STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375461	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Norman, LLC	1050 Rambling Oaks Drive Norman, OK 73072

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on record review and interview, the facility failed to ensure resident assessments were accurately coded for one (#4) of 12 sampled residents reviewed for accurate assessments. The administrator identified 47 Residents resided in the facility. Findings: The facility's Coordination of certification of Assessments policy, revised April 2024, read in part, To ensure each resident assessment will be coordinated by and certified as complete by a registered nurse, and all individuals who complete a portion of the assessment will sign and certify to the accuracy of the portion of their assessment. The policy also read, All information recorded within the MDS assessment reflect the resident status at the time of the assessment reference date. Resident #4 was admitted on [DATE] with diagnoses which included systolic heart failure and depression. A physician order, dated 08/04/24, documented, may administer supplemental oxygen as needed. A comprehensive assessment, dated 08/11/24, documented in section O, Resident #4 did not require oxygen therapy. Resident #4's care-plan did not document oxygen therapy as needed. A O2 Sats Summary document, dated 01/15/24 through 08/13/24, documented, Resident #4 received oxygen therapy on 08/11/24. On 08/13/24 at 10:00 a.m., LPN # 1 was asked to discuss resident #4's respiratory care needs. LPN # stated Resident #4 was on oxygen and had an order for supplemental oxygen as needed. On 08/13/24 at 10:07 a.m., the DON was asked what the care plan documented for Resident #4's respiratory care. The DON stated the resident did have oxygen care needs in their orders but it was not in the care plan and wears oxygen at night. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/13/24 10:08 a.m., the MDS Coordinator #1 was asked to discuss Resident #4's respiratory care orders and MDS assessment dated [DATE]. The MDS coordinator stated the resident had an order for supplemental oxygen. They stated Resident #4 did receive oxygen on 8/11/24. They were asked what does section O in the comprehensive assessment, dated 08/11/24, documented for oxygen therapy. The MDS coordinator stated they selected no in section O when they should of selected yes regarding oxygen therapy because the resident did use oxygen on 08/11/24. They stated the MDS, dated [DATE], was not correct.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46582 Based on record review and interview, the facility failed to provide baths/showers as scheduled for one (#36) of three sampled residents reviewed for activities of daily living. The DON identified 47 residents who resided in the facility. Findings: A Bathing policy, dated 05/24, read in part, .All residents are given a bath or shower in accordance with their preferences. If no preferences on a bath is voiced, a bath or shower will be offered twice per week . Res #36 was admitted [DATE] with diagnoses which included chronic kidney disease, pleural effusion, and fluid overload. The resident was discharged [DATE]. A facility shower schedule documented Res #36 was to receive a shower every Tuesday and Friday. An admission assessment, dated 06/14/24, documented Res #36 was cognitively intact and required substantial to maximal assistance with bathing. A Resident Grievance form, dated 07/07/24, documented the resident had requested a shower for days. Res #36's medical record had no documentation the resident received a shower/bath from admission until discharge. On 08/13/24 at 10:54 a.m., the DON stated Res #36's completed baths should have shower sheets scanned into the EHR or should have been documented as completed under tasks in the resident's medical record. The DON stated if no documentation could be found, then there was no way to prove Res #36 had a shower while in the facility. On 08/15/24 at 8:52 a.m. the administrator in training stated all residents should receive baths twice weekly and as needed. They stated the facility was unable to locate any documentation of completed baths for Res #36.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46582 Based on record review and interview, the facility failed to ensure physician orders were followed for obtaining weekly weights for one (#36) of one sampled resident reviewed for weights. The DON identified 47 residents who resided in the facility. Findings: Res #36 was admitted [DATE] with diagnoses which included chronic kidney disease, pleural effusion, and fluid overload. The resident was discharged [DATE]. A physician order, dated 06/08/24, documented weekly weights every Thursday. A physician order, dated 06/08/24, documented weights taken as prescribed by the physician. Weight differences of greater than 3 pounds in two days or 5 pounds in one week will be communicated to the physician. Weights will be taken using the same scale or other as appropriate based on mobility. A care plan, dated 06/11/24, documented the resident had the potential for alterations in nutrition and hydration related to recent fluid overload with an intervention to obtain and document weights per physician orders. An admission assessment, dated 06/14/24, documented Res #36 was cognitively intact, required a mechanically altered diet, and had no weight gain/loss of 5% or more in the last month or 10% or more in the last 6 months. Res #36's medical record documented the following weights: 06/08/24 = 207.7 lbs. 06/13/24 = 206.8 lbs. 06/27/24 = 231.6 lbs. 07/01/24 = 236.4 lbs. The documentation indicated a weight gain of 28.7 lbs. in 23 days. There was no documentation a weight had been obtained on 06/20/24. There was no documentation the weight gain had been reported to the physician. There was no documentation interventions had been implemented to address the weight gain. On 08/14/24 at 1:16 p.m., LPN #1 stated they were not sure why a weight had not been obtained on Res #36 for 06/20/24. LPN #1 stated they thought they had notified the physician regarding the weight gain but had not documented the notification. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/14/24 at 1:50 p.m., the DON stated there was no documentation of Res #36's weight on 06/20/24. They stated the resident was supposed to have been weighed weekly. On 08/14/24 at 1:56 p.m., the physician #1 stated they do not remember if the staff notified them of Res #36's significant weight gain. They stated the resident was in good spirits upon discharge and voiced no concerns.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review, and interview, the facility failed to prevent an injury to a resident during transfers for one (#29) of two residents sampled for accidents and hazards. The Administrator identified 47 residents resided in the facility. Findings: The facility's Incident and-Accidents policy, dated 11/2018, read in part, If an accident occurs, a full investigation will be initiated, including staff, interviews, equipment, checks, and follow through on policy and procedures. The policy also read, Facility will monitor the effectiveness of the interventions, including adequate supervision consistent with the residents needs, goals, plan of care, and current standards of practice in order to reduce the risk of an accident. The policy also read, The facility shall maintain a file of all written reports of each incident and accident affecting the resident that is not a expected outcome of a residence condition or disease process. Resident #29 was admitted on [DATE] with diagnoses which included fracture of the right femur and dysphasia. A comprehensive assessment dated [DATE] documented Resident #29's cognition was mildly impaired, had range of motion impairments in the lower extremities on both sides, and was dependent for transfers. A care-plan, dated 07/11/24, read in part, Chair/bed-to-chair transfer: Substantial/maximal assistance. On 08/11/24 at 9:58 a.m., Resident #29 was observed with a laceration on left leg below knee with a bandage not affixed and open with a scab. Resident #29 was asked about the injury. The Resident stated they were injured during a transfer from the bed to the wheel chair. They stated it was hurt three weeks ago and then happened again last week. They stated the facility bandaged it and does not think they care planned anything to keep the injury from occuring again. On 08/14/24 at 11:20 a.m., Resident #29 was observed with a new bandage on left knee. Resident #29 stated the injury hurt and was caused during a transfer from aides from the bed to the wheel chair. The resident stated a nurse named LPN #1 dressed the bandage and was told how the injury occurred. The resident stated that the injury has occurred three times during transfers from aides while transferring from the bed to a wheel chair. On 08/14/24 11:25 a.m., Resident #29's health records were reviewed. The EHR did not document the following: a. the left knee wound, b. interventions to prevent injuries during transfers, and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. incidents involving an injury during a transfer. On 08/14/24 at 11:32 a.m., LPN #2 was asked about Resident #29's skin conditions. LPN#2 stated, they observed the resident had a dressed abrasion on the left knee where the skin was broken on 08/13/24. LPN #2 stated they asked the resident what happened and the resident reported that the abrasion happened during a transfer from the bed to the wheel chair. LPN #2 stated they cleaned the wound with cleanser and dressed it on 08/14/24 after the resident requested a new dressing. LPN #2 stated there was documentation of the wound or incident in the health record and they did not document an incident or the wound care in the residents health records. On 08/14/24 at 12:59 p.m., LPN #1 was asked to discuss the injury on Resident #29's left knee. LPN #1 stated, on 08/13/24 around 4:00 p.m., CNA #1 stated the Resident had an abrasion and needed to be assessed. They stated CNA #1 reported the w/c had caught the residents leg during a transfer. LPN #1 stated they dressed the wound after assessing it and the Resident stated that they were transferring and their leg got caught. LPN #1 was asked if they documented anything in the health record or an incident report. They stated ,No, I forgot to do that. LPN #1 was asked what was the facility's policy when a resident gets injured. LPN #1 stated they should of documented the wound care and completed an incident report but they forgot because they got busy. On 08/15/24 at 8:25 a.m., the Administrator was asked for the facility's wound care policy. The Corporate Administrator stated they did an investigation and was able to determine on 08/8/24 that CNA #2 who was working on their first day reported to RN#1 that the resident had an injury during transfer and RN#1 dressed the wound under standing orders. They were asked if RN#1 did an IR and document the incident and wound care. The Corporate Administrator stated, No, I really think its a documentation problem. On 08/15/24 at 9:14 a.m., the DON was asked about the Resident #29's abrasions on their left knee. The DON stated the Resident told them the incident occurred on 8/8/24. The DON stated that LPN #2 and Transport #1 were transferring the Resident and the skin was raised. Next, on 8/10/24, CNA #2 scraped residents leg during a transfer. The CNA told RN #1 and RN #1 put a bandage on the residents left knee abrasion under the standing orders. RN #1 stated she did not put a note in the chart or document. The DON was asked what they thought the deficient practice was. The DON stated they should of been documenting to prevent further injury to the resident. Again, On 8/13/24, CNA #1 reported to LPN #1 that the resident was injured during a transfer on the left knee. LPN #1 evaluated and put a bandage on the abrasion. The DON was asked where they thought the deficient practice was. They stated, it should of been documented. LPN #1 did not document anything.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation and interview, the facility failed to ensure oxygen tubing was labeled and dated, per professional standards of care for three (#4,26, and #93) of three resident sampled for respiratory care. The DON identified 5 residents had orders for oxygen therapy. Findings: 1. Resident #4 was admitted on [DATE] with diagnoses which included acute kidney failure and systolic heart failure. Resident #4's physician orders, dated 8/04/24, read in part, May administer supplemental Oxygen as needed. On 08/11/24 at 9:05 a.m., Resident #4 was observed wearing oxygen via a nasal cannula. The tubing was attached to an oxygen saturator. There was no date observed on the humidifier or oxygen tubing indicating when the tubing was last changed. On 08/11/24 at 9:06 a.m., CNA #3 was asked what the date was on the oxygen tubing and/or humidifier. They stated there was not a date on the oxygen tubing or humidifier. On 08/11/24 at 9:11 a.m., RN #1 was taken to resident #4's room and asked if the oxygen tubing and humidifier was dated. RN #1 stated the tubing was not labeled with the date and it should be changed every 7 days and dated. 2. Resident #26 was admitted on [DATE] with diagnoses which included Atherosclerotic heart disease and and spondylosis without myelopathy. Resident #26's physician orders, dated 07/18/24, read in part, May administer supplemental Oxygen as needed. On 08/11/24 at 8:57 a.m., Resident #26 was observed in bed with head of bed elevated elevated wearing oxygen via a nasal cannula attached to an oxygen saturator. The oxygen tubing or humidifier was not observed to be labeled with the date indicating when it was last changed. On 08/11/24 at 8:59 a.m., RN #1 was shown the oxygen saturator and tubing. They were asked where the date was on the O2 tubing and saturator indicating when it was last changed. RN #1 stated there was not a date and it should be labeled and changed every 7 days. 3. Resident #93 was admitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease and lower respiratory infection. Resident #93's physician orders, dated 7/01/24, read in part, Continuous O2 Via (NC/MASK). The order also read, Change O2 tubing every day shift every Sun and as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/11/24 at 9:16 a.m., Resident #93 was observed wearing oxygen via a nasal cannula attached to an oxygen saturator. There was no date observed on the oxygen tubing or humidifier indicating the last time it was changed. On 08/11/24 at 9:17 a.m., CNA #3 was taken to resident #93's room and asked asked what the date was on the oxygen tubing and humidifier. CNA #3 stated they did not see a date. On 08/11/24 at 9:19 a.m., the ADON was asked to look at Resident #93's oxygen tubing and humidifier. The ADON stated there was not date labeled on the tubing or humidifier indicating when it was last changed. The ADON stated it was a nursing standard and should be changed weekly and labeled with the date.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 46582 Based on observation, record review, and interview, the facility failed to perform an entrapment risk assessment prior to installing bed or side rails for two (#2 and #86) of two residents and failed to obtain a physician order for the medical rationale and use of bed rails prior to installation for one (#86) of two sample residents reviewed for accident hazards. The DON identified 44 residents whose beds were equipped with a bed rail of any type. Findings: An Admission Packet excerpt, undated, read in part, .The grab bars/side rails are/will be implemented for positioning only after a licensed nursing assessment. FULL SIDE RAILS WILL NOT BE UTILIZED. Responsible Party and/or Guest have been advised that bed/side rails may be installed. The risks and alternatives to using bed/side rails, as they apply to Guest's particular condition and circumstances have been clearly explained. A written order from the Guest's attending physician, specifying the medical rational and circumstances for use will be obtained prior to the installation of this medical treatment device. Facility will periodically review and re-evaluate the Guest's need for bed/side rails and Guest Responsible Party and attending physician will be consulted in this matter . 1. Res #2 had diagnoses which included epilepsy, muscle wasting, and morbid obesity. A physician order, dated 03/04/20, documented quarter bed rails for turning and positioning. A care plan, dated 07/09/20, documented Res #2 had an ADL self-performance deficit related to chronic weakness. The care plan documented use of a quarter side rail or enabler/assist bar to improve mobility. An annual assessment, dated 07/11/24, documented the resident was cognitively intact, dependent with most ADLs, and dependent with bed mobility. There was no documentation of an entrapment risk assessment found in the medical record. On 08/11/24 at 9:16 a.m., Res #2 was observed sitting in a recliner beside their bed. The bed was observed to have bilateral upper quarter bed rails. The resident stated they used the rails for turning and positioning. On 08/13/24 at 12:10 p.m., the administrator stated a completed entrapment risk assessment could not be located for Res #2. They stated the assessment should have been completed prior to installation of the bed rails and quarterly thereafter. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Res #86 was admitted with diagnoses which included muscle weakness, difficulty in walking, and peripheral vascular disease. An admission assessment, dated 06/19/24, documented the resident was cognitively intact, required partial to moderate assistance with most ADLs, and required supervision to touch assistance with bed mobility. A care plan, dated 06/26/24, documented Res #86 had an ADL self-care performance deficit related to limitation in physical mobility. The care plan documented use of enabler/grab rails for safety during care provision to assist with bed mobility. The care plan documented to observe for injury or entrapment related to side rail use and reposition as necessary to avoid injury. There was no documentation of a physician order for bed rails or an entrapment risk assessment found in the medical record. On 08/11/24 at 9:37 a.m., Res #86 was observed lying in bed. Bilateral upper quarter bed rails were observed in the up position. The resident stated the rails were used to assist in turning. On 08/13/24 at 12:03 p.m. the administrator stated a completed entrapment risk assessment and physician order could not be located for Res #86. They stated a physician order should have been obtained and the assessment should have been completed prior to installation of the bed rails.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46582 Based on record review and interview, the facility failed to ensure resident medications were administered according to physician ordered parameters for three (#12, 88, and #89) of five sampled residents reviewed for unnecessary medications. The DON identified 47 residents who resided in the facility. Findings: A Pharmacy Services policy, dated 05/24, read in part, .Provide continuity of staff to ensure that medications are administered without unnecessary interruptions through: following specific monitoring related to medications, when ordered or indicated, including specific item(s) to monitor (e.g., blood pressure, pulse, blood sugar, weight), and parameters for notifying the prescriber . 1. Res #12 was admitted [DATE] with diagnoses which included dementia and hypertension. A physician order, dated 07/22/24, documented amlodipine 10 mg one time a day for hypertension. The order documented to hold the medication for a systolic blood pressure less than 110 or a diastolic blood pressure less than 70. A physician order, dated 07/22/24, documented losartan 100 mg one time a day for hypertension. The order documented to hold the medication for a systolic blood pressure less than 110 or a diastolic blood pressure less than 70. An admission assessment, dated 07/26/24, documented the resident was cognitively intact and required supervision to partial assistance with most ADLs. The July 2024 MAR documented amlodipine was administered with a diastolic blood pressure less than 70 on two of nine opportunities. The MAR documented losartan was administered with a diastolic blood pressure less than 70 on two of nine opportunities. The August 2024 MAR documented amlodipine was administered with a diastolic blood pressure less than 70 on three of 13 opportunities. The MAR documented losartan was administered with a diastolic blood pressure less than 70 on three of 13 opportunities. 2. Res #88 was admitted on [DATE] with diagnoses which included dementia, chronic kidney disease, and congestive heart failure. A physician order, dated 08/02/24, documented carvedilol 25 mg two times daily for hypertension. The order documented to hold the medication for a systolic blood pressure less than 110 or a diastolic blood pressure less than 70. A discharge-return anticipated assessment, dated 08/06/24, documented the resident was severely cognitively impaired and required partial to substantial assistance with most ADLs. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The August 2024 MAR document carvedilol was administered with a diastolic blood pressure less than 70 on two of eight opportunities. 3. Res #89 was admitted on [DATE] with diagnoses which included chronic respiratory failure, chronic kidney disease, and hypertension. A discharge-return anticipated assessment, dated 07/29/24, documented the resident was modified independent in cognitive skills for daily decision making and dependent in most ADLs. A physician order, dated 07/26/24, documented metoprolol 12.5 mg two times daily for hypertension. The order documented to hold the medication for a systolic blood pressure less than 110 or a diastolic blood pressure less than 60. The August 2024 MAR documented metoprolol was administered with a systolic blood pressure less than 110 and a diastolic blood pressure less than 60 on two of 20 opportunities. On 08/13/24 at 12:35 p.m., CMA #1 was made aware of the MAR observations for Res #12, 88, and #89. CMA #1 stated the medications should have been held per physician ordered parameters. On 08/14/24 at 11:00 a.m., the DON was made aware of the MAR observations for Res #12, 88, and #89. The DON stated the medication staff should have paid better attention and not given medications when the blood pressure was outside of ordered parameters.

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	375461	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Norman, LLC	1050 Rambling Oaks Drive Norman, OK 73072

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46582 Based on record review and interview, the facility failed to ensure a resident who received psychotropic medications had an acceptable diagnoses/indication for the use of an antipsychotic medication for three (#12, 88, and #89) of five sampled residents reviewed for unnecessary medications. The ADON identified 21 residents who received psychotropic medications. Findings: A Medication Monitoring policy, dated 01/24, read in parts, .Based on a comprehensive assessment of a resident, the facility must ensure residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record .The attending physician in collaboration with the consultant pharmacist must re-evaluate the use of the psychotropic medication and consider whether or not the medication can be reduced or discontinued upon admission or soon after admission . 1. Res #12 was admitted [DATE] with diagnoses which included dementia, anxiety, and depression. A physician order, dated 07/22/24, documented to administer olanzapine (antipsychotic medication) 5 mg two times daily for psychotic disorder. A care plan, dated 07/23/24, documented Res #12 was receiving an antipsychotic medication. The care plan documented to discuss with the physician and family the ongoing need for use of medication and to review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. An admission assessment, dated 07/26/24, documented the resident was cognitively intact, had moderate depression symptoms, had no behaviors, and received antipsychotic medication. There was no documentation of a diagnosis of psychotic disorder found in Res #12's medical record. 2. Res #88 was admitted on [DATE] with diagnoses which included dementia, anxiety, and altered mental status. A discharge-return anticipated assessment, dated 08/06/24, documented the resident was severely cognitively impaired, had moderate depression symptoms, had no behaviors, and received antipsychotic medication. A physician order, dated 08/10/24, documented aripiprazole (antipsychotic medication) 1 mg one time daily for 90 days. There was no diagnosis for use documented in the physician order for the antipsychotic medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Res #89 was admitted on [DATE] with diagnoses which included chronic respiratory failure, chronic kidney disease, and hypertension. A discharge-return anticipated assessment, dated 07/29/24, documented the resident was modified independent in cognitive skills for daily decision making, was unable to complete the mood interview, had no behaviors, and received antipsychotic medication. A physician order, dated 08/03/24, documented quetiapine (antipsychotic medication) 25 mg at bedtime for insomnia. There was no documentation of a diagnosis of insomnia found in Res #89's medical record. On 08/13/24 at 11:51 a.m., the administrator was made aware of the antipsychotic medications ordered for Res #12, 88, and #89. The administrator stated Res #12 and Res #89 did not have an appropriate diagnosis documented to support the use of antipsychotic medication. The administrator stated Res #88 should have had an appropriate diagnosis documented in the physician order for the use of the antipsychotic medication.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46702 Based on observation, record review, and interview, the facility failed to ensure food items were labeled with the date opened in the refrigerators, maintain a clean and sanitary kitchen during two of two kitchen observations. The DON identified 47 residents received nutrition form the kitchen. Findings: The facility's Food & Nutrition Services Sanitation & Food Safety policy, revised 2017, read in part, Refrigerated Potentially Hazardous Food or Time/Temperature Controlled for Safety foods are labeled with the date received. The policy also read, If opened, the cold food item is labeled with the date opened and the date which to discard by. The facility's Dietary Cleaning Policy policy, dated December 2020, read in part, This facility will store, prepare, distribute and serve food under sanitary conditions to ensure that proper sanitation and food handling practices to prevent the outbreak of foodborne illness is attained continuously. On 08/11/24 at 7:26 a.m., the following items were observed in the kitchen refrigerators: a. opened cubed pears were in a round plastic contained with green lid and had no date labeled indicating when they were opened, b. two white sliced cheese containers were opened and wrapped in saran wrap with no date labeled indicating when they were opened, c. opened shredded yellow cheese in a plastic bag was not sealed and had no date labeled when it was open, d. one opened yellow sliced cheeses in plastic wrap had no date labeled indicating when it was opened, e. two yellow cheese cube packages opened had no date labeled indicating when they were opened, f. sour cream opened with no date labeled indicating when it was opened, and g. 7 proportioned water melon cups on a tray covered in saran had no date labeled indicating when they were prepared. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/11/24 at 7:26 a.m., [NAME] #2 was shown the above items and asked what the problem was with these items. [NAME] #2 stated the items did not have date they were opened and the cheeses should be sealed. [NAME] #2 stated they were unsure how old the melon was and it like that when they came in. [NAME] #2 was asked what the policy was for labeling and dating items in the refrigerators. [NAME] #2 stated all items should have been dated and labeled when they were opened and in a sealed container. On 08/12/24 at 8:29 a.m., the CDM was asked what the policy was for labeling and dating items in the refrigerator. The CDM stated all items should of been labeled and dated the items was received and opened. The CDM stated they took responsibility for the watermelon because they should of been thrown out. On 08/12/24 at 10:45 a.m., the following observations were made in the kitchen: a. the top of ice machine had spilled ground coffee, b. the top of coffee machine had spilled ground coffee, c. watermelon juice was observed on the toaster and on top of plastic cereal containers stored below the food prep table, d. the cereal container with cereal inside were stored under the food prep tables had lids that were wet with watermelon juice, d. the surface below the food prep table was covered with a shelf shelf liner soiled with food debris, e. clean plastic containers were observed stored inverted next to grill (6 inches) on a wire rack with dried eggs stuck to outside of the clean containers, f. clean pans were observed next to the grill on bottom wire shelf with spices and a soy sauce container with visible drips on the exterior stored above the clean pans, g. three coffee thermos servers on wire rack on the bottom shelf where clean dishware was stored were not inverted and one had visible food debris on the outside lid area, h. the freezer had a bag of cinnamon rolls not labeled with the date opened, i. a box of bread roles were observed in a freezer opened and not sealed,and j. condiments were observed under the food prep area in yellow handled 6 cup compartment plastic container that was soiled inside and in the handle area with food debris. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/12/24 at 10:45 a.m., the CDM was present and shown the above mentioned items as she walked through with surveyor. The CDM was asked what the policy was for maintaining a clean and sanitary kitchen. The CDM stated they ere unsure of the policy but acknowledged the items and surfaces could cause cross contamination, the kitchen was not clean and sanitary, and they have a problem with labeling and dating items in the refrigerators and freezers. The CDM stated thy had a cleaning schedule that is signed off and they guess they are not doing it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review, and interview, the facility failed to cover a residents nebulizer mask when not in in use to prevent the spread of infection for one (#35) of three residents sampled for infection control practices for nebulizer mask. The DON identified 14 residents used nebulizer's. Findings: Resident #35 was admitted on [DATE] with diagnoses which included fracture of the right lower leg and cognitive communication deficit. Resident #35's physician orders, dated 07/24/24. read in part, Ipratropium Bromide Inhalation Solution 0.02 % (Ipratropium Bromide) 1 application inhale orally every 4 hours as needed for SOB. On 08/11/24 at 12:22 p.m., Resident #35's nebulizer mask and machine was observed in the window next to the bed the residents bed. The nebulizer mask was not in a bag and was laying in the window seal on a paper towel next to some food and drinks. 08/11/24 at 12:50 p.m., CNA #4 was taken into Resident #35's room. CNA # 4 was asked to identify what was in Resident #35's window sill. They stated there was her nebulizer mask on a paper towel and was not bagged. They stated it should of been in a bag. On 08/11/24 at 12:53 p.m., LPN #3 was asked what the policy was when a resident has a nebulizer bed side. They stated the nebulizer mask should be bagged in a set up bag and changed weekly. LPN #3 was asked to go to Resident #35's room and look in the window and discuss what they saw. LPN #3 stated they observed the nebulizer mask was sitting on the window sill on paper tower not in a bag.