STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Health Care Center North	60 Eben Brown Lane Central Falls, RI 02863

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43987 46118 Based on record review, staff interview and resident interview, it has been determined that the facility failed to develop and implement a comprehensive person-centered care plan for smoking for 2 of 2 residents reviewed who are smokers, Resident ID #s 10 and 23. Findings are as follows: 1. Record review revealed Resident ID #10 was admitted to the facility in April of 2024 with diagnoses including, but not limited to, schizoaffective disorder, bipolar type, anxiety disorder, and autistic disorder. Record review of the list of smokers provided by the facility revealed the resident is a smoker. Record review failed to reveal evidence that a smoking evaluation was completed upon admission or quarterly. Record review failed to reveal evidence of a comprehensive care plan that identifies the resident as a smoker which includes safety interventions. During a surveyor interview on 10/10/2024 at 12:45 PM with Resident ID #10, s/he revealed that s/he is a smoker. 2. Record review revealed Resident ID #23 was admitted to the facility in August of 2024 with diagnoses including, but not limited to, anxiety disorder, vascular dementia, and muscle weakness. Record review of an admission smoking evaluation indicated the resident is a smoker. Record review failed to reveal evidence of a comprehensive care plan that identifies the resident as a smoker, which includes safety interventions to be implemented. During surveyor interviews on 10/10/2024 at 12:51 PM and again on 10/11/2024 at 12:15 PM with Registered Nurse, Staff A, she acknowledged that Resident ID #s 10 and 23 are smokers and that care plans had not been developed related to smoking. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During surveyor interviews on 10/10/2024 at 1:02 PM and again on 10/11/2024 at approximately 12:30 PM with the Director of Nursing Services (DNS), she indicated that she would expect that a care plan would be developed on admission related to smoking.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 Based on surveyor observation, record review, staff and resident interview, it has been determined that the facility failed to ensure that services being provided meet professional standards of practice for 1 of 2 residents reviewed relative to wound care, Resident ID #22 and 1 of 1 resident observed receiving medications, Resident ID #16. Findings are as follows: According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, .The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients . Record review revealed Resident ID #22 was admitted to the facility in January of 2022 with diagnoses including, but not limited to, cellulitis of the right and left lower extremities and non-pressure chronic venous ulcers (wounds to the lower extremities due to poor circulation of the blood). Record review of a Braden Scale for Predicting Pressure Score Assessment (a risk assessment tool that predicts the likelihood of developing a pressure injury) dated 4/10/2024, indicates the resident is at risk. Record review revealed the resident was hospitalized from 8/28/2024 through 9/6/2024. Additionally, the resident was readmitted to the facility on [DATE]. Record review revealed a physician's order dated 1/26/2023 to assess ulcer for location, stage, size including the length, width, and depth, presence/absence of granulation tissue (red tissue with cobblestone or bumpy appearance) and epithelialization (new skin that is light pink and shiny (even in persons with darkly pigmented skin) and condition of surrounding skin weekly. Record review of the August, September and October 2024 Treatment Administration Records revealed the above mentioned order was initialed as completed of the following dates: 8/6/2024 8/13/2024 8/20/2024 8/27/2024 9/10/2024 9/17/2024 9/25/2024 (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/1/2024 10/8/2024 Record review of the above-mentioned weekly skin assessments failed to reveal evidence of the wound measurements or description of his/her venous ulcers. Additional review of the record failed to reveal evidence that a weekly skin assessment had been completed on 8/27/2024, 9/10/2024 or on 9/6/2024 when s/he was readmitted to the facility. During a surveyor interview with the Director of Nursing Services (DNS) on 10/11/2024 at 10:36 AM, she acknowledged the wounds were not measured and described weekly as ordered. Additionally, she was unable to provide evidence that the weekly skin assessments were completed on 8/27/2024, 9/6/2024 and 9/10/2024. During a surveyor interview on 10/11/2024 at 12:26 PM with Registered Nurse, Staff A, she was unable to provide evidence of the weekly skin assessments, including measurements and description of the venous ulcers. During an attempt to interview the resident on 10/11/2024 at 1:20 PM, s/he did not want to answer any of the surveyors questions pertaining to his/her wounds. 2. According to Lippincott Nursing Center 2016 Medication Safety: Go beyond the basics states in part, . Prepare medications for one patient at a time . Review of the policy titled, General Dose Preparation and Medication Administration provided by the facility states in part, .Only prepare medications for one resident at a time .Verify resident identification . During a surveyor observation on 10/8/2024 at approximately 9:45 AM, Certified Medication Technician, Staff B, entered Resident ID #16's room with two medication cups and administered one of the cups of medications to the resident while holding the other. During a surveyor interview immediately following the observation with Staff B, he indicated that one of the medication cups contained another resident's medications. Staff B further indicated that one of the residents was not in his/her room at the time that he prepared the medications, so he held onto the resident's medication cup and prepared Resident ID #16's medications. Additionally, Staff B indicated that he should only prepare medication for one resident at a time. During a surveyor interview on 10/8/2024 at 9:47 AM with Resident ID #16, s/he indicated that s/he knew what his/her medications looked like and took the medications. Additionally, s/he indicated that the medication cup is usually labeled with his/her name. During a surveyor interview on 10/8/2024 at 9:59 AM with Registered Nurse, Staff C, she indicated that medications should be administered to one resident at a time. During a surveyor interview on 10/10/2024 at 10:12 AM with the DNS, she revealed that she would expect medications to be prepared and administered to one resident at a time. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37158

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37158 Based on record review, staff and resident interview, it has been determined that the facility failed to provide necessary treatment and services, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 1 of 1 resident reviewed with a pressure ulcer (a localized injury to the skin and/or underlying skin usually over a boney prominence), Resident ID #26. Findings are as follows: Record review of the facility policy titled, Skin Care Policy states in part, .This facility will follow appropriate standards of care as they relate to residents' skin care; identification of those at risk, weekly skin checks, and appropriate interventions and documentation . 4. The weekly skin assessments (documented in the treatment sheet record) will be done for every resident regardless of their risk score . 6. Monitoring: Weekly skin assessments will be done . With each dressing change or at least weekly, the following documentation must be present: -Location and staging; -Size, depth .location . -Exudate, if present; type, color, odor, and approximate amount . -Wound bed: color and type of tissue/character .or necrosis (slough [non-viable tissue that is yellow, tan, gray, green or brown] or eschar [dead tissue that is hard or soft in texture; usually black, brown, or tan in color]; and -Description of wound edges and surrounding tissue . Record review revealed the resident was admitted to the facility in June of 2024 with a diagnosis including, but not limited to, paranoid schizophrenia. Record review revealed an admission skin assessment dated [DATE], that indicated the resident did not have any impairments to his/her skin. Record review of a Braden Scale for Predicting Pressure Score Assessment (a risk assessment tool that predicts the likelihood of developing a pressure injury) dated 6/21/2024, indicates the resident is at risk for developing pressure ulcers. Record review failed to reveal evidence of weekly skin assessments for the weeks of 6/28, 7/5, 7/12, 7/19, 7/26, 8/2, 8/9 and 8/16/2024, indicating the resident's skin was not assessed for 8 consecutive weeks. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a surveyor interview with the Director of Nursing Services (DNS) on 10/11/2024 at 10:36 AM, she revealed that she observed the resident's left heel a few days after his/her admission, and she described the left heel as mushy and asked the nurse to obtain an order for skin prep (a type of wound treatment that provides skin protection). The DNS also revealed the resident's heel was red and then turned black, at which time the wound was assessed by the Wound Physician on 8/19/2024. Record review failed to reveal evidence of a wound assessment completed by the Director of Nursing Services, (DNS) of the resident's left heel, indicating that the left heel was noted to be mushy or that an order was implemented for skin prep in the month of June 2024. Record review revealed the resident was assessed by the Wound Physician on 8/19/2024 and an unstageable (a wound that is covered with slough or eschar and the wound bed cannot be visualized and the depth of soft tissue damage cannot be determined), deep tissue injury (a purple or maroon area of discolored intact skin due to damage of underlying soft tissue, which may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue) was identified to the resident's left heel. Further review of the Wound Physician's assessment completed on 8/19/2024 revealed the left lateral heel wound was intact, with a purple/maroon discoloration. Additionally, the wound measured 3.5 centimeters (cm) in length x 2.9 cm in width with an undetermined depth. Additionally, a recommendation was made to start skin prep to the left heel twice daily. Lastly, there is a notation documented by the Wound Physician which states, per [DNS] at first heel was mushy on admission, then wound developed. Record review revealed a physician's order dated 8/20/2024 for skin prep twice daily. Record review revealed the Wound Physician reassessed the resident's wound on 9/3/2024, and determined that the left heel was unstageable, due to full thickness necrosis (a type of tissue death that occurs when damage extends below the epidermis and dermis into the subcutaneous tissue or beyond). The wound measured 1.9 cm in length x 3.2 cm in width, with an unmeasurable depth due to the presence of non-viable tissue and necrosis. The wound was draining a light serous (thin, clear or yellow in color) fluid and the wound bed was observed with 100% of thick, adherent black necrotic tissue. The resident's heel was surgically debrided (the medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue). New recommendations were made to discontinue the skin prep and start Silver Sulfadiazine (Silvadene-a medication prescribed used to treat or prevent infections) daily and wrap with a gauze dressing. Record review of the physician orders failed to reveal evidence that the skin prep was discontinued or that the Silvadene treatment was initiated as recommended on 9/3/2024. During a surveyor interview on 10/11/2024 at 12:26 PM with Registered Nurse, Staff A, she acknowledged that she failed to transcribe the Silvadene order on 9/3/2024. She further revealed that prior to the 8/19/2024 skin prep order, the resident had a deep tissue injury and that the heel was closed. Additionally, Staff A was unable to explain why there was not a treatment ordered to treat the resident's deep tissure injury until 8/20/2024. Lastly, she was unable to provide evidence of wound measurements or a treatment order to the resident's left heel wound prior to 8/19/2024, as required per the facility's policy. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Further review of the physician orders revealed that the Silvadene order was not initiated until 9/11/2024, 8 days after the treatment was first recommended. Record review revealed a physician's order dated 9/11/2024 to cleanse wound with Normal Saline, apply a small amount of Silvadene and cover with a border gauze. This order failed to include the location as to where the treatment was to be applied. Additional record review of the skin assessments failed to reveal evidence that a skin assessment was completed for the week of 9/29/2024. During a surveyor interview on 10/11/2024 at 10:12 AM with the resident's Physician, he revealed he follows the Wound Physician's recommendations as she is the expert in her field. During the surveyor interview with the DNS on 10/11/2024 at 10:36 AM, she was unable to provide evidence that a treatment order was implemented for the resident's left heel prior to 8/19/2024. Additionally, she was unable to explain why the Silvadene order was not implemented on 9/3/2024, the day it was recommended by the wound physician, or that when the order was initiated on 9/11/2024, it included the location of where the treatment was to be applied. Lastly, the DNS was unable to provide evidence of a completed skin assessments for the for the weeks of 6/28, 7/5, 7/12, 7/19, 7/26, 8/2, 8/9 and 8/16/2024 or the week of 9/29/2024. During a surveyor interview on 10/11/2024 at 1:10 PM with the resident, s/he acknowledged that s/he has a wound to his/her left heel, however s/he was unable to say when or how the wound developed.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. 46118 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents who are trauma survivors, receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents experiences, and preferences, in order to eliminate, or mitigate triggers that may cause re-traumatization of the resident for 1 of 1 resident reviewed with a history of trauma, Resident ID #10. Findings are as follows: Review of the facility's form titled PC [Primary Care]-PTSD [Post Traumatic Stress Disorder]-5 states in part, . The primary PC-PTSD-5 is a 5-item screen designed to identify individuals with probable PTSD. Those screening positive require further assessment, preferably with a structured interview . Record review revealed the resident was admitted to the facility in April of 2024 with diagnoses including, but not limited to, anxiety disorder, schizoaffective disorder, bipolar type, major depressive disorder, personality disorder and autistic disorder. Review of the Primary Care PTSD Screen dated 4/25/2024 revealed the resident answered YES to the screening question In the past month, have you .tried hard not to think about event(s) or went out of your way to avoid situations that remind you of the event(s) . Further review revealed the screening was incomplete. Review of the comprehensive care plan failed to include trauma informed care and interventions to eliminate or mitigate triggers that may cause re-traumatization of the resident. Record review failed to reveal evidence that the resident had been evaluated by a psychiatric provider to address trauma. During a surveyor interview on 10/9/2024 at 10:13 AM with the Administrator, he indicated that he was aware that the resident had a history of sexual abuse. During a surveyor interview on 10/9/2024 at 12:25 PM with the Director of Nursing Services (DNS), she indicated that she was aware that the resident had a history of trauma. She further indicated that she would expect the resident to have a trauma care plan in place. During a surveyor interview on 10/9/2024 at 12:45 PM with the Social Services Designee, she indicated that she is responsible for completed the trauma assessments upon the residents' admissions. She further indicated that the resident indicated that he had childhood trauma, and that the trauma assessment was incomplete. Additionally, she could not provide evidence that interventions to eliminate or mitigate triggers that may cause re-traumatization of the resident were in place. During a surveyor interview on 10/11/2024 at 11:18 AM with the Psychiatric Nurse Practitioner, she indicated that she was unaware that the resident had a history of childhood trauma, however she was aware of the resident's history of sexual abuse. Additionally, she indicated that she had not discussed the history of trauma with the resident.

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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. 43987 Based on record review and staff interview, it has been determined that the facility failed to ensure that residents are free of any significant medication errors for 2 of 5 residents reviewed for unnecessary medications, Resident ID #s 1. Additionally, the facility failed to follow the pharmacy recommendation for a gradual dose reduction (GDR) (psychotropic medications are required by federal guidelines in skilled nursing facilities) for 1 of 2 residents reviewed, Resident ID #23. Findings are as follows: 1a. Record review revealed that Resident ID #1 was admitted to the facility in August of 2024 with diagnoses including, but not limited to, multiple sclerosis (a chronic disease damaging the central nervous system), bladder cancer, constipation and generalized muscle weakness. Record review of the physician's orders revealed an order dated 8/1/2024 for Baclofen (a medication prescribed to treat muscle spasms) 10 milligrams (mg) tablets, take 2 tablets four times a day at 8 AM, 12 PM, 4 PM and 8 PM. Record review of the August, September, and October 2024 Medication Administration Records (MARs) revealed the Baclofen was documented as MISSED with no additional notes on the following dates and times: - 8:00 AM on 8/2, 8/5, 8/15, 8/16, and 8/30/2024. - 4:00 PM on 8/5 and 8/26/2024 - 8:00 AM on 9/4/2024 - 4:00 PM on 9/4, 9/15, 9/16, 9/18 and 9/21/2024 - 8:00 AM on 10/9/2024 - 4:00 PM on 10/1, 10/2, 10/3, 10/4 and 10/8/2024 During a surveyor interview on 10/10/2024 at 9:52 AM with Registered Nurse (RN), Staff A, she acknowledged that the Baclofen was documented as missed on the above-mentioned dates and times and she could not explain why. During a surveyor interview on 10/10/2024 at 10:35 AM with Certified Medication Technician (CMT), Staff B, he was unable to explain why the medications were documented as missed. During a surveyor interview on 10/10/2024 at 3:10 PM with the Director of Nursing Services (DNS), she acknowledged that the Baclofen was marked as missed. Additionally, she was unable to provide evidence that the Baclofen was administered on the above-mentioned dates and times. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. Record review revealed Resident ID #23 was admitted to the facility in August of 2024 with diagnoses including, but not limited to, complete traumatic amputation (an injury to a limb that results in immediate separation of the limb), mild cognitive impairment, chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breath), dementia, generalized muscle weakness and anxiety. Record review revealed the following physician orders: - Quetiapine (a medication prescribed to treat certain mood disorders) 12.5 mg in the morning - Acetaminophen (a medication prescribed to relieve pain) 650 mg four times a day - Aspirin (a medication prescribed to thin the blood) 81 mg once a day - Gabapentin (a medication prescribed to relieve nerve pain) 300 mg three times a day - Breztri Aerosphere (a medication prescribed to treat COPD) inhaler 160-9-4.8 microgram (mcg)/actuation, 2 puffs twice a day - Cetirizine (a medication prescribed to treat allergy symptoms) 10 mg daily Record review of the August 2024 Medication Administration Record (MAR) revealed the following medications were not administered as ordered on the following dates and times: - Quetiapine, at 8:00 AM on 8/24, 8/29 and 8/30/2024 - Acetaminophen, at 8:00 AM on 8/15 ,8/24, 8/29 and 8/30/2024 - Aspirin, at 8:00 AM on 8/15, 8/24, 8/29 and 8/30/2024 - Gabapentin, at 8:00 AM on 8/15, 8/24, 8/29 and 8/30/2024 - Inhaler Breztri Aerosphere, at 8:00 AM on 8/15, 8/24, 8/29 and 8/30/2024 - Cetirizine, at 8:00 AM on 8/15, 8/24, 8/29, 8/30/ 2024 Record review of the September 2024 MAR revealed the following medications were not administered as ordered on the following dates and times: - Quetiapine, at 8:00 AM on 9/4 and 9/5/2024 - Acetaminophen, at 8:00 AM on 9/4 and 9/5/2024 - Aspirin, at 8:00 AM on 9/4 and 9/5/2024 - Gabapentin, at 8:00 AM on 9/4 and 9/5/2024 - Inhaler Breztri Aerosphere, at 8:00 AM on 9/4 and 9/5/2024 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Cetirizine, at 8:00 AM on 9/4 and 9/5/2024 Record review of the October 2024 MAR revealed the following medications were not administered as ordered on the following dates and times: - Quetiapine, at 8:00 AM on 10/9/2024 - Acetaminophen, at 4:00 PM on 10/4/2024 and 8:00 AM on 10/9/2024 - Aspirin, at 8:00 AM on 10/9/2021 - Gabapentin, at 8:00 AM on 10/9/2024 - Inhaler Breztri Aerosphere, at 8:00 AM on 10/9/2024 - Cetirizine, at 8:00 AM on 10/9/2024 During a surveyor interview on 10/11/2024 at 12:43 PM with the DNS, she was unable to provide evidence that the above medications were administered as ordered to Resident ID #23. 2b. Record review of Resident ID #23's pharmacy Consultant Report dated 8/16/2024 revealed a recommendation to attempt a gradual dose reduction for the evening dose of Quetiapine, from 25 mg to 12.5 mg in the evening. Further review of the report indicated that the resident's physician approved the recommendation on 9/19/2024. Record review of the physician's orders failed to reveal evidence that the Quetiapine GDR was implemented, but rather the record indicated that the Quetiapine evening dose was discontinued on 9/3/2024. During a surveyor interview on 10/11/2024 at 1:06 PM with the DNS, she acknowledged that the GDR recommendation for the Quetiapine was not implemented. Additionally, she was unable to explain why the evening Quetiapine dose was discontinued, and not gradually decreased to 12.5 mg as ordered by the physician. 46118

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415108	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Health Care Center North	60 Eben Brown Lane Central Falls, RI 02863

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45855 Based on surveyor observation and staff interview, it has been determined that the facility failed to store and label drugs and biologicals in accordance with currently accepted professional principles for 1 of 1 medication storage rooms observed. Findings are as follows: Review of a facility policy titled, .Storage and expiration dating of medication and biological's last revised on [DATE] states in part, .Facility should ensure that medications and biological's that .have an expired date on the label .have been retained longer than recommended by manufacturer or supplier guidelines .are stored separate from other medications until destroyed or returned to the pharmacy or supplier . During a surveyor observation of the medication storage room on [DATE] at 10:43 AM, in the presence of the Certified Medication Technician, Staff B, the following was observed: - Four, 16-ounce bottles of lactulose (a medication used to treat constipation) with a manufacturer's expiration date of ,d+[DATE]. - Two sealed 0.5 fluid ounce bottles of carbamide peroxide 6.5% (a medication used to remove earwax) with a manufacturer's expiration date of ,d+[DATE]. - One bottle of magnesium (a vitamin) 250 mg (milligrams) with a manufacturer's expiration date of , d+[DATE]. - One opened bottle of loratadine (a medication used to treat allergies) 10 mg, with 18 tablets remaining, with a manufacturer's expiration date of ,d+[DATE]. - One bottle of simethicone (a medication used to relieve symptoms related to excess gas) 80 mg chewable tablets with a manufacturer's expiration date of ,d+[DATE]. During a surveyor interview immediately following the above observations with Staff B, he acknowledged that the above-mentioned medications were stored beyond their manufacturer's expiration date and that they should be discarded. During a surveyor interview on [DATE] at 12:51 PM with the Director of Nursing Services, she acknowledged that the above-listed medications were expired. She further revealed that she would expect the staff to discard them appropriately based on the manufacturer's instructions.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46118 Based on record review, staff and resident interview, it has been determined that the facility failed to accurately document bowel movements (BM) in the resident's medical record for 2 of 2 residents reviewed for constipation, Resident ID #s 1 and 5. Findings are as follows: Review of the policy titled Bowel Function Management states in part, It is the facility's policy to manage each resident's bowel function in order to promote regular, voluntary, controlled bowel evacuation of normal consistency .Every resident's bowel function is to be monitored every day on every shift .The CNA [Certified Nursing Assistant] is responsible to document the resident's BMs in the resident's electronic medical record or in the CNA flow charts as appropriate . 1. Record review revealed Resident ID #1 was admitted to the facility in August of 2024 with diagnoses including, but not limited to, multiple sclerosis (a chronic autoimmune disease that damages the protective coating around nerve fibers in the brain and spinal cord) and constipation. Review of an Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15, indicating the resident's cognition is intact. Further review revealed the resident is incontinent of bowel and is dependent on staff for assistance with toileting. Review of the BM output documentation in the electronic medical record failed to reveal evidence of a documented BM during the following time periods: -From 9/7/2024 through 9/24/2024, 18 days. -From 9/27/2024 through 10/2/2024, 6 days. During a surveyor interview on 10/11/2024 at approximately 2:00 PM with the Director of Nursing Services (DNS), she was unable to provide evidence that there was any documentation of the resident's BMs during the above-mentioned time periods. 2. Record review revealed Resident ID #5 was admitted to the facility in August of 2018 with diagnoses including, but not limited to, transient cerebral ischemic attack (stroke) and major depressive disorder. Review of an MDS assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating the resident's cognition is intact. Further review revealed the resident is incontinent of bowel and requires substantial assistance from staff for toileting. Review of a care plan dated 6/9/2021 revealed the resident experiences bowel incontinence with an approach to ensure adequate bowel elimination. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the BM output documentation in the electronic medical record revealed a BM had not been documented from 9/1/2024 until 9/24/2024. During a surveyor interview on 10/9/2024 at 8:58 AM with Resident ID #5, s/he indicated that s/he sometimes has trouble having BMs and has belly discomfort. The resident further indicated that s/he is usually not offered medications for constipation and does not have a BM for a long time. Additionally, the resident indicated that s/he uses a commode and requires staff assistance. During a surveyor interview on 10/9/2024 at 9:05 AM with Nursing Assistant (NA), Staff D, she indicated that the NAs are expected to document BMs in the electronic medical record each shift. During a surveyor interview on 10/10/2024 at 9:17 AM with Registered Nurse, Staff A she indicated that BMs, or the lack there of, should be documented in the electronic medical record each shift by the NAs. She further indicated that Resident ID #5 typically doesn't have BMs for 3-4 days and that s/he requires staff to assist him/her to the commode. During a surveyor interview on 10/10/2024 at 10:03 AM with the DNS, she indicated that she would expect NAs to document BMs on each shift. She further indicated that the resident regularly does not have a BM for 3 to 5 days. Additionally, she acknowledged that a BM for the resident had not been documented from 9/1/2024 until 9/25/2024, a total of 24 days.

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. 37158 Based on record review, staff and resident interview, it has been determined that the facility failed to implement their smoking policy in accordance with federal, state, and local laws for 1 of 2 residents reviewed for smoking, Resident ID #10. Findings are as follows: Review of the policy titled, Smoking Policy states in part, .Residents who wish to smoke are to be evaluated by the interdisciplinary team for their ability to smoke in a safe manner .on admission .at least quarterly . Record review revealed Resident ID #10 was admitted to the facility in April of 2024 with diagnoses including, but not limited to, schizoaffective disorder, bipolar type, anxiety disorder, and autistic disorder. Record review of the list of smokers provided by the facility revealed the resident is a smoker. Record review failed to reveal evidence of a smoking evaluation upon admission or quarterly. During a surveyor interview on 10/10/2024 at 12:45 PM with the resident, s/he revealed that he is a smoker. During a surveyor interview on 10/10/2024 at 12:51 PM with Registered Nurse, Staff A, she indicated that smoking evaluations should be completed on admission, quarterly, and annually. Additionally, she acknowledged the resident is a smoker and could not provide evidence that a smoking assessment had been completed. During a surveyor interview on 10/10/2024 at 1:02 PM with the Director of Nursing Services, she indicated that smoking assessments are completed on admission and quarterly. Additionally, she could not provide evidence that a smoking assessment had been completed for the resident on admission or quarterly.