STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER: Shannondale Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 7424 Middlebrook Pike Knoxville, TN 37909	

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38810 Based on facility document review, medical record review, and interviews, the facility failed to provide written information to the resident and/or resident representative concerning the right to formulate an advance directive for 22 residents (Resident #103, #156, #34, #5, #69, #45, #14, #102, #356, #67, #31, #47, #73, #99, #96, #8, #65, #3, #22, #12, #21,and #49) of 35 residents reviewed for advanced directives. The findings include: Review of the undated facility document titled, Advanced Directives revealed .On admission the Nurse Liaison inquires if the .resident has any advanced directives. If so, they request a copy and one is placed in the .medical chart .The Social Worker assists .resident .family with obtaining advance directives if requested . Copies are .placed in the .medical chart . Medical record review revealed Resident #103 was admitted to the facility on [DATE] with diagnoses including Hypertension, Anxiety Disorder, and Severe Protein-Calorie Malnutrition. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #103 scored a 5 on the Brief Interview for Mental status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of Resident #103's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #156 was admitted to the facility on [DATE] with diagnoses including Acute Kidney Failure, Hypertension, and Atrial Fibrillation. Review of an admission MDS assessment dated [DATE], revealed Resident #156 scored an 11 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of Resident #156's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure, Anxiety Disorder, and Type 2 Diabetes. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an annual MDS assessment dated [DATE], revealed Resident #34 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of Resident #34's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure, Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease (COPD). Review of a quarterly MDS assessment dated [DATE], revealed Resident #5 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Review of Resident #5's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #69 was admitted to the facility on [DATE] with diagnoses including Atrial Fibrillation, COPD, and Pulmonary Hypertension. Review of a quarterly MDS assessment dated [DATE], revealed Resident #69 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Review of Resident #69's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #45 was admitted to the facility on [DATE] with diagnoses including Hypertension, Type 2 Diabetes, and Depression. Review of a quarterly MDS assessment dated [DATE], revealed Resident #45 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Review of Resident #45's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including Malignant Neoplasm of Lung, Hypertension, and Adult Failure to Thrive. Review of an annual MDS assessment dated [DATE], revealed Resident #14 was rarely or never understood. Review of Resident #14's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #102 was admitted to the facility on [DATE] with diagnoses including Hypertension, Adult Failure to Thrive, and Neoplasm of Prostate. Review of an admission MDS assessment dated [DATE], revealed Resident #102 scored a 9 on the BIMS assessment which indicated the resident had moderate cognitive impairment. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #102's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #356 was admitted to the facility on [DATE] with diagnoses including Atrial Fibrillation, Congestive Heart Failure, and Abdominal Aortic Aneurysm. Review of a 5-day admission MDS assessment dated [DATE], revealed Resident #356 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of Resident #356's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including Atrial Fibrillation, Hypertension, and Chronic Kidney Disease. Review of a quarterly MDS assessment dated [DATE], revealed Resident #67 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of Resident #67's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, End Stage Renal Disease, and Dementia. Review of a quarterly MDS assessment dated [DATE], revealed Resident #31 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of Resident #31's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #47 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, Atrial Fibrillation, and Type 2 Diabetes. Review of a quarterly MDS assessment dated [DATE], revealed Resident #47 scored a 12 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of Resident #47's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including Dementia, Heart Failure, and Visual Hallucinations. Review of a quarterly MDS assessment dated [DATE], revealed Resident #73 scored a 00 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of Resident #73's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review revealed Resident #99 was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease, Type 2 Diabetes, and Hypertension. Review of an admission MDS assessment dated [DATE], revealed Resident #99 scored a 12 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of Resident #99's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #96 was admitted to the facility on [DATE] with diagnoses including Anxiety Disorder, Hypertension, and Obesity. Review of a quarterly MDS assessment dated [DATE], revealed Resident #96 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of Resident #96's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including COPD, Heart Failure, and Alzheimer's Disease. Review of an annual MDS assessment dated [DATE], revealed Resident #8 scored an 11 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of Resident #8's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #65 was admitted to the facility on [DATE] with diagnoses including Acute and Chronic Respiratory Failure, Hypertension, and Anxiety Disorder. Review of a quarterly MDS assessment dated [DATE], revealed Resident #65 scored an 8 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of Resident #65's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Malignant Neoplasm of Prostate, Old Myocardial Infarction, and Hypertension. Review of a quarterly MDS assessment dated [DATE], revealed Resident #3 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of Resident #3's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including COPD, Heart Failure, and Hypertension. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly MDS assessment dated [DATE], revealed Resident #22 scored an 8 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of Resident #22's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Delusional Disorders, Alzheimer's Disease, and Chronic Kidney Disease. Review of a quarterly MDS assessment dated [DATE], revealed Resident #12 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of Resident #12's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction (stroke), COPD, Vascular Dementia, and Anxiety Disorder. Review of a quarterly MDS assessment dated [DATE], revealed Resident #21 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of Resident #21's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. Medical record review revealed Resident #49 was admitted to the facility on [DATE] with diagnoses including COPD, Hyperkalemia (High level of potassium), and Bacterial Infection. Review of a quarterly MDS assessment dated [DATE], revealed Resident #49 scored an 11 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of Resident #49's medical record revealed no written information to the resident and/or resident representative concerning the right to formulate an advance directive. During an interview on 5/29/2024 at 1:00 PM, Nurse Liaison H stated she was responsible to complete the admission paperwork with residents and/or the resident's representative. The Nurse Liaison confirmed she did not provide written information to the resident and/or resident representative concerning the right to formulate an advance directive. During an interview on 5/29/2024 at 4:45 PM, the Social Worker confirmed the facility did not provide written information to the residents and/or resident representative concerning the right to formulate an advance directive. During an interview on 5/31/2024 at 10:20 AM, the Director of Nursing confirmed the facility did not provide written information to the residents and/or resident representative concerning the right to formulate an advance directive.

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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** 36003 Based on facility policy review, review of the Resident Assessment Instrument (RAI) Manual 3.0, medical record review, and interviews, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 2 residents (Resident #21 and #34) of 35 residents reviewed. The findings include: Review of the RAI Manual 3.0 dated 10/1/2023 revealed . primary purpose as an assessment instrument is to identify resident care problems that are addressed in an individualized care plan .the assessment [MDS] accurately reflects the resident's status .registered nurse conducts or coordinates each assessment .One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status .Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring .during the 7-day look-back period . Medical record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Cerebral Infarction (stroke), Delusional Disorders, Chronic Obstructive Pulmonary Disease (COPD), Vascular Dementia, Anxiety Disorder, and Depression. Review of hospital discharge documentation for Resident #21 dated 3/17/2024, revealed the resident's discharge diagnoses included Acute Encephalopathy, COPD, Chronic Respiratory Failure, Acquired Obstructive Hydrocephalus, Cervical Stenosis of Spinal Canal, HTN, Dementia with Psychosis, and history of Cardiovascular Accident (stroke). Review of the quarterly MDS assessment dated [DATE], revealed Resident #21 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had severe cognitive impairment. Continued review revealed the resident had an active diagnosis of Pneumonia. Review of Resident #21's medical record revealed a diagnosis of Pneumonia had not been documented. During an interview on 5/31/2024 at 11:41 AM, the MDS Coordinator confirmed Resident #21 did not have a diagnosis of Pneumonia and confirmed the quarterly MDS assessment dated [DATE] was inaccurate for Resident #21. 50216 Medical record review revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Anemia, Diabetes Mellitus, Hypothyroidism, and Generalized Muscle Weakness. Review of nurse's note for Resident #34 dated 3/6/2023, revealed the resident had natural lower teeth and no upper teeth. Review of the admission MDS dated [DATE], revealed Resident #34's had no dental issues. Review of the annual MDS dated [DATE], revealed Resident #34 had no dental issues. (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 the medical record for Resident #34 revealed no documentation showing the resident had been asked about seeing a dentist or been seen by a dentist. During an interview on 5/30/2024 at 11:00 AM, the DON stated there was no documentation that showed Resident #34's oral condition had been assessed by a nurse or a dentist since the admission assessment. During an interview on 5/30/2024 at 2:25 PM, the MDS Coordinator stated the facility failed to assess the resident oral status. The MDS Coordinator stated it is the MDS Coordinator's responsibility to assess the oral cavity for the MDS and mark the MDS accordingly.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837 Based on medical record review and interview, the facility failed to resubmit a Pre-Admission Screening and Resident Review (PASRR) after a new mental health diagnoses was identified to the state-designated authority for 1 resident (Resident #73) of 14 residents reviewed for PASRR. The findings include: Medical record review revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including Dementia, Anxiety, Panic Disorder and Adult Failure to Thrive. Review of a quarterly Minimum Data Set assessment dated [DATE], revealed Resident #73 scored a 3 on the Brief Interview for Mental Status Score (BIMS) which indicated the resident had severe cognitive impairment. The resident had a diagnoses of psychosis. Review of a PASRR for Resident #73, dated 5/1/2020, revealed .the following mental health conditions that are diagnosed .for this individual .Anxiety Disorder .Panic Disorder .If changes occur or additional information suggests .mental illness .rescreening should occur . Review of Resident #73's medical record revealed a new diagnoses of Psychosis was dated 6/12/2020. During an interview on 5/30/2024 at 8:38 AM, the Director of Nursing confirmed a new PASSR should have been submitted after the new mental health diagnosis of Psychosis was added on 6/12/2020.

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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** 45837 Based on facility policy review, medical record review, observation and interviews, the facility failed to revise a comprehensive care plan with new interventions after falls for 2 residents (Residents #37 and #306) of 35 resident care plans reviewed. The findings include: Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, revealed . comprehensive, person-centered care plan .reflects currently recognized standards of practice for problem areas and conditions .interdisciplinary team reviews and updates the care plan .when the desired outcome is not met . Medical record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including Dementia, Pneumonia and Muscle Weakness. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #37 scored a 7 on the Brief Interview for Mental Status Score (BIMS) which indicated the resident had severe cognitive impairment and had 2 falls with no injury since last assessment. Review of Resident #37's care plan reviewed on 4/3/2024, revealed the resident was at risk for falls related to generalized weakness and difficulty walking. Interventions included keeping the bed in lowest position dated 9/2/2021, and mats to the bedside dated 11/13/2021. There was no intervention documented on the care plan for a fall on 5/9/2024. Review of Resident #37's medical record revealed a Falls Investigation Report dated 5/9/2024 which revealed the resident had an unwitnessed fall. The resident was found in the floor, was assessed, and no injuries were found. Fall interventions were documented to be in place at the time of the fall. Review of a Nurse's Notes for Resident #37 dated 5/9/2024, revealed the resident .was observed sitting on buttocks with back against the side of bed .on mats .No injuries .Informed house supervisor .Neuro [neurological] checks . During an interview on 5/29/2024 at 4:01 PM, the MDS Coordinator stated Resident #37 had a falls care plan but no new interventions were added to the care plan after the fall on 5/9/2024. The Coordinator stated it was her job to update the care plan interventions after a fall. 49568 Medical record review revealed Resident #306 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Atrial Fibrillation. Review of a Baseline Care Plan dated 5/16/2024, revealed Resident #306 had a .History of falls/At risk - Interventions .nonskid socks when out of bed . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an admission MDS assessment dated [DATE], revealed Resident #306 scored a 9 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of the Falls Investigation Report dated 5/27/2024, revealed Resident #306 was found sitting on the floor beside his bed after falling from wheelchair. The immediate intervention was to place anti roll backs (device prevents wheelchair from rolling back as the user attempts to sit or stand) to wheelchair. Review of the Physician's Orders for Resident #306 dated 5/27/2024, revealed anti roll backs applied to wheelchair for safety. Review of the comprehensive care plan dated 5/27/2024, revealed no documentation anti roll backs had been added to the care plan. During an observation on 5/28/2024 at 12:20PM, revealed Resident #306's wheelchair with anti roll backs in place. During an observation on 5/29/2024 at 9:05 AM, revealed Resident #306's wheelchair with anti roll backs in place. During an observation on 5/30/2024 at 9:10AM, revealed Resident #306's wheelchair with anti roll backs in place. During an interview on 5/30/2024 at 2:20 PM, the Director of Nursing (DON) stated anti roll backs were added to Resident #306's wheelchair after fall on 5/27/2024. The DON stated it fall risk interventions were added to prevent falls, the resident's plan of care should be revised to reflect those additions. The DON confirmed Resident #306's care plan had not been updated to reflect the fall prevention intervention for anti roll backs after the fall on 5/27/2024.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003 Based on review of facility policy, observations, and interviews the facility failed to provide personal grooming for 1 resident (Resident #79) of 35 residents reviewed. The findings include: Review of the facility's policy titled Activities of Daily Living (ADL), Supporting, revised 3/2018, revealed . Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living .Residents who are unable to carry out activities of daily living independently will receive .grooming and personal and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with .Hygiene (bathing, dressing, grooming .) . Medical record review revealed Resident #79 was admitted to the facility on [DATE] with diagnoses including Anemia, Candidiasis (yeast), and Bacterial Infection. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #79 scored a 13 on the Brief Interview for Mental Status assessment which indicated the resident was cognitively intact. The resident was dependent on staff for toileting, bathing, and required partial to moderate assistance with personal hygiene. Review of a comprehensive care plan for Resident #79 dated 7/7/2021, revealed staff .Assist [Resident #79] with dressing, grooming, hygiene care daily and prn [as needed] . Review of Resident #79's medical record revealed no documentation the resident had refused nail care. Observation of Resident #79 on 5/28/2024 at 11:38 AM, revealed the resident had long fingernails with brown debris under the nails. Observation of Resident #79 on 5/29/2024 at 9:26 AM, revealed the resident had long fingernails with brown debris under the nails. Observation of Resident #79 on 5/29/2024 at 4:10 PM revealed the resident had long fingernails with brown debris under the nails. Observation of Resident #79 on 5/30/2024 at 10:07 AM revealed the resident had long fingernails with brown debris under the nails. During an observation and interview on 5/30/2024 at 2:15 PM, Resident #79's fingernails were long and had brown debris under the nails. The resident stated she would like to have her nails trimmed.I don't like them [fingernails] to be long .don't do anything but get dirty . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation of Resident #79 on 5/30/2024 at 3:07 PM, Certified Nursing Assistant (CNA) J confirmed Resident #79 had brown debris under her fingernails. During an interview and observation of Resident #79 on 5/30/2024 at 3:10 PM, Licensed Practical Nurse (LPN) C confirmed Resident #79 had brown debris under her fingernails. During an interview on 5/31/2024 at 11:41 AM, the Director of Nursing stated she expected nail care to be provided for residents with daily care and when resident's nails were long or dirty.

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Shannondale Health Care Center	7424 Middlebrook Pike Knoxville, TN 37909

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50407

Based on facility policy review, safety data sheet review, medical record review, observations, and interviews the facility failed to ensure chemicals were secured for 1 resident (Resident #25) and failed to ensure medications were secured for 1 resident (Resident #27) of 35 residents observed.

The findings include:

Review of the facility policy titled Self-Administration of Medications, revised 2/2021 revealed .the interdisciplinary team (IDT) assesses each resident's cognition and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident .Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

Review of the facility's undated policy titled, Hygiene and Grooming Supplies, revealed .The resident's grooming needs are met while addressing . personal preferences and daily routine .all supplies are kept secured .if a resident has a BIMS [Brief Interview for Mental Status] score of 8 or above .may utilize a locked drawer in .room to store .grooming supplies .

Review of the facility's undated policy titled, Chemical Handling and Storage, revealed .Store all hazardous material in containers .segregate .by hazard class .flammable .do not leave chemicals unattended .all chemicals are kept behind .closed locked door when not in use .

Review of a Safety Data Sheet dated 9/2/2015, revealed .Nail Polish Remover .Hazard Identification . flammable liquid .

Review of a Safety Data Sheet revised 3/2016, revealed .Glade Aerosol .Flammable .

Medical record review revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease, Atrial Fibrillation, and Chronic Congestive Heart Failure.

Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #25 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact.

During an observation in Resident #25's room on 5/28/2024 at 1:15 PM, revealed an unsecured full 10- fluid ounce (oz) bottle of nail polish remover and an 8 oz aerosol can of Glade air freshener unsecured on the resident's bedside dresser. Further observation revealed Resident #25 had a private room.

During an interview on 5/20/2024 at 2:42 PM, Licensed Practical Nurse (LPN) F confirmed a full 10 oz bottle of nail polish remover, and an 8 oz aerosol can of Glade air freshener was left unsecured on Resident #25's bedside dresser. LPN F stated there were no wandering residents observed going into the resident's room.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2024 at 4:00 PM, Certified Nursing Assistant (CNA) G, reported Resident #25 kept her door closed when she was not in the room. CNA G further reported she had not witnessed residents wandering into Resident #25's room. During an interview and observation on 5/30/2024 at 1:45 PM, Resident #25 stated she was aware to keep the nail polish remover and aerosol air freshener in a secure location and not to drink the nail polish remover. Resident #25 also stated she kept her door closed to the room and no other residents had wandered into her room. During observations from 5/28/2024-5/31/2024 at various times of the day showed no wandering residents on the 300-hallway (hallway Resident #25 resides). During an interview on 5/30/2024 at 3:45 PM, the Director of Nursing (DON) stated chemicals should not be left unsecured in a resident's room. The DON confirmed the nail polish remover and aerosol air freshener observed in Resident #25's room should be stored in a secure location and not left on the bedside dresser. 50216 Medical record review revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including Presence of Left Artificial Hip Joint, Pain in Left Hip, Atrial Fibrillation, and Anemia. Review of the Physician's Orders for Resident #27 dated 3/6/2023 revealed there was not an order for a multivitamin. Review of an admission MDS assessmen dated 3/13/2024, revealed Resident #27 scored 15 on the BIMS which indicated the resident was cognitively intact. During an observation and interview on 5/28/2024 at 2:30 PM, in Resident #27's room an unsecured 200-count bottle of multivitamins was observed on the sink counter. During an interview Resident #27 stated she had not been assessed for self-administering medications. Resident #27stated she brought the vitamins in when she admitted to the facility, and she kept the bottle on her counter. During an observation on 5/29/2024 at 3:45 PM, revealed the multivitamin bottle was unsecured in Resident's #27 room. During an interview and observation on 5/29/2024 at 3:50 PM, LPN I stated residents had to be assessed and monitored to self-administrater medication. LPN I stated a resident's medications should be locked up in the room if the resident has been assessed to be safe to self-administer their medications. LPN I stated Resident #27 had not been assessed to self administer medications. LPN I went to Resident #27's room and verified there was a 200-count bottle of multivitamins in the resident's room. LPN I removed the multivitamins from the room after permission was given from Resident #27. During an interview on 5/29/2024 at 4:00 PM, Registered Nurse (RN) K stated Resident #27 had not been assessed for self- administration of medication and the multivitamin bottle should not have been left in the room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2024 at 4:15 PM, the DON stated medications are not supposed to be left unsecured in a resident 's room. Medications should have been picked up and taken to the nurses' station.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786 Based on facility policy review, medical record review, and interview, the facility failed to document the fluid restriction amount and the amount consumed by the resident each shift on the Medication Administration Record (MAR) for 1 resident (Resident #31) of 1 resident reviewed for fluid restrictions. The findings include: Review of the facility's policy titled, Fluid Restriction, revised 5/10/2023, revealed .The fluid restriction amount .amount designated for each department .will be documented in the Physician order .and on the MAR .Fluid amount consumed .will be documented each shift .placed on the MAR . Medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including Edema, Acute Kidney Failure, and End Stage Renal Disease Requiring Renal Dialysis. Review of the Physician's Orders for Resident #31 dated 11/30/2023, revealed the resident was on a fluid restriction of 960 ml (milliliter)/day. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #31 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. During an interview on 5/30/2024 at 1:38 PM, Licensed Practical Nurse (LPN) F stated Resident #31 was on a 960 ml/day fluid restriction, nursing provided 120 ml of the fluid ordered per shift, and dietary provided the remainder. LPN F confirmed the amount of fluid consumed by the resident was not documented on the MAR. During an interview on 5/30/2024 at 2:08 PM, Certified Nursing Assistant (CNA) L stated Resident #31 was on a fluid restriction, the resident did not have a water pitcher at her bedside, the CNAs do not offer fluids, and hydration was provided by dietary and nursing. During an interview on 5/31/2024 at 9:21 AM, Resident #31 stated she was aware of her fluid restriction of 960 ml/day. She stated the CNAs do not offer her fluids and she did not have a water pitcher at her bedside. The resident stated she received fluids from dietary on her tray and nursing. The resident also stated she knew how much fluid she was allowed to have daily, and staff did not offer her more fluid than she was allowed. Review of the MAR for Resident #31 dated 5/1/2024-5/31/2024 revealed no documentation of the fluid restriction amount and the amount consumed by the resident each shift. During an interview on 5/31/2024 at 12:15 PM, the Director of Nursing (DON) confirmed the facility failed to document Resident #31's fluid restriction and amount consumed on the MAR.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, medical record review, observation, and interview, the facility failed to develop a Dementia care plan for 2 residents (Resident #12 and #21) of 5 residents reviewed for Dementia Care. The findings include: Review of the facility policy titled, Dementia- Clinical Protocol, revised 11/2018, revealed .For the individual with confirmed dementia, the IDT [Interdisciplinary Team] will identify a resident-centered care plan to maximize remaining function and quality of life . Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Dementia with Psychotic Disturbance, Alzheimer's Disease, and Vascular Disorder of the Intestine. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #12 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Active diagnoses for Resident #12 included Alzheimer's Disease and Non-Alzheimer's Dementia. Review of the comprehensive care plan revealed Resident #12 was not care planned for Dementia. During observations from 5/28/2024 - 5/30/2024, no concerns were observed related to the resident's behaviors or Dementia diagnosis. During an interview and review of Resident #12's medical record on 5/30/2024 at 2:32 PM, the Director of Nursing (DON) confirmed Resident #12 had a diagnosis of Dementia and Alzheimer's Disease. The DON confirmed Resident #12's care plan did not address the resident's Dementia or Alzheimer's disease diagnoses. The DON confirmed it was her expectation that residents with Dementia were care planned for Dementia with person-centered interventions to address Dementia behaviors/needs. During an interview on 5/30/2024 at 3:04 PM, the MDS Coordinator stated she was responsible for care plans. The MDS Coordinator confirmed Resident #12 had a diagnosis of Alzheimer's Disease and Dementia on the quarterly MDS assessment dated [DATE], and should have been care planned for both diagnoses. The MDS Coordinator confirmed Resident #12 did not have a Dementia or Alzheimer's Disease care plan. Medical record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Delusional Disorder, and Severe Vascular Dementia. Review of a quarterly MDS assessment dated [DATE], revealed Resident #21 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment. Active diagnoses for Resident #21 included Non-Alzheimer's Disease and Vascular Dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan revealed Resident #21 was not care planned for Dementia. During observations from 5/28/2024 - 5/30/2024, no concerns were observed related to the resident's behaviors or Dementia diagnosis. During an interview and review of Resident #21's medical record on 5/30/2024 at 2:39 PM, the DON confirmed Resident #21 had a diagnosis of Vascular Dementia and was not care planned for the diagnosis. The DON confirmed residents with Dementia were to have a person-centered care plan for Dementia. During an interview on 5/30/2024 at 3:02 PM, the MDS Coordinator confirmed Resident #21 had a diagnosis of Dementia on the quarterly MDS assessment dated [DATE]. The MDS Coordinator confirmed the resident did not have a Dementia care plan and stated .if it's on the MDS, it should be on the care plan .we must have thought it was already on there [the care plan] .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480 Based on facility policy review, medical record review and interviews the facility failed to provide evaluation and rational for continued use of a PRN (as needed) antianxiety medication for 1 resident (Resident #16) of 5 residents reviewed for unnecessary medications. The findings include: Review of the facility policy titled, Psychotropic Medication Use, revised 7/2022, revealed .Residents will not receive medications that are not clinically indicated to treat a specific condition .A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior .Drugs in the following categories are considered psychotropic medications .Anti-anxiety medications .psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition document in the medical record .PRN orders for psychotropic medications are limited to 14 days . Medical record review revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including Dementia, Depression, and Anxiety. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #16 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of the Physician's Orders for Resident #16 dated 10/23/2023, revealed .ATIVAN [drug affecting the brain used to treat anxiety] 0.5MG [milligram] TABLET .every 6 hours as needed for anxiety x [times/for] 14 days .Discontinue Date: 10/27/2023 . Review of the Physician's Orders for Resident #16 dated 10/27/2023, revealed .ATIVAN 0.5MG TABLET .1/2 tablet [0.25 mg] .every 6 hours as needed . Further review revealed there was no stop date for the PRN anti-anxiety medication. During a telephone interview on 5/30/2024 at 4:45 PM, Nurse Practitioner (NP) Q confirmed Resident #16's PRN Ativan 0.25 mg order did not have a stop date, the resident had not been evaluated for continued use of the anti-anxiety medication, and a rationale had not been documented. During an interview on 5/30/2024 at 5:17 PM, the Director of Nursing (DON) confirmed Resident #16's PRN Ativan 0.25 mg order did not have a stop date. During a telephone interview on 5/31/2024 at 1:45 PM, the Pharmacist Consultant confirmed Resident #16 did not have pharmacy recommendations to discontinue the use of the PRN Ativan 0.25 mg.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480 Based on facility policy review, observations, and interviews the facility failed to label and date 1 medication on 1 medication cart of 3 medication carts observed, failed to assure medications were secure on 1 medication cart of 3 medication carts observed, failed to secure medications in 1 medication room of 2 medication rooms observed, and failed to remove expired supplies from 1 medication room of 2 medication rooms observed for medication storage. The findings include: Review of the facility's policy titled, Medication Labeling and Storage, revised ,d+[DATE], revealed . Compartments .including .carts .containing medications .are locked when not in use and .carts used to transport such items are not left unattended if open or .potentially available to others .Controlled substance . subject to abuse are separately locked in permanently affixed compartments .Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices .The medication label includes .medication name . expiration date .resident's name .Multi-dose vials that have been opened or accessed .are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial . During an observation of medication administration on the 400 hall on [DATE] at 8:37 AM, with Licensed Practical Nurse (LPN) C revealed an insulin pen was observed in the medication cart with other vials of medications. The insulin pen did not have a pharmacy label, a resident name, or an open date. The LPN was prepared to use the unlabeled insulin pen, and surveyor stopped LPN C before the insulin pen was used. LPN C confirmed she did not know when the insulin pen was opened and it should not have been used. During an observation of medication administration on the 300 Hall on [DATE] at 8:40 AM, with Licensed Practical Nurse (LPN) N revealed the LPN prepared medications for Resident #16. Further observation revealed, the LPN left the cart against the wall, walked away from the unlocked medication cart, entered the resident's room, and administered Resident #16's medications. During an interview on [DATE] at 8:45 AM, LPN N confirmed she walked away from the unlocked medication cart, entered Resident #16's room to administer medications, and the medication cart was left unsecured and out of sight. During an interview on [DATE] at 4:00 PM, Registered Nurse (RN) K confirmed insulin pens were to be dated when opened and labeled with the resident's information. During an interview on [DATE] at 4:15 PM, the Director of Nursing (DON) confirmed when the insulin pen or vial was opened, the nurses were responsible to date the pen or vial when opened and ensured it was labeled with the resident's information. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 4:40 PM, the medication room door was propped open, left unattended, and 2 packs of medications were left on a table inside the medication room unsecured. During an observation and interview on [DATE] at 4:45 PM, with LPN O revealed the medication room door was propped open with 2 packs of medications lying unsecured on a table in the medication room. LPN O confirmed 1 pack of the medication was .Hydrocodone 7.5 mg [milligram]/ 325mg APAP [Acetaminophen] . 30 tablets . LPN O also confirmed the second pack of medication was .Oxycodone 5mg XXX,d+[DATE] tabs [tablets] .14 tablets . LPN O confirmed Hydrocodone APAP 30 tablets and Oxycodone 14 tablets were left unsecured and the medications were not in her visual site. During an observation and interview on [DATE] at 4:51 PM, with LPN P in the medication room revealed: 59- 1 ml (milliliter) 27 gauge x (by) ,d+[DATE] inch syringes with an expiration date of [DATE] available for resident use. 2- 24 gauge x 0.75 inch Instaflash (to start an IV) needle with an expiration date of [DATE] available for resident use. 2- IV (intravenous) Start Kits with the following contents, 1 Tourniquet, 1 PVP (Povidone-Iodine Prep) prep pad, 1 Alcohol prep pad, 2 non-woven gauze 2 x 2 inch, 1 transparent bandage dressing 2.37 x 2.75 inch, 1 roll of 2 inch tape with an expiration date of [DATE] available for resident use. 5- C&S (culture and sensitivity) Transfer straw kit (used to collect urine specimen) 4.0 ml with an expiration date of ,d+[DATE] available for resident use. During an interview on [DATE] at 4:50 PM, LPN P confirmed 59 syringes, 2 Instaflash needles, 2 IV start kits with contents, 5 C&S transfer straw kits were expired, stored in the medication room, and available for use. During an interview on [DATE] at 5:15 PM, The Pharmacy Director and the Pharmacist confirmed Hydrocodone APAP 30 tablets and Oxycodone 14 tablets were scheduled 2 narcotics and were to be secured behind 2 locked areas. They also confirmed 59 syringes, 2 Instaflash needles, 2 IV start kits with contents, 5 C&S transfer straw kits were expired. During an interview on [DATE] at 5:17 PM, the Director of Nursing (DON) confirmed during medication administration observation on [DATE] the medication cart should not have been left unsecured on the 300 hall. The DON also confirmed Hydrocodone APAP 30 tablets and Oxycodone 14 tablets were to be secured behind 2 locked areas and the 59 syringes, 2 Instaflash needles, 2 IV start kits with contents, 5 C&S transfer straw kits were expired.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50216 Based on facility policy review, medical record review, observation, and interview the facility failed to arrange dental care for 1 (Resident #34) of 3 residents reviewed for dental care. The findings include: Review of the facility policy titled, Dental Services revised 12/2016, revealed .Routine and 24-hour dental services are provided to our residents through .a contract agreement with licensed dentist that comes to the facility monthly .referral to the resident's personal dentist .referral to community dentist .referral to other health care organizations that provide dental care . Medical record review revealed Resident #34 was admitted to the facility on [DATE], with diagnoses including Anemia, Diabetes Mellitus, Hypothyroidism, and Generalized Muscle Weakness. Review of a Nurse Note written 3/6/2023, revealed Resident #34 had no upper teeth and was missing some lower teeth. Review of an annual Minimum Data Set (MDS) dated [DATE], revealed Resident #34 scored 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. During observations and interview on 5/28/2024 at 11:39 AM, Resident #34 was observed lying in bed watching television. The room had a foul odor like bad breath. Resident #34 was observed to have missing and discolored teeth. Resident #34 stated she had not been asked if she wanted to see a dentist. Resident #34 stated a desire to see a dentist. Review of monthly weight checks for Resident #34 revealed the resident did not have any significant weight loss or gain. A review of Resident #34's medical record revealed no assessment of the resident's mouth by a nurse or dentist could be found. During an interview on 5/30/2024 the Director of Nursing (DON) stated there was no documentation in Resident #34's medical record the resident had seen a dentist since admission.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 49568 Based on facility policy review, observation, and interview, the facility failed to ensure garbage and refuse were properly contained in 1 of 6 dumpsters. The findings include: Review of the facility's policy titled, Trash Disposal, dated 8/23/2023, revealed .dispose of trash appropriately and maintain the dumpster area for cleanliness and prevention of rodents .and that a dumpster plug is securely in place . Observation of the outside dumpster area on 5/28/2024 at 11:20 AM, revealed dumpster #6 did not have a dumpster plug. During an interview on 5/28/2024 at 11:25 AM, the Certified Dietary Manager (CDM) confirmed dumpster #6 did not have a dumpster plug.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49792 Based on facility policy review, medical record review, and interview the facility failed to offer informed consent prior to Pneumococcal vaccine administration for 2 residents (Resident #21 and Resident #38) of 5 residents reviewed for vaccinations. The findings include: Review of the facility's policy titled, Pneumococcal Vaccine (Series), revised 2/7/2023, revealed .Persons who reside in the [Name of Facility] .shall be given the Pneumococcal Immunization on admission unless medically contraindicated or the person has refused .Documented evidence of acceptance or declination against Pneumococcal for each person residing in the [Name of facility] shall be kept on file . Medical record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure, and History of Pulmonary Embolism. Review of the medical record for Resident #21 revealed the resident had not been provided with an informed consent for pneumococcal vaccination. Medical record review revealed Resident #38 was admitted to the facility on [DATE] with diagnoses including Intestinal Obstruction, Chronic Bronchitis, Shingles, and Polyosteoarthritis. Review of the medical record for Resident #38 revealed the resident had not been provided with an informed consent for pneumococcal vaccination. During an interview on 5/30/2024 at 1:45 PM, the Infection Preventionist (IP) stated it was the expectation of the facility that residents were provided with informed consent for pneumococcal vaccination and confirmed there was not an informed consent for Pneumococcal vaccination for Resident #21 and Resident #38.