STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495153	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedars Healthcare Center	1242 Cedars CT Charlottesville, VA 22903

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 41449 Based on staff interview and facility documentation review, the facility staff failed to implement their abuse policy with regards to the pre-screening of employees for 24 employees in a survey sample of 26 employee records reviewed. The findings included: On 11/19/24, a random sample of 26 employees was selected for review of evidence of pre-screening in accordance with state licensure survey activity and compliance with the facility's abuse policy. On 11/21/24, a meeting was held with the human resources director to review the sampled employees' files, and the following was noted: 1. For fourteen employees, the facility staff obtained a criminal background check from the Virginia State Police, beyond 30 days from hire. For Staff #1, #5, #6, #7, #8, #9, #13, #15, #16, #17, #18, #19, #20, and #22, the facility staff obtained a criminal background check from the Virginia State Police on 10/8/24 and 10/9/24, following an audit of employee files. Some of the employees were hired as much as 1 year and 8 months prior to the criminal background being obtained. On 11/21/24 at approximately 9:15 a.m., an interview was conducted with the Human Resource Manager (HRM). The HRM explained that A criminal background check [CBC] is obtained when we send their offer letter. We receive the CBC before they come through orientation. If they change their hire date and it is beyond 30 days, we have to run it again. When asked why a CBC is obtained, the HRM stated, To make sure they don't' have barrier crimes. We can't have anyone with barrier crimes, we have to protect our residents and ourselves. On 11/21/24, during the interview, the HRM explained that she had conducted an audit of all employee files and said, I pretty much re-ran everybody's criminal background, because when I was doing an audit and if I didn't find one, I re-ran them. We QAPI'ed [quality assurance and performance improvement] it. The HRM was asked to provide a copy of her audit. Review of the audit provided revealed that the HRM had identified each of the 14 staff noted above and obtained a criminal background check at that time. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For nine employees (Staff #3, #10, #11, #14, #21, #23, #24, #25, and #26), the facility staff failed to obtain a criminal background check. For Staff #3, who was hired 1/17/23, the facility staff did not have a criminal background check on file from the Virginia State Police (VSP). For Staff #10, who was the human resources manager and hired 8/21/23, the facility had no evidence that a criminal background check had been obtained from the VSP. For Staff #11, who was a physical therapist and was hired 11/21/23, the facility staff had no evidence of a criminal background check being obtained. For Staff #14, who was the director of nursing and was hired 4/3/24, the facility staff had no evidence that a criminal background check from the VSP was obtained. For Staff #21, who was hired as a nurse aide in training on 8/26/24, the facility had no evidence of a criminal background check (CBC) being obtained from VSP. For Staff #23, who was hired as a physical therapist on 9/23/24, the facility had no CBC from VSP on file. For Staff #24 and Staff #25, who were both registered nurses and hired in October 2024, the facility staff failed to have a CBC from VSP on file. For Staff #26, who was an agency CNA and was subject of an abuse investigation, the facility had no evidence of a CBC from VSP being obtained. It was noted that 7 of the 9 employees with no CBC had also been identified during the HRM's audit of employee files as not having a CBC on file. At the time of survey, there was still no CBC available/on file. Staff #24 and #25, were hired after the HRM's audit and were both beyond 30 days of hire at the time of survey. They had no criminal background check on file. Therefore, past non-compliance was not achieved. 3. For five employees (Staff #2, #8, #9, #17, and #20), the facility staff failed to verify the employee's professional license prior to allowing the staff member to work with residents. For Staff #2, who was a certified nursing assistant (CNA), the license verification indicated that the employee had additional public information noted against their license. The facility had no evidence that they had looked at the additional information to determine if Staff #2 was eligible for employment with the facility and what the adverse actions were. For Staff #8, who was hired 6/12/23, as a licensed practical nurse (LPN), the facility did not verify that the employee held a current and unencumbered license to practice until 8/7/23. According to the license look-up verification conducted on 8/7/23, Staff #8 had additional public information against their nursing license. The facility staff had no evidence that they had reviewed this information to determine if the nurse had any disciplinary action against their license that could have been a factor in their ability to work in a nursing home. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For Staff #9, who was a CNA hired 7/6/23, the facility staff failed to verify that the employee held a current certification to practice as a nurse aide until 8/3/23. For Staff #17, who was the facility administrator, the facility had no evidence that they verified that the employee held a current, active, and unencumbered license to practice as a nursing home administrator with the department of health professions. The facility only had a copy of the license on file for Staff #17, which only indicated that the employee held the license as some point. For Staff #20, who was hired as a CNA on 1/18/24, the facility staff failed to verify the employee held a current, active, and unencumbered certificate with the board of nursing until 3/12/24. On 11/21/24, in the morning, an interview was conducted with the HRM. The HRM stated, A license look-up is to make sure their license is active, and they don't have anything pending on their record, to prevent them from giving care to our residents. When asked, when the license look-up is conducted, the HRM stated, We look it up when we do the interview. When asked, what if they have information on their license? The HRM stated, I print it off and give it to the ED or DON [executive director/administrator or director of nursing], they review, and I reach out to my regional. They sign off on it to say if we can hire. We don't want someone in the building if they can cause harm to the residents. We want to know if they are safe to work with residents. According to the facility policy titled, Abuse, Neglect, and Exploitation Policy- Virginia, it read in part, . I. Screening: 1. Employees seeking hire will complete an application including three (3) personal references as well as a work history of the last three (3) positions held, if applicable. a. Following the personal interview and upon recommendation from the interviewer, a background check will be performed . 2. A criminal background check will be completed to meet state requirements . 4. Licensure/registry check will also be performed, as applicable, after the interview to verify a. The Nurse Aide Registry b. State Board of Nursing, c. Other professional registries. 5. This facility will not employ individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriate of their property . On 11/21/24 at 2:50 p.m., the HRM was given a detailed listing of the above findings include the employees' names and items noted above. On 11/21/24, during an end of day meeting, the facility administrator was made aware of the above findings. No additional information was provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 41449 Based on staff interviews, resident interviews, clinical record review, and facility documentation review, the facility staff failed to report allegations of abuse for three residents, Resident #11 (R11), Resident #55 (R55) and Resident #120 (R120) out of a survey sample of 30 residents. The findings included: 1. For Resident #120 - R120, who reported an allegation of rape, the facility reported the initial allegation to the state survey agency but failed to submit a follow-up report with the investigation findings. On 11/20/24, the surveyor reviewed the facility documentation and electronic health record of R120, which noted the resident was no longer a resident of the facility and therefore was not available for interview. On 11/20/24, in the afternoon, the facility administrator was asked to provide any information they had with regards to R120. On 11/20/24, in the afternoon, the facility provided a one-page document that was dated 9/26/24. It read in part, [City name redacted] Police Detective [name redacted] reported to a facility that [R120's name redacted] stated she was raped while she was a resident at the facility. The investigation started immediately. All residents were assessed for injury and harm; none were noted or reported. Per the detective, no identifying information was given by the resident. The form was signed by the director of nursing (DON). The facility administrator stated that no follow-up report was sent because they determined that according to hospital records that R120's allegation was against the hospital and not the facility. The administrator also stated that they would be providing education to the DON. On 11/20/24, the DON was interviewed that afternoon. When questioned about reporting of R120's allegations, the DON stated that the facility doctor had access to the hospital electronic records and noted that the allegation was against the hospital and not this nursing facility. The DON stated that she didn't feel a follow-up report was warranted. However, the DON confirmed that she had filed the initial report, and this information had been determined as part of their investigation process. On 11/20/24, the facility also provided the survey team with copies of R120's hospital records that read in part, .Of note, patient called a nursing hotline while in the ED [emergency department] and endorsed she was being neglected and sexually assaulted under the ED's care . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/24 at 10:20 a.m., a follow-up interview was conducted with the facility administrator, who stated he was the abuse coordinator of the facility. When asked about R120's allegation, and evidence of the investigation that included the residents being assessed as indicated in the form reported to the state survey agency on 9/26/24. The administrator confirmed that they didn't have any evidence of an investigation nor that the investigation results had been reported. When questioned further, the facility administrator confirmed that all allegations of abuse should be reported immediately but no more than two hours if there is bodily harm and all other incidents within 24 hours. The administrator explained that an investigation is started and . once the investigation is concluded, we report with a final report within five days. When asked what was done regarding R120's allegation, the administrator said, We reached out to the hospital for more information, and they said the allegation was against [hospital name redacted] emergency department. The administrator was asked why the DON was handling the allegation involving R120, since the administrator was the facility's abuse coordinator. The Administrator stated, At that time I had not commandeered that process yet and was I will still in training. The administrator stated that they provided the DON with a teachable moment and a copy was provided to the survey team. The document was dated 11/20/24, and read, DON submitted an FRI [facility reported incident] without completing an investigation or 5-day final. Moving forward DON will follow risk escalation process and involve the ED [executive director] in all FRI's. On 11/21/24, a review of the facility's abuse policy was conducted. The policy read in part, . V. Reporting of Incidents and Facility Response: . 3. The results of the facility's investigation must be reported to the survey agency, the ED/Designee [executive director] and other officials in accordance with state law, within five working days of the incident . On 11/21/24 and 11/22/24, during an end of day meeting, the facility administrator was made aware of the above findings. No additional information was provided. 49456 2. The facility staff failed to notify all required agencies of an allegation of abuse that involved R11 and certified nursing assistant, CNA#3. On 11/21/24 a review of facility documentation was conducted, which includent the incident summary and the facility synopsis of an allegation of abuse that involved R11 and CNA#3. No documentation was found that showed that the Virginia Department of Health professions (DHP) was notified of the determination of abuse that involved a certified nursing assistant, identified as CNA3. While the incident summary was completed on 9/15/24. the facility fax confirmation read, no answer, for the DHP on 9/16/24 and 9/19/24, On 11/21/24 at 2:00 p.m., an interview was conducted with the administrator. The Administrator said, Sometimes the fax numbers are busy, and we have to keep faxing. The Administrator was not able to show that the incident had been successfully faxed to fulfill the required abuse reporting. On 11/22/24 a review of facility documentation was completed. CNA#3's employee file was reviewed and there was no sworn statement or criminal background check in her file. 3. The facility staff failed to notify all required agencies of an allegation of abuse for R55. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 a review of facility documentation was completed, which included a facility incident dated 9/13/24. The facility documentation showed that the required agencies were not notified of this allegation of resident to resident abuse of R55 until two days after the allegation was made. The administrator only had one faxed confirmation to all agencies in the facility summary and it was dated 9/15/24. On 11/21/24 at 2:15 p.m., an interview was conducted with the administrator. When asked about the reporting timelines for abuse, the administrator said, We have 2 hours to report allegations of abuse, and the investigation is supposed to begin immediately. When shown the documentation of this abuse allegation, the administrator stated that he did not know why this was reported on 9/15/24 instead of 9/13/24, which was when the incident summary was completed. On 11/21/24 and 11/22/24, during an end of day meeting, the facility administrator was made aware of these findings noted above. No additional information was provided.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 41449 Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide credible evidence of an investigation being conducted following an allegation of sexual abuse for one resident (Resident #120-R120) in a survey sample of 30 residents. The findings included: For Resident #120- R120, who made an allegation of being raped, the facility staff failed to have credible evidence of an investigation being conducted. On 11/20/24, the surveyor reviewed the facility documentation and electronic health record of R120, which noted that R120 discharged from the facility on 9/20/24. According to progress notes dated 9/20/24, which read in part, .Patient had a recent ECO [emergency custody order] for similar symptoms, primarily mania. Due to her current mental status, she likely does not have capacity to make appropriate medical decisions for herself. Because of patient's severe psychiatric symptoms, her interfering with staffs' ability to provide care to herself and others, and her creation of a hostile environment, she would be best served by hospitalization with an ECO for further evaluation . On 11/20/24, in the afternoon, the facility administrator was asked to provide any information they had with regards R120's allegation of rape. On 11/20/24, in the afternoon, the facility provided a one-page document that was dated 9/26/24. It read in part, [City name redacted] Police Detective [name redacted] reported to a facility that [R120's name redacted] stated she was raped while she was a resident at the facility. The investigation started immediately. All residents were assessed for injury and harm; none were noted or reported. Per the detective, no identifying information was given by the resident. The form was signed by the director of nursing (DON). The facility administrator stated that he had no additional information to provide and stated that he would be providing education to the DON. On 11/20/24, in the afternoon, the DON was interviewed. The DON stated that an investigator with the police department had called her and reported that R120 alleged she was raped. The DON stated that because R120 was a resident of the facility when sent to the hospital, the detective was informing the facility. The DON stated the facility doctor had access to the hospital electronic records and noted that the allegation was against the hospital and not this nursing facility, so she didn't feel any further action was needed. On 11/20/24, the facility provided the survey team with copies of R120's hospital records that read in part, . Of note, patient called a nursing hotline while in the ED [emergency department] and endorsed she was being neglected and sexually assaulted under the ED's care . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/24 at 10:20 a.m., a follow-up interview was conducted with the facility administrator, he confirmed he was the abuse coordinator of the facility. When asked about R120's allegation, and the initial report of the allegation indicating that, The investigation started immediately. All residents were assessed for injury and harm, none were noted or reported . The surveyor asked for the evidence of the investigation and resident assessments/interviews. The administrator confirmed that they didn't have any evidence of an investigation nor that the investigation results were reported. The administrator was asked why the DON was handling the allegation involving R120, since the administrator was the facility's abuse coordinator. The Administrator stated, At that time I had not commandeered that process yet and was I will still in training. The administrator stated that they provided the DON with a teachable moment and a copy was provided to the survey team. The document was dated 11/20/24, and read, DON submitted an FRI [facility reported incident] without completing an investigation or 5-day final. Moving forward DON will follow risk escalation process and involve the ED [executive director] in all FRI's. On 11/22/24, a review of the facility's abuse policy was conducted. The policy read in part, . V. Investigation of Incidents: 1. In the event a situation is identified as abuse, neglect or misappropriation, an investigation by the executive leadership will immediately follow. a. The Director of Nursing (DON) and Executive Director (ED) receives reports of resident incidents. The Executive Director determine when an investigation is required and directs the investigation . No additional information was provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on staff interview and clinical record review, the facility failed to develop a care plan for one of thirty one residents. Resident #5 (R5) did not have a complete care plan developed for incontinence. The Findings Included Review of R5's clinical record noted diagnoses for R5 included incontinence of bowel and bladder, chronic congestive heart failure, and chronic atrial fibrillation. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 9/27/24, which assessed R5 with a cognitive score of 14 out of 15, indicating cognitively intact. On 11/19/24 at 11:41 a.m. during an interview, R5 verbalized having incontinent episodes and that the staff did a good job at keeping her clean and dry. Review of R5's MDS dated [DATE], Section H - Bowel and Bladder, documented that R5 was Always Incontinent of bowel and bladder. Review of R5's care plan did not indicate a care plan had been developed for incontinence. On 11/21/24 at 11:54 a.m., license practical nurse (LPN #2, MDS coordinator) was interviewed. After reviewing the MDS and the care plan, LPN #2 verbalized that the nurse should have created a care plan regarding incontinence based on the assessment when first being admitted to the facility, which should have been updated into the care plan. On 11/21/24 at 4:54 p.m., the above finding was presented to the administrator during an end of day staff meeting. No other information was presented prior to exit conference on 11/22/24.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to follow physician orders for seven of thirty residents in the survey sample (Residents #20, #40, #70, #77, #80, #93 and #323). The findings include: 1. Resident #20 was not administered the medication methadone as ordered by the physician. According to the clinical record, Resident #20 (R20) was admitted to the facility with diagnoses that included diabetes, peripheral vascular disease, neuropathy, congestive heart failure, hypertension, and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R20 as cognitively intact. R20's clinical record documented a physician's order dated 11/1/24 for methadone 10 milligrams with instructions to give one tablet twice per day for pain management. R20's medication administration record documented the methadone was not administered as ordered on 11/15/24, 11/16/24, and 11/17/24 (morning dose). Nursing notes on 11/15/24, 11/16/24, and 11/17/24 documented that the methadone was not available in the medication cart and was pending delivery from the pharmacy. A nursing note dated 11/16/24 documented R20's methadone was reordered on 11/12/24. On 11/20/24 at 3:12 p.m., the licensed practical nurse unit manager (LPN #3) caring for R20 was interviewed about the missed methadone doses. LPN #3 stated the scripts were sent to the pharmacy prior to running out but the pharmacy was not timely with deliveries. LPN #3 stated the pharmacy reported the medications were to be delivered but did not show up. LPN #3 stated the pharmacy at times will report that they do not have the needed scripts when the scripts have already been sent. LPN #3 stated methadone was not kept in the backup supply. LPN #3 stated there had been ongoing issues with the pharmacy regarding timely deliveries. On 11/20/24 at 3:33 p.m., R20 was interviewed about the missed doses of methadone. R20 stated she was recently made aware that the methadone had not been received from the pharmacy. R20 denied any pain concerns from the missed doses. R20 stated, I'm on a bunch of stuff and again stated she had no issues with pain control. On 11/20/24 at 4:16 p.m., the director of nursing (DON) was interviewed about medications not available from the pharmacy. When asked if she was aware that nurses reported ongoing issues with getting medicines delivered timely, the DON had no response. The DON stated nurses were able to reorder medications from the refill screen in the computerized health record. This finding was reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p. m., with no further information presented prior to the end of the survey. 2. Resident #40 was not administered Calmoseptine ointment as ordered by the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the clinical record, Resident #40 (R40) was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease), dementia, diabetes, cellulitis, depression, coronary artery disease, and anemia. The minimum data set (MDS) dated [DATE] assessed R40 with severely impaired cognitive skills. R40's clinical record documented a physician's order dated 10/29/24 for Calmoseptine external ointment 0.44-20.6 % (menthol-zinc oxide) with instructions to apply to bilateral buttocks every shift for folliculitis. R40's medication administration record documented the Calmoseptine ointment was not applied on 11/15/24, 11/16/24 or 11/17/24. Nursing notes on 11/15/24, 11/16/24 and 11/17/24 documented the Calmoseptine ointment was on order from the pharmacy and not available for administration. On 11/20/24 at 3:11 p.m., the licensed practical nurse unit manager (LPN #3) was interviewed about the Calmoseptine ointment administration. LPN #3 stated the Calmoseptine ointment was not ordered from the pharmacy but was an in-house stocked item. LPN #3 stated she was not sure why the Calmoseptine ointment was not available. On 11/21/24 at 10:05 a.m., the supply clerk (other staff #4) was interviewed about R40's Calmoseptine ointment. The supply clerk stated nursing usually informed her of needed ointments/creams. The supply clerk stated, Calmoseptine is not something I've ordered. The supply clerk stated she had received no request from nursing or hospice for the Calmoseptine ointment. The supply clerk stated the Calmoseptine ointment was not kept in stock but could be ordered if needed. This finding was reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p.m., with no further information presented prior to the end of the survey. 3. Resident #93 was not administered Pataday 0.2% eye drops and Azelastine 0.05% eye drops as ordered by the physician. According to the clinical record, Resident #93 (R93) was admitted to the facility with diagnoses that included spinal stenosis, bradycardia, sick sinus syndrome, hypertension, neurogenic bladder, depression, and insomnia. The minimum data set (MDS) dated [DATE] assessed as cognitively intact. On 11/19/24 at 11:44 a.m., R93 was interviewed about quality of care in the facility. R93 stated during this interview that he had not received eye drops as ordered by the physician. R93 stated the eye doctor had ordered two medications for his eyes due to itching/redness. R93 stated he had missed several doses of the drops, and he was told they ran out and were not available for some reason. R93 denied any problems from missing the drops but stated he wanted his medications administered as ordered. R93's clinical record documented the following physician orders for eye drops, listed with the order date. 7/6/24 - Azelastine HCL ophthalmic solution 0.05% drops with instructions to instill one drop in both eyes two times per day for allergic conjunctivitis. 11/12/24 - Pataday ophthalmic solution 0.2% with instructions to instill one drop in both eyes each day for itch/redness relief. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R93's medication administration record (MAR) documented the Pataday drops were not administered on 11/2/24, 11/3/24, 11/4/24 and 11/11/24. Nursing notes on these dates documented the medication was on order from the pharmacy and not available for administration. R93's MAR documented the Azelastine drops were not administered on 11/14/24, 11/15/24 and 11/17/24. Nursing notes on these dates documented the last dose was given on the morning of 11/14/24. Notes documented the medication was ordered from the pharmacy and not available for administration starting on the evening of 11/14/24. On 11/20/24 at 3:05 p.m., the licensed practical nurse unit manager (LPN #3) was interviewed about R93's missed eye medications. LPN #3 stated R93's missed eye drop doses were because the medications were not available in the cart. LPN #3 stated that nurses were required to reorder medications when approximately eight doses were left so that medications could be delivered prior to running out. LPN #3 stated there had been trouble with the pharmacy delivering medications timely even when ordered on time. On 11/20/24 at 4:16 p.m., the director of nursing (DON) was interviewed about medications not available from the pharmacy. When asked if she was aware that nurses reported ongoing issues with getting medicines delivered timely, the DON had no response. The DON stated nurses were able to reorder medications from the refill screen in the computerized health record. The facility's policy titled Missed Medication/Medication Error (undated) documented, .The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner .For any medication(s) not available during a routine medication pass .The Charge Nurse will check the E-kit [backup supply] to attempt to offer medication in a timely manner .In the event the medication is not available from the E-kit or the Emergency Pharmacy, the Charge Nurse will notify the Physician immediately .The Charge Nurse will notify the pharmacy and attempt to obtain the medication . The DON/designee is responsible for monitoring undocumented medications to assure residents are receiving their medications as ordered . This finding was reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p. m., with no further information presented prior to the end of the survey. 41449 4. For Resident #80 (R80), who was on methadone for pain, the facility staff failed to administer the medication in accordance with physician orders. On 11/19/24 at 11:18 a.m., R80 was visited and interviewed in his room. During the interview R80 reported that he had cancer and suffers with continuous, unrelieved pain, despite being on pain medication. On 11/19/24-11/20/24, a clinical record review was conducted. According to the physician orders, R80 had a current and active order that read, Methadone HCl Oral Tablet 5 MG (Methadone HCl) Give 7.5 mg by mouth two times a day for Pain Give 3 half tabs to equal 7.5mg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the medication administration record (MAR), R80 was not given the Methadone as ordered on 11/2/24, and 11/3/24. According to the nursing notes, an entry dated 11/2/24, read, On hold MD [medical doctor] aware, waiting for it to come from pharmacy. A nursing note entry dated 11/3/24, read, awaiting pharmacy delivery, MD/RP [medical doctor/responsible party] aware. Documentation indicated that on 11/8/24 and 11/12/24, R80 only received one dose. On 11/13/24, R80 didn't receive either of the two ordered doses and on 11/14/24, only the evening dose was administered. On 11/20/24, in the afternoon, an interview was conducted with R80. R80 confirmed that at times he doesn't receive his Methadone for pain. R80 reported he has pain all the time due to the cancer and can't say that his pain is any worse when he goes without the Methadone. On 11/20/24, during an end of day meeting, the facility leadership was made aware of the above findings. No additional information was provided. 5. For Resident #70 (R70), the facility staff failed to administer Suboxone as ordered by the physician. On 11/19/24 at 10:58 a.m., an interview was conducted with R70. During the interview, R70 reported he doesn't always get his medication. On 11/19/24-11/20/24, a clinical record review was conducted. This review revealed that R70 had an active physician's order that read, Suboxone Sublingual Film 4-1 MG (Buprenorphine HCl-Naloxone HCl Dihydrate) Give 1 film sublingually two times a day for Opioid dependence. The medication administration record documented that R70 did not receive either of the scheduled doses on 11/7/24. R70's nursing note entries were made with regards to the Suboxone that read, waiting for script and hold on order. On 11/20/24 at 3:56 p.m., an interview was conducted with licensed practical nurse #4 (LPN #4) and registered nurse #1 (RN #1). Both nurses explained that if they are administering medications and a medication is not available, they would search for the medication, then would look in the Pixis [an on-site back-up supply of medications], and if still not available, they would call the doctor to notify them that the dose may be missed or delayed, and ask what they wanted the nurse to do. On 11/20/24 at 4:16 p.m., an interview was conducted with the Director of Nursing (DON). When notified of finding multiple instances where residents are not being administered their medications, the DON said that many times there is an insurance issue that prevents the pharmacy from sending the medications. On 11/20/24 at 4:40 p.m., an interview was conducted with the facility's medical director (MD), who was also the attending physician for both R80 and R70. When the MD was made aware that numerous instances were documented when R80 and R70 were not administered medications as ordered, the MD stated, The pharmacy won't send the amount I write for them. [Pharmacy name redacted] has been difficult to work with lately. I send prescriptions via e-script [electronically] and they will say they didn't get it, and it takes multiple calls. Then there are a few days delay in getting them delivered to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Missed Medication/Medication Error, was conducted. The policy read in part, Medication error/incident: any physician/provider prescribed medication that is not administered to the resident as prescribed regardless of the category or the reason for not providing the medication . It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of residents. The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner .II. For any medication(s) not available during a routine medication pass: 1. The charge nurse will check the E-kit [emergency kit/ on-site back-up supply of medications] to attempt to offer medication in a timely manner. 2. If medication is taken from the E-kit, the pharmacy will be notified so the E-Kit can be exchanged. 3. In the event the medication is not available from the E-kit or Emergency Pharmacy, the charge nurse will notify the physician immediately and receive guidance on how to proceed. The physician may give orders to HOLD the medication or an order to change the medication to something that is currently available. 4. The charge nurse will notify the pharmacy and attempt to obtain the medication. 5. The charge nurse will notify the DON of any medication that is not available . On 11/20/24, during an end of day meeting, the facility administrator was made aware of the above findings. No additional information was provided. 49456 6. The facility staff failed to administer R77's pain medication as ordered. On 11/20/24 9:16 a.m., an interview was conducted with R77. R77 said, The staff don't order my pain meds, and I am out for days. Then I just get Tylenol and that does not help. I am without my pain medication, and I have been out since this weekend. On 11/20/24 a clinical record review was conducted. R77 had an order that read, Oxycodone HCl 5 mg tablet give 7.5 mg by mouth every 4 hours for pain. The medication administration record shows that R77 was taking the medication several times daily and had not received any of the pain medication since Saturday 11/16/24. According to the medication administration record, the nursing staff noted that Tylenol was effective following administration. There was no indication that R77's pain was increased or that an alternate pain medication was provided when the Oxycodone was not available. On 11/20/24 at 4:00 p.m., an interview was conducted with a licensed practical nurse, LPN5. LPN5 stated that R77's pain medication . came in today. When questioned further, LPN5 said, [R77's name redacted] was without her pain medication for 3-4 days, but it was ordered. We have problems with getting medications here timely from the pharmacy. On 11/22/24 at 11:00 a.m. an interview was conducted with OS18, who was a pharmacist at the facility's contracted pharmacy. When asked about the unavailable mediations, OS18 stated that R77's prescription was received on 11/19/24 at 6:45 p.m. at the pharmacy and that the pharmacy delivered the medication to the facility on [DATE] at 9:46 a.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/21/24 11:33 a.m., an interview was conducted with the director of nursing (DON). The DON stated that the nurse should go to the E-Kit, which is the facility's stock of medications and get the medication needed. The DON said that if the medication was not available, then the nurse should contact the doctor to obtain a prescription and send it to the pharmacy to have the medication filled. The DON stated that she expected that follow up on medication ordered from the pharmacy was to be ongoing and should be done until the medication has arrived at the facility. On 11/22/24, an end of day meeting was conducted with the administrator and corporate staff about the above findings. No additional information was provided. 7. The facility staff failed to have R323's pain medication available. On 11/19/24 at 4:20 p.m., R323 was observed sitting on the side of her bed. R323 appeared to be anxious, observed to have both hands shaking and shifting weight from side to side. R323 was observed requesting Imodium and Tylenol at 4:30 pm and inquired about her Methadone and Gabapentin medication, which she stated had been missed that morning due to being unavailable. On 11/19/24 4:31 p.m., an interview was conducted with R323. R323 stated that she had not received her pain medications because they are not available. R323 said, I arrived yesterday around 1:30 p.m. and have missed all doses of my medication except for Tylenol. I have not had my Methadone or Gabapentin at all. It was also observed that the nurse returned and administered the Tylenol and Imodium at 5:00p.m. The nurse told R323 that the doctor had sent in a prescription to the pharmacy and the other medications would come in that night. On 11/20/24 at 4:00 p.m., an interview was conducted with LPN5. When asked about R323's pain medications, LPN5 stated, while showing the med drawer, that R323's Methadone and Gabapentin was not at the facility. LPN5 stated that R323 had received one dose of Methadone at the facility and that R323 would go out to the clinic on Friday to get more pain medication. On 11/21/24 11:33 a.m., an interview was conducted with the director of nursing (DON) regarding R323's unavailable medications. The DON stated that Methadone was not available in the E-Kit but Gabapentin should have been available. On 11/22/24 at 11:00 a.m. an interview was conducted with OS18, who was a pharmacist at the facility's contracted pharmacy. OS18 stated that the prescription for the Methadone was sent to the pharmacy on 11/20/24 but did not have an appropriate diagnosis for the medication. OS18 stated that R323's medication order was pending due to an attempted contact with the facility about the prescription, that had not been addressed by the facility. OS18 stated that the pharmacy records did not indicate that the facility had tried to follow up with the pharmacy regarding the issue with the pain medication. On 11/22/24 9:52 a.m., an interview was conducted with the medical director. The medical director said, I put an e-script in for [R323's] narcotics on the 19th at 7am and was notified yesterday on the 21st of a missed diagnosis on the script and needing a new script. I wasn't aware of any missed dose of Methadone until yesterday. No one notified me of needing to contact pharmacy until yesterday, or that they needed a new script for the methadone. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/22/24 a clinical record review was conducted. R323's physician order read, Methadone HCl solution 5mg/5ml give 130 ml by mouth once daily for chronic pain. Gabapentin oral capsule 100 mg give one capsule three times daily for peripheral vascular disease. R323's medication administration record showed that the Methadone was not given on the 19th and that the first dose of Gabapentin R323 received was on 11/21/24 at 9:24 a.m. On 11/22/24 a facility documentation was reviewed. The policy titled, Missed Medications/Medication Error, read in part, .The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner. In the event the medication is not received in the next pharmacy delivery, the charge nurse will contact the pharmacy to attempt to resolve. The charge nurse will check the E-Kit to attempt to offer medication as prescribed. On 11/22/24, an end of day meeting was conducted with the administrator and corporate staff about the above findings. No additional information was provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49456 Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide respiratory care for three residents, Resident #77 (R77), Resident #83 (R83), and Resident #5 (R5) out of a survey sample of 30 residents. The findings included: 1. The facility staff failed to administer oxygen to R77, according to the physician's order. On 11/20/24 at 9:20 a.m., an interview was conducted with R77. R77 said, Staff says all concentrators are broken and sometimes at night I am short of breath. At this time, it was observed that R77's oxygen concentrator setting was on 2.5 liters per minute. On 11/20/24 at 11:00 a.m., a review of R77's clinical record was conducted. The clinical record revealed that R77's physician's order was for oxygen therapy at 5 liters per min via tracheostomy mask every shift for hypercarbia. On 11/20/24 12:22 p.m., an interview was conducted with a licensed practical nurse, LPN5. LPN5 read the physician's order for R77's oxygen and stated that the setting should be at 5 liters per minute. Accompanying the surveyor to R77's room, LPN5 observed that the oxygen concentrator and stated that it was set on 2.5 liters per minute. LPN5 said, [R77] needs a concentrator that will do the 5 liters per minute. On 11/21/24 at 9:00 a.m., an observation was made of a new oxygen concentrator in R77's room. The oxygen concentrator was set at 2 liters per minute. LPN5 came in the room and observed the oxygen concentrator setting. On 11/21/24 at 9:00 a.m., an observation was made of a new oxygen concentrator in R77's room. The oxygen concentrator was set at 2 liters per minute. LPN5 came in the room and observed the oxygen concentrator setting and tried to adjust to the correct setting, but it would not go to 5 liters. LPN5 stated that the oxygen concentrator was not working and will get R77 another concentrator that would go up to 5 liters. On 11/22/24 at 10:15 a.m., an interview was conducted with the corporate executive administrator (ED). The ED stated that R77 has a rental oxygen concentrator, and that the oxygen setting is on 5 liters per minute. The surveyor observed that R77's oxygen concentrator was set on 5 liters per minute. 2. The facility staff failed to administer oxygen to R83, according to the physician's order. On 11/20/24 at 9:41 a.m., an observation was made of R83's oxygen concentrator setting. R83's oxygen concentrator was set at 5 liters per minute. 11/20/24 a clinical record was conducted. R83's physician's order reads,O2 [oxygen] at 2LPM [liters per minute] via NC [nasal canula] continuous, and was written on 9/16/24. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 9:45 a.m., an interview was conducted with LPN5. LPN5 stated that R83's order for oxygen is 2 liters per minute by nasal canula. Accompanying the surveyor to R83's room, LPN5 observed that the oxygen concentrator was set on 5 liters per minute and corrected the setting to 2 liters per minute. LPN5 said, I do not know why it was set on the wrong setting. On 11/20/24 at 4:30 p.m., an end of day meeting was conducted with the administrator and corporate staff, with the above concerns were discussed. No additional information was provided. 28106 3. The facility failed to administer oxygen to R5 based on the physician's order. According to the clinical record, diagnoses for R5 included; Incontinence of bowel and bladder, chronic congestive heart failure, and chronic atrial fibrillation. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 9/27/24, which assessed R5 with a cognitive score of 14 out of 15, indicating cognitively intact. On 11/19/24 at 11:41 a.m., during an interview, R5 was observed receiving oxygen at 2 liters per minute (O2 at 2 LPM). R5 verbalized not having any difficulty with getting oxygen. Review of R5's clinical record revealed a physician order that documented an order placed on 7/3/24 for oxygen at 5 liters/minute continuous via nasal cannula for every shift. R5's oxygen rate was observed two other times on 11/20/24 at 12:30 p.m. set at 3.5 LPM and again at 1:40 p.m. set at 3.5 LPM. At this time license practical nurse (LPN #1), assigned to R5, was asked to check R5's oxygen saturation (O2 SAT) level. The O2 SAT result was observed at 96 percent, indicating R5's oxygen level was within normal range. LPN #1 also observed the oxygen setting, verbalizing that the setting looked to be between 3.5 LPM and 4.0 LPM. LPN #1 then reviewed the order and indicated that the oxygen level was not correctly set. On 11/20/24 at 4:37 p.m., the above finding was presented to the administrator and other corporate staff. No other information was presented prior to exit conference on 11/22/24.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure medications were available for administration for six residents (Resident #80-R80, Resident #69-R69, Resident #70-R70, Resident #20-R20, Resident #40-R40, and Resident #93-R93) in a survey sample of 30 residents. The facility staff also failed to ensure medications were available during medication administration on two units (200 unit and 400 unit) out of four units. The findings included: 1. For R69, the facility staff failed to ensure medications were available for administration as ordered by the physician for pain control. On 11/20/24 at 9:30 a.m., during an interview with R69, the resident reported she had a fall and broke her right foot. R69 was observed to have a cast on her right lower leg. R69 reported that she had several occurrences of running out of her pain medication oxycodone. On 11/20/24, a clinical record review was conducted. According to the medication administration record (MAR), R69 had orders for Percocet 5-325 mg (Oxycodone w/ Acetaminophen) to be given every 6 hours for pain, totalling 4 administrations per day. It was noted on the MAR that R69 did not receive the doses on 11/1/24 as ordered. According to R69's nursing note dated 11/1/24, the entries read in part, Per pharmacy medication will be delivered in am. Awaiting delivery resident made aware-stated That ok, I'll wait I got my Oxy. Thank you, [NAME], [sic] and Medication per pharmacy to be delivered in am. 2. For Resident #80 (R80), the facility staff failed to ensure pharmacy services were adequate to ensure medications were available for administration as ordered by the physician. On 11/19/24 at 11:18 a.m., R80 was visited and interviewed in his room. During the interview, R80 reported that he had cancer and has continuous, unrelieved pain, despite being on methadone for pain management. On 11/19/24-11/20/24, a clinical record review was conducted. According to the physician orders, R80 had a current and active order that read, Methadone HCl Oral Tablet 5 MG (Methadone HCl) Give 7.5 mg by mouth two times a day for Pain Give 3 half tabs to equal 7.5mg. According to the medication administration record (MAR), R80 was not given the Methadone as ordered on 11/2/24, and 11/3/24. According to R80's nursing notes, an entry dated 11/2/24, read, on hold MD [medical doctor] aware, waiting for it to come from pharmacy. Another nursing note entry dated 11/3/24, read in part, awaiting pharmacy delivery, MD/RP [medical doctor/responsible party] aware. On 11/8/24 and 11/12/24, documentation reflects that R80 only received one dose of Methadone. On 11/13/24, R80 didn't receive either of the two ordered doses and on 11/14/24, only the evening dose was administered. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24, in the afternoon, an interview was conducted with R80. R80 confirmed that at times he doesn't receive his Methadone for pain. R80 reported he experienced pain all the time, due to the cancer and couldn't say that it the pain is any worse when he goes without the Methadone. 3. For Resident #70 (R70), the facility staff failed to maintain a system to account for controlled drugs to accurately reflect the quantity of Suboxone available and failed to ensure the medication was available to be administered to the resident. On 11/19/24 at 10:58 a.m., an interview was conducted with R70. During the interview, R70 reported he doesn't always get his medication. On 11/19/24-11/20/24, a clinical record review was conducted. This review revealed that R70 had an active physician's order that read, Suboxone Sublingual Film 4-1 MG (Buprenorphine HCl-Naloxone HCl Dihydrate) Give 1 film sublingually two times a day for Opioid dependence. According to the medication administration record, R70 did not receive either of the scheduled doses on 11/7/24. According to R70's nursing notes, entries were made with regards to the Suboxone that read, waiting for script and hold on order. On 11/20/24 at 3:56 p.m., an interview was conducted with licensed practical nurse #4 (LPN #4) and registered nurse #1 (RN #1). Both nurses explained that if they are administering medications and a medication is not available, they would search for the medication, then would look in the Pixis (an on-site back-up supply of medications), and if still not, available they would call the doctor to notify them that the dose may be missed or delayed and ask what they wanted the nurse to do. Following the above interview with LPN #4 and RN #1, the surveyor asked to see R70's Suboxone. LPN #4 opened the medication cart and retrieved a clear bag which contained 5 individually wrapped packages of Suboxone film. Upon review of the Controlled Drug Administration Record Tablet, it was noted that 6 doses should be remaining. RN #1 spoke up and stated that she had not signed off on the dose given to R70 that morning. RN #1 stated that she should have recorded it at the time of administration. According to the facility policy titled, Medication Administration, it read in part, VI. Narcotic. a. Sign out narcotic controlled substance from narcotic count card when removed . On 11/20/24 at 4:16 p.m., an interview was conducted with the Director of Nursing (DON). When notified of multiple findings where residents are not being administered their medications, the DON stated that many times there is an insurance issue that prevents the pharmacy from sending the medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/20/24 at 4:40 p.m., an interview was conducted with the facility's medical director (MD), who was also the attending physician for R69, R80 and R70. When the MD was made aware that the surveyor saw numerous findings when R80 and R70 were not administered medications as ordered, the MD said, The pharmacy won't send the amount I write for them. [Pharmacy name redacted] has been difficult to work with lately. I send prescriptions via e-script [electronically] and they will say they didn't get it. It takes multiple calls, then there are a few days delay in getting them delivered to the facility. On 11/20/24, during an end of day meeting, the facility administrator was made aware of the above findings. No additional information was provided. 21875 4. The medication methadone was not available for administration to Resident #20 as ordered by the physician. Resident #20 (R20) was admitted to the facility with diagnoses that included diabetes, peripheral vascular disease, neuropathy, congestive heart failure, hypertension and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R20 as cognitively intact. R20's clinical record documented a physician's order dated 11/1/24 for methadone 10 milligrams with instructions to give one tablet twice per day for pain management. R20's medication administration record documented the methadone was not administered on 11/15/24, 11/16/24 and 11/17/24 (morning dose). Nursing notes on 11/15/24, 11/16/24 and 11/17/24 documented the methadone was not available in the medication cart and as pending delivery from the pharmacy. A nursing note dated 11/16/24 documented R20's methadone was reordered on 11/12/24. On 11/20/24 at 3:12 p.m., the licensed practical nurse unit manager (LPN #3) caring for R20 was interviewed about the missed methadone doses. LPN #3 stated the scripts were sent to the pharmacy prior to running out but the pharmacy was not timely with deliveries. LPN #3 stated the pharmacy reported the medications were to be delivered but did not show up. LPN #3 stated the pharmacy at times will report that they do not have the needed scripts when the scripts have already been sent. LPN #3 stated methadone was not kept in the backup supply. LPN #3 stated there had been ongoing issues with the pharmacy regarding timely deliveries. On 11/20/24 at 3:33 p.m., R20 was interviewed about the missed doses of methadone. R20 stated she was recently made aware that the methadone had not been received from the pharmacy. On 11/20/24 at 4:16 p.m., the director of nursing (DON) was interviewed about medications not available from the pharmacy. When asked if she was aware that nurses reported ongoing issues with getting medicines delivered timely, the DON had no response. The DON stated nurses were able to reorder medications from the refill screen in the computerized health record. This finding was reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p. m. with no further information presented prior to the end of the survey. 5. Calmoseptine ointment 0.44-20.6% ointment was not available for administration to Resident #40 as ordered by the physician. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40 (R40) was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease), dementia, diabetes, cellulitis, depression, coronary artery disease and anemia. The minimum data set (MDS) dated [DATE] assessed R40 with severely impaired cognitive skills. R40's clinical record documented a physician's order dated 10/29/24 for Calmoseptine external ointment 0.44-20.6 % (menthol-zinc oxide) with instructions to apply to bilateral buttocks every shift for folliculitis. R40's medication administration record documented the Calmoseptine ointment was not applied on 11/15/24, 11/16/24 or 11/17/24. Nursing notes on 11/15/24, 11/16/24 and 11/17/24 documented the Calmoseptine ointment was on order from the pharmacy and not available for administration. On 11/20/24 at 3:11 p.m., the licensed practical nurse unit manager (LPN #3) was interviewed about the Calmoseptine ointment administration. LPN #3 stated the Calmoseptine ointment was not ordered from the pharmacy but was an in-house stocked item. LPN #3 stated she was not sure why the Calmoseptine ointment was not available. On 11/21/24 at 10:05 a.m., the supply clerk (other staff #4) was interviewed about R40's Calmoseptine ointment. The supply clerk stated nursing usually informed her of needed ointments/creams. The supply clerk stated, Calmoseptine is not something I've ordered. The supply clerk stated she had received no request from nursing or hospice for the Calmoseptine ointment. The supply clerk stated the Calmoseptine ointment was not kept in stock but could be ordered if needed. This finding was reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p.m. with no further information presented prior to the end of the survey. 6. The medications Pataday 0.2% eye drops and Azelastine 0.05% eye drops were not available for administration to Resident #93 as ordered by the physician. Resident #93 (R93) was admitted to the facility with diagnoses that included spinal stenosis, bradycardia, sick sinus syndrome, hypertension, neurogenic bladder, depression and insomnia. The minimum data set (MDS) dated [DATE] assessed as cognitively intact. On 11/19/24 at 11:44 a.m., R93 was interviewed about quality of care in the facility. R93 stated during this interview that he had not received eye drops as ordered by the physician. R93 stated the eye doctor had ordered two medications for his eyes due to itching/redness. R93 stated he had missed several doses of the drops, and he was told they ran out and were not available for some reason. R93 denied any problems from missing the drops but stated he wanted his medications administered as ordered by the physician. R93's clinical record documented the following physician orders for eye drops, listed with the order date. 7/6/24 - Azelastine HCL ophthalmic solution 0.05% drops with instructions to instill one drop in both eyes two times per day for allergic conjunctivitis. 11/12/24 - Pataday ophthalmic solution 0.2% with instructions to instill one drop in both eyes each day for itch/redness relief. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R93's medication administration record (MAR) documented the Pataday drops were not administered on 11/2/24, 11/3/24, 11/4/24 and 11/11/24. Nursing notes on these dates documented the medication was on order from the pharmacy and not available for administration. R93's MAR documented the Azelastine drops were not administered on 11/14/24, 11/15/24 and 11/17/24. Nursing notes on these dates documented the last dose was given on the morning of 11/14/24. Notes documented the medication was order from the pharmacy and not available for administration starting on the evening of 11/14/24. On 11/20/24 at 3:05 p.m., the licensed practical nurse unit manager (LPN #3) was interviewed about R93's missed eye medications. LPN #3 stated R93's missed eye drop doses were because the medication was not available in the cart. LPN #3 stated that nurses were required to reorder medications when approximately eight doses were left so that medications could be delivered prior to running out. LPN #3 stated there had been trouble with the pharmacy delivering medications timely even when ordered on time. On 11/20/24 at 4:16 p.m., the director of nursing (DON) was interviewed about medications not available from the pharmacy. When asked if she was aware that nurses reported ongoing issues with getting medicines delivered timely, the DON had no response. The DON stated nurses were able to reorder medications from the refill screen in the computerized health record. This finding was reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p. m. with no further information presented prior to the end of the survey. 7. Gentamicin eye drops were not available for administration to Resident #274 during a medication pass observation. A medication pass observation was conducted on 11/20/24 at 8:07 a.m. with registered nurse (RN #1) observed administering medications to Resident #274 (R274). R274 was administered all scheduled medications except gentamicin eye drops. RN #1 searched the medication cart and did not locate the drops. RN #1 stated the gentamicin eye drops were not available and that she would contact the pharmacy. R274's clinical record documented a physician's order dated 11/14/24 for gentamicin sulfate ophthalmic solution 0.3% with instructions to instill one drop in the left eye two times per day for 6 months. R274's medication administration record documented the drops were scheduled for administration each morning and evening. On 11/20/24 at 3:14 p.m., the licensed practical nurse unit manager (LPN #3) was interviewed about R274's unavailable gentamicin drops. LPN #3 stated the eye drops should not have run out. LPN #3 stated nurses were supposed to reorder the medications prior to exhausting the current supply. LPN #3 stated the gentamicin drops were not kept in the backup supply. On 11/20/24 at 3:55 p.m., RN #1 was interviewed about the status of R274's gentamicin drops. RN #1 stated the gentamicin drops were reordered from the pharmacy and that R274 was not administered the morning dose of the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled Missed Medication/Medication Error (undated) documented, .The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner .For any medication(s) not available during a routine medication pass .The Charge Nurse will check the E-kit [backup supply] to attempt to offer medication in a timely manner .In the event the medication is not available from the E-kit or the Emergency Pharmacy, the Charge Nurse will notify the Physician immediately .The Charge Nurse will notify the pharmacy and attempt to obtain the medication . The DON/designee is responsible for monitoring undocumented medications to assure residents are receiving their medications as ordered . This finding was reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p. m. with no further information presented prior to the end of the survey. 28106 Resident #15's (R15) Lactulose (given for constipation) was not available for distribution during a medication pass and pour review. The Findings Include: On 11/20/24 at 8:00 a.m. during a medication pass and pour, license practical nurse (LPN #1) began to pull medications from the medication cart for R15 based on physician orders. LPN #1 was unable to locate physician ordered Lactulose in the medication cart. LPN #1 then went to the medication room to look for the Lactulose and returned verbalized that the pharmacy had not sent it to the facility. LPN #1 verbalized that sometimes R15 refuses the Laculose and proceeded to gather other medications and went into R15's room. LPN #1 did not offer R15 the Lactulose. LPN #1 was asked when do nurses usually reorder medications to ensure medications are available. LPN #1 verbalized orders are usually placed two to three days ahead of time saying she had sent the pharmacy a reorder for the Laculose on Monday (11/18/24). When asked to see the reorder, LPN #1 reviewed the reorder on the computer and verbalized the computer did not evidence a reorder was completed. Review of physicians orders indicated an order dated 10/23/24 for Lactulose Solution give 20 grams once a day for constipation. On 11/20/24 at 4:37 p.m. the above finding was presented to the administrator and other corporate staff. A facility policy titled Ordering and receiving Non-controlled Medications was obtained and read in part: Reorder medications based on the estimated refill date on the pharmacy Rx label, or at least three days in advance, to ensure adequate supply is on hand. No other information was presented prior to exit conference on 11/22/24.

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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. 21875 Based on observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than 5 percent. Medication pass observations resulted in two errors out of thirty opportunities for an error rate of 6.67%. The findings include: 1. R274 was not administered a dose of gentamicin eye drops as ordered by the physician. A medication pass observation was conducted on 11/20/24 at 8:07 a.m. with registered nurse (RN #1) observed administering medications to Resident #274 (R274). R274 was administered all scheduled medications except gentamicin eye drops. RN #1 searched the medication cart and did not locate the drops. RN #1 stated the gentamicin eye drops were not available and that she would contact the pharmacy. R274's clinical record documented a physician's order dated 11/14/24 for gentamicin sulfate ophthalmic solution 0.3% with instructions to instill one drop in the left eye two times per day for 6 months. R274's medication administration record documented the drops were scheduled for administration each morning and evening. On 11/20/24 at 3:55 p.m., RN #1 was interviewed about the status of R274's gentamicin drops. RN #1 stated the gentamicin drops were reordered from the pharmacy today (11/20/24) and that R274 was not administered the morning dose of the medication. This finding was reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p. m. with no further information presented prior to the end of the survey. 28106 Resident #15's (R15) Lactulose (given for constipation) was not available for distribution during a medication pass and pour review resulting in a total medication error rate of 6.67 percent. The Findings Include: On 11/20/24 at 8:00 a.m. during a medication pass and pour, license practical nurse (LPN #1) began to pull medications from the medication cart for R15 based on physician orders. LPN #1 was unable to locate physician ordered Lactulose in the medication cart. LPN #1 then went to the medication room to look for the Lactulose and returned verbalized that the pharmacy had not sent it to the facility. LPN #1 verbalized that sometimes R15 refuses the Laculose and proceeded to gather other medications and went into R15's room. LPN #1 did not offer R15 the Lactulose. LPN #1 was asked when do nurses usually reorder medications to ensure medications are available. LPN #1 verbalized orders are usually placed two to three days ahead of time saying she had sent the pharmacy a reorder for the Laculose on Monday (11/18/24). When asked to see the reorder, LPN #1 reviewed the reorder on the computer and verbalized the computer did not evidence a reorder was completed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physicians orders indicated an order dated 10/23/24 for Lactulose Solution give 20 grams once a day for constipation. On 11/20/24 at 4:37 p.m. the above finding was presented to the administrator and other corporate staff. A facility policy titled Ordering and receiving Non-controlled Medications was obtained and read in part: Reorder medications based on the estimated refill date on the pharmacy Rx label, or at least three days in advance, to ensure adequate supply is on hand. A facility policy titled Missed Medication/Medication Error was obtained and defined a medication error/incident as: any physician/provider prescribed medication that is not administered to the resident as prescribed regardless of the category or the reason for not providing the medication. No other information was presented prior to exit conference on 11/22/24.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 21875 Based on observation, staff interview and facility document review, the facility failed to properly store medications on two of four units (200-unit, 300-unit). The findings include: On the 200-unit and 300-unit, it was observed that unopened insulin and eye drops were stored at room temperature when refrigeration was required. In the medication refrigerator on the 300-unit, the controlled medication lorazepam was not stored in a separately locked, permanently affixed compartment. On 11/20/24 at 1:57 p.m., accompanied by the licensed practical nurse unit manager (LPN #3), a 300-unit medication cart was inspected. Stored in the cart at room temperature was an unopened vial of Humalog insulin for a current resident. The label on the insulin directed to refrigerate until opened. On 11/20/24 at 2:05 p.m., accompanied by LPN #3, the medication room on the 300-unit was inspected. Stored in the medication refrigerator was a 30 ml (milliliter) bottle of liquid lorazepam. The lorazepam was stored along with other medications in a tray on the refrigerator shelf. There was no separate, permanently affixed compartment or lock box inside the refrigerator for storage of controlled medications. LPN #3 was interviewed at this time about the insulin and lorazepam storage. LPN #3 stated that she did not know why the unopened insulin was stored on the medication cart. When asked about why the narcotic was not secured, LPN #3 stated that there was no separate lock box for controlled medications in the refrigerator. On 11/20/24 at 2:10 p.m., accompanied by registered nurse (RN) #1, a medication cart on the 200-unit was inspected. Two unopened bottles of Xalatan eye drops (2.5 ml each) for current residents were stored in the cart. The Xalatan drops were labeled from the pharmacy with instructions to refrigerate until opened. There was three Promethegan suppositories for a current resident stored in the medication cart. These suppositories were labeled to store under refrigeration. RN #1 was interviewed at this time about the medications stored at room temperature that were labeled to be refrigerated. RN #1 checked the two bottles of eye drops and verified that they had not been opened. RN #1 stated that she did not know why the drops and suppositories had been placed on the medication cart and not in the refrigerator. On 11/20/24 at 3:00 p.m., the director of nursing (DON) was interviewed about the improperly stored medications. The DON stated medications were supposed to be refrigerated as labeled. The DON stated someone must have placed the medications on the cart instead of the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy titled Storage of Medications (revised 8/2024) documented, .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . All medications are maintained within the temperature ranges noticed in the United States Pharmacopoeia (USP) and by the Centers for Disease Control (CDC) .Medications requiring refrigeration are kept in a refrigerator at temperatures between 36 [degrees] F .and 46 [degrees] F .Controlled substances that require refrigeration are stored within a locked box within the refrigerator that is attached to the inside of the refrigerator . These findings were reviewed with administrator and regional consultants, during a meeting on 11/21/24 at 5:00 p.m., with no further information presented prior to the end of the survey.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide routine dental services to two residents (Resident #80-R80 and Resident #4-R4) in a survey sample of 30 residents. The findings included: 1. For R80, the facility staff failed to provide dental services following a recommendation for extractions. On [DATE] at 11:24 a.m., an interview was conducted with R80. R80 stated he is unable to eat because of his teeth and cancer and relies solely on nutritional drinks. When asked about his dental status, R80 said that he had gone to a dental clinic but was unable to be seen due to having expired identification. On [DATE], a clinical record review of R80's chart was conducted. According to a physician progress note dated [DATE], R80 was s/p [status post] antineoplastic chemotherapy and had a history of synovial sarcoma who had complications of dysphagia related to the pharyngeal/cervical mass . According to R80's dental services note dated [DATE], R80 was seen and the note read in part, Recommend extractions of all remaining teeth and retained roots in order to fabricate upper and lower denture to aide in mastication . Action required by Nursing Home Staff: Refer to oral surgeon if pain or swelling develops; refer to OS [oral surgeon] for extractions of all remaining teeth and retained root tips in order to prepare for fabrication of Upper and Lower Full Dentures; Refer to oral surgeon to evaluate upper left lesion. Within the clinical record, there was no evidence of any oral surgeon consultations or that the facility had attempted to make any arrangements for further dental services/follow-up, since the dental recommendations on [DATE]. On [DATE] at 10:16 a.m., an interview was conducted with the facility social workers (SW). Both social workers stated they had no knowledge of R80 being refused dental care due to an expired identification. The SW reported that they have a dentist that comes on-site to the facility quarterly. When made aware of the recommendations for extractions and dentures in [DATE], the SW's were both asked to provide any evidence of any follow-up, since . On [DATE], in the afternoon, the facility staff provided the survey team with evidence of residents that were seen during follow-up visits by the dentist. There was no indication that R80 was seen by the in-house dentist or by an oral surgeon, following the dental service on [DATE]. The facility did provide a progress note dated [DATE], indicating an appointment had been made for R80 to see a dentist outside of the facility on [DATE]. No other information was provided prior to exit. 2. For R4, who reported difficulty eating due to not having upper teeth, the facility failed to arrange for routine dental services. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:20 p.m., during an interview with R4, the resident reported he has difficulty eating due to not having any upper teeth. R4 reported that his top teeth were pulled while at another facility and that they had said they were going to replace them but didn't. R4 went on to say that he told the doctor at this facility that he needed to see a dentist. On [DATE] at 10:16 a.m., an interview was conducted with the two facility social workers (SW). The SW assistant said, I was informed recently from a unit manager that [R4's name redacted] requested he needed to be seen by a dentist, so I put him on the list with our dentist. He is not going to be able to be seen on the 25th of November, because it was too soon. When asked why R4 had not previously been seen, since according to the census tab of his clinical record R4 had been admitted to the facility [DATE]. The SW assistant stated, They [the resident] should be asked if they would like to see the dentist and should be put on the list. It doesn't look like he was seen before. According to the facility provided documents of residents that were seen on the dentist's visits to the facility, R4 had never been seen for dental services. On [DATE] at 10:59 a.m., R4 was visited again. R4 again stated that he has difficulty chewing foods because, I don't have anything to chew with. When asked if he would like a different consistency of foods, such as ground meats, R4 declined and said that he would continue to manage. R4 again stated, I have told the doctor I want to see a dentist. These teeth [pointing to his bottom teeth] need cleaning and I want to see about getting upper dentures. On the afternoon of [DATE], the social workers provided the surveyor with a list of residents scheduled to be seen by the dentist on [DATE], noting that R4 had been added to the list. On [DATE], during an end of day meeting, the facility administrator and corporate staff were made aware of the above findings. The facility policy regarding dental services was requested, but not received prior to conclusion of the survey. No additional information was provided.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a therapeutic diet and correctly provide foods per the meal ticket for one of thirty residents in the survey samplec, (Residents #103). Resident #103 (R103) was not provided foods per meal ticket for lunch. The findings include: According to the clinical record, diagnoses for R103 included severe protein calorie malnutrition, dementia, and iron deficiency anemia. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/31/24. R103 was assessed with a cognitive score of 12 out of 15, indicating intact cognition. An annual MDS, dated [DATE], Section K documented that R103 had un-prescribed weight loss. On 11/19/24 at 12:45 p.m., R103 lunch meal was observed, R103's meal ticket was verified against the meal served. The meal ticket indicated R103 was to receive a regular advanced dysphagia diet, with an added half cup of fortified pudding parfait and a bowl of pureed meat with gravy. Compared against the meal ticket, the fortified pudding and bowl of pureed meat with gravy were missing from the tray. At this time, registered nurse (RN #1), assigned to R103, also observed the meal ticket, reviewed R103's meal, verified that not all the listed food items had been served, and verbalized she would let the kitchen know. On 11/19/24 at 1:15 p.m., the dietary manager (other staff, OS #1) was interviewed regarding the missing food items from R103's tray. OS #1 verbalized that the food was available but had not been added to the meal tray. Review of R103's clinical record included a dietary progress note, dated 8/2/24, that indicated R103 had a history of weight loss, no longer wanted magic cups or house shakes, and noted that fortified pudding parfait had been recommended with two meals. R103's diet orders indicated that an order was placed on 8/2/24 to include fortified pudding parfait to lunch and dinner. On 11/20/24 at 4:37 p.m., the above finding was presented to the administrator and director of nursing during an end of day staff meeting. No other information was presented prior to exit conference on 11/22/24.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to honor food preferences for one of thirty residents in the survey sample (Resident #93). The findings include: Resident #93 was not provided a fruit salad as listed on the meal ticket and according to assessed food preferences. According to the clincal record, Resident #93 (R93) was admitted to the facility with diagnoses that included spinal stenosis, bradycardia, sick sinus syndrome, hypertension, neurogenic bladder, depression and insomnia. The minimum data set (MDS) dated [DATE] assessed R93 as cognitively intact. On 11/19/24 at 11:38 a.m., R93 was interviewed about quality of life/care in the facility. R93 stated that he was supposed to get a fruit salad each day for lunch and that he never gets the fruit. R93's clinical record documented the resident was prescribed a regular diet. A food preference assessment dated [DATE] listed that R93 liked/preferred fresh fruit. On 11/20/24 at 12:32 p.m., R93's served meal was observed during lunch. R93's meal ticket listed a fresh fruit plate, in addition to roast pork sandwich, green beans, mashed potatoes, and lemon cake. R93 was served all the items listed on the meal ticket except the fresh fruit plate. R93 stated again at this time that he was never served the fresh fruit plate, even though it was listed on the ticket. On 11/20/24 at 4:00 p.m., the dietary manager (other staff #1) was interviewed about R93 not being served fresh fruit as listed on the meal ticket. The dietary manager stated he did not realize the fresh fruit had not been served to R93. The dietary manger stated fruit plates were prepared and available each day. The dietary manager stated kitchen staff were supposed to serve foods according to the meal ticket. The dietary manager stated a previous manager assessed R93's preferences and had added the fresh fruit to the meal ticket based upon preference. R93's plan of care (revised 6/21/24) listed the resident was at risk of nutrition problems related to dependency on staff for eating and history of weight changes. Care plan interventions to maintain proper nutrition and prevent significant weight loss included the provision of diet as ordered and identification of resident food/beverage preferences. This finding was reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p. m., with no further information presented prior to the end of the survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41449 Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare, and serve food in a sanitary manner in the main kitchen and in the dining room. The findings included: 1. The facility staff failed to wear hair restraints (hair nets and beard guards) while preparing and distributing food, to prevent the contamination of food items. On 11/19/24, during lunch, meal service observations were conducted in the dining room. The dietary aide (Other Employee #17) was observed at the tray line, plating food without wearing a beard guard and visible facial hair. On 11/20/24 at 1:40 p.m., during a follow-up visit to the kitchen, the cook (Other Employee #14) was observed by the stove, preparing food without wearing a hair net. The dietary aide (Other Employee #15) was observed preparing beverages, with her hair net was only covering the ends of her hair in the back. When asked about hair nets, Other Employee #15 stated that they don't have any large enough to cover her hair and that she usually has to wear two. The food services district manager was present and stated that OS #15 could put two on as she normally does, and that he would have some larger ones sent to the facility. On 11/20/24 at approximately 1:45 p.m., following the surveyor's conversation with Other Employee #15 about the lack of hair net, OS #14 exited the kitchen and upon return, while walking through the kitchen, was observed putting on a hair net. When asked why he didn't have one on prior to the surveyor entering the kitchen, no response was given. On 11/20/24 at approximately 1:48 p.m., the dietary district manager confirmed that all kitchen staff should wear hair nets and beard guards as appropriate when in the kitchen. On 11/20/24, during an end of day meeting, the facility administrator was made aware of the above concerns. On 11/21/24, at approximately 12:30 p.m., an observation was made in the dining room. The kitchen employee that was working the steam table was distributing food to plates, had visible facial hair but had no beard guard on. On 11/21/24 at 2:24 p.m., walking past the open kitchen door, the surveyor observed the facility's social services director standing by the stove, without a hair net on. On 11/21/24, in the afternoon, an interview was conducted with the social services director. When the surveyor discussed the earlier observation of the employee in the kitchen, the social services director stated that she was dropping off some food that had been brought in. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the facility policy titled, Staff Attire, it read in part, 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained . On 11/21/24, during the end of day meeting, the facility administrator was made aware of the additional observations of facility staff in food preparation areas without proper hair restraints. No further information was provided. 2. The facility staff failed to wash dishes in a manner to prevent contamination of food. On 11/20/24 at approximately 1:45 p.m., a dietary aide was observed manually washing dishes in the three-compartment sink. The employee was only using 2 of the 3 sinks., washing the dishes in the wash sink, then immediately removing them, and taking them to the sanitizer, before placing them on a drying rack. No rinse was provided for the dishes as the middle sink was empty. The surveyor attempted to interview the staff member, but he didn't speak English. The dietary services district manager was present and confirmed the above observations. The district manager was then observed giving gestures to instruct the dietary aide to fill the middle sink and to rinse dishes before dipping into the sanitizer. The facility policy titled, Manual Warewashing was reviewed. The policy didn't address dishes being rinsed. On 11/20/24, in the afternoon, during a follow-up visit to the kitchen, it was observed that after dishes had been washed in the dish washer, they were being stacked wet or wet nesting. An interview was conducted with the dietary aide (Other Employee #15), who confirmed the observation, and stated that not allowing dishes to air dry could cause bacteria growth. According to the facility policy titled, Warewashing, the process guidance read in part, .4. All dishware will be air dried and properly stored. On 11/20/24, during an end of day meeting, the facility administrator was made aware of the above findings. No additional information was provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for one of thirty residents in the survey sample (Resident #94). The findings include: Resident #94's clinical record included documented hospice notes for three other residents (Residents #10, #26 and #101). According to the clinical record, Resident #94 (R94) was admitted to the facility with diagnoses that included diabetes, adult failure-to-thrive, protein-calorie malnutrition, chronic kidney disease, anxiety, and depression. The minimum data set (MDS) dated [DATE] assessed R94 with having short and long-term memory problems and severely impaired cognitive skills. Review of R94's clinical record revealed documentation regarding hospice care/services. Included in R94's clinical record were hospice notes/documentation for three other current residents in the facility, who were also receiving hospice services. The other residents' notes scanned into R94's clinical record were as follows: Resident #10 - hospice notes dated 10/11/24, 10/16/24, 10/17/24, 10/21/24, and 10/24/24. Resident #26 - hospice notes dated 10/24/24 and 10/25/24. Resident #101 - hospice notes dated 10/16/24, 10/17/24, and 10/21/24. On 11/20/24 at 3:22 p.m., the medical records clerk (other staff #3) was interviewed about the co-mingled and mis-filed hospice notes. The medical records clerk stated hospice sent notes to the facility on paper. The medical records clerk stated that she scanned the documentation upon receipt and uploaded the notes to the clinical record. The medical records clerk stated, I must have uploaded incorrectly. I scanned [notes] together and put into his [R94's] record by mistake. This finding was reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p. m., with no further information presented prior to the end of the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 28106 Based on observation, staff interview, and facility document review, the facility staff failed to follow infection control practices during medication pass and pour observation on one of two units. The findings include: License practical nurse (LPN #1) was observed handling medications with cross contaminated gloved hands, during medication pass on unit 400. on 11/20/24 at 8:00 a.m., during a medication pass for Resident #15 (R15), LPN #1 (LPN1)was observed sanitizing her hands and applying gloves. Then LPN1 began using the computer to view information, before reaching into the medication cart draw to pull out needed medications (consisting of bulk bottled medications and medication card packs). LPN1 started popping medications into her hand, reaching into bulk bottled medications with her fingers, and placing the medications into the medication cup, before distributing the medications to R15. After giving medications to R15, LPN #1 then pushed the medication cart to R42's room, sanitized her hands, applied gloves, and again used the computer, placed hands on the table top of the medication cart, reached into the medication draws, popped pills into her hands, and reached into medication bottles using her fingers, before placing medications into the medication cup and distributing the medications to R42. The above finding was presented to LPN #1 at the end of the medication pass observation. LPN #1 verbalized that sometimes it is hard to get the medications out of the bottles when there are just a few left. On 11/20/24 at 4:37 p.m., the above finding was presented to the director of nursing (DON) and administrator. The DON verbalized that the nurses should not be handling medications in that manner. Upon review, the facility's policy titled Medication Administration read in part: K. Use Standard Precautions for medication administration. No other information was presented prior to exit conference on 11/22/24.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 21875 Based on staff interview, facility document review and clinical record review, the facility staff failed to educate about and offer pneumococcal immunizations according to the facility's infection control policy for three of five residents reviewed (Residents #20, #93, and #94). The pneumococcal immunization status was not documented and/or up to date in the clinical record for five of five residents reviewed (Residents #20, #53, #84, #93, and #94). The findings include: On 11/21/24 at 11:45 a.m., accompanied by the regional infection preventionist (RN #2), five residents were reviewed for immunizations, as part of the infection control survey task. Clinical records for Residents #20, #93 and #94 documented no education or offering of the pneumococcal vaccine and their records documented no status/history of pneumococcal immunizations. Resident #84's clinical record did not include the resident's pneumococcal immunization status. Resident #53's record documented the administration of pneumococcal 23 immunization on 1/3/18, prior to age 65. The regional infection preventionist stated that she would investigate the missing information. On 11/21/24 at 2:09 p.m., the infection preventionist stated that she did not find any documentation regarding pneumococcal immunization status for Residents #20, #93, or #94. The regional infection preventionist stated she found no documentation that Residents #20, #93 or #94 had been educated about or offered the pneumococcal vaccine. On 11/21/24 at 4:11 p.m., the regional infection preventionist stated records for Residents #53 and #84 had not been updated with the most recent pneumococcal vaccine status. The regional infection preventionist presented vaccine records indicating Resident #53 had received an additional pneumococcal vaccine (Prevnar 13) on 9/13/18 and Resident #84 had the pneumococcal 23 vaccine on 10/20/21. The regional infection preventionist stated the clinical records for Residents #53 and #84 should have been updated to include vaccines doses administered and that immunization history was supposed to be obtained upon admission. The facility's policy titled Resident Pneumococcal Vaccines (undated) documented, . Residents in the facility will be offered education regarding the pneumococcal vaccine . Residents in the facility will be offered the pneumococcal vaccine unless medically contraindicated or the resident has already been immunized according to the schedule . The resident and/or responsible party will be provided the CDC vaccination education regarding pneumococcal pneumonia and pneumococcal vaccine . This information includes .risks and benefits of receiving the vaccine, and what can be expected as a result of receiving the vaccine and potential side effects . Document administration in the EMR [electronic medical record], on the MAR [medication administration record], and in the immunization tab . These findings were reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p.m. with no further information presented prior to the end of the survey.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 21875 Based on staff interview, facility document review, and clinical record review, the facility staff failed to educate about and offer COVID-19 immunizations according to the facility's infection control policy for two of five residents reviewed (Residents #20 and #94). The findings include: On 11/21/24 at 11:45 a.m., accompanied by the regional infection preventionist (RN #2), five residents were reviewed for immunizations as part of the infection control survey task. Review of clinical records revealed no documentation of COVID-19 immunization status for Residents #20 and #94. The clinical records documented no education about or offering of the COVID-19 vaccine since their admission to the facility. On 11/21/24 at 2:09 p.m., the regional infection preventionist (RN #2) stated that she reviewed the clinical records and did not find any evidence Residents #20 or #94 had been offered the COVID-19 vaccine. The regional infection preventionist stated immunization status was supposed to be obtained upon admission to the facility and vaccines offered if not already received. The facility's policy titled Covid-19 Vaccination-education and Administration for Resident, Education for Healthcare Worker (undated) documented, .Residents residing in the facility are provided education in a manner they understand related to the risk/benefits of the Covid-19 vaccine .Screening residents prior to offering the vaccination for prior immunization, medical precautions, and contraindication is necessary for determining whether they are appropriate candidates for vaccination .Documentation in the resident medical record will include, at a minimum .The resident received the Covid-19 Vaccine .The resident/resident representative received education PRIOR to the immunization, regarding the benefits and potential side effects .monitoring of resident post vaccination .Document the vaccine administration in the eMAR [medication administration record] and PCC [Point Click Care] Immunization Tab . These findings were reviewed with administrator and regional consultants during a meeting on 11/21/24 at 5:00 p.m. with no further information presented prior to the end of the survey.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 49456 Based on observations, resident interview, staff interview, and facility document review, the facility staff failed to ensure oxygen concentrators were in proper working condition for one resident, Resident #77 (R77) out of a survey sample of 30 residents. The findings included: The facility staff failed to provide an oxygen concentrator that would administer the ordered liters of oxygen. On 11/20/24 at 9:20 a.m., an interview was conducted with R77. R77 said, Staff says all concentrators are broken and sometimes at night I am short of breath. At this time, it was observed that R77's oxygen concentrator setting was on 2.5 liters per minute. On 11/20/24 at 11:00 a.m., a review of R77's clinical record was conducted. The clinical record revealed that R77's physician's order was for oxygen therapy at 5 liters per min via tracheostomy mask every shift for hypercarbia. On 11/20/24 12:22 p.m., an interview was conducted with a licensed practical nurse, LPN5. LPN5 read the physician's order for R77's oxygen and stated that the setting should be at 5 liters per minute. Accompanying the surveyor to R77's room, LPN5 observed the oxygen concentrator setting and stated that it was set on 2.5 liters per minute. LPN5 said, [R77] needs a concentrator that will do the 5 liters per minute. On 11/21/24 at 9:00 a.m., an observation was made of a new oxygen concentrator in R77's room. The oxygen concentrator was set at 2 liters per minute. LPN5 came in the room and observed the oxygen concentrator setting and tried to adjust to the correct setting, but it would not go to 5 liters. LPN5 stated that the oxygen concentrator was not working and will get R77 another concentrator that will go up to 5 liters. On 11/21/24 at 5:00 p.m., an end of day meeting was conducted with the administrator and corporate staff and the above concerns were discussed. No additional information was provided.