STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375106	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookwood Skilled Nursing and Therapy	940 Southwest 84th Street Oklahoma City, OK 73139

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21731 Based on record review and interview, the facility failed to ensure information was offered to formulate an advanced directive for one #(61) of three sampled residents reviewed for advance directives. The Administrator identified 106 residents resided in the facility. Findings: Resident #61 was admitted to the facility on [DATE]. A Physician Order, dated 08/04/21, documented Resident #61 was a full code status. A Physician Order, dated 02/07/24, documented Resident #61 was to be admitted to hospice services for senile degeneration of the brain. On 04/30/24 at 12:13 p.m. the clinical record did not contain documentation that information had been offered to Resident #61, or their representative, to formulate an advanced directive. 05/01/24 at 10:30 a.m., the clinical record did not contain documentation that information had been offered to Resident #61, or their representative, to formulate an advanced directive. On 05/01/24 at 1:55 a.m., the DON was asked if information had been provided to Resident #61 or their representative to formulate an advanced directive. They stated, That should have been reviewed when hospice was ordered. On 05/01/24 at 2:10 p.m., the DON reported the facility was waiting for the daughter signature on the forms, the information had not been offered prior to hospice services and the paper work is still pending.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 41872 Based on observation, record review, and interview, and the facility failed to consult/notify the physician of missed antibiotic therapy for a resident with possible osteomyelitis for one (#59) of one sampled resident reviewed for antibiotic use. The Administrator identified 106 residents resided in the facility. The DON identified 13 residents received antibiotics. Findings: A Notification of Change Guideline policy, dated 12/01/09, read in part The facility will consult with the resident's physician of the following events .A need to alter treatment significantly . Resident #59 had diagnoses which included, right BKA, diabetic ulcer, diabetes mellitus and high cholesterol. Resident #59 had dialysis on Mondays and Fridays. An x-ray report, dated 03/20/24, read in part .Impression .Question osteomyelitis vs severe osteopenia of the fifth metatarsal head . A quarterly assessment, dated 03/30/24, documented Resident #59 had no cognitive impairment. A MAR, dated 04/11/24 through 04/17/24 documented the resident had not been administered Cipro 500 mg morning dose ordered twice a day for two of fifteen doses ordered. A MAR, dated 04/19/24 through 04/26/24, documented the resident had not been administered Cipro 250 mg daily morning dose for three of eight doses ordered. A physician order, dated 04/11/24, documented Resident #59 was to be administered Cipro 500 mg tablet twice a day. On 05/03/24 at 10:31 the Corp Nurse Consultant #1 was asked what should have been done when the resident had not been given their antibiotics. They stated the doctor should have been notified and the dose changed to night.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 35749 Based on observation and interview, the facility failed to ensure a mattress was not soiled for one (#70) of eight mattresses observed for homelike environment. The administrator identified 106 residents resided in the facility. Findings: On 04/30/24 at 11:48 a.m., Resident #70's bed was observed to be unmade and without linens. The mattress was observed with brown residue and brown rings. On 04/30/24 at 11:51 a.m., CNA #2 was asked how they ensured mattresses were kept clean. CNA #2 stated they inspected mattresses when they did linen changes. CNA #2 stated they would disinfect the mattresses twice a week. CNA #2 was shown Resident #70's bed. CNA #2 put gloves on to feel if the mattress was wet. They stated the mattress was not wet and brown ring was dried urine. CNA #2 stated the brown substance was poop.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21731 Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed every 12 months for one (#73) of 22 sampled residents reviewed for assessments. The Administrator identified106 residents resided in the facility. Findings: Resident #73 was admitted to the facility on [DATE]. The summary of assessments documented the following: a. An Admission Assessment, was completed on 04/24/23; b. Quarterly Assessments, were completed on 07/11/23, 10/11/23; 01/09/24; and 03/29/24. On 05/23/24, at 11:10 a.m., the DON, MDS coordinator, and Consultant RN, were asked when an Annual or other comprehensive assessment had been completed for Resident #73. The Consultant RN stated, It should have been completed on 03/29/24, instead of a quarterly assessment.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41872 Based on observation, record review, and interview, the facility failed to ensure MDS assessments were accurate for four (#59, 6, 34, and #61) of 22 sampled residents reviewed for MDS accurate assessments. The Administrator identified 106 residents resided in the facility. The DON identified four residents with diabetic ulcers. Findings: 1. Resident #59 had diagnoses which included, right BKA, diabetic ulcer, diabetes mellitus and high cholesterol. A skin/wound note, dated 12/27/23, documented an open area to left medial foot/left medial fifth toe area the wound bed was noted to have a a hard brown colored area. A skin/wound note, dated 01/03/24, documented the wound was to the left lateral side of the foot. A skin/wound note, dated 01/18/24, documented the resident was on antibiotics for a diabetic wound. A quarterly assessment, dated 03/30/24, documented Resident #59 had no cognitive impairment and one unstageable pressure injury as a deep tissue injury. The MDS did not document Resident #59 had a diagnosis of a diabetic foot ulcer. A wound care note, dated 04/04/24 documented the wound as a [NAME] Grade 1 diabetic ulcer not healed with a moderate amount of serous drainage noted with mild odor. The diagnosis was documented as a Type 2 diabetes mellitus with foot ulcer and non-pressure chronic ulcer of other part of left foot. On 05/02/24 at 10:48 a.m., MDS coordinator #1 was asked how they coded pressure ulcer wounds on the MDS. They stated, they got their information from the wound care team. They were asked to review the wound care note which documented a diabetic ulcer and asked if the MDS was accurate. They stated No. 21731 2. Resident #6 had diagnosis to include psychotic disorder, anxiety, atherosclerotic heart disease, depressive disorder, and bipolar disorder. A Physician Order, dated 11/09/22, documented Resident #6 was to be administered Thiothixene, an antipsychotic medication every evening for bipolar disorder. A Quarterly Assessment, dated 01/12/24, documented Resident #6 had been administered a diuretic. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Quarterly Assessment, dated 04/09/24, documented Resident #6 had been administered an antidepressant and a diuretic medication. The clinical record did not contain physician orders for an antidepressant or diuretic medication. On 05/07/24 at 8:30 a.m., the DON, MDS coordinator, and Corporate RN were asked to verify what orders were in place for Resident #6 to be administered a diuretic or an antidepressant medication, as documented on the assessments dated -1/12/24 and 04/09/24. The Corporate RN stated, I am not seeing orders for those medications, appears to be miscoded. 3. Resident #34 had diagnosis to include anxiety. A Physician Order, dated 10/16/23, documented Resident #34 was to be administered Hydroxyzine, an antihistamine, twice a day for anxiety. A Quarterly Assessment, dated 02/07/24, documented Resident #34 had been administered a antianxiety medication. On 05/02/24 at 11:07 a.m., the MDS coordinator and Corporate RN were asked if Resident #34 had been ordered or administered an antianxiety classified medication as documented on the Quarterly assessment on 02/07/24. The Corporate RN stated the orders are for Hydroxyzine, but it is classified as an antihistamine, there is not a medication classified as an antianxiety medication. They stated, the assessment is not correct. 4. Resident #61 had diagnoses to include senile degeneration of the brain, and dementia. A Significant Change of Status Assessment, dated 02/06/24, documented Resident #61: a. had clear speech, understood others and made themselves understood, b. had severe cognitive impairment for daily decision making, c. a brief interview for mental status should be conducted, and d. a resident mood interview should not be conducted due to Resident #61 is rarely or never understood. On 04/30/24 at 9:38 a.m., Resident #61 sat on the side of the bed during an interview with a family member. Resident #61 would smile when spoken to but did not engage in converstion. On 05/01/24 at 2:00 p.m., the MDS coordinator was asked how Resident #61 was assessed for communication. They stated, I spoke with [the resident]. They were asked to clarify if the resident understood others and was able to make themselves understood. They stated the resident does understand and is able to understand others. The MDS coordinator was asked how the assessment dated [DATE], would be correctly coded regarding the resident mood interview should not be conducted due to the resident is rarely or never understood. The MDS coordinator stated a correction needed to be completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 41872 Based on observation, record review, and interview, the facility failed to ensure nail care was provided for one (#76) of three sampled residents reviewed for assistance with activities of daily living. The Administrator identified 106 residents resided in the facility. The DON identified 38 residents who were dependent on staff for assistance with ADL's. Findings: A Fingernail Care policy, dated 10/01/01, read in part .Reduce spread of infections, maintain the resident's hygiene, and provide the resident with a clean and well groomed appearance . Resident #76 had diagnoses which included dementia and high blood pressure. A significant change in status assessment, dated 04/01/24, documented Resident #76 had severe cognitive impairment, and required substantial/maximal assistance with oral hygiene, toileting, showers, dressing, and personal hygiene. On 05/01/24 at 9:10 a.m., Resident #76 was observed sitting in their gerichair in the common area. Their toenails were observed to be long and overgrown. On 05/01/24 at 11:08 a.m., two staff were observed to provide perineal care to Resident #76. Resident #76's hands were observed to have brown debris under their long fingernails. On 05/01/24 at 1:35 p.m., RN #1 was asked to observe the residents fingernails and toenails. They observed the residents toenails and stated they needed to be trimmed. RN #1 then observed the residents fingernails. They were asked who is responsible to provide nail care. They stated that any staff could do it. They were asked if the residents nails were clean. They stated, No.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21731 Based on observation, record review, and interview, the facility failed to ensure: a. coordination of care with hospice for one (#61) of one sampled resident reviewed for hospice, b. wound care treatments were administered as ordered for two (#56 and #59), c. a referral was made to a wound care center as ordered for one (#59) of five sampled residents reviewed for wounds, d. a resident was in the dining room for all meals related to weight loss for one (#18) of 22 sampled residents reviewed for following physicians' orders, and e. lab tests were obtained as ordered for HgBA1C every three months for one (#8) of 22 sampled residents reviewed for following physicians orders. The Administrator identified 106 residents resided in the facility. The DON identified four resident had diabetic ulcers and 21 had hospice services. Findings: 1. Resident #61 had diagnosis to include senile degeneration of the brain. A Care Plan, dated 07/15/22, documented Resident #61: a. was to receive baths on Tuesday and Fridays during the day shift; b. nails were to be trimmed and cleaned on bath day and as necessary; c. a sponge bath would be provided when a full bath or shower could not be tolerated; and d. Resident #61 required limited staff participation with bathing. A Significant Change of Condition Assessment, dated 02/06/24, documented Resident #61 had severe cognitive impairment, and required supervision or touching to complete the bathing process. A Care Plan, dated 03/06/24, documented Resident #61 had a terminal illness and was admitted to hospice on 02/06/24. The care plan did not document how the care would be coordinated between the nursing facility and hospice providers. An undated, Visual/Bedside Kardex Report documented, as of 05/01/24, Resident #61 would receive baths on Tuesdays and Fridays during the day shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The report did not identify that Resident #61 was on hospice services, or what care would be provided by hospice services. The February 2024, bathing records for Resident #61, documented five baths were provided by hospice, on Tuesdays and Fridays. The clinical record and hospice records did not contain documentation that hospice staff were in the facility during the month of February 2024. The Hospice Staff Visit Sign-in Sheet And Communication Note, logs did not contain documentation that hospice staff had visited Resident #61 during February 2024. The March 2024, bathing records for Resident #61, documented nine baths were provided by hospice on Tuesdays and Fridays. The Hospice Staff Visit Sign-in Sheet And Communication Note, logs did not contain documentation that hospice staff had visited Resident #61 on five dates that the facility had documented hospice had provided a bath. The sign-in log documented a hospice aide had signed-in 13 days to provide care. The clinical record and hospice record, did not contain documentation by the hospice aid to indicate what care had been provided on the 13 days they had signed-in at the facility to see Resident #61. The April 2024, bathing records for Resident #61, documented eight baths were provided by hospice staff on Tuesdays and Fridays. The Hospice Staff Visit Sign-in Sheet And Communication Note, logs did not contain documentation that hospice staff had visited Resident #61 on two dates that the facility had documented hospice had provided a bath. The sign-in log documented a hospice aid had signed in 15 days to provide care. The clinical record and hospice record, did not contain documentation by the hospice aide to indicate what care had been provided on the 15 days they had signed-in at the facility to see Resident #61. The clinical record and hospice record, did not contain a hospice care plan, or provider notes to indicate coordination of care was in place. On 04/30/24 at 9:38 a.m., Resident #61's family member stated the resident had dementia that created a challenge for bathing, and the resident was placed on hospice to assist with bathing. On 05/01/24 at 2:04 p.m., the DON was asked who is responsible to ensure a resident is provided a bath. They stated the CNA or if on hospice, the CNA and the hospice. They stated Resident #61, per the care plan, was to receive a bath every Tuesday and Friday. The DON was asked where is the documentation that hospice provided bathing for Resident #61. They stated, We will need to call to get it. The DON was asked what does the hospice care plan document regarding if and when hospice staff are to provide bathing assistance. They stated, We just got the care plan. The DON was asked how was the care coordinated with hospice for resident #61. They stated, It hasn't been for this resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	35749 2. Resident #8 had diagnoses which included Diabetes Mellitus. A Physician's Progress note, dated 06/30/23, documented to obtain a HgBA1C every three months. A Physician's Progress note, dated 02/21/24, documented to continue to monitor HgBA1C every three to six months as indicated. A Physician's Progress note, dated 03/19/24, documented to continue to monitor HgBA1C every three to six months as indicated. Resident #8's clinical records were reviewed. There where no HgBA1C labs in Resident #8's records. On 05/01/24 at 10:44 a.m., the DON was asked for lab orders for Resident #8's lab orders. The DON stated Resident #8 did not have any current lab orders. On 05/01/24 at 1:14 p.m. the DON was asked to locate any HgBA1Cs for Resident #8. On 05/02/24 at 8:51 a.m., the DON was shown the physician's progress note, dated 06/30/23. They were asked if they considered this a physician's order. The DON stated, Yes. No HgBA1C labs were provided. 3. Resident #56 had diagnoses which included chronic non-pressure ulcer. A Physician's Order, dated 04/26/24, documented to cleanse the right dorsal foot with NS, pat dry, apply Dakin's moistened gauze, loosely cover with border dressing daily and prn every day shift related to a non-pressure chronic ulcer of the right dorsal foot. An April 2024 Treatment Administration Record, documented ulcer treatment had been provided for the right dorsal foot as ordered. On 04/29/24 at 1:34 p.m. Resident #56 was observed in bed, positioned toward their right side. A dressing, dated 04/26/24, was observed to the top of their right foot. Resident #56 was asked how often staff changed the dressing. They stated every few days. On 04/29/24 at 2:45 p.m., CNA #3 was asked to observe Resident #56. CNA #3 was asked what date was on the dressing to Resident #56's top of right foot. They stated 04/26/24. On 04/2924 at 2:51 p.m., LPN #2 was asked who was responsible for providing wound care. They stated the wound care nurse did wound care Monday through Friday and the charge nurses did it on the weekends. LPN #2 was asked what the frequency was for Resident #56's top of right foot wound. They stated daily. On 04/29/24 at 2:55 p.m., LPN #2 was shown Resident #56's dressing to the top of the right foot. They were asked the date on the dressing. LPN #2 stated 04/26/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #2 was asked what the policy was for providing wound care. They stated wound care to the right dorsal foot was to be provided daily. 41872 4. Resident #59 had diagnoses which included, right BKA, diabetic ulcer, diabetes mellitus and high cholesterol. A quarterly assessment, dated 03/30/24, documented Resident #59 had no cognitive impairment A wound care note, dated 04/04/24 documented the wound as a [NAME] Grade 1 diabetic ulcer not healed with a moderate amount of serous drainage noted which has a mild odor. The wound is deteriorating. The diagnosis was documented as a Type 2 diabetes mellitus with foot ulcer and non-pressure chronic ulcer of other part of left foot. A physician order, dated 04/11/24, documented Resident #59 was to be administered Cipro 500 mg one tablet twice a day. To clean the wound with normal saline apply silvadene, cover with fibracol and secure with a clean bandage. A physician note, dated 04/19/24, documented to refer to wound care center for wounds to left foot and to follow wound care instructions as ordered. The physician note dated 04/19/24, was not available to staff, until requested by surveyor on 05/03/24. A physician order, dated 04/29/24, documented to clean the wound with saline, apply a thin layer of silvadene, then fibracol and secure with bandage. Resident #59's TAR dated 05/01/24 through 05/31/24, dressing change did not have initials (was blank) on 05/02/24. The clinical health record did not document why the residents wound care had not been changed on 05/02/24. On 05/03/24 at 8:03 a.m., Resident #59 stated RN #1 or LPN #4 usually changed their dressing, but it had not been changed yesterday. On 05/03/24 at 8:13 a.m., CNA #5 was asked what date did they observe on Resident #59's dressing. They stated there was no date. On 05/03/24 at 846 a.m. LPN #4 was observed to complete wound care to Resident #59's left foot. On 05/03/24 at 855 a.m., LPN #4 was asked what date was on the dressing they had removed. They stated they did not know. They were asked to review the May TAR and asked what did the blank mean on 05/02/24. They stated that it means it wasn't clicked off. They were unsure. On 05/03/24 at 11:07 a.m., RN #1 was asked if they had changed Resident #59's dressing yesterday (05/02/24). They stated No. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/06/24 at 9:35 a.m., the DON provided a copy of the physician note from the foot and ankle clinic, dated 04/18/24. They were asked if the resident had been seen by wound care. They stated they had just got the report. They were asked if the resident had been referred to a wound care center for the wound to their left foot. They stated, I just got this. There was no documentation Resident #59 had been referred to a wound care center as ordered by the physician on 04/18/24. 5. Resident #18 has diagnoses which included dementia, type two diabetes mellitus, high blood pressure and mood disorder. A physician order, dated 03/28/23, documented Resident #18 was to be in the dining room for all meals related to weight loss. Resident #18's care plan, date initiated 07/26/23, documented the resident was to in the dining room for each meal due to weight loss. A significant change in status assessment, dated 11/07/23, documented supervision or touching assistance with eating. On 04/30/24 at 11:57 a.m., Resident #18 was observed with their hall tray on their over the bed table. On 04/30/24 at 12:04 p.m., Resident #18 was observed to have eaten one bite of their rice. On 04/30/24 at 1:35 p.m., Resident #18 was still sitting in their bed with the plate of food on the over the bed table. On 05/01/24 at 845 a.m., Resident #18 was observed in their bed with a breakfast tray in front of resident on the over the bed table. On 05/02/24 at 9:36 a.m., the DON was shown the order to be in the dining room for all meals and asked if the order was still active. They stated, If it is still on here then it would be. The DON was asked how staff knew the resident should be taken to the dining room for all meals. They stated, the charge nurse needs to make sure and let them know and ensure the resident is taken to the dining room. They were asked if the resident had been in the dining room. They stated, No. They were asked if the physician orders had been followed. They stated the resident had not been up for meals.

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	375106	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 35749 Based on observation, record review, and interview, the facility failed to ensure pressure ulcer treatment were provided as ordered for one (56) of three sampled residents reviewed for pressure ulcers. The Resident Matrix, dated 04/30/24, documented 13 residents had pressure ulcers. Findings: A Pressure Ulcer policy, dated 03/25/11, read in part, .Purpose .To provide a systematic, standardized approach to the prediction, prevention, and management of pressure ulcers . Resident #56 had diagnoses which included chronic non-pressure ulcers and DTI. A Physician's Order, dated 04/26/24, documented to cleanse the right lateral foot with NS, pat dry, apply nickel thick Santyl, durafiber, and cover with border foam dressing daily and prn. An April 2024 Treatment Administration Record, documented pressure ulcer treatment for the right lateral foot had been provided as ordered. On 04/29/24 at 1:34 p.m. Resident #56 was observed in bed, positioned toward their right side. A dressing, dated 04/26/24, was observed to the top of their right foot. A bed pad under Resident #56's right foot was observed to have yellow, tan, and pink colored drainage. Resident #56 was asked how often staff changed the dressing. They stated every few days. On 04/29/24 at 2:45 p.m., CNA #3 was asked to observe Resident #56. CNA #3 was asked what date was on the dressing to Resident #56's top of right foot. They stated 04/26/24. CNA #3 stated they would go tell the nurse about the drainage. On 04/2924 at 2:51 p.m., LPN #3 was asked who was responsible for provided pressure ulcer care. They stated the wound care nurse did wound care Monday through Friday and the charge nurses did it on the weekends. LPN #2 was asked what the frequency was for Resident #56's top of right foot wound. They stated daily. On 04/29/24 at 2:55 p.m., LPN #2 was shown Resident #56's dressing to the top of the right foot. They were asked the date on the dressing. LPN #2 stated 04/26/24. LPN #2 lifted Resident #56's right foot off of the bed pad. An open area, approximately the size of a silver dollar with necrotic tissue to approximately 80% of the wound, and red peri-wound, was observed to the right lateral foot. no dressing in place. The bed pad under Resident#56's right lateral foot was tan, yellow, and pink tinged. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #2 was asked what the policy was for providing wound care. They stated wound care to the right dorsal foot and right lateral foot were to be provided daily. LPN #2 was asked what staff would do if a wound dressing came off. They stated they would put on in place. LPN #2 was asked how staff ensured wound treatments were provided. They stated a wound care nurse does the dressing Monday through Friday and a charge nurse would do them on the weekends.

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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. 41872 Based on observation, record review, and interview, the facility failed to ensure smoking products (lighter) were kept secure on the nurses cart for one (#211) of one sampled resident who required supervision while smoking. The Administrator identified 106 residents resided in the facility. The DON identified 15 residents who smoked, one resident required supervision. Findings: A Smoking Policy and Procedure, dated 02/24/20, read in part .Residents who require supervision to smoke must surrender their cigarettes and lighters or matches to facility staff for safe keeping . Resident #211 had diagnoses which included, diagnosis paroxysmal atrial fibrillation, anoxic brain damage and angina. A Smoking Assessment, dated 04/26/24, read in part .Decision making .severely impaired .Resident must keep cigarettes/lighter on nurse's cart. Resident requires staff or family to accompany outside while smoking . Resident #211's care plan, dated 04/28/24, documented the resident was a supervised smoker, and the facility was to keep cigarettes and lighter for safe keeping. On 04/29/24 at 2:03 p.m., a lighter was observed on the residents over the bed table. They were asked if they smoked, they stated yes. On 04/30/24 at 9:07 a.m., Resident #211 was observed outside smoking with staff present. An entry assessment, dated 05/01/24, documented Resident #211 had severe cognitive impairment, and used tobacco products. On 05/01/24 at 9:07 a.m., a blue lighter was observed on the residents over the bed table. On 05/02/24 at 9:40 a.m., the DON was shown the smoking assessment and informed of the two observations of a lighter in the resident's room. The DON was asked if the resident had to be supervised while smoking. They stated Yes. The DON was asked if the smoking policy had been followed. They stated, no. They were asked how does staff know which residents can keep their cigarettes and lighters. They stated we try to communicate with staff.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 41872 Based on observation, record review, and interview, the facility failed to ensure: a. an individual narcotic count sheet was correct for one (#59) of three narcotic counts completed, and b. eight hour verification sheets was signed by staff at shift change for one of four sampled medication carts. The Administrator identifed 106 residents resided in the facility. Findings: A Controlled Substance Storage policy, dated January 2022, read in part .At each shift change, or when keys are transferred, a physical inventory of all controlled substances including refrigerated items is conducted by two licensed nurses/CMA's and is documented . A physician order, dated 11/15/23, documented to administer Oxycodone 5 mg every eight hours as needed for pain. Resident #59's MAR, dated 05/01/24 through 05/02/24 documented Resident #59 had received a prn dose on 05/01/24 and 05/02/24. a. On 05/03/24 at 9:51 a.m., a narcotic count was completed with CMA #2. Resident # 59's narcotic count sheet documented there were 37 pills left. The medication card had 38 pills remaining in the card. Resident #59's individual narcotic record, dated 05/02/24 documented 37 Oxycodone 5 mg pills remained. On 05/03/24 at 10:31 a.m., Corp Nurse Consultant #1 was informed about narcotic count sheet discrepancy on cart 200. They stated they reviewed Resident #59's MAR and it was documented it had been given, but may have not been punched out. They were unsure if Resident #59 had received the medication. b. An Eight Hour Verification form, dated 04/27/24 through 05/03/24, did not have signatures, shift change counts had been completed for seven of thirty seven times. An eight hour verification sheet, dated 03/01/24 through 03/31/24 had missing signatures for 22 different shift changes out of 31 days. An eight hour verification sheet, dated 04/01/24 through 04/30/24 had missing signatures for 21 different shift changes out of 30 days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An eight hour verification sheet, dated 05/01/24 through 05/02/24, had missing signatures for one different shift change out of two days. On 05/03/24 at 11:11 a.m., Pharmacy Consultant #1 was shown the eight hour verification sheets for March, April and May 2024. They were asked if there should be blanks (signatures) on the verification report. They stated, No. On 05/06/24 at 9:21 a.m., Corp Nurse Consultant #1 was shown the eight hour verification sheets, they stated if staff work doubles they should have put a slash in the blank spots. They were asked if the sheets had been filled out correctly according to policy. They stated, No.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41872 Based on observation, record review, and interview, the facility failed to ensure infection control was maintained during medication pass, when staff were observed to touch medications with their bare hands for two (CMA #1 and CMA #2) of three CMA's observed preparing medications. The Administrator identified 104 residents resided in the facility. Findings: A Specific Medication Administration procedure, dated January 2022, read in part, .Pour or push the correct number of tablets or capsules into the souffle cup, taking care to avoid touching the tablet or capsule, unless wearing gloves . 1. On 05/03/24 at 9:37 a.m., CMA #3 was observed preparing medications for a resident. They were observed to pop a pill from a medication blister pack, it fell on to the medication cart, they picked it up with their bare hands, placed it in the medication cup, and administered it to a resident. On 05/03/24 at 9:40 a.m., CMA #3 was asked if the pill had dropped on the cart. They stated, Yes. CMA #3 was asked how they put the pill in the medication cup. They stated with their fingers. CMA #3 was asked what the the policy was for touching medications with bare hands. They stated they should not do that. 2. On 05/03/24 at 9:41 a.m., CMA #1 was observed popping medications out of 14 blister packs into their bare hand. On 05/03/24 at 9:45 a.m., CMA #1 was asked what the policy was for administering medications. They stated they looked at the MAR, sanitized their hands before they entered a residents' room, and introduce them self. CMA #1 stated they come out and sanitize their hands again. CMA #1 was asked what the policy was for touching medications with their bare hands. They stated they don't touch the medications, they pop them into a medicine cup. CMA #1 was asked if they popped medications out of the blister packs, into their hand, and placed them into the medicine cup. CMA #1 stated, No, I popped them into a cup. On 05/03/24 at 10:321 a.m., Corp Nurse Consultant #1 was asked if staff should touch medications with their bare hands. They stated no. They were asked what staff should do if the medications falls on the cart. They stated, staff should discard the pill and get another one.