STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425027	A. Building B. Wing	11/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountainview Nursing Home	340 Cedar Springs Road Spartanburg, SC 29302

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 30260 Based on record review, interviews, and review of facility policy, the facility failed to ensure two of two residents (R) 18 and R85 of three reviewed for abuse was free from resident to resident physical and verbal abuse out of a total sample of 24 residents. This had the potential for the residents to sustain injuries from the altercation. Findings include: Review of the facility's undated policy titled, .Abuse and Neglect Management Policy Statement revealed Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. [Facility Name] does not condone any form of abuse and will continually monitor [Facility Name] policies, procedures, training programs, systems, etc. to assist in preventing resident abuse is committed to protecting our residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. [Facility Name] employs systems for screening, training, prevention, identification, investigation, protection and reporting abuse in order to provide a safe environment for our residents. Review of the Facility Reported Incident FRI report dated 08/06/24, submitted by the Director of Nursing (DON) revealed R85 took the TV remote from another resident. R18 verbally confronted R85 for his actions. R85 responded verbally to R18. R18 verbally chastised R85 for his actions. R85 then got up and hit R18 several times. R18 then ran R18's powerchair into R85. Staff intervened and R18 called 911 (emergency services). No injuries were noted at the time. R85 was placed on a 1:1 observation until further notice after completion of investigation. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the 5-day report submitted to the state survey agency revealed that on 08/06/24, at approximately 4:45 PM revealed the following; R85 and R18 were in the common area. Another resident had a remote control in their hand when R85 reached out and took the remote from the resident. The resident made no attempt to retrieve the remote and continued to watch TV. R18, who was seated in their powerchair proceeded to question R85 as to why he took the remote from the resident. R85 verbally responded to R18 by saying that it was none of R18's business and that they were all retards. R18 then attempted to chastise R85 for R85's actions and R85 then responded to R18 by jumping up from the couch and punching R18 on the side of R18's neck. R18 turned on his powerchair and proceeded to try and ram into R85, but R85 fell backwards on the couch and pulled his legs up out of the way of the chair. R18 pushed the couch to the opposite side of the common area. Then R85 jumped off of the couch and attempted to hit R85 again. Certified Nursing Assistant (CNA)4 had heard the commotion and went to the common area when she saw R85 and R18. While yelling for assistance, CNA4 turned off R18's powerchair and got between R85 and R18. R18 then called 911 and demanded that R85 be charged, but the deputy was informed of the incident and no charges were warranted; therefore, no case was opened. R85 was placed on 1:1 observation. R18 was told to stay away from R85. Body audits were conducted on the residents and no injuries were noted. Staff was in-serviced on resident-to-resident abuse via Zoom. The TV remote would be managed by the staff at all times. During an interview on 11/21/24 at 12:39 PM, R85 stated he could not recall the incident on 08/06/24 during which he had an altercation with R18. R85 stated he may have had a disagreement, but could not recall. During an interview on 11/20/24 at 3:20 PM, R18 stated he recalled his altercation with R85 and said R85 punched him in the face, and he said he tried to grab him by the arm, and he punched him a couple more times in the face. That is when CNA4 saw what was going on and tried to separate us. R85 sat for a minute and then got up and tried to start another fight. He stated, I took my wheelchair, and I pushed him down onto the couch and then I called the police. The facility smoothed things down with the police and told them the facility was going to handle the matter in-house. Neither of us was hurt and we did not need to go to the hospital. During an interview on 11/22/24 at 11:23 AM, agency Licensed Practical Nurse (LPN)4 stated she recalled there was an incident involving R18 and R85 a few weeks ago. LPN4 stated she was in the hall when one of the aides came and got her, that some residents were fighting. LPN4 said when she got to the common area, the fight was already over. LPN4 assessed R18 and checked his vitals. There was no bruising. R18 wanted to call 911. LPN4 stated she told R18 he could call 911 if he wanted to, which he did. When the police arrived, they talked to both R18 and R85. The police said there will be no charges. LPN4 recalled there was an in-service online about resident-to-resident abuse. LPN4 also stated she had undergone abuse training at least annually, and that abuse could be physical or verbal, including seclusion and misappropriation. During an interview on 11/22/24 at 6:16 PM, the Director of Nursing (DON) stated she recalled that R18 and R85 were in the common area. She confirmed the incident occurred and there was a resident-to-resident altercation between R85 and R18. The DON further that she submitted a report to the state survey agency and conducted staff training via Zoom (online).

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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** 28306 Based on record review and interview, the facility failed to ensure a written copy of the baseline care plan was provided to the resident and/or responsible party (RP) within 48 hours for one of one resident (Resident (R) 261) reviewed for baseline care plans. This failure had the potential for residents and/or RP not to be informed of the plan of care. Findings include: Review of R261's undated Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses which included epilepsy, anoxic brain damage, diabetes mellitus, and chronic pain. Review of R261's Progress Notes located under the Progress Notes tab in the hard copy of the medical record revealed a physician progress note, dated 10/30/24, which stated R261 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R261 was moderately cognitively impaired. Review of R261's Acknowledgement of Receipt Admission Baseline Care Plan, dated 10/24/24 and located under the MDS tab in the hard copy of the medical record revealed there was no resident and/or RP's signature located on the signature line of this form. During a phone interview on 11/21/24 at 10:37 AM, Family Member (FM)1 stated, No one has reached out to me concerning his care plan at the facility. During an interview on 11/23/24 at 4:10 PM, the Director of Nursing (DON) stated, That would be social services that gets these signed. During a phone interview on 11/23/24 at 4:30 PM, the Social Services Director (SSD) stated, That was an oversight on my part. During an interview on 11/23/24 at 6:00 PM, the Assistant Administrator stated, She [SSD] told me she had made a mistake concerning the baseline care plan for this resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21382 28306 Based on record review, interview, and facility policy review, the facility failed to develop a care plan for refusal of medications and meals for one (Resident (R)92) and failed to develop and implement a care plan for pressure ulcers for one of 24 sample residents R78. This failure had the potential for residents to have unmet care plan needs. Findings include: Review of the facility's policy titled, Care Plans, Comprehensive Person Centered, dated 2017, revealed . The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment . 1. Review of R92's undated Face Sheet located under the Face Sheet in the electronic medical record (EMR) revealed R92 was admitted to the facility on [DATE] with the diagnosis of atrial fibrillation, hypertension, and congestive heart failure. Review of R92's quarterly Minimum Data Set (MDS) located under the MDS Assessments tab in the EMR with an Assessment Reference Date (ARD) of 09/08/24 revealed R92 had short- and long-term memory loss and rarely or never made decisions. Review of R92's Medication Administration Record (MAR) dated November 2024 revealed the resident commonly refused or spit out her medication when administered by the nurse. Review of R92's Progress Note located under the Dietary tab in the hard chart of the medical record revealed a note, dated 10/21/24, which revealed .refusing medications .refuses meal at times . Review of R92's current Care Plan located under the MDS tab in the hard chart of the medical record revealed the resident had not been care planned for the refusals of medications and meals as documented by the dietician in the progress note, dated 10/21/24. During an interview on 11/23/24 at 2:47 PM, Licensed Practical Nurse (LPN)1 stated, I have her care planned for refusal of showers but nothing else, and we use our nursing judgement in feeding her now and going back to offer her the medications and snacks throughout the day. Some days are better than other days for this resident. When asked if these were areas that should have been care planned for this resident, LPN1 stated, Well, I mean I don't know, I guess it should. During an interview on 11/23/24 at 6:00 PM, the Director of Nursing (DON) stated, The care plan needs to reflect the current plan of care for this resident and if she has been refusing her medications and meals this should have been in her care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R78's Face Sheet located under the Face Sheet tab of the paper medical record revealed the resident was admitted to the facility on [DATE]. Review of the quarterly MDS with an ARD of 08/25/24 revealed a BIMS score of 15 out of 15 indicating which indicated the resident was cognitively intact. Review of the paper chart revealed a telephone order, dated 11/12/24, which revealed R78 had a wound on his sacral area and included orders for treatment to the sacral area. The telephone order revealed Clean area to sacrum with antiseptic. Pat dry apply hydrogel to area and cover with optifoam change qd [daily] and PRN [as needed] until healed. Review of R78's Care Plan located in the paper chart under the MDS did not contain a care plan related to a pressure sore. During an interview on 11/21/24 at 5:45 PM, the DON revealed she was not aware R78 had a pressure injury. She confirmed with the wound nurse that R78 did have a pressure injury. During an interview on 11/22/24 at 4:10 PM, the MDS Coordinator (MDSC) confirmed there was not a care plan written when the sacral wound was identified. She stated most care plans were updated by the nurses on the unit and someone missed updating R78's care plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review and interviews, the facility failed to ensure the care plan was revised to reflect an updated advanced directive status for one of one resident (Resident (R)92) reviewed for advanced directives. This failure had the potential for residents to have unmet care plan needs. Findings include: Review of R92's undated Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with the diagnosis of stroke, congestive heart failure, and major depressive disorder. Review of R92's quarterly Minimum Data Set (MDS) located under the MDS Assessments tab of the EMR with an Assessment Reference Date (ARD) of [DATE] revealed R92 had short- and long-term memory loss and rarely or never made decisions. Review of R92's Advance Directive located under the Advance Directive tab in the hard chart of the medical record revealed the daughter signed for a DNR (Do Not Resuscitate) on [DATE] with the admission paperwork that was completed. Review of R92's Physician Orders located under the Physician Order tab in the hard chart of the medical record revealed an order, dated [DATE], which revealed DNR [Do Not Resuscitate]. Review of R92's Care Plan, dated [DATE] and located under the MDS tab in the hard chart of the medical record, revealed a Problem as I want everything done for me in an emergency. Under Approach it stated, Make sure my wishes are on my chart. Let Pharmacy know and outside doctors know what I want. If I am unresponsive, call 911 and start CPR [Cardiopulmonary Resuscitation]. Notify my doctor and family. Review of R92's Care Plan Conference Summary, dated [DATE] and located under the MDS tab of the hard chart of the medical record, and under Adv Dir/Code Status was documented as a Full Code. There were no further care plan conferences documented in the medical record. During an interview on [DATE] at 2:20 PM, the Director of Nursing (DON) stated, The MDS nurse is to update the care plans with each MDS that she does. She will type out a new care plan and include any current interventions in it. The nurses on the floor will write in on these care plans with new interventions or new orders then MDS nurse prints this off and puts the care plan in the chart. During an interview on [DATE] at 2:35 PM, the MDS Coordinator (MDSC) stated, I was following what the care plan had said on wanting to be a full code. When asked if the orders had been reviewed to see if there were any updates to the resident's care plan that needed to be included, the MDSC stated, I don't remember if I reviewed the orders or not when I updated the care plan. The MDSC returned to the conference room and brought in care plan conference summaries for [DATE], [DATE], and [DATE]. The MDSC stated, These were in my office. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:30 PM, Licensed Practical Nurse (LPN)1 stated, The nurses on the floor are to write in the updates as the orders come in for the resident. Then the MDS nurse will review the care plan when she does the next MDS and type up a current care plan with the new orders and interventions that are still current. I don't see where this was done for this resident. During an interview on [DATE] at 6:00 PM, the DON stated, Those should be filed in the medical record and not kept in the MDS office.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on record review and interview, the facility failed to have collaboration of care with the dialysis center for one of one resident (Resident (R)38) reviewed for dialysis. This failure had the potential to put R38 at risk for lack of communication between the facility and the dialysis center. Findings include: Review of R38's undated Face Sheet located under the Face Sheet tab of the electronic medical record (EMR) indicated R38 was admitted to the facility on [DATE] with diagnosis of cerebrovascular accident, end stage renal disease, and chronic kidney disease, stage five. Review of R38's quarterly Minimum Data Set (MDS) located in the EMR under the MDS Assessment tab with an Assessment Reference Date (ARD) of 08/18/24 revealed the resident was coded as receiving dialysis services while a resident in the facility. Review of R38's Physician Order located in R38's hard chart of the medical record, under the Orders tab, revealed orders, dated 06/20/23, which revealed R38 had dialysis on Mondays, Wednesdays, and Fridays. Review of R38's Dialysis Communication Record located in the hard chart of the medical record under the Assessments tab, revealed the records, dated 10/25/24, 11/01/24, 11/11/24, 11/13/24, and 11/18/24, had documentation missing from the dialysis center for shunt site (which described the location, dressings, pain and change in condition), lab values which described the events during the course of treatment, medications given at dialysis, recommendations, and food/fluid intake along with missing signatures and dates. During an interview on 11/23/24 at 6:00 PM, the Director of Nursing (DON) and the Assistant Administrator were notified of the missing components on the Dialysis Communication Record for the above documented dates in R38's medical record. The DON stated, The nurse that receives this back from the dialysis center should call the center and get a report or fax them this sheet and get it completed. The nurse should document this in the progress notes.

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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** 28306 Based on record review, interview, and facility policy review, the facility failed to ensure risk and benefits were explained to the resident and/or representative (RP) prior to the use of psychotropic medications and failed to ensure targeted behaviors and side effects were monitored for administered psychotropics for one of five residents (Resident (R)46) reviewed for unnecessary medications. This failure had the potential for excessive psychotropic administration and for the residents and/or representative not to be able to make an informed decision regarding the use of the psychotropic medications. Findings include: Review of the undated facility's policy titled, Antipsychotic/Psychotropic Medication Use, revealed . The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others .The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications . The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications . Review of R46's undated Face Sheet located under the Face Sheet tab in the electronic medical record (EMR) revealed R46 was admitted to the facility on [DATE] with diagnoses of anxiety and major depressive disorder. Review of R46's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/06/24 and located under the MDS Assessment tab in the EMR revealed the resident was coded as having short- and long-term memory loss with rarely or never making decisions. Mood symptoms present for little interest or pleasure in doing things and feeling down, depressed, or hopeless were all coded as a 9 which represented no response. The resident was marked as receiving antipsychotics on a routine basis and was taking an antidepressant. Review of R46's Physician Orders located in the hard chart of the medical record under the Physician Orders tab, revealed: -Order date: 02/09/24 Effexor ER [extended release] (anti-depressant) 150 mg (milligram) by mouth daily for anxiety and major depressive disorder. -Order date: 07/12/24 Risperidone (antipsychotic) 1mg by mouth at bedtime for severe major depressive disorder. This was an increased order. The original order for Risperidone 0.5 mg daily was dated 02/27/24. -Order date: 03/05/24 Trazodone (anti-depressant) 100 mg by mouth at bedtime for insomnia. -Order date: 07/08/24 Klonopin (anti-anxiety) 0.5 mg by mouth daily for anxiety. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R46's Care Plan, dated 05/29/23, and located in the hard chart of the medical record under the MDS tab, revealed a problem: I have .dementia with agitation and restlessness, I get confused at times. The approach was documented as Don't rush me give me time to speak. Let me do things [sic] I want to do. I like to watch TV, and [sic] do activities of choice. I prefer to stay in my room most of the time. Review of R46's Behavior Documentation and Daily Monitoring, dated October 2024 and November 2024 and located under the Assessments tab in the hard chart of the medical record, revealed either missing documentation of No Behavior This Shift/No Interventions Required and/or incomplete documentation of the behavior observed, what caused the behavior, factors that may have caused or exacerbated the behavior, factors that caused or intensified the behavior, illnesses or conditions that may have caused behavior problems, potential reaction to medications, refer to (name of facility) behavioral manual for behavior management interventions related to the specific behavior exhibited by the resident, and psychoactive medications the resident was currently receiving. Review of the Consent for Use of Psychoactive Medication Therapy located in the hard chart of the medical record revealed a consent for Risperidone, dated 02/27/24. This consent was signed by the RP of R46 on 02/27/24. There was no consent for Effexor ER, Klonopin, and Trazodone located in the hard chart of the medical record. During an interview on 11/23/24 at 2:30 PM, Licensed Practical Nurse (LPN)1 stated, There are no specific behaviors stated but we chart on the care plan when the resident exhibits behavior and what they were. When asked if LPN1 knew what each medication was given for and the specific behavior the LPN1 stated, No, we will chart what we see. When asked what side effects were being monitored for each of the medications the resident received the LPN1 stated, We will monitor lethargy or something like that but nothing specifically for each medication. During an interview on 11/23/24 at 6:00 PM, the Director of Nursing (DON) stated, We document the behaviors that we see but not specific behaviors that each of the medications are specifically administered for. The behavior monitoring sheet that we use should be marked each day if no behaviors were seen, the nurse will mark no behaviors or if there are behaviors the nurse will document what they are seeing. The care plans should reflect the behaviors that we are seeing and any interventions.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 28306 Based on observation, interview, and facility policy review, the facility failed to accurately check the insulin pen that was being used to administer insulin to one of one resident (Resident (R)14) administered insulin out of seven residents being observed during the medication administration task. This failure had the potential for bloodborne pathogens to infect residents by using a reusable insulin pen to a resident other than the resident that it had been ordered for. Findings include: Review of the undated facility's policy titled, Administering Medications, revealed .The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication . During an observation of medication administration on 11/22/24 at 8:09 AM, the label on R14's Humalog insulin Kwik Pen read, Give 12 units every morning. The paper Medication Administration Record (MAR)located in a notebook on the medication cart for R14 matched the label for Humalog which was compared by the surveyor at the time of the preparation of the Humalog Kwik Pen. It was noted at that time, the name on the Humalog Kwik Pen was R101's name and not the name of R14 which the insulin was to be administered. Licensed Practical Nurse (LPN) 8 applied the alcohol prep to R14's left upper arm and uncapped the Humalog Kwik Pen. Before LPN8 was able to stick R14's arm with the insulin pen, the surveyor requested the nurse to stop and check the resident's name on the pen. LPN8 stated, It's [R14's] insulin. Again, the surveyor asked LPN8 to read the name on the label that was on the Humalog insulin Kwik Pen. LPN8 stated, It is [R101]. I need to take this out to the medication cart. The Humalog insulin was not administered to R14 at this time. LPN8 returned to the medication cart and stated, You have to check the medication to make sure it is for the right patient, it is the right dose, the right route, and the right time. During an interview on 11/22/24 at 8:17 AM, LPN5 stated, The nurse is to check to make sure it is for the right patient, right dosage, right route, and right frequency before giving the medication to the patient. During an interview on 11/23/24 at 6:00 PM, the Director of Nursing (DON) stated, The nurse checks each medication to make sure it is the correct patient that the medication is being given to.

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	425027	A. Building B. Wing	11/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountainview Nursing Home	340 Cedar Springs Road Spartanburg, SC 29302

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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** 28306 Based on observation, interview, record review, and facility policy review, the facility failed to have a permanently affixed compartment to store narcotics in the medication refrigerator on two of three units (North and [NAME] Units) which involved three of five residents (Resident (R) 259, R2, and R11) reviewed for medication storage of 24 sample residents This failure had the potential for these medications to be diverted. Findings include: Review of the facility's undated policy titled, Storage of Medications read in part, .Schedule II-V controlled medications are stored in separately lock, permanently affixed compartments . 1. Review of R259's undated Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed this resident was admitted to the facility on [DATE]. During an observation of the medication storage room on the North unit on 11/22/24 at 6:57 AM with Licensed Practical Nurse (LPN) 9, in the unlocked medication refrigerator, there was a transparent plastic container with two locks on it which contained Lorazepam (anti-anxiety medication) 2mg/ml (milligram per milliliter) 20 ml bottle which contained a medication label on it for R259. LPN9 was asked if the plastic container that contained Lorazepam was permanently affixed to the refrigerator. LPN9 confirmed that this plastic container was not permanently affixed to the medication refrigerator. During an interview on 11/22/24 at 11:45 AM, LPN1 stated, Yes, you can take the plastic container with the Lorazepam out of the refrigerator. 2. Review of R2's undated Face Sheet located in the EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE]. Review of R2's Physician's Order's located under the Physician Order tab in the hard chart of the medical record revealed an order, dated 08/21/24, for Lorazepam Injection 2mg/ml 0.25 ml (0.5 mg) intramuscular every two hours as needed for seizure. 3. Review of R11's undated Face Sheet located in the EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE]. Review of R11's Physician Orders located under the Physician Order tab in the hard chart of the medical record revealed an order, dated 08/22/24, Lorazepam 2mg/ml One ml (Two mg) intramuscular every eight hours as needed for seizure. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of the medication storage room on the [NAME] unit on 11/23/24 at 10:00 AM with LPN3, in the unlocked medication refrigerator, there was a transparent plastic container with two locks on it which contained single dose vials of Lorazepam as ordered for R2 and R11, which was not permanently affixed to the medication refrigerator. LPN3 confirmed that the transparent plastic container that contained the single doses of Lorazepam was not permanently affixed to the medication refrigerator. During an interview on 11/23/24 at 6:00 PM, the Director of Nursing (DON) stated she was not aware that the transparent plastic container in the medication refrigerator had to be permanently affixed to the refrigerator because it had Lorazepam in it.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on observations, record review, interviews, and facility policy review, the facility failed to follow infection control guidelines during an medication administration observation for two of seven resident observations (Resident (R) 13 and R19), during an observation of PPE (Personal Protective Equipment) for one of three COVID-19 positive residents (R24), and during a dressing change for one of one resident observation (R74) of 24 sample resident. These failures had the potential for spreading infections including COVID 19 to the vulnerable population in the facility. Findings include: Review of the facility's undated policy titled, Policies and Procedures - Infection Prevention and Control revealed: Policy Statement. The facility adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .Policy Interpretation and Implementation. 1. Infection prevention and control policies and procedures apply to all personnel, consultants, contractors, residents, visitors, and volunteers. 2. The objectives of the infection prevention and control policies and procedures are to: a. monitor, prevent, detect, investigate, and control infections in the facility; b. maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public; and c. provide evidence-based guidelines for infection prevention and control based on current best practices . 1. Review of R13's undated Face Sheet located under the Face Sheet tab in the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with the diagnoses of multiple sclerosis and with a recent diagnosis of gastrostomy tube placement. Review of R13's quarterly Minimum Data Set (MDS) located under the MDS Assessment tab in the EMR and with an Assessment Reference Date (ARD) of 09/01/24 revealed the resident was coded as having a feeding tube. Review of R13's Physician Orders located under the Physician Order tab in the hard chart of the medical record revealed an order, dated 01/19/23, which revealed Resident gets medications crushed and administered per tube. There were also physician orders for Ferrous Sulfate 220 mg (milligram) per five ml (milliliter) Give five ml by tube which was dated 08/28/24 and Vitamin D tablet 1,000 unit Give two tabs (2, 000 unit) per tube daily. There was no order for Enhanced Barrier Precautions due to R13 having a gastrostomy tube. During an observation on 11/22/24 at 6:35 AM, Licensed Practical Nurse (LPN)9 prepared a Ferrous Sulfate liquid 220 mg and when pouring the liquid into the medicine cup, the right index finger of LPN9 touched the inside of the medicine cup. LPN9 proceeded to pour three tablets of Vitamin D into the lid of the bottle and while doing this, LPN9 touched two of the pills with her bare hands as she was pouring these into the medicine cup. LPN9 then applied gloves and stated, I have to stop touching these tablets with my hands. LPN9 was observed wearing gloves only during this medication administration using the gastrostomy tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/22/24 at 10:38 AM, Certified Nurse Aide (CNA)2 was asked if R13 was in Enhanced Barrier Precautions due to having a feeding tube and CNA2 stated, That's a good question. You wear PPE anytime they have stuff on the door, then you wear the PPE that is on the sign to take care of the resident. During an interview on 11/22/24 at 10:47 AM, CNA3 was asked if R13 was in Enhanced Barrier Precautions and CNA3 stated, No, but could you please explain this? 2. Review of R24's undated Face Sheet located under the Face Sheet tab in the EMR revealed the resident was admitted to the facility on [DATE] with diagnoses of cerebrovascular disease, chronic pain, and moderate protein-calorie malnutrition. Review R24's Physician Orders located under the Physician Order tab of the hard chart of the medical record revealed an order, dated 11/15/24, COVID positive. During an observation on 11/22/24 at 7:55 AM, the CNA4 donned (put on) an N95 mask, gloves, and a gown and entered into R24's room. On the outside of R24's door was an isolation sign for Contact Isolation and Droplet Precautions. CNA4 opened R24's door and exited into the hallway wearing her mask, gloves, and gown. CNA4 walked across the hallway and doffed (took off) the mask, gloves, and gown and placed these into a cardboard box lined with a red trash bag that was in the hallway. CNA4 stated, I forgot to take my PPE [Personal Protective Equipment] off before I came out of the resident's room. 3. Review of R19's undated Face Sheet located under the Face Sheet tab in the EMR revealed the resident was admitted to the facility on [DATE] with diagnoses of cerebral palsy and epilepsy. Review of R19's quarterly MDS located under the MDS Assessment tab in the EMR and with an ARD of 09/08/24 revealed the resident was coded as having a feeding tube. Review of R19's Physician Orders located under the Physician Order tab in the hard chart of the medical record revealed an order, dated 02/27/23, which stated, Resident gets medications crushed and administered per tube separately. There was no order for Enhance Barrier Precautions due to R19 having a feeding tube. During an observation and interview on 11/22/24 at 11:10 AM, Registered Nurse (RN)3 wore only gloves while administering medications to R19 by tube. When asked if she knew what Enhanced Barrier Precautions were, RN3 stated, It's for some residents in the nursing home setting, the nurse is to wear gown, gloves, and a mask. When asked when do you wear PPE, RN3 replied, During patient care. When asked if she should have worn a gown when administering medications by tube, RN3 stated, Yes. During an interview on 11/22/24 at 11:14 AM, when asked to explain what Enhanced Barrier Precautions was, CNA1 stated, It is when we do our PPE. When asked if R19 was in Enhanced Barrier Precautions and CNA1 replied, If the sign is on the door, then yes, he is but honestly I can go get the nurse to ask. During an interview on 11/22/24 at 11:18 AM, LPN4 was asked to explain what Enhanced Barrier Precautions was, the LPN4 replied, Some people are on this related to different stuff like contact isolation or dealing with bodily fluids, emptying a catheter, you would wear PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/23/24 at 6:00 PM, the Director of Nursing (DON) stated, Anyone with a tube feeding, a Foley catheter, or dialysis shunt was in Enhanced Barrier Precautions (EBP). She stated when in EBP, the staff was to wear gown and gloves during direct care such as administering medications per tube, emptying a Foley catheter, or giving a bath. The DON stated the resident who was in Droplet and Contact Isolation, the staff were to don the mask, gown, and gloves prior to entering the resident's room and doff (take off) these items prior to exiting the resident's room. 4. Review of R74's undated Face Sheet located under the Face Sheet tab in the EMR revealed the resident was admitted to the facility on [DATE] with most recent diagnosis of sacral ulcer identified on 11/12/24. Review of R74's quarterly MDS located under the MDS Assessment tab in the EMR revealed the resident was at risk for developing a pressure ulcer. Review of R74's Physician Orders located under the Physician Order tab in the hard chart of the medical record revealed an order, dated 11/13/24, which revealed, Clean area to sacrum with Anasept. Pat dry. Apply hydrogel to area [sic] and cover with Opti foam. Change QD [every day] & [and] prn [as needed] until healed. During an observation on 11/22/24 at 9:56 AM, LPN2 was observed performing the dressing change to R74's sacral ulcer, the following failures were identified: -LPN2 cleaned the overbed table with Micro kill at 10:02 AM. At 10:03 AM, LPN2 cleaned the overbed table with an alcohol prep. At 10:05 AM, LPN2 placed the barrier on the overbed table before the table was dried from the alcohol prep. -LPN2 unfasten R74's brief and removed the dressing, then took out a wipe and wiped bowel movement from the anus in an upward motion up and around the wound. During an interview at 10:17 AM, LPN2 was asked what the dry time was for the Micro kill wipe that was used to clean the overbed table. LPN2 was observed reading the container and stated. The dry time is three minutes. LPN2 would not answer when asked if she waited for the dry time before the alcohol prep was applied to the overbed table. During an interview on 11/22/24 at 11:39 AM, the DON stated, The nurse is to wait the dry time for the Micro kill before a barrier is applied to the overbed table and you never wipe germs toward the wound, you wipe away from the wound.