STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375572	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Ridge	102 East Line Avenue Sapulpa, OK 74066

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43023 Based on record review and interview, the facility failed to ensure residents were offered the right to formulate an advanced directive for three (#7, 32, and #107) of six sampled residents reviewed for advance directives. The DON identified 57 residents resided in the facility. Findings: 1. Res #107 was admitted to the facility on [DATE]. Res #107's medical record did not contain an advanced directive or an advanced directive acknowledgement form. 2. Res #32 was admitted to the facility on [DATE]. Res #32's medical record did not contain an advanced directive or an advanced directive acknowledgement form. 3. Res #7 was admitted to the facility on [DATE]. Res #7's medical record did not contain an advanced directive or an advanced directive acknowledgement form. On 11/21/24 at 8:40 a.m., the corporate nurse stated the forms were not completed.

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:	(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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 46387 Based on record review and interview, the facility failed to report an allegation of abuse to OSDH within two hours. The DON identified 57 residents resided in the facility. Findings: A facility Abuse, Neglect, and Exploitation policy, dated 2024, documented the facility was to report all allegations of abuse immediately, but no longer than two hours after the allegation was made. A facility reported incident, dated 10/16/24, documented an allegation of abuse regarding LPN #3. The incident report was not sent to OSDH until 10/17/24. On 11/19/24 at 11:58 a.m., the MDS coordinator stated the incident report should have been sent to OSDH within two hours, but was not.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 46387 Based on record review and interview, the facility failed to conduct a thorough investigation after an allegation of abuse. The DON identified 57 residents resided in the facility. Findings: A facility Abuse, Neglect, and Exploitation policy, dated 2024, read in part, An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. The policy also read 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, or exploitation, and/or mistreatment has occurred, the extent, and cause, and; 6. Providing complete and thorough documentation of the investigation. A facility reported incident, dated 10/04/24, documented an allegation of abuse. The report to OSDH did not include supplemental documentation regarding an investigation. On 11/19/24 at 10:34 a.m., the administrator stated they were responsible for investigations of abuse. They stated the investigation should include personal statements from and safe surveys. They stated there should have also been statements by those who were making the complaints/allegations. They stated inservices should be conducted with staff. Regarding the incident on 10/04/24, they stated they were unable to find the documentation of an investigation.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on record review and interview, the facility failed to complete comprehensive MDS assessments within the required time frame for two (#15 and #109) of five sampled residents reviewed for MDS assessment completion. The DON identified 57 residents resided in the facility. Findings: The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1, dated October 2024, documented a significant change MDS must be completed no later than the 14th calendar day after determination a significant change had occurred. The manual also documented an admission assessment must be completed no later than the 14th day of the resident's admission. 1. Res #15 had a significant change assessment with an ARD of 10/16/24, reflective of the determination date a significant change had occurred. The MDS was not completed and signed until 11/18/24. 2. Res #109 was admitted to the facility on [DATE]. A comprehensive MDS was not completed until 11/18/24. On 11/19/24 at 9:30 a.m., the MDS coordinator stated the facility had been without an MDS coordinator for about five months. They stated they were aware there was an issue with completion of MDS assessments.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. 46582 Based on record review and interview, the facility failed to complete quarterly MDS assessments timely for three (#13, 20, and #31) of five sampled residents reviewed for MDS assessment completion. The DON identified 57 residents resided in the facility. Findings: The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.19.1, dated October 2024, documented quarterly assessments must be completed no later than 14 calendar days after the ARD. 1. Res #13 had a quarterly MDS assessment with an ARD of 10/15/24. The assessment was not completed until 11/18/24. 2. Res #20 had a quarterly MDS assessment with an ARD of 10/15/24. The assessment was not completed until 11/18/24. 3. Res #31 had a quarterly MDS assessment with an ARD of 10/14/24. The assessment was not completed until 11/12/24. On 11/19/24 at 9:30 a.m., the MDS coordinator stated the facility had been without an MDS coordinator for about five months. They stated they were aware there was an issue with completion of MDS assessments.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387 Based on record review and interview, the facility failed to develop a baseline care plan within 48 hours of admission for one (#109) of five sampled residents reviewed for MDS completion. The DON identified 57 residents resided in the facility. Findings: Res #109 was admitted to the facility on [DATE]. On 11/18/24 there was no active care plan documented in the resident's chart. On 11/19/24 at 9:30 a.m., the MDS coordinator stated baseline care plans should be completed within 48 hours of admission. They stated the facility had been without a MDS coordinator for about five months. They stated they were aware there were some issues with care plans.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46582 Based on record review and interview, the facility failed to develop a comprehensive care plan for: a. diabetic monitoring for one (#5) of five sampled residents reviewed for unnecessary medications; b. ADLs for one (#47) of three sampled residents reviewed for ADLs; c. pressure ulcers for one (#17) of two sampled residents reviewed for pressure ulcers, and d. psychotropic medications and diagnosis of psychosis for one (#31) of five sampled residents reviewed for unnecessary medications. The DON identified 57 residents who resided in the facility. Findings: 1. Res #5 was admitted to the facility with diagnoses which included type II diabetes mellitus and atrial fibrillation. A physician order, dated 08/22/24, documented to administer insulin glargine 10 units subcutaneously at bedtime for type II diabetes mellitus. A physician order, dated 08/22/24, documented to obtain FSBS and administer insulin lispro per sliding scale before meals for type II diabetes mellitus. A physician order, dated 08/22/24, documented to administer metformin (hypoglycemic medication) 500 mg two tablets twice daily for type II diabetes mellitus. A physician order, dated 08/22/24, documented to administer apixaban (anticoagulant medication) 5 mg twice daily for atrial fibrillation. A physician order, dated 09/02/24, documented to monitor for signs/symptoms of bleeding. An admission assessment, dated 09/04/24, documented the resident was cognitively intact and received insulin, hypoglycemic medication, and anticoagulant medication. A care plan, reviewed 11/20/24, had no documentation of diabetic monitoring or anticoagulant therapy. On 11/20/24 at 12:01 p.m., the corporate nurse stated diabetic monitoring and anticoagulant therapy should have been documented on Res #5's care plan. 46387 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Res #47 had diagnoses which included shortness of breath, weakness, and chronic kidney disease. A care plan, revised on 11/01/24, did not document ADLs. On 11/19/24 at 11:58 a.m., the MDS coordinator stated ADLs should be care planned. They were asked to review Res #47's care plan and stated they could not say ADLs were documented. 43023 3. Res #17 was admitted to the facility with diagnoses which included of chronic kidney disease, HTN, and chronic pain syndrome. A skin assessment, dated 11/11/24, documented a new open area to the sacrum. A review of the resident's record did not document a care plan had been developed for the pressure ulcer. 4. Res #31 admitted to the facility with diagnosis which included unspecified psychosis. A physician's order, dated 02/06/24, documented Risperdal (antipsychotic medication) 1 mg twice a day. A care plan, dated 11/03/24, contained no documentation for unspecified psychosis or antipsychotic medication therapy. On 11/20/24 at 12:06 p.m., the corporate nurse stated the psychosis diagnosis and the antipsychotic medication should have been 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. 43023 Based on observation, record review, and interview, the facility failed to review/revise a care plan for one (#17) of 15 sampled residents reviewed for care plans. The DON identified 57 residents resided in the facility. Findings: Res #17 was admitted to the facility with diagnoses which included chronic kidney disease, HTN, and chronic pain syndrome. A significant change assessment, dated 09/15/24, documented the resident was frequently incontinent of bladder and required partial to moderate assist with transfers. The assessment did not document the resident had an uindwelling catheter. A physician's order, dated 10/15/24, documented Hoyer lift with all transfers. On 11/18/24 at 11:40 a.m., Resident #17 was observed resting in bed with their eyes open. A catheter was observed draining to gravity at bedside. The resident's record was reviewed and the care plan had not been revised to document transfers with a lift or the catheter. On 11/20/24 at 12:03 p.m., the corporate nurse stated the care plan should have been revised to contain transfers with the lift and the catheter.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 43023 Based on observation, record review, and interview, the facilty failed to obtain a physician's order for a catheter for one (#17) of one sampled resident reviewed for catheters. The DON identified 57 residents resided in the facility. Findings: Res #17 admitted to the facility with diagnoses which included chronic kidney disease, HTN, and chronic pain syndrome. On 11/18/24 at 11:40 a.m., resident #17 was observed resting in bed with their eyes open. A catheter was observed draining to gravity at bedside. The resident's record was reviewed and did not contain a physician's order for a catheter. The resident's care plan was reviewed and did not document the resident's catheter. On 11/20/24 at 12:03 p.m., the corporate nurse stated a physician's order should have been obtained and the care plan for the catheter should have been developed.

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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: a. perform an entrapment risk assessment for four (#3, 5, 14, and #44); b. obtain a physician order for one (#3); d. obtain an informed consent for four (#3, 5, 14, and #44); and e. develop a care plan for side rail use for two (#3 and #14) of four sampled residents reviewed for accident hazards. The DON identified 13 residents whose beds were equipped with a bed rail of any type. Findings: An undated Proper Use of Bed Rails policy, read in parts, As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meets those needs: medical diagnosis, behavioral symptoms, size and weight, sleep habits, medications, acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, cognition, communication, mobility, risk of falling .The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself .Informed consent from the resident or resident representative must be obtained prior to installation and use of bed rails .Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail .The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices. This should be evidenced in the resident's records, including their care plan .A nurse assigned to the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or a change in the type of bed/mattress/rail. 1. Res #3 was admitted to the facility with diagnoses which included morbid obesity, muscle weakness, and reduced mobility. An admission assessment, dated 08/10/23, documented the resident was cognitively intact and required limited one person assistance with bed mobility and transfer. There was no documentation of an entrapment risk assessment, informed consent, or physician order for bed rails found in the medical record. There was no documentation of bed rail use in Res #3's care plan. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/18/24 at 11:52 a.m., Res #3 was observed lying in bed. Bilateral Halo bed rails were observed on the upper portion of the bed. Res #3 stated they used the rails to assist staff with turning them. 2. Res #5 was admitted to the facility with diagnoses which included weakness, pain, and insomnia. A care plan, dated 09/02/24, documented U rails on bed to assist with turning. An admission assessment, dated 09/04/24, documented the resident was cognitively intact, impaired on one side of upper body, and required substantial to maximum assistance with bed mobility. A physician order, dated 09/05/24, documented the resident could use bedside rails for positioning and mobility. The order documented 1/8 rails on both sides of the bed for positioning. There was no documentation of resident and/or representative informed consent for side rails found in the medical record. On 11/18/24 at 12:31 p.m., Res #5 was observed lying in bed. Bilateral half rails were observed on the upper portion of the bed. Res #5 stated the rails were utilized for positioning. 3. Res #44 was admitted to the facility with diagnoses which included muscle weakness, lack of coordination, and reduced mobility. An admission assessment, dated 10/04/21, documented the resident was cognitively intact and required extensive assistance with bed mobility. A care plan, dated 10/18/21, documented U rails on both sides of the bed to assist with positioning. A physician order, dated 11/23/21, document U rails times two for self-positioning. A bed rail entrapment risk assessment, dated 06/27/22, documented use of side rails. There was no documentation of an entrapment risk assessment since June 2022. There was no documentation of resident and/or representative informed consent for side rails found in the medical record. On 11/18/24 at 12:21 p.m., Res #44 was observed lying in bed. Bilateral U rails were observed on the upper portion of the bed. Res #44 stated the bed rails were used for turning in bed. On 11/19/24 11:00 a.m., LPN #1 stated a physician order was required prior to installation of all bed rails. LPN #1 stated they were not aware of informed consent, or a bed rail assessment having been required prior to the use of bed rails. On 11/19/24 at 11:39 a.m., the DON stated a physician order, entrapment risk assessment, and informed consent should have been completed prior to the use of bed rails for all residents in the facility. The DON stated entrapment risk assessments should have been completed quarterly and all residents with bed rails should have had the use of bed rails documented in their care plan. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	43023 4. Res #14 was admitted to the facility with diagnoses which included muscle weakness and cerebral infarction. A quarterly assessment, dated 07/26/24, documented the resident's cognition was moderately intact and was dependent for all functional abilities. There was no documentation of an entrapment risk or informed consent. There was no documentation of bedrail use in Res #14's care plan. On 11/18/24 at 4:27 p.m., Res #14 was observed resting in bed with their eyes open. Half rails were observed on the upper portion of the bed. On 11/19/24 at 11:39 a.m., the DON stated a physician order, entrapment risk assessment, and informed consent should have been completed prior to the use of bed rails for all residents in the facility. The DON stated entrapment risk assessments should have been completed quarterly and all residents with bed rails should have had the use of bed rails documented in their care plan.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 45462 Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5%. A total of 30 opportunities were observed with two errors. The total medication error rate was 6. 67% related to incorrect doses of medication given to one (#55) of four sampled residents observed during the medication pass. The ADON identified 57 residents resided in the facility. Findings: An undated Medication Errors policy, read in part, The facility must ensure that it is free of medication error rates of 5% or greater. A physician's order for Resident #55 documented they were to receive fludrocortisone (steroid) 0.1mg tab - 0. 5mg (5 tabs) by mouth daily and vitamin D3 25mg by mouth daily. A notation on the label of the blister pack for Resident #55's fludrocortisone 0.1mg tab read in part, give 5 tablets by mouth daily. The label on the blister pack for Resident #55's vitamin D3 read in part, vitamin D3 1,000 IU. On 11/20/24 at 10:24 a.m., CMA #1 was observed while administering medications to Resident #55. Medications administered by CMA #1 to Resident #55 by mouth included fludrocortisone 0.1mg tab - 1 tab and vitamin D3 1,000 IU cap - 1 cap. On 11/20/24 at 12:15 p.m., CMA #1 was asked how many tablets of fludrocortisone they had administered to Resident #55. They stated one. CMA #1 was asked to read the notation on the fludrocortisone blister pack and stated, I did not notice that notation there. We have always given [Resident #55] one tab. Usually if the dose is more than one tab it is highlighted. CMA #1 was asked to review Resident #55's order for vitamin D3 and if the dose given (1,000 IU) was equal to 25mg. They stated, I'll have to check with the nurse. On 11/20/24 at 12:25 p.m., LPN #1 was shown the blister pack for Resident #55's vitamin D3 and was asked if the dose of vitamin D3 given was equivalent to 25mg. They placed a call to the pharmacy and verified the dose was not equal to 25mg as ordered. LPN #1 was asked to review Resident #55's order for fludrocortisone and verified the dose given should have been 5 tabs. LPN #1 confirmed two medication errors had occurred. On 11/20/24 at 3:30 p.m., the corp nurse was informed of the observations described above and they acknowledged two medication errors had occurred.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45462 Based on record review and interview, the facility failed to prevent a significant medication error occurred when the incorrect dosage of medication was administered for multiple administrations of a prescribed corticosteroid (steroid) for one (#55) of four sampled residents whose medication administration records were reviewed. The ADON identified 57 residents resided in the facility. Findings: An undated Medication Errors policy, read in part, The facility shall ensure medications will be administered according to physician's orders .Medication errors, once identified, will be evaluated to determine if considered significant or not by utilizing the following three general guidelines .c. Frequency of Error: If an error is occurring repeatedly such as an omission of a resident's medication several times. Resident #55 had diagnoses that included adrenocortical insufficiency and hypothyroidism. A physician's order for Resident #55 documented they were to receive fludrocortisone (steroid) 0.1mg tab - 0.5mg (5 tabs) by mouth daily. The label on the blister pack for Resident #55's fludrocortisone 0.1mg tab documented the prescription was filled on 09/04/24 for 150 tabs. A notation on the label read in part, give 5 tablets by mouth daily. There were 71 tabs remaining from Resident #55's fludrocortisone prescription, filled 09/04/24 for 150 tabs. Only 79 pills had been given from the prescription that was issued on 09/04/24 (79 days ago). On 11/20/24 at 12:15 p.m., CMA #1 was asked how many tablets of fludrocortisone they had administered to Resident #55 during the morning medication pass. They stated one. CMA #1 was asked to read the notation on the fludrocortisone blister pack and stated, I did not notice that notation there. We have always given [Resident #55] one tab. Usually if the dose is more than one tab it is highlighted. On 11/20/24 at 3:30 p.m., the corp nurse was informed of the observations described above. They were asked how long Resident #55's fludrocortisone prescription, filled on 09/04/24 for 150 tabs, would have lasted if the resident had been given 5 tabs daily as ordered. They stated 30 days. The corp nurse was asked if the refill date on the fludrocortisone and the number of pills given from the prescription to date, were an indication that Resident #55 had received the medication as ordered from 09/04/24 to 11/20/24. They stated no and acknowledged a significant medication error had occurred. On 11/21/24 at 9:03 a.m., Pharm Tech verified the last refill of fludrocortisone 0.1mg tab - 150 tabs was sent to the facility on [DATE].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375572	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Ridge	102 East Line Avenue Sapulpa, OK 74066

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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. 46387 Based on observation and interview, the facility failed to ensure food was stored in accordance with professional standards for food service safety and dishes were sanitized prior to use. The DON identified 57 residents resided in the facility and received services from the kitchen. Findings: An initial tour of the kitchen was conducted on 11/18/24 at 10:39 a.m. The following observations were made: a. an open bottle of nectar thickened water with lemon, dated open on 11/07/24. The label on the container documented to discard after 10 days of opening; b. an open bottle of nectar thickened orange juice, dated open 11/03/24. The label on the container documented to discard after 10 days of opening; c. an open bottle of honey thickened orange juice, not dated when opened; d. an open bottle of honey thickened milk, dated open on 11/07/24. The label on the container documented to discard after four days of opening; e. an open bottle of honey thickened orange juice, not dated when opened; and d. the walk in freezer door was observed with ice accumulation on the outside of the seal to the door. Upon opening the door icicles were observed hanging above the door frame. An accumulation of ice was on the inside of the door as well as ice was on the outside of boxes stored in the freezer. There was a layer of ice on the floor of the freezer and the back wall had ice hanging from the cooling fans. On 11/18/24 at 10:40 a.m. an initial test of dish machine sanitation was conducted. The chlorine strips had no reaction. On 11/18/24 at 10:44 a.m., a second test of dish machine sanitation was conducted with the same results. On 11/18/24 at 10:45 a.m., the DM stated the dish machine was tested daily for sanitation. The DM was observed performing a chlorine test with no reaction. They stated they would have to serve on paper and call the dish machine people. On 11/18/24 at 10:55 a.m., the DM was shown the walk in freezer and stated corporate had ordered the part, but it had not come in yet. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/18/24 at 10:57 a.m., the DM was shown the thickened liquids. They stated they should have been thrown out already.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46582 Based on record review and interview, the facility failed to ensure the QAA committee met at least quarterly. The DON identified 57 residents resided in the facility. Findings: The QAA committee meetings were reviewed. The last QAA meeting documented was February of 2024. A QAA form, dated 08/22/24, documented a meeting was not completed in August 2024 due to the lack of a DON and staff. On 11/21/24 at 9:25 a.m., the interim administrator stated QAA meetings should have been completed quarterly. On 11/21/24 at 9:41 a.m., the interim administrator stated documentation of quarterly QAA meetings could not be located.

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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. 46582 Based on record review and interview, the facility failed to maintain a water management program to prevent the growth of Legionella and other opportunistic waterborne pathogens in the building water system. The DON identified 57 residents who resided in the facility. Findings: A Legionella Water Management policy, revised September 2022, read in part, As part of the infection control prevention and control program, our facility has a water management program, which is overseen by the water management team .The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease .The water management program includes the following elements: an interdisciplinary water management team, a detailed description and diagram of the water system in the facility, the identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, the identification of situations that could lead to Legionella growth, specific measures used to control the introduction and/or spread of Legionella, and documentation of the program. No documentation regarding maintenance of a water management program was found from record review. On 11/20/24 at 11:24 a.m., the maintenance supervisor was asked to provide documentation of water management procedures. The maintenance supervisor stated they had never heard of a water management program to reduce the risk and growth of Legionella. They stated they had not monitored the water system for Legionella per the policy and had never been educated to perform this task. On 11/20/24 at 12:07 p.m., the corporate nurse stated the facility had not maintained a water management program.

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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. 46582 Based on observation, record review, and interview, the facility failed to conduct regular inspections of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for four (#3, 5, 14, and #44) of four sampled residents reviewed for accident hazards. The DON identified 13 residents whose beds were equipped with a bed rail of any type. Findings: An undated Proper Use of Bed Rails policy, read in parts, If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails .The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes: checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible and ensuring that the bed's dimensions are appropriate for the resident .Conducting routine preventative maintenance of beds and bed rails to ensure they meet current safety standards and are not in need of repair .The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails. 1. Res #3 was admitted to the facility with diagnoses which included morbid obesity, muscle weakness, and reduced mobility. An admission assessment, dated 08/10/23, documented the resident was cognitively intact and required limited one person assistance with bed mobility and transfer. On 11/18/24 at 11:52 a.m., Res #3 was observed lying in bed. Bilateral Halo bed rails were observed on the upper portion of the bed. Res #3 stated they used the rails to assist staff with turning them. 2. Res #5 was admitted to the facility with diagnoses which included weakness, pain, and insomnia. A care plan, dated 09/02/24, documented U rails on the bed to assist with turning. An admission assessment, dated 09/04/24, documented the resident was cognitively intact, impaired on one side of upper body, and required substantial to maximum assistance with bed mobility. A physician order, dated 09/05/24, documented the resident could use bedside rails for positioning and mobility. The order documented 1/8 rails on both sides of the bed for positioning. On 11/18/24 at 12:31 p.m., Res #5 was observed lying in bed. Bilateral half rails were observed on the upper portion of the bed. Res #5 stated the rails were utilized for positioning. 3. Res #44 was admitted to the facility with diagnoses which included muscle weakness, lack of coordination, and reduced mobility. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An admission assessment, dated 10/04/21, documented the resident was cognitively intact and required extensive assistance with bed mobility. A care plan, dated 10/18/21, documented U rails on both sides of the bed to assist with positioning. A physician order, dated 11/23/21, document U rails times two for self-positioning. A bed rail entrapment risk assessment, dated 06/27/22, documented use of side rails. On 11/18/24 at 12:21 p.m., Res #44 was observed lying in bed. Bilateral U rails were observed on the upper portion of the bed. Res #44 stated the bed rails were used for turning in bed. On 11/19/24 at 1:30 p.m., the DON was asked to provide documentation of regular bed rail inspections for all residents with bed rails. On 11/19/24 at 2:33 p.m., the DON stated the facility was not able to provide documentation of regular bed rail inspections and maintenance. 43023 4. Res #14 was admitted to the facility with diagnoses which included muscle weakness and cerebral infarction. A quarterly assessment, dated 07/26/24, documented the resident's cognition was moderately intact and was dependent for all functional abilities. On 11/18/24 at 4:27 p.m., Res #14 was observed resting in bed with their eyes open. Half rails were observed on the upper portion of the bed. On 11/19/24 at 1:30 p.m., the DON was asked to provide documentation of regular bed rail inspections for all residents with bed rails. On 11/19/24 at 2:33 p.m., the DON stated the facility was not able to provide documentation of regular bed rail inspections and maintenance.