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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375438	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gracewood Health & Rehab	6201 East 36th Street Tulsa, OK 74135

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41809 Based on observation, record review, and interview, the facility failed to ensure residents were provided with privacy curtains. The administrator identified 78 residents resided at the facility. Findings: A Bedrooms policy, reviewed May 2024, read in part, Each room is designed to provide full visual privacy for each resident (in the form of ceiling suspended curtains that extend around the bed) and equipped for adequate nursing care On 01/06/25 at 4:26 p.m., room [ROOM NUMBER] was observed to have no privacy curtain. Resident #24 stated there was no privacy and all activities other than using the restroom were completed in full view of their roommate. On 01/07/25 at 11:52 a.m., room [ROOM NUMBER] was observed to have no privacy curtain. The room had two residents residing in the room. On 01/09/25 at 10:44 a.m., LPN #3 stated a curtain should be in room [ROOM NUMBER] to provide privacy and they did not know why one was not installed. On 01/09/25 at 11:09 a.m., the DON stated one of the resident's in room [ROOM NUMBER] required extensive assist. They stated privacy was provided by closing the door and pulling the curtain. The DON looked in room [ROOM NUMBER] and stated the room had work completed a month ago and maintenance had removed the curtain. They stated privacy was not provided effectively in room [ROOM NUMBER]. On 01/13/25 at 10:17 a.m., maintenance #1 stated they were responsible for the privacy curtains. They stated room [ROOM NUMBER] had no curtain track and they had brought the issue up previously. Maintenance #1 stated they did not know why room [ROOM NUMBER] had no tracks for privacy curtains. They stated neither resident had privacy. On 01/14/25 at 10:35 a.m. the DON stated they were working on the privacy issue. They stated tracking for the privacy curtains needed to be installed.

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 35474 Based on observation, record review, and interview, the facility failed to ensure nail care was provided for one (#57) of one sampled resident who was reviewed for ADL care. The nurse manager identified 56 residents who were dependent on staff for nail care. Findings: The Fingernails/Toenails, Care of policy, dated February 2024, read in parts, The purposes of this procedure are to clean the nail bed, to keep nails trimmed .Nail care includes daily cleaning and regular trimming . Documentation .If the resident refused the treatment, the reason(s) why and the intervention taken .Notify the supervisor if the resident refuses the care. Resident #57 had diagnoses which included unspecified dementia. The Care Plan, updated 11/04/24, documented the resident required varied levels of assistance with ADLs due to weakness. The Activity of Daily Living Record, dated December 2024, documented the resident had been offered and/or received nail care five times, including refusals of nail care, out of 93 opportunities. The Activity of Daily Living Record, dated 01/01/25 through 01/07/25, documented the resident had not been offered, refused, or received nail care out of 21 opportunities. On 01/06/25 at 9:38 a.m., Resident #57 was observed in their room. Their fingernails were observed to be approximately a quarter inch long with dark colored debris under the nails. Resident #57 stated they preferred their fingernails to be shorter. On 01/09/25 at 10:37 a.m., Resident #57 was observed in their room. Their fingernails were observed to be approximately a quarter inch long with dark colored debris under the nails. On 01/09/25 at 10:42 a.m., CNA #7 stated the CNAs were responsible to provide nail care for Resident #57. They stated at times the resident refused care and nail care was documented on the ADL record. On 01/09/25 10:44 a.m., LPN #3 stated the CNAs were to provide nail care for Resident #57 because they were dependent on staff for nail care. They observed Resident #57's fingernails and stated they needed to be trimmed and cleaned. They stated the resident refused care at times, but when a resident refused they asked them to sign a refusal form and documented the refusal. On 01/09/25 at 11:03 a.m., the DON stated fingernail care was to be provided on scheduled shower days and as needed and documented on the Activity of Daily Living Record. The DON reviewed the ADL record for December 2024 and January 2025 and stated they would need to check with the staff because fingernail care had not been documented. The DON stated there were some refusals documented, but there should have been more documentation regarding nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/25 at 11:06 a.m., the DON observed Resident #57's fingernails and stated they did not look good. The DON stated they thought they had dropped the ball and should check resident fingernails more often for care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 41809 Based on observation, record review, and interview, the facility failed to ensure activities were provided for four (#18, 22, 26, and #42) of four sampled residents who were reviewed for activities. The administrator identified 78 residents who resided at the facility. Findings: An Activity Programs policy, revised August 2024, read in parts, Activity programs designed to meet the needs of each resident are available on a daily basis .designed to encourage maximum individual participation and are geared to the individual resident's needs .are scheduled 7 (seven) days a week. 1. Resident #18 had diagnoses which included chronic pain, obesity, and limited mobility. On 01/06/25 at 11:18 a.m., Resident #18 stated they could not go to activities because they did not have a wheelchair that worked. They stated the bottom of the wheelchair had a hole in it and was not comfortable, so they did not get up much. On 01/07/25 at 3:46 p.m., CNA #1 stated they did not know if activities were offered or not. On 01/07/25 at 3:47 p.m., RN #1 stated there was an activities person, but they did not know what they did in patient rooms for residents that did not leave their rooms. On 01/07/25 at 3:59 p.m., CMA #4 stated they did not know of or see any activities in resident rooms for those who did not leave their room. On 01/07/25 at 4:00 p.m., CNA #3 stated the activities person passed out coloring books to patients and read cards to them if they got them in the mail. On 01/08/25 3:18 p.m., the activities director stated they had personal relationships with staff and residents. They stated they ensured all residents were offered activities because they knew who did what. The activities director stated Resident #18 got out of their room and went to most of the activities. The activities director stated they checked on bed bound residents at least once or twice a week, visited with them, offered them coloring opportunities, games, nail painting and anything they may be interested in. They stated it would be documented on the activity flow sheet and when completed the flow sheet would be put in the resident record. On 01/09/25 at 9:44 a.m., CNA #4 stated Resident #18 only got up for showers and had no cushion for their wheelchair. The CNA stated the resident stated their wheelchair was very uncomfortable and if they had a comfortable wheelchair they might get up. On 01/09/25 at 10:40 a.m. LPN #1 stated Resident #18 did not like to get out of their room. They stated they had not had anyone tell them anything about the wheelchair for Resident #18 and had not looked at it themselves. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/09/25 at 10:45 a.m., RN #1 stated Resident #18 refused to get up for activities. They stated Resident #18 did say something to them about getting a better wheelchair. RN #1 stated the physical therapist or social services director would look at it if they needed more items. They stated they did ask Resident #18 why they did not want to get up and encouraged Resident #18 to try. RN # stated they would go up the chain of command to the DON for possibly getting something different for a resident and it would be charted in the shift report if issues were identified. On 01/09/25 at 10:57 a.m., the DON stated if there were an issue with a wheelchair they would have physical therapy look at it to evaluate it. The DON stated it was the facility's responsibility. On 01/09/25 at 11:14 a.m., the DON accompanied the surveyor to the room of Resident #18 and observed the condition of the wheelchair. They removed the wheelchair and stated they would replace it that day. 2. Resident #22 had diagnoses which included dementia and anxiety. The Care Plan, dated 07/10/24, documented Resident #22 was at risk for alteration in activities due to having little interest or pleasure in doing things related to diagnosis of dementia. The plan documented Resident #22 would maintain activity level and continue to be encouraged to participate in activities at least weekly through review date. The plan documented an intervention was that Resident #22 would maintain alternate methods to engage in sensory stimulation and to provide structured activity program for intellectual stimulation. The September 2024 activity calendar for Resident #22 documented exercise, music therapy, and social visit. The activity note, dated 09/30/24, documented Resident #22 passively attended activities. The note documented Resident #22 wandered the hall and visited with other residents. Resident #22 did not have the attention span to actively participate, but did occasionally watch television a few minutes at a time. The October 2024 activity calendar for Resident #22 documented exercise. An undated note documented Resident #22 loved to keep busy and walk the hall regularly for exercise. The November 2024 activity calendar for Resident #22 documented exercise and social visit. An undated note documented Resident #22 walked a lot for exercise and was unable to do many activities due to health. On 01/06/25 at 11:22 a.m., Resident #22 was observed in bed with their eyes closed and facing the wall and covered with a blanket. On 01/07/25 at 1:54 p.m., Resident #22 was observed in bed. No activity was occurring on the memory unit. On 01/08/25 at 9:15 a.m., Resident #22 was observed in bed, legs over the side of the bed with their feet on the floor, but laying over on their side facing the door. No activities were occurring on the memory unit. On 01/08/25 at 9:18 a.m., a CMA #1 reported Resident #22 was being sent out due to a change in condition. They stated the resident was sleeping more, not eating, or getting up. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/13/25 at 11:19 a.m., the activities director was asked what the program activities and goals were for Resident #22. The activities director stated they walked around and visited with Resident #22. They stated Resident #22 would watch, but not get involved. The activity director stated they did not know that anybody monitored the activity documentation, but they reported to the administrator and social services director. 3. Resident #26 had diagnoses which included Alzheimer's disease, dementia, and anxiety. A Care Plan, dated 01/03/23, documented Resident #26 participated in some activities at times such as social events, bingo, birthday parties, but required supervision going to and from activities. The care plan documented Resident #26 would continue with self-directed activities daily through the review date. The interventions/approaches were to introduce Resident #26 to other residents with similar interests, disabilities, or limitations. The September 2024 activity calendar for Resident #26 documented activities for the month to be music, movies, television, and social visit were checked for the month. The activity note, dated 09/30/24, documented Resident #26 was up and out of their room daily. The note documented Resident #26 enjoyed music, TV, and social visits. The October 2024 activity calendar for Resident #26 documented activities for the month to be television and social visits. The note documented Resident #26 loved to hang out with friends and sometimes enjoyed watching television. The November 2024 activity calendar for Resident #26 documented activities for the month to be beauty shop once, movie time, television, and social visit. An undated activity note documented Resident #26 enjoyed watching television and hanging out with friends. On 01/06/25 at 11:54 a.m., no activities were observed on the unit. Residents were observed to be sitting in the dining room waiting for the noon meal and watching television. On 01/13/25 at 11:20 a.m., the activities director was asked what the program activities and goals were for Resident #26. They stated they just sat and visited, and played with their hands. The activities director stated they documented monthly on each resident. They stated the notes probably did need to be dated and they messed up. The activities director stated weekend activities were initiated by residents. 4. Resident #42 had diagnoses which included vascular dementia. A Care Plan, dated 07/23/24, documented Resident #42 had little to no involvement in activities related to cognitive impairment and would participate in at least one activity weekly. It documented to provide one-to-one visits in a quiet location when the resident was unable to tolerate group activities. It documented to provide a structured activity program for intellectual stimulation, when appropriate place Resident #42 in appropriate psychological group activities, give resident verbal reminders of activity before commencement of activity, and establish a daily routine with the same activity personnel/volunteers. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A quarterly assessment, dated 09/30/24, documented the daily activity preferences answered by a resident representative for Resident #42 was going outside for fresh air as very important and to keep up with the news and listening to music as somewhat important. The October 2024 activity calendar for Resident #42 documented activities for the month to include television and social visit. An undated and unsigned note documented Resident #42 enjoyed meal time with friends and watching television and Resident #42 really enjoyed puppy time. The November 2024 activity calendar for Resident #42 documented activities for the month to include television. An undated and unsigned activity note documented Resident #42 enjoyed a good visit and looked forward to meal time. The note documented the resident watched television. The December 2024 activity calendar for Resident #42 documented activities for the month to include television. An undated note documented Resident #42 did not leave their room much and listened to the television and enjoyed a good conversation. On 01/06/25 at 11:17 a.m., no activities were observed to be provided. Resident #42 was observed in the dining area watching television. On 01/13/25 at 11:14 a.m., the activities director stated they were responsible to provide and document activities for the residents. They stated they do a survey for the MDS coordinator when a resident was admitted and that lead them to what the resident wanted to do for activities. When asked how that differed from the dementia unit, they stated they spent a lot of time with every resident. The activity director was asked what the program of activities and goals were for Resident #42. They stated they had taken coloring sheets and puzzles to the unit, but Resident #42 could not do any of that. The activities director stated their documentation did not reflect the interventions in the care plan for activities because they did not know that was something they needed to do. They stated their documentation did not reflect their attempts to encourage group activities or refusals by the resident. The activity director stated they had not had any formal training in dementia care, but they would love some. On 01/13/25 at 11:37 a.m., the administrator stated the activity director was responsible to document and complete activities for the facility. They stated the activity director had been hired three months ago. The administrator stated the activity director had been shown and told what to do and when to do it. They stated the documentation should be daily or monitored and tracked daily by the social services director, but they had been out of the facility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41809 Based on observation, record review, and interview, the facility failed to monitor and evaluate a resident's response to an intervention for one (#26) of one sampled resident who was reviewed for quality of care. The administrator identified 78 residents who resided at the facility. Findings: An Abuse Policy and Procedure policy, dated January 2024, read in parts, nursing staff shall document the incident and interventions in the Medical Record .Nursing Assessment. The Director of Nursing or designee is responsible for assessing the victim and shall document findings .in the medical record. Resident #26 had diagnoses which included vascular dementia, Alzheimer's disease, and delusions. Review of the care plan for Resident #26, dated 01/03/23 and updated 04/01/24, 07/01/24, and 07/25/24, documented a concern for alteration in skin due to incontinence and documented to monitor and notify physician and representative of changes such as bruising. The care plan revealed no concern regarding bruising through the review dates. On 01/06/25 at 11:52 a.m., Resident #26 was observed to have a bruise on the left side of their neck approximately the size of a nickel. Review of priority charting for Resident #26 revealed no documentation regarding a bruise to the left side of their neck. Review of physician progress notes for Resident #26 in 2024 and 2025 revealed no progress notes regarding bruising to the neck. On 01/08/25 at 11:01 a.m., LPN #1 stated they were not aware of a bruise on the neck of Resident #26. They stated the bruise would be an injury of unknown origin and they would need to do a report on it. On 01/08/25 at 11:03 a.m., the DON stated they would have to check on the bruising. On 01/08/25 at 11:11 a.m., CMA #2, CMA #3, CNA #5 and CNA #6 working on the memory unit stated Resident #26 would have random bruising on their neck and then the next day the bruising would be gone. They stated they had reported it to the nurse approximately a year ago. On 01/08/25 at 11:16 a.m. the DON and nurse manager came to the memory unit and questioned the staff. The staff stated to the DON they had addressed it before. The DON stated to this surveyor, [They] was on aspirin so [medical director] took [them] off the aspirin. The DON then walked away. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/25 at 11:53 a.m., the DON stated it was more than a year ago the bruising was addressed and had not been re-addressed because the bruising would resolve without intervention. The physician's progress note which documented the bruising was addressed was requested. On 01/08/25 at 3:52 p.m., the DON stated they had found the progress notes from the medical director and none had documented anything about bruising. The DON requested if they could call the medical director. The DON was informed to follow their protocol. They stated bruising should be reported to the nurse who then assessed and notified the doctor of the issue. The DON did not return with documentation of the bruising being addressed or re-addressed by the physician.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 35474 Based on observation, record review, and interview, the facility failed to ensure residents were assessed for the use of bed rails for one (#57) of one sampled resident who was reviewed for bed rails. The DON identified one resident who had bed rails. Findings: The Proper Use of Side Rails policy, dated December 2022, read in parts, Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents . When used for mobility or transfer, an assessment will include a review of the resident's .bed mobility .risk of entrapment from the use of side rails .that the bed's dimensions are appropriate for the resident's size and weight .Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails .The risks and benefits of side rails will be considered for each resident .Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks. Resident #57 had diagnoses which included unspecified dementia and hemiparesis of the left side. The Admission Data Collection Form, dated 04/05/24, documented a side rail assessment. The assessment was not fully completed and was blank under the recommendations regarding bed rails and intervention areas of the side rail section of the form. The Care Plan, updated 11/04/24, documented the resident required extensive assistance with bed mobility. The care plan did not document the use of bed rails. Review of the clinical record did not reveal documentation the side rails treated a medical condition, a completed assessment had been conducted, alternative interventions had been attempted, that the resident/resident representative had been informed of the benefits and risks of bed rail use, or that consent for the use of bed rails for Resident #57 had been obtained. On 01/06/25 at 9:49 a.m., Resident #57 was observed in bed with half bed rails in the up position bilaterally. Resident #57 stated they did not use the bed rails and they assumed they were applied for safety to keep them in bed. On 01/09/25 at 10:51 a.m., LPN #3 stated Resident #57 utilized the bed rails to assist in repositioning during care. They stated they did not know why the resident had bilateral side rails since they were unable to utilize their left side. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/25 at 10:59 a.m., the DON stated residents were assessed for the use of bed rails prior to installation. The DON stated they did not obtain consents or discuss risks and benefits of side rail use with the resident and/or the resident representative. The DON stated Resident #57 could move their right hand a little. The DON stated they did not know why Resident #57 had bilateral half bed rails. On 01/09/25 at 11:42 a.m., the DON stated the resident preferred half bed rails bilaterally, but did not require them. The DON stated they did not know why the bed rail assessment had not been completed. On 01/13/25 at 10:01 a.m., the DON stated Resident #57 could not properly utilize the half bed rails bilaterally as a positioning device. On 01/13/25 at 11:29 a.m., the care plan coordinator stated they did not know Resident #57 had half bed rails bilaterally.

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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. 41809 Based on observation, record review, and interview, the facility failed to ensure nurse staffing was posted for public view. The administrator identified 78 residents resided at the facility. Findings: A review of the QOC reports for October, November and December 2024 revealed staffing numbers were good with the exception of one day shift in December. On 01/14/25 at 9:20 a.m., the administrator stated they had the staff names and position for each shift on each hall. They stated they did not have the total number of nursing hours posted. On 01/14/25 at 10:32 a.m., the DON stated they had a book for the daily schedule at the nurses desk, but for the time during the survey the book was in their office. They stated total nursing hours were not in the book.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 35474 Based on record review and interview, the facility failed to ensure pharmacist medication regimen reviews were conducted monthly for five (#24, 57, 62, 22, and #59) of five sampled residents who were reviewed for unnecessary medications. The DON identified 78 residents who received medications in the facility. Findings: The Medication Regimen Reviews policy, dated May 2024, read in parts, The Consultant Pharmacist reviews the medication regimen of each resident at least monthly .The Consultant Pharmacist provides the Director of Nursing Services and Medical Director with a written, signed and dated copy of all medication regimen reports .Copies of medication regimen review reports .are maintained as part of the permanent medical record. 1. Resident #24 had diagnoses which included schizoaffective disorder, bipolar type. The Care Plan, dated 12/09/24, read in part, Monitor pharmacist's drug regimen review for identification of potential drug interactions. Review of the clinical record and the monthly medication regimen reviews provided by the DON did not reveal the pharmacist had conducted a medication regimen review in January 2024, February 2024, March 2024, or July 2024 for Resident #24. 2. Resident #57 had diagnoses which included unspecified dementia. The Care Plan, dated 11/04/24, read in part, Monitor pharmacist's drug regime review for identification of potential drug interactions. Review of the clinical record and the monthly medication regimen reviews provided by the DON did not reveal the pharmacist had conducted a medication regimen review in December 2023 or March 2024 for Resident #57. 3. Resident #62 had diagnoses which included vascular dementia. The Care Plan, dated 11/08/24, read in part, Monitor pharmacist's drug regimen review for identification of potential drug interactions. Review of the clinical record and the monthly medication regimen reviews provided by the DON did not reveal the pharmacist had conducted a medication regimen review in January 2024 for Resident #62. 41809 4. Resident #22 had diagnoses which included Alzheimer's disease/dementia, anxiety, and depression. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Gracewood Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 6201 East 36th Street Tulsa, OK 74135	

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility provided medication regimen reviews, but were unable to provide January 2024, February 2024, March 2024, and August 2024. One gradual dose reduction was provided for 09/30/24 to reduce trazodone (an antidepressant) to 75 mg every hour of sleep from 100 mg. The physician refused and documented Resident #22 was stable on the current medication. Review of the clinical record revealed the last physician's orders were dated 07/24/24. A Care Plan, dated 07/10/24, documented a concern for psychotropic drug use and was updated/reviewed 10/08/24. The care plan revealed Resident #22 was taking Nuedexta (an antipsychotic), trazodone and Ativan (an anti-anxiety). The care plan was not updated to include Depakote (an antiepileptic) and Risperdal (an antipsychotic). The care plan documented approaches as evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs. The care plan documented to monitor pharmacist's drug regimen review for identification of potential drug interactions. The care plan documented to administer Ativan and trazadone as per ordered and monitor for side effects. The care plan documented to monitor Resident #22 for signs of tremor documented and to report onset or increase to physician. The care plan documented to observe the resident's gait for steadiness, balance, muscle coordination, and ability to position and turn. The care plan documented to monitor the resident's mental status function and report any changes. 5. Resident #59 had diagnoses which included dementia and anxiety. Review of the clinical record for Resident #59 revealed missing MRR/GDRs for January, February, March, July, August, September and December 2024. The clinical record did not reveal lab results. An annual assessment, dated 05/21/24, documented Resident #59 had inattention and disorganized thinking with delusions. The assessment documented Resident #59 had rejected care four to six days during the seven day look back period. The assessment documented antipsychotic use and antidepressant use. The assessment documented no gradual dose reduction due to the physician documented a reduction would be clinically contraindicated on 12/15/23. Physician's Orders, dated November 2024, documented Resident #59 was ordered the following medications: duloxetine (an antidepressant) 90 mg every day, olanzapine ODT (an antipsychotic) 10 mg every hour of sleep and trazodone 100 mg every hour of sleep. The physician's orders documented an order for CBC and CMP every six months, HGA1C every three months and a lipid panel yearly. An updated care plan, dated 12/09/24, documented a concern for psychotropic drug use of antipsychotic medications olanzapine/duloxetine. On 01/09/25 at 9:58 a.m., the administrator stated they had not located more gradual dose reductions or medication regimen reviews. On 01/09/25 at 11:48 a.m., the DON was asked what the facility policy was regarding gradual dose reductions. The DON did not answer. The DON stated the facility was having an issue with medical records and that was why medication regimen reviews and gradual dose reductions were not in the clinical records. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/13/25 at 1:01 p.m., the DON was asked for the original start date for Ativan, Risperidone, and Depakote DR for Resident #22. The DON stated Resident #22 had started Ativan on 07/18/24, Depakote on 04/13/23 and Risperdal on 06/14/22. No gradual dose reductions or medication regimen reviews were provided by the end of the survey. On 01/13/25 at 5:15 p.m., the pharmacist stated they had not seen an order for Risperidone since they started in April 2023. They stated they had been following Depakote, Ativan, and trazodone for Resident #22 and had no notes about them being on Risperidone recently. The pharmacist stated they did not know how accurate the orders were in the clinical record. They stated they went by the medication administration record to see what the resident had been given and when they found an error, they never go to the actual clinical record because they do not find the record to be helpful at all. The pharmacist stated they had a hard time with labs as well and would ask staff to pull the labs up on the computer and tell them. They stated they had asked for lab access as well because they had not been able to find it in the clinical record. The pharmacist stated the best they could do was see that labs were ordered. They stated they came to the facility on ce a month toward the end of the month and the turn around was a physical delivery the next day or two. The pharmacist stated they would obtain a signature from administrative staff or a nurse.

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F 0758 Level of Harm - Minimal harm or potential for 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. 41809 Based on record review and interview, the facility failed to ensure residents did not receive unnecessary medications for one (#22) of five sampled residents who were reviewed for psychotropic medications. The nurse manager identified 78 residents who received medications. Findings: Resident #22 had diagnoses which included Alzheimer's/dementia, anxiety and depression. A review of the clinical record for Resident #22 did not document side effect monitoring or that the physician was provided an MRR or GDR of Risperdal (risperidone) (an antipsychotic) for review and reduction. A Care Plan, dated 07/10/24, for Resident #22 documented a concern for psychotropic drug use and was updated/reviewed 10/08/24. The care plan revealed Resident #22 was taking an antipsychotic Nuedexta, an antidepressant trazodone, and an anti-anxiety medication of Ativan. The care plan was not updated to include Risperdal. The care plan documented approaches to evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs. On 01/09/25 at 11:48 a.m., the DON was asked what the facility policy was regarding gradual dose reductions. The DON did not answer. The DON stated the facility was having an issue with medical records and that was why medication regimen reviews and gradual dose reductions were not in the clinical records. On 01/13/25 at 1:01 p.m., the DON was asked for the original start date for Ativan (lorazepam), Risperdal, and Depakote DR (an antiepileptic). The DON stated Resident #22 had started Ativan on 07/18/24, Depakote on 04/13/23 and Risperdal on 06/14/22. No evidence was provided. On 01/13/25 at 5:15 p.m., the pharmacist stated they had not seen an order for Risperdal since they started in April 2023. They stated they had been following Depakote, Ativan, and trazadone for Resident #22 and had no notes about them being on Risperdal recently.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35474 Based on observation, record review, and interview, the facility failed to: a. ensure medications were secured for one (300 hall treatment cart) of six medication carts observed; b. ensure medications were dated when opened and/or insulin was discarded after 28 days for two (200 hall treatment cart and 300 hall treatment cart) of three medication carts observed; and c. ensure expired medications were not in use for one (100 hall medication cart) of three medication carts observed. LPN #2 identified six medication carts in the facility. Findings: The Medication Storage policy, dated 07/21/24, read in parts, The facility shall not use .outdated .drugs or biologicals .Compartments (including .carts .) shall be locked when not in use. 1. On 01/07/25 at 4:34 p.m., RN #2 was observed during medication administration to prepare insulin and enter room [ROOM NUMBER]. The 300 hall treatment cart was observed to be left unattended and unlocked. On 01/07/25 at 4:35 p.m., RN #2 was observed to walk to the nurses station to obtain a cup of water. The 300 hall treatment cart was observed to be left unattended and unlocked for approximately 15 to 20 seconds. On 01/07/25 at 4:39 p.m., RN #2 was observed to walk into room [ROOM NUMBER] to administer medication. The 300 hall treatment cart was observed to be left unattended and unlocked. On 01/07/25 at 4:40 p.m., RN #2 returned to the treatment cart, wheeled it to the nurses station, and locked the cart. On 01/08/25 at 9:17 a.m., RN #1 was observed to prepare medications for administration. RN #1 was observed to enter room [ROOM NUMBER]. Four medication cups were observed to be left unattended on top of the 300 hall treatment cart. One cup was observed to contain three capsules, one cup was observed to contain crushed medications, one cup was observed to have a red liquid medication, and one cup was observed to contain a clear liquid medication. On 01/08/25 at 9:19 a.m., RN #1 was observed to return to the treatment cart and obtain the four cups with medications and re-enter room [ROOM NUMBER]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/08/25 at 9:32 a.m., RN #1 was observed to obtain something from the 300 hall medication cart and re-enter room [ROOM NUMBER]. The 300 hall treatment cart was observed to be unattended and unlocked. On 01/08/25 at 9:39 a.m., RN #1 was observed to exit room [ROOM NUMBER]. RN #1 stated they usually locked the 300 hall treatment cart and the carts were to be kept locked when unattended. On 01/13/25 at 3:35 p.m., the DON stated medication carts were to be kept locked when unattended. 2. On 01/13/25 at 2:59 p.m., the 200 hall treatment cart was observed with LPN #2. The following was observed, a. the Trelegy inhaler and albuterol inhaler for Resident #178 were opened, but not dated, b. the Symbicort inhaler and Spiriva inhaler for Resident #49 were opened but not dated, c. the albuterol inhaler for Resident #78 was opened but not dated, d. the Ventolin inhaler for Resident #24 was opened but not dated, e. the Novolog insulin for Resident #66 was opened and dated 12/03/24, f. the Novolog insulin for Resident #16 was dated as opened on 12/03/24, and g. the glucometer test strips were opened and not dated. On 01/13/25 at 3:05 p.m., LPN #2 stated they did not know glucometer test strips were to be dated when opened. LPN #2 stated they kept open insulin for one month and the Novolog insulin for Resident #66 and Resident #16 should have been discarded. On 01/13/25 at 3:09 p.m., the 300 hall treatment cart was observed with RN #2. The glucometer test strips were observed to be open and not dated. On 01/13/25 at 3:35 p.m., the DON stated they did not date opened glucometer test strips and they monitored medication carts to ensure medications were dated when opened. They stated they did not know why medications were not dated when opened or discarded as indicated. 3. On 01/13/25 at 3:13 p.m., the 100 hall medication cart was observed with CMA #4. The following was observed, a. the house stock Tussin DM was observed to have a manufacturer expiration date of 12/2024, and b. the geri-lanta for Resident #179 had an expiration date of 12/20/24 on the label. On 01/13/25 at 3:22 p.m., CMA #4 stated they thought the DON monitored for expired medications on the medication carts. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/13/25 at 3:35 p.m., the DON stated they were responsible to monitor medications on the medication carts for expiration dates. They stated it was an oversight for the geri-lanta and the Tussin DM. On 01/13/25 at 3:44 p.m., the DON observed the house stock Tussin DM and stated it expired 12/2024. The DON observed the geri-lanta for Resident #179 and stated a manufacturer expiration date was not available on the bottle so they would reference the expiration date of 12/20/24 on the medication label.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 35474 Based on record review and interview, the facility failed to ensure labs were completed as ordered by the physician for two (#24 and #62) of five sampled residents whose labs were reviewed. The DON identified 78 residents who had orders for labs. Findings: The Lab and Diagnostic Test Results - Clinical Protocol policy, dated July 2024, read in part, The staff will process test requisitions and arrange for tests. 1. Resident #24 had diagnoses which included schizoaffective disorder, bipolar type. A Physician's order, dated 02/05/21, documented to obtain a valproic acid level every 3 months in July, October, January, and April. A Physician's order, dated 11/01/23, documented the resident was ordered valproic acid 500 mg at bedtime. Review of the clinical record and labs provided by the DON did not reveal a valproic acid level had been obtained in July 2024 or October 2024. 2. Resident #62 had diagnoses which included vascular dementia. A Physician's Order, dated 02/12/24, documented to obtain a CMP every six months. Review of the clinical record and lab results provided by the DON revealed the last CMP was obtained on 05/31/24. A CMP for November 2024 was not seen in the clinical record or provided by the DON. On 01/09/25 at 11:48 a.m., the DON stated they were responsible to ensure labs were obtained as ordered by the physician. They stated there was a lab report binder in the MDS coordinator's office they would provide. On 01/13/25 at 9:32 a.m., the DON stated they felt there was something wrong with medical records obtaining and filing the lab reports, but they did not think they had any additional lab reports to provide. By the end of the survey the lab report binder or additional lab reports had not been provided for Resident #24 or Resident #62.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35474 Based on record review and interview, the facility failed to ensure resident records were complete and accessible for four (#57, 24, 22, and #59) of 18 sampled residents whose records were reviewed. The DON identified 78 residents who resided in the facility. Findings: The Medication Orders policy, dated 06/15/24, read in part, A current list of orders must be maintained in the clinical record of each resident. The Charting and Documentation policy, dated July 2024, read in part, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 1. Resident #57 had diagnoses which included unspecified dementia. Review of the clinical record revealed the last gradual dose reduction from the consultant pharmacist was dated 2023, the latest lab report was dated 11/28/23, and the physician's orders were from October 2024. 2. Resident #24 had diagnoses which included schizoaffective disorder, bipolar type. Review of the clinical record revealed the latest physician's orders in the clinical record were dated October 2024. On 01/09/25 at 11:58 a.m., the DON stated they and the MDS coordinator were responsible to ensure clinical records were complete and accessible. They stated current physician's orders, labs, and consultant pharmacist's reports had not been filed by the medical records staff member. The DON stated they did not know how clinical records were monitored to ensure they were complete and accessible. 3. Resident #22 had diagnoses which included Alzheimer's disease/dementia, anxiety, and depression. Review of the clinical record revealed the last physician's orders were dated 07/24/24. The facility provided medication regimen reviews, but were unable to provide January 2024, February 2024, March 2024 and August 2024. None were located in the clinical record for Resident #22. On 01/09/25 at 9:58 a.m., the administrator stated they had not located more gradual dose reductions or medication regimen reviews from medical records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/09/25 at 11:48 a.m., the DON stated the facility was having an issue with medical records and that was why medication regimen reviews and gradual dose reductions were not in the clinical records. On 01/13/25 at 5:15 p.m., the pharmacist stated they had not seen an order for risperidone (an antipsychotic) since they started in April 2023. They stated they had been following Depakote (an antiepileptic), Ativan (an anti-anxiety), and trazadone (an antidepressant) for Resident #22, and had no notes about them being on risperidone recently. The pharmacist stated they did not know how accurate the orders were in the clinical record. They stated they go by the medication administration record to see what the resident had been given and when they found an error, they never go to the actual clinical record because they do not find the record to be helpful at all. The pharmacist stated they had a hard time with labs as well and would ask staff to pull the labs up on the computer and tell them. They stated they had asked for lab access as well because they had not been able to find it in the clinical record. The pharmacist stated the best they could do was see labs were ordered. They stated they came to the facility on ce a month toward the end of the month and the turn around was a physical delivery the next day or two. The pharmacist stated they would obtain a signature from administrative staff or a nurse. 4. Resident #59 had diagnoses which included dementia and anxiety. Review of the clinical record for Resident #59 revealed missing MRR/GDRs for January, February, March, July, August, September and December 2024. The clinical record did not reveal lab results.

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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. 35474 Based on observation, record review, and interview, the facility failed to ensure enhanced barrier precautions were implemented for one (#279) of one sampled resident with a peg tube observed during medication administration. The nurse manager identified two residents who had peg tubes. Findings: The Enhanced Barrier Precautions policy, dated August 2022, read in parts, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms to residents .EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .device care or use (.feeding tube .) .Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE required .PPE is available outside of the resident rooms. Resident #279 had diagnoses which included unspecified severe protein calorie malnutrition. The significant change assessment, dated 05/27/24, documented the resident had a feeding tube. On 01/08/25 at 8:49 a.m., RN #1 was observed to administer medications to Resident #279 through their peg tube. RN #1 was not observed to utilize PPE, except for gloves. Signage to indicate enhanced barrier precautions and PPE was not observed near the resident's room. On 01/08/25 at 9:30 a.m., RN #1 was observed to perform peg tube site care. RN #1 was not observed to utilize PPE, except for gloves. On 01/09/25 at 11:29 a.m., RN #1 stated they would need to find out what the facility's policy was for enhanced barrier precautions. On 01/13/25 at 9:51 a.m., the DON stated they did not understand what enhanced barrier precautions were and needed to review the facility's policy.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 35474 Based on observation, record review, and interview, the facility failed to ensure resident beds were regularly inspected for safety for one (#57) of one sampled resident who was reviewed for bed rails. The DON identified one resident who had bed rails. Findings: The Bed Safety policy, dated June 2024, read in parts, Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks .Ensure that bedrails are properly installed. Resident #57 had diagnoses which included unspecified dementia and hemiparesis of the left side. Review of the clinical record and maintenance logs did not reveal documentation the resident's bed had been regularly inspected for safety related to the use of side rails. On 01/06/25 at 9:49 a.m., Resident #57 was observed in bed with half bedrails in the up position bilaterally. On 01/13/25 at 10:01 a.m., the DON stated the maintenance staff inspected beds and bed rails for safety. On 01/13/25 at 10:12 a.m., maintenance worker #1 stated they were responsible to review beds for safety. They stated if something was brought to their attention, they checked the bed as soon as possible, otherwise they checked the beds when they did rounds in the facility. They stated they did not document bed safety checks. On 01/13/25 at 4:45 p.m., the administrator stated the maintenance staff were responsible to regularly inspect the residents' beds for safety, but they did not document their inspections.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 41809 Based on observation, record review, and interview, the facility failed to ensure call lights were operational and available for residents. The administrator identified 78 residents who resided at the facility. Findings: A Bedrooms policy, reviewed May 2024, read in part, All resident rooms are equipped with a resident call system that allows residents to call for staff assistance. Review of the maintenance log book revealed on 12/28/24 room [ROOM NUMBER] had a call light ripped from the wall and wires were exposed. The log book documented the date of repair was 12/30/24. The repair was initialed. On 01/08/25 at 11:36 a.m., room [ROOM NUMBER] was observed to have wires coming from the wall where the call light would be. On 01/06/25 at 10:15 a.m., room [ROOM NUMBER]A was observed to have no call light cord. On 01/06/25 at 10:16 a.m., room [ROOM NUMBER]A was observed to have no call light cord. On 01/06/25 at 10:18 a.m., room [ROOM NUMBER]A was observed to have no call light cord. On 01/06/25 at 10:19 a.m., room [ROOM NUMBER]A was observed to have no call light cord. On 01/06/25 at 10:21 a.m., room [ROOM NUMBER]B was observed to have no call light cord. On 01/06/25 at 10:22 a.m., room [ROOM NUMBER]B was observed to have no call light cord. On 01/06/25 at 10:23 a.m., room [ROOM NUMBER]A was observed to have exposed wires at the wall connection of the call light cord. On 01/08/25 at 11:36 a.m., room [ROOM NUMBER] was observed to have exposed wires at the wall connection of the call light cord. On 01/13/25 at 10:17 a.m., maintenance #1 stated residents removed the call lights and did not put them back. They stated it had been about a month since the call lights were ordered by the administrator. On 01/13/25 at 11:42 a.m., the administrator was asked how residents notify staff when they need assistance if they had no call light. The administrator did not answer.