STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375381	A. Building B. Wing	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baptist Village of Oklahoma City	9700 Mashburn Blvd Oklahoma City, OK 73162

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216 Based on observation and interview, the facility failed to promote resident dignity by staff standing over a resident while assisting them to eat. The DON identified 101 residents resided in the facility. Findings: Resident #76 admitted to the facility on [DATE] with diagnosis which included Alzheimer's disease. A quarterly assessment, dated 04/04/24, documented the resident's cognition was severly impaired and they required supervision or touching assistance with eating. On 07/15/24 at 8:08 a.m., LPN #1 pulled a chair over to a table near the TV in the dining area. LPN #1 began assisting Resident #76 with his meal. LPN #1 was standing while they assisted Resident #76 with their meal. On 07/15/24 at 8:23 a.m., LPN #1 continued to assist Resident #76 with their meal. LPN #1 continued to stand while assisting. 07/15/24 at 9:09 a.m., LPN #1 stated they were standing while assisting Resident #76 with their meal. They stated that was not the policy, per policy staff should be seated when assisting residents with their meals. On 07/19/24 at 9:14 a.m., the DON stated staff should be siting when assisting residents with meals.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 48344 Based on observation, record review, and interview, the facility failed to ensure a resident had a physician order and an assessment to self-administer medications for one (#1) of one sampled resident reviewed for self-administration of medications. The DON identified 101 residents resided in the facility. Findings: The Baptist Village Communities Self-Administration of Medications policy, dated 02/20/24, read in part, .The interdisciplinary team will assess the resident to determine if self-administration of medication is clinically appropriate, safe, and feasible. The policy also read, .A physician's order will be obtained and recorded in the chart. The order also will include which specific medications can be kept at the beside. On 07/15/24 at 8:34 a.m., A bottle of saline nasal spray was observed on Resident #1's nightstand. The Resident stated they self-administered the nasal spray at night. There was no documentation the resident had physician orders to self-administer medications or for the use of the nasal spray. On 07/18/24 at 11:56 a.m., LPN #2 stated Resident #1 did not have a physician order or an assessment for the self-administration of the saline spray they observed in the Resident's room. On 07/19/24 at 7:53 a.m., the DON stated a self-administration evaluation and a physician order was needed for medications at bedside.

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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. 49701 Based on record review and interview the facility failed to notify residents they were allowed to have resident council without staff present. The facility's deficient practice interfered with the resident's right to hold group meetings privately. The DON identified 101 residents resided in the facility. Findings: A Resident Rights: Resident and Family Groups policy, dated 02/20/24, stated team members, visitors and other guests may only attend the meeting upon invitation. On 07/17/24 at 10:55 a.m., the nine residents in attendance stated they were unaware they were allowed to have a resident council meeting without staff present. The social service staff member stated the were unaware but would review the policy.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 49701 Based on observation, record review and interview, the facility failed to ensure the ombudsman's contact information was posted in view of residents. The facility's deficient practice interfered with the resident's rights to communicate and access the state's ombudsman office. The DON identified 101 residents resided in the facility. Findings: Review of the facility's policy titled Resident Rights provided by the Administrator revealed .resident's right to . communication with and access to people and services, both inside and outside the facility .exercise his or her rights as a resident of the facility and as a resident or citizen of the United States .exercise his or her rights without interference, coercion .from the facility communicate with outside agencies .state long-term care ombudsman . On 07/17/24 at 11:36 a.m., an interview with the nine resident council members in attendance revealed they were unaware of who the ombudsman was, what their purpose was, or where to find that information. On 07/17/24 at 11:43 a.m., an eight by ten document with the Ombudsman name was located on the information board by the long-term care halls, but was written in small print, displayed out of view for resident's utilizing a wheelchair. There was no information board located on the skilled halls.

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 49701 Based on interview, the facility failed to provide mail delivery to residents on Saturdays. The DON identified 101 residents resided in the facility. Findings: On 07/17/24 at 11:22 a.m., nine members of resident council stated the mail did not get distributed on the weekends. On 07/17/24 at 11:24 a.m., the social services staff stated mail gets delivered Saturdays but does not get passed out until Monday.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 49701 Based on observation and interview, the facility failed to ensure survey results were readily accessible/available to residents and visitors. The DON identified 101 residents resided in the facility. Findings: On 07/17/24 at 11:28 a.m., the nine resident council members stated they did not know where the state inspection book was. On 07/17/24 at 11:43 a.m., a sign was observed posted on the information board on the long-term care halls. The sign documented that survey results could be found at the front desk. There was no sign or mention of the survey results by the skilled halls.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49701 Based on interview and record review, the facility failed to ensure residents and resident representatives were able to file a grievance form anonymously and post information regarding the name of the grievance official. The DON identified 101 residents resided in the facility. Findings: A Grievance Policy and Procedure, dated 02/2024, read in part the health center will provide a mechanism for filing a grievance/complaint without fear of retaliation .will provide residents, resident representatives and others information about the mechanisms and procedure to file a grievance; provide a designated individual to oversee the grievance process . On 07/17/24 at 11:10 a.m., the resident council members stated they did not know how to file a grievance, but that staff usually take care of their issues. On 07/17/24 at 11:22 a.m., the social services staff stated they were not positive who the grievance official was.

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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** 46216 Based on record review and interview, the facility failed to accurately complete a quarterly assessment for one (#45) of 21 sampled residents for accurate MDS assessments. The DON identified 101 residents resided in the facility. Findings: The Facility's Comprehensive Care Plan Policy and Procedure, dated 02/20/24, documented the facility must conduct initially and periodically a comprehensive, accurate, standardized assessment. Resident #45 admitted to the facility on [DATE] with diagnoses which included parkinsonism and psychotic disorder with hallucinations. A physician's order, dated 02/19/24, documented to administer 34 mg of Nuplazid (antipsychotic medication) at bedtime. An admission assessment, dated 03/01/24, document Resident #45 had not received antipsychotic medications. The Feburary MAR documented the Nuplazid had been administered each day of the look back period. On 07/19/24 at 11:11 a.m., MDS Coordinator #1 stated the admission assessment did not document Resident #45 had taken an antipsychotic. On 07/19/24 at 11:12 a.m., MDS coordinator #1 stated the resident had received the Nuplazid during the look back period. They stated the admission assessment had not been coded correctly.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344 Based on observation, record review, and interview, the facility failed to ensure a care plan was revised to include the use of bed rails for two (#4 and #19) of two sampled residents whose care plans were reviewed for bed rail use. The DON identified 101 residents resided in the facility. Findings: The Baptist Village Communities Comprehensive Care Plan Policy and Procedure dated 02/20/24, read in part, The comprehensive care plan .will be updated quarterly .or as needed/identifies as preference changes occur or healthcare need warrant. The BAPTIST VILLAGE COMMUNITIES BED RAIL POLICY AND PROCEDURE dated 02/20/24, read in part, Resident care plan will include use of bed rails as evaluated. 1. Resident #4 had diagnoses which included fracture of right lower leg and need for assistance with personal care. On 07/17/24 at 7:45 a.m., Resident #4 was observed in bed with two bed rails up on each side of the head of the bed. Resident #4's care plan did not document the use of bed rails. On 07/17/24 at 12:29 p.m., MDS Coordinator #2 stated the use of positioning rails was not documented in the Resident's care plan. They stated it should have been documented. 2. Resident #19 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis. On 07/18/24 at 9:18 a.m., the DON stated Resident #19 had the bed rails since admission. Resident #19's care plan did not document the use of bed rails. On 07/18/24 at 9:35 a.m., MDS Coordinator #2 stated the use of positioning rails was not documented in the Resident's care plan.

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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. 48344 Based on observation, record review, and interview, the facility failed to provide care in a timely manner to a resident with a fractured finger for one (#40) of three sampled residents reviewed for falls. The DON identified 101 residents resided in the facility. Findings: Resident #40 had diagnoses which included parkinsonism and pain. A nursing note, dated 02/18/24, documented Resident #40 had a fall and complained of pain to their right hand. An x-ray report, dated 02/19/24, documented acute fracture in the right proximal phalanx of the fourth finger with mild soft tissue swelling. A physician's order, dated 02/19/24, documented ice pack, four times daily for 14 days. Apply ice pack to right hand for 20 minutes max. A physician's order, dated 02/20/24, documented appointment ortho hand specialty referral, send x-ray result. Resident #40 was not seen by any provider until 03/17/24. A physician's order, dated 03/17/24, documented buddy tape 3-4 fingers for three weeks. Resident #40 was first seen for the ortho consult on 04/03/24. On 07/15/24 at 9:19 a.m., Resident #40 stated they fell in 02/24 and broke their ring finger. They stated they did not get therapy for the finger and did not see an ortho surgeon for two months. On 07/17/24 at 10:52 a.m., LPN #4 stated Resident #40 did not see the ortho hand specialist until 04/03/24. They stated the appointment was not set up and they should have followed up to prevent delay in care. On 07/17/24 at 11:03 a.m., LPN #4 stated Resident #40 had a delay in receiving care. On 07/18/24 at 8:48 a.m., the DON stated Resident #40 was first seen by a provider on 03/17/24. On 07/18/24 at 9:14 a.m., the DON stated the interventions implemented between 02/18/24 through 03/17/24 were ice pack and Tylenol as needed for pain.

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48344 Based on observation, record review, and interview, the facility failed to prevent a decrease in range of motion for one (#40) of one sampled resident reviewed for limited range of motion. The DON identified 101 residents resided in the facility. Findings: Resident #40 had diagnoses which included parkinsonism and pain. A nursing note, dated 02/18/24, documented Resident #40 had a fall and complained of pain to their right hand. An x-ray report, dated 02/19/24, documented acute fracture in the right proximal phalanx of the fourth finger with mild soft tissue swelling. A physician's order, dated 03/17/24, documented buddy tape 3-4 fingers for three weeks. A Provider office visit note, dated 04/03/24, documented a boutonniere deformity of the right ring finger and difficulty with extension. It documented Resident #40 was placed in a finger splint and consult placed for surgical evaluation. On 07/15/24 at 9:19 a.m., Resident #40 stated they fell in 02/24 and broke their ring finger. They stated they did not get therapy for the finger and did not see an ortho surgeon for two months. On 07/17/24 at 9:34 a.m., observations were made of Resident #40's right ring finger. The Resident stated they were unable to straighten their ring finger. They stated the facility did not provide range of motion exercise to their finger. There was no documentation the buddy tape was applied as ordered. On 07/17/24 at 11:06 a.m., LPN #4 stated Resident #40 had a decline in hand functionality in the first six weeks of the fracture due to pain and swelling. They stated they do not know if the Resident could straighten their ring finger prior to the fracture. On 07/17/24 at 11:10 a.m., LPN #4 reviewed Resident #4's records. They could not locate documentation the buddy tape was applied as ordered. On 07/18/24 at 9:15 a.m., the DON stated the buddy tape order was not implemented. On 07/18/24 at 9:14 a.m., the DON stated no range of motion or physical therapy was provided to the resident to prevent a decrease in range of motion to Resident #40's fractured finger. They stated they should have provided the Resident with range of motion, physical therapy, and an order to monitor the fractured finger.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46216 On 07/15/24, an Immediate Jeopardy (IJ) situation was determined to exist related to the facilities failure to ensure the shower room door on the memory care unit closed and locked behind them to ensure residents were not able to enter the room. On 7/15/24, during initial tour, the shower room floor was wet and slippery, there was a hair dryer placed in the grab bar area and it was plugged it to the electrical outlet. There were greater than 10 bottles of shampoos, conditioners, alcohol based surface cleaner, and shaving cream covering over half of the shower bench. The cabinet in the shower room was unlocked, razors within reach. Staff stated the shower room door was supposed to close behind them automatically. On 07/15/24 at 4:47 p.m., the Oklahoma State Department of Health was notified and verified the existence of the IJ situation related to the shower room door being unsecured on the memory care unit. On 07/15/24 at 4:55 p.m., the Administrator was notified of the IJ situation. On 07/16/24 at 7:19 a.m., an acceptable plan of removal was submitted to the Oklahoma State Department of Health. The plan of removal documented: 1. The shower room door was trimmed to ensure self-closure by 1800 on 07/15/24. 2. By 10:15 a.m. on 07.15.24, the hair dryer had been removed from the grab bar and locked in the shower room cabinet. At 1700, the hair dryers were removed from the locked cabinet and completely removed from the shower room. 3. The ten bottles of shampoos, conditioners, alcohol-based surface cleaner and shaving cream were removed from the shower room by 10:15 a.m. on 07/15/24. 4. The cabinet in the shower room was locked by 10:15 a.m. on 07/15/24. 5. All nursing team members in the building were educated by 10:15 a.m. on 07.15.24, and all remaining team members were educated by 2000 on 07.15.24. Proof of education is attached. The IJ was lifted, effective 07/17/24 at 8:55 a.m., when all components of the plan of removal had been completed. The deficiency remained at an isolated level with a potential for harm. Based on observation, record review, and interview, the facility failed to ensure the residents were free from accident hazards for 28 residents who resided on the memory care unit. The DON identified 28 residents resided on the memory care unit. Findings: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Know Your Rights policy, undated, read in part, You have the right to a safe, clean, comfortable, and homelike environment. On 7/15/24 at 9:39 a.m., during initial tour, the shower room floor was wet and slippery, there was a hair dryer placed in the grab bar area and it was plugged it to the electrical outlet. There were greater than 10 bottles of shampoos, conditioners, alcohol based surface cleaner, and shaving cream covering over half of the shower bench. On 07/15/24 at 9:41 a.m., the cabinet in the shower room was unlocked, razors within reach. Two emergency call lights were observed to be looped around grab bars in the shower room, they were unable to be pulled to alert staff for assistance. On 07/15/24 at 9:47 a.m., LPN #1 stated the shower room door was to be shut and locked. They stated the hair dry was not to be plugged in and the chemicals were not to be there. They stated the running water posed a hazard and the call lights should not be wrapped around the grab bar. LPN #1 stated residents were not to be in the shower room without staff.

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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. 48344 Based on observation, record review, and interview, the facility failed to ensure oxygen tubing and concentrator filters were changed per physician's order for one (#4) of one resident sampled for respiratory care. The DON identified 11 residents used supplemental oxygen in the facility. Findings: The Baptist Village Communities Oxygen Administration Procedure policy, dated 05/24, read in part, Change nasal cannula .weekly. Resident #4 had diagnoses which included chronic respiratory failure and chronic obstructive pulmonary disease. A physician's order, dated 04/10/24, documented change nasal cannula, clean filters, and dry concentrator filters one time weekly. On 07/15/24 at 7:59 a.m., Resident #4's oxygen tubing on the concentrator was dated 06/24/24. The oxygen tubing on the portable tank was dated 06/03/24. The concentrator filters had dust build up. On 07/15/24 at 3:33 p.m., LPN #3 stated oxygen tubing and concentrator filters were to be changed once a week. On 07/15/24 at 3:36 p.m., LPN #3 made observation of Resident #4's oxygen tubing and filters on the concentrator, and tubing on the portable oxygen tank. They stated the tubing were not changed and the filters were not cleaned as ordered.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48344 Based on observation, record review, and interview, the facility failed to ensure a resident was assessed for the use of bed rails, an order and consent had been obtained prior to installation for two (#4 and #19) of two sampled residents reviewed for bed rails. The DON identified 13 residents who used bedrails in the facility. Findings: The BAPTIST VILLAGE COMMUNITIES BED RAIL POLICY AND PROCEDURE dated 02/20/24, read in part, completion of individual bed rail evaluation. The policy also read, .obtain informed consent from resident and/or resident representative .obtain physician order for medical symptoms evaluating the need for bed rail use. 1. Resident #4 had diagnoses which included fracture of right lower leg and need for assistance with personal care. Resident #4's quarterly resident assessment, dated 06/18/24, documented Resident #4 required extensive assistance with transfers. On 07/17/24 at 7:45 a.m., Resident #4 was observed in bed with two rails up on each side of the head of the bed. There was no documentation the facility assessed the Resident prior to the use of bed rails and no documented order for the bed rails. On 07/17/24 at 10:24 a.m., CNA #2 made observation of Resident #4's bed rails. They stated the resident used the rails to aide in positioning. On 07/17/24 at 11:14 a.m., LPN #4 stated the Resident had used the positioning rails since 01/24. On 07/17/24 at 11:17 a.m., LPN #4 stated there should be a form the facility and resident family filled out prior to the use of the positioning rails, an assessment completed, and should have a physician's order. They stated they could not locate any of the above documents for Resident #4. On 07/17/24 at 12:04 p.m., the Director of Quality stated they could not locate an assessment and consent form for the use of the positioning rails for Resident #4. 2. Resident #19 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis. Resident #19's quarterly resident assessment, dated 07/02/24, documented the Resident had severe cognitive impairment and required extensive assistance with transfers. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/18/24 at 9:18 a.m., the DON stated Resident #19 had the bed rails since admission. There was no documentation the facility assessed the Resident prior to the use of bed rails and no documented order for the bed rails. On 07/18/24 at 10:31 a.m., the DON stated there was no physician's order, consent, or an assessment for the use of the positioning bed rails for Resident #19.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 46216 Based on observation, record review, and interview, the facility failed to ensure staffing information, which included the facility name, date, actual hours worked for RNs, LPNs, CMAs, and CNAs, and the resident census was posted in a prominent place readily accessible to residents and visitors. The DON identified 101 residents resided in the facility. Findings: On 07/15/24 at 7:14 a.m., a tour of the memory care unit was conducted to locate posted nursing staffing information. A plastic note holder located outside of the nurses' station had a daily assignment sheet, there was a list of staff members working the 7:00 a.m. to 3:00 p.m. shift. The date 07/15/24 was located near the left upper side of the page. There was no census or actual hours worked documented. There were no RNs listed on the page. On 07/17/24 at 7:05 a.m., a tour of the facility was conducted to locate posted nursing staffing information. Plastic note holders were located on each unit with daily assignment sheets, there was a list of staff members working the 7:00 a.m. to 3:00 p.m. shift. The date 07/15/24 was located near the left upper side of the pages. There was no census or actual hours worked documented. There were no RNs listed on the pages. On 07/19/24 at 9:20 a.m., the AIT stated we don't put the hours on there, it is for eight hour shift. On 07/19/24 at 9:21 a.m. the AIT stated the assignment sheet did not have the census on it. They stated they had RNs in the building but it was not posted unless it was on the assignment sheet.

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F 0758 Level of Harm - Actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216 Based on record review and interview, the facility failed to review medications for a gradual dose reduction for four (#14, 33, 40, and #41) of five sampled residents reviewed for unnecessary medications. The DON identified 14 residents were on psychotropics medications in the facility. Findings: The Baptist Village Communities Psychotropic Medication Policy and Procedure, dated 02/20/24, read in part, Residents who receive psychotropic medications will receive gradual dose reductions and behavioral interventions unless clinically contraindicated with the intention to decrease or discontinue the use of the psychotropic medication whenever safe and possible. 1. Resident #40 had diagnoses which included dementia and depression. A physician's order, dated 03/09/22, documented escitalopram 10 mg, give one tablet by mouth daily for depression. A physician's order, dated 03/12/23, documented trazodone 50 mg tablet, may give two 25 mg to equal 50 mg one time daily for depression. A review from 07/23 of Resident #40's monthly medication regimen review did not document a recommendation for a gradual dose reduction. On 07/18/24 at 2:19 p.m., the Pharmacist stated they did not suggest a gradual dose reduction recommendation for Resident #40. They stated they were following the Resident's wishes. 2. Resident #14 had diagnoses which included emotional lability and anxiety. A physician's order, dated 05/30/23, documented effexor 75 mg extended release every one day, give with 150 mg to equal 225 mg daily with breakfast for emotional lability. A physician's order, dated 05/30/23, documented effexor 150 mg extended release every one day, give with 75 mg to equal 225 mg daily with breakfast for emotional lability. A physician's order, dated 05/30/23, documented Xanax 0.25 mg tablet at hour of sleep at 10:00 p.m. for anxiety. A physician's order, dated 06/27/22, documented Seroquel 50 mg tablet at hour of sleep for emotional lability. (continued on next page)

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F 0758 Level of Harm - Actual harm Residents Affected - Few	A physician's order, dated 06/27/22, lamotrigine 25 mg, give two tablets to equal 50 mg at bedtime for emotional lability. A review from 07/23 of Resident #14's monthly medication regimen review did not document a recommendation for a gradual dose reduction. On 07/19/24 at 10:35 a.m., the Pharmacist stated they suggested a gradual dose reduction on the above medications on 01/16/24. They stated the Resident did not want their medications changed. A Pharmacist Consult to Provider, dated 01/16/24, documented to continue the above medication regimen as is due to resident behaviors. On 07/19/24 at 10:53 a.m., the APRN, was asked if they considered the above Pharmacist Consult to Provider a gradual dose reduction recommendation for Resident #14's medications. They stated it was not a gradual dose reduction recommendation. 3. Resident #33 admitted on [DATE] with diagnoses which included Alzheimer's disease and dementia. A physician's order, dated 07/24/23, documented to administer 3 mg of melatonin at bedtime for insomnia. A physician's order, dated 07/24/23, documented to administer 75 mg of bupropion HCL (anti-depressant) twice daily for depression. A physician's order, dated 07/24/23, documented to administer 100 mg of Zoloft (anti-depressant) daily for depression. A physician's order, dated 09/05/23, documented to administer 0.5 mg of risperidone (anti-psychotic) at bedtime for dementia with psychotic disturbance. A review of the October 24 MAR, documented Resident #33 had received the above medications as scheduled from 10/01 through 10/15/23. A Resident Incident Reporting Form, dated 10/15/23, read in part, Resident states he fell when leaving the bathroom. This nurse noted him laying on his left side complaining of high stabbing pain on his right side hip area .Called provider on call who stated to send to hosp [sic]. There was no documentation of a review of residents medication. An X-ray was obtained on 10/15/23 at the hospital. The discharge summary documented a diagnosis of acute, moderately displaced interochanteric fracture of the proximal right femur. A monthly drug regimen review, dated 09/11/23, did not contain documentation to gradually reduce any of the above medications. A monthly drug regimen review, dated 10/20/23, documented the psychoactive agents would be addressed at the next onsite visit. Resident #33 returned to the facility on [DATE]. (continued on next page)

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F 0758 Level of Harm - Actual harm Residents Affected - Few	A physician's order, dated 10/20/23, documented to administer 75 mg of bupropion HCL (anti-depressant) twice daily for depression. A physician's order, dated 10/20/23, documented to administer 100 mg of Zoloft (anti-depressant) daily for depression. A physician's order, dated 10/20/23, documented to administer 0.25 mg of risperidone (anti-psychotic) at bedtime for dementia with psychotic disturbance. A physician's order, dated 10/20/23, documented to administer 25 mg of Seroquel (anti-psychotic) daily for dementia with psychotic disturbance. A monthly drug regimen review, dated 11/13/24, did not contain documentation to gradually reduce any of the medications ordered on 10/20/23. A monthly drug regimen review, dated 11/30/24, documented the psychoactive agents would be addressed on the next onsite visit. A monthly drug regimen review, dated 12/09/23, documented a request to discontinue arformoterol 15 mcg per 2 ml. A monthly medication review, dated 01/14/24, documented chart notes indicate continues to have inappropriate behaviors. Has had no recent falls. May we continue? A monthly medication review, dated 02/16/24, documented orders and chart notes reviewed. No recent changes in medication. No reported falls or significant problems of late. Recommend no changes for now. A monthly medication review, dated 04/15/24, documented orders and chart notes reviewed. Two noted falls earlier this month. Can be very aggressive with staff and others. Will not challenge his psychoactive regimen at this time. Suggest no changes for now. A monthly medication review, dated 06/24/24, documented stable currently. No reported falls or significant problems of late. Will wait full 6 months to challenge his psychoactive regimen again. 4. Resident #41 admitted on [DATE] dementia with other behavioral disturbances. A physician's order, dated 02/23/24, documented to administer 25 mg (2 tabs) of quetiapine twice daily for vascular dementia with other behavioral disturbance. A physician's order, dated 06/27/24, documented to administer 25 mg of quetiapine daily related to behaviors On 07/17/24 at 9:20 a.m., the pharmacist stated appropriate Seroquel (generic: quetiapine) was an appropriate medication for dementia with psychosis. (continued on next page)

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F 0758 Level of Harm - Actual harm Residents Affected - Few	The FDA warning, documented, elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel is not approved for the treatment of patients with dementia-related psychosis. 48344

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46653 Based on observation, record review and interview the facility failed to ensure breakfast menu was posted. Findings: The DON reported 101 residents, resided in the facility. The facility's policy Menu Posting and Menu Substitution dated 1/24, read in part Menus are to be posted at least one week in advance or more if state regulation requires. Menus are to be posted at a height and in font (minimum 14 Font) that can be easily read by all residents. Menus should include all daily available for each meal. On 07/12/24 at 8:31 a.m., no breakfast menu was posted. On 07/16/24 at 2:08p.m. the Registered Dietician reported they were not sure if the menu was posted.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46653 Based on observation, record review, and interview, the facility failed to ensure: a. food items were labeled, dated and stored according to facility policy; b. proper food handling practices were followed to prevent the outbreak of foodborne illness; c. that staff changed gloves between task and according to facility policy; d. proper sanitization pratices or safety of the residents according to facility policy; e. hot food temperatures were documented according to facility policy. Findings: The DON reported 101 residents resided in the facility. a. The facility's policy Food and Supply Storage revised 1/24, read in part Cover, label and date unused portions and open packages. On 07/15/24 at 7:11 a.m., Dietary Aide #1 reported that all food items should be dated, labeled and stored. On 07/15/24 at 7:12 a.m., Dietary Aide #1 reported the tater tots, chicken tenders and bread should be dated, labeled and stored. On 07/12/24 at 7:18 a.m., Dietary Aide #1 reported it was bowl of sausages on the counter uncovered. b. The facility's policy Food Handling Guidelines undated, read in part Foods should be held hot for service at a temperature of 135 degree Fahrenheit or higher. On 07/12/24 at 8:00 a.m., Dietary Aide #1 reported the bacon temperature was 125 degrees. On 07/12/24 at 8:01 a.m., Dietary Aide #1 reported the temperature of the bacon was not acceptable, its supposed to be 135 degrees. c. A facility's policy Food Handling Guidelines revised 1/24, read in part Single use disposable gloves are worn when preparing foods that will not be cooked again (ready-to-eat foods) and while serving food. Gloves are to be placed over clean hands. Gloves are changed between tasks or if punctured or ripped. On 07/12/24 at 7:15 am., Dietary Aide #2 cracked eggs, handed silverware and condiments to resident, wiped counter and cooked eggs in skillet. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/12/24 at 7:15 am, Dietary Aide #2 reported they were supposed to change gloves between task. d. A facility's policy Sanitation and Infection Prevention/Control/ Dishwater Temperatures revised 1/24, read in part Final Rinse Sanitizer Solution Concentration 50-100 parts per million (ppm) sodium hypochlorite(chlorine) on dish surface in final rinse (minimum of 100 degree Fahrenheit). Each work area shall be equipped with sanitizing solution. Final rinse sanitizer concentration during each period of use. On 07/12/24 at 7:40 a.m., Dishwasher #1 reported the sanitizer solution bucket was empty and no parts per million (ppm) could be measured. On 07/12/24 at 7:41 a.m., Dishwasher #1 reported that the warewasher is supposed to have sanitizer solution in use to have clean dishes. e. A facility's policy Food Handling Guidelines undated, read in part Temperatures of hot food in service will be documented. On 07/12/24 at 8:04 a.m., no temperatures of hot food was documented; On 07/12/24 at 8:05 a.m., the Dietary Aide reported the hot food temperature log has not been documented.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 46216 Based on record review and interview, the facility failed to ensure a facility assessment was updated annually. The DON identified 101 residents resided in the facility. Findings: A Facility Assessment Tool, documented the date of assessment or update was 11/21/17. It documented the date the facility assessment was reviewed with QAA/QAPI was 12/13/17. On 07/19/24 at 9:23 a.m., the Administrator stated the facility assessment was to be updated annually. On 07/19/24 at 9:27 a.m., the Administrator stated their process was to change any information that required to be updated in the facility assessment. On 07/19/24 at 9:29 a.m., the Administrator reviewed the facility assessment. They stated according to you it has not been updated. 48344

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216 Based on observation, record review, and interview, the facility failed to maintain infection control while handling wet linens. The DON identified 28 resident resided on the memory care unit. Findings: A Infection Control Policy, dated 02/02/24, read in part, The objective of this requirement is for health center to develop a comprehensive infection control policy that establishes a health center-wide system for the prevention, identification, investigation, and control of infections of residents. A Personal Protective Equipment Use to Prevent Spread of Multidrug-resistant Organisms policy, dated 02/20/24, read in part, Use of PPE is based on the team member interaction with residents and the potential for exposure to blood, bodily fluids, or pathogens (e.g., gloves are worn when contact with blood, body fluids, mucous membranes, non-intact skin, or potentially contaminated surfaces or equipment are anticipated). On 07/15/24 at 9:35 a.m., a wet cloth bed pad, a wet blanket, a wet gown, and a clear trash bag were observed on the floor in room [ROOM NUMBER]. On 07/15/24 at 9:37 a.m., CNA #3 was observed to enter room and pick up the dirty linens without wearing appropriate PPE. The linens were not placed in a bag. CNA #3 was observed carrying the wet linens down the hall. The wet linens were touching their clothing. On 07/15/24 at 9:38 a.m., CNA #3 stated they should not pick up or transport dirty linens without wearing gloves. On 07/19/24 at 9:16 a.m., the DON stated wet linens should be placed in a bag and should not be placed on the floor. They stated gloves were to be worn when picking up soiled linens.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46216 Based on observation and interview, the facility failed to ensure call devices were accessible to residents for two (#17 and #58) of 28 resident observed for call lights in the memory care unit. The DON identified 101 residents resided in the facility. Findings: A Call Light Answering Policy and Procedure, dated 02/20/24, read in part, BVC recognizes that residents may call for assistance frequently. It is the responsibility of the team to answer the call for service. 1. Resident #37 admitted on [DATE] with diagnoses which included dementia and heart failure. A quarterly assessment, dated 04/16/24, documented the resident was dependent on staff for assistance with their ADLs. On 07/15/24 at 7:25 a.m.,the call light cord was observed hanging over the head of the bed. The call light was not accessible to Resident #37 2. Resident #58 admitted on [DATE] with diagnoses which included diastolic (congestive) heart failure and Alzheimer's disease. A quarterly assessment, dated 06/06/24, documented the resident required supervision or touching assistance with their ADLs. On 07/15/24 at 7:18 a.m., two call light cords were observed hanging over the foot of the bed of the empty bed in the room. Resident #58 was observed to be lying in his bed with neither call light accessible. On 07/15/24 at 7:26 a.m., CNA #1 stated Resident #58's call light cord was not within reach of the resident. On 07/15/24 at 7:28 a.m., CNA #1 stated Resident #37's call light cord was not within reach of the resident. On 07/19/24 at 9:18 a.m., the DON stated call devices should be within reach at all times.