STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385233	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Court at Keizer	5210 River Road N. Keizer, OR 97303

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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 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. 36494 Based on observation, interview and record review the facility failed to ensure a dignified dining experience by failing to provide meals to all residents at a table at the same time for 1 of 2 dining halls and 1 of 5 sampled residents (#20) reviewed for dining and food services. This placed residents at risk for not being treated in a dignified manner. Findings include: Resident 20 was admitted to the facility in 2018 with diagnoses including dysphagia (difficulty swallowing). An observation on 5/28/24 from 12:20 PM thorough 12:48 PM (28 minutes) revealed Resident 20 was in the 100 hall dining room with other residents. Resident 20 waited for her/his lunch while other residents were eating. Staff began clearing other residents' tables because they finished eating, while Resident 20 continued to wait for her/his meal. On 5/28/24 at 12:40 PM Staff 17 (CNA) stated Resident 20 was in the dining hall since 12:20 PM. Staff 17 acknowledged the resident did not receive her/his lunch meal. Staff 17 stated it was an ongoing problem, with meals often being late or residents' meals not being placed on the correct meal cart. On 5/30/24 at 9:00 AM Staff 16 (CNA) stated Resident 20 ate in the dining room and acknowledged her/his tray was not delivered timely on 5/28/24. Staff 16 stated the facility had difficulty delivering meal cart trays timely and residents' meals were not always placed on the correct meal cart. On 5/31/24 at 9:41 AM Staff 5 (RNCM) and at 11:43 AM Staff 2 (DNS) acknowledged Resident 20's meal was late on 5/28/24 and not served with the other residents in the 100 dining hall. Staff 2 and Staff 5 stated staff were expected to follow up with the kitchen or attempt to locate Resident 20's meal.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 38140 Based on interview and record review, it was determined the facility failed to effectively respond to resident council concerns expressed at 3 of 3 resident council meetings reviewed for facility response to resident council concerns. This placed residents at risk for unmet needs concerning issues of resident care and lessened quality of life. Findings include: The facility's undated Resident Council Policy indicated a Quality Assurance form should be utilized for Resident Council meetings to help track the council's concerns and/or suggestions. A staff designee would fill out the Resident Council Response/Grievances forms immediately following Resident Council meetings. During the 5/29/24 at 2:00 PM Resident Council meeting the residents stated they did not feel heard about their concerns or suggestions. The Resident Council stated they often did not receive a response from administration or departments regarding the concerns or suggestions they reported. On 5/29/24 at 6:15 PM review of the Resident Council/Family Council Department Response Form revealed the following from the Resident Council meetings concerns: -3/25/24, residents expressed concern the laundry took longer and more items came up missing. No response was given to the Resident Council; -4/22/24, residents expressed concern for food quality, supply closets ran short of supplies for briefs and wipes more often than not, residents were not served meals at the same time at dining room tables, and the wipes and mechanical lift slings ran low more often than not. The Central Supply department replied, Works M, W, F and will stock on those days. No resolution or reasoning for the supply shortage was provided and no responses were provided for the other identified concerns. -5/6/24, residents expressed concern that supply closets often ran low with supplies, they would like smaller food portions and lemonade to drink, and the aides were throwing clothes directly on the floor instead of placing them in a bag. No responses were provided to the Resident Council. On 5/31/24 at 10:39 AM Staff 13 (Activities/CNA) confirmed the lack of responses to the Resident Council concerns. Staff 13 stated she assisted the residents with Resident Council and she wrote the Resident Council/Family Council Department Response Forms for each facility department with resident concerns. Staff 13 acknowledged she often did not get responses from facility departments for the residents; concerns and the Resident Council members were frustrated with the lack of response. On 5/31/24 at 11:01 AM Staff 1 (Administrator) acknowledged the lack of response to the Resident Council concerns. Staff 1 expected all Resident Council concerns to be appropriately addressed in written form on the Resident Council/Family Council Department Response Form and given to the Resident Council to review.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. 38140 Based on observation, interview and record review it was determined the facility failed to ensure residents were notified of rights both orally and in writing on an ongoing basis for 1 of 1 facility reviewed for Resident Council. This placed residents at risk for not being informed of their rights. Findings include: The facility's revised 2021 Resident Rights policy indicated copies of the resident rights were posted throughout the facility. Residents were to be informed about rights and responsibilities upon admission and periodically thereafter. Record review of the past Resident Council Meeting minutes on 5/29/24 at 1:47 PM revealed no indication of resident rights provided to residents during the meetings on 3/25/24, 4/22/24 and 5/6/24. On 5/29/24 at 2:00 PM the Resident Council stated they were not informed of resident rights on an ongoing basis and were unsure if any were posted in the facility or where to obtain the resident rights. The reception area and facility common areas were observed on 5/29/24 at 2:53 PM and no resident rights were observed posted. In an interview on 5/31/24 at 10:39 AM Staff 13 (Activities/CNA) stated she did not have a system to track the right rights which she read to residents during the Resident Council. Staff 13 could not ensure all the resident rights were reviewed during Resident Council. Staff 13 did not know how the facility provided ongoing resident rights communication to residents who did not attend Resident Council. On 5/31/24 at 11:01 AM Staff 1 (Administrator) stated she believed resident rights were reviewed through Resident Council. Staff 1 acknowledged the finding of the lack of ongoing resident rights information provided to residents and lack of resident rights posting in the facility.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 38140 Based on observation, interview and record review it was determined the facility failed to ensure a system was in place to receive and resolve resident and/or resident representative grievances for 1 of 1 sampled facility reviewed for Resident Council. This placed residents at risk for unreported and unresolved grievances. Findings include: The facility's undated Grievance policy indicated the facility was to ensure all residents and their family members were afforded the opportunity to express their concerns and suggest changes in the facility formally in writing. Record review of the facility's grievances binder revealed no written grievances were completed by residents or family members since 9/2023. During the 5/29/24 at 2:00 PM Resident Council meeting, residents stated they did not know how to file a grievance and one resident thought there used to be forms in the front reception area. The reception area and facility common areas were observed on 5/29/24 at 2:53 PM. No evidence of information was found on the right to file a grievance in writing or orally, how to file a grievance anonymously, the reasonable timeframe the resident could expect for a completed review of the grievance, the right to obtain the review in writing, the required contact information for the grievance official, or independent entities with whom grievances may also be filed with, or readily available grievance forms. On 5/31/24 at 10:54 AM Resident 6 stated she/he purchased a mechanical lift sling (device required to transfer) for personal use and it was lost months ago. Resident 6 stated she/he told everyone she/he could think of and did not receive a resolution. Resident 6 stated she/he was not offered a grievance form and did not know how to file a grievance. On 5/31/24 at 11:01 AM Staff 1 (Administrator) acknowledged there was no signage or ongoing reminders verbally to instruct residents or family members on the grievance process, and instructions were given in the Resident handbook upon admission. Staff 1 stated the forms were available at nursing stations and residents needed to ask for them. Staff 1 confirmed the lack of grievances filed by residents or resident representatives since 9/2023.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 38140 Based on interview and record review it was determined the facility neglected to ensure resident needs were accommodated related to mechanical lift slings (device required to transfer) and briefs (incontinent undergarment) for 4 of 4 sampled residents (#s 6, 23, 27 and 29) reviewed for accommodation of needs during Resident Council. This placed residents at risk for loss of independence, social isolation and ADL decline. Findings include: On 5/28/24 at 12:50 PM Resident 29 stated the facility often did not have mechanical lift slings and briefs available for residents. Resident 29 stated her/his spouse had to purchase briefs last weekend due to the lack of availability in the facility. Resident 29 stated on many occasions she/he was not able to get out of bed due to the lack of mechanical lift slings. Record review on 5/29/24 at 1:47 PM of Resident Council Meeting minutes revealed the following: -On 4/22/24 the Resident Council expressed concern the mechanical lift slings often were not available and the resident supplies closet often ran low of supplies. -On 5/6/24 the Resident Council expressed concern the resident supplies ran low. On 5/29/24 at 2:00 PM the Resident Council members stated the mechanical lift slings required three days to dry when laundered. There were many times when residents could not get out of bed due to the lack of mechanical lift slings. A council member stated, It's horrible not being able to get out of bed. Resident 23 was not able to get out of bed due the lack of mechanical lift slings. The Resident Council members stated the facility often ran out of briefs and under pads for the bed and it was stressful to worry about them running out of the briefs. On 5/30/24 at 9:00 AM Staff 16 (CNA) stated the facility often experienced a brief and wipes shortage, especially during the weekends. Staff 16 stated the mechanical lift slings were often not available and residents had to stay in bed because the staff had no way to get residents out of bed. On 5/30/24 at 10:58 AM Staff 7 (CNA) stated last week the facility went a whole day without wipes and extra large briefs. The shortage of brief supplies often happened on weekends. Staff 7 stated residents were often not able to shower due to the lack of mechanical lift slings and sometimes staff needed to borrow a mechanical lift sling from another resident if a resident fell and a mechanical lift sling was not available to get the resident off the floor. On 5/30/24 at 3:46 PM Resident 23 confirmed she/he wanted to get out of bed the previous day and was not able due to the lack of a mechanical lift sling. On 5/30/24 at 4:40 PM Resident 27 stated she/he was not able to get out of bed many times due to the lack of a mechanical lift sling. Resident 27 stated the facility often ran out of her/his size of briefs and she/he had to wear the wrong size or no brief at all. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/31/24 at 10:54 AM Resident 6 stated the facility often ran out of mechanical lift slings and incontinent supplies. On 5/31/24 at 11:01 AM Staff 1 (Administrator) stated she purchased mechanical lift slings in the past and was unaware it continued to be a problem. Staff 1 acknowledged the lack of mechanical lift slings and briefs for the residents. Staff 1 expected mechanical lift slings and briefs to be available for all residents.

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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. 38140 Based on interview and record review it was determined the facility failed to ensure care plans were revised to accurately reflect the needs of residents for 1 of 1 sampled resident (#7) reviewed for hospice care. This placed residents at risk for unmet needs. Findings include: Resident 7 was admitted to the facility in 2020 with a diagnosis of Huntington's disease (inherited condition in which nerve cells break down in the brain). Resident 7's health record revealed she/he began hospice services on 3/9/24. The 3/18/24 Significant Change of Condition MDS indicated Resident 7 was expected to live six months or less and received Hospice services. Resident 7's 5/30/24 care plan revealed a focus of ADL Self Care Performance Deficit and limited mobility. The goal was to maintain current level of function for dressing, transfers, bathing and toilet use. The interventions to achieve the goal in dressing, transfers, toileting and bathing were last revised on the care plan on 12/15/23. Review of Resident 7's current care plan provided no evidence the care plan was revised to reflect the resident centered approaches for the anticipated decline of health condition and individual hopice care needs. On 5/31/24 at 12:22 PM Staff 1 (Administrator) acknowledged the need for Resident 7's care plan revision. Staff 1 expected all residents to have resident centered care plans revised to reflect health changes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36494 Based on interview and record review it was determined the facility failed to follow physician orders or implement bowel care timely for 3 of 6 sampled residents (#s 8, 20, and 151) reviewed for medications and pain. This placed residents at risk for adverse side effects and constipation. Findings include: 1. Resident 151 was admitted to the facility on ,d+[DATE] with diagnoses including diabetes. A physician order dated 4/30/24 indicated Resident 151 was to receive alpha-lipoic acid (an antioxidant) 600 MG. Staff were to administer two capsules by mouth at bedtime for a supplement. A review of the resident's 5/2024 MAR revealed Resident 151 did not receive the alpha-lipoic acid from 5/17/24 through 5/20/24 (four days), as well as on 5/27/24 and 5/28/24. The reason for the non-administration was because the medication was marked 9 (not available). A physician order dated 5/1/24 indicated Resident 151 was to receive alpha-lipoic acid 600 MG and staff were to administer one capsule in the morning for a supplement. A review of the resident's 5/2024 MAR revealed Resident 151 did not receive her/his medication from 5/1/24 through 5/4/24 (four days) and from 5/14/24 through 5/21/24 (eight days). The reason for the non-administration was because the medication was marked 9 (not available). On 5/30/24 at 1:38 PM Staff 8 (CMA) and 1:55 PM Staff 6 (LPN) stated when they could not locate Resident 151's alpha-lipoic acid, they marked the MAR as 9, indicating the medication was not available. Staff 8 and Staff 9 stated they reported the lack of medication to Staff 5 (RNCM). On 5/31/24 at 11:32 AM Staff 5 acknowledged Resident 151 missed multiple doses of alpha-lipoic acid and was unsure why. Staff 5 stated the supplement was an over the counter medication and accessible through the facility's central supply system. Staff 5 stated she expected staff to email central supply directly or report to her when the supplement was unavailable. 2. Resident 8 was admitted to the facility in 11/2023 with diagnoses including end stage renal disease and the resident received renal dialysis (removes waste products and excess fluid from the blood). A Comprehensive Care Plan, dated 11/7/23, and revised on 5/23/24, revealed Resident 8 received dialysis on Mondays, Wednesdays and Fridays. A physician order dated 3/30/24, indicated Resident 8 was to receive sevelamer carbonate (a phosphate binder) 800 MG. Staff were to administer two tablets by mouth with meals related to end stage renal disease. A review of the resident's 5/2024 MAR revealed Resident 8 did not receive her/his 8:00 AM medication on 5/3/24, 5/6/24, 5/8/24, 5/10/24, 5/13/24, and 5/17/24 because the resident was out of the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/31/24 at 5:00 AM Witness 1 (Family Member) stated Resident 8 was supposed to be sent with the sevelamer carbonate when the resident went to dialysis, but this did not always occur. On 5/31/24 at 5:09 AM Staff 20 (LPN) stated he assisted Resident 8 with going to her/his dialysis treatments on Mondays, Wednesdays and Fridays. Staff 20 stated he sent paperwork and medications with the resident on dialysis days. Staff 20 further stated he thought there were times when the sevelamer carbonate was not available. On 5/31/24 at 11:44 AM Staff 5 (RNCM) acknowledged Resident 8 was not sent with the 8:00 AM sevelamer carbonate dose and should not have gone without the medication on her/his scheduled dialysis days. 47005 3. Undated documents provided by Staff 2 (DNS) on 5/30/24 and 5/31/24 Staff 2 (DNS) indicate the facility's bowel protocol included: -If resident had no bowel movements in three consecutive days, day shift to give Milk of Magnesia, if no results, then evening shift to give the suppository. If no results, NOC (overnight) shift to give fleet enema. -If offered and refused then it must be documented as refused. Without this documentation it looks like protocol was not followed. -Check medication list for alternative PRN, offer dose and document if refused. Resident 20's Physician Order Summary Report as of 5/28/24 indicated the following PRN bowel medication orders: -bisacodyl suppository PRN every eight hours as needed for constipation. -fleet enema every 24 hours as needed for constipation. -magnesium hydroxide (same as Milk of Magnesia) as needed for constipation. -polyethylene glycol as needed for constipation. a. Resident 20 readmitted to the facility on [DATE] with diagnoses including pneumonia, chronic constipation and stroke with left-sided weakness with dysphagia (difficulty swallowing). Resident 20's 5/2024 bowel records indicated the resident did not have a bowel movement from 5/25/24 through 5/31/24 at noon (six and a half days without a bowel movement). Resident 20's 5/2024 MAR indicated the following: - From 5/25/24 through 5/31/24 there was no indication a bisacodyl suppository was offered or administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- From 5/25/24 through 5/31/24 there was no indication a fleet enema was offered or administered. - From 5/25/24 through 5/28/24 there was no indication magnesium hydroxide was offered or administered. On 5/29/24 magnesium hydroxide was administered and noted to be ineffective. - From 5/25/24 through 5/29/24 there was no indication a polyethylene glycol was offered or administered. On 5/30/24 polyethylene glycol was administered and documented as unknown in effectiveness. A 5/28/24 progress note revealed Resident 20 was on day four of no bowel movement and nursing staff were to start abdominal assessments and offer bowel care/interventions on 5/29/24. On 5/31/24 at 9:52 AM Staff 21 (CMA) stated she recalled Resident 20 was on the bowel list on day three and she was unsure why milk of magnesia was not offered. On 5/31/24 at 10:01 AM Staff 9 (LPN) stated Resident 20 had her/his own bowel protocol because of opioid use and was unsure why it was not initiated on day three. On 5/31/24 at 10:39 AM Staff 5 (RNCM) stated Resident 20 had her/his own bowel protocol which was discontinued when the resident went to the hospital and was not continued when the resident returned from the hospital. Staff 5 acknowledged the house protocol and Resident 20's own bowel protocol were not followed. b. The 5/12/24 physician orders indicated Resident 20 was to receive medications crushed with applesauce with mildly thick liquids. The 5/2024 MAR indicated Resident 20 received duloxetine delayed release particles for depression once a day and bisacodyl delayed release for constipation once a day. On 5/30/24 at 9:00 AM Staff 10 (LPN) stated delayed release medications were not supposed to be crushed. Staff 10 stated Resident 20 had an order for all medications to be crushed. Staff 10 stated she crushed all of Resident 10's medications including the duloxetine and bisacodyl since the resident's admission. On 5/31/24 at 9:52 AM Staff 21 (CMA) stated she crushed all of Resident 10's medication. Staff 21 stated the duloxetine was a capsule and was not crushable, so she opened the capsules and added the medication to the applesauce. Staff 21 stated she did not know if opening the duloxetine capsule changed the efficacy of the delayed release. On 5/31/24 at 11:47 AM Staff 23 (Pharmacist) stated the duloxetine manufacturer did not recommend the delayed release capsules to be opened, but it could be opened and sprinkled in applesauce or juice for no more than two hours, but not crushed and not placed in chocolate pudding. Staff 23 stated it was not recommended for bisacodyl delayed release to be crushed because it would break the enteric coating and decrease the efficacy. On 5/31/24 at 11:56 AM Staff 2 (DNS) stated she expected staff to look in the drug book, ask the charge nurse, and get clarification from the pharmacist and doctor if there were concerns regarding crushing a medication. Staff 2 acknowledged the staff crushed medications that may have decreased the medication's efficacy.

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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. 36494 Based on interview and record review it was determined the facility failed to use the services of a registered nurse for at least eight consecutive hours a day for 9 of 62 days reviewed for registered nurse staffing. This placed residents at risk for lack of RN oversight including resident assessment, care and services. Findings include: A review of the Direct Care Staff Daily Reports for the months of 2/2023, 9/2023, and 5/2024 revealed the following days with no RN coverage during the 24 hour period: 2/2023: 2/4 and 2/11. 9/2023: 9/1, 9/3, 9/10 and 9/11. 5/2024: 5/6, 5/10, 5/12. On 5/31/24 at 9:41 AM Staff 14 (Staffing Coordinator), Staff 15 (Human Resources) and Staff 2 (DNS) were present for an interview. Staff 14 and Staff 15 acknowledged the facility struggled with RN coverage in 2/2023 and 9/2023. Staff 14 stated the facility adjusted RN schedules to ensure appropriate RN coverage was provided in the building. Staff 14 was unable to provide additional information regarding the lack of RN coverage on 5/6/24, 5/10/24 and 5/12/24.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38140 Based on interview and record review it was determined the facility failed to ensure residents were free of unnecessary psychotropic (affects brain activities) medications for 1 of 6 sampled residents (# 303) reviewed for medications. This placed residents at risk for receiving sedation and complications of psychotropic drug use. Findings include: The facility's 8/25/20 Psychoactive (affects brain activities) Medication Management Guideline directed staff to complete the following: -Review Admission Orders for psychotropic medications; -Ensure appropriate diagnosis for use; -If no supporting diagnosis was present, notify the provider and obtain an appropriate diagnosis. Resident 303 was admitted to the facility on [DATE] with diagnoses including mild cognitive impairment. Review of Resident 303's 5/29/24 Physician Order directed staff to administer 25 mg of Quetiapine Fumarate (antipsychotic medication used to treat schizophrenia [serious mental condition] and bipolar disorder [sudden episodes of mania or depression]) at bedtime related to mild cognitive impairment. Review of Resident 303's 5/2024 MAR on 5/29/24 at 11:57 AM revealed she/he was administered the Quetiapine Fumarate medication. Review of Resident 303's health record on 5/29/24 at 12:31 PM revealed no documented behaviors or target behaviors related to the use of Quetiapine Fumarate. On 5/30/24 at 9:15 AM Staff 4 (RNCM) confirmed Resident 303's diagnosis of mild cognitive impairment for the Quetiapine Fumarate. Staff 4 confirmed Resident 303 was administered Quetiapine Fumarate while in the facility. Staff 4 confirmed mild cognitive impairment was not an appropriate diagnosis for Quetiapine Fumarate and Resident 303 was not reported or documented to experience behaviors which indicated the use of an antipsychotic medication. On 5/30/24 at 9:21 AM Staff 2 (DNS) stated she expected all residents at admission to be assessed for appropriateness of medications and if a resident was on an antipsychotic medication, the staff were to obtain an appropriate diagnosis from the physician and put behavior monitors in place to monitor for medication effectiveness. Staff 2 confirmed Resident 303 was administered Quetiapine Fumarate without an appropriate diagnosis.

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	385233	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Court at Keizer	5210 River Road N. Keizer, OR 97303

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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. 39632 Based on observation, interview and record review it was determined the facility failed to ensure a medication pass error rate of less than 5%. There were two errors in 28 opportunities resulting in an 7.14% error rate. This placed residents at risk for adverse medication side effects. Findings include: The Drugs.com website, section titled Metformin Extended Release Tablets Prescribing Information, specified to Swallow metformin hydrochloride extended-release tablets whole. Do not crush, cut, or chew the tablets. The PreserVision AREDS (supplement specifically for eye health) manufacturer's website specified multivitamins were no substitute for an AREDS supplement and did not contain the same levels of nutrients found in the AREDS formula. 1. Resident 27 was admitted to the facility in 6/2023 with diagnoses including type 2 diabetes. Resident 27's 5/2024 Physician Orders included metformin HCl extended release (ER) tablet, 500 mg, give two tablets by mouth in the morning related to type 2 diabetes. On 5/30/24 at 8:50 AM Staff 10 (LPN) was observed for Resident 27's medication administration. Staff 10 dispensed two metformin 500 mg ER tablets into a cup, transferred the tablets into a pouch, crushed the tablets into a powder form, mixed the powder with pudding and administered the mixture to Resident 27. On 5/30/24 at 9:00 AM and 1:57 PM Staff 10 stated ER medications could not be crushed and if a resident preferred their medications crushed, she notified the provider. Staff 10 reviewed Resident 27's metformin order, acknowledged the medication was an ER form and confirmed she should not have crushed the medication. On 5/31/24 at 10:38 AM Staff 1 (Administrator) and Staff 2 (DNS) were notified the metformin ER 500 mg tablets were crushed during Resident 27's medication administration. Staff 2 stated she expected staff to know ER medication was not crushable. 2. Resident 35 was admitted to the facility in 5/2024 with diagnoses including spinal stenosis (narrowing of the space around the spine). Resident 35's 5/8/24 Physician Orders included PreserVision AREDS oral tablet, give one tablet by mouth one time a day for supplement. On 5/29/24 at 11:20 AM Staff 11 (LPN) was observed for Resident 35's medication administration. Staff 11 dispensed and administered a house stock multivitamin with mineral and did not administer PreserVision AREDS. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/29/24 at 1:20 PM Staff 11 reviewed Resident 35's PreserVision AREDS order. Staff 11 stated it was preferred to administer the house stock multivitamin with mineral in place of the PreserVision AREDS. On 5/30/24 at 1:53 PM Staff 5 (RNCM) reviewed Resident 35's PreserVision AREDS order. Staff 5 opened the medication cart, retrieved a large bottle labeled Preservision AREDS and stated this was the supplement staff should administer per physician orders. Staff 5 stated the house stock multivitamin with mineral was not an alternative to PreserVision AREDS. On 5/31/24 at 11:10 AM Staff 1 (Administrator) and Staff 2 (DNS) were notified the PreserVision AREDS was not administered as ordered during Resident 35's medication administration. Staff 2 compared the house stock multivitamin with mineral with the PreserVision AREDS. Staff 2 stated the ingredients were not the same and staff should have administered PreserVision AREDS.

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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. 39632 Based on observation, interview and record review it was determined the facility failed to ensure medications were secured and only accessible to authorized persons for 1 of 1 medication room reviewed for medication storage. This placed residents at risk for drug diversion. Findings include: The facility's 1/2021 Storage of Medication Policy & Procedure specified medications were stored properly and accessible only to licensed nursing personnel or staff members lawfully authorized to administer medications. On 5/29/24 at 1:24 PM the medication storage room was reviewed. Staff 10 (LPN) opened the medication refrigerator, removed a box of Ozempic (used to treat type 2 diabetes) and stated the Ozempic was not supposed to be stored in the medication room refrigerator. When asked where the Ozempic was stored, Staff 10 stated it was stored in Staff 2's (DNS) office refrigerator. On 5/29/24 at 2:11 PM Staff 2's office was observed. The office was located near the facility's entrance, next to Staff 1's (Administrator) office and adjacent to the reception desk. Inside Staff 2's office in plain view was a small, unlocked refrigerator. Staff 2 stated since the middle of last month the Ozempic medication was stored in her office refrigerator. Staff 2 stated the refrigerator did not lock and stated her office door was locked when she was not in the room. On 5/29/24 at 2:29 PM Staff 2's office door was observed propped open. Staff 2 was not in her office and the refrigerator was not locked. On 5/31/24 at 10:38 AM Staff 1 and Staff 2 reviewed the findings of this investigation. Staff 2 stated all medications were to be locked and secured in the appropriate and designated medication storage room to mitigate unauthorized access. Staff 1 and Staff 2 acknowledged the unlocked office refrigerator was not the appropriate place to store medications.

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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. 47005 Based on observation, interview, and record review it was determined the facility failed to ensure foods were labeled and stored in a way to minimize food spoilage, failed to ensure staff wore hair restraints, and failed to maintain a clean and sanitary kitchen for 2 of 2 facility kitchens reviewed for sanitation. This placed residents at risk for potential infection related to foodborne pathogens. Findings include: Review of the US FDA 2022 Food Code revealed: -food prepared and held cold must be clearly marked with date prepared or by day which the food shall be consumed or discarded with a maximum of seven days if held at 41 degrees F. 1. On 5/28/24 at 9:36 AM during the initial kitchen observation, the refrigerator contained the following: -one container of facility made potato salad labeled 4/24/24. -one container of facility made chicken gravy labeled 4/26/24. -one container of facility made country gravy labeled 4/25/24. On 5/28/24 at 9:45 AM Staff 24 (Dietary Manager) acknowledged the April dates on the identified items. Staff 24 stated the refrigerator was checked daily for outdated food and should have been discarded after three days in the refrigerator. 2. On 5/29/24 at 11:16 AM the 5/2024 temperature log for the snack refrigerator in the satellite kitchen was reviewed. The log was blank on the following dates: -5/4/24 -5/5/24 -5/11/24 -5/12/24 -5/18/24 -5/19/24 -5/25/24 -5/26/24 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/29/24 at 11:17 AM Staff 25 (Dietary Aide) stated it was difficult to get the weekend staff to chart the temperature logs on the snack refrigerators. On 5/31/24 at 10:25 AM Staff 24 (Dietary Manager) acknowledged the refrigerator temperatures were not monitored on weekends. 3. On 5/29/24 at 12:36 PM Staff 25 (Dietary Aide) was observed assisting with lunch time tray line in the satellite kitchen without a hair restraint. Staff 25 stated a hair restraint was required when in the kitchen area and acknowledged she was not wearing a hair restraint during tray line. On 5/31/24 at 10:25 AM Staff 24 (Dietary Manager) stated he expected staff to wear a hair restraint when in the kitchen area. 4. On 5/30/24 at 12:08 PM the surveyor requested Staff 24 (Dietary Manager) test the bleach buckets for the correct chemical solution concentration. Staff 24 was observed to test the bleach buckets. The test strips turned white, which indicated zero bleach concentration was in the bleach solution. Staff 24 tested two bleach buckets on the floor and tested a newly dispensed bleach bucket. All the test strips indicated zero bleach concentration. On 5/30/24 at 12:56 PM Staff 24 stated the wrong test strips were used for the bleach buckets and the chemical solution dispenser was serviced.

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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. 39632 Based on observation, interview and record review it was determined the facility failed to ensure appropriate disinfection of a shared glucometer (a device used to obtain blood sugar levels) for 4 of 4 sampled residents (#s 15, 19, 29 and 45) observed for CBG monitoring and failed to ensure bilateral grab bars were sanitary for 1 of 2 sampled residents (#24) reviewed for environment. This placed residents at risk for bloodborne infections and the spread of germs. Findings include: 1. The CDC website, section titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration, specified there was an increased risk for exposure to bloodborne viruses through contaminated equipment, such as glucometers, when shared. Using a glucometer for more than one person without cleaning and disinfecting it in between uses contributed to transmission of HBV (Hepatitis B virus). Glucometers should be cleaned and disinfected after every use. The facility's 10/2011 Obtaining a Fingerstick Glucose level Policy & Procedure specified to always ensure the blood glucose meters were cleaned and disinfected between resident use according to manufacturer's instructions and current infection control standards of practice. Resident 15 was admitted to the facility in 5/2022 with diagnoses including type II diabetes. Resident 19 was admitted to the facility in 10/2022 with diagnoses including type II diabetes. Resident 29 was admitted to the facility in 3/2023 with diagnoses including type II diabetes. Resident 45 was admitted to the facility in 5/2024 with diagnoses including type II diabetes. On 5/30/24 at 11:50 AM Staff 9 (LPN) was observed for residents' CBG monitoring (capillary blood glucose: measurement of blood sugar). Staff 9 gathered supplies from the medication cart, including a glucometer, entered Resident 15's room, placed the glucometer directly on the resident's bed, cleansed the resident's finger, retrieved the glucometer from the bed and obtained the resident's CBG. Staff 9 returned to the medication cart in the hallway, placed the glucometer on a disinfectant wipe on the top surface of the cart and quickly flipped the glucometer side-to-side over the wipe. Staff 9 gathered more supplies and the glucometer and entered Resident 19's room. Staff 9 placed the glucometer directly on Resident 19's bed, cleansed the resident's finger, retrieved the glucometer from the bed and obtained the resident's CBG. Staff 9 returned to the medication cart and quickly flipped the glucometer side-to-side over the same disinfectant wipe, gathered more supplies and the glucometer and entered Resident 29's room. Staff 9 placed the glucometer directly on Resident 29's bed, cleansed the resident's finger, retrieved the glucometer from the bed and obtained the resident's CBG. Staff 9 returned to the medication cart, quickly flipped the glucometer side-to-side over the same disinfectant wipe, gathered more supplies and the glucometer and entered Resident 45's room. Staff 9 placed the glucometer directly on Resident 45's overbed table, cleansed the resident's finger, retrieved the glucometer from the table and obtained the resident's CBG. Staff 9 returned to the medication cart and quickly flipped the glucometer side-to-side over the same disinfectant wipe. Staff 9 failed to thoroughly disinfect all areas and surfaces of the glucometer between each use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the CBG observations, there was no visible blood on the glucometer and Residents 15, 19, 29 and 45's health records revealed no diagnoses including viral bloodborne pathogens. On 5/30/24 at 1:05 PM Staff 9 stated the process for glucometer disinfection included ensuring the front, back and sides were thoroughly wiped with a saturated and new disinfectant wipe between each use. Staff 9 stated she was busy and running behind and acknowledged she did not thoroughly disinfect the glucometer between each use. On 5/31/24 at 10:38 AM Staff 1 (Administrator) and Staff 2 (DNS) were informed of the lack of appropriate glucometer disinfection. Staff 2 stated the glucometer should have been thoroughly disinfected between each use to prevent the spread of blood borne pathogens between residents. 36494 2. Resident 24 was admitted to the facility in 7/2021 with diagnoses including dementia and anxiety. On 5/28/24 at 11:33 AM Resident 24 stated her/his bilateral grab bars helped with being repositioned in bed by staff. Random observations from 5/28/24 through 5/30/24 revealed Resident 24 remained in bed and had bilateral grab bars to assist with repositioning. The bilateral grab bars were coved with coban (self-adhering bandage wrap). The left grab bar had blue coban tape with cracks and brown stains on the blue coban. The right grab bar had brown coban wrapped around and was worn and dirty. On 5/30/24 at 3:39 PM Staff 5 (RNCM) entered the room with the surveyor and acknowledged the bilateral grab bars were covered with coban adhesive, were worn, dirty, and needed to be replaced. Staff 5 stated she was unsure how long the coban adhesive was in place.