STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435040	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Mountain View	916 Mountain View Road Rapid City, SD 57702

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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** 43844 Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (26 and 51) had their care plans followed, updated, and revised promptly to reflect their current status and care needs. Findings include: 1. Interview on 12/12/24 at 10:46 with unlicensed medication aide L and certified nurse aide (CNA) R regarding resident 26 revealed: *Resident 26 was blind in one eye. *This time of year, is hard on resident 26. -She raised her grandchildren and wants to do things for them that she is not able to do. *Resident 26, at times, gets out of line verbally. -When that happens staff would get the nurse or director of nursing to assist them. -Her personal care was provided with two staff members present. *CNA R stated they find information in the resident's Kardex (an electronic summary of a resident's care needs), and the CNA's trained each other on how to care for the residents. Interview and record review on 12/12/24 at 11:04 a.m. with social service director U regarding resident 26 revealed: *Resident 26 was usually very kind and there are times when she is not so kind to some staff. *After reviewing resident 26's care plan interventions for her behaviors she agreed the non-pharmacological (excludes medications) interventions were not listed. *The process to review and update care plans was an interdisciplinary process (involves more than one) process. -She was responsible for updating the behavior area of the resident's care plans. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 12/12/24 at 11:18 a.m. with registered nurse (RN) Q regarding resident 26's behaviors revealed she stated the interventions included cares in pairs, so two staff go in [to care for resident 26] at all times. Review of resident 26's 12/12/24 care plan revealed: *She had a history of manipulative behaviors and false accusations. *The interventions for her manipulative behaviors and false accusations included Non-pharmacological interventions but there were no specific non-pharmacological interventions listed. 2. Review of resident 51's medical record revealed: *He was admitted on [DATE]. *His diagnoses included vascular dementia and stroke. *His physician orders included: -Eliquis (a blood thinner medication) 5 milligrams (mg) by mouth twice daily for irregular heartrate. -Aspirin 81 mg one time a day. Review of resident 51's 12/11/24 care plan included: *A 2/6/24 revised focus area of I am on Antiplatelet therapy [prevents blood platelets from clumping together into a blood clot]/ASA (aspirin) and Plavix related to Cerebrovascular Disease. -A 6/21/23 intervention to Monitor/document/report to MD [medical doctor] as needed signs/symptoms of antiplatelet complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, , diarrhea, muscle joint pain, lethargy, bruising , blurred vision, SOB [shortness of breath], Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s [vital signs]. Interview on 12/12/24 at 11:17 a.m. with RN Q regarding resident 51's medications revealed: *Eliquis and Plavix were not the same medication. *Eliquis required more labs and blood monitoring than Plavix would. *Resident 51 was prescribed Eliquis and not Plavix, his care plan indicated he was taking Plavix. Interview on 12/12/24 at 12:28 p.m. with director of nursing (DON) D regarding resident 51's medications revealed: *Plavix is an anti-platelet medication. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Resident 51 was taking Eliquis. -Eliquis did not require routine lab work. *The care plan process was for the interdisciplinary team to work together to develop and revise the resident's care plans. -The Minimum Data Set nurse would initiate the resident's care plan related to medications. -Medications were not typically specified on the care plan as medications could change. *Her expectation was for the resident's care plan to be updated as the resident's care and needs changed. Review of the provider's 9/30/24 Care Plan policy revealed: *Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. In doing so, the following considerations are made: -Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations. -Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death. *Interventions act as the means to meet the individual's needs. The recipe for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met. Assessment tools are used to help formulate the interventions (they are not THE intervention). *Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. 51816

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40788 A. Based on observation, interview, and policy review, the provider failed to adhere to professional standards of care practice and their facility's process for the accountability of controlled (risk for mental or physical dependence) medications by one of one registered nurse (RN) (I) and two of two licensed practical nurses (LPN) (S and P) who had signed the accounting of controlled medications sheet before a physical inventory of those medications with the oncoming nurse had occurred. Findings include: 1. On 12/10/24, review of the second floor east wing Shift Verification Of Controlled Substances Count sheet at 8:22 a.m. and interview at 2:30 p.m. with LPN S revealed: *At each change of shift, the oncoming and offgoing nurses completed and verified an accounting of all the controlled (risk for mental or physical dependence) medications in the medication cart. -Both nurses signed and dated the verification of controlled substances count sheet after the accounting process was completed. *As the 12/10/24 oncoming nurse for the 6:00 a.m. to 6:00 p.m. shift, LPN S and the offgoing nurse counted the controlled medications in the medication cart together and signed the verification sheet. -LPN S then signed the verification sheet as the offgoing nurse for 12/10/24 even though her shift was not scheduled to have ended until 6:00 p.m. and the controlled medication count with the oncoming nurse for the next shift had not been completed. 2. Review of the second floor west wing Shift Verification Of Controlled Substances Count sheet and interview on 12/10/24 at 8:45 a.m. with LPN P revealed: *As the oncoming nurse for the 6:00 a.m. to 6:00 p.m. shift that day she and an offgoing nurse from the overnight shift had signed that sheet that confirmed they had completed the controlled medication count. -LPN P had signed the verification sheet as the offgoing nurse for 12/10/24 even though her shift was not scheduled to have ended until 6:00 p.m. that night. *LPN P knew she was not to have signed that sheet as the offgoing nurse until the end of her shift after the controlled medication count was completed with the oncoming nurse. 3. Review of the first-floor east wing Shift Verification Of Controlled Substances Count sheet and interview on 12/10/24 at 10:40 a.m. with RN I revealed she: *Had signed the verification sheet as the offgoing nurse for 12/10/24 even though her shift was not scheduled to have ended until 6:00 p.m. that night. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Was not to have signed that sheet as the offgoing nurse until the end of her shift after the controlled medication count was completed with the oncoming nurse. Review of the provider's November 2017 Medication Storage and Controlled Medication Storage policy revealed 6. At each shift change or when keys are surrendered, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report. 51472 B. Based on observation, record review, interview, and policy review the provider failed to accurately document that assessment of the appropriateness and safety of self-administration of medications for one of one sampled resident (59) who self-administered an inhaled medication. Findings include:: *Required assessments and documentation were completed prior to resident 59 self-administering his Ventolin HFA inhaler. *One of two sampled registered nurses (RN) (I) had administered medications prior to documenting that those medications were administered one of one sampled residents (18). Findings include: 1. Observation on 12/10/24 at 11:00 a.m. of resident 59 while in his wheelchair in the hallway revealed he: *Removed a medication inhaler from his shirt pocket. *Inhaled twice from the inhaler. *Returned the inhaler to his shirt pocket. Review of resident 59's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His 11/12/24 Brief Interview for Mental Status (BIMS) assessment score was 10, which indicated he had moderate cognitive impairment. *His diagnoses included lung cancer, chronic obstructive pulmonary disease (COPD)(a group of lung diseases that block airflow and make it difficult to breathe), and dementia. *On 12/10/24 at 11:30 a.m. a physician order was entered that indicated resident 59 May keep [Ventolin HFA inhaler] at bedside. *On 4/11/24 a Ventolin HFA inhaler order was entered into the physician orders that did not include May keep at bedside in the order. *On 12/10/24 at 11:27 a.m. a Medication Self-Administration Evaluation assessment was completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Section four of this assessment was related to disqualifying factors for self-administration. -One of the listed disqualifying factors was Dementia or that affect their ability to self-administer. -There were no previous assessments for self-administration prior to 12/10/24. *His care plan was updated on 12/10/24 to include, May keep Ventolin inhaler at bedside and self-administer. I prefer to keep in my pocket. *There were no documented administrations or self-administrations of the inhaler in resident 59's medication administration record (MAR). 2. Observation and interview on 12/11/24 at 8:17 a.m. with resident 59 revealed: *His inhaler was in his shirt pocket. *He stated that he had been using an inhaler for two to three years. *He stated that he had had the inhaler to take on his own since he was admitted to the facility. *He stated that he was taught how to use the inhaler when he lived in a neighboring state. *When he was asked if staff had talked to him about how and when to use the inhaler since he was admitted , he replied, They might have but I cannot remember. Interview and review of resident 59's EMR on 12/12/24 at 12:00 p.m. with assistant director of nursing (ADON) E revealed: *She had entered the order for May keep at bedside, updated the care plan, and completed the Medication Self-Administration Evaluation on 12/10/24 after she had witnessed resident 59 self-administer his inhaler. *She confirmed resident 59's had a BIMS assessment score of 10 and a diagnosis of dementia. *She confirmed the Medication Self-Administration Evaluation contained a section labeled Disqualifying Factors and one of those disqualifying factors was Dementia or Alzheimer that affect their ability to self-administer. Review of the provider's 11/19/24 Self-Administration of Medications policy revealed: *If the resident has expressed a desire to self-administer, the interdisciplinary team will complete an evaluation of the resident's cognitive, physical and visual ability to carry out this responsibility. The facility may require the drugs to be administered by the nurse until the care planning team has the opportunity to obtain information necessary to make a determination on resident's ability to complete the task. *Evaluations will be completed Quarterly, with change of condition, annually and prn [as needed]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*If the resident is deemed capable to self-administer medications, then the drugs will be stored in a locked box in the resident's room, unless otherwise determined by the interdisciplinary team. *Nursing staff will be responsible for recording self-administration doses in the resident's medication administration record, unless otherwise determined by the interdisciplinary team. 3. Observation on 12/12/24 at 8:40 a.m. of RN I while administering resident 18's medications revealed: *Resident 18 had twelve oral medications and one nasal spray scheduled to be administered. *RN I compared the medication cards to the resident's MAR as she prepared the medications for administration. *She selected the Y [yes] in the MAR as she removed the medications from the cards and bottles. *She signed that she had administered those medications in the MAR. *She then took those medications to resident 18's room and administered the medications. Interview on 12/12/24 at 1:45 p.m. with director of nursing (DON) D revealed she expected medications to be administered to residents prior to staff signing that the medications had been administered. Review of the provider's 9/18 Medication Administration policy revealed The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. 43844 Based on interview, record review and policy review the provider failed to ensure three of three sampled residents (26, 33, and 85) who required dialysis treatment were monitored for abnormalities upon returning from their dialysis treatments. Findings include: 1. Observation and interview on 12/10/24 at 2:07 p.m. with resident 26 revealed: *She was seated in her wheelchair in her room. *She stated she had just returned from dialysis and was waiting for a certified nurse aide (CNA) to assist her into her bed. *She stated there was a dialysis port in her right arm. Review of resident 26's electronic medical record (EMR) revealed: *Her admitted was 5/4/19. *Her diagnoses included: end-stage renal disease, dependence on renal dialysis, heart failure, and Type II diabetes. *Her physician's orders included she was to receive dialysis treatments on Tuesdays, Thursdays, and Saturdays. Review of resident 26's Post-Dialysis Evaluation assessment, Section 3 vitals area documentation revealed: *Her 11/23/24 blood pressure (BP), temperature, pulse, and oxygen (O2); her 11/21/24 respiration rate (RR); and her 11/29/24 blood sugar were documented as her post-dialysis vital on 11/30/24. *Her 11/23/24 BP, temperature, pulse, and O2; her 11/21/24 RR were documented as her post-dialysis vitals on 12/2/24. *Her 12/7/24 BP, temperature, pulse, RR, and O2; her 12/9/24 blood sugar (BS) were documented as her post-dialysis vital on 12/10/24. 2. Interview on 12/10/24 at 3:52 p.m. with resident 33 revealed she stated: *She received dialysis on Tuesdays, Thursdays, and Saturdays. *Nurses sometimes check her vital signs when she returned from dialysis, and at other times she would go to dinner without them being taken. Review of resident 33's EMR revealed: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Her date of admission was 2/26/20. *Her 11/6/24 Brief Interview of Mental Status (BIMs) assessment score was a 13, which indicated her cognition was intact. *Her diagnoses included: chronic kidney disease (CKD) Stage 5, other symptoms and signs involving cognitive functions and awareness, dementia, type 2 diabetes with hyperglycemia, and dependence on renal dialysis. *Her physician's orders included she was to receive dialysis treatments on Tuesdays, Thursdays, and Saturdays. Review of resident 33's Post-Dialysis Evaluation assessment, Section 3 vitals area documentation revealed: *Her 11/23/24 BP, temperature, pulse, and O2; her 11/15/24 RR; and her 11/29/24 BS were documented as her post-dialysis vitals on 11/30/24. *Her 11/23/24 BP, temperature, pulse, and O2; her 11/15/24 RR; and her 12/2/24 BS were documented as her post-dialysis vitals on 12/3/24. *Her 12/7/24 BP, temperature, pulse, RR, and O2; her 12/9/24 BS were documented as her post-dialysis vitals on 12/10/24. 3. Review of resident 85's EMR revealed: *His admitted was 11/8/24. *His diagnoses included: end stage renal disease, dependence on renal dialysis, diabetes, heart disease, acute and chronic heart failure, kidney failure, and orthostatic hypotension(low blood pressure when standing from sitting or lying position). *His dialysis schedule was Monday, Wednesday, and Friday. *His care plan included, Report significant changes in pulse, respirations, and BP [blood pressure] immediately. Review of resident 85's Post-Dialysis Evaluation assessment Section 3 vitals documentation revealed: *His 12/5/24 BP, temperature, pulse, RR, and BS; 12/5/24 02 were documented as his post-dialysis vitals on 12/2/24. 4. Interview on 12/12/24 at 10:45 a.m. with unlicensed medication aide (UMA) L and certified nursing assistant (CNA) R revealed: *The nurse or a CNA would obtain a resident's vitals when a resident returned from dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-When the CNA obtained the resident's vitals, they would write the vitals on a piece of paper and give that paper to a nurse. Interview and record review on 12/12/24 at 11:23 a.m. with registered nurse Q revealed the process for completion of a resident's post-dialysis return assessment was: *The resident's vital signs were obtained when the resident returned from dialysis. -A nurse or anyone was able to take the vital signs. -When a CNA obtained resident's vital signs, they write it down and hand it to us. *When reviewing the post-dialysis assessment in Section 3 and the vitals for that section, she confirmed the documented post-dialysis vitals referred to above were not dated the day the residents returned from dialysis and should have been. Interview and record review on 12/12/24 at 12:56 p.m. with director of nursing D regarding the post-dialysis assessment for residents upon their return from dialysis revealed: *She agreed the post-dialysis assessment vitals were sometimes recorded from a previous day and not the day the resident returned from dialysis. *When a new assessment was started the last documented set of vital signs were pre-populated into that assessment. -Whomever was completing the new assessment were to have removed the pre-populated data and enter that day's post-dialysis resident's vitals. *She confirmed the removal of the pre-populated data was not always completed. *She stated, I should have known about this a long time ago. 47780 5. Review of the provider's revised February 2024 Dialysis Management policy revealed: *The facility has designed and implemented processes which strive to ensure the comfort, safety, and appropriate management of hemodialysis residents. The facility will ensure the following; -7. Upon return from Dialysis Center, review information provided on Dialysis communication form. Communicate and address as appropriate. Complete post-dialysis information and record on UDA [user defined assessment] in PCC [Point Click Care].

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 51472 Based on observation, interview, record review, policy review, and manufacturer's recommendation review the provider failed to ensure the following: *A topical pain medication was applied according to the manufacturer's recommendation for three of three sampled residents (18, 20, 22, and 37) by two of two staff members (RN G and UMA K.) *A nasal spray was administered per the physician's order to one of one sampled resident (18) by one of one RN I. *A nebulizer treatment was administered per the physician's order to one of one sampled resident. *A topical powder was applied to one of one sampled resident (54) without a physician's order. Those observations created a medication error rate of 18.75%. 1. Observation and interview on 12/11/24 from 1:00 p.m. through 1:30 p.m. of RN G during medication administration revealed: *She administered diclofenac sodium external gel 1% (for arthritis pain and inflammation) to resident 20's knees. -The order on the medication administration record (MAR) indicated she was to receive four grams. *She identified that there was a measurement device that was to be used to determine the correct dose, but she did not use it. *She dispensed an unknown amount of gel into a medication administration cup. *She administered diclofenac sodium external gel 1% to resident 22's knees. -The order on the MAR indicated that the medication was to be applied to her knee four times a day as directed. -There was no dose included in the medication order. *She did not clarify the dose with the provider prior to administering it. Observation on 12/11/24 at 4:53 p.m. of the medication pass with UMA K revealed: *She administered diclofenac sodium 1% gel to resident 37's lower back. -The order on the MAR indicated four grams were to be administered. *She did not use the measurement device to determine the correct dose. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The measurement device remained secured to the inside of the box the diclofenac was in. *The tube of diclofenac was partially used prior to that administration. Observation and interview on 12/12/24 at 8:40 a.m. of a medication pass with RN I revealed: *She administered Flonase 50mcg (micrograms)/act two sprays in each of resident 18's nostrils. *The order on the MAR was to administer 1 spray in each nostril twice daily. *She indicated that she had given more Flonase than what was ordered to resident 18. Interview on 12/12/24 at 11:11 a.m. with UMA L revealed: *The measuring device that was included in the box with the diclofenac sodium 1% gel was to be used to determine the dose of the gel to be administered. *He agreed the measurement device remained secured to the diclofenac sodium 1% gel box that was pulled from the medication cart. *He agreed the tube in the box was partially empty. *He indicated that some staff members do not use the device when they administer the medication. Interview on 12/12/24 at 1:45 p.m. with director of nursing (DON) D revealed it was her expectation: *That the measurement device in the diclofenac sodium 1% gel be used to determine the dose of the medication prior to administration. *That the correct dose of medication be administered. Review of the manufacturers' 2/22 recommendations for the diclofenac sodium 1% gel revealed: *Under the heading Measuring the correct amount using the dosing card. -The direction for dose measurement was Squeeze gel from the tube equal to the length shown. Review of the provider's 9/18 Medication Administration policy revealed: *Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices. *Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record. 47780 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation on 12/11/24 at 7:59 a.m. revealed resident 29's nebulizer medicine cup was sitting on her bedside table and contained a clear liquid. Review of resident 29's MAR revealed her morning nebulizer treatment was documented as administered. Interview on 12/11/24 at 11:20 a.m. with resident 29 revealed she: *Had not received her morning nebulizer treatment. *Stated she had been busy during the morning and when she returned to her room, she could not reach the button to start her nebulizer treatment. Interview on 12/11/24 at 11:32 a.m. with director of nursing (DON) D in resident 29's room revealed: *Resident 29 had told DON D she had not had her morning nebulizer treatment. *DON D confirmed the clear liquid in resident 29's nebulizer medicine cup was her morning nebulizer treatment. Continued interview on 12/11/24 at 11:37 a.m. with DON D revealed: *She confirmed resident 29's morning nebulizer treatment was documented as administered. *Her expectations of staff were to fill the nebulizer medication cup when the resident was ready for the treatment and hand the nebulizer treatment to the resident. After the resident was finished with the nebulizer treatment, the staff were to clean the mask and the medicine cup. 51816 3. Observation and interview on 12/10/24 at 11:56 a.m. with resident 54 while in her room revealed: *She was lying in bed covered with a blanket. *She stated she sleeps a lot in the mornings and is tired. *She stated she had a skin concern under [her] tummy. Interview on 12/11/24 at 7:49 a.m. with RN N regarding resident 54's skin revealed: *She stated resident 54 has a severe yeast infection in her groin area, under her breasts, and her left underarm area. Observation on 12/11/24 at 8:23 a.m. of RN N while providing skin care to resident 54 revealed RN N applied Nystatin powder to resident 54's groin area and left underarm area. (continued on next page)

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	435040	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 54's electronic medical record (EMR) revealed there was no current physician's order for Nystatin powder. Record review, observation, and interview on 12/11/24 at 2:11 p.m. with RN N regarding resident 54's Nystatin powder administration revealed: *She was unable to locate an area in resident 54's EMR to document the administration of the above medication. *The label on the bottle of Nystatin said to Reorder after 12/9/24. -She stated when it gets down to here, while pointing at the bottom quarter of the bottle, I'll reorder it. Interview on 12/11/24 at 2:20 p.m. with RN N revealed she had called resident 54's physician and had received an order for Nystatin powder. Interview on 12/12/24 at 12:36 p.m. with DON D regarding medication administration of Nystatin powder for resident 54 revealed: *Her expectation was for all medications to have a current physician's order prior to administration. *She agreed resident 54's Nystatin powder should not have been administered without a current physician order. 43844

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 40788 Based on observation, record review, interview, and policy review, the provider failed to ensure: *One of one sampled resident's (74) prescription Ativan (anti-anxiety medication) was accurately labeled. *Outdated medical supplies had been removed from two of two observed medication storage rooms. *One of one sampled resident (50) had a pharmacy label on his aspart insulin pen. *Two of two sampled residents (18 and 85) opened aspart insulin pens were not available for use after the expiration period. Findings include: 1. Review of the first-floor controlled substance binder revealed: *AnIndividual Resident's Controlled Substance Record page for resident 74's liquid Ativan. -The resident's name and Ativan 2mg [milligrams]/ml[milliliter] was hand-written on it. There was no pharmacy label on that sheet. *That medication was administered as ordered on 11/30/24 and again on 12/8/24. Observation and interview with registered nurse (RN) N on 12/10/24 at 11:50 a.m. in the first-floor medication room revealed: *In the medication refrigerator there was a sealed plastic bag dated 11/30 with resident 74's name on it that contained a bottle of Ativan. -There was no prescription label affixed to that bottle that would have confirmed the identity of the resident that medication was prescribed to, medication dosage information, or the instructions for use. *The 11/30/24 physician's order for that Ativan was 0.5 ml sublingually [under the tongue] every 2 hours as needed for anxiety/restlessness. -Without a label on that medication bottle, the nursing staff were not able to compare it to the physician's order on the resident's medication administration record (MAR) to ensure the medication matched the order before it was administered. 2. Observation on 12/10/24 at 10:25 a.m. in the second floor medication storage room revealed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Three Ambu (artificial manual breathing unit) bags each in an individually sealed package. -The expiration date on two of those packages was 2/25/22 and the expiration date on the third package was 10/21/22. *One bag of hypodermic safety needles with a use by date of 3/2020. 3. Observation on 12/10/24 at 10:45 a.m. in the first floor medication storage room revealed: *One opened box of BD brand blood collection kits that was 75% full. -The expiration date on that box was 7/31/23. *Two boxes of strap tourniquets. -The manufacturer date on one box was 11/2/19 and the manufacturer date on the second box was 4/21/19. The instructions for use on each box indicated best [used] before 24 months from date of manufacturing. 4. Interview on 12/11/24 at 9:20 a.m. with central supply manager/business office assistant O regarding medical supply management for the medication storage rooms revealed she: *Was responsible for ordering, receiving, and stocking the medical supplies in both medication storage rooms. -Unlicensed medication aide (UMA) L was responsible for checking for and removing outdated medical supplies from those rooms. 5. Interview on 12/11/24 at 1:18 p.m. with UMA L regarding medical supply management revealed: *He checked for and removed outdated stock medications (bulk supply of medications not required to be labeled for an individual's use by the pharmacy) from both medication storage rooms on a regular basis. -That task was not assigned to him to have completed but it was something he had started to do on his own. *He had not been checking for and removing outdated medical supplies at the same time he was checking for and removing outdated stock medications. Review of the provider's September 2018 Medication Storage and Storage of Medication policy revealed: *13. Refrigerated medications should be kept in closed and labeled containers . *14. Outdated, contaminated, discontinued, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The policy made no mention regarding the storing and disposal of outdated medical supplies. 51472 6. Observation on 12/12/24 at 11:27 a.m. of residents' insulin pens revealed: *There was a container in a medication cart with resident 50's name on it that had an aspart insulin pen in it. -There was no prescription label affixed to the insulin pen that would have confirmed the identity of whose medication it was, medication dosage information, or the instructions for using that medication. *Resident 18's Novolog insulin pen had an 11/13/24 date written on it. *Resident 85's aspart insulin pen had an 11/8/24 date written on it. Interview on 12/12/24 at 11:27 a.m. with registered nurse (RN) I revealed: *There should be a pharmacy label on all insulin pens. *She could obtain a replacement label from PharMerica. *Insulin pens were to be dated with the date it was opened. *When she was asked what length of time insulin was able to be used after opening, she stated I am sure we have a book. *She was unable to locate the insulin expiration date information. Interview on 12/12/24 at 12:00 p.m. with assistant director of nursing (ADON) E revealed she would have expected: *A pharmacy label to be on all insulin pens. *The staff to date the insulin pens at the time of their first use and to discard the pens after the expiration date. Review of the provider's 7/19 Med-Pass Medication with Shortened Expiration Dates form indicated, Novolog (aspart) insulin expires 28 days after first use or removal from refrigerator, whichever comes first.

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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. 47780 Based on observation, interview, and policy review the provider failed to ensure: *Appropriate whirlpool (WP) tub cleaning by one of one certified nursing assistant (CNA) M in one of two WP tub rooms after bathing residents. *Proper hand hygiene was performed during medication administration by four of four observed staff members (RN N, LPN P, UMA K, RN I) for seven of seven sampled residents (10, 18, 22, 35, 40, 54, and 69) during seven of seven medication administrations observations. Findings included: 1. Observation and interview on 12/11/24 at 10:43 a.m. with CNA M in the WP tub room revealed: *She had been assisting residents with bathing for the past two days. -The regular bath aide had been out sick. *She had been employed with the facility as a CNA since 3/26/23. *She used the following process to clean the WP tub: -She sprayed water into the WP tub while she sprayed WP disinfecting cleaner. -She stated she would scrub the WP tub for 20-30 seconds. -She filled the WP tub with water and scrubbed around the tub chair and the sides of the WP tub for approximately 30 seconds. -She drained the WP tub and then rinsed the WP tub with water. -She opened the back door of the WP tub and dried around the perimeter of the back door of the WP tub with a clean towel. Follow-up interview on 12/11/24 at 10:44 a.m. and review of the posted WP tub cleaning instructions with CNA M revealed: *She had known the instructions were posted on the side of the WP tub. *She was not aware she was to: -Run five gallons of water into the tub and pour 10 ounces of disinfectant into the water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Run disinfectant through the aerator holes/jets, let the aerator/jets run for at least 20 seconds. While the aerator/jets are running, use a brush or sponge to scrub the tub insides, bottom, and chair. Ensure that all surfaces are wetted by the disinfectant solution. *She was not aware that area was to stand for at least 10 minutes. *She was not aware she was to: -While waiting, wipe all other contact areas such as the outside of the bath, door seals, hand control with a cloth soaked in disinfectant solution. -After 10 minutes of contact or longer, drain the bath of the residual disinfectant solution. -Thoroughly rinse the insides of the tub including the chair with water. Fill the tub with enough water to cover the intake valve and turn on jets/aerator and run for 20 seconds to ensure that the disinfectant is thoroughly rinsed. *She agreed she was not cleaning the tub according to the posted instructions. Interview on 12/11/24 at 11:05 a.m. with director of nursing (DON) D revealed: *CNA M had been assisting with baths for two days. -The regular bath aide had been out sick. *She agreed CNA M had not been cleaning the WP tub according to the posted instructions. 51816 2. Observation and interview on 12/10/24 at 10:57 a.m. with resident (54) while in her room revealed: *She was lying on her right side under a blanket. *She stated she had a skin concern under [her] tummy but the nurses were addressing that. Interview on 12/11/24 at 7:49 a.m. with registered nurse (RN) N revealed she stated: *Resident 54 had a yeast infection in her groin area, under her breasts, and her left underarm area. *They were treating this infection by washing and powdering the areas two times a day. Observation on 12/11/24 at 8:23 a.m. of resident 54's personal care and treatment of her yeast infection while in her room revealed: *RN N washed her hands for about five seconds before putting on gloves and then performed personal care for resident (54) with soap, water and a washcloth. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*RN N then put those dirty washcloths on the floor, removed her gloves, and washed her hands again for about five seconds before applying clean gloves. *With those gloved hands RN N dried that area with a towel, removed her gloves, washed her hands for about three seconds with water, and applied clean gloves. *RN N then applied Nystatin powder to the reddened skin in resident 54's groin area. *RN N then removed those gloves, did not wash her hands, applied clean gloves and then washed the resident's left underarm area with soap, water, and a washcloth. *RN N removed her gloves, washed her hands for about three seconds with water, and applied clean gloves then with those gloved hands she dried that area with a towel and applied Nystatin powder to the resident's left underarm area. 3. Observation on 12/10/24 between 10:14 a.m. and 10:20 a.m. of licensed practical nurse (LPN) P revealed she: *Administered oral medications to residents 10, 22 and 40. *Did not perform hand hygiene prior to the preparation of medications for all three of those residents. *Did not perform hand hygiene after she administered the medications to all three of those residents. 4. Observation on 12/11/24 at 4:44 p.m. of unlicensed medication aide K during medication administration revealed: *She did not perform hand hygiene prior to the preparation of medications for residents 35 and 69. *She did not perform hand hygiene after she administered medications to resident 69. 5. Observation on 12/12/24 at 8:40 a.m. of registered nurse (RN) I revealed: *She did not perform hand hygiene prior to putting on gloves. *There was a sign on the door that indicated resident 18 was on contact precautions (use of gloves and gown when providing direct resident care), to whom she administered medications. 6. Interview on 12/12/24 at 12:40 p.m. DON D regarding handwashing during medication administration revealed: *Her expectation was for staff to follow the hand hygiene policy. -This included completing hand sanitizing or washing before entering a resident room, with donning and doffing of personal protective equipment, between dirty and clean areas, and before exiting a resident room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The hand washing should have been at least 20 seconds each time. -Hand washing competencies were completed with all staff at least once per year. 7. Review of RN N's 11/2/23 and 10/15/24 hand washing competencies revealed there were no concerns regarding her hand hygiene. 8. Review of the February 20, 2024, Hand Hygiene policy revealed: *This facility considers hand hygiene the primary means to prevent the spread of infections. *All personnel shall follow the hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. *Vigorously lather hands with soap and rub them together, creating friction to all surfaces. For at least twenty (20) seconds under a moderate stream of running water, at a comfortable temperature. 43844

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 40788 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (68) who received an antibiotic for a potential urinary tract infection (UTI) had met clinical criteria for the use of that antibiotic. Findings include: 1. Review of resident 68's electronic medical record revealed: *Her diagnoses included diabetes, peripheral vascular disease, depression, insomnia, and anorexia. *A 12/4/24 medical provider progress note. Chief complaint: nursing requested to see pt [patient] - mood changes. Nursing note in hucu: [an electronic communication used by facility nursing staff to communicate with the medical provider]. Please add to schedule regarding depression . Intakes are 0-25% and 7 refused meals poss [possibly] d/t [due to] depression. Mirtazapine [an anti-depressant sometimes used as an appetite stimulant] dose increased. *A 12/6/2024 Health Status Note entered at 11:25 a.m.: Bath aid told this nurse to go look at residents floor. Nurse entered room and white milky urine was on floor from resident. Complains of dysuria [pain or discomfort when urinating] and has not been acting like herself. Low appetite. New order obtained to collect UA [urinalysis]. -The resident's last documented vital signs were 11/15/24. There was no description of what not acting like herself had meant. A diminished appetite, weight loss, and mood changes were not new symptoms for the resident. *A 12/6/24 medical provider progress note: Visit Type: Acute. Chief complaint: Nursing requested to see pt - recheck weight and UA order. History of present illness: Nursing note in hucu: Milky urine noted again. Complaints of dysuria. Acting not like herself. -The medical provider ordered: Labs-UA with micro; reflex to culture, can straight cath [a thin, flexible tube used to drain urine from the bladder] if needed, CBC [complete blood count], BMP [basic metabolic panel]. -Start cefdinir [an antibiotic], 300 mg PO [by mouth] BID [twice daily] x 7 days for potential UTI [urinary tract infection]. -Recheck 12/09/24 to review labs. *A Medication Administration Note on 12/6/24 at 11:15 p.m. regarding the physician's order that indicated Unable to obtain (the UA). *A 12/8/24 Infection Note: Resident continues oral antibiotic therapy for UTI, no adverse reaction to medication noted. UA to be collected this evening for C & S. No c/o pain or discomfort. Continue to monitor. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*A 12/9/24 provider progress note indicated the resident's UA was not obtained and an antibiotic had already been started for a potential UTI. Will DC [discontinue] UA and continue to monitor. The resident was stable and looked to be improved. Interview on 12/11/24 at 1:20 p.m. with licensed practical nurse (LPN) F regarding documentation of the nurse assessment and reporting of a suspected UTI to the medical provider revealed a progress note such as the 12/6/24 Health Status Note was used. Interview on 12/11/24 at 4:15 p.m. with assistant director of nursing (E) regarding the nurse assessment and communication tool used by nursing staff to report to a medical provider a resident suspected of having a UTI revealed: *An Agency for Healthcare Research and Quality Suspected UTI SBAR (Situation, Background, Assessment, and Recommendation) form was expected to have been completed by the nurse. -A copy of that form was found at the first floor nurses' station but not found at the second floor nurses' station. Interview on 12/11/24 at 1:10 p.m. with infection preventionist (IP)/LPN T regarding resident 68's potential UTI revealed: *There was no documentation to support: -Why the medical provider's order for a UA was unable to have been obtained. -If any other attempts had been made to collect the resident's urine sample. -If the resident's medical provider was notified regarding the inability to have obtained a UA. -A UTI SBAR form was completed by the nurse upon suspecting the resident had a UTI. -The antibiotic ordered and administered to resident 68 for a suspected UTI had met clinical criteria for use without an appropriate clinical assessment completed by a nurse or a UA having been completed. Review of the 12/7/24 McGeer Criteria for Infection assessment and interview on 12/11/24 at 4:30 p.m. with IP/LPN T revealed: *She had completed that assessment. *Both specific signs and symptoms of a UTI and microbiological criteria were required to support a UTI diagnosis according to that assessment. The assessment indicated resident 68 had met both of those criteria. -IP/LPN T had incorrectly documented that microbiological criteria was met. Review of the provider's revised 2/20/24 Antibiotic Stewardship Program policy revealed: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*It is our Mission to implement an Antibiotic Stewardship Program (ASP) which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use.