STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375396	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lakes	5701 West Britton Road Oklahoma City, OK 73132

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960 Based on observation, record review and interview, the facility failed to notify the attending physician of a wound without a treatment order for one (#18) of two sampled residents with wounds. The DON identified three residents had been admitted to the facility with wounds since 10/01/24. Findings: An undated facility policy, Guidelines for Notifying Physician of Clinical Problems, read in part, These guidelines are to help ensure that .medical problems are communicated to the medical staff in a timely efficient manner .The charger nurse or supervisor should contact the attending physician at anytime if they feel a clinical situation requires immediate discussion and management .the nurse should have the the following information available active medical problems. The Admission Assessment and Follow Up: Role of the Nurse, last revised September 2012, read in part, conduct a physical assessment including skin .contact the attending physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. The Admission Notes policy , last revised September 2012, read in part, When a resident is admitted to the nursing unit, the admitting Nurse must document the following .the general condition of the resident upon admission .the time the attending physician was notified of the admission .the time the physician's orders were received and verified. Resident #18 was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure, Parkinson's disease, acute kidney failure, atrial fibrillation, displaced bimalleolar fracture of left lower leg, and disorder of the skin and subcutaneous tissue. Resident #18's Admission Summary, dated 11/08/24, documented they had surgical wounds, bruises, skin tears/cuts and other open lesions on the foot. Resident #18's skin and wound progress note, dated 11/08/24, documented their right heel had eschar and they were admitted to the facility with it. The wound was unstageable and measured 3 cm X 3 cm with no depth. (continued on next page)

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 - Few	There was no documentation Resident #18's physician had been notified on admission of the right heel wound and no treatments. On 11/20/24 at 9:34 a.m., LPN #3 stated they were the admitting nurse for Resident #18. LPN #3 stated Resident #18 had orders from a previous facility that was reviewed for orders. On 11/20/24 at 10:33 a.m., LPN #3 stated there were no orders for treatment. They stated after completing the admission assessment they left for the day without contacting the physician. LPN #3 stated the physician should have been notified and they were not notified until 11/11/24 when the ADON contacted the physician. On 11/20/24 at 12:54 p.m., the ADON stated Resident #18 was admitted with a wound to their right heel and LPN #3 would know what the treatment order was on admission. After looking through the clinical record they stated there were no orders on admission and the physician should have been notified of the wound to get a treatment order. On 11/20/24 at 1:09 p.m., the DON stated it was the expectation of the facility to notify the physician of any wounds on admission and get orders if needed.

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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. 45583 Based on record review and interview, the facility failed to ensure a MDS was coded accurately for one (#30) of 18 sampled residents reviewed for accuracy of MDS assessments. The DON identified 71 residents resided in the facility. Findings: Resident #30 had diagnoses which included spondylosis and peripheral vascular disease. An admission assessment, dated 10/31/24, documented the resident had an indwelling catheter. On 11/20/24 at 12:45 p.m., MDS coordinator #2 stated Resident #30 did not have a catheter. They stated for some reason the system auto populates. MDS Coordinator #1 stated they would do a correction and that was not the only one. They stated they needed to pay better attention and it was not coded accurately.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 20960 Based on record review and interview, the facility failed to ensure a resident with a new diagnosis of a serious mental health condition had a pre-admission screening and resident review updated for one (#1) of one sampled resident reviewed for PASARR level two. The DON identified 28 residents with serious mental health diagnoses. Findings: The facility policy titled, Admission Criteria, read in part, Nursing and medical needs of individuals with mental disorders, intellectual disabilities will be determined by coordination with the Medicaid Pre-Admission and Resident Review program (PASARR) to the extent possible. Resident # 1 had diagnoses which included psychosis, anxiety, and recurrent depression. Resident #1's Nursing Level of Care Assessment, dated 01/23/18, did not document they had any serious mental health conditions. The primary diagnosis was listed as multiple sclerosis. A review of the order summary medical diagnoses list documented Resident #1 had the following new diagnoses after the initial PASARR was completed in 2018: a. anxiety with an onset date of 09/11/18; b. psychosis not due to a substances or known psychological condition with an onset date of 11/10/23; and c. recurrent depression disorder with an onset date of 11/10/23. An annual MDS assessment, ARD date 07/30/24, docuented Resident #1 did not have a serious mental illness. The assessment further documented Resident #1 had psychiatric mood disorders of anxiety, depression, and psychotic disorder. A care plan, last revised 11/05/24, documented Resident #1 had a diagnoses of anxiety, depression, and psychosis. The documented interventions for all focused areas was for Resident #1 were to be provided their psychoactive medications as ordered by the doctor. Resident #1's physician's orders, dated November 2024, documented Risperdal (antipsychotic medication) 0. 5 mg give one tablet by mouth one time a day related to psychosis. The order was first written on 11/17/23. There was no documentation the facility had completed an updated PASARR with the onset of serious mental health diagnoses of recurrent depression, anxiety, and psychosis. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/24 9:40 a.m, MDS coordinator #1 stated pre-admission screening and resident review was to be completed on admission, when they got referrals, or as soon as they got to the facility. MDS Coordinator #1 stated schizophrenia, recurrent depression, bipolar, and anxiety were all serious mental health diagnoses. They stated Resident #1 had recurrent depression, anxiety, and psychosis which were serious mental health diagnoses. MDS Coordinator #1 stated the diagnoses onset dates were 11/10/23 for recurrent depression and psychosis and 11/20/18 for anxiety. They stated the intital screening occurred on 01/24/18 and it did not list any serious mental health conditions. MDS Coordinator #1 further stated no other screening had been completed after the initial assessment in 2018 and there should have been a new screening to know if there was the need for a level two PASARR. They stated all of Resident #1's serious mental health diagnoses should have had a screen completed. On 11/19/24 at 9:57 a.m., the DON stated a PASARR had to be submitted on admission and if there was a new psychological diagnosis. They stated schizophrenia, recurrent depression, bipolar, and anxiety were all serious mental health diagnoses that would require a screen with the onset of the new diagnosis. The DON stated Resident #1's diagnoses onset dates were 11/10/23 for recurrent depression and psychosis and 11/20/18 for anxiety. They stated a screen should have been completed if they were not on the original screening.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 35389 Based on record review and interview, the facility failed to develop a comprehensive care plan for: a. IV and antibiotic usage for one (#20); b. visual function for one (#6); and c. antipsychotic medication use for one (#35) of 18 sampled residents whose care plans were reviewed. The DON identified 71 residents who resided in the facility. Findings: A Care Plans, Comprehensive Person-Centered policy, revised 12/16, read in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. Resident #20 had diagnoses which included metabolic encephalopathy, chronic kidney disease, and urinary tract infection. A progress note, dated 11/03/24 at 2:31 p.m., documented they received a urine culture report and the resident would need a midline or PICC placement for IV antibiotic. It documented the resident was sent to the emergency room for a long term access device placement and to receive their first dose of antibiotic for monitoring related to a drug allergy to penicillin. A physician's order, dated 11/04/24, documented normal saline flush intravenous solution with 10 cc intravenously every 8 hours related to urinary tract infection. A care plan focus for urinary tract infection, dated 11/04/24, did not include any documentation or interventions for an IV or antibiotic. The medical record was reviewed and revealed the resident completed their antibiotic on 11/17/24. A physician's order, dated 11/22/24, documented to change the PICC line dressing every seven days. On 11/21/24 at 12:08 p.m., MDS coordinator #2 stated the IV and antibiotic for the recent UTI were not on the care plan and they normally were on the care plan. 2. Resident #6 had diagnoses which included anxiety disorder, essential hypertension and tremor. An Annual Resident Assessment, dated 10/25/24, documented Resident #6's cognition was intact and they had impaired vision and used corrective lenses. The CAA documented visual function had triggered and the care plan decision was yes. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6's care plan did not address their visual function. On 11/18/24 at 9:35 a.m., Resident #6 reported they broke their glasses yesterday. On 11/18/24 at 9:36 a.m., Resident #6's glasses were observed with tape on the right upper frame. The right lens was also observed out of the frame. On 11/21/24 at 10:00 a.m., MDS coordinator #2 stated MDS coordinator #1 had completed Resident #6's annual resident assessment. They stated MDS coordinator #1 was not at the facility and MDS coordinator #2 stated they would be able to answer questions about it. On 11/21/24 at 10:02 a.m., MDS coordinator #2 stated visual concerns were captured on a residents MDS assessment if they had glasses or reading glasses. They stated it was documented under section b. They stated the CAA summary was where they got their information for that section. They stated Resident #6's CAA summary did trigger visual function. On 11/21/24 at 10:03 a.m., MDS coordinator #2 stated anything that triggered should be put on the care plan. They reviewed Resident #6's care plan and stated they were not seeing it on the care plan. 3. Resident #35 had diagnoses which included psychotic disorder with delusions due to known physiological condition. A Physician Order, dated 06/29/24, documented Seroquel (antipsychotic medication) 25 mg one tablet by mouth at bedtime related to unspecified insomnia and psychotic disorder with delusions due to know physiological condition. An Admission Resident Assessment, dated 07/06/24, documented Resident #35 had severe cognitive impairment and was taking antipsychotic medication and had an indication for use. The CAA documented psychotropic drug use was trigger and was addressed in the care plan. Resident #35's care plan did not address their antipsychotic medication use or interventions in place to address their psychotic disorder with delusions. On 11/20/24 at 1:34 p.m., LPN #4 stated Resident #35 received Seroquel for psychotic disorder with delusions with known physiological condition. On 11/20/24 at 1:36 p.m., LPN #4 stated Resident #35 occasionally wandered from room to room when their anxiety was high. They stated the resident exhibited restlessness and disorganized thinking. On 11/20/24 at 1:39 p.m., LPN #4 stated staff redirected the resident, provided a calm environment, and would reproach the resident when they exhibited behaviors. They stated medications including antipsychotic medication was monitored and put in resident care plans. On 11/20/24 at 1:41 p.m., LPN #4 reviewed Resident #35's care plan and stated they were not seeing the resident's antipsychotic medication addressed in the care plan. On 11/20/24 at 1:47 p.m., MDS coordinator #2 stated diagnoses, medication, ADLs, and discharge plan interviews were used when developing a resident care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 1:48 p.m., MDS coordinator #2 stated if a resident was taking psychotropic medications they would all be in a group. They stated they would click on mental health disorder, they would click on depression, and the program would load any behaviors, psychoactive medications, and side effects they would watch for. On 11/20/24 at 1:51 p.m., MDS coordinator #2 stated Resident #35 was on Seroquel for psychotic disorder with delusions. They stated they would need to research where the diagnosis came from and update the resident's care plan. On 11/20/24 at 1:52 p.m., MDS coordinator #2 stated the antipsychotic was coded on the resident assessment and they did not see it on the care plan. 45583

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 45583 Based on record review and interview, the facility failed to complete a discharge summary for one (#72) of one sampled resident reviewed for discharge. The Admission/Discharge To/From Report, dated 05/01/24 through 11/18/24, documented 10 residents discharged from the facility within the last six months. Findings: Res #72 discharged from the facility on 09/03/24 after a respite stay since 08/26/24. A communication note, dated 09/03/24 at 4:37 p.m., documented, Resident picked up by transport to be taken home. Wife, Hospice, ADON and PA aware. Personal belongings and medications given to transport. There was no documentation a discharge summary had been completed. On 11/19/24 at 11:16 a.m., LPN #3 stated they did not see the summary. They stated the policy was to document where the resident was going, how they discharged , any teaching, medications, a brief summary, who picked them up, and details of the stay.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20960 Based on observation, record review and interview, the facility failed to ensure wound treatments were provided for one (#18) of two sampled residents reviewed for pressure ulcers. The DON identified three residents had been admitted to the facility with wounds since 10/01/24. Findings: An undated facility policy, Guidelines for Notifying Physician of Clinical Problems, read in part, These guidelines are to help ensure that .medical problems are communicated to the medical staff in a timely efficient manner .The charger nurse or supervisor should contact the attending physician at anytime if they feel a clinical situation requires immediate discussion and management .the nurse should have the the following information available .active medical problems. The Admission Assessment and Follow Up: Role of the Nurse, last revised September 2012, read in part, conduct a physical assessment including skin .contact the attending physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings. The Pressure Ulcer/Injury Risk Assessment policy, last revised July 2017, read in part, documentation in medical record addressing MDS notification if new skin altercation notes with change of plan of care, if needed. The Admission Notes policy , last revised September 2012, read in part, When a resident is admitted to the nursing unit, the admitting Nurse must document the following .the general condition of the resident upon admission .the time the attending physician was notified of the admission .the time the physician's orders were received and verified. Resident #18 was admitted to the facility on [DATE] with diagnoses which included acute respiratory failure Parkinson's disease, acute kidney failure, atrial fibrillation, displaced bimalleolar fracture of left lower leg, and disorder of the skin and subcutaneous tissue. Resident #18's Admission Summary, dated 11/08/24, documented they had surgical wounds, bruises, skin tears/cuts, and other open lesions on their foot. Resident #18's skin and wound progress note, dated 11/08/24, documented their right heel had eschar and they were admitted to the facility with it. It documented the wound was unstageable and measured 3 cm X 3 cm with no depth. Resdient #18's Baseline Care Plan, dated 11/08/24, documented they had pain to their right heel and had a wound on their right heel. The care plan documented Resident #18's wound measured 3 cm X 3 cm with black eschar on the heel and redness around the outer heel. There were no documented orders for a treatment to the right heel on admission. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Order Summary for Resident #18, dated 11/11/24, documented they had the following treatment order for the right heel. Cleanse right heel with hibiclens and pat dry. Apply calcium alginate to wound bed, cover with optifoam heel protector, secure with kerlix every day and prn one time a day related to disorder of the skin. The order was written three days after Resident #18 was admitted . Resident #18's admission MDS assessment, ARD date 11/12/24, documented they had one unhealed pressure ulcer due to slough or eschar on admission. Resident #18's care plan, dated 11/13/24, documented they had a focus area of potential for impairment to skin integrity. The interventions were documented as assist as needed with tranfers with caution to prevent injury, document skin condition weekly, encourage good nutrition and pressure relieving mattress on the bed. The care plan did not address the wound to the right heel. The November 2024 TAR documented the first treament to the right heel was on 11/11/24. There were no documented treatments on 11/08/24, 11/09/24, or 11/20/24. On 11/18/24 at 1:09 p.m., Resident #18 stated they had a hole in their heel. Resident #18 was observed with a heel protector boot in place and a bandage dated 11/17/24 on the right foot and heel. On 11/20/24 at 9:34 a.m., LPN #3 stated they were the admitting nurse for Resident #18. LPN #3 stated Resident #18 had orders from a previous facility that was reviewed for orders. On 11/20/24 at 10:33 a.m., LPN #3 stated there were no orders for treatments on the admitting paperwork. They stated after completing the admission assessment they left for the day without contacting the physician. LPN #3 stated the physician should have been notified and they were not notified until 11/11/24. LPN #3 stated the ADON was the one that notified the physician and got the order for a treatment on the wound. They stated the order was not until 11/11/24 and prior to that there were no orders for treatments. On 11/20/24 at 11:01 a.m., Resident #18 stated they had their wound since admission on their right heel. Resident #18 stated they just started doing a treatment on the right heel about a week ago and have since been doing them everyday. On 11/20/24 at 12:54 p.m., the ADON stated Resident #18 was admitted with a wound to their right heel, and LPN #3 would know what the treatment order was on admission. After looking through the clinical record they stated there were no orders on admission and the physician should have been notified of the wound to get a treatment order. The ADON indicated no treatment was provided for three days after admission when the order was obtained. On 11/20/24 at 1:09 p.m., the DON stated the admitting nurse was to assess's the resident in all areas including the skin. They stated they received orders from the facility they are admitting from and use them as a basis for their orders. The DON stated if there were identified skin issues without orders it was the expectation of the facility to notify the physician and get orders. They stated Resdient #18 was admitted to the facility with a wound to the right heel, and did not have an order from the previous facility for th wound. The DON stated there were no treatments that had been completed until 11/11/24 and Resident #18 went three days without a treatment. The DON stated the facility policy for admission and notification were not followed and it should be been completed on the first day Resident #18 was admitted the facility.

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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. 35389 Based on observation, record review and interview, the facility failed to ensure: a. oxygen tubing was changed; and b. oxygen was administered as ordered for one (#6) of one sampled resident reviewed for oxygen. The DON identified six residents with orders for oxygen resided in the facility. Findings: An Oxygen Administration policy, revised 10/2010, read in part, The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify there is a physician's order for this procedure .After completing the oxygen setup .the following information should be recorded in the resident's medical record . The date and time that the procedure was performed .The rate of oxygen. The Respiratory Therapy Prevention of Infection policy, revised 11/2011, read in part, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy .Check water levels of refillable humidifier units daily when humidified O2 is used .Change the reservoir every forty-eight (48) hours when humidified O2 is used. Resident #6 had diagnoses which included chronic respiratory failure with hypoxia and chronic respiratory failure with hypercapnia. A discontinued order, dated 10/18/23, documented oxygen via nasal cannula at two liters continuous three times a day. A discontinued order, dated 09/19/24, documented oxygen via nasal cannula at two liters continuous three times a day. The September 2024 TAR documented the oxygen tubing and humidifier bottle was to be changed weekly on Saturdays. The last documented oxygen tubing change was on the 7th. A Physician Order, dated 10/09/24, documented oxygen via nasal cannula at two liters continuous three times a day. An Annual Resident Assessment, dated 10/25/24, documented Resident #6 utilized oxygen therapy while a resident at the facility. The October 2024 TAR did not document Resident #6's oxygen tubing had been changed during the month. The November 2024 TAR did not document Resident #6's oxygen tubing had been changed for the month. There was no order to change oxygen tubing located in Resident #6's current physician orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/24 at 9:19 a.m., Resident #6 was observed with oxygen in place via nasal cannula. Resident #6 stated they wore oxygen continuously. The humidifier bottle on the oxygen concentrator was observed with a date of 08/31/24 and the oxygen tubing was not connected to the humidifier bottle. There was no date observed on the oxygen tubing. Resident #6 stated they did not use the humidifier because they did not notice much of a difference with it. They stated their oxygen was to be at three liters. The oxygen was observed running at four liters. On 11/18/24 at 9:25 a.m., LPN #4 entered Resident #6's room and administered an inhaler to the resident. LPN #4 did not observed the flow rate of the resident's oxygen that was running. On 11/19/24 at 10:03 a.m., LPN #3 stated staff dated oxygen tubing. When asked how often it was changed, LPN #3 stated, You do what's best for you. They stated if it looked like moisture or a kink was forming, they would switch it out. They stated sometimes it could have discoloration along the nasal part or ear part and they would throw it away. On 11/21/24 at 10:10 a.m., Resident #6 was observed wearing oxygen via nasal cannula running at four liters. There was no date observed on the oxygen tubing. The humidifier bottle on the oxygen concentrator was observed with a date of 08/31/24 and the oxygen tubing was not connected to the humidifier bottle. On 11/21/24 at 10:15 a.m., LPN #4 stated if a resident was on continuos oxygen, staff would ensure the resident had oxygen on, kept pressures, and monitored oxygen every shift. They stated the humidifying component depended on the physician orders and dryness of the mucosa. On 11/21/24 at 10:16 a.m., LPN #4 stated the rate at which the oxygen was to be set would be included in the orders. They stated the night shift would change out the oxygen tubing weekly and most of the residents were scheduled to have it changed every Saturday at bedtime. On 11/21/24 at 10:19 a.m., LPN #4 stated Resident #6 had and order for continuous oxygen at two liters. On 11/21/24 at 10:21 a.m., LPN #4 stated they did not see an order for changing the tubing. On 11/21/24 at 10:22 a.m., LPN #4 walked into Resident #6's room visualized their oxygen concentrator and stated, Oh my goodness. They stated it was running at four liters. They stated they did not see a date sticker on the tubing. They stated the humidifier part was old because the resident did not use it. They stated it was dated August 31st and removed it from the concentrator. On 11/21/24 at 10:26 a.m., the DON stated staff were to verify the physician order, facility protocol, care plan, and assemble equipment and supplies when providing oxygen to residents. On 11/21/24 at 10:28 a.m., the DON stated residents had specific orders for how many liters to put the oxygen at. On 11/21/24 at 10:29 a.m., the DON stated oxygen tubing was supposed to be changed weekly. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lakes	5701 West Britton Road Oklahoma City, OK 73132

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 10:31 a.m., the DON stated Resident #6 had an order for continuous oxygen at two liters. They stated there was a spot to document checking the oxygen saturation each shift attached to the order.

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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. 35389 Based on observation, record review and interview, the facility failed to: a. ensure an insulin label indicated the order had changed for one (#41); and b. ensure medications were administered following standards of practice for one (#41) of ten sampled residents observed during medication pass. The DON identified five residents with orders for a lidocaine patch. The Resident Matrix, dated 11/18/24, documented 16 residents received insulin. Findings: An Administering Topical Medications policy, revised 10/10, read in part, The purpose of this procedure is to provide guidelines for the safe administration of topical medications .Apply glove to your dominant hand . assess area for .debris .Clean the skin. Remove old medication residue .Don clean gloves if necessary . Trans-dermal patches .Clean and dry a selected area that is approved for application of the patch. Rotate sites with each new application, if possible. An Insulin Administration policy, revised 09/2014, read in part, To provide guidelines for the safe administration of insulin to residents with diabetes .The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order .The nurse shall notify the Director of Nursing Services and Attending Physician of any discrepancies, before giving the insulin . 1. Resident #41 had diagnoses which included chronic pain and type two diabetes mellitus with diabetic neuropathy. A Physician Order, dated 06/25/24, documented lidocaine (local anesthetic medication) external patch five percent apply to right front upper thigh topically one time a day. A Physician Order, dated 09/27/24, documented Lantus (insulin) 100 u/ml inject 55 units subcutaneously one time a day. On 11/19/24 at 9:37 a.m., LPN #3 obtained Resident #41's Lantus from the treatment cart and dialed it to 55 units. The label on the Lantus pen documented inject 45 units subcutaneously once daily with a fill date of 09/09/24. LPN #3 stated, It's 55 in out system. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/24 at 9:47 a.m., LPN #3 stated the facility had a sticker for change of medication for when the label of the medication did not match the order. LPN #3 stated there was not one on Resident #41's Lantus. They stated the order had recently changed to 55 and they would have to get with the pharmacy to have it changed. LPN #3 removed a lidocaine patch five percent from the treatment cart and obtained a pair of scissors from the top drawer of the cart. On 11/19/24 at 9:50 a.m., LPN #3 cut the lidocaine patch container open, removed the patch and dated and initialed the patch. LPN #3 removed the old patch, dated 11/18/24, from Resident #41's right upper thigh, threw it in the trash, and placed a new patch on the same general area of the resident's right upper thigh. LPN #3 did not clean the site prior to placing a new lidocaine patch on the resident's thigh. On 11/19/24 at 10:22 a.m., LPN #3 stated staff were to move lidocaine patches to different areas of the resident's thigh when administering. They stated staff should probably use alcohol to clean the area first. They stated with Resident #41 they at least tried to move the patch in an area a little different from where it was. On 11/19/24 at 11:47 a.m., the DON stated staff were to wash their hands with soap and water or use alcohol based had rub, verify the order with the label on the lidocaine patch, check expiration, verify the resident's identity, apply glove to dominant hand, and assess the area of skin for debris when administering the lidocaine patch. The DON stated staff were to apply clean gloves if necessary, clean and dry the selected area and rotate sites when possible with each new application. On 11/19/24 at 11:51 a.m., the DON stated there was a change of direction sticker staff used when a medication order changed from what was documented on the label. They stated the sticker was supposed to be applied to the medication itself or the container for it.

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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. 45583 Based on observation, record review, and interview, the facility failed to ensure treatment carts were secured when not in use for one observation observed on hall 500 for medication storage. The DON identified 71 residents resided in the facility. Findings: A Storage of Medication policy, dated 4/2007, read in part, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The policy also read, Compartment (including but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others. On 11/19/24 at 3:30 p.m., LPN #2 was observed preparing to do wound care. They were observed to walk away from the unlocked treatment cart and walk up the hall towards the nurses station. On 11/19/24 at 3:32 p.m., LPN #2 returned to the cart. They stated they left the cart unlocked and the policy for securing medications was to lock the cart when they walk away from it.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35389 Based on record review and interview, the facility failed to: a. maintain a water management program to prevent the growth of Legionella and other opportunistic waterborne pathogens in the building water system; b. adhere to enhanced barrier precautions for one (#18) of 18 sampled residents reviewed for infection control; c. remove gloves and/or wash or sanitize hands in order to prevent cross contamination for six (#2, 22, 23, 26, 41, and #49); and d. clean out the nebulizer canister after use for one (#26) of ten sampled residents observed during medication pass. The DON identified 71 residents resided in the facility and eight residents with orders for nebulizer treatments. The Resident Matrix, dated 11/18/24, documented 16 residents received insulin. Findings: A Pulse Oximetry policy, revised 10/2010, read in part, Steps to procedure .Perform hand antisepsis . Remove probe when monitoring is complete .Perform hand antisepsis. The Respiratory Therapy Prevention of Infection policy, revised 11/2011, read in part, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy .Infection Control Considerations Related to Medication Nebulizers .After completion of therapy .Remove the nebulizer container .Rinse with fresh tap water .Dry on a clean paper towel or gauze sponge. An Insulin Administration policy, revised 09/2014, read in part, Steps in the procedure .Wash hands .Check Blood Glucose per physician order .Depress the plunger and remove the needle after approximately five (5) seconds .Dispose of the needle in a designated container .Wash hands. A Handwashing/Hand Hygiene policy, revised 08/2015, read in part, This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents .Wash hands with soap . and water for the following situations .When hands are visibly soiled .After contact with a resident with infectious diarrhea .Use alcohol-based hand rub .or .soap .and water for the following situations .Before and after direct contact with residents .Before preparing or handling medications .After contact with a resident's intact skin .After contact with blood or body fluids .After contact with objects in the immediate vicinity of the resident .After removing gloves .Hand hygiene is the final step after removing and disposing of personal protective equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Legionella Water Management Program policy, dated 07/2017, read in part, As part of the infection prevention and control programs, our facility has a water management program, which is overseen by the water management team. The water management team will consist of at least the following personnel: a. The infection preventionist; b. The administrator; c. The medical director (or designee); d. The director of maintenance; and e. The director of environmental services. A Legionella Surveillance and Detection policy, dated 07/2017, read in part, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaire's disease will be included as part of our infection surveillance activities. 1. Resident #18 had diagnoses which included Parkinson's and a-fib. Resident #18s skin and wound progress note, dated 11/08/24, documented their right heel had eschar and they were admitted to the facility with it. It documented the wound was unstageable and measured 3 cm X 3 cm with no depth. Resdient #18's Baseline Care Plan, dated 11/08/24, documented they had pain to their right heel and had a wound on their right heel. The care plan documented Resident #18's wound measured 3 cm X 3 cm with black eschar on their heel and redness around the outer heel. On 11/20/24 at 10:55 a.m., LPN #1 stated the PPE for EBP was a gown and gloves and they were kept in the shower room. On 11/20/24 at 3:37 p.m., LPN #2 was observed to begin performing the treatment on Resident #18's right heel wound. There was no observation of LPN #2 wearing a gown during the provision of wound care. There was no observation of signage to indicate EBP for Resident #18. On 11/20/24 at 1:13 p.m., the ADON stated the EBP policy was for residents that had a peg tube, wound, nebulizer treatment, all Foleys, trachs, and gastric tube. They stated not skin tears. The ADON stated Resident #18 should have been on EBP. They stated the PPE required was a gown, gloves, and mask if airborne. The ADON stated the policy was not followed if the staff did not wear PPE and there was no signage. 2. On 11/20/24 at 1:52 p.m., the maintenance supervisor stated the city came out annually and if they called them to test if someone got sick. They stated they would need to request the documentation. On 11/20/24 at 8:39 a.m., the maintenance supervisor stated they had not received the Legionella testing results and were still waiting. On 11/21/24 at 8:58 a.m., the maintenance supervisor was shown the facility's policy for Legionella. They stated they did not know they had to do the elements listed in the policy. There was no documentation provided by the facility Legionella monitoring had been completed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #26 had diagnoses which included COPD. A Physician Order, dated 11/11/24, documented Ipratropium-albuterol inhalation solution 0.5-3 ml/ 3 ml one vial inhale orally four times a day. 4. Resident #23 had diagnoses which included shortness of breath. A Physician Order, dated 03/26/22, documented combivent respimat aerosol solution 20-100 mcg/act one puff inhale orally three times a day. 5. Resident #41 had diagnoses which included chronic pain and type two diabetes mellitus with diabetic neuropathy. A Physician Order, dated 06/25/24, documented lidocaine external patch five percent apply to right front upper thigh topically one time a day. A Physician Order, dated 09/27/24, documented Lantus 100 u/ml inject 55 units subcutaneously one time a day. On 11/19/24 at 9:11 a.m., LPN #3 removed one vial of Ipratropium-albuterol inhalation solution 0.5-3 ml/ 3 ml from the treatment cart, sanitized their hands, donned gloves, picked up the vial, locked the cart, opened the resident's nebulizer mask with tubing that was in a bag in their room, connected it to the nebulizer machine, placed the mask on the resident's face, opened the vial, poured it into the canister, connected it to the mask, plugged the tubing into the machine, and turned the machine on. LPN #3 removed the nasal cannula tubing in the room, wrapped it up, and threw it in the trash on the treatment cart located in the hall with their gloves hands. They picked up the pulse oximeter off the top of the treatment cart and placed it on Resident #26's finger. On 11/19/24 at 9:21 a.m., LPN #3 removed the pulse oximeter and placed it back on top of the treatment cart with the same gloved hands. On 11/19/24 at 9:24 a.m., Resident #26's treatment was completed. LPN #3 removed the mask from their face, and placed the mask on the resident's bedside table, removed their gloves, left the room and went to the treament cart and pushed it down the hallway. LPN #3 did not clean out the nebulizer canister after use, wash or sanitize their hands, or clean the pulse oximeter after use. On 11/19/24 at 9:30 a.m., LPN #3 moved the treatment cart down to room [ROOM NUMBER]. Without washing or sanitizing their hands from the last treatment they walked into room [ROOM NUMBER] with a thermometer and took Resident #49's temperature and exited the room without washing or sanitizing their hands. On 11/19/24 at 9:32 a.m., LPN #3 opened the treatment cart, obtained Resident #23's combivent respimat 20 mcg/100 mcg inhaler, entered the room, donned gloves, took the resident's temperature, and watched Resident #23 administer the inhaler. LPN #3 used the same pulse oximeter previously used and without cleaning it, obtained Resident #23's oxygen saturation at 94 percent. LPN #3 returned to the treatment cart with one gloved hand that they had written on and placed the pulse oximeter on the cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/24 at 9:37 a.m., LPN #3 removed the glove and placed the inhaler back in the treatment cart. LPN #3 did not clean the pulse oximeter. On 11/19/24 at 9:37 a.m., LPN #3 sanitized their hands, took out two lancets, two alcohol prep pads, a glucometer, placed a test strip in the glucometer, and a cotton ball. They entered Resident #41's room pricked their finger, wiped the first blood off, obtained their FSBS to be 226, cleaned off their finger, threw the disposable items away, and removed their gloves. Without washing or sanitizing their hands, they documented the FSBS in the computer, obtained Resident #41's Lantus from the treatment cart and dialed it to 55 units. LPN #3 donned gloves, cleaned Resident #41's left arm with alcohol, administered the insulin, threw sharps in the sharps container on the treatment cart, and placed the lid back on the insulin pen all while wearing the same pair of gloves. LPN #3 accessed the computer with the same gloved hands to document the FSBS. On 11/19/24 at 9:47 a.m., with the same gloved hands, LPN #3 removed keys from their pocket, unlocked the treatment cart, and obtained a lidocaine patch five percent from the treatment cart, and obtained a pair of scissors from the top drawer of the cart. On 11/19/24 at 9:50 a.m., with the same gloved hands, LPN #3 cut the lidocaine patch container open, removed the patch and dated and initialed the patch. Wearing the same pair of gloves, LPN #3 removed the old patch, dated 11/18/24, from Resident #41's right upper thigh, threw it in the trash, and placed a new patch on the same general area of the resident's right upper thigh. LPN #3 removed their gloves and threw them in the trash. Without washing or sanitizing their hands, LPN #3 moved back to the treatment cart, obtained keys from their pocket, opened the cart, and started using the computer. LPN #3 obtained the thermometer, took Resident #41's temperature and scratched the resident's left upper back through their gown. LPN #3 went back to the treatment cart and started charting on the computer without washing or sanitizing their hands. On 11/19/24 at 9:55 a.m., without washing or sanitizing their hands, LPN #3 walked into Resident #2's room and took their temperature which read 97.6. Without washing or sanitizing their hands, LPN #3 walked over to the other resident in the room, Resident #22, and took their temperature which read 96.8. Without washing or sanitizing their hands, LPN #3 went out to the treatment cart and documented the readings. On 11/19/24 at 9:56 a.m., LPN #3 stated staff were to turn on water, use soap, lather a good 30 seconds, scrub between fingernails and fingers for 25 to 30 seconds, and rinse the soap off when washing their hands. They stated staff would dry their hands with a paper towel and use the paper towel to turn off the water. LPN #3 stated it was best to sanitize before going into each room, even when using gloves. They stated staff should sanitize anytime they went from room to room. On 11/19/24 at 9:58 a.m., LPN #3 stated staff were to use gloves for each resident. They stated they were not to use the same pair of gloves on two different residents. They stated they would remove gloves when visibly soiled. On 11/19/24 at 9:59 a.m., LPN #3 stated they should clean the pulse oximeter after each use. They stated they did not clean it in between uses and that was their fault. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/24 at 10:01 a.m., LPN #3 stated they did not clean out the canister after administering the nebulizer treatment to Resident #26. They stated they did not know the process for cleaning out the canister. They stated, I don't keep it on there for a whole week or anything like that. They stated sometimes if it got foggy from the temperature, they would switch it out just to be safe. They stated they did not ever date the tubing, but they should. On 11/19/24 at 11:35 a.m., the DON stated staff were to physically wash their hands with soap and water anytime they were visibly soiled. The ADON stated staff were to clean their hands before and after care and could use either sanitizer or soap if not visibly soiled. The DON stated after three uses of sanitizer, staff were supposed to wash their hands. On 11/19/24 at 11:36 a.m., the DON stated staff were clean the nebulizer machine after use per protocol, use soap and water, and allow it to air dry on a paper towel. They stated once it was dry they were to store it in a sanitary manner and change it out every seven days per policy. On 11/19/24 at 11:44 a.m., the DON stated staff would provide hand antisepsis, place probe on the resident's finger, turn on the pulse oximeter, and compare the pulse reading to the radial pulse when obtaining a pulse oximeter reading. They stated staff would perform hand antiseptics afterwards. On 11/19/24 at 11:47 a.m., the DON stated staff would clean the pulse oximeter if they dropped it on the floor, a resident put it in their mouth, or anytime it was dirty. 45583

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45583 Based on record review and interview, the facilty failed to provide documentation the facility administered the pneumococcal vaccine for two (#62 and #69) of five sampled residents reviewed for immunizations. The DON identified 71 residents who resided in the facility. Findings: A Pneumococcal Vaccine policy, dated 8/2016 read in part, Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility. 1. Resident #62 was admitted to the facility on [DATE]. The pneumococcal consent was signed on 12/04/23. The immunization record for the resident did not document the pneumococcal vaccine was administered. 2. Resident #69 was admitted to the facility on [DATE]. The pneumococcal consent was signed on 05/02/24. The immunization record for the resident did not document the pneumococcal vaccine was administered. On 11/21/24 8:38 a.m., the DON stated they were not able to locate any documentation either resident received the pneumococcal vaccine. They stated they had started at the facility in September of this year and they had not administered any vaccines. On 11/21/24 at 9:00 a.m., the DON stated neither Resident #62 nor #69 had received the pneumonia vaccine.