STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375562	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McMahon-Tomlinson Nursing Center	2007 NW 52nd Street Lawton, OK 73505

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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 - Some	Ensure each resident receives an accurate assessment. 41318 Based on record review and interview, the facility failed to ensure assessments were accurate for two (#83 and #87) of 22 sampled residents reviewed for assessments. The Administrator identified 97 residents resided in the facility. Findings: 1. Resident #83 had diagnosis which included weakness. An Alert Note, dated 03/22/24, documented Resident #83 was on the floor with a laceration to their left upper eyebrow and was sent to the hospital. An Admission assessment, dated 03/22/24, documented the resident had one non injury fall since admission. On 04/10/24 at 10:40 a.m., the DON stated they put falls under the health condition on the assessment. She stated a laceration was considered an injury. The DON was asked to review Resident #83's assessment and was asked what was coded for falls. She stated the resident had one no injury fall. The DON stated the resident had an injury from a fall on 03/22/24. She stated the assessment was not coded accurately. 2. Resident #87 had diagnosis which included sepsis. A Discharge Report, dated 01/15/24, documented Resident #87 discharged to a private home. A Discharge assessment, dated 01/15/24, documented Resident #87 discharged to the hospital. On 04/11/24 at 11:25 a.m., the MDS coordinator #1 stated when a resident discharges, they interview the staff then code the assessment. She was asked to review Resident #87's discharge assessment. The MDS Coordinator #1 stated it was documented the resident discharged to the hospital. She stated the notes documented the resident discharged to their home. She stated it was coded wrong.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46702 Based on observation, record review and interview, the facility failed to ensure interventions were added to the care plan after a fall for two residents (#38 and #41) of 20 sampled residents reviewed for care plan revisions. The DON identified 97 Residents resided in the facility. Findings: An Assessing Falls and Their Causes policy, revised 03/2018, read in part, .When a resident falls, the following information should be recorded in the resident's medical record .Appropriate interventions taken to prevent future falls . 1. Resident #38 had diagnoses which included type 2 diabetes mellitus, urinary incontinence, and hypertensive heart disease. Resident #38's quarterly assessment dated [DATE] documented Resident 38's cognition was mildly impaired and required partial to moderate assist with transferring. On 04/08/24 at 12:39 p.m., Resident #38 was observed to have a bruised left eye. Resident #38 stated they fell from the recliner while trying to go to the toilet. A incident report dated 04/15/23, documented the resident had an unwitnessed fall. A incident report dated 12/04/23, documented the resident had an unwitnessed fall. A incident report, dated 03/30/24, documented the resident had an unwitnessed fall. A incident report, dated 03/31/24, documented the resident had an unwitnessed fall. Resident #38's care plan for falls, last revised on 06/20/23, did not document any new interventions after the falls on the following dates: a. 03/30/24, b. 03/31/24, c. 12/04/23, and d. 04/15/23. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/10/24 at 02:35 p.m., the DON was asked about policy and procedure for fall interventions. The DON stated they are supposed to put in interventions in the care plan. The DON reviewed the care plan and stated no interventions for falls had been added to the care plan since 01/12/22. 41872 2. Resident #41 had diagnoses which included altered mental status, dementia and anxiety. Resident #41's care plan, initiated on 12/27/23, documented the resident was at high risk for falls and was unaware of safety needs. The care plan had been revised on 03/13/24 but no specific interventions had been updated for the following falls. An incident report, dated 01/16/24 at 3:07 a.m., documented the resident had an unwitnessed fall in their room. An incident report, dated 01/24/24 at 9:05 a.m., documented the resident had an unwitnessed fall in their room. An incident report, dated 01/24/24 at 12:29 a.m., documented the resident had an unwitnessed fall in their room. An incident report dated 02/02/24 at 8:18 a.m., documented the resident had an unwitnessed fall in their room. An incident report, dated 02/02/24at 3:42 a.m., documented the resident had an unwitnessed fall in their room. An incident report, dated 02/02/24 at 8:25 p.m., documented the resident had an unwitnessed fall in their room. An incident report, dated 02/22/24 at 6:00 p.m., documented the resident had an unwitnessed fall in their room. An incident report, dated 02/27/24 at 9:01 p.m., documented the resident was sitting on the floor. A family member had attempted to transfer the resident. An incident report, dated 03/01/24 at 6:30 p.m., documented the resident slipped to the floor during transfer with a family members assistance. An incident report dated 03/07/24 at 2:35 a.m., documented the resident had an unwitnessed fall in their room. An incident report, dated 03/15/24 at 10:00 a.m., documented the resident had a witnessed fall from a wheelchair. On 04/11/24 at 9:23 a.m., the DON was asked if the care plan had been updated on 04/10/24. They stated the care plan had been updated yesterday.

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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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41872 Based on record review and interview the facility failed to ensure neurological checks were completed after unwitnessed falls for one (#41) of three sampled residents reviewed for falls. The Administrator identified 97 residents resided in the facility. The Resident Matrix documented 21 residents had falls. Findings: A Neurological Assessment policy, revised October 2010, read in part, .The purpose of this procedure is to provide guidance for neurological assessment .when following and unwitnessed fall .When assessing neurological status, always include frequent vital signs .perform neurological checks with the frequency as ordered or per falls protocol . An Assessing Falls and Their Causes policy, revised March 2018, read in part, .Observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and will document findings in the medical record . Resident #41 had diagnoses which included altered mental status, dementia and anxiety. Resident #41's care plan, initiated on 12/27/23, documented the resident was at high risk for falls and was unaware of safety needs. An incident report, dated 01/16/24 at 3:07 a.m., documented the resident had an unwitnessed fall in their room. The clinical health record did not contain documentation neurological checks had been started completed. An incident report, dated 01/24/24 at 9:05 a.m., documented the resident had an unwitnessed fall in their room. Neurological checks were started but were incomplete. An incident report, dated 01/24/24 at 12:29 a.m., documented the resident had an unwitnessed fall in their room. There was no documentation neurological checks had been restarted after the second fall. An incident report dated 02/02/24 at 8:18 a.m., documented the resident had an unwitnessed fall in their room. A Neurological Assessment Flowsheet dated 02/02/24 documented neuro checks were only completed from 8:25 a.m., through 10:25 a.m. An incident report, dated 02/02/24 at 3:42 p.m., documented the resident had an unwitnessed fall in their room. A Neurological Assessment Flowsheet, dated 02/02/24 documented neurological checks were started but were incomplete. An incident report, dated 02/02/24 at 8:25 p.m., documented the resident had an unwitnessed fall in their room. Resident #41 was sent to the hospital for evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An incident report, dated 02/22/24 at 6:00 p.m., documented the resident had an unwitnessed fall in their room. A Neurological Assessment Flowsheet dated 02/22/24 documented neuro checks were unable to obtain at 6:30 p.m., then were blank until 8:30 p.m., then documented the resident was resting at 9:00 p.m., through 5:00a.m. until 02/23/24. The checks were restarted at 9:00 a.m. An incident report, dated 03/15/24 at 10:00 a.m., documented the resident had a witnessed fall from a wheelchair. A Neurological Assessment Flowsheet dated 03/15/24 documented neuro checks were started at 10:00 a.m., then at 1:00 p.m., then 8:30 p.m. The flowsheet documentation was incomplete. On 04/11/24 at 8:37 a.m., the DON was asked for a policy for neurological checks. They stated if there was an unwitnessed fall neurological checks should be started. Resident #41's falls from 01/16/24 through 03/15/24 were reviewed with the DON. The DON stated a. there was no documenation neuro checks had been started on 01/16/24, b. the neuro checks should have been restarted after the second fall on 01/24/24, c. the neuro checks were not accurately completed on 02/02/24 at 8:18 am and 3:42 p.m., d. the neuro checks were not accurately completed on 02/22/24 and 03/15/24.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46702 Based on observation, record review and interview, the facility failed to ensure interventions were implemented for one (#14) of three residents sampled for falls. The DON identified 97 Residents resided in the facility. Findings: a. An Assessing Falls and Their Causes policy, revised 03/18, read in part, .When a resident falls, the following information should be recorded in the resident's medical record .Appropriate interventions taken to prevent future falls . 1. Resident #14 had diagnoses which included macular degeneration, lesion of the plantar nerve, and osteoporosis. A Care plan document, dated 11/22/23, read in part, .Fall mats beside each side of her bed . Resident #14's comprehensive assessment, dated 03/25/24, documented Resident #14 was dependent for transferring from bed to chair and cognition was moderately impaired. On 04/09/24 at 9:36 a.m., Resident #14 was observed in bed unattended with bed in the lowered position. There were no fall mats observed on each side of the bed. On 04/09/24 at 9:41 a.m., CNA #1 was asked what interventions should have been in place to prevent falls for Resident #14. They stated there should be two fall mats on each side of the bed. CNA #1 was asked to observe the resident. CNA #1 stated Resident #14 was in bed sitting up in the lowered position and fall mats were not in place. On 04/09/24 at 9:51 a.m., LPN #2 was asked what interventions should be in place to prevent falls for Resident #14. LPN #2 observed the resident in bed and then reviewed the care plan. LPN #2 stated the resident should of had a low bed and fall mats in place by the bedside. LPN #2 stated the fall mats were not in place. On 04/10/24 at 10:04 a.m., the DON was asked what the facility policy was for implementing interventions after a fall. The DON stated the interventions would be care planned. The DON was asked what happened with Resident #14's fall mats. The DON stated staff felt like Resident #14 was no longer a fall risk. Therefore, staff was not utilizing the fall mats.

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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 - 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, record review and interview, the facility failed to ensure; a. oxygen tubing was labeled and dated, per the facility policy and professional standards of care, for three (#14,64, and #143) and, b. respiratory medications were administered per the standard of practice for one (#64) of three residents sampled for respiratory care. The DON identified 11 residents received oxygen services. Findings: A Departmental (Respiratory therapy) - Prevention of Infection policy, revised 11/11, read in part, .Change the oxygen cannula, and tubing every seven days, or as needed . A Physicians Order, dated 11/15/23, read in part, .Please change oxygen tubing weekly .tag tubing with date a residents name . 1. Resident #14 had diagnoses which included macular degeneration, lesion of the plantar nerve, and osteoporosis. Resident #14's comprehensive assessment, dated 03/25/24, documented Resident #14 was dependent for transferring from bed to chair and cognition was moderately impaired and used oxygen. On 04/08/24 at 9:22 a.m., Resident #14 was observed in a geriatric chair wearing oxygen. The oxygen tubing was dated 02/26. On 04/08/24 at 9:52 a.m., LPN #1 was shown the oxygen tubing on Resident #14 was wearing. LPN #1 stated the tubing was dated 02/26. They stated there was an order to change the tubing every two weeks and it did not follow the physician orders. 2. Resident #64 was admitted with diagnoses which included dependence on supplemental oxygen and cranial cerebrospinal leak. Resident #64's comprehensive assessment, dated 10/18/23, documented Resident #64's cognition was intact and required oxygen therapy. A physicians order dated 05/16/23 read in part, .oxygen @ 2 LPMvia PER NASAL CANNULA two times a day .please change oxygen tubing weekly . Ipratropium-Albuterol Solution 05-2.5 (3) MG/ML 3 milliliter inhale orally every 4 hours as needed for SOB or Wheezing via nebulizer . On 04/08/24 at 8:55 a.m., Resident #64 was observed resident getting a breathing treatment with no nurse present in the room. There was no assesment to self administer medication. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/08/24 9:03 AM LPN #1 came into the Residents room. LPN #1 was asked if they should of been present during the breathing treatment. LPN #1 stated they were outside the door and not present in the room. They stated they were unsure if resident # 64 had an order to self administer medication. On 04/08/24 at 9:08 a.m., no date label on Resident #64's oxygen tubing connected to the oxygen saturator was observed. On 04/08/24 at 9:52 a.m., LPN #1 was shown the oxygen tubing on Resident #64's Oxygen saturator. LPN #1 stated the oxygen tubing was not labeled with a date and it should be. On 04/10/24 at 10:10 a.m., the DON was asked what was the policy for changing O2 tubing. The DON stated the policy says every 7 days and tracked in the TAR. The DON was asked what was their policy for residents receiving breathing treatments. The DON stated the Nurse should administer it. The DON stated Resident #64 does not have an assessment or order to self administer medication. 21731 3. Resident #143 was admitted on [DATE], with diagnoses to include chronic respiratory failure with hypoxia and dependence on supplemental oxygen. Physician Orders:, dated 04/08/24 documented Resident #143 was to wear oxygen, and the tubing was to be changed, labeled, and dated every week on Sundays, and the respiratory bag was to be changed and labeled every two weeks on Sundays. On 04/09/24 at 9:42 a.m., Resident #143 was out of the room. An oxygen concentrator was running at 2-Liter with humidity, the nasal cannula was on bed. There was no date or label on the cannula or tubing. On 04/11/24 at 8:37 a.m., Resident #143 was out of the room. An oxygen concentrator was not turned on. The nasal cannula and tubing were on the bed. There was no date or label on the tubing. On 04/11/24 at 8:41 a.m., LPN #3 was asked what the facility protocol for oxygen tubing and equipment was. They stated the tubing was to be changed every Sunday and the tubing is to be dated. They stated, when the oxygen is not in use, the tubing is to be placed inside a plastic bag to keep it clean.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 21731 Based on record review and interview, the facility failed to ensure a. the resident assessment at the dialysis center was communicated between the dialysis center and nursing staff was in place, and b. pre- and post- dialysis assessments were completed by the facility for one #63) of one resident reviewed for dialysis. The DON stated four residents received dialysis. Findings: A Long Term Care Facility Dialysis Services Agreement dated 05/10/21, read in parts, . Dialysis Center Obligations .provide to Care Facility from time to time all appropriate information and guidance regarding the renal condition of Residents who are patients of Dialysis Center, including administration of medications, directions for handling medical and nonmedical emergencies . and the care of shunts and fistulas . An undated End-Stage Renal Disease, Care of a Resident with policy, read in parts, .Residents .will be cared for according to currently recognized standards of care .Staff .shall be trained in the care and special needs of these residents .Agreements between this facility and the contracted [Dialysis] facility include all aspects of how the resident's care will be managed .care plan will be developed and implemented .information will be exchanged between the facilities . Resident #63 had diagnoses to include orthopedic aftercare following surgical amputation, end stage renal disease, hypertensive chronic kidney disease, and dependence on renal dialysis. Physician Orders, dated 03/05/24 documented Resident #63 was to be provided the following: a. the dialysis access site was to be assessed, and a full set of vital signs obtained on each evening twice each day the resident received dialysis, b. ensure the Dialysis Form is completed and sent with the resident at each dialysis encounter, and c. a pre-dialysis assessment was to include vital signs, current weight prior to leaving the facility. An Admission Assessment, dated 03/08/24, documented Resident #63 was cognitively intact, and received dialysis prior to admission and while a resident of the facility. The facility Hemodialysis Communication Record was divided into three portions to include: a. pre-dialysis assessment of medications administered, vital signs, access site location and assessments, signature and title, and time of departure. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. dialysis center assessment with vital signs, pre- and post- weights, new orders assessment of the access site, lab values, pertinent or relevant observations, dialysis center information, signature and title, date and time. c. return to facility assessment of vital signs, assessment of access site, signature and title, date and time of return from dialysis center. Resident #63 received dialysis 14 events from 03/07/24 through 04/09/24. The Hemodialysis Communication Record, were as follows: a. pre-dialysis assessments had no information for two of 14 events, and the assessment only contained vital signs with not physical assessment of the resident on six of 14 events. b. dialysis center assessments had no information for three of 14 events, and the assessment only contained vital signs and weights with no physical assessment for 11 of 14 events. c. return to facility assessments had no information for eight of 14 events, and the assessment only contained vital signs and weights with no physical assessment for four of 14 events. On 04/08/24 at 8:48 a.m., Resident #63 stated they go to dialysis three times per week and did not know if they do any monitoring. Resident #63 stated, I think they just transport me. On 4/11/24 at 1:37 p.m., the DON stated the communications forms are utilized to communicate with the dialysis center and ensure proper after care upon return to the facility. The DON stated the forms are to be fully completed and remain in the resident's hard chart, staff only put in a progress note if the resident does not return from dialysis. The DON stated the forms are not being filled out completely and should be.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46702 Based on record review and interview, the facility failed to ensure Registered Nurse coverage was provided 8 hours per day for 7 days a week for nine (10/01/23,10/07/23,10/15/23,10/22/23,11/11/23,11/19/23,12/03/23, 12/09/23, and 12/17/23 of 92 days sampled for RN coverage. The DON identified 97 Residents resided in the facility. Findings: A Departmental Supervison, Nursing policy, revised 08/2022, read in part, .A registered nurse provides services at least eight consecutive hours every 24 hours, seven days a week . A Detail of Time documents for the following dates did not document RN coverage for 8 consecutive hours; a.10/01/23, b.10/07/23, c.10/15/23, d.10/22/23, e.11/11/23, f.11/19/23, g.12/03/23, h.12/09/23, and i. 12/17/23. On 04/11/24 at 8:58 a.m., the Administrator was asked to show RN coverage on the above dates. The Administrator stated there was no RN on those dates for 8 consecutive hours which made the facility a one star rating.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 41318 Based on record review and interview, the facility failed to identify the time frames for the steps regarding the medication regimen review, and a medication regimen review was responded to timely for one (#45) of five sampled residents reviewed for unnecessary medications. The Administrator identified 97 residents resided in the facility. Findings: A Drug Regimen Review policy, revised March 2023, did not identify time frame for the steps regarding the medication regimen review. Resident #45 had diagnosis which included depression. An Order Summary report, dated 09/12/23, documented Resident #45 was to receive venlafaxine every morning for depression. A medication regimen review, dated 02/13/24, documented a request to the physician regarding a reduction of venlafaxine or provide a rationale why a dose reduction was clinically contraindicated. The response from the physician was dated 04/05/24. On 04/10/24 at 8:21 a.m., the DON stated staff reviewed the MRR with the physician then scanned in the requests in the residents' EHR. On 04/10/24 at 9:38 a.m., the DON stated there was not a specific time frame in the policy regarding non urgent MRR. The Feburary 2024 MRR was reviewed with the DON with the response from the physician was dated 04/05/24. She was asked if it was addressed timely. She stated she would have to review the policy. The DON was observed to review the policy and stated, It doesn't say in there.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 46702 Based on record review and interview, the facility failed to ensure side effect monitoring was in place for a resident who was prescribed anticoagulant therapy for one (#3) of five residents sampled for unnecessary medication. The DON identified 29 residents were prescribed anticoagulants. Findings: A Anticoagulation-Clinical Protocol policy, revised 11/2018, read in part, .Assess for any signs or symptoms related to adverse drug reactions to to the medication alone or in combination with other medication .The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems . Resident #3 had diagnoses which included pulmonary embolism, hypertensive heart disease, and peripheral vascular disease. A Physician Order, dated 02/02/24, read in part, .Apixaban Oral Tablet 5 mg .Give 1 tablet by mouth two times a day . A Quarterly Assessment, dated 02/03/24 documented resident 3's cognition was intact and was prescribed anticoagulant therapy. Resident #3's care plan for anticoagulant therapy, dated 05/15/23, read in part, .Monitor/document/report PRN adverse reaction of anticoagulant therapy . The Treatment Administration Record dated 02/01/24 through 04/09/24 did not document side effect monitoring for anticoagulants. The Active Order Summary dated 04/09/24, did not document side effect monitoring for anti coagulant therapy. On 04/10/24 at 9:43 a.m.,the DON was asked about the policy for anticoagulant therapy. The DON stated there should be an order and the monitoring is in the TAR. The DON reviewed Resident #3 EHR and stated there was no side effect monitoring in the orders and there was no side effect monitoring in the TAR. The DON stated the policy was not followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375562	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
McMahon-Tomlinson Nursing Center	2007 NW 52nd Street Lawton, OK 73505

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 41872 Based on observation, record review, and interview the facility failed to ensure three extended release medications were not crushed for two (#6 and #23) of eight sampled residents reviewed during medication pass. A total of 39 opportunites were observed with three errors. The medication error rate was 6.94%. The Administrator identified 97 residents resided in the facility. Findings: A Crushing Medications policy, last revised April 2018, read in part, The nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush that the manufacturer stated should not be crushed (for example, long-acting or enteric coated medications) . 1. Resident #6 had diagnoses which included high blood pressure, edema, and atrial fibrillation. A 'Physician Order, dated 05/16/23, documented to administer Metoprolol Succinate extended release 12.5 mg by mouth every morning, Potassium Chloride extended release 20 milliequivalents by mouth every morning, and may crush meds and open capsules as appropriate. On 04/10/24 at 7:43 CMA #1 was observed to prepare Resident #6's medications. CMA#1 was observed to crush and administer Resident #6's medications to include Metoprolol extended release 12.5 mg and Potassium extended release 20 meq. 2. Resident #23 had diagnoses which included high blood pressure. A Physician Order, dated 08/03/23, documented staff may open and crush medications as appropriate, but if medication is extended release to notify pharmacy for alternatives. A Physician Order, dated 12/11/23, documented to administer Metoprolol Succinate extended release 25 milligrams in the morning. On 04/10/24 at 7:58 a.m., CMA #1 was observed to prepare Resident #23's medications. CMA #1 was observed to crush and administer Metoprolol extended release 25 mg to Resident #23. On 04/10/24 at 12:29 p.m., CMA #1 was asked if an extended release medication be crushed. They stated, no. They were asked if they had crushed metoprolol and potassium for Resident #6. They stated yes. They were asked if they had crushed Resident #23's metoprolol extended release. They stated. Yes. On 04/10/24 at 12:59 p.m., the DON was asked if extended release medications can be crushed. They stated they can if the physician is aware, but no we are not supposed to. They were asked if potassium extended release or metoprolol extended release should be crushed. They stated if it is extended release it should not be crushed.

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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. 41872 Based on observation, record review and interview the facility failed to ensure staff maintained infection control measures, and a. changed gloves during provision of perineal care and personal hygiene for one (#55) of one sampled resident reviewed for perineal care, b. sanitized the blood pressure cuff and pulse oximeter during medication observation for three (#6, #64, and #23), and c. sanitized their hands between residents during medication observation for four (#17, #31, #144, #80) of eight sampled residents reviewed during medication pass observation. The Administrator identified 97 residents resided in the facility. Findings: A Cleaning and Disinfection or Resident-Care Items and Equipment policy revised October 2018, read in part, .Non-critical items are those that come in contact with intact skin but not mucous membranes .blood pressure cuffs .Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment . A Handwashing/Hand Hygiene policy, dated August 2019, read in parts, .Hand hygiene products and supplies .shall be readily accessible and convenient for staff use .Use an alcohol-based hand rub .or, alternatively, soap .and water .Before and after direct contact with resident .Before preparing or handling medications .After removing gloves .Before and after entering isolation precaution settings . 1. Resident #55 had diagnoses which included GERD and high cholesterol. A significant change assessment, dated 03/14/24, documented Resident #55 was always incontinent of bowel and bladder, was dependent on staff for assistance with toileting, transfers, dressing, and personal hygiene. On 04/08/24 12:10 p.m., CNA #2 was observed to remove Resident #55's shirt and dress them in a gown then transferred the resident to their bed. On 04/08/24 at 12:19 p.m., CNA #2 removed Resident #55's pants and cleansed the vaginal area with periwash and wipes. CNA #3 entered the room and assisted with positioning Resident #55. CNA #2 was observed to clean Resident #55's buttocks then applied barrier cream. CNA #2 and #3 then positioned Resident #55 to secure the brief. CNA #2 then straightened the residents gown, brushed the resident's hair, used a wipe to clean the residents eyes and mouth, positioned the resident to float their heels, then covered the resident with a blanket. CNA #2 was not observed to change their gloves at anytime during provision of care or during positioning or hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/08/24 12:26 p.m., CNA #2 was asked when they had changed their gloves during pericare. They stated they had not changed their gloves. CNA #2 was asked when they had cleaned Residents #55's eyes and mouth did they still have on the same gloves. They stated yes. 04/10/24 1:09 p.m., the DON was asked when should staff change their gloves when providing incontinent care. They stated when they get finished with dirty and go to clean. They were asked if staff should use the same gloves to clean the residents eyes and mouth that was used to clean their peri area and buttocks. They stated No. 2. On 04/10/24 at 7:43 a.m., CMA #1 was observed to obtain a blood pressure, pulse ox, and pulse using a dynamap machine on Resident #6. CMA #1 was not observed to sanitize the equipment after use. On 04/10/24 at 7:53 a.m., CMA #1 was observed to obtain a pulse ox on Resident # 64, return the dynamap near the medication cart and was not observed to sanitize the pulse oximeter. On 04/10/24 at 7:58 CMA #1 was observed to obtain a pulse ox, pulse and blood pressure on Resident #23 then returned the dynamap to the medication cart. CMA #1 was not observed to sanitize the blood pressure cuff or pulse oximeter after use. On 04/10/24 at 8:09 a.m., CMA #1 was asked when they had sanitized their equipment. They stated they did not sanitize their equipment. They were asked when they should sanitize their equipment. They stated after every resident. On 04/10/24 at 1:05 p.m., the DON was asked what was the policy for sanitizing resident equipment to include pulse oximeter and blood pressure cuff. The DON stated, staff should use wipes (sanitizer) in between residents. 21731 3. On 04/10/24 at 7:38 a.m., CMA #2 was observed to approach a medication cart and replace an insulin pen into a zip bag then into the medication cart. There was no hand sanitizer on the medication cart. Without washing or sanitizing their hands, CMA #2 obtained equipment from the medication cart to obtain a FSBS. CMA #2 walked down the hall, entered the room of Resident #17. Without washing or sanitizing their hands, CMA #2 donned gloves and obtained a FSBS for Resident #17. CMA #2, removed one glove, while holding the used sharps in the gloved hand, returned to the medication cart, disposed of the sharp, and removed the second glove. Without washing or sanitizing their hands, CMA #2 obtained a blood pressure on Resident #31, returned to the medication cart and prepared nine oral medications and administered to Resident #31. On 04/10/24 at 8:00 a.m., CMA #2 was asked what the facility policy for hand sanitation during medications administration was. CMA #2 stated they should have sanitized after each resident then washed their hands with soap and water after every third resident. CMA #2 was asked if they had sanitized their hands between Resident #17 and #31. They stated, No, there is none on the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/10/24 at 8:05 a.m., CMA #3 was observed to approach a medication cart. There was no hand sanitizer on the medication cart. CMA #3 obtained a blood pressure cuff, and enter Resident #144's room to obtain a blood pressure. CMA #3 did not wash or sanitize their hands before obtaining the blood pressure. CMA #3 returned to the medication cart, without sanitizing their hands, prepared five oral medications for Resident #144, returned to the resident room and administered the oral medications. Without washing or sanitizing their hands, CMA #3 returned to the medication cart, and reviewed orders for Resident #80. Without washing or sanitizing their hands, CMA #3 entered into an isolation room, donned gloves and gown, removed gloves, donned clean gloves and obtained a blood pressure for Resident #80. CMA #3 then removed the gown and one glove, while taking the blood pressure cuff to the medication cart, placed the blood pressure cuff on top of the cart, removed their gloves, obtained a sanitizing wipe to clean the blood pressure cuff and the top of the medication cart prior to sanitizing their hands. On 04/10/24 at 8:13 a.m., CMA #3 was asked what the facility policy to wash or sanitize hands was. CMA #3 stated hands should be cleaned or sanitized going into and coming out of every resident room. CMA #3 stated, that was not what they did.