STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525061	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Park Nursing and Rehab LLC	1700 C A Becker Dr Racine, WI 53406

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review and policy review, the facility failed to ensure one of one resident (Resident (R)30) with medications at the bedside had been assessed and evaluated to self-administer medications. Findings include: Review of R30's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with medical diagnoses that included acute respiratory failure. Review of R30's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 10/07/24, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R30 was cognitively intact. During an observation and interview on 11/11/24 at 2:00 PM, R30 was in bed and on the bedside table was a tissue box with a bottle of Fluticasone and saline nasal spray. The resident confirmed they were her meds, got them and kept saying they were over the counter, and she could have them. Review of R30's Orders tab in the EMR revealed there was no physician orders for the administration of Fluticasone nasal spray. Review of R30's Care Plan tab in the EMR lacked documentation of self-administration of medication. An observation and interview on 11/13/24 at 2:41 PM, with Licensed Practical Nurse (LPN)1 confirmed the medications in the room for R30 were saline nasal spray, Fluticasone, and generic Sudafed pills. LPN1 stated the resident will not let us remove the medications because R30 says they belong to the resident. During an interview on 11/14/24 at 2:50 PM LPN1 consulted the Director of Nursing (DON) who suggested asking R30 to borrow the in-room medications to verify what medications they were and confirmed a self-assessment evaluation needed to be done to have medications in the room for self-administration. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 6:01 PM, the DON confirmed an assessment needed to be done for the resident to self-administer medications and R30 did not have an assessment done and should have had one since R30 had medications in the room. Review of the facility policy titled Self-Administration of Medication Management, with an effective date of 06/29/17, revealed A resident may only self-administer medications after the IDT [Interdisciplinary Team] has determined which medications may be safely self-administered.When determining if self-administration is clinically appropriate for a resident, a licensed nurse will complete the Evaluation for Resident Self-Administration of Medications to aid in the determination of resident's ability to self-administer medication.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on interviews, record review and policy review the facility failed to ensure that residents are free from abuse from another resident for one of five residents (Resident (R) 25) reviewed for abuse out of a sample of 23. After R25 bumped into R66 with the wheelchair, R66 aggressively grabbed R25 arm causing an injury of bruising on the left arm of R25. Failure to protect residents from abuse has the potential to result in injury to residents. Findings include: Review of the facility's policy titled, Abuse/Neglect/Exploitation, with revision date 01/05/24, revealed, It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse . Review of R25's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] and a readmitted [DATE] with medical diagnoses that included vascular dementia. Review of R25's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 09/30/24, revealed a Brief Interview for Mental Status (BIMS) score of six out of 15, indicating R25 was severely cognitively impaired. Review of R25's Assessments tab in the EMR revealed a Skin assessment dated [DATE] documented on right forearm scattered bruising 2 x 2 centimeters (cm), 1.5 x 0.5 cm x 2 cm as a new skin issue. During an interview on 11/14/24 at 12:58 PM, the Wound Care Registered Nurse (WCRN) verbalized caring and dressing the wound on R25 on 11/08/24 and confirmed the injury occurred on 11/08/24. Review of R66's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with a readmission on 09/10/24 with medical diagnoses that included unspecified dementia, mild with agitation. Review of R66's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 09/16/24, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating R66 was severely cognitively impaired. Review of the investigation provided by the facility documented an incident between R25 and R66 on 11/08/24. Nursing reported that resident R25 accidentally rolled over the toes of resident R66. R66 then grabbed the arm of resident R25 and twisted [the arm] causing injury. This was a staff witnessed event. Staff were able to immediately intervene and separate residents to maintain safety. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 1:24 PM, the Activities Assistant verbalized witnessing the interaction between R66 and R25 on 11/08/24. The Activities Assistant described seeing the two residents arguing and both were upset and neither of them wanted to initially say what happened. The Activities Assistant observed R66 grabbing R25's arm because R25 rolled over the toes of R66 while propelling backwards in the wheelchair. The investigation provided by the facility, the incident was reported to the Administrator who reported it to the state agency (SA) and the local police department. Interventions were put in place to treat the injury on R25, a psychosocial assessment of both residents and continued psychosocial monitoring for the next 72 hours for both residents. R25 was interviewed on the day of the incident and stated (R25) was coming out the door and (R66) came up to (R25) and twisted (R25's) arm. The interview with R66, R66 stated I have not gotten in trouble with anyone. Review of R25's Care Plan tab in the EMR documented a focus initiated on 11/08/24 the resident has the potential for alteration in psychosocial and an intervention to monitor for any changes in mood, behavior, appetite, sleep pattern and usual activities of choice. Report any changes to licensed nurses and when conflict arises, remove residents to a calm safe environment and allow (R25) to vent/share feelings. Review of R66's Care Plan tab in the EMR lacked documentation of an update for aggressive behavior demonstrated with the incident with R25 on 11/08/24. During an interview on 11/14/24 at 1:43 PM, the Regional Nurse Consultant and the Administrator on the phone confirmed the incident did occur and reviewed the progress notes for R25 and ongoing care of the injury were documented and R25 and R66 documented monitoring of psychosocial wellbeing and neither resident showed any lasting issues or concerns.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42440 Based on interview, record review, and facility policy review, the facility failed to report an allegation of resident-to-resident abuse to the state agency for two residents (Residents (R)52, R77) reviewed for abuse out of a sample size of 33. Findings include: Review of R77's admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 07/28/24 and located in the MDS tab of the electronic medical record (EMR), revealed he scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating intact cognition. He had no behaviors. Review of R52's admission MDS assessment, with an ARD of 08/27/24 and located in the MDS tab of the EMR, revealed she scored ten out of 15 on the BIMS, indicating moderately impaired cognition. She had no behaviors. Review of R54's quarterly MDS assessment, with an ARD of 08/20/24 and located in the MDS tab of the EMR, revealed she scored 13 out of 15 on the BIMS, indicated intact cognition. Review of R77's and R52's EMRs revealed no documentation of any allegation of resident-to-resident abuse. During an interview with R52 on 11/11/24 at 11:21 AM, she reported R77 slapped her across the face while she sat, talking to another resident, in the smoking area outside. R52 stated no one else saw the incident. R52 reported the facility took her report and told R77 to get off the premises, and if he returned, the police would arrest him. She stated she did not feel safe because of what R77 did. During an interview with R54 on 11/11/24 at 3:14 PM, R54 stated R52 had reported that R77 slapped her for no reason. The facility questioned R54 about what R52 said. Review of the facility provided Incidents by Incident Type report revealed no resident-to-resident incidents involving R52 or R77 were recorded. During an interview on 11/12/24 at 4:10 PM, the Administrator reported being aware of R52's allegation against R77 and stated the facility had a soft file of their investigation. During an interview on 11/13/24 at 3:54 PM, the Director of Nursing (DON) stated she found out about the allegation on 10/22/24 around 4:30 PM. Licensed Practical Nurse (LPN) 12 notified her, and the DON then reported it to the Administrator. R52 had told other residents on 10/21/24 that R77 slapped her, but staff did not hear about the allegation until 10/22/24. On 10/23/24, R52 told the DON she did not report to staff because her daughter was at the facility and took her to the police department. R52 reported she felt safe. R52's daughter told the DON she was not at the facility on 10/21/22 and had not taken, nor could not physically transport, R52 to the police station. The DON stated R52's story changed as she was interviewed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 5:35 PM, the DON stated she reached out to the Administrator, who said the facility did not report the allegation of resident-to-resident abuse to the state department because the algorithm the facility used did not indicate the need. Review of the facility's investigative soft file, revealed a form Resident to Resident Altercation Flowchart (Nursing Home Only) from the Department of Health Services/ Division of Quality Assurance, dated 06/2018. In response to the question, Did the other resident[s] suffer pain, physical injury, or psychological or emotional harm as a result of the altercation? the facility responded, no. The directive for this response on the flowchart was, Do not report. Document an immediate assessment showing no harm to the other resident[s]. During an interview on 11/14/24 at 12:49 PM, LPN12 said on 10/22/24 around 4:30 PM, she overheard a resident in the hall talking about the guy who slapped [R52] in the face last night. The resident told LPN12 that R52 told him of the incident. As LPN12 walked to report the allegation to the DON, she met R54 who stated R52 had reported to her on 10/21/22 that R77 had slapped her. When LPN12 went to R52, she stated, Yesterday, the guy [describing R77] slapped me. R52's story stayed consistent. During an interview on 11/14/24 at 5:38 PM, the DON stated she expected the facility to report abuse within two hours in certain situations. In Wisconsin, the abuse was not reported if the algorithm did not indicate it. The facility tried to get all the information within two hours to fill out the algorithm. The DON reported during her interview with R52, R52 stated she was not fearful and felt safe. The administrator is the abuse coordinator and decided not to report. Review of the facility's policy titled Abuse, Neglect, and Exploitation dated 01/05/24 indicated, The facility will have written procedures that include reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified time frames. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on record review, interviews, and policy review, the facility failed to ensure four of four residents (Residents (R) 331, 11, 57, 18) and/or their power of attorney (POA) reviewed for hospitalization , received written notice of transfer. Findings include: Review of the facility's Transfer and Discharge Guideline policy, dated 11/28/17, revealed that for a transfer or discharge the facility will provide a written notice to the resident and resident representative in a manner and language in which is understood. 1. Review of R331's electronic medical record (EMR), under the Census tab revealed she was originally admitted to the facility on [DATE] with diagnosis that included Myasthenia Gravis, metabolic encephalopathy, cognitive communication deficit, generalized muscle weakness, dementia, type 2 diabetes mellitus, and morbid obesity due to excess calories. Review of R331's most recent quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 08/19/24 and located in the MDS tab of the EMR, revealed she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS). Review of R331's EMR revealed a Health Status Note (nurses note), dated 08/31/24 at 1:10 PM. located under the Progress Notes tab, that read, CNA [Certified Nursing Assistant] notified that resident fell on her knees. Resident complained of knee and ankle pain. Resident was sent to the hospital for x-ray to be taken to make sure she nothing was broken. POA was notified and NP [Nurse Practitioner] as well as call Nurse. A document located in R331's EMR, under the Misc tab, titled Bed - Hold Notice revealed that Verbal Consent was given by the POA on 08/31/24. There is no information regarding transfer notices. 2. Review of R11's EMR, under the Census tab revealed she was originally admitted to the facility on [DATE] with diagnosis that included Parkinson's disease, quadriplegia (C1-C4), epilepsy, schizophrenia, and hallucinations. Review of R11's significant change in status MDS assessment, with an ARD of 10/07/24 and located in the MDS tab of the EMR, revealed she scored three out of 15 on the BIMS, indicating severely impaired cognition. R11 is also inattentive and disorganized at times. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Health Status Note (nurses note) in R11's EMR, dated 09/27/24 at 9:57 PM, located under the Progress Notes tab, read Was called to res [resident] room by CNA, res was sitting on her butt on the bathroom floor. She was in a trance. Would not acknowledge any staff. Would not let go of her right pant leg for me to check her vital signs. Her eyes were shifting back and forth rapidly. RN [Registered Nurse] was called to assess but res would not respond to her either. Behavior lasted about 15 minutes from 20:50-21:05 [sic], 911 was called. At this time, she did start acknowledging us a little, but was still not acting normal. arrived at 21:15. POA was notified and DON [Director of Nursing] was notified. NP updated. A document located in R11's EMR, under the Misc tab, titled Bed - Hold Notice revealed that Verbal was given by the POA on 08/31/24. There is no information regarding transfer notices. 3. Review of R57's significant change MDS, with an ARD of 07/29/24 and located in the MDS tab of the EMR, revealed his BIMS showed a score of two out of 15, indicating the resident's cognition was severely impaired. Review of R57's Admissions Record, located in the Profile tab of the EMR, revealed R57 was admitted to the facility on [DATE] with a diagnosis of heart failure, COPD and alcoholic cirrhosis of the liver. The Admission Record also noted R57 had an activated a POA. Review of R57's Census tab revealed non-active status from 05/30/24 to 06/01/24 and 07/15/24 to 07/23/24. Review of R57's Health Status Note, dated 05/31/24 at 4:04 AM and located in the EMR under the Progress Note tab, revealed, writer called for update on resident. He is admitted to [hospital] for observation about complaints of chest pain. Review of R57's Health Status Note, dated 07/15/24 at 8:54 PM and located in the EMR under the Progress Note tab, revealed, POA was notified of the resident being sent out to the hospital. Review of R57's Health Status Note, dated 07/16/24 at 11:42 AM and located in the EMR under the Progress Note tab, revealed, Resident admitted with AMS/UTI [altered mental status/ urinary tract infection] and sepsis. POA updated. Review of R57's Notice of Transfer/Discharge/Room Change forms, dated 05/30/24 and 07/15/24, attached to the Bed-Hold Notice form, located in the Misc tab of the EMR, revealed the POA was verbally notified of the transfer and bed hold policy. During an interview on 11/11/24 at 4:43 PM, the POA reported he received phone calls from the facility when the resident discharged to the hospital. He received no paper documentation. 2. Review of R18's Admission Record found in the Profile tab of the EMR with an admitted [DATE] and diagnosis of schizoaffective disorder bipolar type and alcohol use. Review of R18's annual MDS, with an ARD of 08/03/24 and located in the MDS tab of the EMR, revealed her BIMS showed a score of 13 out of 15, indicating the resident's cognition was intact. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R18's Census tab revealed non-active status from 04/02/24 to 04/10/24, 04/24/24 to 04/29/24, 07/15/24 to 07/23/24, 08/29/24 to 09/04/24, 10/10/24 to 10/15/24, and 10/23/24 to 10/29/24. Review of R18's Health Status Note, dated 04/02/24 at 8:49 PM and located in the EMR under the Progress Note tab, revealed, admitted [to hospital] with alcoholic ketoacidosis and GI [gastrointestinal] bleed. Review of R18's Health Status Note, dated 04/24/24 at 9:24 PM and located in the EMR under the Progress Note tab, revealed, Report from ER [emergency room], Resident transferred to room .at [hospital] for chronic anemia, urinary retention, and acute cystitis hematuria . Review of R18's Health Status Note, dated 07/15/24 at 11:45 AM and located in the EMR under the Progress Note tab, revealed, patient called 911 .left with EMTs [emergency medical transportation] willing. Review of R18's Health Status Note, dated 10/10/24 at 12:42 PM and located in the EMR under the Progress Note tab, revealed, [Resident] was sent out to the ER per NP request. Resident recently has had large fluctuations in electrolytes and abnormal labs. Review of R18's Health Status Note, dated 10/23/24 at 7:14 AM and located in the EMR under the Progress Note tab, revealed, patient reported left sided pain and nauseous [sic] and vomiting NP notified .stated it was okay to sent [sic] patient to the ER [sic] .picked up at 730. Review of R18's Notice of Transfer/Discharge/Room Change forms, dated 04/02/24, 04/24/24, 07/15/24, 10/10/24, and 10/23/24 and attached to the Bed-Hold Notice forms, located in the Misc tab of the EMR, revealed the facility verbally notified R18. During an interview on 11/11/24 at 1:11 PM, R18 reported a few recent admissions to the hospital. She received no written notice of discharge or bed hold that she could recall. During an interview on 11/14/24 at 1:19 PM, the Admissions Director reported she gave verbal notice of transfers to the residents who were their own people, or to the responsible party. The Admissions Director was instructed to go through the forms, get the verbal on the bed hold, and scan it into the EHR. She stated she called and wrote verbal on the Bed-Hold Notice form. During an interview on 11/14/24 at 5:38 PM, the Director of Nursing (DON) reported being unfamiliar with the regulations on the transfer forms. 37590

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 Based on record review, interviews, and policy review, the facility failed to ensure four of four residents (Residents (R) 331, R11, R57, R18) and or their power of attorney (POA) reviewed for hospitalization received written notice of the bed hold policy upon transfer to the hospital. This failure had the potential to cause confusion or distress regarding return to the same room after hospitalization for 83 residents. Findings include: Review of the facility's Bed Hold and Return Guideline policy, dated 04/25/19, revealed, The facility will provide written information to the resident or resident representative before the resident is transferred to a hospital or the resident goes on therapeutic leave that specified the following: - The duration of the state bed-hold policy during which the resident is permitted to return and resume residence in the nursing facility. - The reserve bed payment policy in accordance to the state plan. - The facility's policies regarding bed-hold periods permitting resident to return 1. Review of R331's electronic medical record (EMR), under the Census tab revealed she was originally admitted to the facility on [DATE] with diagnosis that included Myasthenia Gravis, metabolic encephalopathy, cognitive communication deficit, generalized muscle weakness, dementia, type 2 diabetes mellitus, and morbid obesity due to excess calories. Review of R331's most recent quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 08/19/24 and located in the MDS tab of the EMR, revealed she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS). Review of R331's EMR revealed a Health Status Note (nurses note), dated 08/31/24 at 1:10 PM. located under the Progress Notes tab, that read, CNA [Certified Nursing Assistant] notified that resident fell on her knees. Resident complained of knee and ankle pain. Resident was sent to the hospital for x-ray to be taken to make sure she nothing was broken. POA was notified and NP [Nurse Practitioner] as well as call Nurse. A document located in R331's EMR, under the Misc tab, titled Bed - Hold Notice revealed that Verbal Consent was given by the POA on 08/31/24. 2. Review of R11's electronic medical record (EMR), under the Census tab revealed she was originally admitted to the facility on [DATE] with diagnosis that included Parkinson's disease, quadriplegia (C1-C4), epilepsy, schizophrenia, and hallucinations. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R11's significant change in status Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 10/07/24 and located in the MDS tab of the EMR, revealed she scored three out of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. R11 is also inattentive and disorganized at times. A Health Status Note (nurses note) in R11's EMR, dated 09/27/24 at 9:57 PM, located under the Progress Notes tab, read Was called to res room by CNA, res was sitting on her butt on the bathroom floor. She was in a trance. Would not acknowledge any staff. Would not let go of her right pant leg for me to check her vital signs. Her eyes were shifting back and forth rapidly. RN was called to assess but res would not respond to her either. Behavior lasted about 15 minutes from 20;50-21:05, 911 was called. At this time she did start acknowledging us a little, but was still not acting normal. Bp was 182/96-72-18. EMT's arrived at 21:15. POA and DON [Director of Nursing] was notified. NP updated. A document located in R11's EMR, under the Misc tab, titled Bed - Hold Notice revealed that Verbal was given by the POA on 09/29/24. 3. Review of R57's Admissions Record, located in the Profile tab of the EMR, revealed R57 was admitted to the facility on [DATE] with a diagnosis of heart failure, COPD and alcoholic cirrhosis of the liver. The Admission Record also noted R57 had an activated a POA. Review of R57's significant change MDS, with an ARD of 07/29/24 and located in the MDS tab of the EMR, revealed his BIMS showed a score of two out of 15, indicating the resident's cognition was severely impaired. Review of R57's Census tab revealed non-active status from 05/30/24 to 06/01/24 and 07/15/24 to 07/23/24. Review of R57's Health Status Note, dated 05/31/24 at 4:04 AM and located in the EMR under the Progress Note tab, revealed, writer called for update on resident. He is admitted to [hospital] for observation about complaints of chest pain. Review of R57's Health Status Note, dated 07/15/24 at 8:54 PM and located in the EMR under the Progress Note tab, revealed, POA was notified of the resident being sent out to the hospital. Review of R57's Health Status Note, dated 07/16/24 at 11:42 AM and located in the EMR under the Progress Note tab, revealed, Resident admitted with AMS/UTI [altered mental status/ urinary tract infection] and sepsis. POA updated. Review of R57's Bed-Hold Notice form, dated 05/30/24, and located in the Misc tab of the EMR, revealed the POA was verbally notified of the bed hold policy. Review of R57's Bed-Hold Notice form, dated 07/15/24, and located in the Misc tab of the EMR, revealed the POA was verbally notified of the transfer and bed hold policy. During an interview on 11/11/24 at 4:43 PM, the POA reported he received phone calls from the facility when the resident discharged to the hospital. He received no paper documentation and no information regarding the bed hold timeframe nor cost. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of R18's Admission Record found in the Profile tab of the EMR with an admitted [DATE] and diagnosis of schizoaffective disorder bipolar type and alcohol use. Review of R18's annual MDS, with an ARD of 08/03/24 and located in the MDS tab of the EMR, revealed her BIMS showed a score of 13 out of 15, indicating the resident's cognition was intact. Review of R18's Census tab revealed non-active status from 04/02/24 to 04/10/24, 04/24/24 to 04/29/24, 07/15/24 to 07/23/24, 08/29/24 to 09/04/24, 10/10/24 to 10/15/24, and 10/23/24 to 10/29/24. Review of R18's Health Status Note, dated 04/02/24 at 8:49 PM and located in the EMR under the Progress Note tab, revealed, admitted [to hospital] with alcoholic ketoacidosis and GI [gastrointestinal] bleed. Review of R18's Health Status Note, dated 04/24/24 at 9:24 PM and located in the EMR under the Progress Note tab, revealed, Report from ER [emergency room], Resident transferred to room .at [hospital] for chronic anemia, urinary retention, and acute cystitis hematuria . Review of R18's Health Status Note, dated 07/15/24 at 11:45 AM and located in the EMR under the Progress Note tab, revealed, patient called 911 .left with EMTs [emergency medical transportation] willing. Review of R18's Interdisciplinary Team Note, dated 08/29/24 at 3:25 PM and located in the EMR under the Progress Note tab, revealed, Resident was being sent to the hospital today do [sic] to concerns with mental health. Resident is her own decision maker. When asked about the bed hold, she said no because she isn't coming back. Bed hold is declined, the document is signed and loaded into her file. Review of R18's Health Status Note, dated 10/10/24 at 12:42 PM and located in the EMR under the Progress Note tab, revealed, [Resident] was sent out to the ER per NP [Nurse Practitioner] request. Resident recently has had large fluctuations in electrolytes and abnormal labs. Review of R18's Health Status Note, dated 10/23/24 at 7:14 AM and located in the EMR under the Progress Note tab, revealed, patient reported left sided pain and nauseous [sic] and vomiting NP notified .stated it was okay to sent [sic] patient to the ER [sic] .picked up at 730. Review of R18's Bed-Hold Notice form, dated 08/29/24 and located in the Misc tab of the EMR, revealed R18 signed the Bed-Hold Notice. During an interview on 11/11/24 at 1:11 PM, R18 reported a few recent admissions to the hospital. She received no written of the bed hold policy that she could recall. During an interview on 11/14/24 at 1:19 PM, the Admissions Director reported she gave verbal notice of the bed hold policy to the residents who were their own people, or to the responsible party. Residents are offered bed holds but not charged unless the facility is at 98 percent of capacity. The Admissions Director was instructed to go through the forms, get the verbal on the bed hold, and scan it into the EHR. She stated she called and wrote verbal on the Bed-Hold Notice form. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/24 at 5:38 PM, the DON reported being unfamiliar with the regulations on the bed hold forms. 42440

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review, and policy review the facility failed to ensure the care plan included interventions for aggressive behavior, alcohol abuse with disruptive behaviors, and change of a urinary catheter from a Foley to a suprapubic urinary catheter for two of five residents (Resident (R)66 and R77) reviewed for abuse, one of three residents (R69) reviewed for urinary catheter care. As a result of this deficient practice the residents had the potential for lack of needed care and supervision. Findings include: 1. Review of R66's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with a readmission on 09/10/24 with medical diagnoses that included unspecified dementia, mild with agitation. Review of R66's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 09/16/24, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating R66 was severely cognitively impaired. Review of the investigation provided by the facility documented an incident between R25 and R66 on 11/08/24. Nursing reported that resident R25 accidentally rolled over the toes of resident R66. R66 then grabbed the arm of resident R25 and twisted [the arm] causing injury. This was a staff witnessed event. Staff were able to immediately intervene and separate residents to maintain safety. Review of R66's Care Plan tab in the EMR lacked documentation of an update for aggressive behavior demonstrated with the incident with R25 on 11/08/24. During an interview on 11/14/24 at 1:43 PM the Regional Nurse Consultant confirmed the care plan for R66, the aggressor in the incident on was 11/08/24, was not updated and should have been updated. During an interview on 11/14/24 at 3:16 PM, with the Director of Nursing (DON) confirmed the care plan for R66 should have been updated due to the aggressive behavior demonstrated by R66 in the incident with R25 on 11/08/24. Review of the facility policy titled Using the Care Plan, with no date, revealed Changes in the resident's condition must be reported to the MDS Assessment Coordinator so that a review of the residents' assessment and care plan can be made. 2. Review of R77's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnoses, which included alcohol dependence, uncomplicated. R77 was discharged on [DATE]. Review of R77's admission MDS assessment, with an assessment reference date (ARD) of 07/28/24 and located in the MDS tab of the EMR, revealed he scored 13 out of 15 on the BIMS, indicating intact cognition. He had no behaviors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R77's Progress Notes tab of the EMR, revealed entries regarding alcohol use: - On 09/06/24 at 6:39 PM, writer was called to resident room by floor nurse to try and obtain a bottle of alcohol. Resident refused to give the bottle to staff and has it hidden in is room. Since resident was under the influence of alcohol medications were held by floor nurse. -On 09/22/24 at 6:18 PM, Resident was out of facility earlier and returned under the influence of alcohol. Gait unstable when walking and using profanity as well. Writer updated NP [nurse practitioner] on meds [medications] held. -On 09/24/24 at 6:45 PM, Resident look like intoxicated returned back from outside gait unstable when walking and using profanity as well. Writer updated NP on meds held. -On 09/25/24 at 10:53 PM, Resident look like intoxicated returned back from outside gait unstable when walking and verbal abuse to staff and another resident. Writer updated NP and meds held. -On 09/29/24 at 9:48 PM, Resident returned back from outside drunk gait unstable when walking and writer updated NP and meds held. -On 10/04/24 at 10:24 PM, Resident look like intoxicated returned back from outside gait unstable when walking and using profanity as well. Writer updated NP on meds held. -On 10/19/24 at 8:43 PM, Patient educated on alcohol consumption. Patient consumed beer when returned from outing. Patient could barely walk in a straight line and was staggering all over the place. -On 10/20/24 at 6:38 PM, Resident returned from outing to room, when writer approached to indicated [sic] that dinner was in room resident smelled of alcohol and was stumbling with his steps. Writer asked resident if he had been drinking alcohol while out of the building and resident insisted that he was not but writer express that I could not give him any medications under the influence. Resident began yelling and was irate at writer and started to slur his words to get out of his room, writer exited room, resident continued to yell from inside of room. Resident will continued [sic] to be monitored. NP notified and on call. -On 10/21/24 at 8:31 PM, Resident came back to the facility intoxicated yelling and screaming through the building. Resident was redirected, and used vulgar language. Resident did not receive hs [bedtime] medications. Review of R77's Care Plan, located in the Care Plan tab of the EMR, initiated 07/22/24 with a next review date of 11/05/24 revealed no mention of R77's alcohol use, his behaviors, or any interventions the facility had in place. During an interview on 11/12/24 at 3:04 PM, Registered Nurse (RN) 1 stated that after R77 finished treatment for a foot infection, he started signing himself out of the facility and returned appearing intoxicated. RN1 notified his nurse practitioner or doctor as well as management each time. During an interview on 11/12/24 at 3:33 PM, Licensed Practical Nurse (LPN) 2 stated R77 signed himself out of the facility and returned intoxicated. His demeanor after drinking was arrogant, and he used foul language at times. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 4:18 PM, the Social Services Assistant (SSA), reported R77 signed himself out and went to the stores. When staff expected he had been drinking, the nurses were to notify unit managers. Social services did the cognition, mood, and behavior parts of the MDS and was responsible for those areas of the Care Plan, but sometimes nursing opened up a focus area if there was documentation of behaviors. During an interview on 11/13/24 at 4:39 PM, MDS Coordinator (MDSC) stated she heard about R77's alcohol use only once, so it was not on her radar for care planning purposes. If R77 had behaviors, the MDSC expected the Care Plan to address them. During an interview on 11/14/24 at 5:38 PM, the Director of Nursing (DON) stated she expected alcohol use with behaviors to be care planned. 3. Review of R69's Admission Record located in the Profile tab of the EMR revealed she was admitted to the facility on [DATE] and on 10/09/24 had a diagnosis entered of obstructive and reflux uropathy. Review of R69's significant change MDS assessment, with an ARD of 08/15/24 and located in the MDS tab of the EMR, revealed she scored three out of 15 on the BIMS, indicating severely impaired cognition. Review of an Appointment entry on 10/15/24 at 3:46 PM, located in R69's Progress Notes tab of the EMR, revealed, Resident returned back from an appointment with procedure placement of suprapubic urinary catheter. Review of R69's Order Summary, under the Orders tab of the EMR, revealed an order to clean around the suprapubic catheter site daily and apply a drain sponge, which originated 10/16/24. In addition, orders dated 10/15/24, included monitoring the suprapubic puncture site for symptoms of infection every shift and suprapubic catheter care every shift and as needed. Review of R69's Care Plan, located in the Care Plan tab of the EMR, revealed a focus area, dated 04/30/24, which stated R69 had an indwelling foley catheter. The Care Plan contained no information about the suprapubic catheter. During an interview on 11/14/24 at 5:38 PM, the DON stated she expected a suprapubic catheter to be care planned. 42440

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, record review, interview, and facility policy review, the facility failed to reconcile, transcribe, and administer medications to ensure medications were provided to residents as indicated or ordered for three residents reviewed (Resident (R) 12, R18, and R282) out of a sample of 33 residents. This failure had the potential to result in adverse health outcomes. Findings include: Review of the facility's Administering Medications policy, revised December 2012, revealed, The individual administering the medication must check the label three [3] times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. 1. Review of the Admission Record found under the profile tab of the electronic medical record (EMR) revealed the resident was admitted on [DATE] with a diagnosis of heart failure, restless legs syndrome, chronic obstructive pulmonary disease. Review of R12's quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 10/12/24, located in the MDS tab of the EMR, revealed R12 scored 13 out of 15 on the BIMS, which indicated intact cognition. Review of R12's Health Status Note, dated 10/18/24 at 6:00 PM and located in the EMR under the Progress Note tab, revealed, Resident returned via ambulance from [hospital] for acute on chronic respiratory failure with hypoxia and hypercapnia, N/O [new order] azithromycin [an antibiotic] 250mg [milligram] 1 tab PO [by mouth] for 2 days. Cefdinir [an antibiotic] 300mg 1 capsule bid [twice daily] for 10 days. Prednisone [a steroid] 20mg tablet take 2 tablets PO daily with breakfast for 4 doses . Review of R12's Physician Discharge Summary, dated 10/18/24 and located in the EMR under the Misc tab, revealed R12 had COPD, (chronic obstructive pulmonary disease) likely from community-acquired pneumonia. New medications ordered on discharge were: azithromycin 250mg daily for two days, cefdinir 300mg two times daily for ten days, and prednisone 20mg, two tablets, with breakfast for four doses. Review of R12's Medication Administration Record (MAR) located under the EMR Orders tab revealed the azithromycin, cefdinir, and prednisone were not put in the EMR as orders until 10/22/24 and were not administered until 10/22/24 evening. During an interview on 11/14/24 at 1:00PM, R12 stated she went to the hospital about a month ago and was supposed to start an oral antibiotic upon my return. R12 stated she did not get it for almost a week. During an interview on 11/14/24 at 5:38 PM, the Director of Nursing (DON) stated she expected nurses to put new antibiotic orders into the EMR within a few hours of a resident returning from the hospital so the medication was started as soon as possible. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's, Medication Orders policy, revised November 2014, revealed a current list of orders must be maintained in the clinical record of each resident. 2. Review of the Admission Record found under the Profile tab of the EMR revealed the resident was admitted on [DATE] with a diagnosis of Schizoaffective disorder, bipolar type, and alcohol use, unspecified Review of R18's annual MDS, with an ARD of 08/03/24 and located in the MDS tab of the EMR, revealed her BIMS showed a score of 13 out of 15, indicating the resident's cognition was intact. She had a diagnosis of manic depression (bipolar disease). Review of R18's Discharge Summary, dated 09/04/24, and located in the Misc tab of the EMR, revealed R18 discharged from the hospital. Her hospital course included a psychiatric consult for suicidal ideations, and her sertraline (an antidepressant) was increased to 250mg daily. Review of R18's Order Note, dated 09/09/24 and located in the EMR under the Progress Notes tab of the EMR, revealed the sertraline was decreased to 200mg daily. Review of R18's Health Status Note, dated 10/10/24 at 12:42 PM and located in the EMR under the Progress Note tab, revealed, [Resident] was sent out to the ER per NP [nurse practitioner] request. Resident recently has had large fluctuations in electrolytes and abnormal labs. Review of R18's Discharge Summary, dated 10/15/24, and located in the Misc tab of the EMR, revealed R18 discharged from the hospital. The medication list did not include sertraline, nor did it indicate the sertraline was discontinued. Review of R18's MAR, located under the EMR Orders tab revealed the facility administered the sertraline 200mg daily until she went to the hospital on 10/10/24. When R18 returned on 10/15/24, the order to administer sertraline was no longer on the MAR. Review of R18's Nursing Evaluation - v8, dated 10/15/24, and located under the EMR Evaluations tab revealed a medication reconciliation/review was completed with no findings. Review of R18's BH - Psychiatry Follow up note, dated 11/04/24 at 12:45 PM, and located in the EMR under the Progress Note tab, revealed Nurse Practitioner (NP) 2 documented, The patient had been on high-dose sertraline, however in review today it is no longer on her medication record. Not sure when it was discontinued. Medication has not made a difference in her depression in the past. Continue to monitor next visit consider restarting antidepressant therapy. During an interview on 11/14/24 at 10:47 AM, Unit Manager, Registered Nurse (UM) stated the medication reconciliation is done with the pharmacy and the in-house doctor or nurse practitioner, who confirmed the medication list. The facility used the hospital's discharge summary medication orders. R18 was followed by our in-house psychiatric provider and had medications reviewed monthly or quarterly. The UM was under the impression that the sertraline was weaned during the hospital stay. It was not typical to stop 200mg of sertraline quickly, but R18 had a history of refusing medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/14/24 at 3:24 PM, Licensed Practical Nurse (LPN) 2 stated when residents return from the hospital, the nurse reviewed the hospital's medication orders (changed, new, and continued) and verified those against previous orders. During an interview on 11/14/24 at 3:48 PM, NP2 stated she was unaware/not notified that the sertraline had dropped off R18's medication list until she wrote her 11/04/24 note in the Progress Notes tab of the EMR. The resident had tried several antidepressants, and none were helpful. Due to the high dose of sertraline, NP2 planned to wean the resident off it slowly, but since NP2 was not notified the hospital did not have the sertraline in their orders, she was unable. Typically, facilities notified her. She expected to be notified for tapering purposes since it was such a high dose. During an interview on 11/14/24 at 5:38 PM, the Director of Nursing (DON) stated due to the high dose of sertraline R18 was receiving, she expected nursing to notify NP2 shortly after R18's return from the hospital when the sertraline was not on the hospital discharge report. Review of the facility's Reconciliation of Medications on Admission policy, revised October 2010, revealed that staff needed the discharge summary from the referring facility and the most recent MAR, if the resident was a readmission. Using an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the previous MAR (if applicable), and the admitting orders. 3. Review of R282's Admission Record under the EMR Profile tab revealed she was admitted to the facility on [DATE]. R282 had diagnoses which included diabetes, dementia, and heart failure. Review of R282's Evaluations tab in the EMR revealed a Brief Interview for Mental Status (BIMS) score on 11/04/24 of seven out of 15, indicating the resident's cognition was severely impaired. Review of R282's Order Summary Report, located in the Orders tab of the EMR revealed orders which included: aspirin 325mg tablet by mouth daily and insulin glargine Solution 10 units subcutaneously one time a day. Review of R282's Medication Administration Record (MAR) under the EMR Orders tab revealed the aspirin and glargine insulin were scheduled for 9:00 AM. During an observation on 11/13/24 at 8:05 AM, Registered Nurse (RN) 4 checked R282's blood sugar. During an observation on 11/13/24 at 8:11 AM, RN4 obtained medications from the medication cart for R282. RN4 removed one tablet from a bottle of aspirin 81mg tablets and administered it with other 9:00 AM medications. She did not administer any insulin. During an interview on 11/13/24 at 8:17 AM, RN4 was asked if she had any additional medications to administer to R282 for the morning medication pass. She stated she would administer two addition oral medications from the contingency supply in the medication room after she administered medications to another resident. RN4 did not mention the insulin. During an observation on 11/13/24 at 8:36 AM, RN4 retrieved two pills from the contingency supply in the medication room and administered them to R282. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/13/24 at 8:50 AM, RN4 reported she had administered all of R282's morning medications. No other medications were scheduled. When RN4 was asked about insulin, she stated she gave it. When asked if she gave it prior to the blood sugar check, she stated no but then confirmed she had not administered any insulin during the observations, which started with the blood sugar check. RN4 reviewed the MAR, stated she had not given the insulin, retrieved it from the medication cart, and administered it. During an interview on 11/13/24 at 8:54 AM, RN4 verified she administered 81mg of aspirin instead of the ordered 325mg. During an interview on 11/13/24 at 3:31 PM, the Director of Nursing (DON) stated she instructed RN4 to write a medication error for the incorrect dose of aspirin she gave.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37590 Based on interviews, record review, and interviews, the facility failed to provide care in accordance with physician orders and the plan of care for one (Resident (R) 76) out of six residents reviewed for care planning, out of 33 sampled residents. Specifically, the facility failed to perform wound care treatments as ordered. Findings include: A review of the facility's Grievance Log, from January of 2024 through 11/11/24, revealed a grievance filed by R76 on 10/26/24. Per the log, it was reported to a nurse that R76 was upset wound care was not complete this weekend. The log also indicated the Director of Nursing (DON) was assigned to investigate on 10/29/24 and concluded with Discipline given to [employee]. [Education] provided on unacceptable performance and [reiterated] expectation. Review of R76's Facesheet, provided by the facility, revealed the resident was admitted on [DATE] with a primary admission diagnosis of aftercare following a surgical amputation. Secondary diagnoses included heart failure, type 2 diabetes mellitus, and acquired absence of the left leg below the knee. Review of admission Minimum Data Set (MDS) found in the EMR under the MDS Tab with an Assessment Reference Date (ARD) of 10/02/24, that R76 has a Brief Interview for Mental Status (BIMS) of 15 out of 15. An order found in R76's EMR, dated 10/02/24, read, Clean left leg BKA[below knew amputation] site with NS [Normal saline], pat dry, apply calcium alginate over wound bed, apply a long gauze border. Per the order, this treatment is scheduled to be completed once daily, and signs or symptoms of infection are to be reported to the residents' physician. Review of the Treatment Administration Record (TAR) for the month of October 2024, revealed the resident did not receive wound care on 10/26/24 or 10/27/24. In the corresponding date boxes are the staff members' initials and the Chart Code number 2, which indicates Drug Refused. Licensed Practical Nurse (LPN7) who indicated a refusal on the TAR, could not be reached for an interview. Review of the progress notes on the days indicated did not reveal a note corresponding to the charted refusals. R76's Care Plan revealed a focus stating the resident has an amputation of his left leg below the knee that was related to a diagnosis of diabetes mellitus and failure of the wound to heal. Interventions for this focus included checking and documenting on wound daily for signs or symptoms of infection, drainage, bleeding, skin breakdown, and impaired circulation. Another care plan focus related to R76's skin impairments, to include the surgical wound, revealed interventions that state Evaluate and treat per physicians' orders. (continued on next page)

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	525061	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with R76 on 11/12/24 at 3:15 PM, he stated that he did not recall putting in a grievance but added that the facility nursing staff have not been consistent with his wound care. R76 did confirm that he is provided weekly wound care from a provider outside of the facility and that care has been consistent and per the physician's orders. An interview was conducted with the Wound Care Registered Nurse (WCRN) on 11/13/24 at 11:02 AM, she confirmed that R76 is ordered to receive daily wound care, which consists of cleaning the surgical wound with normal saline and redressing. WCRN stated that she provides R76's wound care Tuesday through Friday and the nursing staff are to provide wound care on the weekends. She added that R76 sees a wound care provider outside of the facility, that provides weekly would assessments and cleaning. When asked if she was aware of R76 not receiving wound care per the physicians' orders, WCRN stated that R76 has a habit of refusals, especially if the care is not provided by one of the nurses that he fancies. WCRN did, however, add that her expectation of staff providing wound care is to document the refusal in the TAR and with a corresponding progress note. She also expects staff to reapproach and document that as well. During an interview with the Director of Nursing (DON) on 11/14/24 at 3:45 PM, she confirmed that education was provided to the staff member regarding not appropriately documenting the refusal as well as not passing that information on the next shift, so they could try offering wound as well. Review of the facility's policy Pressure Injury/Skin Integrity dated 11/28/17, revealed It is the policy of the facility to enable nursing staff to manage wounds and select appropriate interventions . The policy continues, stating that based on a resident's comprehensive assessment the facility will ensure the resident receives care, consistent with professional standards of practice. Review of the facility's Skin Management Guideline, dated 11/28/27, revealed residents that are admitted to the facility are evaluated to determine appropriate measures to be taken by the interdisciplinary care team to determine appropriate measures and individualized interventions to prevent, reduce and treat skin breakdown. It is the practice of this facility to properly identify and evaluate residents whose clinical conditions increased the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care. Review of the facility's Wound Care policy, dated October 2010, stated its purpose is to provide guidelines for the care of wounds to promote healing. The policy also confirms what should be recorded in the medical record, and that includes 9. If the resident refused the treatment and the reason(s) why. As well as Reporting to the supervisor if the resident refuses. 42440

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review and policy review, the facility failed to ensure physician orders for oxygen administration were followed and ensure residents with continuous positive air pressure (CPAP) had physician orders to administer the CPAP treatment for two of three residents (Resident (R) 30 and R36) reviewed for respiratory therapy. As a result of this deficient practice the residents had the potential for harm due to inaccurate oxygen administration and providing treatment without physician orders. Findings include: 1. Review of the facility's policy titled, Medication Orders revised November 2014, revealed Oxygen Orders - When recording orders for oxygen, specify the rate of flow, route and rationale. Review of R30's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] with medical diagnoses that included acute respiratory failure. Review of R30's admission Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 10/07/24, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R30 was cognitively intact. An observation on 11/11/24 at 2:00 PM, revealed R30 was in bed and the oxygen concentrator in the room was set at 5 liters per minute (LPM). Observation on 11/12/24 at 1:54 PM revealed the concentrator was set for 5 LPM and an observation on 11/13/24 at 2:40 PM the concentrator was set for 5 LPM. Review of R30's Orders tab in the EMR documented a Physician's Order, dated 10/01/24 that revealed Continuous O2 [oxygen] Via NC [nasal cannula] at 3 lpm every shift. Review of R30's Treatment Administration Record (TAR) dated for November 2024, documented three times a day R30's oxygen level at 3 LPM. Review of R30's Care Plan tab in the EMR documented a focus initiated on 10/01/24, The resident has oxygen therapy r/t [related to] respiratory failure, COPD [chronic obstructive pulmonary disease], with the intervention Oxygen setting: O2 via nasal prongs 3L continuously dated 10/02/24. Care plan lacked documentation of non-compliance by R30 to keep the O2 setting at 3 LPM. During an interview on 11/13/24 at 2:40 PM, Licensed Practical Nurse (LPN)1 confirmed the concentrator setting in the room for R30 was set for 5 LPM and confirmed the physician's order for R30's oxygen level was to be 3 LPM not 5 LPM. During an interview on 11/14/24 at 5:58 PM, the Director of Nursing (DON) confirmed the physician's orders were to be followed and the O2 level on the concentrator should have been set at 3 LPM not 5 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the facility policy titled CPAP/BIPAP Support, revised March 2015, revealed Review the physician's order to determine the oxygen concentration and flow, . pressure (CPAP .) for the machine. Review of R36's Admission Record located in the EMR under the Profile tab, revealed an admitted [DATE] and readmission on 11/07/24 with medical diagnoses that included obstructive sleep apnea. Review of R36's quarterly MDS located in the EMR under the MDS tab with an ARD of 10/03/24 revealed a BIMS score of three out of 15, indicating R36 was severely cognitively impaired. During an interview on 11/11/24 at 12:12 PM, R36's Family Member (FM)1 confirmed the CPAP mask was placed on R36 each night and removed in the morning. FM1 supplied the distilled water used to humidify the air for the CPAP treatment. Review of R36's Orders tab in the EMR lacked a physician's order for CPAP treatment. Review of R30's Treatment Administration Record (TAR), dated for October 2024, documented CPAP treatment each day in October. Review of R36's Care Plan in the EMR documented a focus initiated on 03/08/24, The resident has altered respiratory status/difficulty breathing r/t sleep apnea/asthma with an intervention, dated 03/08/24, BIPAP/CPAP SETTINGS: per home settings. During an interview on 11/13/24 at 2:58 PM, LPN1 confirmed R36's wears the CPAP at night as applied by LPN1. During an interview on 11/13/24 at 3:19 PM, LPN11 confirmed the CPAP was placed each night and reviewed the physician orders and confirmed there was no order for the CPAP treatment. LPN11 stated, prior to R36's hospital stay, there was an order for the CPAP and when R36 returned to the facility, the CPAP treatment order was continued without a physician's order. During an interview on 11/14/24 at 5:57 PM, the DON confirmed there should be an order for the CPAP treatment if being used and treatment orders from prior to a hospital admission should be evaluated upon readmission.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and facility policy review, the facility failed to ensure there was ongoing pre- and post-dialysis communication for a resident receiving dialysis three times a week for one out of one resident (Resident (R)59) reviewed for dialysis out of a sample of 33 residents. This had the potential to affect all residents receiving dialysis. Findings include: Review of R59's Face Sheet, located in the Profile tab of the EMR, revealed that R59 was readmitted on [DATE] with a diagnosis of end-stage renal disease (ESRD). Review of R59's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 09/22/24 located under the MDS tab of the EMR, revealed R59 scored 14 out of 15 on the BIMS, indicating no cognitive impairment. Further review revealed the resident received hemodialysis treatment. Review of R59's Care Plan, located under the Care Plan tab of the EMR dated 12/11/21, revealed the resident required dialysis three times weekly. Review of R59's Physician Orders located under the Orders tab in the EMR dated 11/14/24 revealed an order for dialysis Monday, Wednesday, and Friday. Review of R59 EMR revealed no pre- and post-dialysis communication forms completed. During an interview on 11/13/24 at 4:52 PM the Assistant Director of Nursing (ADON) stated they do not have dialysis communication forms. During an interview on 11/14/24 at 9:16 AM Licensed Practical Nurse (LPN) 1 said when a resident went out to dialysis they did not send a communication form to the dialysis center. She said they would communicate with dialysis as needed. She thinks there were folders floating around that had each resident's dialysis information. She said there was no information with weights or vitals that were sent or received when residents went to dialysis. They got the vitals before the resident went to dialysis, but that information was only doc in the medical records for the facility and was not shared. She said they did not get the residents weights before the resident went to dialysis. She said they would call if there were any concerns. During an interview on 11/14/24 05:20 PM the Director of Nursing (DON) said she knew facility staff communicated as needed with dialysis and the dialysis center would call and update the facility if there was a concern. There were no binders for dialysis residents but there used to be. She said they should be doing communication with the dialysis center regularly and they should be getting vitals and weights before and after dialysis. Review of the facility's policy titled Clinical Guide: Dialysis revised 01/2007 revealed communication between outpatient dialysis providers and facility should include: Written communication form with review of daily weights, and changes in condition or mood.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and facility policy review, the facility failed to ensure residents received medications as ordered by the physician for four of eight residents (Resident (R) 4, R33, R135, and R12) reviewed for medications of 33 sample residents. This failure could result in unwarranted medication side effects and mismanaged medical conditions. Findings include: 1. Review of R33's Admission Record, located in the Profile tab of the electronic medical record (EMR) revealed re-admission to the facility on [DATE] with a diagnosis of anemia in chronic kidney disease. Review of R33's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 09/10/24, revealed the Brief Interview for Mental Status (BIMS) score of 13 out of 15 indicating no cognitive impairment. Review of R33's care plan located under the "Care Plan" tab of the EMR and dated 05/20/24, revealed "The resident has anemia. Interventions in place were to give medications as ordered. Review of R33's Physician Order located under the Orders tab in the EMR, revealed an order on 10/24/24 for retacrit injection solution, inject 10000 intramuscularly in the evening every two weeks for low hemoglobin. Review of R33's Progress Note located under the Progress Notes tab of the EMR, dated 11/07/24, at 4:45 PM written by a Licensed Practical Nurse (LPN) revealed, retacrit injection was never released by pharmacy. The injection was due to be given on 11/06/24. Review of R33's Medication Administration Record (MAR) located under the Reports tab of the EMR, dated November 2024, revealed R33's injection solution was not administered on 11/06/24. During an interview on 11/13/24 at 2:06 PM the Unit Manger (UM) stated there was a verbal order she received on 10/24/24 for labs to be drawn and a dose of retacrit should have been administered on 11/06/24 if the labs showed R33 hemoglobin was under 10. She stated she faxed labs to the pharmacy on 10/24/24 but she did not check for a confirmation that the labs were received, and she did not follow up with the pharmacy to see if they received the labs. When she reached out to the pharmacy on 11/06/24 the labs could not be used since they were over two weeks old. She requested for stat labs, but the resident did not receive the retacrit dose on 11/06/24 and it was not administered until 11/08/24. During an interview on 11/14/24 at 2:21 PM the Pharmacist stated on 10/24/24 an email was sent to facility requesting current labs with hemoglobin levels and they contacted the facility by phone about the labs, but they were never received. They were contacted on 11/07/24 around 7:30 PM which was after their cut off time of 6:00 PM to send same day. The order for retacrit was sent around 8:35 AM on 11/08/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R4's Admission Record, located in the Profile tab of the EMR revealed re-admission to the facility on [DATE] with a diagnosis of rheumatoid arthritis. Review of R4's quarterly MDS under the MDS tab of the EMR, with an ARD of 08/24/24, revealed the BIMS score of 13 out of 15 indicating no cognitive impairment. Review of R4's care plan located under the "Care Plan" tab of the EMR and dated 01/04/19, revealed "The resident had a diagnosis of osteoarthritis related to rheumatoid arthritis (RA). Review of R4's Physician Order located under the Orders tab in the EMR, revealed an order on 04/28/24 for adalimumab pen injector kit 40 MG/0.8 ml inject one dose subcutaneously every evening every Tuesday related to rheumatoid arthritis. Review of R4's Medication Administration Record (MAR) located under the Reports tab of the EMR, May and August 2024, revealed R4 did not receive adalimumab (Humira) pen injector 40 mg on 05/07/24, 08/21/24 and 08/28/24. During an interview on 11/14/24 at 9:42 AM LPN13 said there was quite a few times medications were out, but she was unsure why they were not available. She assumed they were just not in stock. She was an agency nurse and was unsure what the process was to ensure medications were refilled before they ran out and the resident missed a dose. She stated when R4's medication was out she would let the oncoming nurse know. She stated if she documented on R4 Medication Administration Form that the medication was not administered it was because the medication was not available. During an interview on 11/14/24 05:29 PM the Director of Nursing (DON) stated nursing staff should ensure medication refills were ordered before the last dose, or a resident missed a medication. She felt there was a lack of communication between their EMR and the pharmacy that created issues. But she agreed that the facility staff should have done better about communicating and ensuring medications were received prior to the day the medication was due to make sure it was there in the facility to administer on the day it was scheduled to be administered. 3. Review of R135's Admission Record under the EMR Profile tab revealed she was admitted to the facility on [DATE]. R135 had diagnoses which included chronic pain. Review of R135's Progress Note tab of the EMR revealed an entry on 11/13/24 at 1:52 PM which documented a score on the BIMS of 15 out of 15. This score indicated intact cognition. Review of R135's Order Summary Report, located in the Orders tab of the EMR revealed orders which included: glucosamine-chondroitin oral tablet (glucosamine-chondroitin-vitamin C-Manganese) 1 tablet by mouth one time a day. During an observation of R135's morning medication administration on 11/13/24 from 8:19 AM to 8:35 AM, Registered Nurse (RN) 4 did not administer the glucosamine-chondroitin. During an interview on 11/13/24 at 8:51 AM, RN4 stated she was only able to find a bottle of glucosamine sulfate KCL 500mg (60mg chloride). RN4 stated she needed to call the nurse practitioner to clarify the order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R282's MAR under the EMR Orders tab, on 11/13/24, revealed she had not received the glucosamine-chondroitin for the two scheduled doses since her admission. During an interview on 11/14/24 at 11:44 AM, R282 stated she took glucosamine for knee pain. R282 verified she had not received the medication since she admitted . She stated it is an over-the-counter medication, and she understood the facility did not have it yet. Review of the facility's Medication Orders procedure, revised November 2014, revealed when recording orders for medication, specify the type, route, dosage, frequency, strength, and the reason to be administered. 4. Review of R12's quarterly MDS assessment, with ARD of 10/12/24, located in the MDS tab of the EMR, revealed R12 scored 13 out of 15 on the BIMS, which indicated intact cognition. Review of R12's Health Status Note, dated 10/11/24 at 3:59 PM and located in the EMR under the Progress Note tab, revealed, Resident has new order for carbidopa ER 25mg-lovodopa 100mg ER, Resident called [doctor] for neurology and stated she could not stand her restless legs while at dialysis today and the [doctor] prescribed a low dose of this medication. Review of R12's Order Summary Report, located in the Orders tab of the EMR revealed an order dated 10/18/24 for carbidopa 25mg-levodopa 100mg ER three times a day. Review of R12's MAR under the EMR Orders tab revealed an active order for carbidopa-levodopa, scheduled three times a day, which started 10/11/24 and resumed 10/18/24 following a hospitalization . Review of R12's MAR, on 11/13/24, revealed that in November, nursing had documented 9 which indicated other/see nurses note 23 times, 3 which indicated absent from home five times, and 5 which indicated hold/see nurse note twice. Review of R12's Progress Note tab, located in the EMR, revealed 27 notes from 11/01/24 to 11/13/24 of the carbidopa-levodopa being unavailable. Nursing documented awaiting pharmacy, on order, out. A Health Status Note on 11/03/24 at 10:09 PM stated, Writer phoned [pharmacy] in regards to resident's missing medication carbidopa-levodopa 25-100mg. Technician stated [three] cards a total of 90 tablets were sent out on 10/16/24. Writer pulled med from contingency. An eMAR note on 11/05/24 at 9:03 PM stated the medication was coming on the next pharmacy delivery. Some notes, beginning 11/08/24 documented the pharmacy planned to deliver the medication on 11/13/24. There was no documentation regarding doctor or nurse practitioner notification of the missing medication. During an observation on 11/13/24 at 9:08 AM, LPN9 administered R12's morning medications. LPN9 stated the carbidopa-levodopa was not available. It was on hold because of something with insurance but was schedule to arrive that day. During an interview on 11/13/24 at 2:54 PM, LPN2 stated she wrote a note regarding R12's carbidopa-levodopa not being available when she called the pharmacy earlier in the month. She stated she spoke to the Unit Manager, RN (UM) because the pharmacy stated the medication was not covered by insurance since they had sent a month's supply, and it was too early to send more. LPN2 stated the UM instructed her to tell the pharmacy to bill the facility, which she did. When she last worked with R12, the medication (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was available in contingency. During an interview on 11/13/24 at 3:03 PM, the UM stated she gave LPN2 permission for the pharmacy to bill the facility for the medication. She stated she was not aware nursing had documented other/see nurses note 23 times on the MAR in November. The UM stated she planned to talk to the administrator and DON, contact pharmacy, and check on the neurologist's involvement. During an interview on 11/13/24 at 3:31 PM, the DON stated pharmacy was expected to provide medications the facility did not have in stock, within 24 hours. During a follow up interview on 11/14/24 at 9:10 AM, the DON stated staff documented in the eMAR Progress Notes many times that the carbidopa-levodopa was ordered. The order came through in October, and R12 was out and back to the hospital, and she believed the pharmacy lost the medication. During an interview on 11/14/24 at 1:00PM, R12 stated she was aware she had not received her carbidopa-levodopa. R12 stated, To be honest, my restless legs were the least of my concern because about a month ago I was sent out to [the hospital] and was supposed to start an oral antibiotic upon my return. I did not get it for almost a week. During an interview on 11/14/24 at 2:20 PM, the Pharmacist stated the pharmacy sent a six-day supply (18 pills) of the carbidopa-levodopa on 10/11/24. Then on 10/16/24, they sent a 30-day supply (90 pills). The three cards of pills were signed for by the facility on 10/16/24 at 1:29 PM. The pharmacy scanned returned medications into their system, and they had no record that the facility returned the medication to the pharmacy. On 11/05/24 the facility stated to bill them, but the medication was on back order. The facility had the medication in immediate release form in their contingency supply and had pulled two doses for R12, which was an appropriate substitution if the doctor provided an order. 42440

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, record review, interview, and facility policy review, the facility failed to ensure a medication error rate of less than five percent during observation of medication administration. The facility had four errors in thirty-one opportunities, which resulted in a 12.9 percent error rate. This affected two (Resident (R) 135, and R12) out of three residents observed. Medication errors have the potential to result in adverse health outcomes. Refer to F658 and F755. Findings include: Review of the facility's Adverse Consequences and Medication Errors policy, revised August 2014, revealed, the definition of a medication error is the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. Examples of medications errors include: omission - a drug is ordered but not administered, .wrong dose, . 1. Review of R135's Admission Record under the EMR Profile tab revealed she was admitted to the facility on [DATE]. R135 had diagnoses which included chronic pain. Review of R135's Progress Note tab of the EMR revealed an entry on 11/13/24 at 1:52 PM which documented a score on the BIMS of 15 out of 15. This score indicated intact cognition. Review of R135's Order Summary Report, located in the Orders tab of the EMR revealed orders which included: glucosamine-chondroitin oral tablet (glucosamine-chondroitin-vitamin C-Manganese) 1 tablet by mouth one time a day. During an observation on 11/13/24 from 8:19 AM to 8:35 AM, RN4 checked R135's blood sugar, gathered medications from the medication cart, and administered medications to R135. RN4 did not administer the glucosamine-chondroitin. During an interview on 11/13/24 at 8:51 AM, when asked if R135's had received all her morning medications, RN4 stated she had. When asked about the glucosamine-chondroitin, RN4 stated she had to look for it in the medication room. RN4 retrieved a bottle of glucosamine sulfate KCL 500mg (60mg chloride). RN4 stated the order had no dose listed so she was not giving the medication and needed to let the nurse practitioner know. Review of R282's MAR under the EMR Orders tab revealed she had not received the glucosamine-chondroitin for the two scheduled doses since her admission. During an interview on 11/14/24 at 11:44 AM, R282 stated she took glucosamine for knee pain. R282 verified she had not received the medication since she admitted . She stated it was an over-the-counter medication and she understood the facility did not have it yet. 2. Review of the Admission Record found under the Profile tab of the EMR revealed the resident was admitted on [DATE] with a diagnoses of heart failure, restless legs syndrome, chronic obstructive pulmonary disease. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R12's quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 10/12/24, located in the MDS tab of the EMR, revealed R12 scored 13 out of 15 on the BIMS, which indicated intact cognition. Review of R12's Order Summary Report, located in the Orders tab of the EMR revealed an order dated 10/18/24 for carbidopa 25mg-levodopa 100mg ER three times a day. During an observation on 11/13/24 at 9:08 AM, Licensed Practical Nurse (LPN) 9 administered R12's morning medications. LPN9 stated the carbidopa-levodopa was not available. It was on hold because of something with insurance but was due to be delivered that day. During an interview on 11/13/24 at 2:54 PM, LPN2 stated she put in a note regarding R12's carbidopa-levodopa not being available when she called pharmacy earlier in the month. She stated she spoke to the Unit Manager, Registered Nurse (UM) because the pharmacy stated the medication was not covered by insurance since they had sent a month's supply, and it was too early to send more. LPN2 stated she was instructed to tell the pharmacy to bill the facility. During an interview on 11/13/24 at 3:31 PM, the Director of Nursing (DON) stated she instructed RN4 to write a medication error for the incorrect dose of aspirin she gave. A medication error report was to be be completed if a resident received an incorrect medication or if they had not received a scheduled medication. Pharmacy provided medications the facility did not have in stock, and it was expected that R135's glucosamine-chondroitin was available to administer. During an interview on 11/14/24 at 9:10 AM, the DON stated staff documented in the eMAR progress notes that R12's carbidopa-levodopa was ordered many times. The order came through in October, and R12 was out and back to the hospital, and she believed the pharmacy lost the medication. During an interview on 11/14/24 at 1:00PM, R12 stated she was aware she was not getting her carbidopa-levodopa. R12 stated, To be honest, my restless legs were the least of my concern because about a month ago I was sent out to [the hospital] and was supposed to start an oral antibiotic upon my return. I did not get it for almost a week. During an interview on 11/14/24 at 2:20 PM, the Pharmacist stated the pharmacy sent a six-day supply (18 pills) of the carbidopa-levodopa on 10/11/24. Then on 10/16/24, they sent a 30-day supply (90 pills). The three cards of pills were signed for by the facility on 10/16/24 at 1:29 PM. The pharmacy scanned returned medications into their system, and they had no record that the facility returned the medication to the pharmacy. On 11/05/24 the facility stated to bill them, but the medication was on back order. The facility had the medication in immediate release form in their contingency supply and had pulled two doses for R12, which was an appropriate substitution if the doctor provided an order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, staff interview, and review of facility policy, the facility failed to ensure that one of medication carts on Unit 3 Hall was secure when staff were not present. This had the potential to affect all residents on that hall or who were walking by the cart. As well as the facility failed to sure resident medication were secure at time of administration for one for 33 sampled resident (R37.) Findings include: 1. Observation on 11/11/24 at 10:12 AM revealed a medication cart sitting in the hallway outside room [ROOM NUMBER] was not locked and the computer screen was slightly pushed down but the screen was not locked. There was one resident in a wheelchair using the cart to pull himself past in his wheelchair. There was a housekeeping staff, therapy staff and a visitor that walked by. During an interview on 11/11/24 at 10:17 AM Licensed Practical Nurse (LPN) 6 walked up and stated she knew it was unlocked. She did not answer any questions and stated, it's locked now and walked away. During an interview on 11/14/24 at 5:10 PM the Director of Nursing (DON) stated it was a basic expectation that nurses leave their medication carts locked and secured. She said they should definitely lock it before they walk away. Nursing staff have been educated numerous times and it's a basic of nursing. Review of the facility's policy titled, Security of Medication Cart, revised April 2007 revealed, medication carts must be securely locked at all times when out of the nurse's view. 2. Review of the Resident Council Meeting Minutes, dated 09/09/24, documented Nurses are leaving medications on tables and walking away not making sure the residents are taking them. Nurses are also leaving medications in rooms where the residents are not in instead of finding them. The Director of Nursing (DON) was going to provide re-education to nurses that this is not acceptable practice. During an interview on 11/13/24 at 2:34 PM, the DON explained after the resident council meeting in September 2024, an inservice education was done with the nursing staff about not leaving medications at the bedside when the resident was unavailable. Review of R37's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] and readmission on 04/25/24 with medical diagnoses that included acute respiratory failure and muscle weakness Review of R37's annual Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 09/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating R37 was cognitively intact. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 11/11/24 at 2:20 PM, revealed R37 was in bed, facing the window with the bedside table behind R37. On the bedside table was a medicine cup with three pills. Interview at time of observation R37 verbalized the nurse left them there for me. An interview on 11/11/24 at 2:26 PM, Licensed Practical Nurse (LPN)10 confirmed leaving the pills at the bedside and said to the R37 I thought you took those. R37 responded No, I was sleeping. During an interview on 11/14/24 at 6:06 PM the Director of Nursing (DON) confirmed that medications were not to be left at the bedside unsecured, that if the resident was not available to administer the medication (sleeping) the medications were to be secured and offered at later time. Review of facility policy titled Medication Administration, revised 12/2012, revealed For residents not in their rooms or otherwise unavailable to receive medication on the pass, the Medication Administration Record (MAR) may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication. 40902

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 40902 Based on interviews, personnel file review, and review of the job description, the facility failed to ensure a qualified person was designated to serve as the Director of Food and Nutrition Services for 83 of 83 census residents. This failure had the potential to affect kitchen sanitation and resident quality of care related to food and nutrition. Findings include: Review of the personnel record for the Dietary Manager (DM) included no education related to food services. During an interview on 11/14/24 at 8:23 AM, the Dietary Manager (DM) said she has been in her position with the facility for about a year. She was not aware that she needed to be certified. She said nobody has ever asked her about her certification or informed her that she needed to have any certification. She knew it would be better to have but did not know she needed it. She said she will be taking an exam on Friday for the Managerial ServSafe certification. During an interview on 11/13/24 at 3:42 PM, the Administrator stated she was not sure about the DM's certification but stated she was enrolled and had an examination Friday.

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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. 40902 Based on observation, interview, and facility policy review, the facility failed to ensure food prepared by the facility was served at a palatable temperature for five of six residents (Resident (R) 34, R285, R9, R64 and R54) reviewed for palatability of 33 sample residents. As a result of this deficient practice the residents had the potential for poor nutrition and weight loss. Findings include: 1. Review of R34's quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/03/24, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated the resident moderate cognitively impairment. During an interview on 11/11/24 at 11:00 AM R34 stated the food could be better and that it always arrived cold during all meals. 2. Review of R285's entry tracking MDS assessment with an ARD of 10/28/24, revealed no BIMS assessment was completed. During an interview on 11/11/24 at 11:12 AM R235 stated the food sucked. There was no variety or flavor, and they did not provide condiments. 3. Review of R9's quarterly MDS assessment with an ARD of 09/28/24, revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. During an interview on 11/11/24 at 11:15 AM R9 stated the food sucked. It was not cooked properly, and they did not provide condiments. 4. Review of R30's entry tracking MDS assessment with an ARD of 10/07/24, revealed no BIMS assessment was completed. During an interview on 11/11/24 at 1:59 PM R30 stated the food was kind of the same all the time, and it was served cold many times. 5. Review of R64's annual MDS assessment with an ARD of 07/29/24, revealed a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. During an interview on 11/11/24 at 3:16 PM R64 said the food was substandard and it was not the correct temperature when it was served. 6. Review of 54's quarterly MDS assessment with an ARD of 08/20/24, revealed a BIMS score of 13 out of 15 which indicated the resident was cognitively intact. During an interview on 11/11/24 at 3:16 PM R54 stated the food was always cool when it gets to them. They offer alternatives but it was never anything they liked. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 11/14/24 at 11:40 PM of lunch preparation the rice was 195 degrees, chicken patty was 171 degrees, and the broccoli was 146 degrees on the steam line. A test tray left the kitchen at 11:59 AM carrying 15 trays. The last tray was passed at 12:11 PM. The temps taking on test tray with the Dietary Manager (DM) present were rice was 124, chicken patty was 111 and the broccoli was 112 degrees. Licensed Practical Nurse (LPN)9 tested the tray and stated the chicken patty was rough to chew. LPN9 spit it out of her mouth and said no, no, no and stated she could not chew it anymore. She said the rice and broccoli was cold and bland. During an interview on 11/14/24 at 12:31 PM the DM stated they do use plate warmers and that has helped a lot. She was surprised to hear that the food was not warm or palatable. She said there have been concerns in the past by residents about food temperatures, but she was not aware of any current ones. During an interview on 11/14/24 at 5:16 PM the Director of Nursing (DON) stated that the packages of food the facility orders were the top tear trays. She stated she expected food resident could chew and enjoy. Review of the facility' policy titled, Food Service Preparation revised July 2014 revealed, food service employees shall prepare food in a manner that complies with safe food handling practices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, record review, interview, and policy review, the facility failed to follow infection prevention standards during a medication pass, which included not disinfecting glucometer's between residents, for two of two residents (Resident (R) 282, R135) observed. This created a potential for the transmission of blood borne illness to residents who had blood sugar checks. Findings include: Review of the facility's Handwashing/Hang Hygiene policy, revised August 2014, revealed, Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after coming on duty; before and after direct contact with residents; before preparing or handling medications; . After contact with a resident's intact skin; .After removing gloves; . Review of the facility's Blood Glucose Meter Cleaning policy, dated 10/05/18, revealed, If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over blood and infectious agents. The disinfectant recommended by our facility: Clorox Bleach Germicidal Wipes. 1. Review of R282's Admission Record under the electronic medical record (EMR) Profile tab revealed she was admitted to the facility on [DATE]. R282 had diagnoses which included diabetes. Review of R282's Order Summary Report, located in the Orders tab of the EMR revealed orders which included: blood glucose monitoring two times a day and blood sugar check at bedtime, both with order dates of 11/01/24. Review of R282's Evaluations tab in the EMR revealed a Brief Interview for Mental Status (BIMS) score on 11/04/24 of seven out of 15, indicating the resident's cognition was severely impaired. 2. Review of R135's Admission Record under the EMR Profile tab revealed she was admitted to the facility on [DATE]. R135 had diagnoses which included diabetes. Review of R135's Order Summary Report, located in the Orders tab of the EMR revealed orders which included: glucose monitoring four times a day, ordered 11/11/24. Review of R135's Progress Note tab of the EMR revealed an entry on 11/13/24 at 1:52 PM which documented a score on the BIMS of 15 out of 15. This score indicated intact cognition. During an observation on 11/13/24 at 8:05 AM, the medication cart, in-use by Registered Nurse (RN) 4, had an open, unlabeled, plastic bag of snack crackers and a personal mug with a lid on top of the cart as well as dated applesauce containers and a pitcher of water for use with the medication pass. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/13/24 at 8:05 AM, RN4 removed an unlabeled glucometer from the top drawer of the medication cart and placed the glucometer on top of the cart without a barrier between the cart and glucometer. RN4 put on gloves without performing hand hygiene prior, and checked R282's blood sugar, setting the glucometer on the table by the resident without a barrier before and after the check. RN4 then transferred the glucometer to the top of the medication cart. RN4 removed the test strip from the glucometer and discarded it and her gloves before picking up the glucometer with her bare hands and placing it back in the top drawer of the cart. No hand hygiene was completed. The glucometer was not cleaned. During an observation on 11/13/24 at 8:11 AM, RN4 proceeded from placing the glucometer in the cart to preparing pills and administering them to R282 without hand hygiene prior. RN4 returned to the medication cart, and at 8:19 AM, she removed the same uncleaned glucometer she had used for R282, placed it on top of the cart without a barrier, and put on gloves without hand hygiene prior. RN4 placed the glucometer on the tray table in front of the R135 without a barrier prior to checking R135's blood sugar. RN4 brought the glucometer to the medication cart, placed it on top, and removed the test strip and her gloves and discarded them. Without performing hand hygiene, RN4 went down the hall to get R135's insulin. When she returned to the cart, she used her bare hands to place the glucometer back in the top drawer, without cleaning it. RN4 obtained medications from the cart, prepared the insulin pen, administered pills and insulin to R135 without any hand hygiene before of after. RN4 coughed into her left hand twice, and without performing hand hygiene, RN4 retrieved two medications from the medication room and administered them to R282 prior to retrieving insulin from the cart and also administering it to R282 without any hand hygiene. During an interview on 11/13/24 at 8:55 AM, RN4 stated the facility glucometer's were not labeled for individual use and were used on multiple residents. RN4 stated she was to use cleaners or wipes to clean the glucometer between residents, but she did not have any. RN4 stated she needed to perform hand hygiene all the time during the medication pass RN4 verified she had removed her personal food items from the cart after the two residents received their medications and stated the items were not to be on the cart. During an observation on 11/13/24 at 12:02 PM, Licensed Practical Nurse (LPN) 7 used a Clorox healthcare wipe and wiped the glucometer after use. LPN7 then wrapped the glucometer in the wipe and stated she used a different glucometer, if needed, while the wrapped glucometer sat for a few minutes. During an interview on 11/13/24 at 3:31 PM, the Director of Nursing (DON) stated shared glucometer's were expected to be cleaned with Clorox wipes per facility policy. The glucometer's manufacturer's guidance recommended a Medline disinfectant. The DON stated she expected hand hygiene by staff between residents, after donning/doffing gloves, and after coughing. Personal food items of staff were not to be on the medication carts.