STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465172	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
George E Wahlen Ogden Veterans Home	1102 North 1200 West Ogden, UT 84404

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on observation, interview and record review, for 2 of 38 sampled residents, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choice. Specifically, a resident was administered medications by the nurse after he was unable to put them in his own mouth and was experiencing confusion, having difficulty staying awake, had gurgling sounds when breathing, and difficulty keeping oxygen saturation above 90 percent. No monitoring was documented for his change in condition. The resident was discharged to the hospital with an overdose. In addition, a resident was experiencing low oxygen levels in the evening and was not monitored throughout the night to ensure it was above 90 percent after the resident was provided increased oxygen. Resident identifiers: 67 and 77. Findings include: 1. Resident 67 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included type 2 diabetes with polyneuropathy, Post Traumatic Stress Disorder (PTSD), asthma, respiratory failure with hypoxia, fluid overload, dependence on renal dialysis, metabolic encephalopathy, congestive heart failure (CHF), and ischemic cardiomyopathy. On [DATE] at 9:29 AM, an interview was conducted with resident 67 who stated he had gone to the hospital as a result of an accidental overdose. Resident 67's medical record was reviewed between [DATE] and [DATE]. An annual Minimum Data Set (MDS) revealed resident 67 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Resident 67's physician's orders included: a. Melatonin Tablet 3 MG (milligrams) Give 9 mg by mouth at bedtime for insomnia. Start date [DATE]; Discontinued [DATE]. b. Potassium Tablet (Potassium) Give 20 mEq (Miliequivalents) by mouth two times a day for supplement. Start date [DATE]; Discontinued [DATE]. (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

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 0684 Level of Harm - Actual harm Residents Affected - Few	c. Prazosin HCl (Hydrogen chloride) Capsule Give 2 mg by mouth two times a day for nightmares related to Post Traumatic Stress Disorder, Chronic. Start date [DATE]; Discontinued [DATE]. d. Furosemide Oral Tablet (Furosemide) Give 60 mg by mouth three times a day for Edema. Start date [DATE]; Discontinued [DATE]. e, Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for nerve pain. Start date [DATE]; Discontinued [DATE]. f. Morphine Sulfate Oral Tablet 15 MG (Morphine Sulfate) Give 1 tablet by mouth every 8 hours for pain for 2 days. Start Date [DATE]. g. Naloxone HCl Nasal liquid 4 mg/0.1 ml(milliliters); 1 spray in nostril as needed for suspected overdose, if no response in 3 minutes repeat. Start date [DATE]; Discontinued [DATE]. h. Resident may have a RUM shot (Captain [NAME] kept in back med room) or Scotch ([NAME] Whiskey) can have 100 ml po (by mouth) BID (twice daily), PRN (as needed). Administration to be visualized by staff, do not leave in room per POA (Power of Attorney) request. Must choose which one he would like, he cannot have both at same time, as needed BID (twice daily) PRN (as needed). Start date [DATE]; Discontinued [DATE]. (It should be noted that 100 ml of rum is two-1.5 ounces or approximately 3.4 ounces) Resident 67's care plan included: a. [Resident 67] has altered cardiovascular status r/t (related to) pulmonary hypertension due to left heart disease, hypertension due to left heart disease, hyperlipidemia, hypertensive heart and chronic kidney disease without heart failure, hypertension. The goal was, [Resident 67] will be free from untreated complications of cardiac problems through the review date. Interventions included, .Assess for shortness of breath and cyanosis as needed .Obtain vital signs per facility protocol. Notify MD [Medical Doctor] of significant abnormalities .Oxygen settings: O2 [oxygen] via nasal cannula per MD orders. b. [Resident 67] has end stage renal disease and received renal dialysis r/t DM [diabetes mellitus] type 2 with diabetic polyneuropathy, DM type 2 with diabetic foot ulcer, fluid volume overload, Chronic kidney disease [CKD]. The goal was, [Resident 67] will have no untreated s/sx [signs or symptoms] of complications related to fluid overload through the review date. Interventions included, .Encourage [Resident 67] to limit fluids to 1L [liter] QD [once daily] r/t dialysis. [Resident 67] is typically noncompliant with this .Fluids as ordered. Restrict or give as ordered .Monitor vital signs per facility protocol. Notify MD of significant abnormalities. A review of resident 76's Medication Administration Record (MAR) for [DATE] revealed: a. Potassium Tablet (Potassium) Give 20 mEq by mouth two times a day for supplement. Administered on [DATE] at 9:13 PM. b. Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for nerve pain. Administered on [DATE] at 9:14 PM. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	c. Melatonin Tablet 3 MG Give 9 mg by mouth at bedtime for insomnia. Administered on [DATE] at 9:13 PM. d. Prazosin HCl Capsule Give 2 mg by mouth two times a day for nightmares related to Post Traumatic Stress Disorder, Chronic. Administered on [DATE] at 9:14 PM. e. Furosemide Oral Tablet (Furosemide) Give 60 mg by mouth three times a day for edema. Administered on [DATE] at 9:14 PM. f. Morphine Sulfate Oral Tablet 15 MG (Morphine Sulfate) Give 1 tablet by mouth every 8 hours for pain for 2 days. Administered on [DATE] at 9:15 PM. g. Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for nerve pain. Administered on [DATE] at 10:06 PM. It should be noted that 2 doses of Gabapentin were administered within 52 minutes of each other. Resident 67's vital signs were reviewed. On [DATE] at 11:34 PM, resident 67's oxygen was documented to be 92% via nasal cannula. On [DATE] at 5:44 AM, resident 67's oxygen was documented to be 77% nasal cannula. Resident 67's progress notes revealed: a. On [DATE] at 2:45 AM, Resident was not able to hold his pills or put them in his mouth. Nurse had to put pills in Resident's mouth this evening. He was having difficulty staying awake, his appearance was gray, skin was cold and clammy, confusion, gurgling sound when breathing, and had trouble keeping O2 sats (saturation) above 90%. MD called, and orders given to hold morning morphine to see if Resident wakes up and is more responsive. b. On [DATE] at 4:37 AM, Occurrence Report; Vitals; [blood pressure] ,d+[DATE], [heart rate] 62, [respirations] 18, [temperature] 98.9, [saturations] 100% RA [room air]. Resident is on occurrence charting for UWF [Unwitnessed Fall] with no injuries and change in condition r/t pain. Resident continues with c/o [complains of] pain with a ,d+[DATE], PRN pain medications have been effective. Resident has no new injures [sic] noted. He is asleep and call light is within reach. c. On [DATE] at 6:58 AM, Follow-up on [Resident 67's] condition: The CNA's [Certified Nursing Assistant] went into Resident's room to move him from the recliner to his bed to change him. Nurse called in and resident was more awake but unable to voice his needs. He has SOB [shortness of breath], sats were 72% via NC on 2L, skin color was gray with blue around the lips, extreme weakness, loud gurgling, and loud moaning. Skin was clammy and cool to the touch. Resident was suctioned to help him breath. Turned O2 up and called MD. MD said to send to [Hospital name redacted] ER [emergency room]. Handed to the EMS [emergency medical services] transportation people. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	d. On [DATE] at 7:18 AM, This nurse assisted NOC [night] floor nurse with sending [resident 67] out to hospital. Floor nurse reported [resident 67] was having increased confusion, SOB and was desating [sic]. [Resident 67] had audible secretions and day shift nurse was assisting with suctioning him. [Resident 67] is a full code per his POSLT [Physician's Order for Life Sustaining Treatment] and NP [Nurse Practitioner] [Name redacted] ordered for [resident 67] to be sent out. [Resident 67] wished to be sent to [hospital name redacted] ER. NOC floor nurse attempted to reach family and left VM[voice mail]. POLST, SBAR [Situation, Background, Assessment, Recommendation], Transfer form, NP order, infection form was sent out with res [resident] and faxed to [hospital name redacted] ER. [Resident 67] was transported by EMS at approximately 0630 [6:30 AM]. Bed hold policy was verbally explained to [resident 67] but he was unable to sign it. Will go over when we are able to get in contact with family. NOC floor nurse gave report to ER. DON [Director of Nursing] notified. On [DATE], the hospital history and physical revealed, Chief complaint: pt [patient] found with altered LOC [level of consciousness], hypoxia, overdose, narcan given en route, placed on bipap via ems from [facility name redacted]. History of present illness: Was here in our ED [emergency department] 2 days ago for back pain and got prescribed hydrocodone 5 mg QID (four times daily) PRN. Reportedly he's already getting morphine at [facility name redacted] nursing home. Today he was found by staff and thought to be dead but he was revived with oxygen and Naloxone and brought to the ED. He got very agitated with the 2 mg of Naloxone give by EMS. So on arrival he got 25 mcg [micrograms] of fentanyl. He got 4 mg of IV [Intravenous] morphine for his MRI [Magnetic Resonance Imagine]. Since then he's had some restlessness but more recently he's gotten progressively lethargic. He has been very gurgly and required a lot of suctioning. He can't provide history .Vitals & Measurements: T [temperature] 36.9 [36XXX,d+[DATE].3] HR [heart rate] 79 [,d+[DATE]] BP [Blood Pressure],d+[DATE] [100-,d+[DATE]-110] RR [respiratory rate] 7 [, d+[DATE]] O 2 sat 96 6L Nasal cannula (,d+[DATE]) .General: Obtunded but then suddenly wakes up and stares speechless, obese, disheveled .Assessment/plan: 1. Opioid poisoning-Appears to have taken more than opioid and in the setting of severe renal disease he didn't clear it well and thus #2. Start Naloxone drip to titrate to acceptable balance of agitation and sedation. Monitor closely for complications. 2. Toxic metabolic encephalopathy-Due to #1 and #3 and #6. Hold sedating meds [medications] and try to improve renal function. 3. Acute hypercapnic respiratory failure-Likely due to #1 combined with #19. Given his low GCS [glascow coma scale] NIPPV [Noninvasive positive pressure ventilation] would be unsafe. If his airway cannot be made safe with Naloxone then intubation will be needed .6. Acute nontraumatic kidney injury-Suspect poor oral intake in setting of #1 and #2 on top of ACEI [angiotensin-converting enzyme inhibitors] and diuretic use. IV hydration and hold ACEI and diuretic .19. Morbid obesity-Increases risk of respiratory failure .Two Midnight Documentation (inpatients only)-This patient requires inpatient admission in pursue urgent management of new severe, life threatening condition complicated by chronic comorbidities that require close monitoring and IV fluids and airway/respiratory support. This is expected to require that the patient stay at least 2 nights in the hospital (including ED time) to ensure sufficient improvement in mental status and renal function to permit discharge. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:44 PM, an interview was conducted with Licensed Practical Nurse (LPN) 1 who stated resident 67 was A/O (alert and oriented) x 4 (person, place time and situation). LPN 1 stated resident 67 got alcohol 5 days per week (Saturday, Sunday, Monday, Tuesday, and Wednesday). LPN 1 stated resident 67 often asked for the alcohol. LPN 1 stated resident 67 had to wait 2 hours after consuming alcohol before he could take his medications. When asked what the signs and symptoms of an opioid medication overdose were, LPN 1 stated the resident would get despondent, rock back and forth, and it would not be clear about what he was saying. LPN 1 stated there would be breathing changes, oxygen saturation would fall, and the resident would not make sense. When asked about Morphine, LPN 1 stated, Morphine helps with breathing. LPN 1 stated alcohol relaxed someone. LPN 1 stated resident 67 was also taking Ativan and that was why he took his drugs 2 hours from consuming alcohol. LPN 1 stated resident 67 would frequently leave the facility with family and come back intoxicated. LPN 1 stated a few month prior, resident 67 was drinking more and more. LPN 1 stated she was unsure if morphine decreased the respiratory drive. LPN 1 was asked about the progress note she had written on [DATE] at 2:45 AM, about putting pills in the resident's mouth. LPN 1 stated resident 67 had been out with his son and been drinking alcohol. LPN 1 stated by the evening, resident 67 could not put pills in his mouth or walk to his room. LPN 1 stated resident 67 told her he felt really woozy. LPN 1 stated she had to put the pills in his mouth to help him get them down. LPN 1 stated she did not know if morphine was included in the pills that were given. LPN 1 stated she would say resident 67 was having a change in his condition. LPN 1 stated after she assisted resident 67 in taking his pills she checked his vital signs because he was taking heart medication. LPN 1 stated she wanted to be sure resident 67's oxygen level was above 90%. LPN 1 stated resident 67 had standing orders for oxygen and to elevate his legs if his oxygen was below 90%. LPN 1 was asked about the the progress note written on [DATE] at 6:58 AM. LPN 1 stated she did not know how much additional oxygen resident 67 was given. LPN 1 stated she thinks she would have documented it and it would be in a progress note. LPN 1 stated the resident's oxygen should be checked every 15 minutes after turning the oxygen up and the oxygen level should be documented in a progress note or in the vital signs. LPN 1 stated if a resident had a change in condition she should notify the doctor and the night supervisor. LPN 1 stated resident 67 was his own responsible party so he would let them know if they should notify his family. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 3:12 PM, an interview was conducted with LPN 4 who stated on the morning of [DATE], she had just come on shift and did not know resident 67's baseline. LPN 4 stated she was told resident 67's oxygen was low. LPN 4 stated she remembered that resident 67 was not typically on oxygen. LPN 4 stated resident 67 had a change in his level of consciousness. LPN 4 stated resident 67 was lethargic and tired, had changed a narcotic he was taking and she thought he had taken too much. LPN 4 stated she was not told about resident 67 having any alcohol intake. LPN 4 stated LPN 1 told her she gave resident 67 his night medications and he was able to answer questions. LPN 4 stated providing medications was unsafe if the resident could not answer questions, stay awake, continue a sentence or follow a simple command. LPN 4 stated if a resident had a change in condition she would take the resident's vital signs, look to see if the resident was being treated for an infection, look at the medications they were taking, look to see if there had been a medication change or if the resident had been given a PRN dose of a medication. LPN 4 stated any time a resident had a change in condition the physician should be notified. LPN 4 stated if she did not feel it was safe to administer medications, she would notify the provider that she was holding the medications. LPN 4 stated when she arrived to work it was already a hectic situation. LPN 4 stated she was a supervisor and did not know the resident. LPN 4 stated she was helping with the paperwork and the day nurse was with resident 67. LPN 4 stated the night nurse had already called 911 because she felt there was not time to wait and that resident 67 should get to the hospital. LPN 4 stated resident 67's eyes were open and he was able to answer questions. LPN 4 stated she vaguely remembered being told that resident 67 had to be suctioned so he could breathe. LPN 4 stated that morphine can be given when a resident was on hospice and it would help with shortness of breath. LPN 4 stated receiving too much morphine could suppress the respiratory system, and if overdosed, breathing would be much less. LPN 4 stated if respirations dropped below 8 the staff would intervene. LPN 4 stated if a resident had a change in condition, the nurse would write a progress note and do an evaluation. LPN 4 stated there was an SBAR, emergency room transfer form, and an e-interact form to document the resident's baseline. LPN 4 stated sometimes that does not always happen. On [DATE] at 3:30 PM, an interview was conducted with the Infection Preventionist (IP). The IP stated the facility did not have a policy and procedure regarding resident overdose. On [DATE] at 1:15 PM, an interview was conducted with Unit Manager (UM) 1 who stated if a resident took pills while in an altered condition they could choke. UM 1 stated resident 67 had been put on morphine for pain related to a previous fall. UM 1 stated resident 67 had been given 2 administrations of rum on [DATE], but had not been given any on [DATE]. UM 1 stated most nurses document when a resident takes a leave of absence (LOA). UM 1 stated LOA forms were scanned into the resident electronic medical record. UM 1 stated she remembered resident 67 would go out and drink with his son, come back drunk, and then want more rum. UM 1 stated LPN 1 should have used her nursing skills and not provided medication to resident 67. UM 1 stated if resident 67 was provided medications as the orders were written he should not have overdosed. UM 1 stated she did not know how alcohol and Morphine interact. UM 1 stated resident 67 had crappy kidneys and was preparing to go on dialysis. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 6:28 AM, a second interview was conducted with LPN 1. LPN 1 stated resident 67 could not put the pills in his mouth so she put them in and gave him some water. LPN 1 stated often, resident 67 would talk with the staff in the evenings. LPN 1 stated resident 67 had been out with his son and he told her that he had a couple more drinks. LPN 1 stated the doctor had told the staff that if resident 67 asks for a drink they should give it to him. LPN 1 stated resident 67 said he was not feeling the best. LPN 1 stated resident 67's vital signs were normal and he wanted to go and lay down. LPN 1 stated during the night of [DATE], resident 67 tanked and they sent him out. LPN 1 stated resident 67 had the ability to sign himself out. LPN 1 stated resident 67 would meet his son at the front door. LPN 1 stated staff were not supposed to ask if a resident had been drinking. LPN 1 stated resident 67 had been telling her what a good time he had with his son. LPN 1 stated if they were aware that a resident had been drinking staff should wait 2 hours before providing pills. LPN 1 stated if resident 67 has taken his medication, he will ask for the alcohol later. LPN 1 was asked if a resident had more to drink than usual, if the 2 hour window was still appropriate. LPN 1 stated it should have been a longer window. LPN 1 stated she would go by the time the resident returned to the facility. LPN 1 stated resident 67's kidney function could have had an effect on processing his medication as it was compromised. LPN 1 stated after resident 67 went to the hospital the doctor told him he should not drink. LPN 1 stated nobody told her the outcome of resident 67's hospitalization on [DATE]. LPN 1 was asked if it was safe to put pills in resident 67's mouth if he had been drinking. LPN 1 stated resident 67 said he still wanted the medications. LPN 1 stated the resident has the right to take his medication. LPN 1 stated resident 67 normally took his medications, but in this occasion he stated he needed help putting the pills in his mouth. LPN 1 stated resident 67 took Melatonin, Prazosin, and one other medication at night. LPN 1 stated she had no other recollections about additional information related this occurrence. LPN 1 stated they did not do a change in condition because it was a new process that was put in place to correct something. LPN 1 stated there was a paper for occurrence charting and another for a change in condition monitoring. LPN 1 stated the change took place last year and it was just a note. On [DATE] at 12:12 PM, a follow-up interview was conducted with UM 1 who stated she thought LPN 1 had mis-remembered about resident 67 going out drinking with his son because there was no documentation that he had signed out of the building. UM 1 stated staff should be making sure that residents sign out if they were leaving the facility. UM 1 stated staff were educated after this event occurred. UM 1 stated a progress note on [DATE] clearly stated that resident 67 was intoxicated and he should have been monitored. UM 1 stated resident 67 had an unwitnessed fall on [DATE] and was screaming in pain, so neuro checks were started, vital signs were taken, resident 67 rated his pain as ,d+[DATE] and was unable to sit up or transfer back to bed. UM 1 stated resident 67 had a small abrasion on his head. UM 1 stated the NP was contacted and gave an order to send resident 67 to the ER. UM 1 stated resident 67's son was also notified. UM 1 stated information was sent with the paramedics. UM 1 stated resident 67 returned from the ER with orders for Morphine. UM 1 stated resident 67 continued to complain of pain in both hips so x-rays were ordered, and an EKG (Electrocardiogram). UM 1 stated resident 67 received a shot of rum at 3:08 PM on [DATE], and a second shot at 9:45 PM. UM 1 stated the MD saw resident 67 on [DATE] at 9:42 AM and reviewed his medications, his stage 5 kidney disease, and addressed his hip and flank pain. UM 1 stated at that time, resident 67's vital signs were stable, he was alert and in no distress. UM stated resident 67 was having a good response to his pain medications and the provider gave an order to decrease the morphine from TID (three times daily) to BID after the TID order expired on [DATE]. UM 1 stated it was possible that resident 67 took a leave of absence and did not sign out. UM 1 stated she provided training because she was unable to complete write-ups on staff. UM 1 stated there should have been more documentation of monitoring resident 67's change in condition. UM 1 stated nurses should not be putting medications into resident's mouths. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	2. Resident 77 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses that included paroxysmal atrial fibrillation, paranoid schizophrenia, metabolic encephalopathy, acute respiratory failure with hypoxia, major depressive disorder, other mixed anxiety disorders, type 2 diabetes, chronic obstructive pulmonary disease (COPD), and chronic kidney disease. Resident 77's medical record was reviewed between [DATE] through [DATE]. A Quarterly MDS revealed resident 77 had a BIMS score of 13, indicating the resident was cognitively intact. Physician orders included, 02 via nc at ,d+[DATE] lpm (liters per minute) to keep sats >90%. A radiology report signed on [DATE] at 4:12 AM revealed, CHEST 1 VIEW; chest, single view .Findings: The cardiomediastinal silhouette is mildly prominent. Pulmonary vascularity is unremarkable. There is opacification of bilateral hemidiaphragms with moderate predominantly bibasilar patchy densities, left greater than right, compatible with pneumonia. There is blunting of bilateral costophrenic angles with small pleural effusions. The bony mineralization is mildly decreased. Mild degenerative changes are noted in the gleno-humeral joints. IMPRESSION: 1. Opacification of bilateral hemidiaphragms with moderate patchy predominantly bibasilar densities, left greater than right, compatible with pneumonia. Small bilateral pleural effusions. Follow up CXR suggested. 2. Mild cardiomegaly. 3. Mild osteopenia, 4. Mild osteoarthritis demonstrated. Resident 77's care plan included: a. [Resident 77] has altered cardiovascular status r/t paroxysmal atrial fibrillation, acute respiratory failure with hypoxia, chronic kidney disease stage 2, chronic obstructive pulmonary disease, long term use of anticoagulants, type 2 diabetes mellitus with other specified complication. The goal was, [Resident 77] will be free from untreated complications of cardiac problems through the review date. Interventions included, Administer cardiac medications as ordered .Monitor/document/report PRN any s/sx of CAD [coronary artery disease]: chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema, changes in cap [capillary] refill, color/warmth of extremities . Obtain vital signs per facility protocol and record. Notify MD of significant abnormalities, Oxygen settings O2 via nasal cannula as prescribed and PRN. Date initiated [DATE]. b. [Resident 77] has respiratory alterations r/t paroxysmal atrial fibrillation, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, and Gastroesophageal Reflux Disease [GERD] without esophagitis. The goal was, [Resident 77] not experience any untreated s/sx of poor oxygen absorption through the review date. Interventions included, Encourage or assist with locomotion as indicated .[Resident 77] is on oxygen per NC [nasal cannula] as prescribed .Monitor for s/sx of respiratory distress and report to MD PRN: Respiration; increased heart rate; diaphoresis; headaches; lethargy; atelectasis; hemoptysis; cough; pleuritic pain; accessory muscle usage; skin color changes .Promote lung expansion and improve air exchange by positioning with proper body alignment. Encourage head of bed to be elevated to 30 to 45 degrees .Refer to MD as needed. Progress notes revealed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	a. On [DATE] at 7:04 PM, Called into room by CNA who indicated that the resident did not look good. O2 sat checked- on 3 L only at 84%. Increased O2 to 5L and O2 only increased to 85%. Breathing treatment given per schedule and an additional prn dose also given. The resident remained on 5L n/c after the treatment and was only sating ,d+[DATE]%. Dr. [physician name removed] notified and received order for stat [without delay] CXR [chest x-ray] and a dose of Lasix 40 mg x1. Changed out the resident's concentrator as the other had a faulty filter. Information given to night nurse and supervisor. It should be noted that when the medical record was reviewed on [DATE] at 8:15 AM, there was no additional documentation after the [DATE] 7:00 PM entry in resident 77's progress notes. b. On [DATE] at 8:50 AM, STAT CXR results received this morning. Results: impression: 1. Opacification of bilateral hemidiaphragms with moderate patchy predominantly bibasilar densities, left greater than right, compatible with pneumonia. Small bilateral pleural effusions. Follow up CXR suggested. 2. Mild cardiomegaly. 3. Mild osteopenia. 4. Mild osteoarthritis demonstrated. Electronically signed by [physician name redacted] [DATE] 0412 [4:12 AM]. MD notified of results, gave new order for Levaquin 500 mg QD [daily] x 7 days. Order for acidophilus 1 capsule TID x 10 days also implemented per facility protocol. Resident is his own responsibility party and was notified of CXR results and new abx [antibiotic] order. First dose pulled from Omnicell and given at 0910 [9:10 AM]. Infection prevention RN [registered nurse] notified. Floor nurse notified to start resident on infection charting. TO: [treatment order]: Levaquin Oral Tablet 500 mg [Levofloxacin] Give 500 mg PO [by mouth] one time only for pneumonia for 1 day AND Give 500 mg PO QD for Pneumonia for 6 Administrations. TO: Acidophilus Oral Capsule (Lactobacillus) Give 1 capsule PO TID for Abx Use for 30 Administrations. On [DATE] at 8:41 AM, an interview was conducted with Licensed Practical Nurse (LPN) 5 who stated resident 77 was doing better. LPN 5 stated the STAT x-ray was completed at about 11:00 PM on [DATE]. LPN 5 stated resident 77's change in condition was happening about the time of shift change on [DATE] so she stayed to help prepare paperwork. LPN 5 stated the night nurse should have written a progress note after the x-ray was completed and what the result was. On [DATE] at 9:24 AM, an interview was conducted with Certified Nursing Aide 1 who stated resident 77's cognition was gradually decreasing and he was pretty sleepy a lot of the time. CNA 1 stated in the mornings, the nurse on duty completed vital signs on the resident. CNA 1 stated CNA's could complete vital signs if requested. CNA 1 stated for the afternoon shift, the CNA's checked resident vital signs as soon as they came on shift. CNA 1 stated resident 77's oxygen has been low recently. CNA 1 stated resident 77 required an increase in oxygen to keep his saturations above 90 percent. CNA 1 stated he learned of resident 77's drop in oxygen level this morning when he arrived at work. CNA 1 stated if he noticed a resident's oxygen saturations were low, he would notify the nurse before making a change to the oxygen. CNA 1 stated if a resident has had lower oxygen levels, the nurse would request the CNA check saturations more frequently. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:57 PM, an interview was conducted with UM 1 who stated a change in condition could be anything that was completely different from the resident's normal behavior or level of cognition. UM 1 stated lethargy was something staff looked for. UM 1 stated if the oxygen saturation was consistently low, it could be a change in condition. UM 1 stated if there was a respiratory problem, that could be a change in condition. UM 1 stated if there was concern for a change in condition, the nurse should do a full assessment and try to determine why the oxygen saturation was low. UM 1 stated a respiratory assessment should also be conducted if the resident was using oxygen. UM 1 stated the medical provider should be contacted for guidance. UM 1 stated the facility had focused assessment guidance for what to do and what kind of information the provider would need. UM 1 stated that with each assessment, the nurse should take the next steps in contacting the physician. UM 1 stated that during the night her expectation would be that the nurse on duty should check on the resident. UM 1 pulled up resident 77's medical record and acknowledged that there was no documentation stating that resident 77's oxygen level had improved with the interventions in place. UM 1 stated it appeared that no follow-up had been done during the night on resident 77 and the nurse on duty should document what was monitored. On [DATE] at 6:23 AM, an interview was conducted with LPN 1 who stated she got a report on resident 77 and a chest x-ray was ordered. LPN 1 stated radiology did not come until almost midnight. LPN 1 stated resident 77 was monitored through the night on [DATE]. LPN 1 stated the staff put resident 77 on an oxygen tank and a nasal cannula because his oxygen concentrator was not working correctly. LPN 1 stated she did not document in the resident's medical record the monitoring that was done. LPN 1 stated she was not told to document the resident's vital signs in the computer. LPN 1 stated resident 77's last oxygen reading was 97% at 5:00 AM. LPN 1 stated there was no order from the doctor to monitor resident 77's oxygen levels. LPN 1 stated the process for a change in condition was there was a paper that was supposed to be filled out. LPN 1 stated the nurse on duty before her had a paper, and she was told to check resident 77's oxygen a few times during the night to make sure it was above 90%. LPN 1 stated the nurse on duty was supposed to put in a progress note. LPN 1 stated she usually put one in, especially if there was a change in condition. LPN 1 stated she would probably have considered the incident on [DATE] a change in condition.

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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** 30563 Based on interview and record review it was determined, for 1 of 38 sampled residents, the facility did not ensure each resident's environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, a resident rolled out of a high bed and hit his head on a feeding tube pump. In addition, a family member noticed the change in condition and transported the resident to the hospital. Resident identifier: 119. Findings include: Resident 119 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included metabolic encephalopathy, Parkinson's disease with dyskinesia, acute kidney failure, dysphagia, muscle weakness, muscle wasting and atrophy, and traumatic subdural hemorrhage without loss of consciousness. Resident 119's medical record was reviewed 7/29/24 through 8/7/24. An admission Minimum Data Set (MDS) dated [DATE] revealed that resident 119 had short and long term memory problems. Resident 119 had severe cognitive impairment with making decisions regarding tasks of daily living. Resident 119 had altered level of consciousness. Resident 119 was dependent which meant helper did all of the effort for rolling left to right, lying to sitting on side of the bed, siting to standing, chair/bed to chair transfer and wheeling 50 feet with two turns. A care plan dated 4/4/24 revealed [Resident 119] is at RISK for FALLS r/t [related to] Metabolic encephalopathy, Parkinson's disease with dyskinesia with fluctuations, dehydration, severe protein calorie malnutrition, severe dementia, personal history of TIA [Transient ischemic attack] , cachexia, hypovolemia, sarcopenia. The goal was [Resident 119] will be free of untreated injury r/t falls through the review date. Interventions dated 4/4/24 were anticipate and meet needs; be sure call light is within reach and encourage resident to use it for assistance as needed and resident needed prompt response to all requests for assistance; educate the resident/family/caregivers about safety reminders and what to do if a fall occurs; ensure appropriate footwear prior to ambulating; physical therapy evaluate and treat as ordered and as needed; and review information on past falls and attempt to determine cause of falls. Record possible root causes. After remove any potential causes if possible. Educate resident/family/caregivers/Interdisciplinary Team as to cause. Interventions developed on the care plan 4/30/24 were bed in lowest position while occupied, fall mat at bedside while occupied, one hour safety checks and use a Call, don't fall sign in room. A nursing progress note on 4/26/24 at 4:22 AM revealed, Initial incident: This nurse was called into room after CNA [Certified Nursing Assistant] witnessed resident fall to floor hitting his head on pole holding kangaroo bags. Neurological observations initiated. Skin tear to right knee, lacerations to right brow and scalp noted. Orders placed to treat wounds. MD [Medical Doctor] and family notified. Resident later sent to [local hospital] ER [emergency room] for evaluation. [Name removed], his son, took resident to hospital at 23:30 [11:30 PM]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The incident report dated 4/25/24 at 8:20 PM revealed the same progress note. The resident description was resident 119 said he was getting up. Resident was not taken to the hospital and was alert and oriented to person. Resident 119 had a laceration to the top of his scalp and face with a skin tear to right knee. A nursing progress note dated 4/27/24 at 1:32 PM revealed, resident 119 remained at the hospital. A form titled NSG (nursing) Neurological Observation revealed on 4/25/24 at 8:20 PM the incident happened. The form had the time, temperature, heart rate, respirations, blood pressure, loss of consciousness, pupils, hand grasps, physician notification of change, and comments. Resident 119's blood pressures were documented: a. Initial blood pressure was 160/72. b. At 8:35 PM, 156/70 c. At 8:50 PM, 160/62 d. At 9:05 PM, 142/69 e. At 9:35 PM, 150/67 f. At 10:05 PM, 99/59 g. At 11:05 PM, 93/53 h. At 12:05 AM, admitted to hospital. According to the form 358 submitted to the State Survey Agency (SSA) resident 119 was admitted to the ER after a fall. Resident 119 was assessed after the fall and had a skin tear to right knee, laceration to right eyebrow and laceration to scalp. The resident's family member noticed a change in cognition and transported resident 119 to the hospital. It was documented by the Administrator that It was determined the bed was in normal position, not low to the ground. The form 359 revealed that resident 119 returned back to the facility and was not a candidate for surgery due to the brain bleed. There was a form title Performance Documentation Form for the nurse that was on shift the night resident 119 fell . The issue was not notifying the MD of the fall and complications within limit of major incident. The Incident Management -Falls form revealed required tasks for nurses. The tasks were assess for injuries before moving, assess for injures after moving, possible signs and symptoms of fracture, notify family or responsible party within one hour of incident, notify MD within 1 hour, complete the first responder packet, write treatment order, place resident on 72 -hour charting, implement a new intervention to prevent future falls and complete incident report. A form title 5-Why's revealed resident was lying be bed, bed height in normal position, not low to the ground. Resident was attempting to get out of bed before staff assisted. Call light at 7:56 PM went off for 4 min and 33 seconds. The root cause was resident 119 did not wait for assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the form titled Investigation Summary dated 4/30/24 there was a fall with an injury. The summary of events or allegation revealed that staff went in to answer resident 119's call light. As staff were entering they saw resident 119 roll out of bed, hit his head on the tube feeding pole and floor. Resident 119 was sent to the hospital later that night with his son to the ER. Resident 119's physical condition was a brain bleed that was diagnosed by the hospital. Summary of Employee Witness Sweeps revealed that resident 119 was not normally in highest position in his bed. Resident 119's History and Physical Reports from the hospital dated 4/26/24 revealed This is an elderly male with severe dementia fell out of bed and presents to the emergency room with interfalcine hemorrhage. This is a nonsurgical medical condition . The Assessment and Plan revealed .1. Subdural hematoma. 2. Scalp Laceration. On 8/6/24 at 3:18 PM, an interview was conducted with Registered Nurse (RN) 3. RN 3 stated if a change in condition was observed or reported she would take down all the information, notify the physician, notify the family and notify the MDS coordinator or Unit Manager (UM). RN 3 stated the nurse was to complete alert charting every shift. RN 3 stated she had only cared for resident 119 once or twice but was a supervisor during the night shift. RN 3 stated she helped nursing staff with cares for resident if there was a concern. RN 3 stated she had assessed residents, contact the physician and notify the administration when there was a concern. RN 3 stated she was supervising the nurses the night resident 119 fell . RN 3 stated she was not notified of the fall until later. RN 3 stated she was told neurological checks were stated and later in the shift resident 119's blood pressure dropped. RN 3 stated the son was at the facility and the son took the resident to the hospital. RN 3 stated she was not sure why the son took the resident instead of calling for an ambulance. RN 3 stated if she had been made aware of resident 119's fall and blood pressure decrease she would have contacted the physician, obtain physician's orders, and made sure that resident did not have a brain bleed. RN 3 stated she thought that resident 119 was diagnosed with a brain bleed at the hospital. On 8/6/24 at 3:32 PM, an interview as conducted with UM 2. UM 2 stated if a resident sustained a fall, a nurses should respond to fall, assess the resident and check for injuries. UM 2 stated after the assessment, as long as CNA's were able to help get the resident up, then the resident was moved. UM 2 stated the physician and family were notified. UM 2 stated the nurse then completed a risk management/incident report and a nurses note. UM 2 stated if there was an injury the MD was notified for new orders and instructions. UM 2 stated resident 119 sustained a fall and the son was notified. UM 2 stated the son came to the facility immediately and felt there was a change in condition. UM 2 stated the physician was notified and the family member felt resident 119's cognition was changing. UM 2 stated the staff notified the physician about the residents change and the resident was taken to the hospital by his family member. UM 2 stated resident 119 had a gash in his head and was bleeding. UM 2 stated she could not remember what his diagnoses at the hospital was but thought it was a brain bleed. On 8/7/24 at 12:38 PM, a follow-up interview was conducted with Unit Manager (UM) 2. UM 2 stated neurological checks were completed after resident 119 fell . UM 2 stated resident 119's systolic blood pressure was averaging 120 to 130 before he fell . UM 2 stated resident 119's blood pressure dropped and his family member took him to the hospital. UM 2 stated the nurse should have documented more monitoring of residents condition. UM 2 stated the RN supervisor on shift was not notified of the blood pressure decreasing. The Fall Prevention Program dated 4/19 and revised on 2/2020 revealed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Intent: The Fall Prevention Program is designed to provide a safe environment for residents. Each resident will be evaluated upon admission, quarterly and, as needed to assess his/her individual level of risk. The Interdisciplinary Team will review fall risk assessments completed by the nursing department. Program Goals: 1. To identify residents at risk in a timely manner. 2. To gather accurate, objective and consistent data for the purpose of implementing an individualized, person-centered care plan designed to meet the resident's needs. 3. To provide consistency in the implementation of preventive measures to assist with reduction of falls. 4. To evaluate outcomes. Guidelines: 1. Upon admission, residents will be considered at risk for falls and general precautions will be implemented. 2. The Fall Risk Assessment will be completed within 24 hours of admission to determine the resident's fall risk factors. 3. The Fall Risk Assessment will be completed on admission, quarterly, and if the resident experiences a significant change of condition. 4. The results of the Fall Risk Assessment will be scored to identify the resident's risk category. 5. Fall committee meeting weekly to build upon interventions as needed. 6. The identified interventions will be implemented and added to the resident's person- centered care plan. 7. Resident falls will be tracked using the Fall Tracking Log. 8. Each resident fall will be thoroughly investigated. 9. Implementation of interventions will be monitored by nursing staff on a routine basis. 10. The 4 P's Rounding program will be a part of the Falls Program. 11. Falls will be reviewed for trends and patterns routinely during a Fall Committee Meeting. Recommendations will be made by the committee, as appropriate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12. The Falls Committee meeting is held routinely, preferably weekly. 13. Fall trends and patterns will be reported to the QAPI Committee on a monthly basis.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30563 Based on interview and record review it was determined, for 2 of 38 sampled residents, that the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, a resident was unable to provide verbal pain scores. The resident sustained a fall and an x-ray was not obtained for 15 days with revealed the resident sustained an L2 fracture. In addition, another resident had pain medication that was documented as ineffective and there was no follow-up. Resident identifiers: 77 and 78. Findings include: 1. Resident 78 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction due to occlusion or stenosis of small artery, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hypertension, dementia, stable burst fracture of second lumbar vertebra, and spinal stenosis. On 7/29/24 at 11:17 AM, an interview was conducted with resident 78's family member. Resident 78's family member stated resident 78 sustained falls prior to admission. Resident 78's family member stated the only issue with the facility was resident 78 fell in the bathroom. Resident 78's family member reported the fall was reported to them immediately and staff reported resident 78 did not have pain. Resident 78's family member stated when they came to the facility and resident 78 complained of pain in his right hip and was rubbing it with some grimacing. Resident 78's family member stated the next day it was reported that resident 78 was complaining of back pain. Resident 78's family member stated about a week later they got a call that resident 78 was being aggressive and they wanted to try a mood stabilizer. Resident 78's family member stated they asked the staff to obtain an x-ray and a urine analysis. Resident 78's family member stated resident 78 had x-ray and he had something wrong with his spine. Resident 78's family member stated they talked with Unit Manager (UM) 1 about resident 78 not getting an x-ray sooner and UM 1 stated that was a mistake by the facility. Resident 78's medical record was reviewed 7/29/24 through 8/7/24. An admission Minimum Data Set (MDS) dated [DATE] revealed resident 78 had a Brief Interview of Mental Status (BIMS) score of 3 out of 15 which indicated severe cognitive impairment. The MDS revealed resident 78 was administered scheduled and as needed pain medication. The MDS revealed that resident 78 was not provided non-pharmalogical interventions for pain. The MDS further revealed that a resident pain interview was conducted. The next section revealed resident 78 was unable to answer if he had the presence of pain. The MDS revealed resident had a fall since admission with an injury. A care plan dated 11/30/23 revealed [Resident 78] has UNDESIRABLE BEHAVIORS as evidenced by wandering, verbal and physical aggression, rejection of cares r/t [related to] Moderate dementia with agitation, MDD [major depressive disorder], insomnia, anxiety disorder 1/12/24 - Resident to Resident Altercation 1/27/24 - Resident to resident altercation (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/8/24 - Resident to Resident altercation 3/6/24 - Resident to Resident Altercation 6/20/24 - Resident to Resident Altercation The goals were [Resident 78's] safety will be maintained daily and he will not experience elopement through the next review and [Resident 78] will not harm others or be harmed by others QD [every day] TNR [through next review] One of the interventions dated 1/29/24 revealed, Ensure pain is addressed. Another care plan dated 11/14/23 revealed [Resident 78] is at RISK for UNCONTROLLED PAIN r/t Cerebral infarction, Moderate dementia with agitation, pain, migraines, old myocardial infarction, MDD, insomnia, anxiety disorder. The goal was [Resident 78] will not have an interruption in normal activities due to pain through the review date. Interventions included Administer analgesia as per orders; Anticipate [resident 78's] need for pain relief and respond immediately to any complaint of pain; Monitor/record pain Severity (1 to 10 scale) every shift and PRN [as needed]; Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment; Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain; and Offer and assist with non-pharmacological interventions for complaints of pain (ie: rest/reposition, heat/ice, massage, sensory stimulation, distraction, etc.). Resident 78's progress notes revealed on 1/25/24 at 1:58 PM, Initial occurrence VS [vital signs] 97.4 [temperature], 51 [heart rate], 18 [respirations], 108/68 [blood pressure]. This nurse was called into residents' room by CNA [Certified Nursing Assistant]. Per CNA resident was being assisted with a shower, as she was finishing and drying the floor resident had his crocs on, attempted to stand and hit a wet spot before CNA could get to that area, resident fell on his behind falling against the plastic shower chair. Back and lower back of his head hit shower chair. When this nurse arrived CNAs had gotten resident up and was ambulating back to his bed. [NAME] [sic] was steady with no issues or pain noted. Assessed for pain or injuries once in bed, ROM [range of motion] is intact per baseline. Assessed leg length, no issues. No injuries present, some redness to bottom however likely due to sitting on shower chair due to area forming a circular design similar to shower chair. Hand grasps equal, A/O [alert and oriented] per baseline. L [left] pupil is reactive, R [right] pupil is enlarged and sluggish. Contacted POA [power of attorney] regarding fall and pupil, per POA pupil to L eye occurred following most recent stroke. Hospital was aware and assessed, nothing new came of it. Placed on NPs [Nurse Practitioner] list to be assessed Friday due to POA having concern that this may not be a normal stroke occurrence. Stated she was OK to wait until NP comes in due to having this issue upon arrival with no changes noted. No further concerns present. Will follow up as needed [POA name removed] aware, MD aware, placed on incident charting as well as neuro checks. No further issues noted, will follow up as needed. A progress note dated 1/26/24 at 8:51 AM, Resident complains of lower back pain. New order per house standing orders: Acetaminophen 650mg [miligrams] PO [orally] Q [every] 6 hrs [hours] PRN [as needed] NTE [not to exceed] 3G [grams] in 24 hours. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 1/26/24 and discontinued on 2/8/24 revealed Acetaminophen Oral tablet 650 mg by mouth every 6 hours as needed for pain. Resident 78's January 2024 Medication Administration Record (MAR) revealed on 1/26/24 at 9:00 AM resident had a pain score of 8 out of 10, on 1/26/24 at 4:36 PM a pain score of 6 and on 1/27/24 at 7:21 AM pain score of 5. A progress note dated 1/26/24 at 5:28 PM, .He has complaints of some back pain today. PRN Acetaminophen administered with reported good effect . A progress note dated 1/27/24 at 10:42 AM, .Resident stating that PRN APAP [acetaminophen] has not been managing pain effectively. New order Ibuprofen 400 mg Q 8h PRN for pain. POA and MD notified. A progress note dated 1/27/24 at 2:02 PM, Dietary staff was standing at door to res [resident] room when this nurse walked by. res was standing near his bed and res2 was on floor by the door. This nurse stood by res to keep him away from res2 and noticed bld [sic] on res left hand. Res yelling at res 2. Res stated that res 2 was standing in door and wouldn't let res out of room. res stated res 2 was yelling at res so res hit res 2. Res has cut to left forth finger and bruise to left 3rd finger. Cut cleansed and bandage applied. A progress note dated 1/27/24 at 2:51 PM, .Resident on charting for witnessed fall on 1/25. Resident has been endorsing back pain this shift unrelieved by APAP. No other s/s [signs and symptoms] injury observed. New order for ibuprofen added. Shoes or nonskid socks on AAT [at all times]. Ensuring pain is managed and needs are met. A progress note dated 2/2/24 at 3:17 PM, [Resident 78's] fall on 1/25 was reviewed in antigravity on 1/30/24. [Resident 78] was in the shower, assisted by CNA. He slipped on a wet spot on the floor standing up from the shower chair. No injuries noted at the time of occurrence, but [resident 78] later c/o [complained of] of [sic] back pain. PRN Ibuprofen was given over the course of 5-7 days. Staff reports it was effective with pain management and that he no longer has complaints of back pain. Grip tape was place [sic] in bathroom outside of shower. A progress note dated 2/2/24 at 4:06 PM, This am at breakfast res starting yelling and swearing at male residents at a different table. Res was taken into the dayroom by RNA [Restorative Nurses Aide] who had res sit at table for breakfast. Once res sat down he flipped off the res at the other table. RNA stayed with res until he calmed down. Will continue to monitor behaviors. A progress note dated 2/3/24 at 3:17 PM, Refused 2 or more meals in the day. Nurse to document and start supplements. If continues, consult Registered Dietitian. Res ate snacks and is able to let staff know when he is hungry. A progress note dated 2/8/24 at 10:19 AM, Occurrence charting Physical aggression received. This nurse heard res yelling in dining room. This nurse and CNA split residents apart and had res leave dining room. Res 2 was going into dining room to sit at his normal table where Res was sitting sideways in a chair. Res 2 pushed res chair to the side and toward table. This upset res who stood up and slapped res 2 in face. Res 2 stated that it didn't hurt, he was fine and didn't really feel anything. Res stated that Res 2 pushed him, so res stood up and hit res 2. This nurse talked with res about what happened and asked that if res has something happen that he doesn't like to come to a staff member. Dgtr [daughter] [name removed] notified who stated she would talk with SSW [Social Service Worker] next week at the res care conference. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 2/8/24 at 11:36 AM, This nurse spoke with [physician name removed]. [Physician's name] regarding [resident 78]'s recent mood swings from very happy to very angry rapidly that resulted in a few resident to resident occurrences and regarding possible unaddressed pain due to [resident 78] not always being able to communicate his needs effectively. [Physician's name] recommended changing PRN acetaminophen to 650mg PO BID [twice daily] for pain and starting Depakote125 mg PO BID to help with mood swings. This nurse spoke with daughter [name removed] regarding MD recommendations. [Name removed] is agreeable to scheduling acetaminophen. She would like to have some time to research possible adverse effects of Depakote as to make an educated decision regarding a mood stabilizer medication for her dad. She has had issues with prior facilities and administering medications without notifying her of adverse reactions that have occurred. This nurse educated [name removed] regarding facility psychotropic protocol including monitors each shift for possible adverse effects of medications and quarterly psychotropic meetings . No further concerns at this time. New order: Acetaminophen 650mg PO BID for pain. Keep PRN dose as ordered. Resident 78's February 2024 MAR revealed a physician's order for Acetaminophen give 650 mg by mouth two times a day related to pain. In addition, Acetaminophen 650 mg administer every 6 hours as needed for pain was administered on 2/9/24 with a pain score of 7 and it was ineffective. A social services note dated 2/8/24 at 3:19 PM, .[Family member] then went on to discuss Depakote, pain, and [resident 78's] aggression She also requested that [resident 78] be tested for a UTI [urinary tract infection] and get an xray of the hip he most recently fell on to rule out infection and fracture as the causes of aggression . A progress note dated 2/8/24 at 3:32 PM, This nurse spoke with [name of physician] regarding Daughter [name removed] request for an x-ray and UA [urine analysis]. [Name of Physician] is agreeable to x-ray and UA. New orders: 1- Lumbar x-ray 2-AP and Lateral Pelvis x-rays 3-UA with culture and sensitivity if indicated . A progress note dated 2/9/24 at 1:46 AM, X-ray results of lumbar spine show compression fracture of T10, T9, and L2. On call NP notified by floor nurse at approx 0135 [1:35 PM] of results, NP ordered a referral to neuro surgeon. Rn supervisor notified Administrator of new fx [fracture] findings at 0137 [1:37 AM]. Daughter notified of xray result at 0145 [1:45 AM] by night floor nurse, answering questions and educating her on process for setting up appt [appointment] for referral. res has been denying pain, but does groan and grimace when getting self from lying to standing position. res has prn Tylenol and ibuprofen for treatment of pain. res has been ambulatory without assistance. res was offered pain meds tonight but refused them. will cont to monitor. A nursing note dated 2/9/24 at 5:18 AM, .Resident on charting d/t [due to] being recipient of physical aggression from another resident. Resident responded with aggression himself. Resident has been in good mood this shift. No agitation or aggression noted this shift. Resident denies pain but s/sx of 2/10 pain noted while this nurse was assessing resident. Resident was moaning as he lifted self from laying to sitting position. Resident had x-ray results returned this shift . A nursing note dated 2/9/24 at 3:44 PM, NP [name removed] ordered the following. 1- tramadol 50mg PO TID [three times a day] PRN as needed for pain 2- Thoracic and lumbar spine MRI without contrast related to fractures (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents daughter notified of new orders. A Physician/Practitioner note dated 2/13/24 at 12:39 PM, Asked to see patient to evaluate his lumbar compression fractures. Patient has had recurrent falls both before he was admitted and has had some since. Patient states that he has had chronic back pain. He states that his pain is no worse now than it was before. It is been well managed. He has had x-ray that show compression fractures of unknown age and recommend CT scan .Musculoskeletal: Some mild tenderness with percussion of his thoracic and lumbar spine. Assessment/plan Compression fractures: Patient has had x-rays showing age indeterminate compression fractures. These could be from prior to admission or since admission. He has not noticed any change in his pain. He has had falls. Will obtain a CT scan for better evaluation. Will also get a DEXA bone scan. By a definition with compression fractures he does. Have some osteoporosis if were osteopenia at least. A nursing progress note dated 2/13/24 at 2:44 PM, TO [telephone order]: CT [computed tomography] for thoracic, lumbar spine. Per [Physician's name],MD. for compression fractures to T9, T10, L2. Signed order, facesheet faxed to [local hospital] Imaging on 2/13/24. Appointment was then scheduled for Wednesday, February 21, 2024 at 3:30pm . On 7/31/24 at 9:38 AM, an interview was conducted with CNA 2. CNA 2 stated she was assisting resident 78 with a shower on 1/25/24 when he dropped a rag and stepped on to the floor and fell down. CNA 2 stated she was in resident 78's room to grab his clothing because resident 78 was able to shower independently. CNA 2 stated resident 78 has a shower bench but refuses to sit when showers. CNA 2 stated she was able to see resident 78 but was unable to get to resident quick enough before he fell backwards into a sitting position. CNA 2 stated resident 78 hit the lower back on the ground. CNA 2 stated resident complained of pain to his privates. CNA 2 stated there were no increased complaints of pain that day. CNA 2 stated with resident 78's personality, she was not sure if he would ever tell staff he was in pain. CNA 2 stated resident 78 had the tough guy personality and it was tough to know when he was in pain. CNA 2 stated when resident 78 was in pain, he slept more or laid down more. On 7/31/24 at 9:07 AM, an interview was conducted with LPN 7. LPN 7 stated resident 78 would not tell staff if something hurts or if he was in pain. LPN 7 stated staff ask him daily about pain. LPN 7 stated each resident has a pain evaluation completed daily. LPN 7 stated resident 78 had complained of his back being sore. LPN 7 stated that if staff ask resident 78 if he is in pain he will say no, but if staff ask about a specific area of his body he will report pain. On 7/31/24 at 9:19 AM, an interview was conducted with RN 4. RN 4 stated staff tried to manage resident 78's pain and he had as needed Tramadol and Tylenol with scheduled Ibuprofen. RN 4 stated she watched resident for non-verbal cues of pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 10:15 AM, an interview was conducted with Unit Manager (UM) 2. UM 2 stated pain was monitored daily with vital signs for each resident. UM 2 stated after resident 78 sustained a fall on 1/25/24 and then a resident to resident altercation on 1/27/24, resident was started on as needed pain medication. UM 2 stated staff were monitoring to see if the aggression was from increased pain or aggression with dementia. UM 2 stated if staff asked resident 78 if he was in pain, he would say he was fine. UM 2 stated staff were to use a non-verbal pain scare for resident 78 because he moaned and groaned when he was moving but when asked would say he was fine. UM 2 stated as needed Tylenol seamed to work really well. UM 2 stated some nursing staff were recording resident 78's pain as no pain but other staff members were observing non-verbal pain. UM 2 stated resident 78 was cranky, aggressive, moaned, groaned and winced to show he was in pain. UM 2 stated that resident 78 was having pain probably for less than a month after his fall. UM 2 stated the numerical pain scale was not appropriate to use for him. UM 2 stated the she was not not sure if there was education to nurses regarding using the non-verbal pain scale. UM 2 stated CNA's were good at alerting UM's about resident 78's non-verbal pain. UM 2 stated resident 78's pain was discussed in a clinical meeting and an x-ray was ordered after about a week because his pain was not improving. UM 2 stated the clinical meeting would have been documented in the progress notes. UM 2 stated she was unable to find notes about the clinical meeting but the progress notes revealed resident 78's pain was not controlled. UM 2 stated that staff were to get x-rays within 24 to 48 hours after a fall. UM 2 stated resident 78's x-rays were delayed because resident 78 had a history of back pain. UM 2 stated the x-rays should have been completed sooner. On 8/5/24 at 9:00 AM, an interview was conducted with the Administrator. The Administrator stated that resident 78 did not have increased complaints of pain after the fall. The Administrator stated that she was sure the x-ray would come back negative because resident 78 did not appear to be in pain. The Administrator provided pain scores for resident 78. The form revealed that staff were using a numerical system to determine pain verses PAINAD (non-verbal). The form revealed pain from 0 to 8 reported between 1/25/24 through 2/9/24. 43212 2. Resident 77 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses which consisted of CHF(congestive heart failure), morbid obesity, PTSD (post traumatic stress disorder), palliative care, insomnia, metabolic disorder, suicide attempt, hypokalemia, obstructive uropathy, anxiety disorder, MDD (Major Depressive Disorder), fusion of spine, pain, HTN (Hypertension), BPH (Benign Prostatic Hypertrophy), and OSA (Obstructive Sleep Apnea). On 7/30/24 at 7:48 AM, an interview was conducted with resident 77. Resident 77 stated he had pain in both knees and he thought the left knee might be broken. Resident 77 stated he had pain in the back and shoulders also. Resident 77 stated that his current level of pain was 8/10. Resident 77 stated that his pain medication did not alleviate his pain. Resident 77 stated that nothing made the pain more tolerable. Resident 77 stated that the facility had tried everything to decrease his pain. Resident 77 stated that he had worked with physical therapy to improve his strength. Resident 77's medical record was reviewed between 7/29/24 and 8/7/24. Resident 77's physician's orders revealed: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. On 5/13/24, Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Milligram per milliliter) (Morphine Sulfate) Give 1 ml by mouth every 1 hours as needed for Pain or SOB (shortness of breath) b. On 3/7/24, Gabapentin Oral Tablet 600 MG (Gabapentin) Give 600 mg by mouth three times a day for chronic pain related to other idiopathic peripheral autonomic neuropathy. c. On 2/20/24, Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth two times a day related to other chronic pain d. On 8/22/23, Acetaminophen Oral Tablet (Acetaminophen) Give 1000 mg by mouth three times a day for pain related to pain. e. On 9/27/22, Question resident about presence of pain or burning including pressure points. Monitor for pain using 0-10 scale. 0 for no pain, 10 for worst pain possible. If resident is not able to answer, use painad scale. Review of the July 2024 MAR revealed that all scheduled pain medication was documented as administered per the physician orders. The as needed Morphine was documented as administered 12 times for the month. It should be noted that the Morphine was ordered Q (every)1 hr as needed. On 7/1/24 at 10:10 PM and on 7/3/24 at 10:28 AM the administration was documented as ineffective. Review of the MAR progress notes revealed the following: a. On 7/1/24 at 12:50 AM, an administration progress note revealed, Note Text: Morphine Sulfate (concentrate) Oral Solution 20 MG/ML(milligrams per milliliter); Give 1 ml by mouth every 1 hours as needed for pain or SOB; PRN Administration was : Ineffective; resident stated pain is still bad; Follow-up Pain Scalel was: 7. It should be noted that no additional doses of pain medication were documented as administered for the ineffective pain relief. b. On 7/3/24 at 10:28 AM, an administration progress note revealed, Note Text: Morphine Sulfate (concentrate) Oral Solution 20 MG/ML; Give 1 ml by mouth every 1 hours as needed for pain or SOB. Reports 10/10 generalized pain. It should be noted that additional doses of pain medication were not administered until 2 hours after the initial administration. c. On 7/3/24 at 12:31 PM, an administration progress note revealed, Note Text: Morphine Sulfate (concentrate) Oral Solution 20 MG/ML; Give 1 ml by mouth every 1 hours as needed for pain or SOB. PRN administration was: Ineffective; Follow-up pain scale was: 10; First dose not effective. Another dose administered. Resident 77's Care Plan revealed, [Resident's name redacted] has a TERMINLA PROGNOSIS r/t CHF, metabolic disorder; Date initiated: 3/8/2024, Revision on: 3/8/2024. The goals were: [Resident 77] comfort will be maintained through the review date. Date initiated: 3/8/2024; Revision on: 3/8/2024; Target Date: 9/2/2024. Interventions included: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Adjust provision of ADLS [Activities of Daily Living] to compensate for [Resident 77] changing abilities. Encourage participation to the extent [Resident 77] wishes to participate; Date Initiated: 03/08/2024 b. Assess [Resident's name redacted] coping strategies and respect [Resident's name redacted] wishes; Date Initiated: 03/08/2024 c, Contact [Hospice company] @ [phone number]; Date Initiated: 03/08/2024 d. Encourage family and [Resident's name redacted] to attend and participate in IDT [interdisciplinary team] meetings; Date Initiated: 03/08/2024 e. Encourage support system of family and friends; Date Initiated: 03/08/2024 f. Encourage to follow homelike routine, encourage family to provide personal items to increase comfort; Date Initiated: 03/08/2024 g. Encourage visits from family and friends; Date Initiated: 03/08/2024 h. Ensure [Resident 77] comfort and quality of life is met at the highest potential daily; Date Initiated: 03/08/2024 i. Evaluate the need for support services and assist with referral PRN; Date Initiated: 03/08/2024 j. [Resident 77] is on Hospice; Date Initiated: 03/08/2024; Revision on: 03/08/2024 k. [Resident 77] is under the care of Bristol Hospice Services; Date Initiated: 03/08/2024 l. Nursing staff monitor and manage symptoms r/t end of life care and notify hospice when noted. Symptoms such as: changes in pain, nausea, agitation, respiratory concerns, lethargy, vertigo, skin is [resident's name redacted], or infections in order to keep [resident's name redacted] comfortable. Date Initiated: 03/08/2024 m. Observe (Resident 77) closely for signs of pain, administer pain medications as ordered, and notify physician if interventions are unsuccessful or if current complaint is a significant change from [resident's name redacted] past experience of pain. Date Initiated: 03/08/2024 n. Observe resident closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain. Date Initiated: 03/08/2024 o. Refer to Hospice MD (Medical Doctor) PRN; Date Initiated: 03/08/2024 p. Refer to Social Services PRN; Date Initiated: 03/08/2024 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	q. The [Name of facility redacted] and [Name of Hospice redacted] will coordinate (Resident 77) cares, medications, and treatments. On 8/7/24 at 8:54 AM, an interview was conducted with LPN 3 who stated resident 77 complained of generalized pain. LPN 3 stated resident 77 had scheduled Morphine and Tylenol. LPN 3 stated depending on his pain, resident 77 had prn morphine also. LPN 3 stated that sometimes resident 77 forget that he had been given his morphine and asked for it again. LPN 3 stated, For the most part his pain is controlled. LPN 3 stated resident 77's hospice provider came to see him, but he did not know how often, maybe every 2 days. LPN 3 stated the hospice RN was at the facility every other day as well. LPN 3 stated that after providing Morphine, the nurse would ask about resident 77's pain, and if the pain medication was not effective they could offer an additional dose. LPN 3 stated if resident 77 was sleeping and comfortable, the pain medication would be considered effective. On 8/7/24 at 1:19 PM, an interview was conducted with LPN 4 who stated she had taken care of resident 77 since he was signed on to hospice services. LPN 4 stated sometimes resident 77 had to take a few doses before the Morphine became effective. LPN 3 stated there were a few times when resident 77 refused his pain medication. LPN 4 stated if resident 77's pain medication was ineffective, she would give a second dose of morphine. LPN 4 stated she remembered there were a couple of times that the dose of Morphine was not effective. LPN 4 stated she would check with resident 77 after half an hour to see if his pain medication was effective.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43212 Based on observation and interview, the facility did not have the nurse staffing information posted. The facility must post the following information on a daily basis: The facility name, the current date, the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: Registered Nurses, Licensed Practical Nurses, Certified Nurses Aides, and the resident census. The facility must post the nurse staffing data on a daily basis at the beginning of each shift and maintain the posted daily nurse staffing data for a minimum of 18 months. Additionally, the information must be displayed in a prominent place readily accessible to residents and visitors. Findings include: On 7/29/24 at 8:05 AM, an observation was made of the nursing staff posting which was located inside the facility entry area across from the reception desk. There were 2 days of postings observed: One of the postings was dated 7/14/24, the other was dated 7/15/24, with the 5 being difficult to read legibly. On 8/7/24 at 8:15 AM, an observation was made of the nursing staff posting. One of the postings was dated 8/4/24, the other was dated 8/5/24. On 8/7/24 at 10:53 AM, an interview was conducted with the Certified Nursing Aide Coordinator (CNAC) who stated the night supervisor in the building was responsible for posting the nursing hours. The CNAC stated the information on the postings was different every day based on who was scheduled to work.

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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. 38031 Based on observation, interview and record review it was determined that the facility did not ensure that the medication error rates was not 5 percent or greater. Observations of 35 opportunities revealed 2 medication errors which resulted in a 5.71 percent medication error rate. Specifically, a resident was administered thyroid medication not on an empty stomach and an apical pulse was not obtained prior to administering Digoxin. Resident identifier: 24. Findings included: On 7/31/24 at approximately 8:25 AM, an interview was conducted with resident 24. Resident 24 was being administered his morning medication by Licensed Practical Nurse (LPN) 2. Resident 24 stated that he had just finished breakfast and it was his favorite, biscuits and gravy. LPN 2 was observed to administer all morning medications to the resident 24 which included Digoxin tablet 125 micrograms (mcg) by mouth one time a day for atrial fibrillation and Levothyroxine tablet 75 mcg by mouth one time a day for hypothyroidism. Resident 24's physician's orders were reviewed and revealed no supplemental information or hold parameters that were specific to a pulse. The Levothyroxine order documented an administration time of 6:00 AM. On 7/31/24 at 8:31 AM, an interview was conducted with LPN 2. LPN 2 stated that she obtained resident 24's vital signs with the machine and the heart rate was 87. LPN 2 stated that it was safe to administer the medication because the HR was above 60 beats per minute. LPN 2 stated no apical pulse was obtained for the Digoxin. LPN 2 stated that the order did not have instructions to obtain an apical pulse. LPN 2 stated that she should double check with an apical pulse. LPN 2 stated that the Levothyroxine was scheduled to be administered at 6:00 AM, and was administered late. Registered Nurse (RN) 2 stated she was the supervising RN. RN 2 stated that the Levothyroxine should be administered 30 minutes to 1 hour before any other medications or food for better absorption because if it was administered with food or other medication it became less effective. On 7/31/24 at 10:35 AM, an interview was conducted with RN 1. RN 1 stated with Digoxin staff should take an Apical pulse prior to administration. RN 1 stated that the pulse should be checked prior to administration because it lowers the heart rate and the order should say to hold if heart rate is less than 60. RN 1 stated it should be noted that the order did not contain parameters to hold the medication. RN 1 stated that the radial pulse could be different, and apical pulse was more accurate. RN 1 stated that it was a nursing standard of practice to obtain an apical pulse prior to administration of Digoxin. RN 1 stated that the physician ordered the Digoxin because 24 was having his Metoprolol held due to hypotension. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 8:39 AM, an interview was conducted with Unit Manager (UM) 1. UM 1 stated that staff should be giving scheduled medication within an hour of the administration time unless a resident requested not to have it at that time. UM 1 stated Levothyroxine should be administered 30 to 60 minutes prior to meals and be given on an empty stomach. UM 1 stated what was why it was scheduled at 6:00 AM and could be administered as late as 7:00 AM. UM 1 stated that resident 24 liked to have all his medication together in the dining room, and it should be on his care plan. UM 1 reviewed the care plan and stated no documentation could be found of the resident preferences with regards to medication administration. The Levothyroxine order was reviewed by UM 1 and she stated that it did not state to administer with other medication. UM 1 stated that the medication should be given on an empty stomach. UM 1 stated that nurses should be taking apical pulse for 30 seconds to 1 minute prior to administration of the Digoxin. UM 1 stated staff were looking for any abnormal or low heart rate prior to administration and if it was within the parameters to administer. Review of the Nursing 2022 Drug Handbook documented that prior to oral administration of Digoxin the nurse was to take a apical-radial pulse for 1 minute. The guidance further stated to notify the prescriber of any significant changes such as sudden increase or decrease in pulse rate, pulse deficit, or irregular beats. Wolter Kluwer. 42nd Edition Nursing 2022 Drug Handbook. 2022, Philadelphia, pp. 436-440.

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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** 30563 Based on interview and record review it was determined, for 2 of 38 sampled resident, that the facility did not ensure each resident was free of any significant medication errors. Specifically a resident was administered pain medication and anti-anxiety medications not according to physician's orders. In addition, another resident had a blood thinner held longer than 7 days. Resident identifiers: 50 and 119. Findings include: 1. Resident 50 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included chronic obstructive pulmonary disease, anxiety disorder, chronic kidney disease, major depressive disorder and osseous stenosis ofneural canal ofcervical region. Resident 50's medical record was reviewed 7/29/24 through 8/7/24. Resident 50's physician's orders revealed the following orders: a. On 5/23/24 Methadone HCl (hydrochloride) Oral Tablet 10 MG (milligrams) (Methadone HCl). Give 30 mg by mouth two times a day related to vertebrogenic low back pain; other chronic pain; Watch dose Give with breakfast and lunch. b. On 5/23/24, Methadone HCl Oral Tablet 10 MG (Methadone HCl) Give 40 mg by mouth at bedtime related to Vertebrogenic low back pain; other chronic pain *watch dose*. c. On 5/2/23 and discontinued on 5/20/24 Methadone HCL Oral Tablet 10 MG (Methadone HCL) Give 30 mg by mouth two times a day related to other chronic pain and give 40 mg by mouth at bedtime related to other chronic pain. d. On 10/31/23 and discontinued on 11/14/23, Xanax Oral Tablet 0.25 MG (Alprazolam) Give 0.25 mg by mouth as needed for Anxiety/restlessness related to anxiety disorder . BID (twice daily) PRN [as needed]. Progress notes, incident reports and narcotic records were reviewed and revealed the following: a. On 4/19/23 at 4:27 PM, Occurrence Charting VS [vital signs]: [Temperature] 97.9, [heart rate] 63, [respirations] 16, [blood pressure] 144/76, [saturations] SpO2 97% on 3LPM [liters per minute] via NC [nasal cannula] This nurse administered 10mg of methadone this AM [morning] instead of the prescribed 30mg as ordered. [Physician's name removed] notified no new orders at this time. No s/o [sic] [signs and symptoms] if increased pain this shift. [Name removed], Resident's daughter notified via telephone by this nurse, verbalized understanding. Call light within reach. On 4/19/23 at 7:23 AM, the incident report documented, This nurse administered only one tab instead of three as ordered of his methadone. Resident did not say anything about pain until afternoon. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Narcotic record for Methadone HCL 10 MG tablets revealed resident was administered 1 tablet on 4/19/23 at 7:23 AM. b. On 11/5/23 at 6:55 PM, During Shift count it was noted that res this shift has been given Xanax rather than methadone. MD, res [resident] and family was notified. No new orders other than to monitor res. This nurse did move prn narcotics behind scheduled ones. This nurse will continue to review orders and ensure correct medication is to be given. res did report he was a little more tired than usual. res is scheduled for a shower today however res requesting to be have shower changed until tomorrow evening. Res and staff to help with cares and transfers as res may be needing more assistance. On 11/5/23 at 6:00 PM, an incident report documented the same note as above and Res did report that he was a little more tired. Immediate action taken was Notification to supervisor, MD, res and family done. Res prn narcotics moved to behind scheduled ones. Res shower moved to tomorrow to monitor res. The incident report was prepared by Licensed Practical Nurse (LPN) 8. Resident 50's Narcotic Record for November 2023 revealed Methadone was administered on 11/3/24 at 8:00 PM 3 tablets that were 10 mg each. Alprazolam 0.25 mg tablets on 11/4/24 at 3:45 PM 1 tablet was administered with 12 tablets left and then on 11/5/23 it was documented that count was corrected with 5 tablets left. c. On 3/27/24 at 1:39 PM, Occurrence Charting- Med Error VS; 175/84, 76, 18, 97.9, 91% RA This nurse was going through the narcotics book and on his page noticed that he had been given 10 mg of methadone last shift instead of 40 mg. Supervisor and resident notified (res his own POA). Resident said that he had noticed there was only to spoonful last night instead of the usual three or four and he hadn't been able to sleep last night or get comfortable. Resident rated pain 6/10 this morning before he knew about the error. Resident frustrated and said that he didn't think he would have to count his pills like he did when he was at home. On 3/27/24 at 10:30 AM, an incident report documented, Nurse was going through narcotics record book and discovered that resident was given 10 mg of methadone instead of 40 mg in the shift before. Resident rated pain 6/10 that morning before error was discovered. The resident description was I guess that explains why I didn't sleep well last night. I couldn't get comfortable. I noticed that the nurse only gave me two spoonfuls of medication instead of three or four like usual. That nurse doesn't work over here often does she? I guess I'll need to count my pills like I did at home. I didn't think I would have to here. The Immediate Action Taken was RN [Registered Nurse] supervisor and resident notified. Daughter came in for a visit and nurse talked about it with her as well. Vital signs are WNL [within normal limits], pain was rated 4/10 later in the day after methadone doses were given in the morning and afternoon of the shift. No change in LOC [loss of consciousness]. The nurse documenting the incident report was RN 5. A review of resident 50's Narcotic Record for March 2024 revealed on 3/26/24 at 10:45 PM 1 tablet was administered. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 at 12:12 PM, an interview was conducted with LPN 8. LPN 8 stated that she was proctoring a student nurse on 11/5/24. LPN 8 stated that the she overlooked the medication dose while talking to the student. LPN 8 stated that she thinks that she dispensed the medication and administered it and not the student nurse. LPN 8 stated resident 50 was a new admission and she was not familiar with his medication. LPN 8 stated resident 50 was supposed to have 30 mg or three tablets and he received 10 mg or one tablet. LPN 8 stated that she could not recall how she identified the error. LPN 8 stated that she notified the supervisor, family and the MD and he was monitored for 72 hours post incident and they conducted a full set of VS per shift. LPN 8 stated there was no worsening or increased complaints of pain with the medication omission. LPN 8 stated the family was worried that resident 50 might have increased pain and the methadone was the only medication that helped. LPN 8 stated the physician stated to monitor resident 50. LPN 8 stated she did not administer the additional dose at the time of the identification of the error. LPN 8 stated that when dispensing they should be looking for the right patient, right dose and right route for administration. On 8/1/24 at 12:26 PM, an interview was conducted with RN 5. RN 5 stated that she was familiar with resident 50, but that she had not cared for resident 50 in a couple of months. RN 5 stated that when she pulled the morning dose on 3/27/24 she identified that the previous shift had given him only one 10 mg tablet instead of 40 mg tablet. RN 5 stated that the nurse who made the error was another nurse. RN 5 stated that she texted the supervisor and notified the MD. RN 5 stated she then went in and told the resident and the daughter what had happened. RN 5 stated that she checked the residents VS and asked him if he was in any pain. RN 5 stated that resident 50 took his medication in applesauce and that was what he meant by spoonfuls. RN 5 stated resident 50 usually rated his pain high even without the medication error and he always said he could not sleep. RN 5 stated that she recalled that resident 50 did report more pain that day. RN 5 stated that she administered resident 50's scheduled methadone and monitored the effectiveness. RN 5 stated that after the resident was informed of the dosage error he rated his pain higher. RN 5 stated the MD instructed her to monitor his pain level but no further orders were provided. RN 5 stated that she was not aware if resident 50 had any additional PRN pain medication. RN 5 stated that she did not administer any additional pain medication to resident 50. On 8/1/24 at 1:10 PM, an interview was conducted with Unit Manager (UM) 2. UM 2 stated staff should look for any PRN medication, notify the MD, and conduct an assessment for any change in condition or complaints of pain. UM 2 stated resident 50 had a recent order for the Xanax. UM 2 stated in the narcotic book the medication was separated by resident and resident 50 had scheduled methadone and she popped the Xanax instead of the methadone. UM 2 stated the nurse did not verify the medication blister pack with the narcotic count and MAR. UM 2 stated the nurse didn't notice that she had done it until she reconciled with the next shift. UM 2 stated that she did not know if the Xanax and methadone looked alike. UM 2 stated staff should be verifying the 5 to 7 rights of medication administration, verifying right drug, right patient, right dose, right route, right time. UM 2 stated the nurse should have looked at the MAR, the narcotic sheet and the narcotic blister card. UM 2 stated resident 50's did not complain of any increased pain. UM 2 stated resident 50 did not have any noticeable side effects. UM 2 stated resident 50 reported the next morning that he was more tired and asked his shower to be changed. UM 2 stated resident 50 had asked staff for help with care and transfers. 2. Resident 119 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included metabolic encephalopathy, Parkinson's, acute kidney failure, and dysphagia, traumatic subdural hemorrhage without loss of consciousness, fall on same level. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 119's medical record was reviewed from 7/29/24 through 8/7/24. Progress notes revealed the following: Resident 119's progress notes revealed the following: a. On 4/25/24 at 11:00 PM, T.O. [telephone order] Send to [local hospital] ER [emergency room] for evaluation r/t [related to] fall with head injury. b. On 4/25/24 at 11:48 PM, 2305 [11:05 PM]: Son told floor nurse who then relayed info to this RN supervisor that 'Per his Cardiologist,[Name and clinic name removed] he can't have any Beta Blockers or Blood Thinners d/t [due to] his fall with head injury.' This RN placed an order to hold Plavix [Clopidogrel Disulfate] x7 days with info to f/u [follow up] as instructed by son at [phone number removed] to have it stopped, with any Beta Blockers. MD notified. Floor nurse aware. It should be noted that the progress note was a created on 4/26/24 at 4:51 PM. c. On 5/29/24 at 4:44 PM, Orders - Administration Note Plavix is currently on HOLD (x7 days). Per son, f/u [follow up] with Cardiologist, .to have it stopped *And any Beta Blockers* d/t fall with head injury. D/C ORDER AND PUT IN A NURSES NOTE ONCE COMPLETED. every shift for Son's Request. Order reinstated. d. On 5/29/24 at 5:44 PM a nursing note revealed, This nurse was notified by floor nurse that [resident 119's] order for Plavix was still on hold. Resident had a previous fall w/ [with] head injury and on 4/26 his neurologist requested that Plavix be held x 7 days and should have been restarted on 5/3/24. [Resident 119] has not shown any adverse side effects during this time. [Physician's name removed] was contacted, and stated 'OK, no problem'. Plavix was restarted today. Voicemail was left for son to call UM back. WCTM [will continue to monitor]. A physician's order dated 3/16/24 revealed Clopidogrel Disulfate Oral Tablet 75 MG. Give 1 tablet via NG [nasogastric]-tube one time a day related to Atherosclerotic heart disease of native coronary artery without angina pectoris. According to the April 2024 Medication Administration Record (MAR) the last dose of Clopidogrel Bisulfate was administered between 6:00 AM and 10:00 AM was on 4/24/24. According to the May 2024 MAR Clopidogrel Bisulfate was administered on 5/30/24 and 5/31/24. Resident 119 was not provided the blood thinner from 4/24/24 until 5/30/24. On 8/6/24 at 3:18 PM, a phone interview was conducted with RN 3. RN 3 stated resident 119 sustained a fall and hit his head. RN 3 stated she was not sure which physician had staff hold resident 119's blood thinner. RN 3 stated she clarified orders as part of her supervising position. RN 3 stated she was not aware that the blood thinner was held longer than 7 days. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/24 at 3:32 PM, an interview was conducted with UM 2. UM 2 stated resident 119 sustained a fall and had a gash in his head from hitting his head. UM 2 stated that a family member took resident 119 to the hospital and had contacted resident 119's specialist to let them know about the fall. UM 2 stated the family member told the nurse at the facility to hold the blood thinner incase there was a brain bleed according to the specialist. UM 2 stated staff were waiting for the family member to contact the facility to restart the blood thinner instead of contacting the physician. UM 2 stated the facility physician was notified when it was found that resident 119 was not receiving his blood thinner. UM 2 stated the risks of not having the blood thinner could be another stroke.

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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. 38031 Based on observation, interview and record review it was determined that the facility did not ensure that all drugs and biologicals were stored and labeled in accordance with accepted professional principles, under proper temperature controls and cautionary instructions, and the expiration date when applicable. Specifically, a medication cart was left unlocked and unattended. In addition, medication was available for use past the expiration date. Resident identifiers: 60. Findings include: 1. On 7/31/24 at 7:36 AM, an observation was made of the 200 hallway. Registered Nurse (RN) 6 was observed with a medication cart. RN 6 was observed to unlock her medication cart and walk away from the cart leaving it unattended. RN 6 was interviewed and stated she could not believe she left the cart unlocked and unattended. 2. On 7/31/24 at 9:19 AM, an observation was made of the 200 hallway medication cart. There was a Basaglar kwikpen with an open date of 6/29/24 that was available for use and was labeled for resident 60. Licensed Practical Nurse (LPN) 3 was interviewed and stated the medication should have been discarded. LPN 3 stated the medication was good for 28 days from the time that it was opened. On 8/1/24 at 8:30 AM, an interview was conducted with Unit Manager (UM) 1. UM 1 stated that if a staff member stepped away from the medication cart they should lock the medication cart and lock the computer screen, and no medications should be left sitting out. UM 1 stated the process for checking for expired medications was done by the nurses. UM 1 stated the leadership team conducted random audits. UM 1 stated insulin pens were only good for 28 days from the date of open. UM 1 stated she reminded the staff to check their medication cart monthly for any expired medications, and the central supply staff rotated the over the counter stock. UM 1 stated the Central Supply Clerk should notify the nursing staff of any expired medication in the central supply.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43212 Based on interview, the facility did not employ a clinically qualified full-time dietitian or another clinically qualified nutrition professional to serve as the director of nutrition services. Specifically, the facility did not employ a full time Registered Dietitian (RD) and the Dietary Manager (DM) did not meet the requirements to serve as the director of food and nutrition services. Findings include: On 7/29/24 at 9:14 AM, an interview was conducted with the DM who stated she was in the middle of getting her certification to serve as the DM. The DM stated she had been doing the job as a DM for [AGE] years, and had been employed at the facility for 2 years. The DM stated another full time kitchen employee ([NAME]) had completed the certification for DM, but was not working in that role. On 8/7/24 at 11:04 AM, a follow-up interview was conducted with the DM who stated it was her understanding that having 2 years of experience as the DM met the requirement to serve as the DM. The DM stated she was taking the required courses, but had to obtain an extension due to a medical concern, and had not yet completed the course. The DM stated the RD conducted a kitchen audit once per month and shared her findings with the DM, the Administrator, the infection control coordinator, and the corporate Dietitian. The DM stated the RD also conducted an audit of one kitchenette area out of the four each month and rotated between them. The DM stated if the RD had findings she would provide her with recommendations. On 8/7/24 at 11:05 AM, an interview was conducted with the [NAME] who stated she had been working at the facility for [AGE] years, but was no longer certified to be a dietary manager.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43212 Based on observation and interview, it was determined that the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food items in the walk-in freezer and walk-in refrigerator were open to air. Findings include: On 7/29/24 at 9:14 AM, an initial kitchen tour was conducted. In the walk-in freezer a box of peanut butter cookie dough was open to air, a box with egg patties was open to air, a box containing corn on the cob was open to air, a box containing breaded chicken was open to air, and a box containing corn dogs was open to air. On 8/7/24 at 11:04 AM, a follow-up kitchen tour was conducted. In the walk-in refrigerator, a bag of parmesan cheese was open to air. In the walk-in freezer a box of peanut butter cookie dough was open to air, a box with sausage links was open to air, a box with frozen cut corn was open to air, a box with frozen peas was open to air, a box with chicken fried beef patties was open to air, and a box containing corn dogs was open to air. On 8/7/24 at 11:18 AM, an interview was conducted with the Dietary Manager (DM) who stated if food items in the freezer were taken from a box and the box was not emptied, it would be returned to the freezer. The DM stated if there was very little food from that box left it would be wrapped and dated and returned to the freezer or thrown away. The DM stated items in the refrigerator and freezer were checked every day. The DM stated the morning managers checked items in the refrigerator and freezer in the mornings. The DM stated the cooks should be aware if the food items were stored properly. The DM stated that the Registered Dietitian (RD) came to the facility on ce per week, and conducted a kitchen audit once per month. The DM stated if the RD had concerns she would share them with the DM, the administrator, the Infection Control coordinator and the corporate dietitian. The DM stated items left open to air in the refrigerator or freezer could result in freezer burn or contamination and all items should be sealed and dated whether inside the box or outside of the box.