STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515066	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45173 Based on observation and staff interview, the facility failed to provide a dignified and respectful existence for Resident #88 and #104. These were random opportunities of discovery. Facility Census: 118. Findings included: a) Resident #88 On 03/18/24 at 12:40 PM, an observation was made during preparation for wound care. Registered Nurse (RN) #102 was performing hand hygiene and Nurse Aide #107 was gathering supplies for incontinence care. After the incontinence care was complete, the resident remained uncovered from 12:42 PM through 12:52 PM. Resident #88 was lying in bed with her brief unfastened and folded down. On 03/18/24 at 12:52 PM, NA #107 obtained a blanket from the resident's closet and covered the resident after wound care was completed. On 03/18/24 at 12:58 PM, RN #102 was notified of the time frame the resident was exposed. RN #102 stated, oh, okay. On 03/18/24 at 1:05 PM, the Director of Nursing (DON) was notified about the resident being exposed while awaiting wound care. The DON stated, thank you for letting me know. 49467 b) Resident #104 At approximately 2:02 PM on 03/17/24, while conducting an interview with Resident #104 in their room, Nurse Aide (NA) #132 opened the door without knocking and stated, I'm here to change you, when they entered the room. When NA #132 noticed an interview was being conducted with Resident #104, they turned around and exited the room. Upon finishing the interview with Resident #104, an interview was conducted with NA #132 at approximately 2:15 PM. NA #132 stated, I know I should have knocked on the door before I entered, I just didn't think of it at the time.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 22140 Based on record review, staff interview, and resident interview, the facility failed to consider the views of the resident counsel and act promptly upon the grievances and recommendations of the group concerning issues of resident care and life in the facility. This has the potential to affect more than a limited number of residents at the facility. Resident identifiers: #27, #95, #15, #29, #103, #16 and #58. Facility census: 118. Findings included: a) Resident council meeting During the resident council meeting held at 10:00 AM on 03/19/24, numerous residents of the of the seven (7) residents attending (Residents #27, #95, #15, #29, #103, #16 and #58) either complained of medications being late, waiting for 30 minutes to an hour for call lights to be answered, or cold food. The residents said there was a problem with not having enough staff. They explained staff were scheduled to work but would, call in, leaving the facility short on help. The Residents said staff do the best they can and will apologize when they are late to answer a call light and will even explain what caused them to be late. All the Residents in attendance agreed the above issues had been discussed in the council meetings during the last several months. The surveyor reviewed the minutes of the last six (6) months of meetings with the residents in attendance and noted none of these issues were listed as being discussed in the minutes. The Residents said, We talk about staff in every meeting and we have talked about the food and receiving medications late. The residents in attendance said they had not received any follow up answers to their concerns other than the facility is trying to hire staff. One resident did say, The woman in the kitchen is usually at the meetings and will try to help us with food issues. After the meeting adjourned, at 11:06 AM on 03/19/24, the Director of Recreation (DR) #85, the facilitator of the monthly resident council meetings and the recorder of the minutes from the meetings was interviewed along with the administrator. DR #85 said he reviewed the concerns of the resident group in stand up meetings. If residents present concerns on the meeting day, then we would talk about those concerns at the 3:00 PM daily stand up meeting. DR #85 did say residents had complained about not having enough staff for the midnight shift, but he has never filled out any grievance forms. He said he did grievance forms for missing and lost items. When asked if information could be provided to substantiate the residents' concerns and show follow-up information was provided to the residents, he said he had no documentation to provide. On the afternoon of 03/19/24, the administrator provided a grievance form for the concerns and said the concerns would be addressed with the residents.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49467 Based on observation, record review, and resident and staff interview, the facility failed to provide a safe, comfortable, and homelike environment by failing to ensure water temperatures in the shower room were comfortable for Resident #73. This was a random opportunity for discovery. Resident identifiers: #73. Facility census: 118. Findings included: a) Resident #73 At approximately 12:24 PM on 03/17/24, an interview was conducted with Resident #73 concerning the care they received while residing in the facility. Resident #73 stated their showers are frequently cold when they receive them. An interview was conducted with RN #41, in which it was confirmed Resident #73 received their showers in the 100 Hall Shower Room. At approximately 02:25 PM on 03/18/24, temperatures were taken in the shower rooms with the Maintenance Director (MD) and Maintenance Helper (MH) #99. The water temperature of the shower room on the 100 hall, where Resident #73 received showers, was taken twice. The first temperature taken by the MD was 86. 9 degrees fahrenheit. The MD stated, This doesn't feel right, I'm gonna let it run a little longer and take the temperature again. When the MD took the temperature the second time, it was 80.7 degrees fahrenheit. The MD stated, I will need to go and adjust the water for this shower room. Review of the facility's water management program states the facility's water temperatures will be between 98 and 110 degrees fahrenheit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 22140 Based on record review, observation and staff interview, the facility failed to develop and/or implement care plans for six (6) of 38 residents reviewed during the long term care survey. Residents #17, #88 and #117 did not receive care and treatment for pressure ulcers as directed by the care plan. Resident #71 was not care planned for advanced directives. Resident #108's care plan was not implemented for the prevention of edema. Resident #63 did not have care plan interventions in place for the prevention of falls. Resident identifiers: #17, #63, #117, #108, #88, and #71. Facility census: 118. Findings included: a) Resident #17 Review of the current care plan found the following: Focus: (Revised 03/03/14) Resident at risk for skin breakdown related to decreased mobility and has actual skin breakdown unstageable to right buttock, skin tear to right knee. The goal associated with the focus: The resident's wound/skin impairment will show signs of healing as evidenced by decrease in size, absence of erythema and drainage and/or presence of granulation within 90 days. Interventions included: Turn and Reposition every 1-2 hours Observation on 03/18/24 found the following: At 12:00 AM on 03/18/24, observation found the resident was in her bed laying on her back. At 1:43 PM on 3/18/24, the resident said she is sometimes repositioned in the mornings, at meal times and sometimes in the night if she asks them to turn her. The resident said she could not turn herself, honestly I don't think the bed is even big enough for me to try. The Resident was in bed laying on her back. Observation at 2:00 PM on 03/18/24, found the resident was in bed laying on her back. Observation At 3:00 PM on 03/18/24, found the Resident was in bed still in the same position, on her back. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:10 PM on 03/18/24, the resident's nurse aide (NA) #108 was asked if she was turning and repositioning the resident? NA #108 said, I guess I didn't turn her after they did her dressing. At a minimum she should be turned every one (1) to two (2) hours. (The wound treatment was observed at 11:45 AM on 03/18/24.) Review of the resident bed mobility status, recorded by the NA's, in the electronic medical for the last 14 days (3/6/24 - 3/18/24) found resident requires either limited assistance (defined as resident highly involved in activity, staff provide guided maneuvering of limbs or other non weight bearing assistance;) or extensive assistance with bed mobility (defined as Resident involved in activity, staff provide weight-bearing support;) or total dependence (defined as full staff performance.) The resident was never coded as being independent or requiring supervision for bed mobility during this period. On 03/19/24 at 1:34 PM, the above observations and review of the mobility status were discussed with the DON. The DON confirmed the care plan directs to turn and reposition the resident every one (1) to two (2) hours. b) Resident #63 Review of the current care plan found the following focus: The Resident is at risk for falls: cognitive loss, medications. The goal associated with the focus is: Resident will have no falls through the next review. Date Initiated: 03/07/202 Interventions included: Place call light within reach while in bed or close proximity to the bed. Date Initiated: 04/03/2020 Created on: 04/03/2020 Observation on 03/17/24 at 11:00 AM, found the resident was in bed, the resident's call light was hanging behind the head of her bed and was not within reach. Licensed Practical Nurse (LPN) #67 confirmed the call light was not within reach. At 8:30 AM on 03/19/24, observation found the call light was in the floor, the resident was in bed. This observation was verified with the Director of Nursing (DON,) who confirmed the call light was not within reach. At 8:50 AM on 03/20/24, the resident's call light was in the floor, the resident was in bed. This observation was verified by nurse aide (NA) #50, who confirmed the call light was not within reach. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/24 at 1:34 PM, the above observations and care plan were discussed with the DON. No further information was provided. c) Resident #117 Record review found the resident was admitted to the facility on [DATE] with a Stage III pressure ulcer. Review of the current care plan created on 02/28/24 found the following focus: Resident at risk for skin breakdown related to decreased activity , frail fragile skin, incontinence, limited mobility, nutritional concerns and actual skin breakdown: pressure wound to sacrum . The goal associated with the problem: Healing Goal: The resident's wound /skin impairment will heal as evidenced by decrease in size, absence of erythema and drainage and/or presence of granulation through next review. Date Initiated: 02/28/2024 Interventions included: Provide preventative skin care i.e. lotions, barrier creams as ordered Created on: 02/28/2024 Provide wound treatment as ordered Created on 02/28/24 Review of the Treatment Administration Record (TAR) for February and March 2024 found: On 02/28/24 an order was written to, Cleanse the Stage III pressure wound to sacrum with in house wound cleanser (IHWC), gently pat dry, apply Plurogel to wound bed, cover with Optifoam gentle lite as needed (PRN.) On 03/01/24 an order was written to Cleanse the Stage III pressure wound to sacrum with in house wound cleanser (IHWC), gently pat dry, apply Plurogel to wound bed, cover with Optifoam gentle lite every day shift, Monday, Wednesday, and Friday. According to the TAR, the resident received no treatments to the Stage III pressure ulcer for six (6) days from 02/27/24 until 03/03/24. The first treatment was provided on 03/04/24. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/18/24 at 1:38 PM, the treatment nurse, Registered Nurse (RN) #102 reviewed the TAR's with the surveyor. She stated she was sure the resident did receive treatments in the first six (6) days of his admission but she was unable to find any documentation. She stated she staged the wound on 02/28/24 and she would have provided a treatment herself but she guessed she forgot to initial the TAR as having provided the treatment. In addition, RN #102 confirmed the second order for treatment, dated 03/01/24 was written on a Monday and the resident should have received a treatment on that day but the TAR did not indicate the treatment was performed. On 03/19/24 at 1:00 PM, the Director of Nursing (DON) confirmed the facility had no documentation that the resident's pressure ulcer was treated during the first siz (6) days of the resident's admission. The DON confirmed the resident should have been receiving treatments during this time period. In addition, when the order was written on 03/01/24 to provide treatment on M-W-F, the resident missed his first treatment to be provided on Monday, 03/01/24. d) Resident #108 On 03/17/24 at 11:30 AM, a record review was completed for Resident #108. The review found a physician's order stating, Patient to wear medium edema glove to right hand to decrease swelling and pain in R (right) hand. May remove for bathing. (Typed as written.) The record review, also, found the care plan stated under the focus area for at risk for skin breakdown an intervention which reads as Utilize edema glove to right hand to decrease swelling and pain in R (right) hand. May remove for bathing. (Typed as written.) The following dates and times, the resident was observed not wearing the edema glove to the right hand: --03/17/24 at 11:55 AM --03/18/24 at 9:47 AM --03/18/24 at 4:00 PM --03/19/24 at 8:20 AM On 03/19/24 at 8:20 AM, the resident was asked, Do you wear a glove on your right hand? The resident responded, no. On 03/19/24 at 9:12 AM, the DON was notified and, also, observed the resident was not wearing an edema glove to the right hand. The DON stated, We should be following the care plan. e) Resident #88 On 03/17/24 at 11:25 AM, a record review was completed for Resident #88. A physician's order was found stating, Extremity Protectors to be in place to bilateral arms. Remove every shift and prn (as needed) for bathing/skin inspections. (Typed as written.) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan under the focus area of resident has pressure injury to sacrum; open lesion to front right knee (Typed as written.) An intervention was noted as stating, Use arm protectors as ordered. (Typed as written.) On the following dates and times, the extremity protectors were not in place: --03/17/24 at 11:40 AM --03/18/24 at 12:40 PM --03/18/24 at 4:00 PM --03/19/24 at 8:20 AM On 03/19/24 at 8:25 AM, the resident was interviewed and asked, Do you wear the extremity protectors on your arms? The resident stated, I haven't worn them for a couple of weeks .I don't know when the last time was. On 03/19/24 at 9:25 AM, the Director of Nursing (DON) was notified. The DON stated, they should be in place .we follow the care plan. 45171 f) Resident #71 On 03/18/24 at 01:42 PM record review revealed Resident #71 had no personalized comprehensive care plan for the advance directives they had in place according to the Physicians Order for Scope of Treatment. This was confirmed with the Director of Nursing on 03/18/24 at 02:16 PM. 45173

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 31498 45171 Based on record review and staff interview the facility failed to revise comprehensive care plans as needed. This was true for three (3) of thirty-eight (38) care plans reviewed during the Long Term Care Process. Resident Identifiers: #93, #77 and #51. Facility Census: #118 Findings include: a-1) Resident #93 On 03/20/24 at 11:15 AM record review of Resident #93's care plan shows she is permitted to smoke with supervision per the smoking assessment. The care plan was created on 08/29/22. According to the two smoking assessments on file, dated 10/02/23 and 01/03/24 Resident #93 is not allowed to smoke. Confirmation with the Director of Nursing on 03/20/24 at 11:30 AM confirms that Resident #93 does not smoke. a-2) Resident #93 On 03/20/24 at 11:15 AM record review of Resident #93's care plan shows she is at risk for complications related to the use of psychotropic drugs: anti-psychotic, anti-depressant, anti-manic and anti anxiety medications. The care plan was created on 04/05/22 and revised on 06/13/23. Review of current medications ordered for Resident #93 shows she is not on ant anti-psychotic or anti-manic medications, only anti-depressant and anti-anxiety medications This was confirmed with the Director of Nursing on 03/20/24 at 12:10 PM. 45173 b) Resident #51 On 03/19/24 at 12:37 PM, a record review was completed for Resident #51. The review found on the care plan a focus area of the resident has a diagnosis of diabetes: Insulin Dependent. (Typed as written.) However, after reviewing the physician's orders, there were no current orders for any type of insulin. All previous insulin orders had been discontinued on 01/06/24, 01/07/24 and 01/08/24. On 03/19/24 at 1:00 PM, the Director of Nursing was notified of the focus area of the care plan. The DON stated, it must have been discontinued. c) Resident #77 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A medical record review on 03/20/24 revealed a Smoking Evaluation was completed on 01/22/24, which indicated Resident #77 was able to smoke independently. The care plan had not been revised to reflect the resident no longer requires assistance to smoke. An interview with the Director of Nursing (DON) on 03/20/24 at 10:30 AM, verified the care plan had not been revised regarding Resident #77 being able to smoke independently.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49467 Based on observation and resident and staff interview, the facility failed to provide activities of daily living (ADL) care to a dependent resident by not providing proper nail care to Resident #104. This was true for one (1) of two (2) residents reviewed for ADL care. Resident identifier: 104. Facility census: 118. Findings included: A) Resident #104 At approximately 01:55 PM on 03/17/24, while conducting an interview with Resident #104, their toenails were observed as being long. Resident #104 was asked if they preferred having long toenails, to which they stated, Not really, I would like to have them trimmed, but they haven't been touched in a long time. At approximately 2:57 PM on 03/17/24, an interview was conducted with Nurse Aide (NA) #132, who was providing care for Resident #104. NA #132 stated they knew Resident #104 would like to have their toenails trimmed and that it had not been done yet. NA #132 stated, I know they're long and they need trimmed but we just haven't had a chance to get to it yet. At approximately 09:45 AM on 03/19/24, Resident #104's toenails were observed as still not having been trimmed.

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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. 22140 31498 45171 45173 Based on record review, resident interview and staff interview, the facility failed to follow or obtain physician's orders regarding medication administration, obtain a weight and a physician's order for advance directives. This is true for seven (7) of 38 residents reviewed during the survey process. Resident identifiers: #88, #9, #108, #112, #103 and #71. Facility Census: 118. Findings Included: a) Resident #88 On 03/17/24 at 11:40 AM, a physician's order was found stating, Extremity Protectors to be in place to bilateral arms. Remove every shift and prn (as needed) for bathing/skin inspections. (Typed as written. On the following dates and times, observations were made to show the extremity protectors were not in place: --03/17/24 at 11:40 AM --03/18/24 at 12:40 PM --03/18/24 at 4:00 PM --03/19/24 at 8:20 AM On 03/19/24 at 8:25 AM, the resident was interviewed and asked do you wear the extremity protectors on your arms? The resident stated, I haven't worn them for a couple of weeks .I don't know when the last time was. On 03/19/24 at 9:25 AM, the Director of Nursing (DON) was notified. The DON stated, they should be in place. b) Resident #9 On 03/17/24 at 12:05 PM, the resident was interviewed regarding her medication. The resident stated, my medication is always late or sometimes I don't get them. On 03/18/24 at 3:15 PM, a review of the Medication Administration Audit Report for late medications from 03/04/24 through 03/18/24 was completed. The following medications were administered late: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--03/07/24 Depakote 500mg by mouth daily was ordered for 10:00 AM, was administered at 12:15 PM, which is 2 hours and 15 minutes late. --03/07/24 Eliquis 5mg by mouth two times daily was ordered for 10:00 AM, was administered at 12:14 PM, which is 2 hours and 14 minutes late. --03/07/24 Furosemide 20 mg by mouth daily was ordered for 10:00 AM, was administered at 12:15 PM, which is 2 hours and 15 minutes late. --03/07/24 Amiodarone 200 mg by mouth daily was ordered for 10:00 AM, was administered at 12:14 PM, which is 2 hours and 14 minutes late. --03/07/24 Atorvastatin 40 mg by mouth daily was ordered for 10:00 AM, was administered at 12:14 PM, which is 2 hours and 14 minutes late. --03/07/24 Metformin 1000 mg by mouth two times daily was ordered for 10:00 AM, was administered at 12:15 PM, which is 2 hours and 15 minutes late. --03/07/24 Metoprolol Succinate ER 25 mg by mouth daily was ordered for 10:00 AM, was administered at 12:16 PM, which is 2 hours and 16 minutes late. --03/08/24 Depakote 500 mg by mouth daily was ordered for 10:00 AM, was administered at 12:30 PM, which is 2 hours and 30 minutes late. --03/08/24 Eliquis 5 mg by mouth two times daily was ordered for 10:00 AM, was administered at 12:30 PM, which is 2 hours and 30 minutes late. --03/08/24 Furosemide 20 mg by mouth daily was ordered for 10:00 AM, was administered at 12:30 PM, which is 2 hours and 30 minutes late. --03/08/24 Amiodarone 200 mg by mouth daily was ordered for 10:00 AM, was administered at 12:30 PM, which is 2 hours and 30 minutes late. --03/08/24 Atorvastatin 40 mg by mouth daily was ordered for 10:00 AM, was administered at 12:30 PM, which is 2 hours and 30 minutes late. --03/08/24 Metformin 1000 mg by mouth two times daily was ordered for 10:00 AM, was administered at 12:30 PM, which is 2 hours and 30 minutes late. --03/08/24 Metoprolol Succinate ER 25 mg by mouth daily was ordered for 10:00 AM, was administered at 12:30 PM, which is 2 hours and 30 minutes late. --03/09/24 Amiodarone 200 mg by mouth daily was ordered for 10:00 AM, was administered at 12:33 PM, which is 2 hours and 33 minutes late. --03/09/24 Atorvastatin 40 mg by mouth daily was ordered for 10:00 AM, was administered at 12:33 PM, which is 2 hours and 33 minutes late. (continued on next page)

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	515066	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dunbar Center	501 Caldwell Lane Dunbar, WV 25064

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--03/09/24 Metformin 1000 mg by mouth two times daily was ordered for 10:00 AM, was administered at 12:33 PM, which is 2 hours and 33 minutes late. --03/09/24 Metoprolol Succinate ER 25 mg by mouth daily was ordered for 10:00 AM, was administered at 12:34 PM, which is 2 hours and 34 minutes late. --03/15/24 Depakote 500 mg by mouth daily was ordered for 10:00 AM, was administered at 11:42 AM, which is 1 hours and 42 minutes late. --03/15/24 Eliquis 5 mg by mouth two times daily was ordered for 10:00 AM, was administered at 11:42 AM, which is 1 hour and 42 minutes late. --03/15/24 Furosemide 20 mg by mouth daily was ordered for 10:00 AM, was administered at 11:42 AM, which is 1 hour and 42 minutes late. --03/15/24 Amiodarone 200 mg by mouth daily was ordered for 10:00 AM, was administered at 11:42 AM, which is 1 hour and 42 minutes late. --03/15/24 Atorvastatin 40 mg by mouth daily was ordered for 10:00 AM, was administered at 11:42 AM, which is 1 hour and 42 minutes late. --03/15/24 Metformin 1000 mg by mouth two times daily was ordered for 10:00 AM, was administered at 11:42 AM, which is 1 hour and 42 minutes late. --03/15/24 Metoprolol Succinate ER 25 mg by mouth daily was ordered for 10:00 AM, was administered at 11:42 AM, which is 1 hour and 42 minutes late. On 03/17/24 at 1:30 PM, the facility policy entitled, Medication Administration Times states in section 2, Facility should commence medication administration within sixty (60) minutes before the designated times of administration and should be completed by sixty (60) minutes after the designated times of administration. (Typed as written.) On 03/18/24 at 4:00 PM, an interview was held with Licensed Practical Nurse (LPN) #135 regarding late medication administration. LPN #135 states, I'm new .I'm still learning and the internet freezes up. On 03/18/24 at 4:12 PM, the DON was notified of the late medication administration for Resident #9. The DON stated, medications should not be late .if they are the nurses need to call the doctor and get a new order. c) Resident #108 On 03/17/24 at 11:30 AM, a record review was completed for Resident #108. The review found a physician's order stating, Patient to wear medium edema glove to right hand to decrease swelling and pain in R (right) hand. May remove for bathing. (Typed as written.) The following dates and times, the resident was observed while not wearing a edema glove to the right hand: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--03/17/24 at 11:55 AM --03/18/24 at 9:47 AM --03/18/24 at 4:00 PM --03/19/24 at 8:20 AM On 03/19/24 at 8:20 AM, the resident was asked, do you wear a glove on your right hand? The resident responded, no. On 03/19/24 at 9:12 AM, the DON was notified and, also, observed the resident was not wearing an edema glove to the right hand. d) Resident 112 A medical record review on 03/20/24 revealed Resident #112 had a significant weight loss. On 11/02/23 the resident weighed 280 pounds and on 12/04/23 the weight recorded was 266 pounds. There was a 14 pound weight loss and there was no reweigh completed for the weight fluctuation. An interview with the Director of Nursing (DON) on 03/20/24 at 9:48 AM, verified there was no reweigh completed on the weight loss and it was their standard of practice to complete a reweigh when there was a five (5) pound fluctuation. e) Resident #103 Review of the facility policy entitled, Long Term Care Facility's Pharmacy Services and Procedures Manual, revised on 01/01/22 found: .2. Facility should commence medication administration within sixty (60) minutes before the designated times of administration and should be completed by sixty (60) minutes after the designated times of administration. During an interview with the resident on 03/17/24 at 3:18 PM, the resident said her medications were frequently given late. Review of the medication administration audit report ran from 03/04/24 through 03/17/24 found the following dates when medications were administered outside the parameters: 03/05/24 Potassium Chloride ER Oral extended release, give 10 milligrams (mg) - the medication was scheduled to be given at 9:00 AM, the medication was given at 12:17 PM, 2 hours and 17 minutes late. Fluticasone Propionate Suspension, 50 MCG/ACT 1 spray in each nostril one time a day for allergies. The medication was scheduled to be given at 9:00 AM, the medication was administered at 12:17, 2 hours and 17 minutes late. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wellbutrin SR Oral tablet, extended release 12 hour 150 mg. The medication was scheduled to be given at 9:00 AM, the medication was administered at 12:17, 2 hours and 17 minutes late. Celebrex capsule 100 mg one time a day for arthritis. The medication was scheduled to be given at 9:00 AM, the medication was administered at 12:17, 2 hours and 17 minutes late. Gabapentin 100 mg given 2 times a day for neuropathy. The medication was scheduled to be given at 9:00 AM, the medication was administered at 12:17, 2 hours and 17 minutes late. Lorazepam 0.5 mg, give 1 tablet by mouth 2 times a day for anxiety. The medication was scheduled to be given at 9:00 AM, the medication was administered at 12:17, 2 hours and 17 minutes late. 03/07/24 Potassium Chloride ER Oral extended release, give 10 milligrams (mg) - the medication was scheduled to be given at 9:00 AM, the medication was administered at 10:23, 23 minutes late. Fluticasone Propionate Suspension, 50 MCG/ACT 1 spray in each nostril one time a day for allergies. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:23 AM, 23 minutes late. Wellbutrin SR Oral tablet, extended release 12 hour 150 mg. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:23 AM, 23 minutes late. Celebrex capsule 100 mg one time a day for arthritis. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:23 AM, 23 minutes late. Gabapentin 100 mg given 2 times a day for neuropathy. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:23 AM, 23 minutes late. Lorazepam 0.5 mg, give 1 tablet by mouth 2 times a day for anxiety. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:23 AM, 23 minutes late. 03/08/23 Lorazepam 0.5 mg, give 1 tablet by mouth 2 times a day for anxiety. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:32 AM, 32 minutes late. Potassium Chloride ER Oral extended release, give 10 milligrams (mg) - the medication was scheduled to be given at 9:00 AM, the medication was administered at 10:32, 32 minutes late. Fluticasone Propionate Suspension, 50 MCG/ACT 1 spray in each nostril one time a day for allergies. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:30 AM, 30 minutes late. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wellbutrin SR Oral tablet, extended release 12 hour 150 mg. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:32, AM, 32 minutes late. Celebrex capsule 100 mg one time a day for arthritis. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:30 AM, 30 minutes late. Gabapentin 100 mg given 2 times a day for neuropathy. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:32 AM, 32 minutes late. 03/12/24 Lorazepam 0.5 mg, give 1 tablet by mouth 2 times a day for anxiety. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:11 AM, 11 minutes late. Potassium Chloride ER Oral extended release, give 10 milligrams (mg) - the medication was scheduled to be given at 9:00 AM, the medication was administered at 10:16, 16 minutes late. Fluticasone Propionate Suspension, 50 MCG/ACT 1 spray in each nostril one time a day for allergies. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:59 AM, 59 minutes late. Wellbutrin SR Oral tablet, extended release 12 hour 150 mg. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:16, AM, 16 minutes late. Celebrex capsule 100 mg one time a day for arthritis. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:16 AM, 16 minutes late. Gabapentin 100 mg given 2 times a day for neuropathy. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:11 AM, 11 minutes late. 03/13/24 Lorazepam 0.5 mg, give 1 tablet by mouth 2 times a day for anxiety. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:59 AM, 59 minutes late. Potassium Chloride ER Oral extended release, give 10 milligrams (mg) - the medication was scheduled to be given at 9:00 AM, the medication was administered at 11:03, 1 hour and 3 minutes late. Wellbutrin SR Oral tablet, extended release 12 hour 150 mg. The medication was scheduled to be given at 9:00 AM, the medication was administered at 11:02, 1 hour and 2 minutes late. Gabapentin 100 mg given 2 times a day for neuropathy. The medication was scheduled to be given at 9:00 AM, the medication was administered at 10:58 AM, 58 minutes late. At 3:00 PM on 03/18/24, Licensed Practical Nurse (LPN) #40 who administered medications late on 03/12/13/24 and 03/13/24 said she would run late when the facility scheduled 3 LPN's but only 2 would show up. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 4:09 PM on 03/18/24, the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #57 were interviewed. LPN #57 who administered the medications late on 03/05/24 said she gave the medications on time but she didn't initial the medications as being given until later. The DON said she would expect all nurses to initial the medications on the electronic medical record when they were actually administered. The DON reviewed the medication administration audit report and confirmed medications were not always given one (1) hour before or one (1) hour after their scheduled times. No further information was provided. f) Resident #71 On 03/18/24 at 01:42 PM Record review shows Resident #71 had no Physician's order for the advance directives that were in place for the resident according to the Physician's Order for Scope of Treatment. This was confirmed with the Director of Nursing on 03/18/24 at 01:44 PM.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22140 Based on observation, record review, resident interview and staff interview, the facility failed to ensure three (3) of four (4) residents reviewed for the care area of pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Resident identifiers: #17, #117, and #33. Facility census: 118. a-1) Resident #17 - Treatments During an interview with the resident on 03/17/24 at 12:07 PM, the resident stated she developed a pressure ulcer on her backside while at the hospital, she still has it, but believes the area is getting better. Record review found the resident was admitted to the facility on [DATE] with an unstageable pressure ulcer to the right gluteus. Review of the treatment administration record (TAR) for February and March 2024 found the following orders for treatment to the pressure ulcer: -On 02/06/24 an as needed (PRN) order was written to, cleanse the unstageable pressure wound to the right gluteus with normal saline, gently pat dry. Apply Marathon barrier ointment to peri wound, paint on in circular motion. Apply Santyl to eschar and slough. Cover with foam dressing. This order was discontinued on 02/16/24. (No PRN treatments were provided from 02/06/24 through 02/16/24.) -On 02/07/24 an order was written to monitor the site daily for status of surrounding tissue and wound pain. Monitor for status of dressing, if applicable. Additional documentation in nursing notes if needed every day shift - this order continues. -On 02/07/24 an order was written to, Cleanse the unstageable pressure wound to the right gluteus with normal saline, gently pat dry. Apply Marathon barrier ointment to peri wound, paint on in circular motion. Apply Santly to eschar and slough. Cover with foam dressing every day. This order was discontinued on 02/16/24. -On 02/07/24 an order was written to apply Santyl external ointment 250 unit (Collagenase) to the right gluteus topically every day shift - this order continues. -On 02/16/24 an order was written to, Cleanse unstageable pressure wound to right gluteus with IHWC, (in house wound cleanser) pat dry, apply Plurogel to wound bed, cover with optifoam dressing as needed - this order continues. On 02/19/24 an order was written to, Cleanse unstageable pressure wound to right gluteus with IHWC, gently pat dry. Apply Plurogel to the wound bed, cover with Optifoam dressing every Monday, Wednesday and Friday. This order continues. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/19/24 at 9:00 AM, the residents' treatment orders were reviewed with the wound care nurse, Registered Nurse (RN) #102. RN #102 confirmed that according to the information on the TAR, the resident received no treatment to the wound on Saturday 02/10/24 when she was ordered a daily treatment. In addition there was no evidence the wound was monitored that day according to the TAR. According to the treatment orders on the TAR since 02/19/24, the Resident was receiving treatment with IHWC, apply Plurogel to the wound and cover with optifoam dressing every Monday, Wednesday, and Friday, yet a second order required Santyl to be applied daily to the wound. RN #102 was asked how a nurse would apply Santly daily when the wound was covered with a foam dressing along with Pluroget being applied every Monday, Wednesday, and Friday (M-W-F.) She was asked if the foam dressing was being removed on Tuesday, Thursday, Saturday and Sunday to apply the Santyl? Also during the wound treatments administered on M-W-F were both debriding agents - Santyl and Pluroget being applied? RN #102's first comment was, Well the Santyl should have been discontinued. RN #102 provided a copy of the wound care guidelines used by the facility. She said wound care is ordered based on the description of the wound. She noted the resident's wound was shallow and wet, and the guidelines directed Plurogel or a Therahoney sheet to be applied and covered with optifoam dressing. The wound care guidelines did not suggest using Santyl based on any wound descriptions. On 03/19/24, at 2:15 PM, Licensed Practical Nurse (LPN) #69 was interviewed. A copy of the March 2024, TAR was provided for her viewing. LPN #69 initialed the TAR on 03/07/24 as having applied the Santyl to the pressure area. She was asked if she removed the optifoam dressing to apply the Santyl. She said the optifoam was probably already off or she wouldn't have removed the foam dressing. She stated the dressing falls off all the time, you can't keep it on there. She was asked if the foam was not in place, what should she have done? She stated, I would have used the Plurogel and then reapplied the Optifoam. The surveyor pointed out there was a PRN order to apply Plurogel and Optifoam but she had not initialed the TAR on 03/07/24 indicating she had done so. At 2:42 PM on 03/19/24, the Director of Nursing (DON) said the order for Santyl had been discontinued by the physician and she provided a copy of the order. No further information was provided by the facility. a-2) Resident #17 (Resident observations) (Revised 03/03/14) Resident at risk for skin breakdown related to decreased mobility and has actual skin breakdown unstageable to right buttock, skin tear to right knee. The goal associated with the focus: The resident's wound/skin impairment will show signs of healing as evidenced by decrease in size, absence of erythema and drainage and/or presence of granulation within 90 days. Interventions included: Turn and Reposition every 1-2 hours. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:00 AM on 03/18/24, observation found the resident was in her bed laying on her back. At 1:43 PM on 3/18/24, the resident said she is sometimes repositioned in the mornings, at meal times and sometimes in the night if she asks them to turn her. The resident said she could not turn herself, honestly I don't think the bed is even big enough for me to try. The Resident was in bed laying on her back. Observation at 2:00 PM on 03/18/24, found the resident was in bed laying on her back. Observation At 3:00 PM on 03/18/24, found the Resident was in bed still in the same position, on her back. At 3:10 PM on 03/18/24, the resident's nurse aide (NA) #108 was asked if she was turning and repositioning the resident? NA #108 said, I guess I didn't turn her after they did her dressing. At a minimum she should be turned every one (1) to two (2) hours. (The wound treatment was observed at 11:45 AM on 03/18/24.) Review of the resident bed mobility status, recorded by the NA's, in the electronic medical for the last 14 days (3/6/24 - 3/18/24) found resident requires either limited assistance (defined as resident highly involved in activity, staff provide guided maneuvering of limbs or other non weight bearing assistance;) or extensive assistance with bed mobility (defined as Resident involved in activity, staff provide weight-bearing support;) or total dependance (defined as full staff performance.) The resident was never coded as being independant or requiring supervision during this period. On 03/19/24 at 1:34 PM, the above observations and review of the mobility status were discussed with the DON. No further information was provided. b) Resident #117 During an interview with the resident on 03/17/24 at 11:35 AM, the resident said he had a place on his rear end when he was admitted , stating it's getting better. Record review found the resident was admitted to the facility on [DATE] with a Stage III pressure ulcer. The length was noted to be 3.99 centimeters (cm), width was 1.43 cm, and the area was 5.74 cm. The wound bed was described as containing islands of epithelium, a light amount of serosanguineous exudate, no odor after cleaning, the edges were attached, the surrounding skin was fragile with no swelling or edema. Review of the Treatment Administration Record (TAR) for February and March 2024 found: On 02/28/24 an order was written to, Cleanse the Stage III pressure wound to sacrum with in house wound cleanser (IHWC), gently pat dry, apply Plurogel to wound bed, cover with Optifoam gentle lite as needed (PRN.) On 03/01/24 an order was written to Cleanse the Stage III pressure wound to sacrum with in house wound cleanser (IHWC), gently pat dry, apply Plurogel to wound bed, cover with Optifoam gentle lite every day shift, Monday, Wednesday, and Friday. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the TAR, the resident received no treatments to the Stage III pressure ulcer for six (6) days from 02/27/24 until 03/03/24. The first treatment was provided on 03/04/24. On 03/18/24 at 1:38 PM, the treatment nurse, Registered Nurse (RN) #102 reviewed the TAR's with the surveyor. She stated she was sure the resident did receive treatments in the first six (6) days of his admission but she was unable to find any documentation. She stated she staged the wound on 02/28/24 and she would have provided a treatment herself but she guessed she forgot to initial the TAR as having provided the treatment. In addition, RN #102 confirmed the second order for treatment, dated 03/01/24 was written on a Monday and the resident should have received a treatment on that day but the TAR did not indicate the treatment was performed. On 03/19/24 at 1:00 PM, the Director of Nursing (DON) confirmed the facility has no documentation that the resident's pressure ulcer was treated during the first 6 days of the resident's admission. The DON confirmed the resident should have been receiving treatments during this time period. No further information was provided. 45171 c) Resident #33 On 03/18/24 at 01:56 PM record review shows Resident #33 has a pressure ulcer to her sacrum. She has a low air loss mattress to relieve the pressure on her sacrum. She also had a red area to her right heel that turned into an open lesion. She has a surgical wound to her left lower quadrant abdomen and an ileostomy appliance. Review of the Treatment Administration Record (TAR) for February and March, 2024 shows the following missed treatments in February. Check the setting and function of the 36 low air loss mattress every shift for a setting of four (4). This was not performed on 02/10/24 for day, evening or night shift. Clean red area to right heel with cleanser, pat dry, apply sure prep and dry dressing every day and night shift. This was not performed on 02/10/24 day or night shift. Cleanse surgical wound to left lower quadrant abdomen with normal saline solution (NSS), pat dry, apply silvasorb gel to wound bed, loosely fill with saline moistened gauze, cover with abdominal (ABD) pad and secure with paper tape every day shift This was not performed on 02/10/24 and 02/19/24. Cleanse unstageable pressure wound to sacrum with NSS, pat dry, apply thin layer of santyl to wound bed, then apply calazime to surrounding excoriated skin and cover with dry dressing every day shift, This was not performed on 02/19/24. Ileostomy appliance change every day shift every three (3) days. This was not performed on 02/10/24, 02/19/24 and 02/22/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ileostomy care every day and night shift. This was not performed on 02/20/24 day or night shift and on 02/19/24 on day shift. Wound(s): Monitor sites daily for status of surrounding tissue and wound pain. Monitor for status of dressing(s). If applicable additional documentation in nurse note if needed every day shift. This was not performed on 02/10/24 and 02/19/24. The above information was confirmed with the Director of Nursing on 03/20/24 at 09:10 AM.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45173 Based on observation, resident interview and staff interview, the facility failed to maintain a safe and accident-free environment as possible. These were a random opportunities for discovery. Resident identifiers: #87 and #73. Facility Census: 118. Findings Included: a) Resident #87 On 03/17/24 at 11:47 AM, an interview with Resident #87 was held. During the interview, an observation of two (2) medication cups with a clear cream inside was found sitting on the over-the-bed table by the bed. The resident was asked, do you know what is in the medication cups? The resident responded, I think they use that for my wound on my leg. On 03/17/24 at 11:50 AM, Licensed Practical Nurse (LPN) #135 was notified regarding the two medication cups with a clear cream inside. LPN #135 stated, let me get rid of that .I'm not sure what it is .it looks like Aquaphor. On 03/17/24 at 12:30 PM, the Director of Nursing (DON) was notified and confirmed no medication should be kept at bedside. b) Resident #73 At approximately 12:27 PM on 03/17/24, an observation was conducted in the bathroom of Resident #104. A wash basin was sitting on the bathroom sink with two souffle cups full of a white cream. Resident #73 stated I'm not sure what kind of cream that is or why it's there. At approximately 12:41 PM on 03/17/24, Licensed Practical Nurse (LPN) #135 acknowledged the white cream in the souffle cups and stated they did not know what the cream was or what it would be used for. 49467

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45173 Based on observation and staff interview, the facility failed to maintain professional standards of care for residents receiving dialysis. This was true for one (1) of one (1) residents reviewed under the care area of dialysis. Resident Identifier: #51. Facility Census: 118. Findings Included: a) Resident #51 On 03/19/24 at 10:36 AM, a record review was completed for Resident #51. The review found the dialysis communication book was incomplete. On the following dates the hemodialysis communication book was missing information: --03/01/24 pre-dialysis facility nurse signature and date --03/01/24 post dialysis no assessment of the arteriovenous (AV) shunt and no indication of new orders from the dialysis center --03/04/24 dialysis center AV assessment was incomplete and the nurse signature and date were missing --03/04/24 post dialysis vital signs were not completed by the facility nurse --03/08/24 dialysis center section was incomplete in all fields including pre-and post weights --03/11/24 dialysis center section was incomplete in all fields including pre-and post weights --03/13/24 dialysis center section was incomplete in all fields including pre-and post weights --03/13/24 post dialysis section was incomplete including the facility nurse signature and date On 03/19/24 at 11:45 AM, the Director of Nursing (DON) was notified of the missing information. The DON stated, all sections should be complete, if it is the dialysis center section, the nurse can call and find out the missing information.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49467 Based on record review and staff interview, the facility failed to complete performance reviews for Nurse Aides at least once every twelve months. This was true for one (1) of five (5) employees reviewed for performance reviews during the long term care survey process. Facility census: 118. Findings included: a) Nurse Aide #34 At approximately 01:39 PM on 03/19/24, record review was conducted for the facility's staffing. The Director of Nursing (DON) produced the yearly performance reviews for the requested employees, and stated We are missing the one for Nurse Aide (NA) #34. Upon further record review, it was confirmed the yearly performance review for NA #34 was missing.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 45171 Based on record review and staff interview the facility failed to identify a diagnoses for psychotropic medications. This was true for one (1) of five (5) residents reviewed for unnecessary medications. Resident Identifier: #93 Facility Census: #118 Findings include: a) Resident #93 On 03/20/24 at 08:36 AM record review shows Resident #93 is on three (3) antidepressants. There is an active medical diagnosis listed for Resident #93 of depression and anxiety disease. Behavior documentation was reviewed. The Physician orders are written as: Escitalopram Oxalate Tablet 20 milligrams (MG) give one (1) table by mouth one time a day for targeted behavior(s) potential to demonstrate verbal behaviors related to: ineffective coping skills, related to not wanting a roommate, blasting volume on TV to bother roommates, making false allegations against staff members, can be become angry and yell at staff. Trazodone CL Tablet 50 MG Give 1 tablet by mouth at bedtime for targeted behavior(s) potential to demonstrate verbal behaviors related to: ineffective coping skills, related to not wanting a roommate, blasting volume on TV to bother roommates, making false allegations against staff members, can be become angry and yell at staff. Wellbutrin SR Oral tablet extended release 12 hour 100 MG Give 1 tablet by mouth one time a day for targeted behavior(s) potential to demonstrate verbal behaviors related to: ineffective coping skills, related to not wanting a roommate, blasting volume on TV to bother roommates, making false allegations against staff members, can be become angry and yell at staff. Wellbutrin SR Oral tablet extended release 12 hour 150 MG Give 1 tablet by mouth one time a day for targeted behavior(s) potential to demonstrate verbal behaviors related to: ineffective coping skills, related to not wanting a roommate, blasting volume on TV to bother roommates, making false allegations against staff members, can be become angry and yell at staff. The above orders do not identify a medical diagnosis for use, only the behaviors the Resident may exhibit for use of the medication. The above was confirmed with the Director of Nursing on 03/20/24 at 10:55 AM at which time she stated all of the orders listed should read for depression and then list the as evidenced behaviors.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171 Based on observation and staff interview, the facility failed to ensure all medical supplies stored in the medication storage room were stored in accordance with currently accepted professional principles. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents. Facility Census: #118 Findings include: a) Medication Storage Room on 200 hall On [DATE] at 10:42 AM observation of the medication storage room on the 200 hall found the following supplies to be expired: Expired supplies as listed: Fifty two (52) Female Luer Lock Caps expired 1- expired on [DATE]. 18 - expired on [DATE] 13 - expired on [DATE] 3 - expired on [DATE] 14 - expired on [DATE] 3 expired on [DATE] Eleven (11) Magellan 1 milliliter Tuberculin Safety Syringes expired on [DATE]. The above information was confirmed with the Director of Nursing on [DATE] at 10:50 AM.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49467 Based on observation and staff interviews, the facility failed to post accurate menus prior to meal times. This was a random opportunity for discovery. This has the potential to affect more than a limited number of residents. Facility census: 118. Findings included: a) Observation At approximately 10:40 AM, on 03/17/24, the facility was observed having old menus hanging on the 300 and 400 hallways. The following menus were posted: Thursday's Breakfast Specials Cereal and Juice Oatmeal Scrambled Eggs Eggs prepared to order Choice of Bakery Breads Friday's Lunch Specials Tossed Salad with Signature Dressing Chicken Pot Pie Dinner Roll with Margarine or, Spinach Frittata Hash Browns Dinner Roll with Margarine Seasonal Fresh Fruit Saturday's Dinner Specials (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Baked Ham Seasoned Green Beans Sweet Potato Casserole Dinner Roll with Margarine or, Roasted Chicken Season Green Beans Sweet Potato Casserole Dinner Roll with Margarine Scalloped Apples At approximately 10:50 AM, the Record Management Manager (RMM) acknowledged the incorrect menus posted in the hallways. At approximately 11:00 AM on 03/17/24, Licensed Practical Nurse (LPN) #57 acknowledged the incorrect menus hanging in the hallways and made copies of the menus. At approximately 11:05 AM on 03/17/24 an interview was conducted with Cook #150 concerning the menus. Cook #150 stated, We gave them to the aides this morning to hang up, I guess they didn't do it.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 22140 45171 Based on observation, record review, and resident interview, the facility failed to serve food at palatable temperatures for resident consumption. There were a total of 18 complaints of cold food during the survey process. This had the potential to affect more than a limited number of residents. Resident identifiers: #224, #223, #117, #33, #12, #51, #82, #59, #103, #73, #71 #55, #27, #95, #15, #29, #16 and #58 complained of cold food during the long term care survey. Facility census: 118. Findings included: a) Resident interviews Residents #224, #223, #117, #33, #12, #51, #82, #59, #103, #73, #71, #55 #27, #95, #15, #29, #103, #16 and #58 complained of cold food during the long term care survey on 03/17/24. In addition Residents #27, #95, #15, #29, #103, #16 and #58 complained of cold food during the resident council meeting held on 03/19/24 at 10:00 PM. b) Food temperatures At approximately 01:26 PM on 03/18/24, temperatures were taken by the Registered Dietitian (RD), along with the District Manager of Dietary Services (DMDS) and the Dietary Account Manager (DAM), from a test tray in the last hallway served. The facility served mashed potatoes (served hot) that were recorded at 122 degrees Fahrenheit and yogurt (served cold) that was 49.8 degrees Fahrenheit. c) Policy According to the facility's policy on food handling, hot food will be served at no less than 135 degrees Fahrenheit, while cold food will be served at no more than 41 degrees Fahrenheit, and be palatable to residents. 49467

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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** 31498 Based on record review and staff interview the facility failed to maintain complete and accurate medical records. This was true for one (1) of three (3) resident records reviewed for discharge during the Long-Term Care Survey Process. Resident #120 was discharged and the physician did not complete the recapitulation of the resident's stay. Resident identifier: #120. Facility census: 118 Findings included: a) Resident #120 A medical record review on 03/19/24 for Resident #120 revealed the resident was discharged on [DATE], with no anticipation to return to the facility. The physician failed to complete a recapitulation of the resident's stay. In an interview with the Nursing Home Administrator (NHA) on 03/19/24 at 10:52 AM, reported he was unable to locate the physician's recapitulation of Resident #120's stay while in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45171 Based on observation, record review and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections due to not wearing protective protection equipment (PPE) in an enhanced barrier room and touching the surroundings with soiled glove for Resident #88, for proper storage of a nebulizer mask for Resident #62, no hand hygiene completed before meals for room [ROOM NUMBER], 408 and 411 and by placing a dirty meal tray on a clean dining cart. These were random opportunities for discovery. Resident Identifiers: #88 and #62 . Facility Census: 118. Findings Included: a1) Resident #88 On 03/18/24 at 12:40 PM, Nurse Aide (NA) #107 was observed completing incontinence care for Resident #88 without wearing proper PPE (gown). The door was noted with signage stating, Enhanced Barrier Precautions .during high-contact resident care activities .changing briefs and assisting with toileting .a gown and gloves are to be worn. On 03/18/24 at 12:41 PM, NA #107 was interviewed and asked, did you have a gown on during incontinence care? NA #107 shook her head no. On 03/18/24 at 1:10 PM, the Director of Nursing (DON) was notified. The DON stated, the staff should be aware of rooms requiring PPE while completing care for the resident. a2) Resident #88 On 03/18/24 at 12:52 PM, during an observation of wound care for Resident #88 was being completed by Registered Nurse (RN) #102, the resident was incontinent of bowel. NA #107 was assisting RN #102 with the wound care. When NA #107 completed the incontinence care, the soiled gloves were not removed. NA#107 touched the door handle of the room, obtained a clean blanket from the resident's closet and placed the blanket over the resident. On 03/18/24 at 1:03 PM, the wound care was completed by RN #102 and NA #107 removed her soiled glove and completed hand hygiene. The NA exited the room. On 03/18/24 at 1:05 PM, RN #102 was notified of the infection control breach and stated, I will talk to her. On 03/18/24 at 1:12 PM, the DON was notified of the infection control breach. The DON stated, I will discuss this with NA #107. b) Resident #62 On 03/17/24 at 11:30 AM, an observation of Resident #62 was completed. The observation found a nebulizer not stored properly in a respiratory bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Three (3) additional observations were made on following dates and times of the nebulizer mask not being stored properly: --03/18/24 at 9:45 AM --03/18/24 at 4:00 PM --03/19/24 at 8:20 AM On 03/19/24 at 9:10 AM, the DON, also observed the nebulizer mask not stored properly in a respiratory bag. The DON stated, let me get rid of this. The DON removed the nebulizer mask and threw it away in a trash can in the room. c) room [ROOM NUMBER] A & B On 03/17/24 at 11:40 AM observation of the noon meal pass on the 400 hall found there were no hand hygiene procedures performed for the residents in room [ROOM NUMBER] prior to the meal. Certified Nurse Aide (CNA) passed lunch trays to three (3) rooms without offering any of the six (6) residents hand hygiene products. When ask about it she replied, we usually use a wash cloth with soap. When the surveyor commented that no hand hygiene had been observed, the CNA went to the drink cart and retrieved a hand wipe packet and held it up to show the surveyor. The surveyor interviewed the six (6) residents and they all commented they use to get hand wipes but they don't give us those anymore. d) room [ROOM NUMBER] A & B On 03/17/24 at 11:40 AM observation of the noon meal pass on the 400 hall found there were no hand hygiene procedures performed for the residents prior to the meal. Certified Nurse Aide (CNA) passed lunch trays to three (3) rooms without offering any of the six (6) residents hand hygiene products. When ask about it she replied, we usually use a wash cloth with soap. When the surveyor commented that no hand hygiene had been observed, the CNA went to the drink cart and retrieved a hand wipe packet and held it up to show the surveyor. The surveyor interviewed the six (6) residents and they all commented they use to get hand wipes but they don't give us those anymore. e) room [ROOM NUMBER] A & B On 03/17/24 at 11:40 AM observation of the noon meal pass on the 400 hall found there were no hand hygiene procedures performed for the residents prior to the meal. Certified Nurse Aide (CNA) passed lunch trays to three (3) rooms without offering any of the six (6) residents hand hygiene products. When ask about it she replied, we usually use a wash cloth with soap. When the surveyor commented that no hand hygiene had been observed, the CNA went to the drink cart and retrieved a hand wipe packet and held it up to show the surveyor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor interviewed the six (6) residents and they all commented they use to get hand wipes but they don't give us those anymore. The above was confirmed with the Administrator on 03/17/24 at 1:10 PM. 49467 f) At approximately 01:13 PM on 03/18/24, while observing the facility's tray pass during lunch in the 200 hallway, the Activities Director (AD) was observed removing a tray from the delivery cart and delivering it to room [ROOM NUMBER]-B. Upon entering the room, the AD realized the resident was not there, at which point, they removed the tray, took it back to the delivery cart, and placed it inside with the remaining clean trays. The AD was notified the dirty tray could not be placed back in the clean delivery cart, to which they replied, I really had no idea it couldn't go back on there. At approximately 01:20 PM on 03/18/24, the Director of Nursing (DON) was notified of the AD placing the dirty tray back on the clean cart.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 22140 Based on observation and staff interview, the facility failed to ensure a resident's call light was accessible. These were random opportunities for discovery and affected only a limited number of residents. Resident identifiers: #4 and #63. Facility census: 118. Findings included, a) Resident #4 At approximately 02:18 PM on 03/17/24, the call device for Resident #4 was observed lying on the floor beside the resident's bed and the resident was not able to reach from the bed to retrieve it. At approximately 02:33 PM on 03/17/24, the call device for Resident #4 was observed still on the floor, with the resident still unable to reach it. At approximately 02:35 on 03/17/24, Registered Nurse (RN) #41 entered Resident #4's room to provide assistance to their roommate. Upon entering, Resident #4 asked RN #41 for assistance. RN #41 acknowledged Resident #4, stepped over the call device, and moved the bedside table closer to Resident #4's bed. RN #41 then stepped over the call device again to go to Resident #4's roommate. As RN #41 turned around to leave the room, they walked past the call device again. At this point, RN #41 was alerted to the call device in the floor, turned around, acknowledged the device in the floor, and placed it on Resident #4's bed. b) Resident #63 Observation on 03/17/24 at 11:00 AM, found the resident was in bed, the resident's call light was hanging behind the head of her bed and was not within reach. Licensed Practical Nurse (LPN) #67 confirmed the call light was not within reach. At 8:30 AM on 03/19/24, observation found the call light was in the floor, the resident was in bed. This observation was verified by the Director of Nursing (DON,) who confirmed the call light was not within reach. At 8:50 AM on 03/20/24, the resident's call light was on the floor, the resident was in bed. This observation was verified by nurse aide (NA) #50, who confirmed the call light was not within reach.