STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495294	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pulaski Hlth & Rehab Cntr	2401 Lee Highway Pulaski, VA 24301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) notification for 1 of 3 residents selected for SNF Beneficiary Notification Review (Resident #98). The findings included: For Resident #98, the facility staff failed to provide a SNF ABN notification when the resident was discharged from Medicare Part A services with skilled benefit days remaining while continuing to reside in the facility. Resident #98's diagnosis list indicated diagnoses, which included, but not limited to Pneumonitis, Dysphagia, Generalized Muscle Weakness, and Dementia. The minimum data set (MDS) with an assessment reference date (ARD) of 1/27/24 assigned the resident a brief interview for mental status (BIMS) summary score of 1 out of 15 indicating the resident was severely cognitively impaired. Resident #98's clinical record included a progress note by the discharge planner dated 3/04/24 10:16 AM which read in part, SW [social worker] [name omitted] spoke to patient's POA [power of attorney] [name omitted] to issue NOMNC [Notice of Medicare Non-coverage] with LCD [last covered day] 3/08/24 and converting to LTC [long term care] 3/09/24. Appeal rights were went [sic] over and POA declined wanting to appeal. SW [name omitted] to have business office to call POA to go over private pay prices and if patient would be eligible for Medicaid . Surveyor requested to review notices that were provided to Resident #98's POA when discharged from Medicare Part A services. Surveyor received a copy of a NOMNC indicating skilled services would end on 3/08/24 and signed by the POA on 3/04/24. On 7/24/24 at 1:58 PM, surveyor spoke with the SW who stated a SNFABN was not provided because Resident #98 went from skilled care to private pay receiving comfort care. Surveyor requested and received the facility policy titled Advanced Beneficiary Notice (ABN) with an effective date of 4/01/22 which read in part 3. The ABN for Part A is used when a patient is coming off of a Part A stay, has days left in the benefit period and is remaining in the Center . (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 4:40 PM, the survey team met with the Administrator, Regional Director of Clinical Services, and the Director of Nursing and discussed the concern of Resident #98 not receiving a SNFABN. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/24/24.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49622 Based on clinical record review and facility document review, the facility staff failed to ensure timely revision of the comprehensive plan of care for 1 of 20 current sampled residents, Resident #53. The findings included: For Resident #53, the facility staff failed to revise the person-centered care plan to discontinue the need for thickened liquids per the physician's order. Resident #53's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Dysphagia, Transient Ischemic Attack (TIA), and Cognitive Communication Deficit. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 06/23/2024, assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 for cognitive abilities, indicating Resident #53 was moderately impaired in cognition. Resident #53's physician's orders included an active order dated 11/14/2023, which read in part, Regular diet .Thin Liquids consistency . Surveyor reviewed Resident #53's comprehensive care plan with a revision date of 07/01/2024, that read in part, Focus .on a mechanically altered diet with thickened liquids .Revision on: 11/14/2023 .Goal .Revision on: 07/01/2024 .Interventions .therapeutic diet as ordered .Created on: 05/30/2023 . Further review of the clinical record revealed a Skilled Note, dated 06/15/2023, that read in part, .Swallow study .now on thin liquids . Further review of physician's orders revealed a physician's order with a start date of 06/15/2023 that read in part, .Regular diet .Thin Liquids consistency . This concern was discussed at the end of day meeting on 07/23/24 at 4:53 PM with the administrator, director of nursing, and regional director of clinical services and again at the pre-exit meeting on 07/24/24 at 4:40 PM. Surveyor requested and received the facility policy titled Care Planning which read in part, .5. Care plans will be updated on an ongoing basis as changes in the patient occur . No further information regarding this concern was presented to the survey team prior to the exit conference on 07/24/24.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49622 Based on staff interview, clinical record review and facility document review, the facility staff failed to provide services that met professional standards of clinical practice for 1 of 20 residents, Resident #21. The findings included: For Resident #21, the facility staff failed to transcribe a verbal medical provider order for the administration of ten (10) units of insulin on 07/13/2024 and failed to document the administration of the insulin. Resident #21's diagnosis list indicated diagnoses, which included, but not limited to, Type 2 Diabetes Mellitus, Cognitive Communication Deficit, Presence of Cardiac Pacemaker, and Cerebral Infarction (stroke). The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 07/09/2024, assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely cognitively impaired. A review of the medication administration record (MAR) for July 2024 revealed on 07/13/2024 that Resident #21's BS (blood sugar) was 410 and the MAR was coded as, 9 (nine), which indicated, 9=other/see progress note. A review of the Orders Administration Note dated 07/13/2024, read in part, .Lyumjev KwikPen Subcutaneous Solution Pen-injector 100 (one hundred) UNIT/ML (milliliter) Inject as per sliding scale .401+ Notify MD (medical doctor) if greater than 400 .Notified [name omitted], NP (nurse practitioner) advised to give 10 U (units) . Surveyor reviewed Resident #21's clinical record and was unable to locate a provider order or documentation of administration of Lyumjev insulin. On 07/23/24 at 9:30 AM, surveyor interviewed licensed practical nurse #5 (LPN#5) and director of nursing (DON). LPN#5 stated she gave Resident #21 the 10 U of insulin after speaking with the NP and she thought the note would verify that she gave it. Surveyor asked the process for giving medication when there was not an order as the BS of 410 was outside of the parameter. LPN#5 stated she would have notified her supervisor and put in a note. Surveyor asked what was required when there was no order, as there was no documentation to verify the medication was given, the time of the administration or the amount. The DON stated a verbal order should have been entered and this would have allowed it to have been documented as administered on the MAR. This concern was discussed on 07/22/24 at 4:50 PM during the end of day meeting with the administrator, regional director of clinical services, and the director of nursing and again during the end of day meeting on 07/23/2024 at 4:53 PM and the pre-exit meeting on 07/24/24 at 4:40 PM. Surveyor requested and received the facility policy titled, Non-Controlled Medication Orders, that read in part, .III .B. New Verbal Orders .The nurse documents the verbal order .on the .electronic medical record .F. Completing Documentation .Transcribe .medications on the MAR . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor also requested and received a facility policy titled, Administration Procedures for All Medications, that read in part, .III .a. Check the MAR .for the order .IV .7. After administration .and document administration in the MAR . Surveyor requested and received a facility policy titled, Nursing Care & Services, that read in part, .Nursing staff will provide nursing care and services following current standards of practice recognized by .Procedure 1. The center will utilize .and/or Clinical Nursing Skills & Techniques by [NAME], [NAME], and Ostendorff as a reference for nursing services and skills not otherwise provided in the Policies and Procedures Manuals. On 07/23/24 at 4:33 PM, DON brought surveyor copies of requested pages from the facility copy of Clinical Nursing Skills & Techniques by [NAME], [NAME], and Ostendorff, (February 7, 2022) located at the nurse's station for reference, that read in part, .Chapter 4 .Telephone and Verbal orders .when receiving a TO (telephone order) or VO (verbal order), enter the complete order into the computer .Chapter 20 .use the MAR to prepare and administer medications .ensure that the MAR clearly shows .the dosage, route .Document the administration of each medication on the MAR as soon as you give it . The DON informed surveyor facility staff use the MFA (Medical Facilities of America) policies first and then go to [NAME] & [NAME]. No further information was provided to the survey team prior to the exit conference on 07/24/2024.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 21227 Based on observations, staff interviews, and facility document review, the facility staff failed to ensure a safe environment as evidenced by the absence of documentation addressing the training, health, and/or vaccinations for an animal/pet (Pet #1) present at the facility. Pet #1 was reported to be one (1) of the five (5) animals/pets to frequent the facility. The findings include: On 7/23/24 at approximately 3:50 p.m., the surveyor knocked on a closed office door at the facility. A dog inside the door was heard to bark. A facility staff member opened the door. The dog could not be seen but was heard to be growling. The dog (Pet #1) was placed in a wire pet kennel. The dog was heard to growl while in the wire pet kennel. Pet #1 had been observed, earlier in the survey, to walk unleashed in the facility with its owner nearby. On 7/23/24 at 4:10 p.m., the surveyor interviewed the facility's Administrator with the Vice-President of Operations present. The Administrator reported the animal/pet in question was considered a center pet. The Administrator reported no injury had ever occurred at the facility related to an animal/pet. The following information was found in a facility policy titled Therapeutic Pets (with an effective date of 1/22/24): - The Recreation Director/staff will ensure any pets and animals integrated into the activity program on a permanent basis are disease free with appropriate documentation on file. Recreation staff will monitor pets and animals and follow safety precautions to ensure patient safety. Pets and animals will be treated humanely and maintained in a safe environment. - Center Pets: . Will be cleared by a veterinarian prior to placement. Examination will include checking for all parasites, diseases, etc. that can be transmitted to humans. Pets and animals will be treated as necessary . Documentation will be kept on file in the recreation department . Dogs: . Will receive obedience training by a certified trainer . Will be treated for fleas and ticks. Pet #1's documentation was a one-page form which did not include the veterinarian's name, address, and/or contact information. This form indicated Pet #1's last Parasite Control was Drontal administered orally on 6/28/23. This form indicated Pet #1's last vaccines were administered on 6/28/23 (10 way and Rabies (3 yr)); the location and route of these vaccines were not documented. No documentation indicating Pet #1 had been cleared by a veterinarian was found by or provided to the surveyor. No documentation indicating Pet #1 had received obedience training by a certified trainer was found by or provided to the surveyor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/24/24 at 11:38 a.m., the surveyor met with the facility's Administrator and a Regional Director of Clinical Services (Administrative Staff #4). The Administrator reported there was no documentation to indicate Pet #1 had been cleared by a veterinarian. The Administrator reported they were still waiting for information from the veterinarian. The Administrator confirmed Pet #1 was not required to be on a leash while in the facility. The Administrator reported Pet #1 would only interact with residents if its owner was present. During this meeting, the absence of documentation of Pet #1 having received obedience training by a certified trainer was discussed. On 7/24/24 at 4:39 p.m., the survey team met with the facility's Administrator, Director of Nursing, and Administrative Staff #4. During this meeting, the Administrator reported no additional documentation related to Pet #1 was available.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47299 Based on observation, resident and staff interview, clinical record review and facility document review, the facility staff failed to provide the proper amount of fluid to maintain an appropriate fluid and electrolyte balance for one of 20 current residents in the survey sample, Resident #66 (R 66). The findings included: R 66's diagnoses included but were not limited to acute and chronic respiratory failure, chronic obstructive pulmonary disease, essential hypertension and peripheral vascular disease. R 66's most recent minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/25/24 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15 indicating they were cognitively intact. Review of R 66's clinical record indicated they were on a 1,200 ml/day fluid restriction per a physician's order written on 7/5/2024. On 7/23/24 at 10:20 AM this surveyor noted that resident had a measured water pitcher with 900 ml (milliliter) capacity, 300 ml's were remaining, a 20-ounce Styrofoam cup filled with soda (20 ounces = 591. 471 ml) and a small plastic cup with approximately 3 ounces of water remaining in it. Surveyor asked resident if they were aware of their 1,200 ml fluid restriction, they indicated that they were not aware of it. When asked what they had to drink for breakfast, they stated, A carton of milk, a cup of coffee and some juice. Resident stated the staff fill up their water pitcher for them twice daily and give them a fresh cup of ice for their soda whenever they ask. On 7/23/24 at 10:40 AM this surveyor interviewed Certified Nursing Assistant (C.N.A.) # 1. When asked how they know when a resident is on fluid restriction they stated, It'll be on their tray cards. C.N.A. #1 could not explain how they monitor fluid restrictions and stated they don't document how much fluid a resident drinks on their shift. On 7/23/24 at 10:45 AM this surveyor interviewed C.N.A. #3. They stated they were not sure how to know if a resident is on fluid restriction, I think I would just ask the nurse. On 7/23/24 at 10:53 AM Registered Nurse #1 was interviewed and stated that fluid restrictions are monitored and documented by the nurses on the Treatment Administration Records (TAR). They could not state why R 66 was on a fluid restriction, It's usually related to a diagnosis like CHF (congestive heart failure). On 7/23/24 at 11:11 AM this surveyor interviewed the Nurse Practitioner (NP) caring for R 66. They stated, It's due to a specific diagnosis but I'll have to look at the chart to make sure what that is. (Resident) knows he/she is on it but is noncompliant with it. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the TAR revealed that nurses were signing off that R 66 was on a fluid restriction but there was no where to document the number of ml's provided per shift. There was no indication in the record that resident had been educated or informed about the fluid restriction and no documentation of noncompliance. This surveyor interviewed the Registered Dietician (RD) on 7/23/24 at 12:20 PM. They stated that resident was on the fluid restriction for hyponatremia. They provided a copy of R 66' s' tray card for the day. According to the tray card R 66 was provided with 8 ounces of orange juice, 16 ounces of coffee/tea and 16 ounces of milk for breakfast. That is a total of 1,182.941 ml's. For lunch R 66 tray card indicated they got 16 ounces of milk and 16 ounces of coffee/tea for 946.353 ml's. R 66 was scheduled to get another 16 ounces of milk and 16 ounces of coffee/tea for the supper meal. Surveyor requested and received a copy of the policy entitled, Fluid Restriction with an effective date of 1/29/2024. Under procedure the policy read in part, 2. Provide education to the patient on specific fluid restrictions. 3. Inform the patient of the amount of fluid allowed orally, including ice chips, gelatin, and ice cream. 4. Per the provider's order for daily fluid allowance. Determine the amount of fluids to be provided with each meal, before bedtime and with medication administration. Consideration of patient preferences. On 7/24/24 the surveyor was referred to an addendum of a progress note dated 7/23/24. The addendum was written at 12:42 PM by the NP and read, Resident was admitted and came into the facility with an order for a fluid restriction, resident was aware of the fluid restriction but unsure why. After reviewing records, her CXR (chest x-ray) shows emphysema, no pneumothorax, effusion, infiltrate or edema. Cardiac silhouette normal in size. Her last echocardiogram was on 5/5/21 which showed an EF (ejection fraction) of with normal LV systolic function, normal diastolic function and mild pulmonary hypertension with an RVSP of 45-50. Bony thorax intact. No clinical indications for the fluid restriction. Laboratory results reviewed. On 7/4/24 resident had a low sodium level of 129 (normal is 136-145). The physician was notified and on 7/5/24 ordered a 1,200 ml fluid restriction and weekly lab work. Sodium on 7/11/24 was 130 and on 7/18/24 was 132. Resident was admitted to the facility on [DATE]. This concern was reviewed with the Administrator, Director of Nursing and Regional Director of Clinical Services on 7/24/24 during a meeting with the survey team. No further information was provided to the survey team prior to the exit conference.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to act upon drug regimen review recommendations for 2 of 5 residents selected for drug regimen review (Resident #32 and Resident #54). The findings included: 1. For Resident #32, the facility staff failed to provide evidence of the 8/26/23, 9/26/23, 10/27/23, 1/26/24, and 3/25/24 drug regimen reviews being acted upon by the medical provider. Resident #32's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Anxiety Disorder, and Generalized Muscle Weakness. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/16/24 assigned the resident a brief interview for mental status (BIMS) summary score of 7 out of 15 indicating the resident was severely cognitively impaired. Documentation within Resident #32's clinical record indicated drug regimen reviews (DRRs) were completed on 8/26/23, 9/26/23, 1/26/24, and 3/25/24, each with pharmacist recommendations. Surveyor was unable to locate the recommendation reports in the resident's clinical record. A 10/27/23 DRR read in part This resident is on an antipsychotic medication and a current AIMS [Abnormal Involuntary Movement Scale] could not be located in the chart .AIMS should be done within the first 30 days of either admission or initiating therapy, then at least every 6 months after that . The medical provider reviewed the 10/27/23 DRR but failed to address the recommendation for an AIMS test. The only AIMS test located in Resident #32's clinical record was dated 6/20/24. On 7/23/24 at 11:25 AM, surveyor spoke with the Director of Nursing (DON) and requested the 8/26/23, 9/26/23, 1/26/24, and 3/25/24 DRRs and any evidence of an AIMS test being completed prior to 6/20/24. The DON returned to the surveyor at 2:33 PM and provided copies of the requested 8/26/23, 9/26/23, 1/26/24, and 3/25/24 DRRs which had not been reviewed or signed by the medical provider. The DON stated the provider also failed to address the pharmacist's recommendation on the October DRR and there were no AIMS tests completed prior to 6/20/24. Surveyor requested and received the facility policy titled Medication Regimen Review with an effective date of 1/29/24 which read in part, .The physician is to review and sign the patient's individual MRR [medication regimen review] and document that he/she has reviewed the pharmacist's identified irregularities within 30 days of receipt . On 7/23/24 at 4:53 PM, the survey team met with the Administrator, Regional Director of Clinical Services, and the DON and discussed the concern of the medical provider failing to address Resident #32's DRRs. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit conference on 7/24/24. 49622 2. For Resident #54, the facility staff failed to provide evidence of the 1/26/24 and 3/25/24 drug regimen reviews being reported to and acted upon by the medical provider. Resident #54's diagnosis list indicated diagnoses, which included, but not limited to, Zoster Encephalitis, Hemiplegia and Hemiparesis, Aphasia, Peripheral Vascular Disease, Depression, Anxiety, Mixed Receptive-Expressive Language Disorder, and Cognitive Communication Deficit. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/24/24 indicated the resident had severely impaired decision-making and is rarely/never understood. Surveyor spoke with the Director of Nursing (DON) on 7/23/24 and requested the drug regimen review recommendation reports completed by the pharmacist for Resident #54. On 7/24/24 at 8:00 AM, the DON provided copies of the requested drug regimen reviews. The Consultant Pharmacist Recommendation to Physician reports dated 1/26/24 and 3/25/24, had not been signed by the medical provider indicating review. The 1/26/24 Consultant Pharmacist Recommendations to Physician read in part, .This resident is taking Depakote routinely. The recommended routine lab work includes VPA (valproic acid) level and Ammonia level . The lab results could not be located on the clinical record, indicating the January recommendation was not addressed. The 3/25/24 Consultant Pharmacist Recommendation to Physician read in part .The resident has been taking Omeprazole 20 mg (milligrams) QD (once a day) since 9/1/2023 without a dose reduction. Please consider a trial dose reduction to Omeprazole 10 mg . A provider order decreasing the dose of Omeprazole could not be located, indicating the March recommendation was not addressed. On 7/24/24 at 9:59 AM, surveyor discussed these findings with the DON, and she stated they could not be found. This concern was discussed on 7/24/24 at 4:40 PM during the pre-exit meeting with the administrator, regional director of clinical services, and the director of nursing. Surveyor requested and received the facility policy titled Medication Regimen Review which read in part The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist .The physician is to review and sign the patient's Individual MRR (medication regimen review) and document that he/she has reviewed the pharmacist's identified irregularities within 30 days of receipt . No further information regarding this concern was presented to the survey team prior to the exit conference on 7/24/24.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49622 Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure that residents are free of any significant medication errors for 1 of 20 sampled residents, Resident #25. The findings included: For Resident #25, the facility staff failed to follow provider orders for the administration of the medications, Invanz and Culturelle for 14 (fourteen) days. Invanz is an antibiotic indicated for the treatment of moderate to severe infections, Culturelle is a probiotic used to maintain digestive health. Resident #25's diagnosis list indicated diagnoses, which included, but not limited to, Type 2 Diabetes Mellitus, Age-Related Physical Debility, Heart Failure, Overactive Bladder, Chronic Kidney Disease, and Urinary Tract Infection. Resident #25's most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/11/24 assigned the resident a brief interview for mental status (BIMS) summary score of 5 out of 15 for cognitive abilities, indicating the resident is severely cognitively impaired. A provider's progress note dated 7/5/24, read in part, .SUMMARY OF VISIT: Resident is being seen today per nursing request for UA (urinalysis) results, final urine culture indicates ESBL (extended spectrum beta-lactamase). Orders for contact precautions, Invanz 1 GM (gram) IM (intramuscular) QD (once a day) x 14 days, Culturelle 1 tab (tablet) po (by mouth) BID (twice a day) x 14 days . A review of Resident #25's July 2024 MAR (medication administration record) revealed Invanz and Culturelle were administered for 10 days. Resident #25's provider orders included an order dated 7/5/24 to give Culturelle for 10 days and Ertapenem Sodium Solution Reconstituted (Invanz) for 10 days. According to the provider's orders and the July 2024 MAR, the medications were not given as ordered for 14 days. On 7/24/24, surveyor interviewed the nurse practitioner (other staff #1) and she stated she did direct staff to administer the Invanz and Culturelle for 14 days. She stated staff informed her the order was transcribed incorrectly to be administered for 10 days and she provided a new order for an additional 4 days of the medications on 7/23/24. On 7/24/24 at 10:03 AM, surveyor interviewed director of nursing (DON) and she stated the order was entered incorrectly and agreed that was why 4 more days were added to Resident #25's treatment on 7/23/24. This concern was discussed on 7/23/24 at 4:53 PM at the end of day meeting with the administrator, director of nursing and the regional director of clinical services and again at the pre-exit meeting on 7/24/24 at 4:40 PM. (continued on next page)

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	495294	A. Building B. Wing	07/24/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received the facility policy titled, Non-Controlled Medication Orders, that read in part, .I. Elements of the Medication Order 1. Medication orders specify the following .f. Quantity or duration (length) of therapy .III. Documentation of the Medication Order .F. Completing Documentation .Transcribe newly prescribed medications on the MAR .After completion, document each medication order entered on the appropriate form . No further information regarding this concern was presented to the survey team prior to the exit conference on 07/24/24.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47299 Based on observation, resident interview, staff interview, clinical record review and facility document review, the facility staff failed to ensure safe and secure storage of medications for one of 20 current residents in the survey sample, Resident #66 (R66). The findings included: R66's diagnoses included but were not limited to acute and chronic respiratory failure, chronic obstructive pulmonary disease, essential hypertension and peripheral vascular disease. R66's most recent minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/25/24 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15 indicating they were cognitively intact. On 7/21/24 at 2:20 PM this surveyor noted that R66 had a bottle of Tums, a bottle of saline nasal spray and a partial tube of diclofenac sodium topical gel on their bedside table. They stated these medications are some they had been taking routinely for a number of years and that the nurses, rub that on my legs, I don't know what I'd do without it referring to the diclofenac tube. The clinical record was reviewed on 7/22/24. There were no orders noted for Tums, saline nasal spray or diclofenac sodium. On 7/23/24 this surveyor noted that the medications were no longer on the bedside table and R66 stated, I put them away. When asked if they had a locked box to keep their medications in, they stated, no. When asked if the staff knew they had the medications they sated, I don't know if they do or not but that doesn't matter, they don't need to know it do they? R66 indicated the medications were in their nightstand drawer. On 7/23/24 at 2:46 PM this surveyor interviewed Registered Nurse (RN) # 1. They stated they were not aware of R66 having medications at bedside. When asked what the policy is for medications at bedside they stated, They shouldn't have any medications at bedside. RN # 1 stated, I'll take care of it. On 7/23/24 at 3:20 PM this surveyor requested and received the policy entitled, Self-Administration of Medications at Bedside, with an effective date of 1/29/24, The policy read in part, 1. The patient may request to keep medications at bedside for self-administration in a lock box. 2. Complete Medications Self-Administration Safety Screen assessment. 3. The Interdisciplinary Team will review the assessment together, use clinical judgment to determine if the patient is eligible. 4. If eligible, medications that are ordered by a provider to be self-administered will be identified in the medical record. On 7/23/24 at 5:00 PM this concern was discussed during an end of day wrap up meeting with the Administrator, Director of Nursing, and Regional Director of Clinical Services. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 12:20 PM the Regional Director of Clinical Services stated the medications were removed from the room and the Nurse Practitioner was meeting with R66 to review medications. A progress note dated 7/24/24 at 12:40 PM read, Spoke with resident regarding having medications at bedside. Reviewed facility policy with resident and (omitted) verbalized understanding. Discussed obtaining orders for medications and nursing staff to administer as ordered. Resident agreed. New orders obtained from NP (name omitted) for orders for PRN voltaren gel, nasal saline spray, fluticasone spray, and tums. No further information was provided to the survey team prior to the exit conference.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide laboratory services to meet the needs of the resident for 1 of 20 sampled residents (Resident #22). The findings included: For Resident #22, the facility staff failed to obtain a comprehensive metabolic panel (CMP), complete blood count (CBC), and a lactic acid blood level as ordered by the medical provider. Resident #22's diagnosis list indicated diagnoses, which included, but not limited to Polyneuropathy, Chronic Pancreatitis, and Chronic Gout. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/14/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. A review of Resident #22's clinical record revealed a medical provider order dated 7/12/24 to obtain a CMP, CBC, and a Lactic Acid level on 7/13/24. Resident #22 was seen by the nurse practitioner (NP) on 7/12/24, the progress note read in part .Resident being seen per nursing request for follow up on cellulitis and for generalized weakness .obtain CBC CMP in am, lactic acid in am . Surveyor reviewed Resident #22's clinical record and was unable to locate the results of the CMP, CBC, and lactic acid blood tests. On 7/23/24 at 2:33 PM, surveyor spoke with the Director of Nursing (DON) who stated they have spoken with the lab and the lab tests were not obtained. Surveyor requested and received the facility policy titled Laboratory/Diagnostic Testing with an effective date of 1/29/24 which read in part .1. A licensed nurse will obtain laboratory, radiology, or other diagnostic services to meet the needs of its patients as ordered by the provider. 2. A licensed nurse will monitor and track all provider ordered laboratory, radiology, and other diagnostic tests; ensure that tests are completed as ordered and communicate results to the provider . On 7/24/24 at 4:40 PM, the survey team met with the Administrator, Regional Director of Clinical Services, and the DON and discussed the concern of the facility staff failing to obtain lab tests as ordered for Resident #22. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/24/24.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 49622 Based on observations, staff interview, clinical record review and facility document review, the facility staff failed to provide appropriate assistive devices to residents who need them to maintain or improve their ability to eat independently for 1 of 20 sampled residents, Resident #21. The findings include: For Resident #21, the facility staff failed to provide a divided plate as recommended by the Certified Occupational Therapy Assistant. Resident #21's diagnosis list indicated diagnoses, which included, but not limited to, Type 2 Diabetes Mellitus, Cognitive Communication Deficit, Dementia, Dysphagia, and Cerebral Infarction (stroke.) The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 07/09/2024, assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating the resident was severely cognitively impaired. On 07/21/24 at 2:41 PM, surveyor observed Resident #21 sitting in wheelchair in her room with a lunch tray on the over-the-bed table in front of resident. The meal ticket on the tray read in part, .Divided Plate . A regular glass plate was observed to be on the resident's tray. On 07/22/24 at 8:42 AM, surveyor observed Resident #21 in her room sitting in her wheelchair with her breakfast tray on the over-the-bed table in front of her. The meal ticket on the tray read in part, .Divided Plate . A regular glass plate was observed to be on the resident's tray. Surveyor interviewed licensed practical nurse #3 (LPN#3) and she agreed meal ticket read divided plate and stated Resident #21 should have a divided plate and that she would check into it. Surveyor reviewed the physician's orders, the comprehensive person-centered care plan, progress notes, and dietary assessments for Resident #21 on the electronic clinical record and was unable to locate any information about the divided plate for the resident. On 07/22/24 at 9:03 AM, surveyor interviewed Dietary Manager, other staff #2 (OS#2). Surveyor observed Resident #21's meal ticket in his hand and Divided Plate was scratched out with ink. OS#2 stated OT (occupational therapy) told him, resident no longer needed a divided plate. On 07/22/2024 at 9:25 AM, surveyor interviewed certified occupational therapy assistant, other staff #4 (OS#4). OS#4 stated Resident #21 was on therapy caseload approximately two weeks ago and she had a goal for self-feeding. OS#4 stated Resident #21 mostly uses fingers to eat but felt she could benefit from a divided plate when she uses utensils so she would have a wall to scoop against. OS#4 stated she talked with dietary about a divided plate for Resident #21 and dietary told her they did not have enough divided plates for Resident #21 to have one. OS#4 also stated there are several residents here that would benefit from divided plates. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor spoke with OS#4 again at 9:40 AM on 07/22/24 and asked her if she had a note or diet communication slip for the requested divided plate for Resident #21 and she stated she did not write it (divided plate) in her notes or do a diet communication slip/order for the divided plate because dietary had told her they did not have enough divided plates. On 07/22/24 at 9:56 AM, surveyor interviewed Regional Dietary Manager for Aramark Services, other staff #3 (OS#3). She stated someone, jumped the gun and put the divided plate on Resident #21's meal ticket while they (dietary) were waiting to order it. On 07/22/2024 at 10:10 AM, surveyor interviewed the administrator (ADM) and OS#3. ADM stated if someone needed a divided plate, she would have ordered it. On 07/22/24 at 3:25 PM, surveyor interviewed OS#4 again to clarify that she spoke with dietary staff members about divided plate for Resident #21. She stated she spoke to three or four dietary staff in the kitchen at the time she went to the door. This concern was discussed on 07/22/24 at 4:50 PM during the end of day meeting with the administrator, regional director of clinical services, and the director of nursing and again during the end of day meeting on 07/23/2024 at 4:53 PM and the pre-exit meeting on 07/24/24 at 4:40 PM. Surveyor requested and received Resident #21's meal tickets for a variety of days in June 2024 and July 2024 and received a meal ticket dated 7/10/24 that read in part, .Divided Plate . OS#3 stated she was not sure how it (divided plate) got on there today (07/22/2024) and surveyor informed OS#3 it was observed on Resident #21's meal ticket yesterday as well. A review of the policy, Assistive Devices read in part: .It is the center policy to provide assistive devices .1. The Dining Services Director will provide appropriate assistive devices .as indicated . No further information regarding this concern was presented to the survey team prior to the exit conference on 07/24/24.