STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515087	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Center	302 Cedar Ridge Road Sissonville, WV 25320

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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. 39043 Based on observation, record review and staff interview, the facility failed to ensure services to meet professional standards of care. A medication labeled by the pharmacy to be used for a specific resident was used for another resident. This was a random opportunity for discovery found during medication administration observation. Resident identifiers: #4 and #52. Facility census: 110. Findings included: a) Residents #4 and #52 The facility's policy titled Medication Administration General Guidelines dated January 2024 gave the following procedure: - Medications supplied for one resident are never administered to another resident. On 07/18/24 at 7:38 AM, Licensed Practical Nurse (LPN) #28 was observed administering medications to Resident #4. The resident had an order written on 06/25/24 for Lactulose, 10 grams in 15 milliliters concentration, give 45 ml by mouth two (2) times a day for hyperammonemia (high ammonia level). LPN #28 could not find lactulose for Resident #4. There was an unopened Lactulose bottle with a label for Resident #52. The Lactulose concentration was 10 grams in 15 milliliters. LPN #28 stated Resident #52 was no longer in the facility. LPN #28 stated she could use Resident #52's Lactulose for Resident #4 since the bottle was unopened and Resident #52 was no longer in the facility. She poured the Lactulose from the bottle into a medication cup and administered it to Resident #4. LPN #28 stated a bottle of Resident #4's Lactulose needed reordered from the pharmacy and she did so using the computer. On 07/18/24 at 11:00 AM, the incident was reported to the Administrator, the Director of Nursing (DON), and the Corporate Nurse were notified. They confirmed the facility's policy that medications supplied for one (1) resident are never administered to another resident. No further information was provided through the completion of the investigation.

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

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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	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 39043 Based on record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice. Physician-ordered medication parameters were not followed. This deficient practice had the potential to affect (1) of four (4) residents reviewed during the investigation. Resident identifier: #39. Facility census: 110. Findings included: a) Resident #39 Resident #39 had the following physician-ordered medication parameters: - Amlodipine besylate, 10 mg, one (1) tablet by mouth one (1) time a day for hypertension. Hold for pulse below 60 or SBP [systolic blood pressure] less than 110 or DBP [diastolic blood pressure] less than 70 and notify provider, ordered on 02/23/23. - Propranolol, 20 mg, one (1) tablet by mouth two (2) times a day for hypertension. Hold for pulse below 60 or SBP less than 110 or DBP less than 70 and notify provider, ordered on 01/08/24. According to the resident's Medication Administration Record (MAR), at the following dates and times, amlodipine besylate was administered despite the resident's vital signs being outside the administration parameters: - 07/02/24 at 8:00 AM, pulse was 59 beats per minute - 07/10/24 at 8:00 AM, diastolic blood pressure was 66 - 07/11/24 at 8:00 AM, diastolic blood pressure was 66 - 07/14/24 at 8:00 AM, diastolic blood pressure was 66 At the following dates and times, propranolol was administered despite the resident's vital signs being outside the administration parameters: - 07/01/24 at 8:00 PM, pulse was 59 beats per minute - 07/02/24 at 8:00 AM, pulse was 59 beats per minute - 07/19/24 at 8:00 PM, diastolic blood pressure was 64 - 07/10/24 at 8:00 AM, diastolic blood pressure was 66 - 07/19/24 at 8:00 PM, diastolic blood pressure was 66 - 07/11/24 at 8:00 AM, diastolic blood pressure was 66 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 07/14/24 at 8:00 AM, diastolic blood pressure was 66 On 07/18/24 at 11:20 AM, the Director of Nursing (DON) confirmed amlodipine and propranolol had been administered to Resident #39 when the parameters indicated the medications should have been held. No further information was provided through the completion of the investigation.

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39043 Based on record review and staff interview, the facility failed to ensure four (4) residents were free of significant medication errors. On 07/11/24, the facility reported to the Office of Health Facility Licensure and Certification (OHFLAC), Adult Protective Services (APS), and the Ombudsman that Resident #69, Resident #74, Resident #39, and Resident #108 were administered their 8:00 AM medications twice due to incomplete medication administration documentation. The facility developed and implemented a plan of correction on 07/11/24. The state agency investigated the matter on 07/18/24 and determined on 07/11/24 Resident #69, Resident #74, Resident #39, and Resident #108 were in an Immediate Jeopardy situation due to potential adverse consequences from duplicate medication administration. The stage agency reviewed the facility's plan of correction and documentation and determined the Immediate Jeopardy situation had been abated on 07/14/24 when all education with staff was completed. This was prior to the state agency's investigation which made this past non compliance. Resident identifiers: #69, #74, #39, #108. Facility census: 110. Findings included: a) Facility-reported incident and Plan of Correction On 07/11/24, the facility reported to the Office of Health Facility Licensure and Certification (OHFLAC), Adult Protective Services (APS), and the Ombudsman that Resident #69, Resident #74, Resident #39, and Resident #108 were administered their 8:00 AM medications twice due to incomplete medication administration documentation. Both nurses involved were removed from direct care at the time of the allegation and an investigation was initiated. Poison Control was contacted regarding all four (4) residents. Poison Control recommended emergency room evaluation for Resident #39 and Resident #108. Poison control recommended frequent monitoring in the facility for Resident #69 and Resident #74. The facility's plan of correction initiated 07/11/24 was as follows: The licensed nurse conducted a change in condition on 07/11/24 with notification to the medical provider for all four (4) residents who received duplicate medication. The Nurse Practice Educator conducted an audit on 07/11/24 of all licensed nurses' medication administration competencies to ensure all licensed nurses are competent with medication administration within the last 12 months with any correction action immediately upon discovery. The Unit Managers/designee conducted an audit on 07/11/24 for all residents' medication administration records for July 2024 to ensure free from medication errors with any corrective action immediately upon discovery. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Re-education was provided by the Director of Nursing (DON)/Designee to all licensed nurses starting on 7/11/24 on safe medication administration practices including verification of correct, patient, drug, route, dose, time, special consideration, and expiration date with a Post-test to validate understanding. Any licensed nurses not available during this time frame will be provided re-education, including post-test and return demonstration by DON/designee prior to the beginning of the next shift to work. New Licensed nurses will be provided education, including post-test during orientation by the DON/designee. Annual in-servicing will be provided to licensed nurses regarding medication administration. The Unit Managers (UM)/Designee will conduct observations starting on 7/12/24 to ensure all licensed nurses are passing medications according to Genesis medication administration policies including verification of right patient, drug, route, dose, time, special considerations, and expiration dates across all shifts for 2 weeks including weekends and holidays, then 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then randomly thereafter. Results of observations will be reported by the Unit Manager (UM)/designee monthly to the Quality Improvement Committee (QIC) for any additional follow-up and or in-servicing until the issue is resolved, then randomly thereafter as determined by the QIC committee. The facility submitted a five (5) day follow-up investigation on 07/16/24 which verified the allegation. The five (5) day follow-up investigation contained the following additional information: Witness statements were obtained and interviews were conducted with the licensed nurses on duty at the time of the med error. It has been determined that LPN [#106] was not familiar with the unit in which she was passing medications, and was unaware there was a 6:00 AM med pass. LPN [#106] was attempting to pass the medications for the 8:00 AM med pass, and when the computer gave her an error message, she proceeded to pre-pull 8:00 AM medications, not realizing that she failed to change the shift time on her MAR to the correct med pass time. This allegation of neglect will be substantiated and reported to the [NAME] Virginia State Board of Examiners for Licensed Practical Nurses. Prior to her return to work, LPN [#106] will receive education on safe administration practices including verification of correct patient, drug, route, dose, time, special considerations, and expiration date with a Post-test to validate understanding. LPN [#106] will receive seven supervised medication passes and be subjected to random monitoring during medication pass. The facility's inservices regarding medication administration and shift reporting were reviewed. The inservice information, sign-in sheets, and post-tests were reviewed. Medications audits performed by the Unit Managers and Director of Nursing were reviewed. Medication administration was observed on the morning of 07/18/24. The nurses performing medication administration, Licensed Practical Nurse (LPN) #28, LPN #62, LPN #42, and LPN #55, were able to correctly answer questions regarding medication administration and documentation. b) Policy and Procedure (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's policy titled Medication Administration General Guidelines dated January 2024 gave the following procedures: - Medications were to be administered within 60 minutes of scheduled time - The individual who administered the medication dose was to record the administration on the resident's Medication Administration Record (MAR) immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. c) Resident #69 Resident #69 was a [AGE] year-old man who has resided in the facility since 2022. He did not have capacity to make medical decisions and an Adult Protective Services worker was appointed as his Health Care Representative. According to the resident's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 05/29/24, the resident's Brief Interview for Mental Status (BIMS) score was 9, indicating moderate cognitive decline. The resident had diagnoses of dementia, personality disorder, anxiety disorder, depression, alcohol abuse, congestive heart failure, atrial fibrillation, hyperglycemia, hypertension, and peripheral vascular disease. The following progress note was written by Licensed Practical Nurse (LPN) #105 for Resident #69 on 7/11/2024 at 8:36 AM: This nurse was passing 0800 meds and entered another resident room, resident states she already took 0800 meds. This nurse went to [LPN #106] to ask if she passed 0800 meds to some residents. [LPN #106] states she gave some 0800 meds but is unsure of what [Registered Nurse (RN) #43] gave. This nurse notified [LPN #40], [RN #47]. [LPN #40] is to tell [Nurse Practitioner (NP) #104]. The following late entry note was written by the Director of Nursing (DON) on 7/11/2024 at 11:28AM: Resident received duplicate dosing of a.m. medication; provider notified; poison control consulted; order noted to obtain blood pressure q 1 hour x 4; Resident blood pressures obtained per order; po fluids encouraged and consumed. RP [resident representative] notified of medication error and plan of care. According to the resident's Medication Administration Record (MAR), Resident #69 was scheduled to receive the following medications daily at 8:00 AM: - Amlodipine 5 mg, one (1) time a day for hypertension - Aspirin 81 mg, one time a day for hyperlipidemia - Divalproex sodium, extended-release, 500 mg, one time a day for personality disorder - Eliquis (apixaban) 5 mg, two (2) times a day for atrial fibrillation (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Metoprolol extended release, 100 mg, one (1) time a day for hypertension - Seroquel (quetiapine) 25 mg, one (1) time a day for depression Of these medications, the following could have adverse consequences with over dosages: - Amlodipine, which could cause hypotension. - Metoprolol, which could cause hypotension, bradycardia, bronchospasm, and cardiac failure. - Seroquel, which could cause slowed tachycardia, hypotension, heart block, arrhythmias, and drowsiness or sedation. - Eliquis, which could cause risk of bleeding. - Divalproex, which could cause coma, heart block, and somnolence. (Source: medication product label, available on-line from the Food and Drug Administration at www.accessdata.fda.gov.) The following note was written by Nurse Practitioner # 104 on 7/12/2024 at 5:50 PM, [AGE] year-old male with history of dementia, anxiety, depression, personality disorder, chronic systolic heart failure, A-fib [atrial fibrillation], COPD [chronic obstructive pulmonary disease], hyperlipidemia and alcohol abuse. Patient being seen today for follow-up. Per nursing patient received his a.m. medication twice on 7/11/2024 this included aspirin, Seroquel, divalproex sodium, amlodipine and metoprolol. Poison control was notified and gave recommendations to monitor patient in house including vital signs every hour x 4. Patient resting in bed this a.m. He is alert and appropriate. Denies complaints of dizziness, weakness, vertigo, shortness of breath or chest pain. Patient is stable. He has resumed his current medications. On 07/11/24 at 8:27 AM, the resident's blood pressure was 114/66. The resident's blood pressure was monitored hourly for four (4) hours and frequently after that. The resident's blood pressure stayed within normal range. The top number of the blood pressure (systolic) remained over 100. The bottom number of the blood pressure (diastolic) remained over 60. The resident had skilled nursing evaluations performed on 07/12/24, 07/13/24, 07/14/24, and 07/15/24. The resident had no change in vital signs or mental status following the medication error. Resident #69 was interviewed on 07/15/24 at 10:56 AM. He had no complaints about the facility. When specifically asked about medications, the resident had no complaints. d) Resident #74 Resident #74 was a [AGE] year-old who had resided in the facility since 2015. The resident did not have the capacity to make decisions and a family member was the health care surrogate. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The resident had diagnoses of dementia, chronic obstructive pulmonary disease, convulsions, cerebrovascular disease, traumatic hemorrhage of cerebrum, hemiplegia/hemiparesis, bipolar affective disease, and anxiety disorder. According to the resident's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 06/11/24, the resident's Brief Interview for Mental Status (BIMS) score was 4, indicating severe cognitive decline. On 07/11/24 at 10:09 AM, an SBAR (Situation, Background, Assessment, and Recommendation) summary for providers was completed for Resident #74. The summary stated, Resident was given a duplicate dose of 8 am medications. Nurse called poison control and DON to make aware of the situation Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Poison control was notified and recommended that patient was stable to monitor at this time. [NP #104] was notified and agreed to monitor resident and not needed to send out at this time. According to the resident's Medication Administration Record (MAR), Resident #74 was scheduled to receive the following medications daily at 8:00 AM: - Acetaminophen, 325 mg, two (2) tablets, every six (6) hours for pain and discomfort - Metamucil fiber, one (1) packet, one time a day for constipation - Paroxetine, 10 mg, one (1) time a day for depression - Potassium chloride, 10 mg, one time a day for hypokalemia - Risperdal (risperidone) 0.5 mg, two (2) times a day for Bipolar - Umeclidinium bromide inhalation, one (1) puff, one (1) time a day for chronic obstructive pulmonary disease - Vitamin D3, 400 units, one (1) time a day for hypovitaminosis D Of these medications, the following could have adverse consequences with over dosages: - Paroxetine, which could cause somnolence, coma, nausea and vomiting, tremor, tachycardia, and confusion. - Potassium chloride, which could cause elevated potassium levels. - Risperdal, which could cause drowsiness or sedation, tachycardia, and hypotension. (Source: medication product label, available on-line from the Food and Drug Administration at www.accessdata.fda.gov.) (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 07/12/24 at 6:11 PM, NP #104 wrote the following note: [AGE] year-old male with history of COPD, CVA [cerebral vascular accident], dementia and bipolar disorder. Patient being seen today for follow-up visit. Per nursing patient received his a.m. meds twice yesterday including paroxetine, Risperdal, potassium chloride, and Metamucil. Poison control was notified and patient was monitored in house. Patient resting in bed this a. m. he is alert to person. No acute distress noted. Poor historian due to advanced dementia. The resident had skilled nursing evaluations performed on 07/12/24, 07/13/24, 07/14/24, and 07/15/24. The resident had no change in vital signs or mental status following the medication error. The resident was observed on 07/15/24 at 11:20 AM but was not interviewable. e) Resident #39 Resident #39 was an [AGE] year-old admitted in February 2023. The resident did not have capacity to make decisions due to intracranial hemorrhage and cognitive impairment. A family member was the health care surrogate. According to the resident's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 05/24/24, the resident's Brief Interview for Mental Status (BIMS) score was 13, indicating the resident was cognitively intact. In addition to intracranial hemorrhage, the resident had diagnoses of major depressive disorder, breast cancer, hypertension, and hyperlipidemia. On 07/11/24 at 8:40 AM, an SBAR summary for providers was completed for Resident #39. The summary stated, Resident was given a double dose of her medications. Poison control called. Sending out to ER for evaluation. According to the resident's MAR, the resident was scheduled to receive the following medications daily at 8:00 AM: - amlodipine besylate, 10 mg, one (1) time a day for hypertension - dicyclomine hydrochloride, 10 mg, twice a day for irritable bowel syndrome - exemestane 25 mg, one (1) time a day for breast cancer - letrozole, 2.5 mg, one (1) time a day for breast cancer - propranolol 20 mg, two (2) times a day for hypertension - Wellbutrin (bupropion) 100 mg, one (1) time a day for depression (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The poison control center provided a toxic substance review to the hospital emergency room . The review stated amlodipine had a low margin for safety and double doses could cause toxicity in patient on multiple cardiac drugs or with brittle cardiac status. Life threatening hypotension (low blood pressure) could occur. Heart block and bradycardia (slow heart rate) were common. Atrioventricular dissociation (a condition in which the atria and the ventricles operate independently from each other) could persist for nine (9) to 48 hours. Pulmonary edema, drowsiness, confusion, and nausea and vomiting could also occur. According to the toxic review, an established toxic dose for bupropion was not established. The following conditions could occur with bupropion overdose: seizures, tremors, agitation, excitement, confusion, tachycardia (increased heart rate), and acute psychotic reactions, including visual hallucinations. Cardiovascular collapse and cardiac arrest could occur with massive overdoses. As for anticholinergics (dicyclomine) the toxic review stated specified toxic doses had not been established. Drowsiness and tachycardia could occur. The toxic review stated beta-blocking agents (propranolol) could cause hypotension (low blood pressure), bradycardia, seizures, and cardiac dysrhythmias. Cardiac conduction disturbances and cardiovascular shock could occur with severe toxicity. The toxic review also stated the amounts of exemestane and Letrozole ingested by the resident were well below toxic range and significant effects were not expected. According to the emergency room records, the resident reported dizziness. Laboratory testing was within normal limits. The resident was discharged to return to the facility on [DATE] at 2:22 PM. The resident had no changes in vital signs or mental status upon return to the facility. On 07/12/24 at 5:34 PM, NP #104 wrote the following note: [AGE] year-old female with history of major depressive disorder, IBS, hypertension, hyperlipidemia, hypothyroidism, nontraumatic intracranial hemorrhage, cerebral edema, and personal history of malignant neoplasm of the breast. Patient being seen today follow-up for ER [emergency room] visit. Patient was sent to [hospital name] 7/11/2024 for medical screening at poison control's recommendation due to accidental drug overdose. Per nursing patient received double her morning meds including: Amlodipine, dicyclomine, letrozole, propranolol, Wellbutrin, and exemestane. Patient sitting up in wheelchair this afternoon. She just returned from having a cataract removed from her left eye. She is alert and oriented. She has no acute complaints of pain or discomfort at this time. The resident had skilled nursing evaluations performed on 07/12/24, 07/13/24, 07/14/24, and 07/15/24. Resident #39 was interviewed on 07/15/24 at 11:30 AM. When asked if she had any problems with the care she received, the resident stated she was given her pills twice on Friday morning. She stated she had to go to the emergency room for evaluation. The resident stated, But I was okay .Those kinds of things happen. f) Resident #108 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #108 was a [AGE] year-old who was admitted [DATE]. The resident did not have the capacity to make medical decisions due to cognitive impairment. A family member was health care surrogate for the resident. According to the resident's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 07/02/24, the resident's Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact. The resident had diagnoses of congestive heart failure, atherosclerotic heart disease, Parkinson's Disease, general anxiety disorder, major depressive disorder, and hypertension. On 07/11/24 at 7:00 AM, an SBAR summary for providers was completed for Resident #108. The summary stated, 0800 medications given twice by two separate nurses. poison control notified, physician notified. orders to send resident to ER for evaluation. Resident #108's blood pressure was 91/58 at 7:30 AM on 07/11/24. The resident's most recent recorded blood pressure was 134/78 on 06/04/24. According to Emergency Medical Services (EMS) records, Resident #108 reported feeling tired and dizzy. His blood pressure was noted to be 95-100 systolic, which EMS notes is lower than the resident's baseline blood pressure. The Emergency Medical Technicians inserted an intravenous catheter and began normal saline infusion to increase his blood pressure. According to the resident's Medication Administration Record (MAR), Resident #108 was scheduled to receive the following medications daily at 8:00 AM: - Acetaminophen, 325 mg, two (2) tablets, four (4) times a day for pain - Aspirin, 81 mg, one (1) time a day for coronary artery disease - Carbidopa-Levodopa extended release, 50-200 mg, five (5) times a day for Parkinson's Disease - Carbidopa-Levodopa 25-100 mg, four (4) times a day for Parkinson's Disease - Furosemide 20 mg, one (1) time a day for edema - Isosorbide extended-release tablet, 30 mg, one (1) time a day for hypertension - Paroxetine, 20 mg, one (1) time a day for depression/anxiety - Plavix (clopidogrel) 75 mg, one (1) time a day for coronary artery disease - Sennosides, 8.6 mg, two (2) tablets, one (1) time a day for constipation - Tizanidine, 2 mg, three (3) times a day for muscle relaxant Of these medications, the following could have adverse consequences with over dosages: - Paroxetine, which could cause somulence, coma, nausea and vomiting, tremor, tachycardia, and confusion. (continued on next page)

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	515087	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Center	302 Cedar Ridge Road Sissonville, WV 25320

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

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Carbidopa-Levodopa, which could cause heart arrhythmias. - Furosemide, which could cause dehydration, hypotension, and electrolyte imbalances. - Isosorbide, which could cause hypotension, nausea and vomiting, syncope, bradycardia, heart block, coma, and seizures. - Plavix, which could cause increased breathing. - Tizanidine, which could cause hypotension, bradycardia, coma, somnolence, confusion, and respiratory depression. (Source: medication product label, available on-line from the Food and Drug Administration at www.accessdata.fda.gov.) Laboratory testing at the hospital was within normal limits. The resident returned to the facility on [DATE] at 1:57 PM. On 07/12/24 at 5:06 PM, NP #104 wrote the following note: [AGE] year-old male with history of chronic diastolic heart failure, arteriosclerotic heart disease, Parkinson's disease, hypertension and hypothyroidism. Patient being seen today to follow-upfor ER visit. Patient was sent to the ER yesterday 7/11/2024 at [hospital name] for evaluation due to accidental medical overdose after Poison control was consulted and made recommendation. Per nursing patient was given his a.m. medicine x 2 including Zanaflex, Sinemet and isosorbide. Patient was seen and evaluated in ED [emergency department] and later sent back to facility. Patient sitting up in activity room this a.m. He is alert to person/place. Appears at baseline. Patient's vital signs have been monitored. And his regular medication regimen has resumed. The resident had skilled nursing evaluations performed on 07/12/24, 07/13/24, 07/14/24, and 07/15/24. Resident #108 was interviewed on 07/22/24 at 9:45 AM. He had no complaints about the facility. When specifically asked about medications, the resident had no complaints. He acknowledged that he had been evaluated in the emergency room but was unable to provide any additional information about the emergency room visit. g) Staff Interview The Director of Nursing and Administrator were interviewed on 07/15/24 at 3:00 PM. They stated the nurse had given the 8:00 AM medications during the 6:00 AM medications administration pass and had not signed them out as given. Additionally, the nurse had been pulled to another area of the facility and, therefore, had not given report to the on-coming nurse to let her know that medications had been given. The DON stated the nurse had not returned to the facility during the investigation of the incident. If the nurse is permitted to return to the facility after the investigation has concluded, the nurse will have an improvement plan with preceptorship in place. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	At the time of the Facility Reported Incident investigation on 07/15/24. All staff had been re-educated before their next shift after the incident. Education had begun on 07/11/24 and was completed on 07/14/24.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30153 Based on observations, resident and staff interviews, the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed for residents with Multidrug-resistant Organisms (MDRO's). Resident identifiers: #12, #17 and #72. Facility census: 110. On 07/18/24 at 3:51 PM an immediate jeopardy (IJ) was called at as this failed practice had the potential to affect all residents residing in the facility. Findings included: a) Resident #12 Resident #12 was admitted on [DATE]. Diagnoses included paraplegic, neurogenic bladder with suprapubic catheter, decubitus ulcers, vascular ulcers both heels, chronic kidney disease, and insulin dependent diabetic. Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/11/24 had a Brief Interview of Mental Status (BIMS) with a score of 15. This indicates intact cognition. The resident had the capacity to make medical decisions. On 07/18/24 at 10:55 AM observed two (2) Nurse Aides (NA's) performing direct resident care of changing urine soaked brief and linens wearing only gloves and no gowns. An EBP sign was on the door. When asked if Resident #12 was on EBP, Registered Nurse (RN) #71 responded I don't know, I will go look, and left the room. On 07/18/24 at 11:00 AM an interview with the NA instructor #25 stated that NA #108 was only there to observe the care being provided. NA #66 stated that she was new and had only been here two (2) weeks. Observed RN #71 and NA #108 reenter room wearing gowns and gloves. An interview with Resident #12 at 11:00 AM on 07/18/24 stated that no staff had worn a gown when providing care. b) Resident #72 An additional interview with Resident #72 on 07/18/24 at approximately 1:00 PM stated that no staff had worn a gown when providing care. Record review revealed a history of ESBL and also currently had a Foley Catheter. c) Resident #17 In reviewing residents who had a Foley and residents were to be on contact precautions, found Resident #17 did have a Foley which was not leaking and initially had an EBP sign on the outside of the door. On 07/18/24 at 11:24 AM an interview with NA #15 stated that the Foley was not leaking and had been changed the day before for Resident #17. An EBP sign was posted on the outside of the door and later changed to contact precautions by the IP on 07/18/24 at approximately 2:26 PM. Resident # 17 had wounds that the drainage could not be contained and had MRSA and ESBL in the wounds and was currently being treated with antibiotics. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In addition, 49 residents were on Enhanced Barrier Precautions (EBP) were followed for residents with Multidrug-resistant Organisms (MDRO's) including Methicillin-Resistant Staphylococcus Aureus (MRSA), Carbapenem-resistant Enterobacterales (CRE), Vancomycin-resistant Enterococci (VRE), Extended-spectrumbeta-lactamase (ESBL). c) Resident #72 An interview with Resident #12 at 11:00 AM on 07/18/24 stated that no staff had worn a gown when providing care. An additional interview with Resident #72 on 07/18/24 at approximately 1:00 PM stated that no staff had worn a gown when providing care. Record review revealed a history of ESBL and also currently had a Foley Catheter. An interview with the IP and Corporate RN confirmed the staff had not been using EBP as stated in policy on 07/18/24 at 2:29. The IP stated that she had not been the IP but just a few weeks. On 07/18/24 at 3:51 PM an immediate jeopardy (IJ) was called at F880 at an L as this failed practice had the potential to affect all residents residing in the facility. The Plan of Correction (POC) was received on 07/18/24 at 3:54 PM. After consulting with the State Office the POC was approved and agreed to an abatement on 07/18/24 at 4:17 PM. After the abatement, the L was changed to an F as the failed practice had the potential to affect all residents, staff and visitors. The POC was as follows: The Infection Preventionist (IP) provided education to the nursing staff in (on) Resident #12 regarding the use of EBP during high contact resident care activities on 07/18/24. All residents of the facility have the potential to be affected. The Infection Preventionist/designee conducted an observation round on 07/18/24 to ensure nursing staff is donning Personal Protective Equipment (PPE) for residents who are in enhanced barrier precautions with any corrective action immediately upon delivery. All center staff will be reeducated by the Director of Nursing (DON)/designee on 07/18/24 regarding the facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections including nursing staff is donning appropriate PPE for residents who are in enhanced barrier precautions. A posttest completed to validate understanding. All staff not available during this timeframe will be provided reeducation including posttest by the Director of Nursing (DON)/designee prior to the next scheduled shift. New staff will be provided education and posttest during orientation by the Infection Preventionist (IP)/designee. The DON/designee will conduct an observation round starting on 07/18/24 to ensure nursing staff is donning appropriate PPE for residents who are in enhanced barrier precautions daily across all shifts for 2 weeks, including weekends and holidays, then 5 times a week for 4 weeks then 3 times a week for 4 weeks, the randomly thereafter. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Results of monitors will be reported by the Nursing Home Administrator/designee to the Quality Improvement Committee (QIC) monthly for any additional follow-up and or in-servicing until the issue is resolved, then randomly thereafter as determined by the Quality Improvement Committee. A review of the facility policy and procedure titled IC308 Enhanced Barrier Precautions with a revision date of 01/08/24. As of July 2022, the Center Disease Control (CDC) targeted MDRO's are defined as pan-resistant organisms, CRE, CR Pseudomonas, CR Acinetobacter baumaii and Candida auris. Additional MDRO's that might be included based on local requirements: MRSA, ESBL, VRE, MDRO-Pseudomonas aeruginosa and drug resistant Streptococcus pneumoiae. In the procedure section titled Enhanced Barrier Precautions with an effective date of 08/01/23 and revision date of 05/01/24. Enhanced barrier: All residents with any of the following: infection or colonization with a targeted MDRO Chronic wounds and/or indwelling medical devices such as central line, urinary catheter, enteral feeding tube regardless of MDRO colonization status. During high contact resident care activities: providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, central line, urinary catheter, enteral feeding tube . wound care; and skin opening requiring a dressing.