STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425155	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancaster Health and Rehabilitation	2044 Pageland Hwy Lancaster, SC 29720

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31846 Based on review of facility policy, record review and interviews, the facility failed to ensure Resident (R)138 or her personal representative received a copy of the bed hold policy with bed hold rate and the duration of the bed hold in a timely manner for 1 of 5 residents reviewed for hospitalization . Findings include: Review of the undated facility policy titled, Discharge/Transfer states under policy, The patient/resident will be discharged /transferred (home/another entity) by order of his/her attending physician. Facility will include the patient/resident and family in developing a safe discharge plan to address the patient's/resident's individual needs. Procedures: 2 states, Notify the patient/resident, or his/her legal representative, if any, or an interested family member and document the discharge. Number 3, Types of discharges: B. Emergency: 1) Complete emergent transfer form. 2) Send the patient's/resident's face sheet, Advance Directive, bed hold policy, physician orders, MAR, TAR, and any state specific records in accordance with state regulations with the patient/resident. If unable to complete the information, verbally communicate the necessary information and fax when complete. C. Resident-Initiated Discharge to another health care agency such as a hospital or nursing facility: 1) Complete the Resident Transfer Form when the patient/resident is discharged to another health care agency such as a hospital or nursing facility. E. Involuntary Discharge: 1) d) Complete and provide a written notice of transfer/discharge to the patient/resident and, if known, a family member or legal representative, and the Office of the State Long-Term Care Ombudsman. The facility admitted R138 on [DATE] with diagnoses including, but not limited to: end stage renal disease, atherosclerotic cardiac disease and dialysis dependence. Review of R138's Progress Notes dated [DATE] revealed, Called to resident room by family member at 03:55 PM. Family member states resident went out. Upon arriving in the room, noted resident is not breathing and has no pulse. Code blue called and CPR began, EMS notified at 4:00 PM. CPR in progress. EMS arrived at 04:10 PM. EMS took over CPR. EMS left with resident at 04:17 PM on stretcher with CPR in progress. Resident was last seen by this nurse at 03:45 PM checking FSBS (finger stick blood sugar). Residents personal representative/family notified by visiting family member. (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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R138's Electronic Medical Record revealed no documentation could be found the R138's personal representative received a copy of the bed hold policy with the bed hold rate and the duration of the bed hold in a timely manner. During an interview on [DATE] at 3:05 PM, the Administrator stated the documents of the transfer and the bed hold are sent in a packet to the hospital along with other documents for the hospital staff. The Administrator provided a copy of the bed hold policy with R138's name and date she was sent to the hospital. But no documentation to ensure it was sent to the personal representative notifying her of the bed hold and the amount of the bed hold if R138 was hospitalized beyond the duration of the bed hold, in a timely manner. During an interview on [DATE] at 3:20 PM, the Business Office Manager, confirmed there was no documentation to ensure the Bed Hold Policy was sent to the personal representative in a timely manner.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47812 Based on observation, record review, interviews, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for 3 of 5 residents (Residents (R)102, R121, and R122) reviewed. Findings include: Review of the facility policy titled, Minimum Data Set revised on 05/05/23, revealed, Policy Statement: An MDS, which is a comprehensive, accurate, standardized reproducible assessment will be completed for each resident, using the RAI process. Facility staff complete a comprehensive assessment of each resident's needs, strengths, goals, life history, and preferences, and offer guidance for further assessment once problems have been identified. The comprehensive assessment is completed initially and periodically. Each staff member will note their liability for the accuracy of the data recorded by signing (electronically) their name and identifying the MDS sections and questions to which they provided responses. Review the resident's medical record. This review may include pre-admission activities. Identify resident status, care and services rendered during the Observation Period or the current assessment. Review is to include, but not be limited to pre-admission, admission, and transfer notes; current plan of care, physician's orders, progress notes, history and physical; nursing, dietary, activity, social service, and therapy notes and assessments; medication administration records and treatment records. 1. Review of R102's Face Sheet indicated the facility admitted R102 on 02/13/24, with diagnoses including but not limited to: metabolic encephalopathy, anxiety disorder, dementia, psychotic disturbance, mood disturbance, Parkinsonism, epilepsy, and paranoid schizophrenia. Review of R102's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/20/24, revealed R102 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating the R102 was moderately cognitively impaired. Further review of the MDS revealed, Section N: Medications, R102 was coded as taking antipsychotic medication and Section V: Care Area Assessment Summary revealed the care area and care planning decision for psychotropic drug use was triggered. Review of R102's Physician Orders revealed, Olanzapine 5 MG tablets were discontinued on 02/15/24 and Risperidone 3 MG tablets were discontinued on 02/15/24. Review of R102's Care Plan dated 02/13/24, revealed R102 was not care planned for psychotic/antipsychotic medication use. 2. Review of R121's Face Sheet revealed R121 was admitted to the facility with diagnoses including but not limited to: constipation, diarrhea, nausea with vomiting, pain, restlessness and agitation, major depressive disorder, and dementia without behavioral disturbance. Review of R121's Admission MDS with an ARD of 02/19/24, did not indicate the use of oxygen therapy. Review of R121's Care Plan indicated continuous oxygen therapy and to administer O2 as ordered. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R121's Physician Orders with a start date of 02/15/24 indicated, O2 at 2L liters per minute via nasal cannula as needed . During an observation on 04/01/24 at approximately 12:47 PM, and on 04/02/24 at approximately 12:30 PM and 3:07 PM, revealed that R121 was receiving oxygen therapy via nasal cannula. 3. Review of R122's Face Sheet revealed R122 was admitted to the facility with diagnoses including but not limited to: metabolic encephalopathy, hemiplegia and hemiparesis, dementia, hypertensive heart disease with heart failure, pressure ulcer of sacral region, stage 3, major depressive disorder, and muscle weakness. Review of R122's Scheduled 5-day MDS with an ARD of 03/12/24, indicated no difficulty in normal conversation, social interaction, or listening to TV. Review of R122's Care Plan did not indicate hearing problems, goals, or approaches. Review of R122's Physician Progress Note dated 12/13/23 at 5:39 PM, indicated R122 continued to have difficulty hearing but could answer most questions. Review of R122's Physician Progress Note dated 03/06/24 at 12:33 PM, indicated R122 had a significant hearing deficit. During an observation on 04/01/24 at approximately 11:08 AM and on 04/04/24 at approximately 2:00 PM, revealed R122 required elevated voice levels and repetition of statements to hear adequately. During an interview on 04/03/24 at approximately 10:15 AM, the MDS Coordinator indicated that she pulls MDS information from but is not limited to, resident documentation, doctor notes, and interviews with resident and resident representatives, social services, and dietary. The MDS Coordinator further stated that if a resident has hearing concerns, it should be indicated on the MDS. The MDS Coordinator further stated that she is aware that R122 can be hard of hearing sometimes, but when she interviewed him, she used a normal tone, and he was able to understand everything that she said. The MDS Coordinator confirmed that adequate hearing was selected for Section B - hearing abilities on his MDS. During an interview on 04/03/24 at approximately 1:00 PM, the MDS Coordinator stated that if a resident uses oxygen, it would be included under section O - Special Treatments, Procedures, and Programs. The MDS Coordinator confirmed that oxygen use is not checked off under Section O because the order was never signed off by a nurse on the MAR (Medication Administration Record). If an order is not signed off on the MAR, then it won't be included in the MDS. During an interview on 04/03/24 at 3:11 PM, the MDS Coordinator stated R102 was admitted on [DATE] and had to be sent back out the hospital on 02/14/24. At that time some of the resident's medications were discontinued. Upon R102's return to the facility on [DATE], Section N (medications) of the Admission MDS assessment that was completed on 02/20/24 was miscoded. The MDS Coordinator further stated, the resident was no longer taking any antipsychotic medications. The MDS Coordinator confirmed R102's MDS should not have been coded or triggered for antipsychotic medications at the time of admission. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/04/24 at 12:47 PM, the Administrator stated that MDS documentation should be accurate, and coordinators pull information from patient observations and documentation. The Administrator further stated that if MDS information is documented incorrectly, the coordinators should create a correction MDS with the correct information and supporting documentation. 48834

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31846 Based on review of facility policy, record review, and interviews, the facility failed to ensure Resident (R)88, with mental illness, was screened and evaluated for a PASARR Level II. The facility further failed to ensure R102, with a diagnosis of Paranoid Schizophrenia, was screened and evaluated for a PASARR Level II for 2 of 4 residents reviewed with diagnosis that warrant screening and evaluation. Findings include: Based on the facility policy titled PASARR Documentation Policy General Guidelines for PASAR states: 1. PASARR requires that: A. All applicants to a Medicaid-certified nursing facility are evaluated for mental illness and or intellectual disability, prior to admission and; B. Offered the most appropriate setting for their needs which may be in the community, a nursing facility, or an acute care setting, and; C. Receive necessary services in those settings to address any specific need related to the diagnosis of mental illness or intellectual disability. 10. The facility must notify the state-designated mental health or intellectual disability authority promptly when a resident with mental disability (MD) or intellectual disability (ID) experiences a significant change in mental or physical status. PASARR CARE PLAN: 6. Any resident with newly evident or possible serious mental disorder, ID or a related condition must be referred, by the facility to the appropriate state-designated mental health or intellectual disability authority for review. Examples of individuals who may not have previously been identified by PASARR to have MD, ID or a related condition include: - A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). - A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. Review of an undated document provided by the facility on PASARR Level II screening states: The federal definition of Mental Illness and possible indicators for a level II for PASARR is best understood in terms of the four D's: 1. A diagnosis or suspicion of a major mental illness such as schizophrenia, bipolar disorder, major depression, or an anxiety disorder. 4. A particular level of disability. The individual's Mental Illness must have resulted in functional limitations in major life activities within the past 3 to 6 months. The individual need not have received treatment. The severity of the impairment and how recently it occurred are important, not whether the individual was hospitalized or was seen by a mental health professional. Review of R88's Face Sheet revealed R88 was admitted to the facility on [DATE], with diagnoses including, but not limited to: pain, neuromuscular dysfunction of the bladder, and systolic congestive heart failure. Review of R88's PASARR Level 1 dated 09/07/22 revealed the following diagnosis not listed on the PASARR Level 1, bipolar disorder. Review of R88's Physician Orders revealed the antipsychotic medication Latuda 20 milligrams daily (used to treat certain mental/mood disorders such as schizophrenia, and depression associated with bipolar disorder). Further review of the Physician Orders revealed an order for Trintellix 15 milligrams at bedtime for major depressive disorder and Hydroxyzine for anxiety. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R88's Comprehensive Care Plan dated 04/17/23 revealed the following problems: Resident has potential for injuries, adverse reactions and side effects related to antipsychotic, anxiety and antidepressant medication use for bipolar. An additional problem dated 12/26/22, revealed, Resident has signs and symptoms of behavior/mood distress as evidenced by, verbalizing feeling down and bad about self, tearful at times. Resident has history of making sexually inappropriate suggestions/comments to female staff. Resident refuses showers and getting out of bed due to manipulating staff that are assisting him by providing false reasons as to why he cannot get out of bed. Review of R102's Face Sheet indicated the facility admitted R102 on 02/13/24, with diagnoses of but not limited to: anxiety disorder, dementia, psychotic disturbance, mood disturbance, and anxiety, and paranoid schizophrenia. Review of R102's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/20/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated the resident was moderately cognitively impaired. Review of R102's PASARR Level I dated 02/01/24, revealed the PASARR Level I was incomplete. The diagnoses section was not completed and Part II screening for mental illness indicators listed a diagnosis of Paranoid Schizophrenia. Section IV: Recommendation of Reviewer was not completed. Also, no PASSAR Level II was completed for mental illness diagnosis of paranoid schizophrenia. During an interview on 04/03/24 at 10:03 AM, Social Services (SS) stated that they had not had R102 evaluated for a Level II PASSAR despite diagnosis of Schizophrenia. The resident had displayed no symptoms or behaviors that would warrant such. During an interview on 04/04/24 at 10:05 AM, SS stated that she had not filled out any paperwork for screening or evaluation for R88 for a PASARR Level II. 47812

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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** 50085 Based on review of facility policy, record review, observation and interview the facility failed to implement care plan interventions related to pressure ulcer prevention for Resident (R)19. The facility further failed to develop and implement care plan interventions for R65 for related to Activities of Daily Living (ADL) function and right sided limitations for 2 of 3 residents. Findings include: Review of a facility policy titled Person-Centered Care Plan revised on 06/09/23. Policy and procedure states, 3. The person-centered care plan is interdisciplinary and created to guide facility staff in providing treatment care, and service necessary for the patient/resident to obtain and maintain the highest physical, mental, and psychological well-being possible. Review of R19's face Sheet revealed R19 was admitted to the facility on [DATE] with diagnoses including, but not limited to: muscle weakness (generalized), contracture right and left knees, human immunodeficiency virus, and pain. Review of R19's Quarterly Minimum Data Set with an Assessment Reference Date of 02/22/24, revealed R19's Brief Interview of Mental Status (BIMS) score was not conducted due to resident's cognitive skills are severely impaired. Further review of the MDS revealed no rejection of care behavior exhibited by R19. Review of R19's Physician Ordered revealed an order to float feet on pillow while in bed as resident will tolerate monitor every shift. Review of R19's Care Plan revealed, [R19] has a potential for skin breakdown related to history of pressure wounds, impaired bed mobility and incontinence, resident has peg-tube and colostomy. Intervention/Approach: Float feet on pillow while in bed as resident will tolerate. monitor every shift. Goal: [R19] will remain free of pressure ulcers/skin breakdown with current interventions thru next review. Review of R65's Face Sheet revealed R65 was admitted to the facility on [DATE] with diagnoses including, but not limited to: stage 3 chronic kidney disease, type 2 diabetes mellitus with diabetic neuropathy, cerebrovascular disease, hemiplegia, and hemiparesis following cerebral infarction affecting right dominant side, muscle weakness, lack of coordination, and pain. Review of R65's Quarterly MDS with an ARD of 01/30/24 revealed R65's BIMS score of 7 out of 15 indicating the resident was severely cognitively impaired. Further review of the MDS revealed no rejection of care behavior exhibited by R65. Review of R65's Electronic Medical Record on 04/02/24 revealed no physician orders, no progress notes, and no care plan that addressed right hand swelling and assistive device (splint) to aid in ensuring the affected hand is in neutral functional position, promoting joint alignment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation 04/01/24 at 11:11 AM, R19 had no floating heels, no pillow under or between contracture bilateral knees while laying bed. During an observation and interview on 04/01/24 at 12:20 PM, R65 revealed his right arm does not move due to him having a stroke years ago. R65's right hand was swollen, facing downward, and laying on the right side of resident's girthy stomach close to the metal side of wheelchair. R65 states that the swelling started years ago. There was no splint or assistive devices noted for right hand. During an observation on 04/02/24 at 11:41 AM, R19 was laying in semi-Fowler's position (resident is seated in a semi-sitting position and may have knees either bent or straight) with bilateral contracture knees hanging on the side of the bed without floating heels, no pillow between knees, or under knees. During an observation and interview on 04/02/24 at 12:15 PM, R65 revealed that he had a splint, but it is at his sister's house but someone from therapy told him that they would order him a splint. R65 was watching television with his right hand swollen, being held by his left hand, and resting on his stomach. During an interview on 04/02/24 1:21 PM, the Assistant Director of Nursing (ADON) revealed R19's floating heel boots should have been discontinued. The ADON stated, I am doing that right now as we speak. This wound care treatment could have been for the side of her foot to not break down, but I will have to follow up with the wound nurse. There should be a pillow between her legs. I will have to follow up with the wound care nurse. The expectation is that the staff are following her care plan. During an interview on 04/02/24 at 01:08 PM, the ADON revealed that she is familiar with R65 but states that it had to be therapy that spoke with the resident regarding a splint. The ADON states that admission assessments as well as weekly skin assessments are performed on each resident. The ADON is not aware of right-hand edema. It is expected that any abnormal findings will be recorded and reported to the MD. During an interview on 04/02/24 at 1:14 PM, the Director of Rehabilitation (DOR) revealed that she is familiar with resident R65, and there is no goal for a splint on his right hand. The DOR states that she can add it and will have the department look at it. She will call and speak with the Occupational Therapist (OT), to see if she spoke with him Saturday regarding the splint. The DOR will follow up on this with the OT this week. He has been in our care since 01/24/24. During an interview on 04/02/24 1:26 PM, Licensed Practical Nurse (LPN)1 revealed that R19 bilateral lower extremity is contracture and R19 treatment is for feet floated, air overlay to reduce pressure, pillows under to raise her feet and between her legs. LPN1 stated that this is done to help prevent pressure sores. The expectations are that the plan of care is being carried out by all staff. During an observation and interview on 04/03/24 at 10:08 AM, R65 was in a wheelchair, moving self with a resting splint on right hand in place secured by Velcro straps. R65 tolerating well. R65 states therapy just gave it to him and denies any issues at this time. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/03/24 at 12:35 PM, Occupational Therapy Assistant (OTA) revealed that she knew R65's right hand looked different than his left hand for months but was unsure if it had been addressed. It should have been put in the occupational therapist's initial evaluation if it was an issue. OTA reported that she has reported the swelling to nursing several times, and she does not remember who she spoke with on these occasions. OTA stated that R65 denied any pain or discomfort during 4 to 5 times a week session and this is a routine question asked during sessions. OTA stated that she had not spoken with the Occupational Therapist (OT) about his swollen right hand because it was there when he first came. R65 did not mention that he had a splint being used at home. We had one here, so we placed one on him today. During an interview on 04/03/24 at 12:46 PM, OT revealed there was a difference in R65's right hand during initial evaluation in January. He did report that he used a right-hand splint at home, and I wanted to give him the opportunity to get that device from home. When seen on Saturday 03/30/24 I noticed that he did not have the splint. We spoke about it briefly and activities of daily life. I forgot to chart this for the visit on Saturday because I see so many residents. When called by DOR I remembered, and I placed an order for a resting hand splint. During an interview on 04/04/24 at 11:53 AM, the ADON revealed R65 has right sided hemiplegia and staff is expected to follow and execute intervention and approaches. The care plan reflects resident's needs and preferences. It is patient centered and not generalized. The care plans are revised as there are changes in condition. It should be reasonable, measurable with short- and long-term goals with timeframes present as it relates to each discipline. R65's profile also gives information on what assistance this patient needs, it was previously called the Kardex.

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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. 50085 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure the nurse followed policy regarding dispensing controlled medication for 1 of 3 medication carts. Findings included: Review of a facility policy titled 2.2 Administration of scheduled controlled medications dated 04/01/22, revealed, administration of scheduled controlled substances will be consistent with the policies for general medication administration with the additional requirement of logging all doses on a controlled drug receipt/record/disposition form for each controlled substance order. 2. All scheduled controlled medications removed from storage for the purpose of administering doses to the resident will be entered onto the resident's-controlled drug receipt/record/disposition. Review of an Admission Record indicated the facility admitted Resident (R)122 on 03/05/24 with diagnoses including but not limited to: cellulitis of right upper limb, rheumatoid bursitis, elbow, edema, rheumatoid bursitis, pelvic and perineal pain, and pressure ulcer of sacral region, stage 3. A review on 04/03/24 at 1:01 PM, of R122's Controlled Drug Receipt/Record/Disposition Form dated 04/01/24, revealed, Oxycontin 20mg tablet count listed on record 25 pills on 04/02/24, however, the narcotic box contained 24 pills. During an interview on 04/03/23 at 1:26 PM, Licensed Practical Nurse (LPN)4 stated the nurses are expected to utilize the five rights when administering medications. Prior to administering a narcotic, we are to check orders and when the narcotic is pulled the expectation is to sign it out from the narcotic book. On the Electronic Medication Administration Record (EMAR) we are to select prep and once it is given, we select administered on the EMAR. If there is a discrepancy on the narcotic sheet, we immediately discuss with the nurse that worked the cart, and then administration if not corrected. The supervisor must be involved immediately to resolve discrepancies. During an interview on 04/03/24 at 1:32 PM, Assistant Director of Nursing (ADON) revealed that her expectation is that narcotics are given in a timely manner, per order and review order to ensure accuracy. Once the narcotic is pulled the card is immediately returned and the narcotic is signed out of the narcotic book. The Matrix is set up to prep and once medication is administered select given. The nurse is to also complete five patient rights with patient administration.

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Lancaster Health and Rehabilitation	2044 Pageland Hwy Lancaster, SC 29720

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 48834 Based on observations, record reviews, interviews, and facility policy review, the facility failed to ensure Resident (R)122 received an audiology consult as needed per physician orders. Findings include: A review of the facility policy titled, Leadership Policies and Procedures- Medical Services- Vision and Hearing Services, revised 11/01/17, indicated that The facility will assist the resident, when necessary or requested, in locating and utilizing available resources for the provision of vision and/or hearing services the resident needs. This includes A. Making appointments . Review of R122's Face Sheet revealed R122 was admitted to the facility with diagnoses including but not limited to: metabolic encephalopathy, hemiplegia and hemiparesis, dementia, hypertensive heart disease with heart failure, pressure ulcer of sacral region, stage 3, major depressive disorder, and muscle weakness. Review of R122's Physician Progress Note dated 12/13/23 at 5:39 PM, indicated R122 continued to have difficulty hearing but could answer most questions. Review of R122's Physician Progress Note dated 03/06/24 at 12:33 PM, indicated R122 had a significant hearing deficit. Review of R122's Physician Order Sheet created on 03/05/24, indicated an, Audiology consult and treat as needed. During an interview on 04/01/24 at 11:08 AM, R122 stated that they had hearing and some vision issues before admission to the facility. R122 further stated that they did not have hearing aids but would like some. During an interview on 04/03/24 at approximately 11:10 AM, Licensed Practical Nurse (LPN)4 stated she was unaware of hearing concerns for R122, the resident could understand what she said when she spoke to them in a normal tone. LPN4 further stated if she ever noticed any concerns related to R122's hearing, she would inform her supervisor, and document it in the book that was used for nurses to relay messages of any concerns that they had. LPN4 concluded stated she was unsure if R122 had ever been scheduled for an audiology appointment. During an interview on 04/03/24 at approximately 1:00 PM, Social Services stated that she was unaware of any audiology referrals made for R122, and she had not been made aware of any concerns related to R122's hearing. During an interview on 04/04/24 at 2:00 PM, R122 stated that they informed staff members of their hearing concerns but could not remember who they spoke to. R122 further stated that staff members must repeat questions frequently for them to properly hear what was being said.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 31846 Based on review of facility policy, observations, record review, and interviews, the facility failed to follow a procedure during wound cleaning for Resident (R)103 and R121 to prevent the likelihood of infection for 2 of 3 residents reviewed with pressure ulcers. Findings include: Based on the facility policy titled Performing A Dressing Change states as the policy: A dressing change will follow specific manufacturer's guidelines and general infection control principles. The Procedures listed are: NOTE: (Wash hands before and after donning gloves). 1. Don gloves. 2. Remove old dressing and packing (if present). (Change gloves) 3. Cleanse the wound of drainage, debris, or dressing/filler residue. (Change gloves) 4. Assess the wound (measuring done here). (Change gloves) 5. Pack the dead space of large wounds. (Change gloves - if needed). 6. Apply a cover dressing - date and initial cover dressing, place a time reference on it. (Remove gloves, discard waste). 7. Provide the patient/resident and caregiver education. 8. The clinician documents all procedures performed as well as the patient's/resident's/caregiver's response. 9. Follow manufacturer's guidelines (available on the wound care product's package insert and physician orders when using any wound care product. Review of a document titled Staff Education/Orientation Policies and Procedures Nursing Competency: Dressing, Simple: Application Of revealed #38. states, Cleanses wound as ordered. No other instructions included on the correct procedure in cleaning a wound/wound bed. Review of the Lippincott Nursing Manual provided by the facility revealed on page 801, on caring for wound, states: For an open wound, clean the wound in a full or half circle, beginning in the center and working outward. Use a new pad for each circle. Clean at least 1 inch (2.5 cm) beyond the end of the new dressing. Review of R103's Face Sheet revealed the facility admitted R103 with diagnoses including, but not limited to: Alzheimer's/Dementia and acquired a stage 4 pressure ulcer while residing in the facility. Review R103's Physician Order revealed an order for, daily dressing changes to stage 4 pressure ulcers. The order stated, to cleanse the left buttock with normal saline and apply alginate and cover with border gauze daily. An order for wound care to the coccyx stated to cleanse the coccyx with normal saline and apply mesalt and alginate and cover with border gauze daily. During observation of wound care for R103 on 04/03/2024 at 8:40 AM went as follows: Licensed Practical Nurse (LPN)1 performed the wound care and a Certified Nursing Assistant (CNA) assisted. R103 is on advanced barrier precautions due to the open wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LPN and the CNA knocked on R103's door and asked permission to enter. The LPN explained the procedure to the resident. The LPN and the CNA proceeded to wash their hands, and this surveyor asked permission to observe the nurse performing wound care and she nodded, indicating that it would be ok. Privacy was provided. The LPN opened a plastic bag of supplies and placed a drape on the over bed table. She taped 2 clear plastic bags, one on each end of the table, one for trash and one for soiled linen used during the dressing change. The CNA applied a gown, due to the advanced barrier precautions, washed her hands and applied gloves. The CNA then aided the resident to position onto her right side. The LPN then washed her hands, applied a gown and gloves, and opened the supplies, cleaned the scissors and placed them on the drape on top of the table. The LPN removed her gloves and gown, washed her hands and applied gloves and placed 4x4's into 2 plastic cups. She poured normal saline into one cup of 4x4's. The LPN then further aided the CNA in positioning the resident further over in the bed making the wound more accessible for the wound care. The LPN then removed the soiled dressing from the coccyx and while in hand pulled the glove over the soiled dressing and discarded it into the trash. The wound bed is beefy red with a scant amount of drainage. No odor. The LPN then removed her gown and washed her hands and then applied a gown and gloves and took the normal saline soaked gauze and cleaned down the outside of the wound, each side using a clean 4x4 soaked with normal saline. The LPN then cleaned inside the wound bed with a saline soaked 4x4 x1, going from top to bottom, starting outside the wound bed at the top and continuing beyond the outer edges of the open wound bed. The LPN removed her gloves and gown and washed her hands, she applied a gown and gloves and applied a small cut piece of mesalt and alginate into the wound bed and applied the border gauze. The LPN removed her gloves and gown, washed her hands and applied a gown and gloves and removed the soiled dressing from the left buttock, taking the soiled dressing into her right gloved hand and removing her gloves so that the soiled dressing went inside the glove and then placed the soiled gloves into the trash. LPN1 then removed her gown and washed her hands. The LPN applied a gown and gloves for the wound care of the left buttock. She cleaned the wound with normal saline. First cleansing each outer side of the wound with one swipe and discarding the soiled 4x4. The wound bed has a small amount of slough, and is small in size. The LPN then removed her gloves and gown, washed her hands and applied a gown and gloves. Using a saline soaked gauze she wiped from top to bottom of the wound, bringing the outside area of the wound through the wound bed. The LPN then removed her gloves and gown and washed her hands and applied a gown and gloves and placed a small amount of alginate into the wound bed and covered it with bordered gauze. The LPN then took a marker and wrote the date and initials on the clean dressing. The LPN aided the CNA in making the resident comfortable. She placed the soiled linen and the trash in the soiled linen room and washed her hands and then charted the treatment. Review of R121's Face Sheet revealed the facility admitted R121 with diagnoses including, but not limited to: Alzheimer's Disease and a pressure ulcer of the left and right buttocks. During observation of wound care for R121 on 04/03/2024 at 9:13 AM went as follows: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN1 performed the wound care and CNA assisted. Review of the physician's order states, Cleanse the left and right buttocks with normal saline and apply Alginate and cover with a border gauze. The LPN knocked on the resident's room door, asked permission to enter, the LPN informed this surveyor that R121 is usually non verbal. R121 is also on Advanced Barrier Precautions. This surveyor asked permission to observe the wound nurse providing wound care and she said, yes. LPN1 explained the procedure to the resident. The LPN and the CNA washed their hands, provided privacy. The CNA applied PPE which consisted of a gown and gloves. The LPN went to the treatment cart to get 2 trash bags and came back into the room and taped the 2 bags to the over bed table, taped one on each end of the table. The LPN applied gloves and applied a drape on top of the over bed table and opened the supplied, removed her gloves and washed her hands and applied a gown and gloves. She placed 4x4's into 2 plastic cups and in one cup of 4x4's she poured the normal saline. LPN1 then removed her gloves and gown and washed her hands and applied a gown and gloves. The CNA raised the bed, and both aided the resident in turning and positioning onto her right side. Then the LPN unfastened the resident's brief and removed the soiled dressing from the left buttock. The wound bed is pink, with debris, with pieces of alginate that has stuck to the outer edges. The wound bed is long, the surrounding tissue is dark in color. The LPN then removed her gloves and gown and washed her hands, she wiped the outer right side of the wound 1x with normal saline soaked gauze from top to bottom and then discarded the soiled gauze. The LPN took another saline soaked gauze and wiped from top to bottom of the wound 2x taking care not to go beyond the wound bed and onto the surrounding edges to drag the outside tissue of the wound into the wound bed, bringing debris and germs. The LPN then removed her gloves and gown and washed her hands and applied a gown and gloves, and applied alginate to the wound bed and covered the wound with border gauze. She then removed her gloves and gown and washed her hands. She then applied a gown and gloves and removed the dressing from the right buttock. The wound bed is round in size with a small amount of slough, and 3 other small peeling raw areas. The surrounding tissue is dark in color and is easily peeling off. The LPN removed her gloves and gown and washed her hands. She then applied a gown and gloves and took saline soaked 4x4's and cleaned the surrounding tissue and the wound bed at the same time, wiping from top to bottom 3x. The small quarter size wound peeled as she wiped from the top of the wound and as she kept wiping, the open wound peeled even more. The wound bed was cleaned in a circular motion from the center to the outside edges. The LPN then removed her gloves and gown and washed her hands, applied a gown and gloves and opened the alginate and applied it to the wound bed and then applied the border gauze. The LPN then removed her gloves and gown and washed her hands and applied a gown and gloves and wrote the date and her initials onto the border gauze of each of the 2 wounds. She aided the CNA in making the resident comfortable. The LPN then removed her gloves and washed her hands and bagged the trash and the soiled linen and carried it to the soiled utility room and washed her hands and charted the treatment. During an interview on 04/03/24 at 9:30 AM, LPN1 confirmed that she had cleaned the wounds from top to bottom, cleaning the outside first and then the wound bed dragging debris and outer tissue into the wound beds.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 48834 Based on observations, interviews, record reviews, and facility policy review, the facility failed to provide and document oxygen therapy for Resident (R)121 at the appropriate levels as ordered by the physician. Findings include: Review of the facility's policy titled Initiation of Oxygen Therapy, Concentrator dated 04/01/22, indicated, The licensed staff will provide the prescribed amount of oxygen therapy to the patients/residents as prescribed by the physician and per facility procedures. Review of R121's Face Sheet revealed R121 was admitted to the facility with diagnoses including but not limited to: constipation, diarrhea, nausea with vomiting, pain, restlessness and agitation, major depressive disorder, and dementia without behavioral disturbance. Review of R121's Physician Order Sheet created on 02/15/24, indicated orders for oxygen at 2 liters (L) per minute via nasal cannula as needed. Review of R121's April 2024 Treatment Administration Record (TAR) revealed no documentation for the use of oxygen on 04/01/24 and 04/02/24. During observations on 04/01/24 at approximately 12:47 PM, and on 04/02/24 at approximately 12:30 PM and 3:07 PM, revealed R121's oxygen level was set at four liters instead of two liters as ordered by the physician. During an interview on 04/02/24 at 2:30 PM, the Administrator confirmed that R121's oxygen was set at four liters and had nursing staff turn it down to two liters. During an interview on 04/03/24 at approximately 11:10 AM, Licensed Practical Nurse (LPN)4 stated that R121's current physician orders were for two liters. LPN4 stated that she frequently had to encourage R121 to wear their oxygen because they liked to take it off and play with the nose area. LPN4 further stated that she did not know why the TAR was not signed off on 04/01/24 and 04/02/24 because she was not on shift until 04/03/24. During an interview on 04/03/24 at approximately 12:49 PM, Registered Nurse (RN)3 stated she did not know why the TAR was blank, and the order for the oxygen should have been signed as being administered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47812 Based on observations, interviews, and facility policy review, the facility failed to properly label, store and discard expired foods in 1 of 1 kitchen. Findings include: Review of the facility's Cold Storage Chart revised on [DATE], revealed, references to food products with proper storage temperatures and length of storage for (opened, unopened, and cooked) foods, in the refrigerator and freezer. During an observation on [DATE] at 10:32 AM, an initial kitchen walkthrough with the Dietary Manager (DM) revealed the following: (1) one bag of iceberg lettuce discolored, opened not dated or labeled. (1) one package of sliced bologna, expired [DATE]. (1) one large metal serving pan of chicken salad sandwiches, pinto salad sandwiches, and peanut butter and jelly sandwiches, not dated or labeled. (1) container of coleslaw, expired [DATE] cornbread in saran wrap, expired [DATE]. During an interview on [DATE] at 10:32 AM, the DM stated the food truck came every Monday and Thursday. When inventory was received the items are labeled with the date before being put away. Staff were to label food items opened, pulled for use, or thawed, with the date and time. The leftover food that would be used again, were to be labeled with what the items were, the date, time, and the expiration/use by date. The DM stated that staff were aware of how to properly label and store food items because there was a chart posted in both the dry storage and refrigeration areas of the kitchen which stated the number of days a food item could be stored or with the use by date.