STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455903	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Lodge Nursing & Rehabilitation	3800 Marina Dr Lake Worth, TX 76135

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 FACILITY Resident Council 10/16/24 09:57 AM Omb TC: [NAME] Niens Omb: [NAME] Perehoduk (volunteer) Residents in attendance: [NAME]- RC President [NAME] [NAME] Brown [NAME] Howler [NAME] [NAME] [NAME] [NAME] Falls [NAME] Bill [NAME] (late arrival) (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Res says staff have not responded to requests/recommendations from residents or council meetings/ same req each month; per Adm res have rights unless it conflicts with her; res state no reasons being given for not responding to , when res go back they are told someone has dropped the ball and start over from sq one Grievance Rep is ADM and she is not responding per residents (per Omb grievance process is supposed to be started with SW) wait times for care 30-45 mins on average; still issues with staff spending /focusing on personal conversations and on personal cell phones during time providing res care; staff still on phones/using ear buds when providing care to res res state not always getting snacks when asked for; feel staff pick and choose what res get snacks (mostly 6p-6a shift that are choosy who they will give a snack, mostly the off crew for tonight not all staff) res state staff will be dismissive when stating their res rights are being violated, some act as though they dont have to respect the res choices and rights-- mailny 6p-6a (today's on crew is very good, respectful, the others are not!) (Day shifts generally ok) key for mail not available on saturdays? states gets from admin and she is not here on weekends to provide key to box to retrieve? nurses getting loud on night shift at nurses station with the rowdy group; no response if addressed with DON/ADM as was interrupted Bill [NAME] states the off shift for tonight is the less professional group of staff, different culture natively and they are bring it to the building and it doesnt fit well with them (the res) concerns with SW not following through in timely manner or at all (one called SW two faced) *Omb confirmed this is something that is being worked on* (third month in a row have expressed that issues ongoing concerns are about all mgmt staff of getting back at res for filing grievances- mgrs have daily mtg on weekdays, everyone in that meeting will decide how/what they will be responding to on the day **aide came in to shower room to talk to other aide while resident in middle of shower, undressed, and they stood with door open while they had personal conversation Bill [NAME] states overall care is good, some individuals are lesser trained and less able to deal with the elderly than some. Feels state should be holding to higher standards and have more control over things like kitchen menu/staffing (kitchen mgr/chef)/state should not be coming in and disrupting their daily routines, stated surveyors are just roaches invading their space complaints about same food different name, tired of routine, too many carbs, no variety just new names to items **grievance started with SW and where problem lies (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10:45am [NAME] and Mark [NAME]- ADm not enough time to eval effectively, gives appearance to be willing to work with ombs, seen has gotten to know residents and individuals Mark- adm good attitude, willing to listen; some items resolved some not as quickly as liked, ombs need to have res consent to bring issues to facility attention and they not always give, tries to make res council when can, bringing in mgmt staff to speak to res/answers ques, hear reviews; 1 dept mgr each month going forward [NAME]- SW has been inconsistent; i.e. one case started in march and still ongoing; ombs expressed issue with getting resident consent; saw same grievances being listed on res council notes, [NAME] explained in res council mtg grievance process but there seems to be a break in follow up/follow through rec recaps of last mtg to track and remind and look at trends and what he was told; recommend checking on/follow up empl entering and exiting when res council in session

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on interviews and record reviews the facility failed to review the risks and benefits of bed rails and enabler/grab bars (smaller bars used by the person in bed to reposition themselves), with the resident or resident representative, conduct a safety assessment, and obtain informed consent prior to installation for two (Residents #3 and #63) of six residents observed for bed rails/enabler bars. The facility failed to have an informed consent, assessment of the resident for risk of entrapment, or care planning for the safe use of bed rails/enabler bars for Residents #3 and #63. This failure could affect residents who used bed rails/enabler bars at risk of the resident/responsible party not being aware of the risks, informed consent not being obtained from the resident or responsible party, and care plan not being properly documented. Findings included: Resident #3: Observation of Resident #3 on 10/15/2024 at 9:20 AM revealed the resident asleep in a bed that was pushed against the wall of the room along the left-hand side, both half bedrails were raised. Resident did not arouse to a knock on the door, or her name being announced. Resident was observed a second time in bed asleep with both half bedrails raised on 10/16/2024 at 2:48 PM. Resident was observed a third time in bed with half bedrails raised on /17/2024 at 2:35 PM awake and briefly interviewable. Record review of Resident #3's face sheet, dated 09/24/24, reflected a [AGE] year-old, female resident with an original admitted [DATE] and most recent admitted [DATE]. Resident #3's diagnoses including: Unspecified Dementia, Moderate, with Mood Disturbance (a group of symptoms caused by disorders that affect the brain by personality changes and emotional disorders, impaired concentration, and loss of the ability to think, remember, learn, make decisions, and solve problems), Spinal Stenosis, Site Unspecified (narrowing of the spinal canal in an unspecified level of the spine), Muscle Wasting and Atrophy, Muscle Weakness (Generalized), Unspecified Lack of Coordination, History of Falling, and Cognitive Communication Deficit (difficulty with communication caused by a disruption in cognitive processes). Resident #3 was noted to receive care from a hospice agency. Resident #3 was listed to have a medical and financial power of attorney and was not her own responsible party. Record review of Resident #3's MDS, dated [DATE], reflected a Brief Interview for Mental Status assessment was not able to be completed. Resident #3's cognitive skills for daily decision making was moderately impaired and indicated to have memory problems. Resident #3's functional status reflected the resident utilized a manual wheelchair for mobility. Section P- Restraints and Alarms, reflected that no bed rail or other items were used in bed for Resident #3. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review on 10/17/2024 of Resident #3's Care Plan updated 07/14/2024 reflected resident was a risk for falls related to dementia, muscle wasting and weakness, was at risk for wandering and at risk for alteration in comfort or pain. The Care Plan indicated a limited physical mobility related to spinal stenosis with a goal of the resident to demonstrate appropriate use of adaptive device(s) to increase mobility . Device: wheelchair. The Care Plan did not included use of bed rails/grab bars. Review of medical records from Resident #3's admitted [DATE] to 10/17/24 for Resident #3 reflected no assessment for safe use of bilateral half bed rails nor Bed Rail Consent form for the bilateral half bed rails signed by the resident or resident's responsible party or noted to have verbal permission for the bilateral half bed rails was in documented in the clinical record. Interview with Resident #3 on 10/17/2024 at 2:35 PM revealed that the resident was glad the bedrails were there as she uses them for repositioning. Resident stated she did not mind that they were half rails and not grab bars, she did not remember if there had been an assessment for safety or if she gave consent for the bed rails. Resident #63: Observation on 10/15/2024 at 9:25AM revealed the resident asleep in a bed that was pushed into the corner of the room with the left-hand side pushed against the wall of the room, head of the bed against another wall, and right side with one half bed rail raised. There was a fall matt along the right-hand side of the bed. The call light was observed looped around the bed rail in reach of the resident. Resident was also observed on 10/16/2024 at 2:08 PM lying in bed that was pushed into the corner of the room with half bed rail along the right-hand side raised. Resident was conversing with a friend who was visiting in Spanish. Resident was dressed casually. Record review on 10/17/2024 of Resident #63's face sheet reflected a [AGE] year-old, female resident who originally admitted on [DATE] and most recently on 09/02/2024. Resident #63 was noted to have diagnoses including: Unspecified Dementia, Severe, with Agitation (a group of symptoms caused by disorders that affect the brain by personality changes and emotional disorders, impaired concentration, agitation, and loss of the ability to think, remember, learn, make decisions, and solve problems; agitation can be a symptom of physical changes in the brain caused by dementia), Muscle Weakness (Generalized), Unsteadiness on Feet, Repeated Falls,. Resident #63 was noted to receive care from a hospice agency. Record review on 10/17/2024 of Resident #63's Quarterly MDS, dated [DATE], reflected Resident #63 needed an interpreter to communicate with a doctor or healthcare staff. A Brief Interview for Mental Status assessment was not able to be completed for Resident #63. Resident #63's cognitive skills for daily living was indicated as moderately impaired and indicated to have memory problems. Section P- Restraints and Alarms, reflected that no bed rail or other items were used in bed for Resident #3. Record review on of Resident #63's Care Plan updated 08/06/2024 reflected resident was a risk for falls and a risk for wandering and elopement. The Care Plan had not included use of bed rails as an intervention for any risk. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of medical records from Resident #63's admitted [DATE] to 10/17/24 for Resident #63 reflected no assessment for safe use of bed rails completed not was there a Bed Rail Consent form for the half bed rail signed by the resident or resident's responsible party or noted to have verbal permission for the half bed rail. Interview with Visitor 1 (V1) for Resident #63 revealed that she and the resident had been close friends for over [AGE] years. V1 stated she comes to see the resident daily to make sure she was doing ok. V1 stated that the resident had had several falls since admitting to the facility. V1 stated Resident #63 was concerned about continuing to fall and that the resident felt more secure with the bedrails on the bed. V1 did not recall any assessment or the resident signing any consent for bed rails, and when V1 asked Resident #63 about an assessment or consent form the resident did not recall either having been completed with her since her admission. In an interview on 10/17/24 at 1:10 PM, the Maintenance Manager (MM) stated if a resident asked directly for bed rails the request would be forwarded to nursing and therapy for review and authorization, nursing and therapy also informed prior to a new resident being admitted if bed rails were requested. In an interview on 10/17/2024 at 1:50 PM CNA A stated bed rails/grab bars could pose a risk to a resident if the resident was not able to be safe with the bed rail/grab bar. In an interview on 10/17/2024 at 2:03 PM the ADON who stated that bed rails/grab bars were included in information in the residents' EHR for all direct care staff to see. The ADON shared that the Kardex (a quick reference system that displays information such as Care Plans, Orders, and medications by resident) was checked by direct care staff for resident information such as orders and care plans and would reflect if bed rails/grab bars were needed and why. The ADON also stated that nurses could review assessments for a resident, which should be done quarterly for bed rails/grab bars, as well as for a signed consent form. The ADON stated that when filling in on the floor and a bed was seen with bed rails/grab bars that a brief audit of the resident's care plan and assessments was done to confirm all documents were in place. When asked if information for bed rails/grab bars should be in a care plan, the ADON responded when a prompt yes. The ADON did not address why Residents #3 and #63 did not have an assessment, consent, or care plan for bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/17/2024 at 2:18 PM with the DON revealed that bed rails/grab bars were only used for residents to reposition while in bed and assist with ADL or other care by direct care staff. The DON stated that a resident should have an assessment and signed consent form in the EHR for the bed rails/grab bars. The bed rails/grab bars should also be care planned and have orders. The DON stated that consent forms may need verbal consent if a responsible party was not able to come to the facility to sign, if a resident was their own responsible party, they will be asked to sign the consent form and if not able to sign will obtain verbal consent and notate on the form. The DON stated if the physician orders the bed rails/grab bars as part of the admission orders, the physician will sign orders as consent. The DON stated if a resident has had bed rails/grab bars on their bed and has been using them that was considered verbal consent. The DON stated that weekly audits are completed to endure all assessments and consents have been done and are in the system, i.e., for room changes and bed rails/grab bars. The DON stated that if a resident were on hospice care and can be assessed at admission to the facility then the assessment and consent was completed as for any other resident; if the assessment is not able to be completed then bed rails/grab bars are not placed on the bed. The ADON did not address why Residents #3 and #63 did not have an assessment, consent, or care plan for bed rails. In an interview on 10/17/2024 at 2:45 PM the ADM, stated clinical staff were responsible for assessments the resident for appropriateness for bed rails/grab bars. The ADM stated if a resident was appropriate, the clinical staff were to obtain a signed consent from the resident or responsible party and ensure the bed rails/grab bars were properly care planned. The ADM indicated residents could be at risk for injury if bed rails/grab bars were on beds of inappropriate residents. Record review of the facility's provided Bed Rail policy from Restraint Mini Manual, MM RE 4-00, November 8, 2016, reflected a Policy Statement of This facility will utilize bed rails for those residents that use them for bed mobility. Further review of the Policy reflected applicable information of: The facility will attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements: o Assess the resident for risk of entrapment from bed rails prior to installation. o Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. o Ensure that the bed's dimensions are appropriate for the resident's size and weight. Assessment: o Prior to use of a bed rail the resident will be assessed to ensure the proper rail is utilized for the resident's need. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o The facility will re-evaluate the use of the rail on a periodic basis o Based on the resident assessment, the interdisciplinary team (IDT) will make the determination for the plan of care as it relates to bed rails. Consent - The resident and/or resident representative will provide consent for the use of rails prior to installation.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #37) of nine residents reviewed for pharmacy services. The facility failed to ensure LVN C did not administer expired insulin to Resident #37 on [DATE] that had expired on [DATE]. These failures could place residents at risk for altered medications due to being expired and could result in residents not receiving the intended therapeutic effects of their medications causing a health decline. Findings included: Review of Resident #37's factsheet dated [DATE] revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her secondary diagnoses included type 2 diabetes mellitus with hyperglycemia (uncontrolled high blood sugars), and high blood pressure. Review of Resident #37's orders dated [DATE] reflected current orders for the following: *Insulin Glargine Solution 100 UNIT/ML Inject 5 unit subcutaneously one time a day for diabetes. Active order dated [DATE]. Started [DATE]. [long-acting insulin] *Humalog Kwik Pen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 450 = 16 units, subcutaneously before meals and at bedtime for dm. Active order dated [DATE]. Started [DATE]. [short-acting/ fast-acting insulin] Review of Resident #37's admission MDS dated [DATE], revealed a BIMS score of 99 indicating resident was unable to complete due to severe cognitive impairment. MDS indicated Resident #37 had long term and short-term memory problems and she had severe impaired cognitive skills for daily decision making. Observation of Medication pass and interview with LVN C on [DATE] at 8:12 AM revealed three insulin pens. Two of the insulin pens were named Humalog KwikPen with a resident's name written in black ink but no date when they were opened was written on them. The other insulin pen was Lantus with a pharmacy label dated [DATE]. LVN C stated all the insulins pens belonged to Resident #37. She took the Lantus and administered 5 units of the expired insulin pen to Resident #37. LVN C stated Resident #37 was a newly admitted resident, and she was the only one who received insulin in the secure unit. LVN C stated all 3 insulin pens were opened but she did not know when they were opened. She stated they were most likely opened on [DATE] when resident admitted . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN C on [DATE] at 8:22 AM, she sated she did not know who placed the office stationery items in the same basket as the insulins. She stated she did not know who had opened the three insulins, two of which were the same insulin with no date and all insulins should have residents' names on them. LVN C stated the insulins were still good because the resident had just admitted recently. She stated the long-acting insulin was good to be used for 42 days after opening and the short acting insulin was good for 28 days after opening. She stated she did not see any risk to the resident because the insulin was within the time frame since Resident #37 was newly admitted . LVN C stated the insulin was obtained from the facility's pharmacy when Resident#37 was admitted . LVN C stated insulin should be separated from office supplies because of cross contamination to the insulins. In an interview with the ADON on [DATE] at 12:20 PM, she stated all insulins should be dated with opening date and they should have the residents' names on them. She stated insulins should be kept in a clean container/basket free of pens, markers, rubber bands, paper clips and other stationary items. She stated the nurses were responsible for making sure that the insulin was dated when it was opened and not expired. The ADON stated herself and DON did random medication carts audits, however each nurse was ultimately responsible for their med carts. She stated not having the opening date on the insulin can cause confusion not knowing if the insulin was good. She stated the risk to the resident was insulin potency which could cause not achieving the desired medication outcome. In an interview with the DON on [DATE] at 2:36 PM, she stated she had already started to in-servicing on medication and the ADON had removed all the expired insulins out of the nurse med cart. She stated, she expected nursing staff to date the insulin at the time of opening them. She stated the ADON was responsible for weekly med cart audits, and she (DON) did monthly med cart audits, and the pharmacist did monthly medication cart audits upon request, so she was not sure how it was missed. She stated all insulins should be stored separate from stationery items due to contaminations and the risk to resident having expired insulin was insulin potency/strength. In an interview with the Administrator on [DATE] at 3:42 PM, she stated she expected nursing staff to follow medication storage policies. She stated all nurses were responsible for making sure medications were dated and labeled with resident's names. She stated the DON and ADON were responsible for monitoring medication policies were being adhered to by nursing staff. Review of facility policy tilted Pharmacy Policy & Procedure Manual revision date ,d+[DATE] read in part . Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that it is clear when the medication was opened. Below is a list of medications that require a date when opening and the recommended time frame the medication should be used. This is not an all-inclusive list and the manufacturer. recommendations will supersede this list. INSULINS (Vials, Cartridge, Pens) Humulin R, N, ,d+[DATE] and Mix (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Humalog and Humalog Mix Humalog FlexPen ,d+[DATE] and ,d+[DATE] pens expire 10 days after opening. Novolog and Novolog Mix Insulin Glargine (Lantus)

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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** 48520 Based on observation and interview, and record review, the facility failed to ensure a medication error rate less than 5 percent. There were 2 errors out of 26 opportunities which resulted in a 7 percent medication error rate for two (Resident #25, #30, and #37) of nine residents reviewed for medication errors. 1. CMA B administered medication Methocarbamol 500 MG belonging to Resident #30 to Resident #25. 2. LVN C did not follow manufacturer's recommendation for Lantus Insulin when she administered it to Resident #37. This failure could place residents at risk of not receiving the maximum benefit of the medication, decreases controlling conditions and overall well-being. Findings included: Error #1 During an observation of the medication pass on [DATE] at 8:12 AM revealed LVN C administered 5 units of Lantus insulin that was expired to Resident #37. Review of physician order dated [DATE] reflected a [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses of diabetes with high blood sugars. The physician order reflected Insulin Glargine Solution 100 UNIT/ML Inject 5 unit subcutaneously one time a day for diabetes, which was ordered on [DATE] Observation of Medication pass and interview with LVN C on [DATE] at 8:12 AM revealed three insulin pens. Two of the insulin pens were named Humalog KwikPen with a resident's name written in black ink but no date when they were opened was written on them. The other insulin pen was Lantus with a pharmacy label dated [DATE]. LVN C stated all the insulins pens belonged to Resident #37. She took the Lantus and administered 5 units of the expired insulin pen to Resident #37. LVN C stated Resident #37 was a newly admitted resident, and she was the only one who received insulin in the secure unit. LVN C stated all 3 insulin pens were opened but she did not know when they were opened. She stated they were most likely opened on [DATE] when resident admitted During an interview on [DATE] at 08:22 AM, LVN C stated the insulins were still good because the resident had just admitted recently. She stated the long-acting insulin was good to be used for 42 days after opening and the short acting insulin was good for 28 days after opening. She stated she did not see any risk to the resident because the insulin was within the time frame since Resident #37 was newly admitted . Review of facility policy, Insulin Glargine (Lantus) revised ,d+[DATE], revealed, .Expires 28 days after initial use regardless of product storage refrigerated or room temperature . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455903	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Lodge Nursing & Rehabilitation	3800 Marina Dr Lake Worth, TX 76135

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy tilted Pharmacy Policy & Procedure Manual revision date ,d+[DATE] read in part . Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that it is clear when the medication was opened. Below is a list of medications that require a date when opening and the recommended time frame the medication should be used. This is not an all-inclusive list and the manufacturer. recommendations will supersede this list INSULINS (Vials, Cartridge, Pens) Insulin Glargine (Lantus) Insulin Glargine (Apidra) o Refrigerate until initial use o Expires 28 days after initial use regardless of product storage (refrigerated or room temperature). Review of manufacturers of Lantus SOLOSTAR Lantus.pdf revealed, read in part Lantus is a long-acting man-made insulin used to control blood sugars in adults and children with diabetes mellitus. 10 ml multiple dose vial in use (opened) 28 days refrigerated or room temperature. 3 ml single patient use Solostar prefilled pens, in use (opened) 28 days. Room temperature only . Error #2 During an observation of medication pass on [DATE] at 1:30 PM, CMA B took out and administered 2 tablet of Methocarbamol Oral Tablet 500 MG to Resident #25. Record review of Resident #25's Physician orders dated [DATE] indicated Resident #25 admitted [DATE], was [AGE] year-old female with diagnoses for chronic pain. The physician order revealed Robaxin-750 tablet (methocarbamol) give 2 tablets by mouth three times a day for pain related to other chronic pain. Record review of Resident #30's Physician order dated [DATE] indicated Resident #30 was a [AGE] year-old female admitted on [DATE], with diagnoses of falls and multiple fractures. The physician order revealed Methocarbamol Oral Tablet 500 MG Give 1 tablet by mouth every 8 hours for Spasms; give at least 1 hour apart from Oxycodone Hold for sleep/sedation. During an interview on [DATE] at 1:32 PM, CMA B stated she was nervous and did not realize that she took medication that belonged to Resident #25's roommate Resident #30. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 2:36 PM with the DON revealed during medication pass, nurses were supposed to check the medication administration record, follow the 7 rights of medication administration , [right individual, right medication, right dose, right time, right route, right documentation and right response], and follow the medication administration record to make sure medication was not expired and it was the right dose and right person. She stated all insulins should be stored separate from stationery items due to contaminations and the risk to resident having expired insulin was insulin potency/strength. In an interview with the administrator on [DATE] at 3:42 PM, she stated she expected nursing staff to follow medication rights to administration (right patient, right name, right route, right time, right dose). She stated all nurses were responsible for making sure medications were dated and labeled with resident's names. She stated the DON and ADON were responsible for monitoring medication policies were being adhered to by nursing staff. Review of facility undated policy titled Liberalized Medication Policy, did not reflect medication errors.

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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** 48520 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 medication carts (nurse med cart) reviewed for labeling and storage. 1.The facility failed to date and remove expired insulin from the nurse medication cart in the secure unit. 2. The facility failed to ensure that 3 insulin pens were stored separate from office stationery materials pens, markers, paper clips and rubber bands. These failures could place residents at risk for altered medications due to being expired, exposure to unsanitary storage conditions and could result in residents not receiving the intended therapeutic effects of their medications causing a health decline. Findings included: Review of Resident #37's factsheet dated [DATE] revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her secondary diagnoses included type 2 diabetes mellitus with hyperglycemia (uncontrolled high blood sugars), and high blood pressure. Review of Resident #37's orders dated [DATE] reflected current orders for the following: *Insulin Glargine Solution 100 UNIT/ML Inject 5 unit subcutaneously one time a day for diabetes. Active order dated [DATE]. Started [DATE]. [long-acting insulin] *Humalog Kwik Pen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 3 units; 201 - 250 = 6 units; 251 - 300 = 9 units; 301 - 350 = 12 units; 351 - 450 = 16 units, subcutaneously before meals and at bedtime for dm. Active order dated [DATE]. Started [DATE]. [short-acting/ fast-acting insulin] Review of Resident #37's admission MDS dated [DATE], revealed a BIMS score of 99 indicating resident was unable to complete due to severe cognitive impairment. MDS indicated Resident #37 had long term and short-term memory problems and she had severe impaired cognitive skills for daily decision making. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Medication pass and interview on [DATE] at 8:12 AM revealed LVN C was passing medications and checking blood sugars using the nurse med cart. Blood sugar reading for Resident #37 was 127. LVN C stated she would administer 5 units of insulin to Resident #37. She opened the top drawer, and it revealed a 2X6 small white basket. Inside the small white basket were three insulin pens, 3 black permanent markers, 2 ink pens, 3 tan colored rubber bands and 2 paper clips all inside the same basket. LVN C started to remove the markers, pens, rubber bands, and paper clips from the basket with the insulins stating, these should not be in here. The 2 of the 3 insulin pens were undated. Two of the insulins' pens were named Humalog KwikPen with a resident's name written on them with no date when they were opened. The other insulin pen was Lantus with a pharmacy label dated [DATE]. LVN C stated all the pen insulins belonged to Resident #37. She took the Lantus and administered 5 units of the expired and contaminated insulin pen to Resident #37. LVN C stated Resident #37 was a newly admitted resident, and she was the only one who received insulin in the secure unit. LVN C stated all 3 insulin pens were opened but she did not know when they were opened. She stated they were most likely opened on [DATE] when resident admitted . In an interview with LVN C on [DATE] at 8:22 AM, she sated she did not know who placed the office stationery items in the same basket as the insulins. She stated she did not know who had opened the three insulins, two of which were the same insulin with no date and all insulins should have residents' names on them. LVN C stated the insulins were still good because the resident had just admitted recently. She stated the long-acting insulin was good to be used for 42 days after opening and the short acting insulin was good for 28 days after opening. She stated she did not see any risk to the resident because the insulin was within the time frame since Resident #37 was newly admitted . LVN C stated the insulin was obtained from the facility's pharmacy when Resident#37 was admitted . LVN C stated insulin should be separated from office supplies because of cross contamination to the insulins. In an interview with the ADON on [DATE] at 12:20 PM, she stated all insulins should be dated with opening date and they should have the residents' names on them. She stated insulins should be kept in a clean container/basket free of pens, markers, rubber bands, paper clips and other stationary items. She stated the nurses were responsibly for making sure that the insulin was dated when it was opened and not expired. The ADON stated herself and DON did random medication carts audits, however each nurse was ultimately responsible for their med carts. She stated not having the opening date on the insulin can cause confusion not knowing if the insulin was good. She stated the risk to the resident was insulin potency which could cause not achieving the desired medication outcome. In an interview with the DON on [DATE] at 2:36 PM, she stated she had already started to in-servicing on medication and the ADON had removed all the expired insulins out of the nurse med cart. She stated, she expected nursing staff to date the insulin at the time of opening them. She stated the ADON was responsible for weekly med cart audits, and she (DON) did monthly med cart audits, and the pharmacist did monthly medication cart audits upon request, so she was not sure how it was missed. She stated all insulins should be stored separate from stationery items due to contaminations and the risk to resident having expired insulin was insulin potency/strength. In an interview with the administrator on [DATE] at 3:42 PM, she stated she expected nursing staff to follow medication storage policies. She stated all nurses were responsible for making sure medications were dated and labeled with resident's names. She stated the DON and ADON were responsible for monitoring medication policies were being adhered to by nursing staff. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy tilted Pharmacy Policy & Procedure Manual revision date ,d+[DATE] read in part . Medications that require an open date as directed by the manufacturer should be dated when opened in a manner that it is clear when the medication was opened. Below is a list of medications that require a date when opening and the recommended time frame the medication should be used. This is not an all-inclusive list and the manufacturer. recommendations will supersede this list. INSULINS (Vials, Cartridge, Pens) Humulin R, N, ,d+[DATE] and Mix Humalog and Humalog Mix Humalog FlexPen ,d+[DATE] and ,d+[DATE] pens expire 10 days after opening. Novolog and Novolog Mix Insulin Glargine (Lantus) Insulin Glargine (Apidra) o Refrigerate until initial use o Expires 28 days after initial use regardless of product storage (refrigerated or room temperature).