STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455672	A. Building B. Wing	01/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Palms Rehabilitation and Retirement	2101 Treasure Hills Blvd Harlingen, TX 78550

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48278 Based on observation, interviews, and record review, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing and prevent infections for 1 of 3 (Resident #19) residents reviewed for quality of care. The facility failed to ensure LVN C labeled and dated Resident #19's wound treatment dressing after completing wound care on 01/23/2025. This deficient practice could affect residents who receive wound care treatments by placing them at risk for receiving inadequate treatments resulting in the worsening of the wounds. The findings included: Record review of Resident #19's face sheet dated 01/24/2025 reflected a [AGE] year-old female who originally admitted to the facility on [DATE] and readmitted on [DATE]. Pertinent diagnoses included Cerebral Infarction (condition that affects blood flow to the brain), Right hip Osteoarthritis (the breakdown of cartilage that leads to pain and inflammation), Embolism and Thrombosis of superficial veins of left lower extremity (blood clot that occurs in veins under the skin), and Unspecified Protein-Calorie Malnutrition (a disorder caused by a lack of proper nutrition or inability to absorb nutrients from food). Record review of Resident #19's quarterly MDS assessment, dated 11/22/2024, reflected a BIMS score of 03, indicating severe cognitive impairment. Section M, titled Skin Conditions, indicated Resident #19 had one stage four pressure ulcer. Record review of Resident #19's comprehensive person-centered care plan, dated 12/31/2024, reflected Resident #19 had has pressure ulcer or potential for pressure ulcer development r/t cerebral infarction, Right hip Osteoarthritis, Embolism and Thrombosis of superficial veins of left lower extremity. Wounds to sacral area (large, triangular bone at the base of the spine), stage four. The interventions included monitor and report to physician as needed for any changes in skin status: signs and symptoms of infection, appearance, color, wound healing, wound size, stage, and treatments as ordered. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #19's physician order summary, dated 01/24/2025, reflected an order to cleanse sacral wound with wound cleanser, pat dry with gauze. Apply wet to dry (dakins solution) BID. May redress if dressing becomes soiled or dislodged as needed for Stage IV and cover with a dressing. During an observation of a wound treatment for Resident #19, on 01/23/2025 at 02:20 p.m., completed by LVN C. Resident #19's LVN C completed the wound treatment, redressed the wound, and did not label the dressing with date, time, and initials. Upon placing the dressing towards the bottom, LVN C realized Resident #19 had bowel movement and the edge of the dressing touched stool. LVN C completed the wound treatment again, redressed the wound, and again, did not label the dressing. In an interview on 01/23/2025 at 02:45 p.m. with LVN C, she stated she did not label the dressing because it slipped her mind. She stated that she always labels the dressings with her initials, time, and date. LVN C stated it was important to label the dressing with the initials, time, and date for when the doctor makes his rounds, and for other staff to know when it was changed. In an interview on 01/23/2025 at 03:06 p.m. the DON, stated the nurse was to initial, time, and date the wound dressings at the time the dressing was applied. The DON said the importance of dating, putting the time, and initialing the wound dressings was because it was the process, and it was the only way of knowing when the dressing was changed. The DON also stated that the negative outcome of not labeling dressing was that if it does not get changed, the wound can get worse and harbor bacteria. Record review of a facility document titled, Wound Care- Skills Checklist, undated reflected [NAME] tape with initials, time, and date and apply to dressing. Review of facility policy titled, Skin Management System revised date December 2019, reflected Policy: It is the policy of this facility that any resident who enters the facility without pressure ulcers will have appropriate preventive measures taken to ensure that the resident does not develop pressure ulcers, or that resident admitted with wounds will not develop signs and symptoms of infection, unless the residents clinical condition makes development unavoidable.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 49301 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible for 1 of 1 resident (Resident #1) reviewed for accidents. The facility failed to ensure an exit door was secured to prevent elopement. Resident #1 eloped from the facility on 9/19/24 and was found by hospital security guards. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on 9/19/24 and ended on 10/3/24. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of sustaining serious injury, harm, and death. Findings included: Record review of Resident #1's electronic facility face sheet dated 1/24/2025, revealed he was an [AGE] year-old male admitted to the facility on [DATE]. He had diagnoses of mild protein-calorie malnutrition, muscle weakness, and other reduced mobility. Record review of MDS dated [DATE] indicated Resident #1 had moderately impaired cognition with a BIMS score of 10 out of 15. The MDS revealed his mobility functional abilities for self-care were partial/moderate assistance to supervision or touching assistance. Resident #1 had no wandering behavior. Record review of Resident #1's undated care plan revealed elopement from facility on 9/19/24. Interventions included assess for fall risk and document wandering behavior and attempted diversional interventions. Date Initiated: 09/19/2024. Record review of the Incident Report dated 9/19/24 revealed at 9:15 am, MA A noted resident not in his room. Staff alerted and 100 % head count completed, then on-site and off-site search initiated. Facility driver called facility to inform Resident #1 had been in front of neighboring hospital with hospital security guards. DON arrived where resident was located, and resident returned to facility via facility van at approximately 9:58 am. No injuries noted to resident, but resident complained of pain to right knee. As per security guards, resident was found on sidewalk in the grass on his knees and stated he lost balance and fell . Resident voiced wanted to go fishing. Immediate Action Taken: MD, DON, and RP notified. Full body assessment completed. Vital signs taken and within normal limits, resident sent out to ER for evaluation. Record review of SBAR Communication Form dated 9/19/24 completed by RN B, revealed resident had change of condition: patient eloped from facility on 9/19/24, it was unknown if resident had any elopement prior, and resident had increased confusion or disorientation. Record review of the Nursing note dated 9/19/24 completed by DON, revealed elopement risk assessment done by RN B and Resident #1 is high risk and is currently at hospital per MD order. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a History and Physical from hospital Resident #1 was admitted from dated 9/12/24, revealed no previous elopement history. Record review of nursing note dated 9/19/24 revealed at 9:15 am MA A noted Resident #1 was not in his room and could not be found throughout facility. Staff alerted and immediately completed 100% resident head count. On-site and off-site search began immediately, and resident found within minutes across parking lot at neighboring hospital with 2 security guards. Resident brought back to facility via facility van. As per security guard resident was found on sidewalk in the grass on his knees and stated he lost balance and fell . Visual assessment initially completed with no visible abnormalities. Resident stated pain to right knee. Upon arrival to facility, at approximately 9:58 am head to toe assessment completed. Resident's speech clear and coherent and able to answer questions appropriately when asked. No visible injuries or abnormalities noted. No new skin issues noted. Placed call to MD and received orders to transfer resident to ER for evaluation. Placed call to RP and made aware of elopement and transfer to ER. injuries noted to resident, but resident noted with confusion. Record review of document dated 9/19/24 by unknown author with question on first line that says, What was done to prevent incident from reoccurring? revealed Within less than an hour of elopement, maintenance director activated the sound on the East Hall door which was identified as the door the resident used to exit the building. All staff present were in serviced on alarm sound and directed to no longer use East door for regular exit purposes. Record review of the provider investigation report dated 9/26/24 indicated in an interview on 9/19/24 at 10:12 am by DON, Staff A stated during med pass she noticed resident was missing and stated looking for him and couldn't find him, so notified ADON at time that he was missing. Record review of the provider investigation report dated 9/26/24 indicated in an interview on 09/19/2024 at 10:56 am by DON, with RN B stated Resident #1 was last seen resting in room after he ate breakfast. Record review of the Wanderguard Checklist revealed Exit Doors for Main Entrance, Elevator, Bistro, Chandelier, Stairs 1200 Hall, Stairs 1100 Hall, and Hall 1100 were being checked daily from 9/20/24 to 12/31/24. Record review of the Weekly Checklist for Wander System: Door Devices revealed the door devices were checked on 9/19/24, 9/21/24, 9/23/24, 9/27/24, 9/29/24, and 10/1/24. The logs revealed the facility continued to assess door devices from 10/4/21 to 12/20/24 sporadically. Beginning 12/30/24 to 1/17/15 the door devices were checked daily Monday - Friday. Record review of Abuse, Neglect and Exploitation and Elopement in-services and Drills revealed they were conducted on the day of elopement for 1st and 2nd shift on 9/19/24 at 6:35 pm and 9/20/24 at 10:00 am. Record review of Elopement Drills revealed they were conducted for 1st and 2nd shifts on 9/19/24 and 9/20/24, 9/23/24 and 9/24/24, 9/25/24, 10/1/24, 10/4/24, 10/25/24, and 12/20/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Head Count of resident head count document revealed 100 % head count conducted on 9/19/24 and 9/20/24. All residents accounted for on 1st and 2nd shifts. Record review also revealed 100% head count were conducted on 9/21/24, 9/23/24, 9/25/24, 9/27/24, 9/30/24, 10/2/24, 10/4/24, 10/7/24, 10/9/24, and 10/11/24. Record review of the Elopement Risk Re-evaluation revealed it was conducted on 9/19/24, 10/15/24, 11/2024, 12/2024 and 1/2025. In an interview on 1/24/25 at 10:31 am CNA F said the facility had elopement trainings prior to incident but since the incident they were more frequent. She said when an alarm goes off, they must look to see where it was coming from. She said if a resident was missing, everyone looked for the resident and they didn't stop until they found them. In an interview on 1/24/25 at 12:16 pm MA A stated that she didn't remember much due to Resident #1 arrived the evening before. MA A said she was the medication aide for that day. She said she was making rounds about to do med pass and Resident #1 was not in room. She said she was not sure of the time but was in the morning. She said she usually started med pass around eight beginning in the 1200 hall first, then began med pass in 1100 hallway. She said she does not remember the alarm going off. She said once she reported it, everyone went out to go search for Resident #1. She said that Resident #1 was new. She said he arrived at the facility the evening before, so there was no opportunity to hear him saying he wanted to leave. In an interview on 1/24/25 at 12:30 pm RN B stated that she remembered working that day and somebody noticed Resident #1 wasn't in his room in the morning, so an elopement code was started immediately. RN B said she did not remember a time frame of when she last saw Resident #1. She said she did not remember hearing an alarm go off. She said Resident #1 was new, but she didn't think he was a wanderer. RN B said she thinks he left through the door at end of 1100 hallway. She said she is not sure, but she thinks it is always locked. In an interview on 1/24/25 at 1:05 pm with the Maintenance Supervisor he said, upon inspection of the alarm system for exit door down hallway 1100, they learned the alarm for that exit door was silenced. He said they immediately turned the alarm sound back on with laptop. He said it could have been turned off by the IT person that was servicing the system 3 to 4 days before. Maintenance Supervisor said they checked the doors weekly prior to the elopement, but no log was kept. He said now they keep a log of all door checks. He said the facility put a plan of correction in place and it was still ongoing. He said they check the doors daily to ensure they were locked and now the door alarms are checked weekly to ensure the alarms go on every time the doors open. He said they must check the doors for 6 months. In an interview on 1/24/25 at 1:22 pm RN G said she was working on the 1200 hall when heard that a resident was missing. She said all staff stopped and searched for the resident. They searched inside and outside of the facility, and the resident was located approximately 20 minutes later. She said prior to the incident they had in-services on elopement, but after the incident they had them more frequently. She said all staff must look if a door alarm or wander guard alarm goes off. If it was an actual elopement, they used walkies to inform everyone and all staff must stop and search for the resident. She said they completed a head count to ensure all residents were accounted. She said they do not stop searching until the resident was located. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 1/24/25 at 2:43 pm with the facility's Driver, he said on the morning of 9/19/24, while driving towards the facility he saw Resident #1 sitting at the neighboring hospital with security. He turned back and they asked if resident was from the nursing facility he worked for, and he said yes. The Driver said security would not release Resident #1 without identification. The Driver called the facility and informed the person who answered where the resident was. The DON was informed, and she arrived at the hospital with a face sheet and ID. They released him and brought him back to facility in the van. It took about 15 minutes in total to get him back to the facility. Driver said resident was walking and doesn't remember resident limping. He said resident stated he wanted to go fishing. He said resident really didn't say much more. In an interview on 1/25/25 at 10:28 LVN H said the facility had elopement in-services and drills when she worked on the weekends. She said elopements were called code yellow on the walkies. She said they must check inside the building and then check outside the building. She said they do not stop searching until the resident was located. She said a head count was completed to ensure all residents were accounted for and they must always notify the MD, RP, DON and Administrator when there was an actual elopement. In an interview on 1/25/25 at 11:10 LVN D said the facility had done multiple code yellow trainings and drills. He said elopements were called code yellow. He said if they heard an alarm go off, they must lookd to figure out the source. He said if a resident was missing, they do a head count then it's all hands-on deck to make sure they find the resident as soon as possible. If resident is located, MD and family were notified. If the resident can not be located, the authorities must also be contacted. He said the resident was assessed, an investigation was done, and resident and staff were re-educated. The plan of care was modified as needed and the resident could be placed on a wanderguard if indicated. In an interview on 1/25/25 at 12:32 pm with the DON, she said around 9:15 am she was notified resident was not found in his room. While the search was ongoing, the front desk received a phone call from the Driver that Resident #1 was seen at the neighboring hospital with 2 security guards and they wouldn't release him without some type of identification that he belonged at the facility. The DON said she went with resident's information and when resident was released to their care, he was brought back in the facility's van. She said they notified RP and MD, and they received orders to send resident to the emergency room for evaluation. The DON said Resident #1's wife met the resident at the facility and went with the resident to the emergency room . The DON said she felt the resident was confused due to new environment. The DON said Resident #1 was admitted to facility the day before on 9/18/24 in the evening, and the elopement happened the next morning. The DON said the resident walked out the exit door from the 1100 hallway. The DON said there was an alarm on that door, but it did not go off when resident left. The DON said the Maintenance Director looked at the door and made corrections. The DON said prior to the elopement on 9/19/24, elopement training was done. The DON said elopement training was done upon hire and annually. She said that after the elopement on 9/19/24, elopement trainings and drills were done. She said they had elopement drills twice a week for 2 weeks and 100% head count twice a week for 2 weeks. DON said staff was in-serviced on code yellow for elopement. The DON said there have been no other elopements since. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 1/25/25 at 12:43 pm ADON said elopement in-services had been done at the facility and that drills were done frequently. He said for the elopement drills, they used radios and called out code yellow. He said they go room by room and searched the premises for the resident. He said they contact law enforcement if they resident was not located. He said that the family, DON and administrator were always contacted when a resident was missing. He said they do not stop searching for the resident until they were located. In an interview on 1/25/25 at 1:45 pm with the Administrator. She said that for the elopement on 9/19/24, once they found out that someone was missing, they did a head count. They then called a code yellow, so everyone knew to start looking. All staff check inside and outside of the facility. She said this would be done for any elopement and they don't stop looking until the resident is found. The RP and MD were called once he was found, and he was sent out to the hospital for evaluation. Staff completed a new elopement risk evaluation because the status has changed. The Administrator said the nurses usually have 24 hours to complete the elopement assessment, but they try to get them as soon as they can when they come in. The Administrator said for all elopements a wander guard would be placed, and the information would be placed into a binder kept at the nurse's station. The Administrator said that Resident #1 did not return to the facility from the hospital. The Administrator said they provided in-services on Abuse and Neglect and Elopement for all staff. The Maintenance Supervisor assessed the door and learned the alarm had been silenced, so he turned it back on. She said they initiated a plan of correction which included 100 % head counts for residents, weekly tests of the door alarms and elopement drills for the next couple of weeks. During an observation on 1/24/25 at 1:05 pm, this surveyor observed the exit door in the 1100 hallway that Resident #1 used to exit the building along with the Maintenance Director. The Maintenance Director opened the door, the alarm sounded, then he entered the alarm code into the keypad located on the inside of the facility to turn the alarm off. The front entry door alarm was observed in working order throughout the the survey. During an observation on 1/24/25 at 3:00 pm, the elopement binder was observed at the nurse's station and staff were aware of which residents had exit seeking behavior. During an observation on 1/24/25 at 5:30 pm, this surveyor noted that the path the resident took to the neighboring hospital had a busy street the resident would have crossed. This street brought in traffic from the hospital and from another street which includes all types of vehicles entering and exiting to get to the hospital, medical offices, and the Facility including ambulances and the Facility's own van. The time the resident walked to the neighboring hospital would have been a busy weekday. Record review of Elopement/Unsafe Wandering policy with date revision/review of 12/2023 revealed: Policy: It is the policy of this facility to provide a safe environment, as free of accidents as possible, for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement while maintaining the least restrictive manner for those at risk for elopement. Definitions: .Elopement occurs when a resident leaves the premises or a safe area without the authorization (i.e. an order for discharge, appointment, or leave of absence), and/or any necessary supervision to do so. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was notified on 1/24/2025 at 5:00 pm, that a past noncompliance Immediate Jeopardy situation had been identified due to the above failures. It was determined these failures placed Resident #1 in an Immediate Jeopardy situation on 9/19/24. The facility had corrected the noncompliance before survey began. The facility had implemented the following interventions as per Provider Investigation Report dated 9/26/24: 1. Head to Toe Assessment completed 2. Notification of MD 3. Notification of RP 4. Clinicians initiated and completed 100% re-evaluations for elopement risk and no other new residents were identified as medium to high risk All new admissions to be reviewed within 24hr by DON/designee and LN staff educated/inserviced to notify DON/designee of any new admissions flagging medium to high risk on UDA. In-service on Abuse and Neglect and Elopement initiated and completed 6. 100% of resident head count was conducted by licensed nurses at time of incident and all active residents accounted for and Facility initiated 100% of head count qshift x48hr 9/19124 & 9/20/24. 100% Head count will continue 3xW 2nd shift x2 weeks 7. East exit door sound activated on door resident used to elope through. 8. Maintenance director tested all doors with alarms to ensure alarm sounds at in working order. Maintenance director/designee will test alarm sounds 3xW x2 consecutive weeks for working order. 9. Alert system placed to residents left wrist 10. Elopement drills initiated on 09/19/24 and continued on 9/19/24. Effective 9/23/24 elopement drills will be conducted 2xW for both 1st and 2nd shift for a period of 2 weeks Record review of Nursing note dated 9/19/24 revealed Resident #1's family member picked up his belongings at the facility. The family member stated she was overwhelmed with resident's gradual decline and has decided to go to another city to live with a family member, and where another family member lives a block away, to help her.

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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** 48278 Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 5 (Resident #39) residents reviewed for respiratory care. The facility failed to ensure Resident #39's oxygen was administered at the correct setting of 3 liters per minute on 01/22/2025 as ordered by the physician. This deficient practice could place residents who receive respiratory care at an increased risk of developing respiratory complications and a decreased quality of care. The findings included: Record review of Resident #39's face sheet dated 01/22/2025 reflected an [AGE] year-old female with an admitted [DATE]. Pertinent diagnoses included Acute and Chronic Respiratory Failure with Hypoxia (a condition where you don't have enough oxygen in your body), Bronchiectasis (condition that occurs when the tubes that carry air in and out of your lungs get damaged, causing them to widen and become loose and scarred), Idiopathic Pulmonary Fibrosis (a disease that causes scarring (fibrosis) of the lungs), Allergies, Primary Hypertension (high blood pressure), and Depression Unspecified. Record review of Resident #39's MDS assessment, dated 01/10/2025 reflected continuous oxygen therapy. Resident #39's BIMS score of 15, indicating cognitively intact. Record review of Resident #39's comprehensive person-centered care plan, dated 01/16/2025 reflected Resident #39 has altered respiratory status/difficulty breathing r/t Acute and Chronic Respiratory Failure with Hypoxia, Bronchiectasis, Idiopathic Pulmonary Fibrosis, Allergies. Intervention Provide oxygen as ordered. Record review of Resident #39's physician order summary, dated 01/22/2025, reflected oxygen at 3 L/min via nasal cannula continuous every shift. During an observation of Resident #39 on 01/22/2025 at 02:35 p.m. revealed the oxygen level on the oxygen concentration machine to be at 1L/min via nasal cannula. Observed Resident #39 in bed, awake. No signs of respiratory distress noted. In an interview on 01/22/2025 at 2:37 p.m. with Resident #39 stated, she was admitted about two weeks ago and was doing well. She denied any chest pain, shortness of breath or headache. (continued on next page)

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Golden Palms Rehabilitation and Retirement	2101 Treasure Hills Blvd Harlingen, TX 78550

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/22/2025 at 2:40 p.m. with RN B, stated she was the nurse for Resident #39. RN B verified that the O2 setting was set at 1L/min. She stated she did not know what the setting was supposed to be at and needed to check in the computer. RN B then logged onto her computer, reviewed Resident #39's oxygen setting physician order and stated it was supposed to be set at 3L/min. RN B stated the person responsible for checking that the oxygen setting was correct, was the person who put it on Resident #39. In this case, it was the night shift nurse who was supposed to check the oxygen setting and change the tubing. RN B stated her shift started at 6 a.m. and she had not checked the oxygen setting today. She stated that she normally does but she was working on a discharge. RN B stated that she did her rounds this morning upon shift change but did not look at her oxygen concentrator. RN B stated that when she checks the resident's oxygen, she checks their vital signs, checks that it was the right dose, humidifier, that the concentrator was working, that all the tubing was in place, and that the resident was connected to the nasal cannula or mask. RN B stated she has had respiratory care training in the past but cannot remember of exact date. She stated the negative outcome to keeping Resident#39's oxygen setting at 1L/min was that she can get short of breath and be in respiratory distress. In an interview on 01/22/2025 at 2:52 p.m. with the DON, stated that the floor nurse was responsible for checking the resident's oxygen setting. She stated that the facility has angel rounds, where the department heads check them daily in the morning before the 9 a.m. meeting. The DON stated the nurse should check the oxygen setting whenever she goes into the room, and as needed. She stated that training was provided for oxygen administration upon hire and annually. The DON stated that the negative outcome to keeping Resident#39's oxygen setting at 1L/min was that she can get hypoxia and go into respiratory distress. In an interview on 01/25/2025 at 3:35 p.m. with the ADON stated the nurses, the DON, and himself are responsible for checking the resident's oxygen setting. He stated the nurses are to check the oxygen setting each shift and they are to monitor them throughout the day. The ADON stated they are to follow oxygen setting physician orders. He stated that the nurses get respiratory care training upon hire and annually. The ADON stated the negative outcome to keeping Resident#39's oxygen setting at 1L/min was that she was not getting enough oxygen and she can go into a medical emergency. Record review of the facility's policy subject titled, Oxygen Administration, dated December 2023, revealed, Policy: It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. Purpose: The purpose of the oxygen therapy is to provide sufficient oxygen to the blood stream and tissues. Procedure: #13. Reassess oxygen flowmeter for correct liter flow.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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** 49301 Based on observations, interviews, and record reviews the facility failed to store all drugs and biologicals under proper temperature controls, for 1 of 3 (black fridge) refrigerators in the medication storage reviewed, in that, The black fridge was not maintained between ,d+[DATE] degrees as per facility policy. This failure placed residents at risk for harm by not receiving the therapeutic effects of their medications. The findings included: During an observation accompanied by the Administrator, of the medication storage room located behind the front desk on [DATE] at 11:13 AM the temperature inside the black fridge was at 45 degrees F. Checked refrigerator again at 11:55 AM and temperature was at 50 degrees F. The black refrigerator contained insulins and eye drops. The temperature log located at the side of the refrigerator revealed the temperature should read between ,d+[DATE] degrees F. If not notify Supervisor immediately. In an interview on [DATE] at 11:10 am LVN D he stated the night nurses were in charge of checking the temperatures on the refrigerators located in the medication storage room. He said if the temperature was above or below the recommended range, the medications located in the refrigerator could expire and no longer be effective. In an interview on [DATE] at 11:55 am LVN E said checking the temperatures of the refrigerators in the medication room were one of her responsibilities. She said she did not check the black refrigerator on [DATE] because it had already been checked off by one of the other night nurses. She said she did not recall who. She said if the refrigerator was not in the recommended range on the log, the medication could go bad. She said they must read the directions on each medication. She said if she noticed the temperature was not within the recommended degrees she must report to maintenance, ADON, DON and document. She said they would probably have to call the pharmacy to get assistance. She said she received training on medications needing refrigeration during orientation. In an interview on [DATE] at 12:43 pm with the ADON, he said refrigerator temperatures in the medication storage room were checked by night nurses. He said as the ADON, he and DON must verify the next day to ensure it was checked nightly by the night shift. He said that morning he did not check the log. He said if the refrigerator was not kept within the recommended temperatures, the medication could go bad. He said they must also take into consideration what the labels of each medication recommend. He said he does not recall the protocol for what to do if the temperature was out of range because he was still in training. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 1:25 pm with the DON, she said the night nurses check the temperatures on the refrigerators. She said if the refrigerator was not within the recommended range, the medications could no longer be effective, and she would have to re-order those medications. She said she reviews medication requiring refrigeration with nurses upon hire and annually. Record review of the Refrigerator Temperature Log for the Black Refrigerator dated [DATE] reflect the temperature has been checked daily from [DATE] to [DATE] and temperatures ranged from 36 degrees F to 39 degrees F. The last temperature documented was the night shift of [DATE] at 36 degrees F. Record review of the facility's Storing and Controlling Medications policy revealed, Policy: It is the policy of this facility to: 1. Store medications safely, securely, and properly following manufacturer's recommendations or those of the supplier, and in accordance with federal and state laws and regulations. 8. Medications requiring storage in the refrigerator will be kept by the staff in the medication room refrigerator. Refrigerated temperatures will be maintained between ,d+[DATE] degrees Fahrenheit. 9. Medications that are discontinued, expired, contaminated, or deteriorated, .are immediately removed from the locked medication storage area and disposed of in accordance with the Facility policies and procedures.