STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375535	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Latimer Nursing Home	103 Southwest 9th Street Wilburton, OK 74578

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46909 Based on observation and interview, the facility failed to ensure a resident was treated with dignity during a transfer for one (#1) of one sampled resident observed for dignity. The administrator identified 23 residents residing in the facility. Findings: Res #1 Res #1 was admitted to the facility with cerebral brain stem hemorrhage without loss of consciousness, anxiety disorder, and depression disorder. A quarterly assessment, dated 04/12/24, documented the resident had problems with short- and long-term memory and required total assistance with most ADL's. On 05/02/24 at 9:17 a.m., an observation was made of CNA # 3 transporting Res #1 to their room from the shower room exposing their body to those in the hallway. On 05/02/24 at 9:18 a.m. CNA #3 stated they should have utilized two sheets to cover Res #1 lower part of her body. They also stated they did not notice the lower part of the Res #1 body was even exposed while transporting the Res #1 in the hallway.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER Latimer Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 103 Southwest 9th Street Wilburton, OK 74578	

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 45913 Based on record review and interview, the facility failed to ensure residents were offered the choice to formulate advanced directives for three (#17, 20 and #25) of six sampled residents reviewed for advanced directives. The administrator identified 23 residents residing in the facility. Findings: 1. Res #17 was admitted with diagnoses which included hypertension and diabetes. There was no advance directive or advance directive acknowledgement in Res #17's electronic health record or paper chart. 2. Res #20 was admitted with diagnoses which included diabetes. There was no advance directive or advance direcgtive acknowledgement in Res 20's electronic health record or paper chart. The ADON was unable to provide documentation Res #17 and #20 had been offered the choice to formulate an advance directive. 3. Res. #25 was admitted to the facility with diagnoses including convulsions, peripheral vascular disease, anemia, and anxiety disorder. An admission assessment, dated 01/10/24, documented the resident was cognitively intact and maximum assist with showering and dressing the upper body and dependent with lower body dressing, putting on and off footwear, and toileting. A record review was conducted on 04/30/24, and a document titled Acknowledgement of Receipt Advanced Directive/Medical Treatment Decisions was marked that Res #25 had chosen to formulate an advanced directive by the durable power of attorney on 05/25/23. On 05/03/24 at 11:10 a.m., the ADON reported the durable power of attorney should have assisted Res #25 with filling out an advanced directive. The ADON reported there was no documentation Res #17 had been offered the choice to formulate an advance directive. The ADON reported there may not be an advance directive acknowledgement in the chart for Res #20 because they are a fairly new admission. The ADON reported Res #17 and #20 should have an advance directive or advance directive acknowledgment in their medical record. 46909

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. 46909 Based on record review and interview, the facility failed to ensure resident assessments were accurate for three (#2, 5, and #16) of 14 sampled residents whose resident assessments were reviewed for accuracy. The administrator identified 23 residents who resided in the facility. Findings: 1. Res #2 was admitted to the facility with diagnoses of diabetes mellitus type II, atrial fibrillation, cerebral infarction, depressive disorder, heart failure. A quarterly assessment, dated 01/22/23, documented the resident was cognitively intact and dependent on most ADLs. This assessment also documented the resident was taking an anti-anxiety and anit-depressive medications. On 02/07/24, a physician's order, documented bupropion 100 mg, give one tab by mouth daily for depressive disorder. On 05/03/24 at 11:16 a.m., the ADON/MDS Coordinator stated the resident was only taking antidepressive medication and they marked anti-anxiety by mistake. 2. Res #5 was admitted to the facility with diagnoses of transient cerebral ischemic attack, HTN, convulsions, injury of kidney, and depressive disorder. A quarterly assessment, dated 02/06/24, documented the resident was severely impaired with cognition and required maximal assistance with most ADLs. The assessment also documented the resident's weight was 131 pounds and had a weight loss. On 05/03/24 at 11:03 a.m., the ADON/MDS Coordinator stated the 131 pounds was a typo and it should have been 121 pounds instead. 3. Res #16 was admitted to the facility with diagnosis of malignant neoplasm of the bone, myocardial infarction, diabetes mellitus type II, and HTN. A significant change assessment, dated 08/17/23, documented the resident was cognitively impaired and required total assistance with all ADLs. The assessment also documented the resident was taking opioid's for pain. There was no documentation of malignant neoplasm cancer on the significant change assessment. On 05/03/24 at 11:16 p.m., the ADON/MDS Coordinator stated the significant change assessment should have malignant neoplasm cancer documented.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45913 46909 Based on record review and interview, the facility failed to implement a comprehensive care plan: a. for five (#6, 8, 10, 16, and #25) of five reviewed for bedrails, b. for one (#13) of one reviewed for hospice care, c. for two (#2 and #13) of two reviewed for respiratory care, and d. for three (#13, 16, an #21) of 4 reviewed for unnecessary medications. The administrator identified 23 residents who resided in the facility. Findings: A. Bedrails 1. Res #6 was admitted to the facility with diagnoses of cerebral palsy, chronic pain syndrome, anxiety disorders, and cardiomegaly. A quarterly assessment, dated 03/01/24, documented the resident was cognitively intact and required total assistance with all ADLs. On 04/30/24 at 9:51 a.m., an observation was made of the resident lying in their bed with bedrails on each side of the bed. On 05/02/24 at 8:36 a.m., CNA #3 stated the resident cannot remove or lower the bedrails but they do use them to help roll from side to side. On 05/03/24 at 1:08 p.m., the ADON/MDS Coordinator stated there was no assessment for bedrails and the bedrails were not added to the care plan. 2. Res #8 was admitted to the facility with diagnoses of multiple fractures of ribs, fracture of the second cervical vertebra, anorexia, and dementia. A significant change assessment date 02/26/24, documented the resident had problems with short- and long-term memory. The assessment also documented the resident required total assistance with all ADLs. On 04/30/24 at 9:48 a.m., an observation was made of the resident lying in the bed with a half bedrail raised on the outer side of bed the other side of bed was up against the wall. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/03/24 at 8:25 a.m., CNA #3 stated the resident cannot remove or lower the rails. They also stated the bedrail is up to prevent the resident from falling out of bed related to them lean on the bedrail. On 05/03/24 at 1:08 p.m., the ADON/MDS Coordinator stated there was no assessment for bedrails and the bedrails were not added to the care plan. 3. Res #10 was admitted to the facility with diagnoses of fracture of hip, malaise, multiple sclerosis, convulsions, atrial fibrillation, and mood disorder. An annual assessment, dated 12/14/23, documented the cognitive with daily decision making and independent with all ADLs. On 04/29/24 at 5:16 p.m., an observation was made of half bedrails on bed but are not up at this time. On 05/03/24 at 10:56 a.m., CNA #3 stated the resident was not able to put the bedrails down, so they stay down all the time. On 05/03/24 at 1:10 p.m., the ADON/MDS Coordinator stated there was no assessment for bedrails and the bedrails were not added to the care plan. 4. Res #16 was admitted to the facility with diagnosis of malignant neoplasm of the bone, myocardial infarction, diabetes mellitus type II, and HTN. A significant change assessment, dated 08/17/23, documented the resident was cognitively impaired and required total assistance with all ADLs. On 04/29/24 at 5:38 p.m., an observation of bedrails bilaterally on the upper bed with a padding taped on the outer rail. The resident the bedrails stop them from falling out of bed. On 05/02/24 at 8:36 a.m., CNA #3 stated the resident cannot remove or lower the rails but she utilizes the bedrails to pull up in the bed. On 05/03/24 at 1:13 p.m., the ADON/MDS Coordinator stated there was no assessment for bedrails and was not aware they should be assessing bedrails for residents. They also stated they just discovered there was a bedrail assessment in the EHR. 5. Res #25 was admitted to the facility with diagnoses including convulsions, peripheral vascular disease, anemia, and anxiety disorder. An admission assessment, dated 01/10/24, documented the resident was cognitively intact and maximum assist with showering and dressing the upper body and dependent with lower body dressing, putting on and off footwear, and toileting. On 04/29/24 at 5:28 p.m., bed rails bilateral to upper bed, residents stated they requested them for fear of falling out of bed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Hospice Care 1. Res #13 was admitted to the facility with diagnoses of dementia, depressive disorder, encephalopathy, and Parkinson's disease. A significant change assessment, dated 03/04/24, documented the resident had problems with short- and long-term memory and required moderate assistance with all ADLs. The assessment did document the resident was on hospice. On 02/21/24, a physician's order documented to admit resident to hospice. On 05/03/24 at 1:14 p.m., the ADON/MDS Coordinator stated the care plan should have included hospice care. C. Respiratory Care 1. Res #2 was admitted to the facility with diagnoses of diabetes mellitus type II, atrial fibrillation, cerebral infarction, depressive disorder, and heart failure. A quarterly assessment, dated 11/22/23, documented the resident was cognitively intact and dependent on most ADLs. This assessment also documented the resident was on oxygen. There was no care plan documentation for oxygen. On 05/03/24 at 12:00 p.m., the ADON/MDS Coordinator stated there was no care plan for the oxygen. 2. Res. #13 was admitted to the facility with diagnoses of dementia, depressive disorder, encephalopathy, and Parkinson's disease. A significant change assessment, dated 03/04/24, documented the resident had problems with short- and long-term memory and required moderate assistance with all ADLs. The assessment also documented the resident was on oxygen. There was no care plan documentation for oxygen. On 05/03/24 at 12:00 p.m., the ADON/MDS Coordinator stated there was no care plan for the oxygen. D. Unnecessary Medications 1. Res. #13 was admitted to the facility with diagnoses of dementia, depressive disorder, encephalopathy, and Parkinson's disease. A significant change assessment, dated 03/04/24, documented the resident had problems with short- and long-term memory and required moderate assistance with all ADLs. There was no documentation of anti-psychotics on the assessment. There was no documentation of anti-psychotics on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/03/24 at 11:52 a.m., the ADON/MDS Coordinator stated the anti-psychotics should have been on the care plan. 2. Res. #16 was admitted to the facility with diagnosis of malignant neoplasm of the bone, myocardial infarction, diabetes mellitus type II, and HTN. A significant change assessment, dated 08/17/23, documented the resident was cognitively impaired and required total assistance with all ADLs. The assessment also documented the resident was taking Lasix for myocardial infarction. There was no documentation of anti-diuretics on the care plan. On 05/03/24 at 11:16 a.m., the ADON/MDS Coordinator stated there was not a care plan for Lasix. 3. Res #21 was admitted with diagnoses which included congestive heart failure, ischemic cardiomyopathy and atrial fibrillation. A physician's order, dated 11/17/23, documented Res #21 was on Brilinta (a blood thinner/anticoagulant) 90mg twice a day. There was no comprehensive care plan for Res #21's use of an anticoagulant. On 05/03/24 at 11:40 a.m., the MDS Coordinator reported there should have been a care plan for anticoagulant use. The MDS Coordinator reported they are new to the position and still learning care plans and what should be care planned.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 45913 Based on observation, record review, and interview, the facility failed to revise a care plan for one (#11) of nine sampled residents whose care plans were reviewed for accuracy. The administrator identified 23 residents who resided in the facility. Findings: Res #11 had diagnoses which included peripheral vascular disease and a right above the knee amputation. Res #11's care plan, dated 02/23/24, documented Res #11 has the potential for skin issues. The care plan was not revised when Res #11 developed their right stump wound. A physician's order, dated 03/26/24 documented a wound care treatment of silvadene cream to Res #11's right stump daily. On 05/02/24 at 10:05 a.m., observed Res #11's wound care treatment to their right stump wound. On 05/03/24 at 11:40 a.m., the MDS Coordinator reported the care plan should have been revised when Res #11 developed a right stump wound. The MDS Coordinator reported they are new to the position and still learning care plans and what should be care planned.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45913 Based on record review and interview, the facility failed to document a recapitulation of a resident's stay on a discharge summary for one (#26) of two sampled residents whose closed records were reviewed. The administrator identified 23 residents who resided in the facility. Findings: Res #26 was admitted on [DATE] and discharged to another facility on 02/05/24. There was no recapitulation of Res #26's stay in the facility on the discharge summary. On 05/03/24 at 12:15 p.m., the MDS Coordinator/ADON reported they recently received an example of how a discharge summary should be documented and reported they will be documenting a recap of the resident's stay going forward.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46909 Based on observation, record review, and interview, the facility failed to develop and implement physician's orders for oxygen tubing care maintenance for two (#2 and #13) of two resident sampled for oxygen therapy. The administrator identified 23 residents residing in the facility. Findings: A document titled, Orientation of Residents to the Facility, read in part, .Oxygen Administration .Procedure . 12. At regular intervals, check and clean oxygen equipment, masks, tubing, and cannula's . 1. Res #2 was admitted to the facility with diagnoses of diabetes mellitus type II, atrial fibrillation, cerebral infarction, depressive disorder, and heart failure. A quarterly assessment, dated 11/22/23, documented the resident was cognitively intact and dependent on most ADLs. This assessment also documented the resident was on oxygen. There were no physician orders to check and clean oxygen equipment, masks, tubing, and/or cannula's. 2. Res #13 was admitted to the facility with diagnoses of dementia, depressive disorder, encephalopathy, and Parkinson's disease. A significant change assessment, dated 03/04/24, documented the resident had problems with short- and long-term memory and required moderate assistance with all ADLs. The assessment also documented the resident was on oxygen. There were no physician orders to check and clean oxygen equipment, masks, tubing, and/or cannula's. On 05/03/24 at 12:00 p.m., the ADON/MDS Coordinator stated there was nothing telling our nursing staff when to change the oxygen equipment. There should have been an order to let our nursing staff know when to change the oxygen equipment.

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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 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. 45913 Based on observation, record review, and interview, the facility failed to attempt appropriate alternatives and perform an entrapment risk assessment prior to installing bed or side- rails for (#6, 8, 9, 10, 13, 16, 17, and #25) of eight residents reviewed for accident hazards. The administrator identified 23 residents residing in the facility. Findings: A restraints policy, written in by hand and read in part, .6. Full bedrails/siderails (assist rails or 1/2 rails is not restraints) NO RESTRAINT WITH LOCKING DEVICEs WILL BE USED. NOTE: Restraing assessment will be done prior to use . 1. Res #6 was admitted to the facility with diagnoses of cerebral palsy, chronic pain syndrome, anxiety disorders, and cardiomegaly. A quarterly assessment, dated 03/01/24, documented the resident was cognitively intact and required total assistance with all ADLs. On 04/30/24 at 09:51 a.m., an observation was made of the resident lying in their bed with bedrails on each side of the bed. On 05/02/24 at 8:36 a.m., CNA #3 stated the resident cannot remove or lower the bedrails but they do use them to help roll from side to side. On 05/03/24 at 1:08 p.m., the ADON/MDS Coordinator stated there was no assessment for bedrails and the bedrails were not added to the care plan. 2. Res #8 was admitted to the facility with diagnoses of multiple fractures of ribs, fracture of the second cervical vertebra, anorexia, and dementia. A significant change assessment date 02/26/24, documented the resident had problems with short- and long-term memory. The assessment also documented the resident required total assistance with all ADLs. On 04/30/24 at 09:48 a.m., an observation was made of the resident lying in the bed with a half bedrail raised on the outer side of bed the other side of bed was up against the wall. On 05/03/24 at 8:25 a.m., CNA #3 stated the resident cannot remove or lower the rails. They also stated the bedrail is up to prevent the resident from falling out of bed related to them lean on the bedrail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/03/24 at 1:08 p.m., the ADON/MDS Coordinator stated there was no assessment for bedrails and the bedrails were not added to the care plan. 3. Res #9 had diagnoses which included dementia and osteoarthritis. There was no documented alternatives attempted prior to initiating side rails or side rail/entrapment risk assessments in the clinical record. On 05/01/24 at 2:00 p.m., Res #9 was sitting on the side of the bed. Half rails were in the upright position. On 05/01/24 at 2:05 p.m., CNA #1 reported the rails were in place to keep the Res #9 from falling out of bed. 4. Res #10 was admitted to the facility with diagnoses of fracture of hip, malaise, multiple sclerosis, convulsions, atrial fibrillation, and mood disorder. An annual assessment, dated 12/14/23, documented the cognitive with daily decision making and independent with all ADLs. On 04/29/24 at 5:16 p.m., an observation was made of half bedrails on bed but are not up at this time. On 05/03/24 at 10:56 a.m., CNA #3 stated the resident was not able to put the bedrails down, so they stay down all the time. On 05/03/24 at 1:10 p.m., the ADON/MDS Coordinator stated there was no assessment for bedrails and the bedrails were not added to the care plan. 5. Res #13 was admitted to the facility with diagnoses of dementia, depressive disorder, encephalopathy, and Parkinson's disease. A significant change assessment, dated 03/04/24, documented the resident had problems with short- and long-term memory and required moderate assistance with all ADLs. On 05/03/24 at 10:56 a.m., an observation was made of half bedrails on the resident's bed. 6. Res #16 was admitted to the facility with diagnosis of malignant neoplasm of the bone, myocardial infarction, diabetes mellitus type II, and HTN. A significant change assessment, dated 08/17/23, documented the resident was cognitively impaired and required total assistance with all ADLs. On 04/29/24 at 5:38 p.m., an observation of bedrails bilaterally on the upper bed with a padding taped on the outer rail. The resident the bedrails stop them from falling out of bed. 05/02/24 at 8:36 a.m., CNA #3 stated the resident cannot remove or lower the rails but she utilizes the bedrails to pull up in the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Res #17 had diagnoses which included osteoarthritis, bilateral hip replacements and right knee replacement. There was no documented alternatives attempted prior to initiating side rails or side rail/entrapment risk assessments in the clinical record. On 05/01/24 at 2:45 p.m., Res #17 was in their bed with both side rails up. 8. Res #25 was admitted to the facility with diagnoses including convulsions, peripheral vascular disease, anemia, and anxiety disorder. An admission assessment, dated 01/10/24, documented the resident was cognitively intact and maximum assist with showering and dressing the upper body and dependent with lower body dressing, putting on and off footwear, and toileting. On 04/29/24 at 5:28 p.m., bed rails bilateral to upper bed, residents stated they requested them for fear of falling out of bed. On 05/03/24 at 11:35 a.m., the ADON/MDS Coordinator reported they were not aware side rails/entrapment risk assessments were required. The ADON/MDS Coordinator was not aware of any alternative attempted prior to using side rails for Res #9 and Res #17 On 05/03/24 at 1:13 p.m., the ADON/MDS Coordinator stated there was no assessment for bedrails and was not aware they should be assessing bedrails for residents. They also stated they just discovered there was a bedrail assessment in the EHR. 46909

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NAME OF PROVIDER OR SUPPLIER Latimer Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 103 Southwest 9th Street Wilburton, OK 74578	

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 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. 45913 46909 Based on record review and interview, the facility failed to ensure a consultant pharmacist reviewed the medications of each resident in the facility monthly for four (#2, 10, 16, and #21) of five sampled residents reviewed for unnecessary medications. The administrator identified 23 residents who resided in the facility. Findings: 1. Res #2 was admitted to the facility with diagnoses of diabetes mellitus type II, atrial fibrillation, cerebral infarction, depressive disorder, and heart failure. A quarterly assessment, dated 11/22/23, documented the resident was cognitively intact and dependent on most ADLs. This assessment also documented the resident was taking antianxiety, antidepressants, and diuretics. 2. Res #10 was admitted to the facility with diagnoses of fracture of hip, malaise, multiple sclerosis, history or schizophrenia, convulsions, atrial fibrillation, and mood disorder. An annual assessment, dated 12/14/23, documented the cognitive with daily decision making and independent with all ADLs. The assessment also documented the resident was taking antipsychotics and opioids. 3. Res. #16 was admitted to the facility with diagnosis of malignant neoplasm of the bone, myocardial infarction, diabetes mellitus type II, and HTN. A significant change assessment, dated 08/17/23, documented the resident was cognitively impaired and required total assistance with all ADLs. The assessment also documented the resident was also taking opioid's and diuretics. 4. Res #21 had diagnoses which included Alzheimer's, diabetes, depression, anxiety, and atrial fibrillation. Physician's orders documented Res #21 was taking an anti-anxiety, anti-coagulant, insulin, and an anti-depressant. There was no policy and procedure provided for drug regimen review. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/01/24 at 9:46 a.m., the DON stated when they returned to the facility in September 2024, after a short leave of absence, they discovered the pharmacist had completed the monthly reviews for May, June, July, and August 2024 but the acting DON did not follow through with the gradual dose reductions. They also stated as soon as they returned as DON, they contacted the pharmacist to implement all the recommendations for gradual dose reductions.

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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. 45913 Based on observation and interview, the facility failed to ensure medication cards were labeled appropriately with an expiration date for 49 of 55 sampled medication cards. The administrator identified 23 residents who resided in the facility. Findings: The labeling of medications policy, undated, read in part, .ALL PRESCRIPTION MEDICATIONS WILL HAVE THE FOLLOWING LABELING REQUIREMENTS SATISFIED: .To every box, bottle, jar, tube or other container of a prescription legend med which is dispensed, there shall be affixed a label bearing: .the expiration of the medication. On 05/02/24 at 2:40 p.m., the medication cart for female residents was inspected with 30 of 34 medication card labels to have no expiration date. The expiration date at the bottom of the label is cut off or cannot be read. On 05/02/24 at 2:50 p.m., the medication cart for male residents was inspected with 19 of 21 medication card labels to have no expiration date. The expiration date at the bottom of the label is cut off or cannot be read. On 05/02/24 at 2:51 p.m., CMA #1 was unable to read the expiration date on the medication cards. CMA #1 reported they would have no way to know what the expiration date is for the medication and stated, We would just have to basically guess. 05/03/24 at 9:15 a.m., the consultant pharmacist reported they were not aware there was no expiration date on the labels.

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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 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. 46909 Based on observation and interview, the facility failed to serve food under sanitary conditions for 23 residents who ate meals prepared by the kitchen. The administrator identified 23 residents who resided in the facility. Findings: On 05/02/24 at 12:12 p.m., the dietary manager was observed serving lunch trays to the residents in the dining room wearing gloves. The dietary manager would exit the kitchen with a food tray wearing gloves, place the food tray on the table for the resident in the dining area, and then enter the kitchen again to collect another food tray for another resident. The dietary manager did this several times wearing the same set of gloves and without proper hand washing in between residents. On 05/02/24 at 12:23 p.m., the dietary manager stated they thought if they were wearing gloves they could exit and enter the kitchen without washing their hands to serve the residents in the dining area. They also stated they would begin handing the food trays to the aides without leaving the kitchen so they would not cross-contaminate from the kitchen to the dining area.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 46909 Based on observation, record review, and interview, the facility failed develop, implement a policy and procedure for a water management program to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems. The administrator identified 23 residents who resided in the facility. Findings: There was no policy and procedure for Legionella and other opportunistic waterborne pathogens in the building water system. On 05/03/24 at 10:16 a.m., the maintenance man stated the facility did not have a policy and procedure for Legionella at this time, but they were working on writing a policy and procedure for Legionella and other waterborne pathogens for the facility.

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 45913 Based on observation, interview, and record review, it determined the facility failed to ensure regular inspections of resident beds equipped with side rails were conducted for eight (#6, 8, 9, 10, 13, 16,17, and #25) of eight residents reviewed for accident hazards. The administrator identified 23 residents residing in the facility. Findings: 1. Res #6 was admitted to the facility with diagnoses of cerebral palsy, chronic pain syndrome, anxiety disorders, and cardiomegaly. A quarterly assessment, dated 03/01/24, documented the resident was cognitively intact and required total assistance with all ADLs. On 04/30/24 at 09:51 a.m., an observation was made of the resident lying in their bed with bedrails on each side of the bed. On 05/02/24 at 8:36 a.m., CNA #3 stated the resident cannot remove or lower the bedrails but they do use them to help roll from side to side. On 05/03/24 at 1:08 p.m., the ADON/MDS Coordinator stated there was no assessment for bedrails and the bedrails were not added to the care plan. 2. Res #8 was admitted to the facility with diagnoses of multiple fractures of ribs, fracture of the second cervical vertebra, anorexia, and dementia. A significant change assessment date 02/26/24, documented the resident had problems with short- and long-term memory. The assessment also documented the resident required total assistance with all ADLs. On 04/30/24 at 09:48 a.m., an observation was made of the resident lying in the bed with a half bedrail raised on the outer side of bed the other side of bed was up against the wall. On 05/03/24 at 1:08 p.m., the ADON/MDS Coordinator stated there was no assessment for bedrails and the bedrails were not added to the care plan. 3. Res #9 had diagnoses which included dementia and osteoarthritis. There was no documented alternatives attempted prior to initiating side rails or side rail/entrapment risk assessments in the clinical record. On 05/01/24 at 2:00 p.m., Res #9 was sitting on the side of the bed. Half rails were in the upright position. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Res #10 was admitted to the facility with diagnoses of fracture of hip, malaise, multiple sclerosis, convulsions, atrial fibrillation, and mood disorder. An annual assessment, dated 12/14/23, documented the cognitive with daily decision making and independent with all ADLs. On 04/29/24 at 5:16 p.m., an observation was made of half bedrails on bed but are not up at this time. 5. Res #13 was admitted to the facility with diagnoses of dementia, depressive disorder, encephalopathy, and Parkinson's disease. A significant change assessment, dated 03/04/24, documented the resident had problems with short- and long-term memory and required moderate assistance with all ADLs. On 05/03/24 at 10:56 a.m., an observation was made of half bedrails on the resident's bed. 6. Res #16 was admitted to the facility with diagnosis of malignant neoplasm of the bone, myocardial infarction, diabetes mellitus type II, and HTN. A significant change assessment, dated 08/17/23, documented the resident was cognitively impaired and required total assistance with all ADLs. On 04/29/24 AT 5:38 p.m., an observation of bedrails bilaterally on the upper bed with a padding taped on the outer rail. The resident the bedrails stop them from falling out of bed. 7. Res #17 had diagnoses which included osteoarthritis, bilateral hip replacements and right knee replacement. There was no documented alternatives attempted prior to initiating side rails or side rail/entrapment risk assessments in the clinical record. On 05/01/24 at 2:45 p.m., Res #17 was in their bed with both side rails up. 8. Res #25 was admitted to the facility with diagnoses including convulsions, peripheral vascular disease, anemia, and anxiety disorder. An admission assessment, dated 01/10/24, documented the resident was cognitively intact and maximum assist with showering and dressing the upper body and dependent with lower body dressing, putting on and off footwear, and toileting. On 04/29/24 at 5:28 p.m., bed rails bilateral to upper bed, residents stated they requested them for fear of falling out of bed. On 05/03/24 at 8:16 a.m., the maintenance man stated they only check the bedrails when someone reports a problem or when they move the bed. 46909