STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445539	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Care Center of Medina	401 Promise Way Lane Medina, TN 38355

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49269 Based on medical record review, and interview, the facility failed to develop an accurate baseline care plan within 48 hours for 2 of 17 (Resident #47 and #412) sampled residents reviewed for baseline care plans. The findings include: 1. Review of the medical record revealed Resident #47 was admitted to the facility on [DATE], with diagnoses including Extended Spectrum Beta Lactamase (ESBL), Urinary Tract Infection (UTI), Dementia, Fracture of Upper and Lower End of Left Fibula, and Depression. Review of the admission Minimum Date Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #47 was severely cognitively impaired without behaviors. Review of the Baseline Care Plan dated 1/2/2025, revealed risk for complications related to cognitive decline/impaired communication. Resident #47 was on Antidepressants and Psychotropic medication. Resident had an altered thought process related to short- and long-term memory problem. Review of the Baseline Care Plan was not completed within 48 hours of admission. During an interview on 3/11/2025 at 3:28 PM, License Practical Nurse (LPN) B confirmed that Resident #47's care plan was not completed in a timely manner and should have been done within 48 hours of admission. During an interview on 3/11/2025 at 4:00 PM, Director of Nursing (DON) was asked when the baseline care plan should be completed. The DON replied, .The baseline care plan needs to be completed within 48 hours of admission of the resident . The DON was asked if this care plan was completed in a timely manner. The DON replied, .No, it should have been done within 48 hours of admission . 2. Review of the medical record Resident # 412 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Atherosclerotic Heart Disease, Chronic Obstructive Pulmonary Disease, Depression, and Diabetes. Review of the Physician's Orders dated 3/6/2025, revealed .Eliquis [used to treat and prevent blood clots] 5mg [milligrams] q [every] 12 hours for atrial fibrillation .embolism and thrombosis . (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Baseline Care Plan dated 3/6/2025, revealed facility failed to care plan resident for the use of anticoagulant therapy. During an interview on 3/12/2025 at 11:50 AM, the DON confirmed that Resident #412's Baseline Care Plan did not reflect the use of anticoagulant therapy. 51365

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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** 49269 Based on policy review, medical record review, and interview the facility failed to timely notify the physician and failed to reassess pain for a resident with a fall that resulted in a fracture for 1 of 4 (Resident #212) sampled residents reviewed for falls. The findings include: 1. Review of the facility policy titled, Fall Prevention Program, dated 2/2025, revealed .The Fall Prevention Program is designed to ensure a safe environment for all Residents .When fall occurs .Conduct a physical assessment .Notify MD [Medical Director] and transfer to ER [emergency room] for evaluation for obvious injury. Notify nursing supervisor, responsible party, and family . Review of the facility policy titled, Pain Management dated 3/2025, revealed The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice .Manage or prevent pain, consistent with comprehensive assessment and plan of care, current professional standards of practice .The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. Based on professional standards of practice, an assessment or evaluation of pain by appropriate members of the interdisciplinary team (.nurses, practitioner, pharmacists, and anyone else who has direct contact with the resident) may necessitate gathering the following information .Asking the patient to rate the intensity of his/her pain using a numerical scale .Duration of pain, Frequency, Location, Timing, Pattern, Radiation of pain .Obtaining descriptions of the pain (stabbing, aching, pressure, spasms) .Impact of pain on quality of life (sleeping, functioning, appetite and mood) .Physical and psychosocial issues that might be causing or exacerbating the pain .Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences . 2. Review of the medical record revealed Resident #212 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Left femur fracture, Anxiety, and Osteoporosis. Review of the admission Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 15, which indicated that Resident #212 was cognitively intact. Resident required staff assistance with Activities of Daily Living. Review of the Care plan revised on 2/6/2025, revealed .Fractures - I have fractures to the left ankle with ligament injury .Assess for pain level. Administer pain medication as ordered. Observe effectiveness of pain medications . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Incident Case Report documentation dated 2/6/2025 at 12:31 AM, revealed .Type: Fall .Incident location: Resident room .Observations: Alert with Moderately impaired .Foot wear: footwear off . Socks only .Full weight bearing .Uses walker .Bed mobility .Requires assistance .Major injuries: Fracture . Location: Lower extremities/feet .Comments: Resident stated that she was coming back to her bed from the restroom with her rolling walker and her left ankle went out on her and she went down. Resident stated that she did not hit her head but did bend ankle a little. Upon further interview, resident was almost back to the bed, and she went to grab the side rail and her hand slipped, she then was trying to grab onto the bed linens and got tangled and fell .Notified Physician [Nurse Practitioner] on 2/6/2025 at 8:00 AM . Review of the Xray results dated 2/6/2025, revealed .There is fracture involving the medial and lateral malleoli with displacement. The joint is disrupted with medial displaced tibia relative to the talus. There is associated soft tissue swelling. Ankle fractures and ligament injury as described . Review of the Medication Administration Record dated 2/2025, revealed that staff failed to reassess resident's pain after the administration of Hydrocodone/Acetaminophen (used to treat pain) 5/325mg (milligram) at the following times: a. 2/6/2025 at 12:47 AM with resident's pain was 9/10 on pain scale. Resident's pain was not reassessed. b. 2/6/2025 at 12:47 PM with resident's pain 8/10 and reassessed on 2/11/2025 at 10:49 AM as effective decreased pain level 2/10 c. 2/6/2025 at 5:52 PM with resident's pain 7/10 and reassessed on 2/11/2025 at 8:43 AM with medication effective. d. 2/6/2025 at 11:50 PM with resident's pain 10/10 and reassessed on 2/9/2025 at 7:28 PM effective pain 4/10 During an interview on 3/11/2025 at 2:13 PM, the Director of Nursing (DON) confirmed that pain should be reassessed within 1 hour after administration and confirmed that the physician should have been notified immediately of resident's fall.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50408 Based on policy review, medical record review, observation, and interview, the facility failed to follow physician orders and to monitor the oxygen flow rate for 2 of 2 (Resident #59 and #412) sampled residents reviewed for respiratory therapy. The findings include: 1. Review of the facility policy titled, Oxygen Therapy/Administration, dated 11/2018, revealed .The purpose of this procedure is to facilitate breathing by providing supplemental oxygen to Residents so that oxygen concentrations are increased to enhance tissue perfusion .Turn oxygen on the prescribed amount . 2. Review of the medical record revealed Resident #59 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure with Hypoxia [inadequate supply of oxygen to the body's tissues], Pulmonary Hypertension, Pneumonia, and Interstitial Pulmonary Disease. Review of the Physician orders dated 2/21/2025, revealed .02 [oxygen] @ [at] 4LPM [liters per minute] by NC [nasal canula]- Every Shift .to decrease the risk for Hypoxia r/t [related to] to dx [diagnosis] of respiratory failure . Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #59 was cognitively intact. Resident was assessed for shortness of breath or trouble breathing when lying flat and required oxygen therapy. Review of the Progress Note dated 3/6/2025, revealed .continuous 02 via nasal cannula @4l/m, rhonchi noted, shortness of breath . Observations in Resident #59's room on 3/10/2025 at 9:07 AM, 3:48 PM, and 3/11/2025 at 9:26 AM, revealed oxygen set at 3.5 liters/minute. During an interview on 3/11/2025 at 4:25 PM, the Director of Nursing (DON) confirmed that if the order is for oxygen at 4 liters, the concentrator should be set at 4 liters. The DON confirmed that physician orders should be followed. 3. Review of the medical record revealed Resident #412 was admitted to the facility on [DATE], with diagnoses including Alzheimer's, Anxiety Disorder, and Chronic Obstructive Pulmonary Disease. Review of the Physician's Orders 3/6/2025, revealed .O2 [oxygen] at 2 lt/min[liters/minute] by nc [nasal cannula] every shift .to decrease the risk for hypoxia . Observations in Resident #412's room on 3/11/2025 at 9:19 AM, revealed oxygen was set at 5 liters/minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 3/11/2025 at 9:33 AM, Licensed Practical Nurse C confirmed that Resident #412's oxygen was set at 5 liters, and it should have been set at 2 liters as ordered. During an interview on 3/12/2025 at 11:50 AM, the DON confirmed that physician orders should be followed for oxygen flow rates. 51365

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50408 Based on policy review, medical record review, and interview, the facility failed to ensure a resident's medication regimen was free from unnecessary medications in excessive dosages for 1 of 6 residents (Resident #33) sampled for unnecessary medications. The findings include: 1. Review of the facility's policy titled, .Orders for Services . dated 10/2024, revealed .Products, service, treatment, and care are provided in accordance with the most current physician's order .When a written order is received, appropriate staff will verify it for accuracy, completeness, and appropriateness .Service, treatment and/or care will be provided based on the most current written order . 2. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE], with diagnoses including Diabetes, Morbid Obesity, Chronic Obstructive Pulmonary Disease, and Hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #33 has a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #33 was cognitively intact. Review of the Physicians Order dated 11/7/2024, revealed .OZEMPIC [diabetic/weight loss medication] . Subcutaneous [applied under the skin] .Weekly on Thursday .Give 0.25mg [milligrams] x [times] 4 weeks . Review of the Physician Order dated 12/19/2024, revealed .OZEMPIC .Weekly on Saturday . Review of the Medication Administration Record (MAR) dated January 2025, revealed Resident #33 received an Ozempic Injection on 1/2/2025, 1/4/2025, 1/9/2025, 1/16/2025, 1/23/2025. Review of the MAR dated February 2025 revealed Resident #33 received an Ozempic Injection on 2/1/2025, 2/6/2025, 2/13/2025, 2/15/2025, 2/20/2025, 2/27/2025. Review of the MAR dated March 2025 revealed Resident #33 received an Ozempic Injection on 3/6/2025 and 3/8/2025. Resident #33 was receiving the Ozempic injections more than weekly. During an interview on 3/12/2025 at 11:03 AM, Licensed Practical Nurse (LPN) B was shown the January, February, and March 2025 MAR's, and was asked did she sign both Ozempic order injections for Thursday and Saturday in the same week. LPN B stated, If I signed my name, I would have given it, I will look at that order and see if it may be a duplicate order. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/2025 at 11:14 AM, the Director of Nurses (DON) was asked how often a Ozempic Injection should be given. The DON stated, Weekly. The DON was asked should the Ozempic physician order on Thursday's been discontinued. The DON stated, Yes. The DON was asked did Resident #33 receive multiple doses of OZEMPIC injections during some weeks. The DON stated, Yes .I will go get this corrected immediately.

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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** 51365 Based on policy review, medical record review, and interview the facility failed to ensure residents' medication regimen was free of unnecessary medications when the facility failed to provide evaluation and rationale for continued orders for (PRN) as needed psychotropic medications for 2 of 6 (Resident #19 and Resident #412) sampled residents reviewed for unnecessary medications. The finding include: 1. Review of the facility policy titled, Psychotropic Medications, revised 11/2022, revealed .Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition .PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. [that is] 14 days) .If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order . 2.Review of the medical record revealed Resident #19 was admitted to the facility on [DATE], with diagnoses including Anxiety (excessive worry and fear about everyday situations), Depression, Dementia, and Alzheimer's Disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #19 had severe cognitive impairment. Review of the Physician Orders dated 3/2025, revealed .Order Date .11/03/24 [11/3/2024] .Xanax [a controlled substance that is used to treat anxiety disorders] 1 MG TABLET (ALPRAZolam) 1 mg [milligram] Oral PRN BID [twice daily] for . Anxiety disorder . Facility was unable to provide physician documentation to extend the PRN psychotropic medication beyond 14 days or indicate the duration for the PRN psychotropic medication. 3. Review of the medical record Resident # 412 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Anxiety Disorder, Dementia, and Depression. Review of the Physician Orders dated 3/2025, revealed .Order Date .3/06/25 [3/6/2025] .LORAZEPAM [a controlled substance that is used to treat anxiety disorders] 0.5 MG TABLET (LORazepam) 1 TAB [Tablet] Oral PRN BID for .Anxiety Disorder . Facility was unable to provide physician documentation to indicate the duration of the PRN psychotropic medication. During an interview on 3/12/2025 at 11:50 AM, Director of Nursing (DON) confirmed that PRN psychotropic medications should be ordered for 14 days and have a stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51670

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51365 Based on review of rosemontpharma.com, Medlineplus.gov, policy review, medical record review, observation, and interview, the facility failed to ensure 2 of 6 (Licensed Practical Nurse (LPN) F and LPN C) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 2 errors were observed out of 28 opportunities, resulting in a medication error rate of 7.14%. The findings include: 1. Review of the rosemontpharma.com article titled, Information For Patients On The Dangers Of Tablet Crushing, dated 9/2023, revealed . The clinical consequences for the patient of crushing tablets or opening capsules can mean that the drug is less effective or more likely to cause side effects. When crushing disrupts a drug's sustained-release properties, the active ingredient is no longer released and absorbed gradually, resulting in overdose. When a gastro-resistant layer is destroyed by crushing, underdosing is likely . Enteric coatings .These stop the drug breaking down in the stomach, to protect either the stomach or the drug, or to enable it to be released further along the digestive process . Modified or prolonged release .These drugs - also known as extended release, slow release or controlled release - are steadily released, which means they don't have to be taken so frequently . Review of the Medlineplus.gov article titled, Sevelamer, dated 7/20/2024, revealed .Sevelamer is in a class of medications call phosphate binders. It binds phosphorus that you get from foods in your diet and prevents it from being absorbed into your blood stream .It is usually taken three times a day with meals. Follow the directions on your prescription .Take sevelamer exactly as directed . Review of the facility's policy titled, Medication Administration- Unit Dose Cart System, dated 1/2025, revealed .Objective .To correctly administer medications as prescribed .Verify right ordered time for administration . Review of the facility's policy titled, Medication Administration-Feeding Tube, dated 5/2024, revealed .Do not crush enteric coated, sustained-released or sublingual medications . 2. Review of medical record revealed Resident #413 was admitted to the facility on [DATE], with diagnoses including Thrombocytopenia, Dementia, Anxiety Disorder, Hypertension, and Heart Failure. Review of Physician Orders dated 3/7/2025, revealed Potassium Chloride 20 MEQ [milliequivalent] tablet, extended release .1 tablet oral twice a day. [Time: 8:00, 16:00] for Acute on chronic diastolic (congestive) heart failure . Review of Physician Orders dated 3/11/2025, revealed .Buspirone 5mg tablet .1 tablet oral twice a day. [Time: 8:00, 16:00] for generalized anxiety disorder, metabolic encephalopathy . Observation during medication administration on 3/11/2025 at 3:43 PM, revealed LPN F removed the following medications from the cart to administer to Resident #413. a. Buspirone 5 mg tablet 1 tablet. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Furosemide 40 mg tablet 1 tablet. c. Potassium chloride 20 MEQ Extended Release 1 tablet. LPN F crushed the medications including the extended-release potassium, mixed in pudding, entered the room and administered medications to Resident #413, resulting in a medication error for crushing an extended-release medication. During an interview on 3/12/2025 at 11:43 AM, the Director of Nursing (DON) confirmed that extended-release medications should not be crushed. 3. Review of medical record revealed Resident #414 was admitted to the facility on [DATE], with diagnoses including Atrioventricular Block, End Stage Renal Disease, Cardiac Arrhythmia, Anemia, and Diabetes Mellitus. Review of admission MDS assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #414 was cognitively intact. Review of Physician orders dated 3/10/2025, revealed .Sevelamer Carbonate [a phosphate binder used to prevent low levels of calcium for kidney disease] 800 mg [milligram] tablet .3 tabs [tablets] oral with bkfst [breakfast], lun [lunch], and din [dinner] [Time .17:00 [5:00 PM] for chronic kidney disease . Observation during medication administration on 3/11/2025 at 4:05 PM, LPN C removed the following medications from the cart to administer to Resident #414. a. Sevelamer Carbonate 800 mg tablet 3 tablets LPN C removed the medications from the cart, offered medications to Resident #414, resident asked about taking meds with meal, nurse instructed to take before the meal, medication administered, resulting in a medication error for not administering a medication at the scheduled time with the dinner meal. During an interview on 3/12/2025 at 11:43 PM, the DON confirmed that a physician order to administer a medication with meals is for an important reason and should be followed, and that administering a medication that is to be taken with food an hour before a meal is not following the order.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51365 Based on review of rosemontpharma.com, Medlineplus.gov, policy review, medical record review, observation, and interview, the facility failed to ensure 2 of 6 (Licensed Practical Nurse (LPN) F and LPN C) nurses administered medications with a medication error rate of less than 5 percent (%). A total of 2 errors were observed out of 28 opportunities, resulting in a medication error rate of 7.14%. The findings include: 1. Review of the rosemontpharma.com article titled, Information For Patients On The Dangers Of Tablet Crushing, dated 9/2023, revealed . The clinical consequences for the patient of crushing tablets or opening capsules can mean that the drug is less effective or more likely to cause side effects. When crushing disrupts a drug's sustained-release properties, the active ingredient is no longer released and absorbed gradually, resulting in overdose. When a gastro-resistant layer is destroyed by crushing, underdosing is likely . Enteric coatings .These stop the drug breaking down in the stomach, to protect either the stomach or the drug, or to enable it to be released further along the digestive process . Modified or prolonged release .These drugs - also known as extended release, slow release or controlled release - are steadily released, which means they don't have to be taken so frequently . Review of the Medlineplus.gov article titled, Sevelamer, dated 7/20/2024, revealed .Sevelamer is in a class of medications call phosphate binders. It binds phosphorus that you get from foods in your diet and prevents it from being absorbed into your blood stream .It is usually taken three times a day with meals. Follow the directions on your prescription .Take sevelamer exactly as directed . Review of the facility's policy titled, Medication Administration- Unit Dose Cart System, dated 1/2025, revealed .Objective .To correctly administer medications as prescribed .Verify right ordered time for administration . Review of the facility's policy titled, Medication Administration-Feeding Tube, dated 5/2024, revealed .Do not crush enteric coated, sustained-released or sublingual medications . 2. Review of medical record revealed Resident #413 was admitted to the facility on [DATE], with diagnoses including Thrombocytopenia, Dementia, Anxiety Disorder, Hypertension, and Heart Failure. Review of Physician Orders dated 3/7/2025, revealed Potassium Chloride 20 MEQ [milliequivalent] tablet, extended release .1 tablet oral twice a day. [Time: 8:00, 16:00] for Acute on chronic diastolic (congestive) heart failure . Review of Physician Orders dated 3/11/2025, revealed .Buspirone 5mg tablet .1 tablet oral twice a day. [Time: 8:00, 16:00] for generalized anxiety disorder, metabolic encephalopathy . Observation during medication administration on 3/11/2025 at 3:43 PM, revealed LPN F removed the following medications from the cart to administer to Resident #413. a. Buspirone 5 mg tablet 1 tablet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445539	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Care Center of Medina	401 Promise Way Lane Medina, TN 38355

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Furosemide 40 mg tablet 1 tablet. c. Potassium chloride 20 MEQ Extended Release 1 tablet. LPN F crushed the medications including the extended-release potassium, mixed in pudding, entered the room and administered medications to Resident #413, resulting in a medication error for crushing an extended-release medication. During an interview on 3/12/2025 at 11:43 AM, the Director of Nursing (DON) confirmed that extended-release medications should not be crushed. 3. Review of medical record revealed Resident #414 was admitted to the facility on [DATE], with diagnoses including Atrioventricular Block, End Stage Renal Disease, Cardiac Arrhythmia, Anemia, and Diabetes Mellitus. Review of admission MDS assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #414 was cognitively intact. Review of Physician orders dated 3/10/2025, revealed .Sevelamer Carbonate [a phosphate binder used to prevent low levels of calcium for kidney disease] 800 mg [milligram] tablet .3 tabs [tablets] oral with bkfst [breakfast], lun [lunch], and din [dinner] [Time .17:00 [5:00 PM] for chronic kidney disease . Observation during medication administration on 3/11/2025 at 4:05 PM, LPN C removed the following medications from the cart to administer to Resident #414. a. Sevelamer Carbonate 800 mg tablet 3 tablets LPN C removed the medications from the cart, offered medications to Resident #414, resident asked about taking meds with meal, nurse instructed to take before the meal, medication administered, resulting in a medication error for not administering a medication at the scheduled time with the dinner meal. During an interview on 3/12/2025 at 11:43 PM, the DON confirmed that a physician order to administer a medication with meals is for an important reason and should be followed, and that administering a medication that is to be taken with food an hour before a meal is not following the order.

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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** 51365 Based on policy review, medical record review, observation, and interview the facility failed to ensure medications were properly and securely stored when 2 medications were left unattended in a resident's room for 1 of 1 (Resident #22) sampled residents and when 1 of 4 nurses (License Practical Nurse (LPN) A left medications unsecured and unattended at the bedside of Resident #48 during medication administration. The findings include: 1. Review of the facility policy titled, Medication Administration - Self-Administration by Resident, dated 1/2025, revealed .Self-administered medication must be stored in a safe place, which is not accessible to other Residents .As part of their overall evaluation, the staff and practitioner will assess the Resident's mental and physical abilities, to determine whether the Resident is capable of self-administering medications . 2. Review of the medical record revealed Resident #22, was admitted to the facility on [DATE], with diagnoses including, Fracture Lower End Left Femur, Osteoporosis, and Hypothyroidism. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #22 was cognitively intact. During a random observation in Resident #22's room on 3/10/2025 at 8:50 AM,10:35 AM, 11:40 AM, 2:08 PM and 3:50 PM revealed Resident #22 had Tylenol in a basket on the overbed table. During an interview on 3/10/2025 at 4:41 PM, LPN C was taken to resident #22 room and asked if the Tylenol medication should be left unsecured and unattended in the resident's room. LPN C confirmed that medication should not be left in a residents' room unless in a locked boxed, and resident has orders to self-administer medications. 3. Review of the Medical Records revealed Resident #48 was admitted on [DATE], with diagnoses including Dysphagia (difficulty swallowing), Chronic Kidney Disease, Benign Neoplasm (noncancerous mass of abnormal cells), and Malignant Neoplasm (cancerous tumor). Review of the annual MDS assessment dated [DATE], revealed Resident #48 had a BIMS score of 13, which indicated the Resident #48 was cognitively intact. Observation in the hallway during medication administration on 3/11/2025 at 4:33 PM, revealed LPN A prepared the following medications to administer to Resident #48: a. Hydroxyzine hcl (hydrochloride) (used to treat allergies/itching) 25 mg 1 tablet b. Meclizine (a medication to treat motion sickness) 12.5mg 1 tab (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Acetaminophen (a pain reliever) 325 mg 2 tabs LPN A entered the Resident's room, where Resident #48 was up in his wheelchair wheeling himself around in the room. LPN A placed the medications on the bedside table, then entered the bathroom leaving the medications unsecured and unattended, within reach of Resident #48. During an interview on 3/12/2025 at 9:42 AM, the Director of Nursing (DON) confirmed medications should not be in a Resident room unsecured and unattended. The DON stated, .Medication must be kept in a locked box at bedside so other resident cannot access the medication .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51365 Based on policy review, observation, and interview the facility failed to ensure practices to prevent the potential spread of infection were maintained when 2 of 6 nurses (Licensed Practical Nurse (LPN A) failed to clean reusable equipment before and after use, and failed to wear Personal Protective Equipment (PPE) in an enhanced barrier precautions room, and when LPN C failed to properly dispose of sharps. The findings include: 1.Review of the facility policy titled, Medication Administration: Feeding Tube, dated 5/2024, revealed .put on gloves . Review of the facility policy titled, Cleaning of Equipment, dated 9/2021, revealed .Reusable resident-care equipment will be cleaned and disinfected in accordance with the current CDC recommendations in order to break the chain of infection .Reusable multiple-resident items are items that may be used multiple times for multiple residents .Multiple-resident use equipment shall be cleaned and disinfected after each use . Review of the facility policy titled, Enhanced Barrier Precautions, dated 11/2022, revealed .Initiation of Enhanced Barrier Precaution . feeding tubes .Staff will don gown and gloves immediately prior to entering the room for high contact resident care activities .High-contact resident care activities include .feeding tubes . Review of the facility's policy titled, Sharps, dated 8/2024, revealed .It is the policy of this facility to ensure the safety of staff and proper management of sharps .Contaminated sharps will be placed in appropriate sharps containers at the point of use . 2. Review of the Medical Records revealed Resident #48 was admitted on [DATE], with diagnoses including Dysphagia and Gastrostomy. ?? Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the Resident #48 was cognitively intact.? ?? Observation during medication administration on 3/11/2025 at 4:26 PM, revealed Licensed Practical Nurse (LPN) A administered medications and enteral feeding through a PEG (Percutaneous Endoscopic Gastrostomy a feeding tube placed directly into the stomach through the abdominal wall) without the use of PPE (personal protective equipment), and then removed pulse oximeter from pocket, checked Resident #48's oxygen saturation, and returned pulse oximeter to pocket without cleaning or disinfecting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/12/2025 at 11:43 AM, revealed the Director of Nursing (DON) confirmed staff should use PPE when administering medications/feedings through a PEG tube, and stated, .that would be an infection control error . The DON confirmed that a pulse oximeter should be cleaned and not be stored in a pocket or returned to a pocket after use. 3. Review of medical record revealed Resident #414 was admitted to the facility on [DATE], with diagnoses including Atrioventricular Block, End Stage Renal Disease, Cardiac Arrhythmia, Anemia, and Diabetes Mellitus. Review of admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #414 was cognitively intact. Observation during medication administration and blood glucose check on 3/11/25 at 4:05 PM, revealed LPN C entered Resident #414's room, obtained blood glucose check, exited room and disposed of used lancet in trash can on medication cart. During an Interview on 3/12/2025 at 11:50 AM the DON was asked where a used lancet should be disposed of, DON replied, In a sharps box. The DON confirmed a trash can is not appropriate for disposal of a used lancet.