STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366347	A. Building B. Wing	10/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veranda Gardens & Assisted Living	11784 Hamilton Avenue Cincinnati, OH 45231

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 35314 Based on review of Resident Council Minutes, resident interviews, staff interviews and policy review, the facility failed to provide responses to resident's expressed concerns. This had the potential to affect seven of seven that regularly attend Resident Council meetings. The census was 89. Findings included: Review of the Resident Council Meeting minutes dated March 2024, revealed the section titled Follow-up from last meeting / Action Taken / Current status: was blank. The minutes revealed the section titled New Questions / Comments: indicated the residents had concerns with nursing, dietary, housekeeping, laundry, and activities. Review of the Resident Council Meeting minutes dated April 2024, revealed the section titled Follow-up from last meeting / Action Taken / Current status: included Follow up from March reviewed [with] no further follow up needed. The minutes revealed the section titled New Questions / Comments: indicated the residents had concerns with nursing, dietary, housekeeping, laundry, and activities. Review of the Resident Council Meeting minutes dated May 2024, revealed the section titled Follow-up from last meeting / Action Taken / Current status: included Follow up from April reviewed w/[with] no further follow up needed. The minutes revealed the section titled New Questions / Comments: indicated the residents had concerns with administration, nursing, dietary, housekeeping, laundry, and maintenance. Review of the Resident Council Meeting minutes dated June 2024, revealed the section titled Follow-up from last meeting / Action Taken / Current status: was blank. The minutes revealed the section titled New Questions / Comments: indicated the residents had concerns with nursing, dietary, laundry, and maintenance. Review of the Resident Council Meeting minutes dated July 2024, revealed the section titled Follow-up from last meeting / Action Taken / Current status: was blank. The minutes revealed the section titled New Questions / Comments: indicated the residents had concerns with administration, nursing, social services, dietary, and maintenance. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident Council Meeting minutes dated August 2024, revealed the section titled Follow-up from last meeting / Action Taken / Current status: was blank. The minutes revealed the section titled New Questions / Comments: indicated the residents had concerns with administration, nursing, dietary, housekeeping, laundry, and maintenance. Review of the Resident Council Meeting minutes dated September 2024, revealed the section titled Follow-up from last meeting / Action Taken / Current status: was blank. The minutes revealed the section titled New Questions / Comments: indicated the residents had concerns with administration, nursing, dietary, housekeeping, laundry, and activities. Interview on 10/08/24 at 10:26 A.M., during a resident group meeting, Residents #61 stated the Resident Council's concerns were given to the Administrator. Resident #61 stated the Administrator should be doing the investigations into the resident's concerns and provide them with a solution. Resident #61 stated when there was an issue was expressed, there was no response provided. Interview on 10/10/24 at 9:00 A.M., with Resident #6 stated the resident stopped going to the Resident Council meetings because the facility did not provide any feedback regarding concerns that were expressed. Interview on 10/10/24 at 11:55 A.M., with the Activity Director stated she started in the position on 10/07/24. Activity Director stated she had not attended a Resident Council meeting and stated Activity Personnel #20 was attending the meetings. Interview on 10/10/24 at 10:55 A.M., with Activity Personnel (AP) #20 revealed she had been in the position for over a year. AP #20 stated she attended the Resident Council meetings and documented the residents' concerns. AP #20 stated after she received the Resident Council's concerns, she provided the concerns to the Administrator, who then provided them to each department director. AP #20 stated she was supposed to get the responses back from the Administrator, but that did not happen. AP #20 stated the residents had not received feedback regarding their concerns brought up in the Resident Council meetings. AP #20 stated the residents complained there was no response to their concerns. Interview on 10/10/24 at 4:23 P.M., with the Administrator, revealed the activities staff were responsible for writing down the Resident Council's concerns. Administrator stated their concerns were provided to the department director and each department director was responsible for documenting the resolution. The Administrator revealed the activities personnel who facilitated the meetings should inform the residents of the resolutions. Interview on 10/11/24 at 9:18 A.M., with the Director of Nursing (DON) revealed the feedback to Resident Council concerns were communicated to residents by an activities staff. DON stated she expected the staff set up a time after the meetings to meet with the residents to go over their concerns. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy titled, Resident Council, revised March 2007, revealed The Residents' Council is intended to promote resident interest and provide a forum for the residents to voice their opinions, concerns, suggestions for change in the day to day operation of the facility. The policy revealed, Investigation of Resident Concerns: The Activity Director or designee will submit concerns expressed at council meeting to the appropriate facility department directors or administrator on a Resident Council Concern Form. Before the next meeting the department directors will return this form and an action plan to the staff person and state how it will be resolved. The Council Chairperson or staff representative will present the action taken at the next Resident Council Meeting.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure residents had access to their personal funds after hours and on weekends. This affected two (#3 and #31) of three residents reviewed for personal funds with the potential to affect 70 residents who had a personal funds account. The facility census was 89. Findings included: Review of Resident #3's medical record revealed an admitted [DATE]. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/09/24, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Interview on 10/09/24 at 8:52 A.M.,with Resident #3 stated the resident was only able to access their personal funds on Mondays, Tuesdays, Thursdays, and Fridays, until 3 P.M Resident #3 stated the resident had been informed if the Business Office Manager (BOM) was not working, they were unable to get any funds from the facility. Resident #3 stated the resident had asked the Social Worker, about access to their funds and stated they were told they would have to wait until the BOM returned to be able to get the funds. Review of Resident #31's medical record revealed an admitted [DATE]. Review of the quarterly MDS, with an ARD of 07/10/24, revealed Resident #31 had a BIMS score of 15, which indicated the resident had intact cognition. Interview on 10/07/24 at 11:27 A.M., with Resident #31 stated there was no one available on the weekends to give the residents their funds, so they had to get their entire fifty dollars at once and then spend it when needed. Review of the document titled, Trial Balance, dated 10/10/24, revealed Resident #3 and Resident #31 had accounts with the facility. Interview on 10/11/24 at 12:47 P.M., with the BOM stated each of the residents listed on the Trial Balance form had funds. Interview on 10/09/24 at 10:55 A.M., with the BOM stated residents had access to their funds twenty-four hours a day. The BOM stated there were funds on the 400-Hall nurses' cart for access after-hours or weekends. The BOM said on Wednesdays she worked from home and the Administrator had access to the resident funds. Interview on 10/11/24 at 9:28 A.M., with the Director of Nursing (DON) revealed there were funds located on the 400-Hall nurses' cart and the nursing staff were informed. The DON stated the Administrator handled the petty cash on Wednesdays because the BOM was off on Wednesdays. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/10/24 at 4:29 P.M., with the Administrator stated the residents had access to funds on the 400-Hall nurses' cart during non-banking hours, but she did not know if the facility staff had been educated on the location of the money. Interview on 10/09/24 at 10:39 A.M., with Licensed Practical Nurse (LPN) #19 stated she did not know how residents received funds during non-banking hours. LPN #19 stated if a resident requested money during non-banking hours, she would inform the resident she was not sure how they would access their funds. Interview on 10/09/24 at 11:10 A.M., with State tested Nursing Assistant (STNA) #9 stated if a resident asked her about accessing personal funds during non-banking hours; she would inform the resident the business office would re-open on Monday or the next business day and they would have access to their funds then. Interview on 10/09/24 at 11:11 A.M., with LPN #4 stated if a resident asked for funds after banking hours, she would tell the resident to speak with social services regarding their funds because she was not aware of any money located on a nursing cart for resident personal funds. LPN #4 stated she had worked on the 400-Hall and had been responsible for the nurses' cart. She stated she was not aware that the nurses' cart on the 400-Hall had money available for residents to access. Interview on 10/09/24 at 11:18 A.M., with STNA #28 stated if a resident requested funds during non-banking hours on the weekend, she would inform the residents they would have to wait until Monday because the administration staff did not work on the weekend. Interview on 10/11/24 at 12:52 P.M., with STNA #22, who served as the former activity director, stated if a resident wanted money on the weekend, she had no idea how to access the funds. She stated she was not aware of money being available on the nurses' cart. Review of the undated policy titled, Resident Trust Fund Accounting and Records, revealed a nursing facility shall allow a resident access to petty cash, in the amount less than fifty dollars, on an ongoing basis and shall arrange for access to funds in excess of fifty dollars.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45645 Based on medical record review, facility document review, staff interviews, and review of the Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to ensure diuretic medication was accurately coded on Minimum Data Set (MDS) assessments. This affected one (#32) of five residents reviewed for unnecessary medication. The facility census was 89. Findings included: Review of Resident #32's medical record revealed an admitted [DATE] and most recently admitted the resident on 08/20/21. Diagnoses for Resident #32 included: chronic obstructive pulmonary disease (COPD), unspecified combined systolic (congestive) and diastolic (congestive) heart failure, presence of cardiac pacemaker, and hypertension. Review of Resident #32's care plan included a focus area, initiated 08/16/12, indicated the resident was at nutritional risk due to factors that included routine diuretic therapy. Review of Resident #32's Medication Administration Record (MAR), for June 2024, revealed the transcription of an order, started on 05/29/24 and discontinued on 06/18/24, for Lasix (a diuretic medication) 20 milligrams (mg) by mouth one time a day for fluid retention. The MAR reflected documentation indicated staff administered the resident's Lasix as ordered from 06/01/24 through 06/10/24. Review of the quarterly MDS, with an Assessment Reference Date (ARD) of 06/10/24, revealed section N0415G1 was not checked to reflect the resident received a diuretic medication during the seven-day look-back period. Review of Resident #32's MAR for September 2024 revealed the transcription of an order, started on 06/18/24, for Lasix 20 mg by mouth two time a day for water retention. The MAR reflected documentation indicated staff administered the resident's Lasix as ordered from 09/01/24 through 09/09/24. Review of the annual MDS, with ARD 09/09/24, revealed section N0415G1 was not checked to reflect the resident received a diuretic medication during the seven-day look-back period. Interview on 10/09/24 at 8:35 A.M., with the MDS Nurse confirmed Resident #32 received diuretic medication during the 7-day look-back periods for the resident's 06/10/24 and 09/09/24 MDS assessments and stated diuretic usage should have been coded on the MDS assessments. The MDS Nurse stated it was important to code Lasix medication accurately because the resident had COPD, and the medication affected circulation, breathing, and weight loss/gain. Interview on 10/09/24 at 12:12 P.M., with the Director of Nursing (DON) stated MDS assessments must be complete and accurate. Interview on 10/10/24 at 1:06 P.M., with the Administrator stated she expected MDS assessments to be accurate and reflective of the residents' conditions. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the undated document labeled, Re [Regarding]: MDS Accuracy Policy revealed, the facility does not have a policy on MDS accuracy. Review of the CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, version 1. 19.1, dated October 2024, section NO415: High-Risk Drug Classes: Use and Indication revealed, Steps for Assessment 1. Review the resident's medical record for documentation that any of these medications were received by the resident and for the indication of their use during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). The manual further revealed, N0415G1. Diuretic: Check if a diuretic medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

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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** 51682 Based on observation, resident interview, staff interview, medical record review, and policy review, the facility failed to ensure medications were maintained in a safe and secure manner. This affected one (#61) of two sampled residents reviewed for accidents. This faciliy census was 89. Findings included: Review of Resident #61's medical record revealed an admitted [DATE]. Diagnoses for Resident #61 included: chronic obstructive pulmonary disease (COPD), bronchopneumonia, anxiety, polyneuropathy, insomnia, malignant neoplasm of the lung, type 2 diabetes mellitus (DM), hyperlipidemia, essential hypertension (HTN), heart failure, peripheral vascular disease (PVD), and interstitial pulmonary disease. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/24, revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #61 received antianxiety, hypnotic, and hypoglycemic medications during the assessment period. Review of Resident #61's care plan, revealed a focus area initiated on 02/17/23, that indicated the resident had altered health maintenance. Interventions directed staff to administer medications as ordered. Resident #61's care plan, revealed a focus area initiated on 02/20/23, that indicated the resident was at risk for alteration in comfort. Interventions directed staff to administer medications as ordered. Resident #61's care plan did not include self-administration of medications. Observation on 10/07/24 at 8:13 P.M., with Registered Nurse (RN) #31 entered Resident #61's room, turned on the light, and placed two inhalers and medicine cups that contained a total of seven pills on the overbed table in front of the resident. After RN #31 observed Resident #61 self-administer the two prescribed inhalers, RN #31 retrieved the inhalers and stated she had to pass medications elsewhere. RN #31 left two medication cups on the overbed table in front of Resident #61, one cup contained six pills, and one cup contained one pill, which RN #31 stated was the resident's sleeping pill. RN #31 turned off the light and left Resident #61's room without observing the resident take any of the medications left on the overbed table. Interview on 10/07/24 at 8:17 P.M., with Resident #61 stated it was common for nursing staff to leave nightly medications at the bedside to be taken later and stated they did not recall a nurse ever watching them take their sleeping pill at night. Resident #61 picked up the cup of pills and stated they were uncertain if the medications in the cup were prescribed to them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 10/07/24 at 8:25 P.M., with the Assistant Director of Nursing (ADON) entered Resident #61's room where the call light was illuminated. The ADON asked Resident #61 how she could assist, and the resident stated they had concerns if the medications on the overbed table were theirs. The ADON stated nurses were expected to verify each medication was correct before bringing the medication to the resident and then watch the resident take the medication before leaving the room. The ADON then told Resident #61 she would have to review their medication administration record to answer the question, and then she left Resident #61's room leaving the medications on resident's overbed table. Observation on 10/07/24 at 8:29 P.M., with the ADON entered Resident #61's room to inform the resident the assigned unit nurse would be there soon to answer questions related to the concerns with the medications. The ADON left Resident #61's room again leaving the medications on the resident's overbed table. Interview on 10/07/24 at 8:32 P.M., with RN #31 stated she brought Resident #61 their sleeping medication early because later in the shift, she would be busy downstairs administering medication when Resident #61 would want the sleeping medication, and the resident would have to go downstairs to get the medication. RN #31 revealed the sleeping medication was a controlled substance. RN #31 stated the sleeping medication was kept in a locked box in the nurses' cart but was unaware that it should not be left at the bedside. RN #31 stated she knew Resident #61 was to be observed during medication administration but was caught off guard, did not pay attention, and thought the member of the survey team could watch medication administration on her behalf. Interview on 10/08/24 at 4:10 P.M., with the Director of Nursing (DON) stated RN #31 should verify medications administered were correct, verify the patient, and make sure the resident took each medication before leaving the room. Interview on 10/11/24 at 12:52 P.M., the Administrator stated she expected nursing staff to follow the proper procedures that were in place for medication administration. Review of the policy titled, Medication Storage, effective 07/23/19, revealed the section titled Procedure, indicated, 2. Only licensed nurses, the Consultant Pharmacist, and those authorized to administer medications (e.g. [exempli gratia, for example] medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682 Based on observation, staff interview, and medical record review, the facility failed to ensure urostomy (an abdominal wall opening to allow urine to drain from the body) tubing was secured. This affected one (#53) of three residents reviewed for catheter care. The faciliy census was 89. Findings included: Review of Resident #53's medical record revealed an admitted [DATE] and most recently admitted the resident on 08/23/23. Diagnoses for Resident #53 included: neuromuscular dysfunction of the bladder, urinary retention, and stage 4 pressure ulcer of the sacral region. Review of the quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 07/09/2024, revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. According to the MDS, the resident had an ostomy, and their urinary continence was not rated, because the resident had a catheter, urinary ostomy, or no urinary output during the seven-day look-back period. Review of Resident #53's care plan included a focus area initiated on 05/20/2021 that indicated the resident had a urostomy. According to the care plan, Resident #53's urostomy drained into a urinary drainage system. An intervention directed staff to secure the resident's urostomy catheter tubing to prevent accidental dislodgment. Observation on 10/07/24 at 10:37 A.M., revealed Resident #53 lying in their bed with a urinary drainage bag hanging on the left side of their bed. There was no securement device observed. Observation and interview on 10/09/2024 at 2:06 P.M., with License Practical Nurse (LPN) #18, Resident #53 was observed lying in bed with a urostomy stoma (surgical opening) with a drainage system that consisted of catheter tubing that allowed the resident's urine to drain into a urinary drainage bag. No securement device was observed. LPN #18 observed and verified Resident #53 did not have a securement device in place for the catheter tubing of their urostomy. LPN #18 stated securement devices were used in the facility to prevent the catheter tubing from coming loose, but she was unsure why Resident #53 did not have one in place. LPN #18 stated the resident required pressure ulcer care, which required a lot of shifting in the bed, and the resident should have a securement device in place. Interview 10/11/24 at 8:34 A.M., with the Director of Nursing (DON) confirmed Resident #53 had a urostomy. The DON further stated some residents should have their catheter tubing secured to lock it in place.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51682 Based on observation, interview, record review, and facility policy review, the facility failed to clean oxygen concentrators in accordance with physician's orders and the facility's policy for two (Resident #31 and Resident #61) of three residents reviewed for respiratory care. The facility census was 89. Findings included: 1. An Admission Record revealed the facility admitted Resident #31 on 07/23/12. According to the Admission Record, the resident had a medical history that included a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/10/24, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #31 experienced shortness of breath when lying flat and had not used oxygen therapy during the assessment look-back period. Resident #31's care plan, included a focus area initiated 10/07/23, that indicated the resident had respiratory deficiencies or abnormalities of pulmonary function related to COPD with shortness of breath with exertion at times and lying flat. The focus area revealed the resident required supplemental oxygen at night and occasionally during the day. Interventions directed staff to administer supplemental oxygen as ordered. Resident #31's Physician Orders, with active orders as of 09/01/24, contained an order, dated 07/28/24, to clean the filter on the oxygen concentrator weekly on Sundays during night shift. Resident #31's Treatment Administration Record (TAR), for the timeframe from 10/01/24 through 10/07/24, revealed a transcription of an order dated 07/24/24 for continuous supplemental oxygen per nasal cannula to maintain oxygen saturation above 92 percent (%) every night shift. The TAR revealed a transcription of an order dated 07/24/24 for continuous supplemental oxygen per nasal cannula to maintain oxygen saturation above 92 % every shift as needed. The TAR revealed that staff had documented that the resident utilized the supplemental oxygen on 10/01/24, 10/02/24, 10/03/24, 10/04/24, 10/05/24, and 10/06/24. The TAR revealed a transcription of an order dated 07/28/24, to clean filter on the oxygen concentrator weekly every night shift on Sundays. The TAR revealed no documentation that staff had cleaned the oxygen concentrator on 10/06/24. During a concurrent observation and interview on 10/07/24 at 11:36 AM, Resident #31 was observed lying in bed with a supplemental oxygen concentrator machine running at 2 liters per minute with the tubing lying next to the resident in their bed. Resident #31 was not using the supplemental oxygen concentrator and stated they mostly wore it at night and as needed. The oxygen concentrator filter/vent region on the rear of the machine revealed a thick, gray, fuzzy textured substance on the surface that obscured visibility. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 10/07/24 at 8:55 PM, revealed a supplemental oxygen concentrator machine running with a nasal cannula attached and lying on Resident #31's bed. Resident #31 was not in the room at the time of the observation. The oxygen concentrator filter/vent region on the rear of the machine revealed a thick, gray, fuzzy textured substance on the surface that obscured visibility. During a concurrent interview, the Assistant Director of Nursing (ADON) observed the oxygen concentrator filter/vent region of the machine and stated it did not appear to have been cleaned on 10/06/24 during the night shift. During a telephone interview on 10/09/24 at 4:33 PM, Registered Nurse (RN) #10 revealed he had not received any training on cleaning the oxygen concentrator filters and did not think there was a way to clean them and therefore he had never cleaned them. RN #10 stated he did not clean them when he worked on 10/06/24. 2. An Admission Record indicated the facility admitted Resident #61 on 02/16/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of COPD. A quarterly MDS, with an ARD of 08/20/2024, revealed Resident #61 had a BIMS score of 15 which indicated the resident had intact cognition. The MDS indicated Resident #61 experienced shortness of breath when lying flat and had not used oxygen therapy during the assessment look-back period. Resident #61's care plan, included a focus area initiated on 02/20/23, that indicated the resident required supplemental oxygen due to COPD. Interventions directed staff to administer supplemental oxygen as ordered. Resident #61's Physician Orders, with active orders as of 10/01/24, contained an order, dated 07/28/24, to clean the filter on the oxygen concentrator weekly on Sundays during night shift. Resident #61's TAR for the timeframe from 10/01/24 through 10/11/24, revealed a transcription of an order dated 07/28/24 to clean the filter on the oxygen concentrator weekly every night shift on Sundays. The TAR revealed there was no staff documentation to indicate the filter had been cleaned 10/06/24. An observation on 10/07/24 at 11:55 AM, revealed Resident #61 sitting in their motorized wheelchair with supplement oxygen running at 4 liters per minute delivered via nasal cannula with a 20-foot-long tube attached to an oxygen concentrator located in the adjacent room where the resident's bed was located. The oxygen concentrator filter region located on the back side of the machine was filled with a gray fuzzy textured substance. An observation on 10/07/24 at 8:08 PM, revealed Resident #61 sitting in the adjacent room from the oxygen concentrator with supplement oxygen running at 4 liters per minute delivered via nasal cannula with a 20-foot-long tube attached to an oxygen concentrator. During the observation, the filter/vent region was observed on the rear of the oxygen concentrator to contain a gray fuzzy matter which covered the surface preventing visibility. During an observation and interview with Registered Nurse (RN) #31 on 10/07/24 at 8:51 PM, RN #31 observed Resident #61's oxygen concentrator and acknowledged the filter/vent region had dust on the area. RN #31 was not able to articulate knowledge of the care of maintenance of the filters and cleaning of the concentrator per orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview with the Assistant Director of Nursing (ADON) on 10/07/24 at 8:53 PM, the ADON observed and acknowledged Resident #61's oxygen concentrator filter/vent region contained a dust substance and stated the concentration filter/vent region did not appear to have been cleaned on 10/06/24 during night shift. The ADON stated the filters on oxygen concentrators should be cleaned weekly on Sundays by night shift staff. During an interview on 10/11/24 at 8:34 PM, the Director of Nursing (DON) stated the oxygen concentrator filter/vent region no longer has an external filter that must be removed and cleaned by staff, but the area should have been cleaned where the filter/vent region is located weekly when oxygen is ordered. During an interview on 10/11/24 at 12:52 PM, the Administrator stated she expected staff to follow all protocols for maintenance and care of the oxygen concentrator machine. A facility policy titled, Respiratory Equipment Cleaning/Disinfecting, revised 09/14/18, indicated, 2. Oxygen Concentrators: a. Clean external surfaces as needed. b. Filters cleaned weekly or as needed.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682 Based on observation, record review, interviews with staff, residents, and a family member, facility document review, and review of the Facility Assessment, the facility failed to ensure designated and consistent staffing was provided on one (500-Hall) of five total halls in the facility to ensure sufficient staff to provide needed care and services to the 13 residents that resided on the 500-Hall. This resulted in Immediate Jeopardy and the potential for serious injury, harm, impairment and/or death, when observations during the survey on 10/07/24 and 10/08/24 revealed times where the residents were left unattended on the 500-Hall with no staff members in the area. Staff reported there was no process in place to coordinate supervision, monitoring, or assistance for the residents on the 500-Hall. In addition, the call system on the 500-Hall only illuminated on the annunciator panel located on that hall; therefore, in the event of an emergent need, when no staff were present on the 500-Hall, the residents were not able to alert staff in other areas of the facility. Residents reported if they needed assistance, they had to utilize the elevator to go down to other floors of the facility to locate staff. Additionally, residents reported that due to no staff presence on the 500-Hall at mealtimes, residents had to retrieve their own meal trays from the food carts because no staff were available to assist. This affected 13 residents (#4, #11, #17, #26, #31, #43, #44, #56, #61, #67, #78, #82, and #90) who currently reside on the 500-Hall. The total census of the facility was 89. The Senior Administrator and Administrator were notified the Immediate Jeopardy began on 10/07/24 when the survey team observed that there were no staff present on the 500-Hall when Resident #61 activated their call light. A copy of the Immediate Jeopardy template was provided on 10/09/24 at 1:01 P.M. A removal plan was requested. The removal plan was accepted by the state survey agency on 10/10/24 at 12:24 P.M. The Immediate Jeopardy was removed on 10/09/24, after the survey team performed onsite verification that the removal plan had been implemented; however, the noncompliance remained at a Severity Level 2 (no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy) as the facility is still in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings included: During the entrance conference on 10/07/24 at 9:21 A.M, the Administrator reported the facility currently had a census of 89. The facility's floor plan revealed the facility had a 100-Hall, 200-Hall, 300-Hall, 400-Hall, and 500-Hall. Review and analysis of the facility's floorplan and layout on 10/09/24 at 7:33 P.M. revealed the facility had three floors. The 100-Hall and 200-Hall were located on one side of the facility, and the 300-Hall, 400-Hall, and 500-Halls were located on the other side. The floor plan revealed that the 300-Hall was on the ground floor, and the 400-Hall and 500-Hall were each on a separate level and had to be accessed by either a stairwell or an elevator. The floor plan indicated the 300-Hall had 15 private rooms, the 400-Hall had 12 rooms (10 private and two semi-private), and the 500-Hall had 12 rooms (11 private and one semi-private). (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Admission Record indicated the facility admitted Resident #61 on 02/16/23. According to the Admission Record, Resident #61 had a medical history that included diagnoses of Chronic Obstructive Pulmonary Disease (COPD), bronchopneumonia, hypothyroidism, anxiety, polyneuropathy, Gastro-Esophageal Reflux Disease (GERD), dementia, depression, insomnia, malignant neoplasm of the lung, iron deficiency anemia, type 2 Diabetes Mellitus (DM), hyperlipidemia, Essential Hypertension (HTN), diastolic heart failure, Peripheral Vascular Disease (PVD), and interstitial pulmonary disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/20/24, revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS revealed Resident #61 required substantial to maximum assistance from staff with toileting hygiene, bathing, and lower body dressing, partial to moderate assistance from staff with bed to chair transfers, and supervision or touching assistance from staff with eating, oral hygiene, upper body dressing, personal hygiene, toilet transfers, bed mobility, and when transitioning from a seated position to standing or lying down. Resident #61's care plan contained a focus area, initiated 02/20/23, that indicated the resident may require assistance with Activities of Daily Living (ADLs) and may be at risk for developing complications associated with decreased ADL self-performance. Interventions indicated that the resident required assistance with ambulation, bathing, bed mobility, oral care, toileting, and transfers. Interventions also indicated that the resident required supervision with eating. During the initial pool process on 10/07/24 at 11:42 A.M., Resident #61 reported there were not always staff members working on the 500-Hall. Resident #61 further stated residents had to go to the food carts to get their own meal trays and said over the prior weekend, if their family had not been present and passed meal trays, they would not have eaten. During a telephone interview on 10/09/24 at 8:06 P.M., Resident #61's family member, Family Member #33, indicated they were at the facility on Sunday, 10/06/24, between 4:00 P.M. to 6:30 P.M. and observed there to be no staff on the 500-Hall. Family Member #33 stated when supper trays arrived there were multiple residents on the hall who got their meals independently without staff assistance. Family Member #33 indicated that when they visited the resident on weekends between the hours of 2:00 P.M. to 7:00 P.M., there were rarely staff visible. Family Member #33 stated that they had notified administration of the concern of lack of staff on the 500-Hall and was told the concern would be addressed. The family member stated they were concerned because if Resident #61 choked or fell , staff would be unaware if they were not on the hall. During an interview on 10/07/24 at 1:30 P.M., Resident #44, who also resided on the 500-Hall, stated they had to retrieve their own meal trays and hunt staff down if they needed anything. During an interview on 10/07/24 at 1:45 P.M., Resident #11, who also resided on the 500-Hall, stated that most of the time there were no staff available on the 500-Hall. Resident #11 reported residents had to go hunt and find staff on other halls of the facility. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A facility document titled, Daily Nursing Staffing Sheet, dated [DATE] Monday, revealed there was not a scheduled nurse designated to work on the 500-Hall, but there was a designated State tested Nursing Assistant (STNA) during the day shift. The staffing sheet indicated the Licensed Practical Nurses (LPNs) assigned to work the 300-Hall and 400-Hall were also responsible for the 500-Hall during the day shift. Per the staffing sheet, there was no designated nurse or STNA for the 500-Hall on the night shift, but the STNAs assigned to the 300 Right and 300 Left were also responsible for the 500-Hall. The staffing sheet did not indicate any night shift nurses were responsible for the 500-Hall. Registered Nurse (RN) #31 was listed as being assigned to the 300-Hall. During a night shift observation of the 500-Hall on 10/07/24 beginning at 8:13 P.M., RN #31 entered Resident #61's room to provide medications. RN #31 placed two medication cups containing seven total pills on the resident's over-the-bed table and informed the resident she was going downstairs to the 300-Hall to pass their medications. On 10/07/24 at 8:17 P.M., after RN #31 left the resident's room, Resident #61 said they were not sure if the medications left by the nurse were correct, and the surveyor immediately went to the nurses' station to look for RN #31. However, RN #31 was seen turning the corner to go to the elevator that led to the 300-Hall, where she indicated she was going. The surveyor then went down the hallway to locate other staff members but was unable to locate any other staff on the hallway. The surveyor returned to Resident #61's room and asked the resident if they could activate their call light so that the resident could ask staff about their medications. Resident #61 said that activating their call light was a waste of time, because after the night shift staff left the hallway, the residents did not see staff again until the following morning, unless it was a rare occasion. Resident #61 further stated they had previously been told by staff that the call lights on the 500-Hall did not go off anywhere else in the facility, so staff would not know. However, Resident #61 agreed to activate the call light. At 8:25 P.M., the Assistant Director of Nursing (ADON) arrived on the 500-Hall via the back stairwell door and was carrying her personal belongings. The ADON was headed towards her office, which was located on the same hall, when she passed Resident #61's room, with their call light still sounding. The surveyor then approached the ADON and asked who she was, because she did not answer the resident's call light as she passed. The ADON informed the surveyor of her title and said she had returned to the facility to assist the surveyors with the survey after receiving a call the survey team had re-entered the facility earlier in the evening. At 8:29 P.M., the ADON informed Resident #61 that RN #31 would come back up to speak with them about their medications, and the ADON then left the 500-Hall via the stairwell exit-door. At 8:32 P.M., RN #31 returned to Resident #61's room to address their question regarding their medications and then told the resident she was going back downstairs. Observations on 10/11/24 from 3:39 P.M. to 3:45 P.M. revealed that when the call light for room [ROOM NUMBER] was activated, the call system annunciator panel illuminated on the 500-Hall; however, observations of the annunciator panels located on the other four halls (100-, 200-, 300-, and 400-Halls) revealed they did not illuminate when call lights were activated on the 500-Hall. A facility document titled, Daily Nursing Staffing Sheet, dated [DATE] Tuesday, revealed that during the day shift, RN #32 was designated to work on the 500-Hall with a designated STNA, along with a nurse assigned to the 400-Hall that was to also assist with the 500-Hall. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation of the 500-Hall on 10/08/24, RN #32 left the hall via the elevator at 3:51 P.M. No other staff were able to be located on the hall. At 3:55 P.M., a housekeeping staff member was observed at the end of the 500-Hall and exited the hall via the elevator. At 3:59 P.M., RN #32 returned to the hall. During an interview on 10/08/24 at 3:59 P.M., RN #32 stated she was alone on the 500-Hall because the assigned STNA was on a break. A list provided by the facility indicated that, as of 10/07/24, 13 residents resided on the 500-Hall, of which seven residents were cognitively intact, one resident had moderate cognitive impairment, four residents had severe cognitive impairment, and one resident's cognitive status was illegible. Review of the comprehensive care plans for the 13 residents on the 500-Hall revealed each resident required assistance from staff with ADLs. In addition, the care plans indicated the resident population on the 500-Hall included residents at risk for alteration in skin integrity, alteration in comfort, alteration in nutrition and hydration status, high and low blood sugar levels, and falls, as well as residents with respiratory deficiencies and behaviors. During an interview, on 10/08/24 at 9:40 A.M., LPN #6 stated the nurses had to split the 500-Hall medication pass at times, but the STNA assigned to the 500-Hall did everything else. She stated there was normally a schedule posted that reflected which STNA was assigned to the 500-Hall. LPN #6 further stated the 500-Hall sometimes had a designated STNA the entire shift, but sometimes the schedule required the STNAs to split that responsibility, leaving no one fully assigned to the 500-Hall at all times. LPN #6 stated the staff get up there as much as they can. LPN #6 said there were times when no staff were on the 500-Hall, because staff did not coordinate with one another to ensure someone was always present on the hall. She stated that most of the time, if the residents on the 500-Hall needed something, they came down to another hall to get a staff member. During an interview on 10/08/2024 at 9:46 A.M., STNA #9 stated that her primary responsibility was providing care to residents on the 300-Hall. STNA #9 stated there were times when there were no staff on the 500-Hall. STNA #9 stated the STNAs may cross paths while transitioning between halls, but, typically, they did not know when other staff were on the 500-Hall. STNA #9 stated there was a weekend that someone was not assigned to the 500-Hall or did not come to work and a nurse provided medications, but did not communicate to the other staff that there was not an STNA on the 500-Hall, and residents received their meal trays late. STNA #9 further stated that when she was splitting the responsibility of the 500-Hall and another hall, she could not keep eyes on the residents on the 500-Hall; instead, she would ask them if they had any needs, then return downstairs. STNA #9 explained that when call lights were used by residents on the 500-Hall, they could not be seen by staff on other halls of the facility. STNA #9 reported that residents on the 500-Hall called the front desk or came downstairs to look for a staff member. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 10/08/24 at 10:33 A.M., STNA #21 said that when a nurse was assigned to the 500-Hall, the nurse worked as both the nurse and the aide for the hall, but when no nurse was assigned to the 500-Hall, the STNAs from the 300-Hall and the 400-Hall split the responsibility of the 500-Hall. STNA #21 said that the STNAs who split the responsibility of the 500-Hall did not coordinate when they went to the hall. STNA #21 stated that when she was assigned Rooms 506 through 511, she checked on the residents at the beginning of her shift, then randomly checked on them throughout the night. She stated that if any resident on the 500-Hall used their call light, she would not be alerted if she was working on another hall. During a telephone interview on 10/08/24 at 10:59 A.M., STNA #15 said that the STNAs assigned to the 300-Hall and the 400-Hall split duties to each cover a portion of the 500-Hall. STNA #15 said the STNAs periodically checked on the residents on the 500-Hall, and the residents also came downstairs to let staff know when they needed something. According to STNA #15, there were no staff working on the 500-Hall multiple times a week. STNA #15 also stated that if a resident on the 500-Hall attempted to utilize their call light, staff on other halls would not be alerted. During an interview on 10/08/24 at 2:12 P.M., STNA #24 said she had frequently been assigned to work both a portion of the 400-Hall and a portion of the 500-Hall. STNA #24 stated that other times, staff were not notified until later in the shift that they needed to assist with the 500-Hall. STNA #24 stated that when breakfast trays arrived between 8:00 A.M. to 9:30 A.M., staff were notified via text message if no one was working on the 500-Hall and meal trays needed to be passed. STNA #24 said there was no organization, and the residents on the 500-Hall accessed the meal cart to get their own trays most of the time. STNA #24 further stated she did not feel comfortable working on the 400-Hall while not knowing if any call lights were activated on the 500-Hall. STNA #24 said she went up to the 500-Hall when she was able, but she took care of the residents on the 300-Hall or 400-Hall primarily, before tending to any residents on the 500-Hall. She stated the residents on the 500-Hall came down the elevator to the 300-Hall or 400-Hall to hunt down staff. STNA #24 voiced concern that the residents on the 500-Hall were dining without supervision, and staff would have no way of knowing if anyone got strangled or choked. STNA #24 said she had reported her concerns to the Scheduling Coordinator and told her she was not willing to continue attempting to work on two separate halls at the same time. STNA #24 said there should be staff designated to work the 500-Hall at all times, since there were residents that resided on that hall. During an interview on 10/09/24 at 10:20 A.M., the Scheduling Coordinator said she typically made staffing assignments by utilizing four nurses on the day shift, four nurses on night shift, eight STNAs on the day shift, and six to seven STNAs on night shift. The Scheduling Coordinator stated the 100-, 200-, and 300-Halls were scheduled with two STNAs on day shift and night shift, and the 400-Hall was scheduled with two STNAs on day shift and one STNA on night shift. She stated that if all staff showed up for their scheduled shifts, the STNAs assigned to the 300-Hall and the 400-Hall also split the 500-Hall. The Scheduling Coordinator further explained the 300-Hall nurse and the 400-Hall nurse also split the 500-Hall. She stated that if there was not a nurse or aide scheduled for the 500-Hall, then the 300-Hall nurse went to the 500-Hall after completing the 300-Hall medication administration and should remain on the hall the remainder of the shift. She stated that if a nurse had to leave the hall, staff should coordinate to ensure someone was on the hall. The Scheduling Coordinator stated she was not aware that there had been times when staff were not present on the hall. The Scheduling Coordinator stated the Director of Nursing (DON) or Administrator had to approve the facility's staffing levels based on the acuity of the residents. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 10/09/24 at 10:54 A.M., the DON said the allotted amount of staff was calculated through the corporate office to be the following: The 100-Hall was allowed one nurse and two STNAs, the 200-Hall was allowed one nurse and two STNAs, the 300-Hall was allowed one nurse and one STNA minimum but two STNAs when possible, the 400-Hall was allowed one nurse and one STNA minimum, and the 500-Hall was staffed with either a nurse or an aide when possible. The DON stated that when a staff member was not scheduled for the 500-Hall, the 300-Hall nurse should sit on the 500-Hall between medication passes and float between halls, with the 300-Hall STNA reporting to the 500-Hall when the nurse was not there. The DON said if there was a nurse assigned to the 500-Hall, the nurse was responsible for all care for the residents and completed both the nursing and STNA duties, and if there was an STNA assigned to the 500-Hall without a nurse, the 300-Hall and 400-Hall nurses split the responsibility of medication administration for the 500-Hall. The DON further stated the ADON was also on the 500-Hall during the day shift. The DON said she was unaware of any time there would be a reason for there not to be staff on the 500-Hall. During an interview on 10/11/24 at 4:41 P.M., the ADON, whose office was on the 500-Hall, stated that she was not responsible for the care of the residents on the 500-Hall. She stated that she was the unit manager for the 300-, 400-, and 500-Halls, and if nurses on those halls had concerns, they reported to her. During an interview with the Administrator and the Senior Administrator on 10/09/24 at 11:23 A.M., the Administrator said she was unsure the number of allocated staff allowed to be scheduled for the facility and stated that the numbers were managed by the Scheduling Coordinator and were calculated based on the acuity of the residents, the daily census, and the state minimum staffing requirements. She stated that adjustments were made when a resident required one-to-one supervision or when major changes occurred in the facility. The Administrator stated that nurses and STNAs on the 300-Hall and the 400-Hall split the responsibilities of covering the 500-Hall. The Senior Administrator stated that she expected staff to communicate to ensure someone was present on the 500-Hall at all times, via two-way radios, cellular phones, or there were also phones on the halls that were available for communication. She further stated there were times when there was a nurse assigned to all the duties on the 500-Hall, but they could call for help if they needed additional assistance. The Facility Assessment, dated 2024, revealed, A.1. Function- Sufficiency Analysis Summary 1. Staffing and scheduling systems: Facility staffing based on current census and resident's needs. Facility uses PPD [Per Patient Day]. Staff assigned to units to ensure continuity of care and 3. A review of individual staff assignments and systems for coordination and continuity of care for residents within and across staff assignments occur as census and resident needs adjust. 4. Staffing policies updated and reviewed and [sic] acuity and patient care needs indicate. An undated, facility document, Re [Regarding]: Staffing, revealed, Facility does not have policy on staffing, facility goes by state guidelines: The minimum number of staff required based on acuity/resident to staff ratio and current regulatory compliance, including upcoming minimum staffing requirements. On 10/10/24 at 12:24 P.M., a removal plan was submitted by the facility and accepted by the state survey agency as follows: (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Director of Nursing (DON)/designee reviewed staffing assignments and made adjustments to the staffing assignment to ensure staffing personnel are present at all times on the 500 unit. Review completed 10/09/24 at 2 P.M. Corrective action completed on 10/09/24. 2. Licensed Nursing Home Administrator (LNHA)/designee to complete one-time audit of all staff assignments for the rest of the building to ensure appropriate staffing levels. Corrective action completed on 10/09/24. 3. IDT [Interdisciplinary team] team, consisting of LNHA, Medical Director, DON, Assistant Director of Nursing (ADON) and clinical support Registered Nurse (RN), to review facility assessment to ensure facility staffing plan is consistent with residents' care needs. Corrective action completed on 10/09/24. 4. LNHA/designee to post notice at conspicuous location in facility to notify facility staff to ensure timely communication of unit departure to ensure appropriate coverage and resident needs are met. Corrective action completed on 10/09/24. 5. LNHA/designee notified facility Medical Director regarding the Immediate Jeopardy on 10/09/24 at 2:22 P. M. via phone. 6. ADON completed assessments including vital signs and head to toe assessments on all residents residing on the 500-Hall. No residents have suffered any adverse effects related to the Immediate Jeopardy. Assessments were completed on 10/09/24. 7. Senior LNHA provided education to LNHA and DON regarding the responsibility to ensure each hall in the facility is appropriately supervised to ensure resident needs are met in accordance with each resident's plan of care. Corrective action completed on 10/09/24. 8. Facility DON/designee to educate all facility STNAs and nurses regarding their responsibility to ensure appropriate staff personnel are available to meet the needs of the residents on their designated unit and that there should always be a staff member present. The Corrective action to be completed on 10/09/24 or prior to their next scheduled shift. 9.Human Resources Director/designee to provide education to all new hire nurses and STNAs in new hire orientation prior to working their first shift. The facility does not use agency staffing. 10. Scheduler/designee to provide a laminated call sheet for staff to be posted in conspicuous areas on the 500-Hall for who to contact for relief including phone numbers reflecting day, time, and off hours. Corrective action was completed on 10/09/24. 11. LNHA/designee to monitor daily staffing assignment sheets to ensure proper staffing coverage for all units in the facility. This monitoring shall take place for 8 weeks and will be ongoing thereafter as needed as determined by the facility QAPI [Quality Assurance and Performance Improvement] committee. Additionally, any adverse findings will be shared with the facility QAPI committee and adjustments to corrective action plan will be made as needed. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	12. DON/designee to monitor daily x [times] 2 weeks, then 5 x weekly x 2 weeks and then 3 x weekly x 4 weeks and ongoing thereafter as needed as determined by facility QAPI committee to ensure there is no lapse in supervision on the 500-Hall. Monitoring is to be conducted randomly and includes monitoring on off hours including evenings and weekends. Monitoring consists of conducting rounds on the 500-Hall unannounced to ensure there is always a staff member available to address any potential resident needs. Any adverse findings will be shared with the facility QAPI committee and adjustments to corrective action plan will be made as needed. The credible allegation for the Immediate Jeopardy removal was validated on 10/10/24 at 12:31 P.M. through 10/12/24 at 11:30 A.M. A review of staff in-service education records indicated staff were educated they were not to leave their units unattended without notification of another staff member. Interviews with nursing staff revealed each had been educated they were not to leave their assigned unit without notifying another staff member and that the 500-Hall was not to be left unattended at any time. The interviews also revealed a list of designated phone numbers were provided to key personnel for additional coverage of the unit. Observations were made of the postings located on the 500-Hall nurses' station, including observations of the posted information regarding staff communication about unit coverage and the laminated call sheet with contact numbers. The staffing assignments, facility audit, staffing plan, and resident head-to-toe assessments for the 500-Hall were reviewed. Staff schedules for the timeframe from 10/11/2024 to 10/25/2024 were reviewed to ensure coverage was designated for the 500-Hall on all shifts.

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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. 35314 Based on observation, interview, and facility policy review, the facility failed to ensure medication carts were locked when unattended by staff. This affected one (100-Hall) of six medication carts observed. The facility census was 89. Findings included: During an observation on 10/10/24 at 8:14 AM, Licensed Practical Nurse (LPN) #2 left the 100-Hall medication cart unlocked and unattended when she entered a resident's room to administer medications. While LPN #2 was administering medications, the medication cart was not within her line of sight. During an observation on 10/10/24 at 10:31 AM, LPN #2 left the 100-Hall medication cart unlocked and unattended while she went to the kitchen to retrieve some water. During an interview on 10/10/24 at 2:11 PM, LPN #2 confirmed she left the medication cart unlocked and unattended and stated the cart should have been locked. During an interview on 10/11/24 at 8:54 AM, the Assistant Director of Nursing (ADON) said that when staff walk away from a medication cart, they should lock the cart. During an interview on 10/11/24 at 9:46 AM, the Director of Nursing (DON) said she expected nursing staff to lock the medication carts when the cart was not within their reach or line of sight. A facility policy titled, Medication Storage, dated 07/23/19, revealed, Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. The policy revealed, 2. Only licensed nurses, the Consultant Pharmacist, and those authorized to administer medications (e.g. [exempli gratia, for example] medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682 Based on observation and interview, the facility failed to ensure open food items were sealed to prevent potential contamination and expired food items were discarded. These failures had the potential to affect all residents receiving meals from the dietary department. The facility census was 89. Findings included: During an initial tour of the facility's kitchen on [DATE] at 9:09 AM, with the Dietary Supervisor (DS) present, the walk-in refrigerator was observed to contain an open box of bacon that was not sealed and a gallon-sized container of cottage cheese labeled with a sell-by date of [DATE]. During an interview on [DATE] at 9:25 AM, the DS indicated he did not have any staff responsible in his absence to ensure food items were labeled, rotated, or discarded, because staff were new and not responsible enough for this task. The DS stated that because of this, every Monday morning, the DS completed the tasks of labeling, dating, and discarding items.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35314 Based on interview, record review, and facility policy review, the facility failed to ensure nursing staff accurately documented the administration of medications on the medication administration record for one (Resident #31) of five residents reviewed for unnecessary medication. The facility census was 89. Findings included: An Admission Record indicated the facility originally admitted Resident #31 on 07/23/12 and most recently admitted the resident on 10/01/20. According to the Admission Record, the resident had a medical history that included diagnoses of contracture, chronic pain, anxiety disorder, and quadriplegia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/10/24, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #31's Order Summary Report, listing active orders as of 09/01/24, revealed the following medication orders: buspirone hydrochloride (HCl) 10 milligram (mg) oral tablet, one tablet by mouth three times a day related to anxiety (started 07/19/24); Eliquis 5 mg tablet, one tablet by mouth two times a day (started 05/07/22); escitalopram oxalate 10 mg tablet, one tablet by mouth one time a day related to major depressive disorder (started 12/09/23); and Fentanyl patch 75 micrograms per hour, apply one transdermal patch every 72 hours related to chronic pain (started 11/19/21). Resident #31's Medication Administration Record (MAR) for 10/2024 revealed no documented evidence staff administered the following ordered doses of the resident's medications: buspirone HCl 10 mg on 10/05/24 and 10/07/24 at 2:00 PM; Eliquis 5 mg on 10/05/24 and 10/07/24 at 5:00 PM; escitalopram oxalate tablet on 10/05/24 and 10/07/24 at 1:00 PM; and Fentanyl patch on 10/07/24 at 1:00 PM. During an interview on 10/11/24 at 2:56 PM, Resident #31 stated they had no issues receiving their medications. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on 10/11/24 at 3:39 PM, Resident #31 stated they received all their medications. Resident #31 further stated they received their medications late on 10/05/24, because the nurse arrived to work late, which resulted in a later start for passing medications; however, the resident indicated they had no other difficulties receiving any of their medications. During an interview on 10/11/24 at 4:14 PM, Licensed Practical Nurse (LPN) #4 stated she was the assigned nurse for Resident #31 after 1:00 PM on 10/05/24 and 10/07/24 and was able to give all the resident's medications. LPN #4 stated she was not aware that she had not documented on the MAR that Resident #31's medications were administered. She stated she should have signed the medications off on the MAR after they were administered. During an interview on 10/12/24 at 9:46 AM, the Director of Nursing (DON) stated she expected nurses to document that medications were given following the administration of the medications. During an interview on 10/12/24 at 8:30 AM, the Administrator stated she expected nurses to follow the proper procedure and document medication administration accurately. A facility policy titled, Documentation: Charting, revised 09/16/19 revealed, Each resident's medical record shall contain an accurate representation of the resident and include information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The policy revealed, 1. Licensed staff and interdisciplinary team members shall document assessments, observations, and services provided in the resident's medical record in accordance with state law and policy. 2. Documentation may be completed at the time of service or during the shift in which the assessment, observation, or care service occurred. 3. Principles of documentation may include but are not limited to: a. Documentation shall be factual, objective, and complete.

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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. 43648 Based on observation, interview, record review, facility policy review, and the Centers for Medicare & Medicaid Services (CMS) memorandum, the facility failed to ensure staff implemented Enhanced Barrier Precautions (EBP) for one (Resident #91) of five sampled residents reviewed for infection control. The facility further failed to ensure a urinary catheter bag did not rest on the floor for one (Resident #20) of five sampled residents reviewed for urinary catheters. The facility census was 89. Findings included: 1. An Admission Record revealed the facility admitted Resident #91 on 08/28/24. According to the Admission Record, the resident had a medical history that included a diagnosis of pyogenic arthritis. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/06/24, revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #91 required substantial/maximal assistance with toileting hygiene, bathing, upper and lower body dressing, personal hygiene, and putting on/taking off footwear. The MDS indicated Resident #91 received intravenous medications. Resident #91's care plan included a focus area, initiated 09/05/24, that indicated the resident was at risk for infection related to increased white blood cells and received an intravenous antibiotic. Interventions directed staff to implement enhanced barrier precautions, provide sterile site care per policy for the central line, and evaluate the intravenous site each shift and as needed for redness, swelling, and discomfort. Resident #91's Order Summary Report, for the timeframe from 08/28/24 through 10/10/24, revealed an order dated 10/07/24, for reconstituted ceftriaxone 2 grams one time a day for bacterial infection arthritis. During a concurrent observation and interview on 10/08/24 at 8:37 AM, Licensed Practical Nurse (LPN) #3 applied a mask and entered Resident #91's room to administer medications to the resident. LVN #7 wore no other Personal Protective Equipment (PPE). During an observation on 10/10/24 at 8:26 AM, State tested Nursing Assistant (STNA) #16 provided Resident #91 morning care and assisted the resident to dress. The PPE put on by STNA #16 was a gown. During an observation on 10/10/24 at 8:31 AM, the medical records (MR) personnel delivered Resident #91's breakfast tray and assisted STNA #16 in transferring the resident to a wheelchair. The MR personnel only applied a pair of gloves as the PPE to assist the staff with transferring the resident. During an interview on 10/09/24 at 3:35 PM, the Infection Control Practitioner (ICP) stated residents were placed on EBP if the resident had an indwelling urinary catheter, wounds, gastrostomy tubes, any lines, and any tubes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 8:37 AM, the MR personnel stated she had not worked with Resident #91 before and did not know if the resident had a PICC line. The MR personnel stated for repositioning Resident #91 in the chair, she would only wear gloves. During an interview on 10/10/24 at 8:41 AM, Resident #91 stated the staff always wore gloves, but no gowns. During an interview on 10/10/24 at 9:05 AM, the ICP stated any resident with a PICC line should be on EBP. During a follow-up interview on 10/10/24 at 9:16 AM, the ICP stated Resident #91 did need to be on EBP. During an interview on 10/10/24 at 9:27 AM, the MDS Nurse stated she care planned Resident #91 for EBP because the resident was at a higher risk for infection related to having the PICC line. During an interview on 10/10/24 at 10:19 AM, the Administrator stated she expected staff to follow the EBP guidelines established by CMS. During a follow-up interview on 10/11/24 at 9:17 AM, the Director of Nursing stated staff should wear a gown and gloves when they provide care to Resident #91. A facility policy titled, Standard and Transmission-based Precautions, revised 03/24/24, indicated, Policy: It is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents. This policy specifies the different types of precautions, including when and how isolation should be used for a resident. The CMS Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, memorandum dated 03/20/24, revealed EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. The memorandum revealed, Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. A peripheral intravenous line (not a peripherally inserted central catheter) is not considered an indwelling medical device for the purpose of EBP. 45645 2. An Admission Record indicated the facility admitted Resident #20 on 05/25/22. According to the Admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following cerebral infarction and obstructive and reflux uropathy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/24, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #20 had an indwelling urinary catheter. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #20's care plan included a focus area initiated 06/01/22, that indicated the resident had an indwelling urinary catheter. Interventions directed staff to provide catheter care every shift and to ensure the catheter bag was in place as needed. On 10/07/24 at 9:30 AM, Resident #20 was observed resting in a low bed with the indwelling catheter drainage bag on the floor. On 10/08/24 at 7:50 AM, Resident #20 was observed asleep in a low bed with their indwelling catheter drainage bag on the floor. On 10/08/24 at 2:13 PM, State tested Nurse Aide (STNA) #14 stated Resident #20's indwelling catheter bag should not be on the floor. On 10/08/24 at 2:19 PM, STNA #17 stated Resident #20's indwelling catheter bag should not be touching the floor due to infection control concerns. On 10/09/24 at 2:28 PM, Licensed Practical Nurse #3 stated Resident #20's indwelling catheter bag should not be on the floor and must be kept as clean as possible to prevent infection. On 10/10/24 at 12:00 PM, the Director of Nursing stated Resident #20's indwelling bag should not be on the floor. On 10/10/24 at 3:35 PM, the Administrator stated the indwelling catheter bag should not be on the floor and the expectation was the staff would follow correct protocols, procedures, and standards regarding indwelling catheters.