his cellular phone during the interview. Observation on 03/24/25 at 2:55 P.M. revealed the Director of Nursing (DON) entering Resident #122's room without first putting on a disposable gown or gloves. The DON picked up a tie from the Surveyor's disposable gown from the ground and placed it in the trash. The DON then began to discuss with Resident #122 difficulties regarding arranging transportation to an appointment. Resident #122 handed his phone to the DON to show the DON a text conversation between Resident #122 and the transportation company. The DON held Resident #122's phone, read the information, and handed Resident #122's back to him. Continued observation revealed the DON left Resident #122's room, without performing hand hygiene, walked into the hall, and walked directly into Resident #123's room whose call light was on. The DON walked into the bathroom to assist Resident #123 who was seated on the toilet. Before the DON began to assist Resident #123, Certified Nursing Assistant (CNA) #345 entered the room and offered to assist Resident #123. The DON then left the bathroom and walked out of Resident #123's room. Interview on 03/24/25 at approximately 3:00 P.M. with the DON confirmed she did not put on a gown or gloves before entering Resident #122's room, confirmed she picked up a tie from the ground with her bare hands in Resident #122's room, held Resident #122's cellular phone in her hands, and did not perform hand hygiene before entering Resident #123's bathroom to provide personal care. The DON confirmed she should have put on a gown and gloves before entering Resident #122's room. The DON further stated she planned to wash her hands in Resident #123's bathroom before providing assistance. Review of the undated policy, Hand Hygiene, revealed staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of pratice.